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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiverï¿½s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

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

B. Program Title:
Comprehensive Developmental Disabilities Services waiver

C. Waiver Number:NE.4154
Original Base Waiver Number: NE.4154.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/25
Approved Effective Date of Waiver being Amended: 03/01/22

2. Purpose(s) of Amendment

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

Update Public Input (Main-6.Additional Requirements);
Correct spelling and grammar mistakes (All Appendixes);
Update all mentions of the ICAP to the state-mandated ICF/IID level of care assessment tool;
Specify the target group for eligibility and enrollment in the CDD waiver (Appendix B-1);
Select option that the state does not limit the number of participants that it serves at any point in time during a waiver year (Appendix B-3b);
Removed reserved capacity (B-3-c);
Update Level of Care (LOC) criteria and process for evaluation/reevaluation (Appendix B-6);
Replace Individual Support Plan (ISP) language with person-centered plan (PCP) (Appendix B-6);
Update Qualifications of Individuals Performing Initial Evaluation (Appendix B-6);
Replace Disabilities Service Specialist (DSS) with DDD personnel (Appendix B-6, B-Quality Improvement);
Specify plan access to services for individuals with Limited English Proficiency (LEP) (Appendix B-8);
Allow for payment to Legally Responsible Individuals (LRIs) and Relatives/Legal Guardians (Appendix C-2);
Revise Service Specifications for the following services (Appendix C-1/C-3):
- Home Modifications;
- Vehicle Modifications;

Update language for all services related to school hours set by the local school district (Appendix C-1/C-3);
Update language for all services that offer virtual supports as a modality to remote supports (Appendix C-1/C-3);
Remove EVV requirement from the following services:
- Medical In-Home; and
- Behavioral In-Home.

Break out Residential Habilitation into the following separate services (Appendix C-1/C-3):
- Continuous Home;
- Host Home;
- Shared Living; and
- Youth Continuous Home;

Add the following services to better address participant needs (Appendix C-1/C-3):
- Benefits Counseling;
- Employment Exploration;
- Health Maintenance Monitoring;
- LRI Personal Care
- Remote Supports; and
- Adult Day Retirement.

Remove the following service (Appendix C-1/C-3):
- Therapeutic Residential Habilitation.

Update applicable services to include services may be offered by legal guardians (Appendix C-1/C-3);
Update Qualifications of Service Coordinators (Appendix D-1);
Update Participant Direction of Services (Appendix E-1);
Update reasons for grievances (Appendix F-3);
Update language to comply with the HCBS Final Settings Rule (Appendix G-1);
Added Critical Incident performance measure (Appendix G-Quality Improvement);
Update supervision requirements for board-certified behavioral analysts (BCBAs) (Appendix C-1/C-3, G-2);
Updated services that require the use of EVV (Appendix I-1);
Add risk tiers (Appendix I-2); and
Update cost analysis information (Appendix J-2).

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**	
☒ **Appendix A ? Waiver**	

Component of the Approved Waiver	Subsection(s)
Administration and Operation	
☒ Appendix B ? Participant Access and Eligibility	1, 3, 6, 8
☒ Appendix C ? Participant Services	1, 2, 3
☒ Appendix D ? Participant Centered Service Planning and Delivery	1
☒ Appendix E ? Participant Direction of Services	1
☒ Appendix F ? Participant Rights	3
☒ Appendix G ? Participant Safeguards	1, 2, Quality Improvement
☒ Appendix H	
☒ Appendix I ? Financial Accountability	2
☒ Appendix J ? Cost-Neutrality Demonstration	2

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

☒ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☒ **Add/delete services**

☒ **Revise service specifications**

☒ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☒ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

Update language to comply with HCBS Final Settings Rule;
Correct spelling and grammar mistakes.

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

1. Request Information (1 of 3)

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

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

Comprehensive Developmental Disabilities Services waiver

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.4154
Draft ID: NE.002.07.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 03/01/22
Approved Effective Date of Waiver being Amended: 03/01/22

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 in 42 CFR § 440.160**

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

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

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

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

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Purpose:
The Nebraska Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) offers a menu of services and supports intended to allow people with intellectual or developmental disabilities (DD) to maximize their independence as they live, work, socialize, and participate to the fullest extent possible in their communities. Services have been added and modified to encourage and promote the full vision of the HCBS Settings Waiver Transition Plan requirements. We continue to encourage services, which are self-directed as well as offered by either an independent or agency provider to ensure the maximum flexibility for the participants served under this waiver.

Participant-directed services, delivered by independent providers, are services directed by the participant, their legal representative, or family/advocate. Participant-directed services are intended to give the participant more control over the type of services received, as well as control or choice of the direct providers of those services.

Agency-based services are habilitative services providing residential and day habilitative training and are delivered by certified DD agency providers with the exception of Respite, which are non-habilitative by design. Independent services are self-directed by the participant with their representative as needed; they are habilitative in nature except Respite.

Goals and Objectives:
To offer participants an array of services, which focus on choice, independence, employment, community inclusion, and integration to meet the needs and wants of the participant by:
•Encouraging the use of community-based services rather than institutionalized care in an Immediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or nursing facility for participants whose needs can be met by community-based developmental disability providers.
•Promoting a high quality of service delivery in community-based services, which supports inclusion, integration, employment, and choice.
•Expanding participant direction of services.
•Providing an opportunity for participants to transition from school-based programs to adult services, thus ensuring the continuation of skill development.

Organizational Structure and Service Delivery:
DDD, a Division within the Single State Medicaid agency, administers the Home and Community-Based Services (HCBS) Developmental Disabilities (DD) Comprehensive waiver, which serves children and adults with no maximum age limit.

Designated DHHS personnel and a provider screening and enrollment vendor enroll all agency and independent providers as Medicaid providers. Specialized DHHS personnel, DD Surveyors, certify DD provider agencies. DDD supports the free choice of participants and their legal representatives to select from the available pool of agency-based and independent providers to deliver services and supports, with assistance as needed provided by DDD service coordination. DDD service coordination is funded as a Medicaid State Plan targeted case management service. Designated DDD personnel,EWaiver Services Specialists, complete the initial level of care (LOC) evaluations, and eligibility and service coordination personnel complete LOC reevaluations. Services are prior authorized by DDD personnel, and individualized funding is based on an objective assessment process.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 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 section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are 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 public input process for this waiver amendment is done in accordance with 42 CFR 441.304(f). The following strategies are used to secure public input for the 4154 amendment:

Specific to Tribal Notice, the public comment period allows at least 30 days for comment before the anticipated submission date and per the Nebraska State Plan, includes written 30 day notification to all federally-recognized Tribal Governments which maintain a primary office or majority population within the State in accordance with section 5006(e) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), Indian health programs, and Urban Indian Organizations. The Tribal Notice for the 4154 amendment was distributed on September 11, 2024. The Tribal Notices are available through DHHS Division of Medicaid and Long Term Care (DHHS-MLTC) and DHHS-DDD.

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

DHHS-DDD conducted presentations via webinar on September 12, 2024. During the public comment period from September 11 to October 11, 2024, DHHS solicited input through: virtual and telephonic opportunities with tribal representatives; waiver participants; families; guardians; advocates; providers; the DHHS public website; and submitted a non-electronic public notice in the Omaha World Herald, a newspaper with statewide circulation.

The state provided statements of public notice and public input procedures. DHHS's public website contained public notice; the draft waiver amendment application; a link to e-mail questions or comments; and a contact and address to mail comments.

Full details of the public comment are available online at: dhhs.ne.gov/Pages/DD-Public-Comment.aspx There were no substantial changes needed as a result of the comments.

A summary of the 63 comments and questions from 7 individuals received during public comment is listed below:

- Comments in support of the supplemental payments
- Suggestions for other uses of ARPA funds including supporting the construction of new community-based spaces, technology to enhance EVV compliance,
- Questions regarding the amount of funding being obligated and post-payment reporting.
- Questions regarding the rate methodology for the supplemental payments explained in I-2a
- Questions regarding the allowable uses of ARPA funding and other spending priorities

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

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

7. Contact Person(s)

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

Last Name: Green

First Name: Tony

Title: Director, Division of Developmental Disabilities

Agency: Nebraska Department of Health and Human Services

Address: P.O. Box 98947

Address 2: 301 Centennial Mall South

City: Lincoln

State: **Nebraska**

Zip: 68509

Phone: (402) 471-6038 **Ext:** ☐ **TTY**

Fax: (402) 471-8792

E-mail: Tony.Green@nebraska.gov

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

Last Name: Large

First Name: Colin

Title: Policy Administrator

Agency: Nebraska Department of Health and Human Services

Address: P.O. Box 98947

Address 2: 301 Centennial Mall South

City: Lincoln

State: **Nebraska**

Zip: 68509-8947

Phone: (402) 853-1452 **Ext:** ☐ **TTY**

Fax: (402) 471-8792

E-mail: colin.large@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 section 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:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Gonshorowski

First Name: Drew

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

Agency: Department of Health and Human Services

Address: 301 Centennial Mall S

Address 2:

City:

Lincoln

State: **Nebraska**

Zip:

68509

Phone:

(402) 471-4535 **Ext:** ☐ **TTY**

Fax:

(402) 471-2351

E-mail:

colin.large@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:

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.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Additional information continuing from Appendix I-2a:

The following services use an alternative rate methodology:
Transitional Services, Environmental Modification Assessment, Home Modification and Vehicle Modification, Assistive Technology, and Personal Emergency Response System are provided at a market rate and approved on a per-case basis.
The service cap limits were established based on historical precedence in the state. The caps have been adequate over the past several years to enable waiver participants to receive the services at market prices.

Reimbursement for Transportation service is based on the Nebraska standard for mileage reimbursement, pursuant to Neb. Rev. Stat. § 81-1176.

Information about payment rates is made available verbally and in writing to waiver participants and providers by DHHS staff.

To ensure rates remain consistent with the provisions of §1902(a)(30)(A), DDD monitors utilization of waiver services on a monthly basis via reporting. This reporting calculates many of the statistics required on the CMS 372 reports and provides assurance the cost neutrality requirement of the waiver are being met. DDD intends to review rates paid to providers annually. The review will determine the number of providers, both independent and agency, providing services in the Metropolitan Statistical Areas within Nebraska and compare this figure to prior years to identify trends in provider availability. In addition, DDD will review on an annual basis the number of participants served on the waiver, including new participants, and the reserve capacity slots utilized for new entrants.

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

Division of Developmental Disabilities

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

a) The functions performed by the Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD): DDD performs participant waiver enrollment activities; management of approved limits; monitoring of expenditures; level of care evaluations; review of participant service plans; prior authorization of waiver services; utilization management; establishment of statewide rate methodology; establishment of rules, policies, and procedures governing the waiver program; and Quality Improvement (QI) activities. A provider screening and enrollment vendor performs enrollment of qualified providers and executes Medicaid provider agreements under the oversight of the Division of Medicaid and Long-Term Care (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 employed by the designated State Medicaid Director in the oversight of these activities: The State Medicaid Director is the Director of MLTC. Oversight is a collaborative effort among designated personnel within MLTC and DDD. Designated Administrators from MLTC and DDD have regularly scheduled meetings to review discovered and/or anticipated issues; direct remediation and proactive activities; and strategically plan for collaborative alignment of Nebraska’s Medicaid HCBS waivers.
Oversight methods include but are not limited to review of reports of provider non-compliance, coordinating corrective action measures with DDD service coordination and DD surveyors as necessary and appropriate. MLTC prepares or reviews statistical and financial data for CMS reports in collaboration with DDD. MLTC personnel attend the quarterly DDD QI Committee meetings as an active participating member and meet with DDD personnel to review program and client issues as necessary and appropriate. Monthly, MLTC tracks the use of Medicaid funding on the use of Medicaid HCBS waiver funding relative to the budgeted amounts; monitors expenditures and budget projections; reviews the development, renewal, or amendments of HCBS waivers; and has final approval and electronic submittal authority. They also review the cost neutrality formulas developed in collaboration with DDD and submit claims quarterly for federal funds for allowable activities administered or supervised by DDD.
The frequency of the oversight is related to the oversight activity or collaborative projects and tasks, and ranges from monthly budget activities to annual reporting activities.

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

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.:*

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

A provider screening and enrollment vendor is the contracted entity who performs 1) Qualified provider enrollment and 2) Execution of the Medicaid Provider Agreement. In conjunction with designated DHHS personnel, and within established timeframes, the provider screening and enrollment vendor electronically enrolls prospective independent and agency providers, conducts first-time or annual background checks, provides on-line and phone enrollment assistance to prospective providers, provides notice to the provider of approval or denial, and completes 5-year revalidation of provider status. The provider screening and enrollment vendor does not complete wage negotiation with the provider.

○ **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:

DDD is responsible for assessing the performance of the QIO-like entity.

MLTC is responsible for assessing the performance of the contracted provider enrollment vendor.

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 provider enrollment vendor submits monthly reports to MLTC Data Analytics Team. The Data Analytics Team in Medicaid reviews the information supplied by the vendor monthly to compare data against contract deliverables. The data, such as a monthly average days to enrollment is utilized to address sub-assurances. The data submitted monthly covers both functions performed by the contracted entity.

The state reviews the monthly Nebraska Quality Mortality Report prepared by the QIO. All systematic quality improvement recommendations and/or follow up actions made by the Mortality Review Committee will be reviewed by the assigned DDD representative.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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:
A.1. 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:
Electronic data base

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:
A.2. Number and percent of QI Committee meetings held by the Division of Developmental Disabilities (DDD). N = Number of QI Committee meetings held by DDD. D = Number of QI Committee meetings scheduled.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.3. Number and percent of mortality reviews in which DDD determined Mortality Review Committee (MRC) took appropriate action. Numerator: Number of mortality reviews in which DDD determined MRC took appropriate action. Denominator: Total number of mortalities reviewed by the MRC.

Data Source (Select one):
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.

Nebraska's population centers are clustered in the eastern portion of the state and the distribution of waiver openings and execution of provider agreements reflect the disproportionate distribution of the population. Therefore, the State does not measure the uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver and does not measure equitable distribution of waiver openings in all geographic areas.

Quarterly off-site file reviews are conducted by the DDD quality team. One hundred percent of the data available to report on these performance measures are analyzed by the DDD quality team. The DDD quality team conducts their reviews to ensure activities are being applied correctly, and reviews and remediation activities are completed as assigned.

The DDD quality team is responsible for reporting all individual problems requiring remediation identified during discovery processes to supervisory personnel. This information is summarized and reviewed by the DDD QI Committee (QI Committee) quarterly.

The continuing efforts are to oversee and refine the formal design and implementation of QI systems, which allow for systematic oversight of services across the state by the QI Committee, while ensuring utility of the information at the local service coordination level. A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The QI Committee minutes show review of results, recommendations for remediation, and follow-up of recommendations or assigned tasks to address issues which have been identified and to proactively decrease the likelihood of similar problems occurring in the future. A continuous evaluation component is built into the system for evaluation of utility, information received, and effectiveness of strategies.

The QI Committee receives reports and information and provides/shares feedback and support to the service districts. DDD makes all meeting minutes and reports available to the Medicaid Director for their review.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs 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 participant's DDD Service Coordinator (SC) has primary responsibility for discovery and remediation of individual problems. Discovery processes include: monitoring; conducting supervisory file reviews; reviewing incidents; and following up on complaints.

The SC is responsible for in-person, on-site monitoring of participant health and welfare, and monitoring of the implementation of the service plan. Service coordination also monitors to ensure a participant resides in and receives services in a setting, which meets the HCBS regulations and requirements. Please see Appendix D QI-b-i for additional information on monitoring and methods of correction.

By statute, providers have to report any suspected incidents of abuse/neglect to DHHS Protection and Safety Specialists. When providers report alleged abuse and neglect of participants that are not required to be reported by law, the Protection and Safety personnel share this information with DDD service coordination and DHHS DD Surveyors within 24 hours of receipt. DHHS personnel triage/review the information and make a determination whether to do a complaint investigation or handle it in another manner.

The database for incidents is a state-mandated web-based case management system used for incident reporting and the database allows DDD to review and aggregate data in various formats. Quarterly, providers submit a report to DDD detailing the incidents in the quarter and actions taken both on a participant and provider wide plans to address the any identified issues and to decrease the likelihood of future incidents. The QIO performs data analysis and The QI Committee determines the need for systemic follow-up and additional areas requiring probing or DDD management intervention.

Grievances, complaints, questions, or concerns are responded to by designated DDD program personnel. The DDD Director or DDD program personnel work with participants, the general public, service coordination, providers, legislators, or advocacy groups to address the grievance/complaint.

As part of their discovery processes, all Service Coordinator Supervisors (SCSs) are required to conduct a review of services coordination activities on an on-going basis as outlined in the approved DDD standard operating procedures. These reviews ensure all service coordination activities are being applied correctly. The review responses are documented in an electronic data system. Indicators that do not meet standards require remediation/supervisory follow-up. Threshold concerns are reviewed with the local DDD Service District Administrator and brought to the attention of DDD Central Office Administrator of Operations as needed. The summarized data for the service plan review are also shared with service coordination personnel at the local service coordination level.

MLTC is responsible for ensuring effective oversight of the enrollment broker. DDD works in collaboration with MLTC to identify processes and expectations of the enrollment broker that are not met as required. DDD analyzes data from MLTC to report on the performance measures. As problems are discovered with provider enrollment screenings or processing, DDD meets with the MLTC representative responsible for the enrollment broker contract to implement corrective actions.

Annual monitoring of agency provider settings is conducted by the DDD quality team. Providers who are found to be out of compliance or not progressing towards a plan for compliance with HCBS setting requirements are sent a results letter and given a set timeframe in which they are required to submit a remediation plan and supporting documents. Once the provider submits the remediation plan, it has a set timeframe in which to become compliant. Written communication to the provider states that failure to respond timely to requests for plans or documentation will be considered non-compliance and could result in a termination of all services in that setting.

The DDD quality team is responsible for scheduling the QI Committee meetings. If a meeting is cancelled, the DDD quality team is responsible for rescheduling.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **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 Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☒	Autism	0		☒
	☒	Developmental Disability	0		☒
	☒	Intellectual Disability	0		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Eligibility and enrollment in the Comprehensive Developmental Disabilities (CDD) waiver is extended to those participants:

- Meeting Nebraska's intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care (LOC), as specified in B-6 of this waiver application; and
- Who cannot have their assessed needs met as determined by the State's approved functional needs assessment, through the following 1915(c) programs:
  - Nebraska Developmental Disabilities Adult Day (DDAD) waiver (NE.0394); or
  - Nebraska Family Support Waiver (FSW) (NE.2366); and
- For participants 18 and under, need for placement outside of their family home necessitating access to the Residential Habilitation - Continuous Home Service as defined in this 1915(c) waiver application, due to any of the following assessed risks as determined by the State's approved functional needs assessment:
  - Behavioral/Harm to Self and Others; and
  - Lack of natural supports for appropriate supervision and monitoring, based on the care needs of the participant; or
  - Residential instability in the last two years.

If requested, a clinical review of a participant's unique needs may be requested to determine if enrollment in the CDD waiver is appropriate if not otherwise indicated by the State's approved functional needs assessment.

A participant’s needs are assessed using the state-approved functional needs assessment tool, and further informed through person-centered planning conversations as delineated in Appendix D of this waiver application.

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

◉ **Not applicable. There is no maximum age limit**

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

    [ ]

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

  [ ]

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

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

    Specify dollar amount: [ ]

    The dollar amount *(select one)*

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

      Specify the formula:

      [ ]

    - ( ) **May be adjusted during the period the waiver is in effect. The state will submit a waiver**

amendment to CMS to adjust the dollar amount.

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4300
Year 2	4500
Year 3	5200
Year 4	5200
Year 5	5200

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

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

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

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

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

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

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

The waiver provides for the entrance of all eligible people.

Nebraska does not have a waiting list for the Comprehensive Developmental Disabilities waiver and is not expected to require a waiting list due to available slots. In the event a waiting list is necessary, applicants shall be prioritized as set forth in Neb. Rev. Stat. § 83-1216.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

○ **Section 1634 State**

◉ **SSI Criteria State**

○ **209(b) State**

2. Miller Trust State.

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

◉ **No**

○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

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

☐ **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:

•Former Foster Care Children (435.150)
•Infants and Children Under Age 19 (435.118)
•Pregnant Women (435.116)
•Parent/Caretaker Relative (435.110)
•Reasonable Classification (435.222)
•Children Eligible under Title IV-E Foster Care and Adoption Agreements (435.145)
•Children under 19 with Non-IV-E Adoption Assistance (435.227)
•Optional Targeted Low Income Children (435.229)
•TMA (1925)
•Breast or Cervical Cancer Treatment Group (1902(a)(10)(A)(ii)(XVIII))
•Deemed Newborns (435.117)
•DAC (1634(c))
•Pickle (435.135)
•1619(b) recipients
•Disabled Widow(er) (435.138)
•Medicaid expansion (42 CFR 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 who are medically needy with spenddown: The State will use the actual maximum monthly allowable ICF/IID 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 section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

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

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

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time 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:

• Independent living arrangements (Room and Board, Apartment/house, Public Housing – 100% FPL)
• Centers for Persons with Developmental Disabilities and Adult Family Homes – current grant Standard of Need

○ **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 section 1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

- ○ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ◉ **Medically needy income standard**
- ○ **The following dollar amount:**

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

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

  Specify:

- ○ **Other**

  Specify:

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

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

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time 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:

  • Independent living arrangements (Room and Board, Apartment/house, Public Housing – 100% FPL)
  • Centers for Persons with Developmental Disabilities and Adult Family Homes – current grant Standard of Need

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:

The minimum frequency for the provision of the waiver service is 90 days. A participant's approved waiver slot will remain available to the participant when the participant is hospitalized, receiving rehabilitation services, receiving non-community-based crisis services, or is incarcerated and cannot utilize a waiver service for 90 days. A request to keep the slot available beyond 90 days for a participant must be based on critical health or safety concerns and other relevant factors and is subject to approval by the Department.

SCs will make monthly contact with all participants or identified team members on their caseload to make sure that services are provided as outlined in the PCP. This monitoring will continue when services are provided less than monthly.

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

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

Specify the entity:

- ○ **Other**

Specify:

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

Level of care assessors who perform the initial evaluation of level of care for waiver applicants must possess the following educational and professional qualifications:
1. Bachelor's Degree in a human behavioral sciences field such as human services, social work, psychology, education, sociology, or a related field; OR
2. Four years equivalent experience in services or programs for persons with intellectual or other developmental disabilities, long-term care, gerontology, rehabilitation, health/disability case management, children with special health care needs, health/medical, education, psychology, social work, sociology, human services, or a related field

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

Individuals who are deemed to require ICF/IID institutional level of care are enrolled in and maintained on (pursuant to reevaluation) this waiver. Individuals are evaluated based on the following pathways:

Children aged 0-35 months: a severe, chronic disability that results in at least one developmental delay.

Individuals aged 3 years and older: The following waiver eligibility criteria, which are the same as the state's ICF/IID level of care criteria, are assessed to initially determine, or evaluate, whether an individual needs services through the waiver.

a. Self-care in six activities of daily living;
b. Receptive and Expressive Language;
c. Learning;
d. Mobility;
e. Self-direction;
f. Capacity for Independent Living;
g. Social Skills and Personality; and
h. Economic Self-sufficiency.

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

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

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

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

(1) For Children aged 0-35 months: The level of care assessor gathers documentation to confirm the diagnosis of a severe, chronic disability that results in at least one developmental delay.

(2) For Children aged 4-17 years: The level of care assessor gathers information using the interRAI Child and Youth Mental Health and Developmental Disability (chYMH-DD).

(3) For Adults: The level of care assessor gathers information using the interRAI Intellectual Disability (ID).

All ICF/IID LOC assessment tools used for initial waiver evaluation and reevaluation are comparable to the ICF/IID Utilization Review assessment tool completed for institutional ICF/IID placement. Both tools note skills, abilities, preferences, and needs, including health needs, means of communication, and behavioral concerns. The participant, their family or guardian, their LOC assessor, and others who are familiar with the participant complete the applicable tool. State regulations that define what constitutes ICF/IID LOC do not change regardless of which tool is being used.

While Adults aged 18 and over use a different tool than children aged 4-17, reliability and validity testing using a sampling methodology indicates that the outcome of the determinations yielded from the ICF/IID LOC assessment tools was the same as the functional criteria of determination yielded from the assessment completed for institutional ICF placement.

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

The process for ICF/IID LOC evaluation and reevaluation includes an in-person assessment and observation with the participant, guardian, or an individual with knowledge of the individual’s functioning when needed. All LOC evaluations and reevaluations are completed by DDD personnel in the Eligibility and Enrollment Unit (E&E). The level of care assessor must meet in person with the participant to evaluate ICF/IID LOC. The assessment must be conducted, if possible, at the participant’s residence to allow observations of the home situation. The assessment must be held at a date and time convenient to the participant.

The same criteria, three of eight limitations, are required at the reevaluation. The process for the annual reevaluation includes a review of the ICF/IID level of care assessment tool; the service plan; and Medicaid eligibility status. DDD personnel will complete the applicable tool by working directly with the participant, family, guardian, provider, etc.

As a last step, DDD personnel provide notification of the annual ICF/IID level of care reevaluation to the participant, their family, and their service plan team. When eligible, the participant is maintained on the waiver. When the participant is not eligible, because they do not meet ICF/IID level of care, notice is sent to the participant and the waiver case is closed.

Participants who are determined not eligible for waiver services receive written notification of their ineligibility via a Notice of Determination and are then eligible for a Fair Hearing under the state regulations when they believe the eligibility determination was made in error or the ICF/IID level of care determination is not accurate.

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):*

DDD has an internal policy that outlines timelines to ensure reevaluations are completed in a timely manner. DDD personnel who complete reevaluations utilize the web-based case management system, which are components of case management to ensure timely reevaluations of waiver eligibility. DDD personnel run electronic reports to determine when reevaluations are conducted timely and review findings at monthly supervision meetings.

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:

Initial evaluation and annual reevaluation for ICF/IID level of care are maintained electronically by DDD in an electronic record for each participant. The electronic records are permanently maintained in a web-based case management system.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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:
A.1. Number and percent of new waiver applicants with a reasonable indication of need for whom an evaluation for LOC was provided. Numerator = Number of new

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **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:
C.1. Number and percent of initial/annual LOCs in which LOC criteria were appropriately applied according to the approved waiver. Numerator = Number of initial/annual LOCs in which LOC criteria were applied according to the approved

waiver; Denominator = Number of initial/annual LOC determinations.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level 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.

Annual reevaluation of waiver eligibility is completed for all (100%) waiver participants. The ICF/IID level of care assessment tool is reviewed during the participant's annual service plan meeting and documented in the service plan.

b. Methods for Remediation/Fixing Individual Problems

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

The state monitors level of care (LOC) evaluations and reevaluations, and takes action to address discovered individual problems, which may include failure to complete LOC evaluations/reevaluations, failure to follow established timelines, inaccurate determinations, and missing or incomplete documentation.

Monthly quality assurance reports are electronically generated for access by DDD personnel and are reviewed at both the field office and central office levels to ensure continued Medicaid and DD waiver eligibility for participants. DDD personnel review reports and take appropriate action as needed on individual cases. These positions are responsible for the initial waiver eligibility determinations and they complete a LOC assessment when a funding offer is available for a new participant. When there are issues identified with LOC evaluations involving personnel performance the personnel will be retrained. When the personnel find issues with participant's maintaining their eligibility, they are responsible for correcting the issue such as facilitating activities for recertification of Medicaid, correcting a service authorization to change or end DD waiver services, completing a LOC assessment, etc.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Nebraska waiver participants are afforded choice among waiver services as well as between waiver services and institutional care and this information is provided by the participant's SC. Information about Nebraska's DDD waiver services, feasible alternatives, and freedom of choice is provided verbally and in written materials to assist the participant in understanding DDD waiver services, funding of their services, and their roles and responsibilities. Choice of ICF/IID or waiver services is documented on a waiver consent form which also explains the right and process to appeal.

A signature for consent, documenting the waiver participant's choice to receive community-based waiver services over services in an institutional setting, is obtained upon initial determination of waiver eligibility and is kept in the participant's electronic waiver file. When guardianship or legal status changes, the SC must obtain a new, signed consent.

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.

The waiver consent form is kept in the participant's electronic file maintained by DDD personnel. The records are maintained permanently in electronic files by DDD personnel.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The following methods are utilized to provide meaningful access to services by individuals with limited English proficiency at entrance to waiver services and on an ongoing basis:

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Continuous Home**		
Statutory Service	**Prevocational**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment - Individual**		

Service Type	Service		
Other Service	Adult Day Retirement		
Other Service	Adult Day		
Other Service	Assistive Technology		
Other Service	Behavioral In-Home Habilitation		
Other Service	Benefits Counseling		
Other Service	Child Day Habilitation		
Other Service	Community Integration		
Other Service	Consultative Assessment		
Other Service	Day Supports		
Other Service	Employment Exploration		
Other Service	Environmental Modification Assessment		
Other Service	Health Maintenance Monitoring		
Other Service	Home Modifications		
Other Service	Homemaker		
Other Service	Host Home		
Other Service	Independent Living		
Other Service	LRI Personal Care		
Other Service	Medical In-Home Habilitation		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Remote Supports		
Other Service	Shared Living		
Other Service	Small Group Vocational Support		
Other Service	Supported Employment - Follow Along		
Other Service	Supported Family Living		
Other Service	Transitional Services		
Other Service	Transportation		
Other Service	Vehicle Modifications		
Other Service	Youth Continuous Home		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Continuous Home

HCBS Taxonomy:

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

08 Home-Based Services	08010 home-based habilitation

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

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

Service Definition *(Scope):*

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

Continuous Home is a habilitative service which is delivered in a provider-owned or leased, operated, or controlled residential setting and provided by agency provider shift staff not living in the setting. Continuous Home consists of individually tailored continuous supports to assist with the acquisition, retention, or improvement in skills not yet mastered which will lead to more independence for the participant to reside in the most integrated setting appropriate to their needs.

Continuous Home includes adaptive skill development of activities of daily living (ADLs), such as personal grooming and cleanliness, laundry, bed making and household chores, eating and the preparation of food, inclusive community activities, transportation, and the social and leisure skill development necessary to enable the participant to live in the most integrated setting appropriate to their needs. This service also includes the provision of personal care, health maintenance activities, supervision, and protective oversight.

When a participant is admitted to an in-patient, acute care hospital, due to a critical health or safety concern, this service can be provided. Support includes habilitation to maintain learned skills, implementation of behavioral support, if needed, and assistance with ADLs to support the participant's treatment and recovery. This level of support will assist the participant to not regress or lose learned skills they had before they were in an in-patient, acute care hospital.

This service is provided to meet needs of the participant that are not met through the provision of acute care hospital services. This service is in addition to, and may not substitute for, or are not duplicative of, the services the acute care hospital is obligated to provide. This service will be used to ensure smooth transition between acute care setting and community-based setting and to preserve the participant's functional abilities. When authorized this service must be identified in the participant's person-centered service plan.

Prior to discharge the person-centered plan (PCP) will be updated to reflect the participant's needs and supports for transition back to the community-based setting.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

When a portion of this service is delivered remotely, the following conditions apply:

- The total combined hours for remote supports may not exceed a weekly amount of 10 hours. A participant can choose to receive a portion of this service remotely, but cannot replace all in-person assistance. The majority of the service provided each week must be provided in-person.
- The provider is responsible for ensuring technologies used to deliver remote supports comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534.
- Remote supports will be delivered in a way that respects the privacy of the individual and are not intended to monitor ADLs. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- Use of remote supports will be addressed in the participant's PCP and the provider must have a plan and/or policies to ensure the participant's rights of privacy, dignity, and respect.
- Use of remote supports must be a person-centered decision and facilitate community integration, not risk leading to the isolation of the participant from the community or from interacting with other people.
- Use of remote supports is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in person services if they choose. The decision to use remote supports as a portion of the service array must be clearly documented in the participant's PCP and assure that the participant's needs must be able to be met by supports that can be provided remotely.
- The state is requiring provider's to be responsible for ongoing training of the participant and direct support staff in use of the remote support devices.
- Providers are required to develop a policies and procedures which include:
  - Identifying whether health and safety needs can be addressed safely via remote supports;
  - Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA compliance of the technology used for remote support;
  - Obtaining written informed consent from the participant, guardian (if applicable), and any others potentially impacted by provision of remote supports, and maintaining records of these consents;

- o A backup person for when in-person support is needed;
- o A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
- o Ongoing training for direct support staff.

When a portion of this service is delivered via electronic health maintenance monitoring, the following conditions apply:

- Participants receiving Health Maintenance Monitoring must be under the supervision of a treating physician, physician's assistant, or advanced practice nurse who is directly providing care and treatment for their medical condition and not merely engaged to authorize the monitoring service.
- Electronic Health Maintenance Monitoring requires the participant or guardian to have the capability to utilize any monitoring tools involved or shall include the regular presence of an individual in the home who can utilize the involved monitoring tools and have the internet or cellular internet connection necessary to accommodate any needed remote patient monitoring equipment in the home.
- Health Maintenance Monitoring will be addressed in the participant's PCP and include the frequency, duration, and schedule of each health monitoring task including the criteria for abnormal findings and when to consult the participant's doctor.
- Health Maintenance Monitoring will be delivered in a way that respects the privacy of the individual and is not intended to monitor ADLs. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- The use of Health Maintenance Monitoring is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose.
- The participant or guardian must consent to receive the monitoring service and is responsible for the oversight and supervision of the monitoring.
- The participant's residence must have space for all program equipment and full transmission capability.
- The provider maintains a participant's record supporting the medical necessity of the service, all transmissions and subsequent reviews received from the participant, and how the data transmitted from the participant is being utilized in the continuous development and implementation of the participant's care.
- Health care providers performing a telehealth or digital health service shall, as appropriate for the service, provider, and participant, utilize the following modalities of communication delivered over a secure communications connection that complies with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA):
  - o Live or real-time audio and video asynchronous telehealth technology;
  - o Asynchronous store-and-forward telehealth technology;
  - o Remote patient monitoring using wireless devices, wearable sensors, or health monitors, such as:
  - o Heart rhythm with an electrocardiogram (ECG), respiration, blood oxygen level (SpO2), non-invasive blood pressure (NIBP), glucose monitor weight, apnea monitors, specialized monitors for dementia and temperature.
  - o Audio-only telecommunications systems;
  - o Clinical text chat technology; and
  - o Medication dispensing and monitoring.
- Health Maintenance Monitoring can be used to monitor the following:
  - o Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.
  - o Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
  - o Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes.
  - o Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes.
- Interpretation of data and any teaching or coaching of the participant and guardian must be done by a Registered Nurse (RN), Nurse Practitioner (NP), Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Medical Doctor (MD) or Doctors of Osteopathy (DO).
- Providers are required to develop policies and procedures which include:
  - o Identifying whether health and safety needs can be addressed safely via health maintenance monitoring;
  - o Assurance of the participants' rights to privacy, dignity, and respect, and the HIPAA compliance of the technology used for health maintenance monitoring;
  - o A plan for how to respond to abnormal findings and when to consult the participant's doctor.

- A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
- Ongoing training for direct support staff.

Continuous Home may not be self-directed.

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

Continuous Home is only available to participants aged 19 and older. Exceptions may be requested for participants aged 18 and under and will be subject to DDD Central Office approval.

Placement is limited to those individuals that demonstrate any of the following assessed risks as determined by the State's approved functional needs assessment: Behavioral/Harm to Self and Others; and Lack of natural supports for appropriate supervision and monitoring, based on the care needs of the participant; or Residential instability in the last two years. If requested, a clinical review of a participant's unique needs may be conducted to determine if Continuous Home is appropriate if not otherwise indicated by the State's approved functional needs assessment. A participant's needs are assessed using the state-approved functional needs assessment tool, and further informed through person-centered planning conversations as delineated in Appendix D of this waiver application.

Continuous Home is provided in a residential setting and must meet all federal standards for home and community-based settings.

Continuous Home may be provided to no more than 3 participants in the residence at the same time, unless the residence is licensed as a Center for the Developmentally Disabled.

Continuous Home is based upon the participant's assessed need or risk requiring the service.

Continuous Home is reimbursed at a daily rate. The provider must be in the residence with the participant, providing a combination of habilitation, supports, protective oversight, and supervision for a minimum of 10 hours in a 24-hour period 12:00am - 11:59pm for the provider to bill a daily rate. When the provider is in the residence with the participant, providing a combination of habilitation, supports, protective oversight, and supervision for any amount of time less than 10 hours in a 24-hour period 12:00am - 11:59pm, the provider will be paid at half of the daily rate.

Participants receiving Continuous Home daily rate cannot receive Host Home, Shared Living, Independent Living, or Supported Family Living on the same day.

Participants receiving Continuous Home cannot receive Respite, LRI Personal Care, and Homemaker.

Transportation required in the provision of Continuous Home is included in the rate. Non-medical transportation to the site at which Continuous Home begins is included in the rate. Non-medical transportation from the site at which Continuous Home ends is included in the rate.

The provider agency is responsible for staffing Continuous Home.

A lease, residency agreement or other form of written agreement will be in place for each participant receiving a Continuous Home service. The participant has, at a minimum, the same responsibilities, and protections from eviction that tenants have under the landlord/tenant laws of the state, county, city, or other designated entity.

Medicaid payment may not be made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

The rate tiers for this service are determined based upon needs identified in the Objective Assessment Process.

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

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after-school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid

State Plan or HCBS Waiver service, including EPSDT.

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	DD Agency - Habilitative Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Continuous Home

Provider Category:

Agency

Provider Type:

DD Agency - Habilitative Services

Provider Qualifications

License *(specify):*

A license is required for each Continuous Home setting with 4 or more participants. Title 175 Nebraska Administrative Code 3-000.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with the designated provider screening enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Prevocational

HCBS Taxonomy:

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

04 Day Services	04010 prevocational services

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

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

Service Definition *(Scope):*

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

Prevocational is a habilitative service that focuses on teaching the participant to develop general, non-job-task-specific skills, which will contribute to future competitive integrated employment. Services may be furnished in a variety of locations, with the majority of the service provided in the community. When delivered in provider-controlled settings where other waiver services are offered, staff providing Prevocational cannot provide any other waiver service during the same time. A participant can choose to receive a portion of this service virtually. This service also includes the provision of personal care, activities related to health maintenance, and supervision.

Prevocational enables each participant to develop employable skills in the most integrated setting, related to the participant's interests, strengths, capabilities and personal goals. Services are intended to develop, teach, and refine general transferable skills leading to competitive and integrated employment.

Prevocational includes, but is not limited to developing communication skills to communicate effectively with others; learning commonly acceptable social skills and attire for employment; use of technologies used in today's industry; learning to follow multi-step directions and instructions; developing the ability to stay on task for extended period of time; developing self-direction and general problem solving skills and strategies; and developing general safety and mobility skills across environments.

Prevocational is expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the participant and their team. Participants receiving Prevocational must have a goal to obtain competitive, integrated employment and have broad-based employment-related goals in their service plan; the general habilitation activities must be designed to support such employment-related goals. The outcome of this service is to gain experience leading to further career development and individual integrated community based employment.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

Participation in Prevocational is not a required pre-requisite for Supported Employment – Individual or Supported Employment – Follow-Along services provided under the waiver.

When a portion of this service is delivered virtually, the following conditions apply:

- The total combined hours for virtual supports may not exceed a weekly amount of 10 hours and is included as part of the currently existing limit of 35 hours per week of services provided during the day. A participant can choose to receive a portion of this service virtually, but cannot replace all in-person assistance. The majority of the service provided each week must be provided in-person.
- A participant can choose to receive a portion of this service virtually but it cannot replace all in-person assistance. Most of the service provided each week must be provided in-person.
- The provider is responsible for ensuring technologies used to deliver virtual supports comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534.
- Virtual supports will be delivered in a way that respects the privacy of the individual and is not intended to monitor ADL's. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- Use of virtual supports will be addressed in the participant's person-centered plan and the provider must have a plan and/or policies to ensure the participant's rights of privacy, dignity, and respect.
- Use of virtual supports must be a person-centered decision and facilitate community integration, not risk leading to the isolation of the participant from the community or from interacting with other people.
- Use of virtual supports is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose. The decision to use virtual supports as a portion of the service array must be clearly documented in the participant's person-centered plan and assure that the participant's needs must be able to be met by supports that can be provided virtually.
- The state is requiring provider's to be responsible for ongoing training of the participant and direct support staff in use of the virtual support devices.
- Providers are required to develop a policies and procedures which include:
  - Identifying whether health and safety needs can be addressed safely via virtual supports;
  - Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA

compliance of the technology used for virtual support;
- Obtaining written informed consent from the participant, guardian (if applicable), and any others potentially impacted by provision of virtual supports, and maintaining records of these consents;
- A backup person for when in-person support is needed;
- A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
- Ongoing training for direct support staff.

Prevocational may not be self-directed.

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

Prevocational is time-limited and must not exceed 12 consecutive months. When the participant's employment-related goals have not been fully met, up to 12 additional months may be approved after the participant submits a referral to Vocational Rehabilitation. After 24 months, additional months must be approved by DDD Central Office.

Prevocational may be provided to individuals, small groups, and a large group based on the participant's assessed needs. A small group may consist of two to three participants and a large group may consist of four to five participants.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Prevocational is reimbursed at an hourly unit.

Transportation required in the provision of Prevocational is included in the rate. Non-medical transportation to the site at which Prevocational begins is not included in the rate. Non-medical transportation from the site at which Prevocational ends is not included in the rate.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

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

For each participant receiving this service, and on the wait list under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services), documentation must be maintained in the service coordination file. Documentation must include that the participant is on the Vocational Rehabilitation Services wait list, and the service is not available due to the program's wait list.

Waiver funds cannot be used to compensate or supplement a participant's wages.

Federal financial participation must not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
- Payments made to an employer to encourage or subsidize the employer's participation in Prevocational;
- Payments passed through to users of Prevocational; or
- Payments for training not directly related to a participant's employment skills development.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT, or Vocational Rehabilitation.

The total combined hours for day services may not exceed a weekly amount of 35 hours. A week is defined as 12:00am Monday through 11:59pm Sunday.

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	DD Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational

Provider Category:

Agency

Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09012 respite, in-home

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Respite is a non-habilitative service that is provided to participants unable to care for themselves and is furnished on a short-term, temporary basis for relief to the usual unpaid caregiver(s) living in the same private residence as the participant. Respite includes assistance with activities of daily living (ADLs), health maintenance, and supervision.

Respite may be provided in the caregiver's home, the provider's home, or in community settings.

Respite may be self-directed.

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

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Respite provided in an institutional setting requires prior approval by the Department, and is authorized only when no other option is available.

Respite, other than in an institutional setting, is reimbursed at an hourly rate. Respite cannot be billed or authorized for more than 8 hours in a 24-hour period.

Respite In-Home requires the provider use Electronic Visit Verification (EVV).

Respite is limited to no more than 360 hours per annual budget year. Unused Respite cannot be carried over into the next annual budget year.

The 360 hours were determined based on historical and actual data and the limitation of hours has historically addressed the health and welfare of waiver participants. If a participant's needs cannot be met within the established number of hours, the participant's team will meet to determine what alternatives may be available, such as another type of residential setting. If alternatives are unavailable, additional developmental disabilities funding could be requested through the established exception process.

Federal Financial Participation (FFP) must not to be claimed for the cost of room and board except when provided as a part of respite care furnished in a facility approved by DDD Central Office and not a private residence.

Transportation during the provision of Respite is included in the rate. Non-medical transportation to the site at which Respite begins is not included in the rate. Non-medical transportation from the site at which Respite ends is not included in the rate.

Respite is not available to the usual unpaid caregiver(s) for employment or attending classes, or in lieu of Child Day Habilitation, Supported Family Living, or childcare responsibilities of the usual unpaid caregiver.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

Respite is not available to participants residing in a Continuous Home, Host Home, Shared Living, or Youth Continuous Home setting.

Respite must not be provided by any independent provider who lives in the same private residence as the participant.

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

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

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Agency - Non-Habilitative Services
Individual	Independent Individual - Non-Habilitative Services
Agency	DD Agency - Non-Habilitative Services
Agency	Independent Respite Care Service Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Independent Agency - Non-Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

All providers delivering Respite In-Home must have the computer skills and access to the technology needed to navigate Electronic Visit Verification (EVV).

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Independent Individual - Non-Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

All providers delivering Respite In-Home must have the computer skills and access to the technology needed to navigate Electronic Visit Verification (EVV).

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

DD Agency - Non-Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

All providers delivering Respite In-Home must have the computer skills and access to the technology needed to navigate Electronic Visit Verification (EVV).

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Independent Respite Care Service Agency

Provider Qualifications

License *(specify):*

175 NAC Health Care Facilities and Services Licensure.

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

All providers delivering Respite In-Home must have the computer skills and access to the technology needed to navigate Electronic Visit Verification (EVV).

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment - Individual

HCBS Taxonomy:

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

03 Supported Employment	03021 ongoing supported employment, individual

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Supported Employment – Individual is one-to-one formalized teaching and staff supports available to a participant who, because of their disability, needs intensive, sometimes on-going support, to maintain an individual job in competitive or customized employment or self-employment, in an integrated work setting in the general workforce. A participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by a person without a disability. Support may be utilized for referring the participant to gain access to an employment network, Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified employment service programs, which provide benefits planning. A participant can choose to receive a portion of this service virtually. The outcome of this service is sustained paid employment, which meets personal and career goals in an integrated setting in the general workforce, particularly work sites where persons without disabilities are employed.

Services are provided in a variety of integrated community locations to offer opportunities for the participant to achieve their personally identified goals for refining employment-related skills, and for developing and sustaining a network of positive natural supports. Locations must be non-disability specific and meet all federal standards for home and community-based settings. This service cannot take place in licensed facilities, or any type of facility owned or leased, operated or controlled by a provider of other Medicaid waiver services. Supported Employment – Individual must be provided in an integrated community employment setting, unless the support is to develop a customized home-based business.

Services include habilitation needed to sustain paid work by a participant and are designed to maintain or advance employment. When Supported Employment – Individual is provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, teaching, and supervision required by participants receiving waiver services because of their disabilities. This service does not include payment for the supervisory activities rendered by the employer as a normal part of the business setting.

Individual habilitation programs must be identified in the participant's person-centered plan (PCP) supporting the need for continued job coaching with a written plan to gradually decrease job coaching.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

When a portion of this service is delivered virtually, the following conditions apply:

- The total combined hours for virtual supports may not exceed a weekly amount of 10 hours and is included as part of the currently existing limit of 35 hours per week of services provided during the day. A participant can choose to receive a portion of this service virtually, but cannot replace all in-person assistance. The majority of the service provided each week must be provided in-person.
- A participant can choose to receive a portion of this service virtually but it cannot replace all in-person assistance. Most of the service provided each week must be provided in-person.
- The provider is responsible for ensuring technologies used to deliver virtual supports comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534.
- Virtual supports will be delivered in a way that respects the privacy of the individual and is not intended to monitor ADL’s. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- Use of virtual supports will be addressed in the participant’s person-centered plan and the provider must have a plan and/or policies to ensure the participant’s rights of privacy, dignity, and respect.
- Use of virtual supports must be a person-centered decision and facilitate community integration, not risk leading to the isolation of the participant from the community or from interacting with other people.
- Use of virtual supports is a person-centered decision that must only be authorized in circumstances in which the individual’s health and safety would not be at risk, and the person must still have the option of in-person services if they choose. The decision to use virtual supports as a portion of the service array must be clearly documented in the participant’s person-centered plan and assure that the participant’s needs must be able to be met by supports that can be provided virtually.
- The state is requiring provider’s to be responsible for ongoing training of the participant and direct support staff in use of the virtual support devices.
- Providers are required to develop a policies and procedures which include:
  - Identifying whether health and safety needs can be addressed safely via virtual supports;

o Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA compliance of the technology used for virtual support;
o Obtaining written informed consent from the participant, guardian (if applicable), and any others potentially impacted by provision of virtual supports, and maintaining records of these consents;
o A backup person for when in-person support is needed;
o A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
o Ongoing training for direct support staff.

Supported Employment – Individual may be self-directed.

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

Income from customized home-based businesses is not required to be commensurate with minimum wage requirements with other employment.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Supported Employment – Individual is reimbursed at an hourly unit.

A provider of Supported Employment – Individual cannot be the employer of the participant to whom Supported Employment – Individual is provided.

Waiver funds cannot be used to compensate or supplement a participant's wages.

Transportation required in the provision of Supported Employment – Individual is included in the rate. Non-medical transportation to the site at which Supported Employment – Individual begins is not included in the rate. Non-medical transportation from the site at which Supported Employment – Individual ends is not included in the rate.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

For each participant receiving this service, and on the wait list under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services), documentation must be maintained in the service coordination file. Documentation must include that the participant is on the Vocational Rehabilitation Services wait list, and the service is not available due to the program's wait list.

Federal financial participation must not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
o Payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
o Payments passed through to users of supported employment programs; or
o Payments for training not directly related to a participant's supported employment program.

Supported Employment - Individual may be provided by a relative but not a legal guardian or legally responsible individual.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT, or Vocational Rehabilitation.

The total combined hours for day services may not exceed a weekly average amount of 35 hours and a maximum of 1820 hours per year. A week is defined as 12:00am Monday through 11:59pm Sunday.

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	DD Agency - Habilitative Services
Individual	Independent Individual - Habilitative Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment - Individual

Provider Category:

Agency

Provider Type:

DD Agency - Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment - Individual

Provider Category:

Individual

Provider Type:

Independent Individual - Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

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

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

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

A provider of this service must:

- Complete all provider enrollment requirements;
- Have necessary education and experience, and provide evidence upon request:
  - o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
  - o Have four or more years of professional experience in the provision of habilitative services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
  - o Have any combination of education and experience identified above equaling four years or more;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - o Cardiopulmonary resuscitation; and
  - o Basic first aid;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Day Retirement

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
04 Day Services	04060 adult day services (social model)
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Adult Day Retirement is a non-habilitative service that provides direct care and supervision of adults aged 50 or over, in community and home-based settings for the purpose of providing active supports which foster independence, encompassing both health and social services needed to ensure the optimal functioning of the participant. Adult Day Health Retirement includes assistance with activities of daily living (ADLs), health maintenance, and supervision.

Required service components include:

A balance of purposeful activities to meet the participant's interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical, and spiritual) designed to improve or maintain the optimal functioning of the participant.

Activities shall take into consideration individual differences in age, health status, sensory deficits, lifestyle, ethnicity, religious affiliation, values, experiences, needs, interests, and abilities by providing a variety of types and levels of involvement.

Time for rest and relaxation shall be provided as needed or prescribed.

Assistance with or supervision of activities of daily living (e.g., walking, eating, toileting, and personal care) as needed.

Provision of health-related services appropriate to the participant’s needs as identified in the provider assessment and/or physician's orders, including health monitoring, nursing intervention on a moderate or intermittent basis for medical conditions and functional limitations, medication monitoring, medication administration or supervision of self-administration, and coordination of health services.

The Adult Day Retirement provider must be within immediate proximity of the participant, as outlined in the person-centered plan (PCP), to allow staff to provide support and supervision, safety and security, and activities to keep the participant engaged in their environment. Alone time cannot be utilized during this service.

Adult Day Retirement is for participants who need the service and support in a safe, supervised setting. Adult Day Retirement does not require training goals and strategies of habilitation services. Adult Day Retirement does not offer as many opportunities for getting participants engaged in their community or participating in community events mainly due to age, compromised health issues, and significant limitations of participants. Providers are not allowed to engage participants in work. Participants may attend community volunteer activities of their own choosing.

Adult Day Retirement may not be self-directed.

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

Adult Day Retirement is available for participants who are 50 years and older. Participants under 50 may request a medical exception subject to DDD Central Office approval.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Adult Day Retirement is reimbursed at an hourly unit.

Transportation required in the provision of Adult Day Retirement is included in the rate.

Adult Day Retirement does not cover therapies: OT, PT, or Speech.

Adult Day Retirement may be provided by a relative or legal guardian but not a legally responsible individual.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service.

The total combined hours for day services may not exceed a weekly amount of 35 hours. A week is defined as 12:00am Monday through 11:59pm Sunday.

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	DD Agency - Non-Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day Retirement

Provider Category:

Agency

Provider Type:

DD Agency - Non-Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with the designated provider screening enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Day

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04060 adult day services (social model)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Adult Day is a non-habilitative service consisting of meaningful day activities which takes place in the community, in a non-residential setting. Adult Day provides active supports which foster independence, encompassing both health and social services needed to ensure the optimal functioning of the participant. Adult Day includes assistance with activities of daily living (ADL), health maintenance, and supervision. Participants receiving Adult Day Services are integrated into the community to the greatest extent possible.

Adult Day is for participants who need the service and support in a safe, supervised setting. Adult Day does not require training goals and strategies of habilitation services. Adult Day does not offer as many opportunities for getting participants engaged in their community or participating in community events mainly due to compromised health issues and significant limitations of participants. Providers are not allowed to engage participant in work or volunteer activities.

The Adult Day provider must be within immediate proximity of the participant to allow staff to provide support and supervision, safety and security, and provide activities to keep the participant engaged in their environment.

When a participant is admitted to an in-patient, acute care hospital, due to a critical health or safety concern, Adult Day can be provided. Support includes assistance to maintain learned skills, implementation of behavioral support, if needed, and assistance with daily living activities to support the participant’s treatment and recovery. This level of support will assist the participant to not regress or lose learned skills they had before they were in an in-patient, acute care hospital.

This service is provided to meet needs of the participant that are not met through the provision of acute care hospital services. This service is in addition to, and may not substitute for or are not duplicative of, the services the acute care hospital is obligated to provide. This service will be used to ensure smooth transition between acute care setting and community-based setting and to preserve the participant’s functional abilities. When authorized this service must be identified in the participant’s person-centered service plan.

Prior to discharge the person-centered plan will be updated to reflect the participant’s needs and supports for transition back to the community based setting.

Adult Day may not be self-directed.

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

Adult Day is available for participants who are 21 years and older.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Adult Day is reimbursed at an hourly unit.

Transportation required in the provision of Adult Day is included in the rate. Non-medical transportation to the site at which Adult Day begins is not included in the rate. Non-medical transportation from the site at which Adult Day ends is not included in the rate.

Adult Day cannot be provided in a residential setting.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

Adult Day may be provided by a relative or legal guardian but not a legally responsible individual.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver services.

The total combined hours for day services may not exceed a weekly amount of 35 hours. A week is defined as 12:00am Monday through 11:59pm Sunday.

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	DD Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day

Provider Category:

Agency

Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Assistive Technology is equipment or a product system such as devices, controls, or appliances, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants and be necessary to ensure participants health, welfare and safety. The use of assistive technology enables participants who reside in their own homes to increase their abilities to perform activities of daily living in their home, or to perceive, control, or communicate with the environment they live in, thereby decreasing their need for assistance from others as a result of limitations due to disability.

All devices and adaptations must be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design, and installation.

Assistive Technology includes the equipment or product system as well as:

a. Services consisting of purchasing or leasing assistive technology devices for participants.
b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.
c. Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan.
d. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant.
e. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Assistive Technology may be self-directed.

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

Assistive Technology has a participant annual budget cap of $2,500.

The $2,500 cap was determined based on historical and actual data and the funding limitation has historically addressed the health and welfare of waiver participants. If a participant's needs cannot be met within the established funding limitation, the participant's team will meet to determine what alternatives may be available, such as the Vocational Rehabilitation AT4All program which has used and reconditioned equipment for sale, free, for loan, or for rent. If alternatives are unavailable, additional developmental disabilities funding could be requested through the established exception process.

DDD may require an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate Medicaid enrolled professional providers. DDD may use a third party to assess the proposed modification and need for the modification to ensure cost effectiveness and quality of product. This assessment will be funded by the Environmental Modification Assessment service; as such, it will be reimbursed separately. The cost of the Environmental Modification Assessment is not included in the $2,500 cap on Assistive Technology.

Assistive Technology is limited to devices, controls, or appliances to assist the participant to perceive, control, or communicate with the environment they live in.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Assistive Technology is reimbursed per item directly to the Medicaid enrolled provider or the manufacturer.

Providers cannot exceed their charges to the public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) must apply the same discount to the participants who would otherwise qualify for the discount.

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

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

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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
Individual	Independent Individual - Non-Habilitative Services
Agency	Independent Agency - Non-Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Independent Individual - Non-Habilitative Services

Provider Qualifications

License *(specify):*

Electricians must be licensed in accordance with Neb. Rev. Stat. §§81-2106 - 2118. Plumbers must be licensed in accordance with Neb. Rev. Stat. §§18-1901 - 1919.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Independent Agency - Non-Habilitative Services

Provider Qualifications

License *(specify):*

Electricians must be licensed in accordance with Neb. Rev. Stat. §§81-2106 - 2118. Plumbers must be licensed in accordance with Neb. Rev. Stat. §§18-1901 - 1919.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral In-Home Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Behavioral In-Home Habilitation is a short-term habilitative service provided to waiver participants who have a chronic or severe mental health condition that prevents them from fully participating in community activities or employment opportunities. Behavioral In-Home Habilitation is provided to participants who may be experiencing episodic or cyclical behaviors, or who may have been prescribed a medication or dosage for which correct dosage and reaction is unknown. Behavioral In-Home Habilitation is provided to participants who are unable to remain alone during the hours that they would otherwise be away from their residence.

Services are based on the current needs and capabilities of the participant and under the direction of ongoing clinical oversight provided by the DD provider. Behavioral In-Home Habilitation includes adaptive skill development or refinement of daily living activities, such as personal grooming and cleanliness, laundry, bed making and household chores, and eating and the preparation of food. This service also includes the provision of personal care, health maintenance activities, supervision and protective oversight.

Individual programs must be specific and measurable and updated when not yielding progress, and data must be tracked and analyzed for trends. Monthly summary reports on progress or lack of progress must be made available upon request.

Behavioral In-Home Habilitation may not be self-directed.

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

Behavioral In-Home Habilitation must be provided in the participant's residence. The provider must be in the residence with the participant, providing service during daytime hours, as documented in the service plan.

Behavioral In-Home Habilitation is limited to 90 calendar days annually. Additional days must receive DDD Central Office approval.

Behavioral In-Home Habilitation is only available to participants receiving Continuous Home, Host Home, Shared Living, or Youth Continuous Home.

Behavioral In-Home Habilitation is not available to participants receiving Independent Living or Supported Family Living.

The amount of prior authorized services is based on the participant's need as periodically assessed by the state clinical team, and documented in the service plan, and within the participant's approved annual budget.

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

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT, or Nebraska DHHS Economic Support programs.

The total combined hours for this service may not exceed a weekly average amount of 35 hours and a maximum of 152 hours per month. A week is defined as 12:00am Monday through 11:59pm Sunday.

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	DD Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral In-Home Habilitation

Provider Category:
Agency
Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Benefits Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Benefits Counseling is a service designed to inform the participant of their pathways to obtaining individualized integrated employment or self-employment and how employment may impact their current benefits. The goal of the service is to promote participant's economic self-sufficiency through the use of available work incentives.
Benefits Counseling service includes three service delivery options: Benefits Education, Benefits Planning, and Benefits Management.

Benefits Education is for a participant who is exploring the possibility of competitive integrated employment by providing introductory education and information on their federal, state and/or local benefits (SSI, SSDI, Medicaid, Medicare, etc.) and an overview of work incentives available. Educational information is provided to the person and their legal guardian and payee (if applicable) and other supports of their choice. This service includes performing pre-employment benefits and resource information gathering and verification and identifying the projected impact of work on those benefits. The outcome of this service is to address any concerns the participant may have or the uncertainty of losing necessary supports and benefits in choosing to work. This service addresses myths and alleviates concerns related to seeking and working through accurate, individualized assessment.

Benefits Planning is a service for when a participant is actively seeking employment or advancement opportunities. This service includes a comprehensive individualized written summary of the participant's current benefits and earnings, analysis, and projected impact of employment earnings on the participant's benefits. The outcome of this service is to develop a plan that promotes the continuation of competitive integrated employment while maintaining needed supports and benefits. Essential benefit programs including SSI, SSDI, Medicaid, Medicare, housing assistance, economic assistance programs, etc. and related work incentives are reviewed. The service also will provide information to the person and family/supports regarding income reporting requirements for public benefit programs. Information about Ticket to Work Services, additional eligible benefits, and other needed services will be discussed in the plan. Benefits planning can be provided in-person or via virtual service delivery to the participant and team in creating a plan identifying reporting requirements and responsibility for reporting.

Benefits Management service is for a participant needing assistance due to a change in benefits, income, or resources that requires some problem-solving. This service involves problem-solving and advocacy support, assistance with accessing additional work incentives, or a revisit of benefits information if a critical milestone has been achieved (transitioning to a different phase of benefits, employment changes, being eligible for a new benefit off own or parent's work record, transitioning to retirement benefits, etc.). An updated summary of benefits information and supports provided is completed and provided to the participant and team.

When a portion of this service is delivered virtually, the following conditions apply:
• The total combined hours for virtual supports may not exceed a weekly amount of 10 hours and is included as part of the currently existing limit of 35 hours per week of services provided during the day. A participant can choose to receive a portion of this service virtually, but cannot replace all in-person assistance. The majority of the service provided each week must be provided in-person.
The provider is responsible for ensuring technologies used to deliver virtual supports comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534.
• Virtual supports will be delivered in a way that respects privacy of the individual and are not intended to monitor ADLs. Video cameras/monitors are not permitted in bedrooms and bathrooms.
• Use of virtual supports will be addressed in the participant's person-centered plan and the provider must have a plan/policies to ensure the participant's rights of privacy, dignity, and respect.
• Use of virtual supports must be a person-centered decision and facilitate community integration, not risk leading to the isolation of the participant from the community or from interacting with other people.
• Use of virtual supports is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose. The decision to use virtual supports as a portion of the service array must be clearly documented in the participant's person-centered plan and assure that the participant's needs must be able to be met by supports that can be provided virtually.
• Providers are responsible for ongoing training of the participant and direct support staff in use of the virtual support devices.
• Providers are required to develop policies and procedures which include:
o Identifying whether health and safety needs can be addressed safely via virtual supports;
o Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA compliance of the technology used for virtual support; obtaining written informed consent from the participant,

guardian (if applicable), and any others potentially impacted by provision of virtual supports, and maintaining records of these consents;
o A backup person for when in-person support is needed;
o A plan for contacting EMS if the participant experiences an emergency during virtual support or requires on-site support; and
o On-going training for direct support staff.

Benefits Counseling may not be self-directed.

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

Benefits Counseling services are reimbursed at an hourly rate. Benefits Counseling is limited to 20 hours per year with a minimum of 365 days between the services. The 20 hour limit can be applied to any combination of Benefits Education, Benefits Planning, and Benefits Management.

Transportation is not included in the rate.

Documentation must be maintained in the service coordination file for each participant receiving this service that the service is not otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services).

This service may be provided when the Federal Work Incentives Planning and Assistance (WIPA) program was sought and is documented in the person-centered service plan that such services were not available because of a waitlist that would result in services not being available within 30 calendar days.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT, Vocational Rehabilitation, or through any other program such as the Federal Work Incentives Planning and Assistance (WIPA) program.

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	Agency - Non-Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits Counseling

Provider Category:

Agency

Provider Type:

Agency - Non-Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

All providers must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate certifications.

Staff (direct, contracted or in a consulting capacity) who will work directly with the participant to provide Benefits Counseling services shall hold a Community Work Incentives Counselor or Community Partner Work Incentives Counselor certification that is accepted by the Social Security Administration.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Child Day Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Child Day Habilitation is a habilitative service that provides teaching and staff supports to meet the age-appropriate needs of a child due to a disability or special health conditions. Child Day Habilitation takes place in the community, separate from the participant's private family residence, in a provider setting approved, registered, or licensed by the Nebraska Department of Health and Human Services. Participants receiving Child Day Habilitation must be integrated into the community to the greatest extent possible.

Child Day Habilitation activities and environments are designed to teach adaptive skills and build positive social behavior while meeting the child's additional needs related to a disability or special health conditions. Child Day Habilitation includes individually tailored teaching to assist with the acquisition, retention, or improvement in adaptive skill development not yet mastered in daily living activities, inclusive community activities, and the social and leisure skill development necessary which will lead to more independence and personal growth to live in the most integrated setting appropriate to their needs. Child Day Habilitation includes the provision of supervision, and protective oversight beyond what is normally provided to children without disabilities or special health conditions.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

Child Day Habilitation may be self-directed or provider managed based on the preference of the participant.

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

Child Day Habilitation is available for participants living in their private family residence who are under 21 years.

Child Day Habilitation is not available to participants receive Community Integration, Continuous Home, Host Home, Shared Living, and Youth Continuous Home.

The rates for this service do not include the basic cost of childcare unrelated to a child's disability. The "basic cost of child care" means the rate charged by and paid to a childcare center or individual provider for children who do not have special needs. Regular childcare is expected to cover the care and supervision provided to children whose parents have elected to work or attend school and must arrange for someone else to take on those responsibilities in absentia. The cost of regular childcare is the responsibility of the participant's parents and is separated from the cost of habilitative services and staff supports due to the child's disability or special health condition. This is done by determining the cost of routine childcare and analyzing historical claims payment for the service to establish a rate that covers the exceptional physical, medical or personal care needs required by the participant.

Child Day Habilitation only covers necessary services and supports associated with the child's physical, medical, personal care, or behavioral needs not included in regular childcare. Regular childcare and its cost paid by parents do not cover the medically necessary services needed to address disability and special health care conditions. Cost sharing is payment made for a covered service and is usually in the form of a co-insurance, co-payment, or deductible.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Child Day Habilitation cannot exceed a weekly amount of 70 hours for participants living in their private family residence. A week is defined as 12:00 AM Monday through 11:59 PM Sunday.

Child Day Habilitation is reimbursed at an hourly rate.

The rate tier for this service is determined based upon needs identified in the Objective Assessment Process.

Transportation during the provision of Child Day Habilitation is included in the rate. Non-medical transportation to the site at which Child Day Habilitation begins is not included in the rate and is the parents' responsibility. Non-medical transportation from the site at which Child Day Habilitation ends is not included in the rate and is the parents' responsibility.

Child Day Habilitation may be provided by a relative or legal guardian but not a legally responsible individual.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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
Individual	Independent Individual - In-Home Child Care Provider - Habilitative Services
Agency	Independent Agency – Licensed Child Care Center – Habilitative Services
Individual	Independent Individual – Licensed Family Child Care Home I or II – Habilitative Services
Individual	Independent Individual – License-Exempt Family Child Care Home – Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Day Habilitation

Provider Category:

Individual

Provider Type:

Independent Individual - In-Home Child Care Provider - Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

In accordance with 474 NAC Social Services for Families, Children, and Youth.

Other Standard *(specify):*

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

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

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

A provider of this service must:
• Complete all provider enrollment requirements as defined by the Department;
• Have necessary education and experience, and provide evidence upon request:
o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
o Have four or more years of professional experience in the provision of age-appropriate services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
o Have any combination of education and experience identified above equaling four years or more;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a person legally responsible for the participant; and
• Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Day Habilitation

Provider Category:

Agency

Provider Type:

Independent Agency – Licensed Child Care Center – Habilitative Services

Provider Qualifications

License *(specify):*

In accordance with 391 NAC Children's Services Licensing or 474 NAC Social Services for Families, Children, and Youth.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

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

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

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

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Day Habilitation

Provider Category:

Individual

Provider Type:

Independent Individual – Licensed Family Child Care Home I or II – Habilitative Services

Provider Qualifications

License *(specify):*

In accordance with 391 NAC Children's Services Licensing or 474 NAC Social Services for Families, Children, and Youth.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

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

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

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

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Day Habilitation

Provider Category:

Individual

Provider Type:

Independent Individual – License-Exempt Family Child Care Home – Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

In accordance with 474 NAC Social Services for Families, Children, and Youth.

Other Standard *(specify):*

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

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

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

A provider of this service must:
• Complete all provider enrollment requirements;
• Have necessary education and experience, and provide evidence upon request:
o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
o Have four or more years of professional experience in the provision of age-appropriate habilitative services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
o Have any combination of education and experience identified above equaling four years or more;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be age 19 or older and authorized to work in the United States;
• Not be a person legally responsible for the participant; and
• Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Integration

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Integration is a habilitative service that provides formalized teaching, person-centered activities, and staff supports for the acquisition, retention, or improvement in self-help, behavioral skills, and adaptive skills that enhance social development. Habilitative activities are designed to foster greater independence, community networking, and personal choice. Community Integration provides an opportunity for the participant to practice skills taught in therapies, counseling sessions, or other settings to plan and participate in regularly scheduled community activities. Community Integration includes supports furnished in the community. A participant can choose to receive a portion of this service virtually. Community Integration includes assistance with activities of daily living (ADL), health maintenance, and supervision.

Individual programs must be specific, and measurable, and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system

When a participant is admitted to an in-patient, acute care hospital, due to a critical health or safety concern, Community Integration can be provided. Support includes habilitation to maintain learned skills, implementation of behavioral support, if needed, and assistance with daily living activities to support the participant's treatment and recovery. This level of support will assist the participant to not regress or lose learned skills they had before or while they were in an in-patient, acute care hospital.

This service is provided to meet needs of the participant that are not met through the provision of acute care hospital services. This service is in addition to, and may not substitute for or are not duplicative of, the services the acute care hospital is obligated to provide. This service will be used to ensure smooth transition between acute care setting and community-based setting and to preserve the participant's functional abilities. When authorized this service must be identified in the participant's person-centered service plan.

Prior to discharge the person-centered plan will be updated to reflect the participant's needs and supports for transition back to the community based setting.

When a portion of this service is delivered virtually, the following conditions apply:

- The total combined hours for virtual supports may not exceed a weekly amount of 10 hours and is included as part of the currently existing limit of 35 hours per week of services provided during the day. A participant can choose to receive a portion of this service virtually, but cannot replace all in-person assistance. The majority of the service provided each week must be provided in-person.
- A participant can choose to receive a portion of this service virtually but it cannot replace all in-person assistance. Most of the service provided each week must be provided in-person.
- The provider is responsible for ensuring technologies used to deliver virtual supports comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534.
- Virtual supports will be delivered in a way that respects the privacy of the individual and is not intended to monitor ADL's. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- Use of virtual supports will be addressed in the participant's person-centered plan and the provider must have a plan and/or policies to ensure the participant's rights of privacy, dignity, and respect.
- Use of virtual supports must be a person-centered decision and facilitate community integration, not risk leading to the isolation of the participant from the community or from interacting with other people.
- Use of virtual supports is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose. The decision to use virtual supports as a portion of the service array must be clearly documented in the participant's person-centered plan and assure that the participant's needs must be able to be met by supports that can be provided virtually.
- The state is requiring provider's to be responsible for ongoing training of the participant and direct support staff in use of the virtual support devices.
- Providers are required to develop a policies and procedures which include:
  - Identifying whether health and safety needs can be addressed safely via virtual supports;
  - Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA compliance of the technology used for virtual support;
  - Obtaining written informed consent from the participant, guardian (if applicable), and any others potentially impacted by provision of virtual supports, and maintaining records of these consents;

- A backup person for when in-person support is needed;
- A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
- Ongoing training for direct support staff.

Community Integration may be self-directed.

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

Participants may not perform paid work activities or unpaid work activities in which others are typically paid, but may perform hobbies in which minimal money is received, or volunteer activities.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Community Integration is reimbursed at an hourly unit. The Community Integration provider is primarily in the community, providing a combination of habilitation, supports, protective oversight, and supervision to bill in hourly units.

The rate tier for this service is determined based upon needs identified in the Objective Assessment Process.

Transportation required in the provision of Community Integration is included in the rate. Non-medical transportation to the site at which Community Integration begins is not included in the rate. Non-medical transportation from the site at which Community Integration ends is not included in the rate.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

Community Integration may be provided by a relative or legal guardian but not a legally responsible individual.

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

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

The total combined hours for day services may not exceed a weekly amount of 35 hours. A week is defined as 12:00am Monday through 11:59pm Sunday.

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
Individual	Indpendent Individual - Habilitative Serivces
Agency	DD Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration

Provider Category:

Individual

Provider Type:

Indpendent Individual - Habilitative Serivces

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

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

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

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

A provider of this service must:

- Complete all provider enrollment requirements;
- Have necessary education and experience, and provide evidence upon request:
  - o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
  - o Have four or more years of professional experience in the provision of habilitative services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
  - o Have any combination of education and experience identified above equaling four years or more;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - o Cardiopulmonary resuscitation; and
  - o Basic first aid;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration

Provider Category:

Agency

Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consultative Assessment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Consultative Assessment is provided when a behavior support plan is developed and implemented to assist participants in maintaining their current living environment while ensuring their safety and the safety of others. Consultative Assessment is necessary to improve the participant's independence and inclusion in their community. Consultative Assessment activities may include team consultation, behavioral assessment, behavior support plan development, and implementation.

This service is performed by a Licensed Independent Mental Health Practitioner (LIMHP), Licensed Psychologist, Advanced Practice Registered Nurse (APRN), or a Board-Certified Behavior Analyst (BCBA or BCBA-D).

A behavioral assessment identifies specific target behaviors, the purpose of the behaviors, and what factors maintain the behaviors that are interfering with the participant's adaptive skills development and participation in integrated community living and employment. The behavioral assessment, including assessment of level of risk, is necessary in order to address problematic behaviors in functioning that are attributed to developmental, cognitive and or communication impairments. Observations where the participant lives, and/or takes part in day services or other activities are conducted at any time of the day or night in person or by Telehealth, depending upon when and where the specific problematic behaviors occur. The current interventions are documented, and efficacy assessed.

The assessment process leads to the development of a positive behavior support plan (BSP) to teach acceptable alternative behaviors. The resulting BSP focuses on teaching a new behavior and social skills and may require modification to environments, activities, and delivery of intervention and teaching strategies. The assessment process is completed in collaboration with the service planning team and includes assessment of risk levels, strengths, needs, and preferences; recommendations for the development of a behavior support plan, safety plan, and other habilitative plans; and recommendations to carry out the developed plans. Best practices in intervention strategies, medical and psychological conditions, and/or environmental impact to service delivery are provided to the participant's team. Behavioral interventions are developed, piloted, implemented, evaluated, and revised, as necessary.

When the behavior support plan, safety plan, and other habilitative plans are written by provider staff that is not the LIMHP, Licensed Psychologist, APRN, or a BCBA or BCBA-D, licensed psychologist, or APRN who completed the assessment, all service planning team members, including the provider of the assessment must agree to the intervention strategies.

Individual programs must be specific and measureable and updated when not yielding progress, and data must be tracked and analyzed for trends. Monthly summary reports on progress or lack of progress must be made available upon request.

Consultative Assessment may be self-directed.

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

The amount of prior authorized services is based on the participant's need as documented in the service plan and is not limited by the amount approved for the participant's annual budget.

Consultative Assessment is reimbursed at an hourly unit.

Provider's transportation and lodging is included in the reimbursement rate.

Providers of this service must be available for consultation with the team either via telecommunication (phone or Telehealth) or in person for a minimum of two conference meetings per person-centered plan (PCP) year, and this team consultation is included in the rate. More frequent conferences may be necessary based on frequency of high incident reports.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State plan or HCBS Waiver services.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Agency - Habilitative Services
Individual	Independent Individual - Habilitative Services
Agency	DD Agency - Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultative Assessment

Provider Category:

Agency

Provider Type:

Independent Agency - Habilitative Services

Provider Qualifications

License *(specify):*

Staff or agencies that provide a service for which a license is required must hold the license in accordance with applicable state laws and regulations. Applicable staff must be licensed in good standing with the Division of Public Health and functioning within their scope of practice, i.e. LIMHP, licensed clinical psychologist or APRN.
Neb. Rev. Stat. §38-121
Neb. Rev. Stat. §§38-2121 - 38-2123
Neb. Rev. Stat. §§38-3115 - 38-3120

Certificate *(specify):*

Staff or agencies that provide a service for which a license, certification, or registration, or other credential is required, must hold the license, certification, registration, or credential in accordance with applicable state laws and regulations. Applicable staff must be certified and in good standing with DHHS and functioning within their scope of practice, i.e. BCBA, BCBA-D. Neb. Rev. Stat. §44-7.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultative Assessment

Provider Category:

Individual

Provider Type:

Independent Individual - Habilitative Services

Provider Qualifications

License *(specify):*

Individuals that provide a service for which a license is required must hold the license in accordance with applicable state laws and regulations. Applicable staff must be licensed in good standing with the Division of Public Health and functioning within their scope of practice, i.e. LIMHP, licensed clinical psychologist or APRN.
Neb. Rev. Stat. §38-121
Neb. Rev. Stat. §§38-2121 - 38-2123
Neb. Rev. Stat. §§38-3115 - 38-3120

Certificate *(specify):*

Staff or agencies that provide a service for which a license, certification, or registration, or other credential is required, must hold the license, certification, registration, or credential in accordance with applicable state laws and regulations. Applicable staff must be certified and in good standing with DHHS and functioning within their scope of practice, i.e. BCBA, BCBA-D. Neb. Rev. Stat. §44-7

Other Standard *(specify):*

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

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

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

A provider of this service must:

- Complete all provider enrollment requirements;
- Have necessary education and experience, and provide evidence upon request:
  - o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
  - o Have four or more years of professional experience in the provision of habilitative services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
  - o Have any combination of education and experience identified above equaling four years or more;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - o Cardiopulmonary resuscitation; and
  - o Basic first aid;
- Be age 19 or older and authorized to work in the United States;
- Not be a legally responsible individual or guardian to the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultative Assessment

Provider Category:

Agency

Provider Type:

DD Agency - Habilitative Services

Provider Qualifications

License *(specify):*

Staff or agencies that provide a service for which a license is required must hold the license in accordance with applicable state laws and regulations. Applicable staff must be licensed in good standing with the Division of Public Health and functioning within their scope of practice, i.e. LIMHP, licensed clinical psychologist or APRN.
Neb. Rev. Stat. §38-121
Neb. Rev. Stat. §§38-2121 - 38-2123
Neb. Rev. Stat. §§38-3115 - 38-3120

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act. Applicable staff must be certified and in good standing with DHHS and functioning within their scope of practice, i.e. BCBA, BCBA-D. Neb. Rev. Stat. §44-7

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Day Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Day Supports is a habilitative service offering habilitative activities in a provider-owned or controlled non-residential setting when not delivered virtually. Day Supports provides person-centered activities, formalized training, and staff supports for the acquisition, retention, or improvement in self-help, behavioral skills, and adaptive skills to enhance social development. Day Supports activities assist in developing skills in performing activities of daily living, and community living. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice. This service is provided to participants who do not have a specific employment goal, and are therefore not currently seeking to join the general work force.

Day Supports focuses on enabling the participant to attain or maintain their maximum functional level and must be coordinated with, but may not supplant, any physical, occupational, or speech therapies listed in the service plan. In addition, the services and supports may reinforce but not replace skills taught in therapy, counseling sessions, or other settings. This service also includes the provision of personal care, health maintenance activities, supervision, and protective oversight.

Individual programs must be specific, and measurable, and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

When a participant is admitted to an in-patient, acute care hospital, due to a critical health or safety concern, Day Support can be provided. Support includes habilitation to maintain learned skills, implementation of behavioral support, if needed, and assistance with daily living activities to support the participant's treatment and recovery. This level of support will assist the participant to not regress or lose learned skills they had before or while they were in an in-patient, acute care hospital.

This service is provided to meet needs of the participant that are not met through the provision of acute care hospital services. This service is in addition to, and may not substitute for or are not duplicative of, the services the acute care hospital is obligated to provide. This service will be used to ensure smooth transition between acute care setting and community-based setting and to preserve the participant's functional abilities. When authorized this service must be identified in the participant's person-centered service plan.

Prior to discharge the person-centered plan will be updated to reflect the participant's needs and supports for transition back to the community based setting.

When a portion of this service is delivered virtually, the following conditions apply:

- The total combined hours for virtual supports may not exceed a weekly amount of 10 hours and is included as part of the currently existing limit of 35 hours per week of services provided during the day. A participant can choose to receive a portion of this service virtually, but cannot replace all in-person assistance. The majority of the service provided each week must be provided in-person.
- A participant can choose to receive a portion of this service virtually but it cannot replace all in-person assistance. Most of the service provided each week must be provided in-person.
- The provider is responsible for ensuring technologies used to deliver virtual supports comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534.
- Virtual supports will be delivered in a way that respects the privacy of the individual and is not intended to monitor ADL's. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- Use of virtual supports will be addressed in the participant's person-centered plan and the provider must have a plan and/or policies to ensure the participant's rights of privacy, dignity, and respect.
- Use of virtual supports must be a person-centered decision and facilitate community integration, not risk leading to the isolation of the participant from the community or from interacting with other people.
- Use of virtual supports is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose. The decision to use virtual supports as a portion of the service array must be clearly documented in the participant's person-centered plan and assure that the participant's needs must be able to be met by supports that can be provided virtually.
- The state is requiring provider's to be responsible for ongoing training of the participant and direct support staff in use of the virtual support devices.

- Providers are required to develop a policies and procedures which include:
  - Identifying whether health and safety needs can be addressed safely via virtual supports;
  - Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA compliance of the technology used for virtual support;
  - Obtaining written informed consent from the participant, guardian (if applicable), and any others potentially impacted by provision of virtual supports, and maintaining records of these consents;
  - A backup person for when in-person support is needed;
  - A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
  - Ongoing training for direct support staff.

Day Supports may not be self-directed.

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

Day Supports may not provide for the payment of services that are vocational in nature (i.e., for the primary purpose of produces goods or performing services).

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Day Supports is reimbursed at an hourly unit. The Day Supports provider must be in the day site setting or community setting, providing a combination of habilitation, supports, protective oversight, and supervision to be billed in hourly units.

The rate tier for this service is determined based upon needs identified in the Objective Assessment Process.

Transportation required in the provision of Day Supports is included in the rate. Non-medical transportation to the site at which Day Supports begins is not included in the rate. Non-medical transportation from the site at which Day Support ends is not included in the rate.

Day Supports may be provided by a relative or legal guardian but not a legally responsible individual.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

Documentation must be maintained in the service coordination file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services).

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

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT or Vocational Rehabilitation programs.

The total combined hours for day services may not exceed a weekly amount of 35 hours. A week is defined as 12:00am Monday through 11:59pm Sunday.

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	DD Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Day Supports

Provider Category:

Agency

Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Employment Exploration

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other

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

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

Service Definition *(Scope):*

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

Employment Exploration is a time-limited and targeted service designed to help a person make an informed choice about whether they wish to pursue individualized integrated employment or self-employment. This service shall be completed no more than thirty (30) calendar days from the date of service initiation. This service is not appropriate for Employment and Community First CHOICES (ECF) members who already know they want to pursue individualized integrated employment or self-employment.

This service includes career exploration activities to identify a person's specific interests and aptitudes for paid work, including experience and skills transferable to individualized integrated employment or self-employment. This service also includes exploration of individualized integrated employment or self-employment opportunities in the local area that are specifically related to the person's identified interests, experiences, and/or skills through four to five uniquely arranged business tours, informational interviews, and/or job shadows. (Each person receiving this service should participate in business tours, informational interviews, and/or job shadows uniquely selected based on the participant's individual interests, aptitudes, experiences, and skills most transferable to employment. All persons should not participate in the same experiences.) Each business tours, informational interviews, and/or job shadow shall include time for set-up, prepping the participant for participation, and debriefing with the participant after each opportunity.

The provider shall document each date of service, the activities performed on that day, and the duration of each activity. This service culminates in a written report summarizing the process and outcomes, using a standard template. The written report is due no later than fourteen (14) calendar days after the last date of service has concluded. Employment Exploration is paid on an outcome basis, after the written report is received and approved, and the provider submits documentation detailing each date of service, the activities performed on that day, and the duration of each activity.

Employment Exploration adheres to principles of person-centered planning. Employment Exploration helps individuals identify their desired employment outcomes, which are documented in their person-centered plan (PCP). The exploration process considers the participant's interests, skills, and preferences to ensure alignment between the service and their overall goals.

Participation in Employment Exploration is not a required pre-requisite for Supported Employment – Individual or Supported Employment – Follow-Along services provided under the waiver.

When a portion of this service is delivered virtually, the following conditions apply:

- The total combined hours for virtual supports may not exceed a weekly amount of 10 hours and is included as part of the currently existing limit of 35 hours per week of services provided during the day. A participant can choose to receive a portion of this service virtually, but cannot replace all in-person assistance. The majority of the service provided each week must be provided in-person.

The provider is responsible for ensuring technologies used to deliver virtual supports comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534.

- Virtual supports will be delivered in a way that respects privacy of the individual and are not intended to monitor ADLs. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- Use of virtual supports will be addressed in the participant's person-centered plan and the provider must have a plan/policies to ensure the participant's rights of privacy, dignity, and respect.
- Use of virtual supports must be a person-centered decision and facilitate community integration, not risk leading to the isolation of the participant from the community or from interacting with other people.
- Use of virtual supports is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose. The decision to use virtual supports as a portion of the service array must be clearly documented in the participant's person-centered plan and assure that the participant's needs must be able to be met by supports that can be provided virtually.
- Providers are responsible for ongoing training of the participant and direct support staff in use of the virtual support devices.
- Providers are required to develop a policies and procedures which include:

o Identifying whether health and safety needs can be addressed safely via virtual supports;

o Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA compliance of the technology used for virtual support; obtaining written informed consent from the participant, guardian (if applicable), and any others potentially impacted by provision of virtual supports, and maintaining

records of these consents;
o A backup person for when in-person support is needed;
o A plan for contacting EMS if the participant experiences an emergency during virtual support or requires on-site support; and
o On-going training for direct support staff.

Employment Exploration may not be self-directed.

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

Employment Exploration is limited to 40 hours per year with a minimum of 365 days between re-authorization of the service.

Transportation is not included in the rate.

Documentation must be maintained in the service coordination file for each participant receiving this service that the service is not otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services).

This service may be provided when the Federal Work Incentives Planning and Assistance (WIPA) program was sought and is documented in the person-centered service plan that such services were not available because of a waitlist that would result in services not being available within 30 calendar days.

Employment Exploration may be provided by a relative but not a legal guardian or legally responsible individual.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT, Vocational Rehabilitation, or through any other program such as the Federal Work Incentives Planning and Assistance (WIPA) program.

The total combined hours for day services may not exceed a weekly amount of 35 hours. A week is defined as 12:00am Monday through 11:59pm Sunday.

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	Agency - Non-Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Exploration

Provider Category:

Agency

Provider Type:

Agency - Non-Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Staff (direct, contracted, or in a consulting capacity) who will work directly with the participant to provide Employment Exploration services shall hold a Community Work Incentives Counselor or Community Partner Work Incentives Counselor certification that is accepted by the Social Security Administration.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with the designated provider screening enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Modification Assessment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

An Environmental Modification Assessment is a functional evaluation with the participant to ensure the health, welfare and safety of the participant or to enable the participant to integrate more fully into the community, and to function in the participant's private home (not provider owned or leased, operated or controlled), or in the participant's family's home, when living with their family.

The on-site assessment of the environmental concern includes an evaluation of functional necessity, the determination of the provision of appropriate assistive technology, home, or vehicle modification for the participant, and the need for the modification to ensure cost effectiveness.

Environmental Modification Assessment may be self-directed.

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

Participant's annual budget cap for Environmental Modification Assessments is $1,000. A critical health or safety service request that exceeds the annual cap is subject to available waiver funding and approval by DHHS-DD.

The amount of prior authorized services is based on the participant's need as documented in the participant's service plan, and within the participant's approved annual budget.

Environmental Modification Assessment is reimbursed per assessment.

Providers shall not exceed their charges to the general public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to the participants who would otherwise qualify for the discount.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Agency - Non-Habilitative Services
Individual	Independent Individual - Non-Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modification Assessment

Provider Category:

Agency

Provider Type:

Independent Agency - Non-Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

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

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

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

Agency provider employees and back-up staffing delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be authorized to work in the United States;
• Be 19 years of age or older;
• Not be a person legally responsible for the participant;
• Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation;
• Ensure that all items and assistive equipment recommended or provided meet the applicable standards of manufacture, design, and installation; and
• Obtain, at a minimum, three bids/cost proposals to ensure cost effectiveness.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modification Assessment

Provider Category:

Individual

Provider Type:

Independent Individual - Non-Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

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

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

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

A provider delivering this service must:
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be authorized to work in the United States;
• Be 19 years of age or older;
• Not be a person legally responsible for the participant;
• Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation;
• Ensure that all items and assistive equipment recommended or provided meet the applicable standards of manufacture, design, and installation; and
• Obtain, at a minimum, three bids/cost proposals to ensure cost effectiveness.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Health Maintenance Monitoring

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11010 health monitoring

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14031 equipment and technology

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Health Maintenance Monitoring involves the monitoring of personal health and collecting medical data to improve the management, care, and support for chronic medical conditions. The goal is to identify any changes or concerns early, allowing for prompt intervention and preventing serious health complications. Health professionals provide education, support, and guidance on effectively managing conditions by teaching participants or guardians how to monitor symptoms, follow treatment plans, and make lifestyle modifications to maintain their health and well-being. This service can include medication monitoring if other aspects of a participant's health are also monitored.

This service is delivered via electronic communication technologies that remotely monitor a participant's vital signs, biometrics, or subjective data by a monitoring device that transmits such data electronically to a healthcare practitioner for analysis and storage.

Healthcare providers use digital technology that collects medical and health data from individuals in one location to electronically transmit that information securely to a healthcare provider in a different location.

Participants receiving Health Maintenance Monitoring must be under the supervision of a treating physician, physician's assistant, or advanced practice nurse who is directly providing care and treatment for their medical condition and not merely engaged to authorize the monitoring service.

Electronic Health Maintenance Monitoring requires the participant or guardian to have the capability to utilize any monitoring tools involved or shall include the regular presence of an individual in the home who can utilize the involved monitoring tools and have the internet or cellular internet connection necessary to accommodate any needed remote patient monitoring equipment in the home.

Health Maintenance Monitoring will be addressed in the participant's person-centered plan (PCP) and include the frequency, duration, and schedule of each health monitoring task including the criteria for abnormal findings and when to consult the participant's doctor.

Health Maintenance Monitoring will be delivered in a way that respects the privacy of the individual and is not intended to monitor ADLs. Video cameras/monitors are not permitted in bedrooms and bathrooms.

The use of Health Maintenance Monitoring is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose.

The participant or guardian must consent to receive the monitoring service and is responsible for the oversight and supervision of the monitoring.

The participant's residence must have space for all program equipment and full transmission capability.

The provider maintains a participant's record supporting the medical necessity of the service, all transmissions and subsequent reviews received from the participant, and how the data transmitted from the participant is being utilized in the continuous development and implementation of the participant's care.

Health care providers performing a telehealth or digital health service shall, as appropriate for the service, provider, and participant, utilize the following modalities of communication delivered over a secure communications connection that complies with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA):
- Live or real-time audio and video asynchronous telehealth technology;
- Asynchronous store-and-forward telehealth technology;
- Remote patient monitoring using wireless devices, wearable sensors, or health monitors, such as:
  - Heart rhythm with an electrocardiogram (ECG), respiration, blood oxygen level (SpO2), non-invasive blood pressure (NIBP), glucose monitor weight, apnea monitors, specialized monitors for dementia and temperature.
- Audio-only telecommunications systems;
- Clinical text chat technology; and
- Medication dispensing and monitoring.

Health Maintenance Monitoring can be used to monitor the following:
- Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.
- Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow

rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
• Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes.
• Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes.

Interpretation of data and any teaching or coaching of the participant and guardian must be done by a Registered Nurse (RN), Nurse Practitioner (NP), Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Medical Doctor (MD) or Doctors of Osteopathy (DO).

Providers are required to develop policies and procedures which include:
• Identifying whether health and safety needs can be addressed safely via health maintenance monitoring;
• Assurance of the participants' rights to privacy, dignity, and respect, and the HIPAA compliance of the technology used for health maintenance monitoring;
• A plan for how to respond to abnormal findings and when to consult the participant's doctor.
• A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
• Ongoing training for direct support staff.

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

When this service is provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities.

This service cannot be authorized for a participant receiving Continuous Home, Host Home, Shared Living, Youth Continuous Home, or any other waiver service that includes personal care assistance.

Interpretation of data and any teaching or coaching of the participant and guardian must be done by a Registered Nurse (RN), Nurse Practitioner (NP), Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Medical Doctor (MD) or Doctors of Osteopathy (DO).

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

Health Maintenance Monitoring may be provided by a relative but not a relative legal guardian or legally responsible individual.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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	DD Agency - Health Maintenance Monitoring Agency
Agency	Independent Agency - Health Maintenance Monitoring Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health Maintenance Monitoring

Provider Category:

Agency

Provider Type:

DD Agency - Health Maintenance Monitoring Agency

Provider Qualifications

License *(specify):*

175 NAC Health Care Facilities and Services Licensure.

Interpretation of data and any teaching or coaching of the participant and guardian must be done by a Registered Nurse (RN), Nurse Practitioner (NP), Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Medical Doctor (MD) or Doctors of Osteopathy (DO).

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

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

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

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

Agency provider employees and back-up staffing delivering direct services and supports must:
- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation; and
  - Basic first aid;
- Be authorized to work in the United States;
- Not be a legally responsible individual or guardian to the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

Providers of Health Maintenance Monitoring must:
- Employ or contract with a healthcare provider with the required qualification or license of a registered nurse (RN), physician, physician's assistant (PA), or advanced practice nurse (APRN) to provide the following, according to participant need:
  - Health assessments;
  - Nursing services;
  - Review and interpret participant data;
  - Report to the supervising practitioner who is directly providing care and treatment for their medical condition;
  - Complete necessary records;
  - Provide teaching and coaching as necessary to the recipient and guardian; and
  - Analyze data and develop and document interventions by qualified staff based on the information and data reported.
- For remote monitoring, the provider must:
  - Deliver, provide, maintain, repair, or replace equipment, supplies, and accessories, and ensure proper functioning when connected to the participant’s existing internet, cell, or phone services.
  - This may be done remotely as long as all routine requests are resolved within 3 business days.
  - Train the participant and caregiver in the use of the equipment.
  - Electronically collect and automatically uploaded all physiologic data to a secure location where the data can be available for analysis and interpretation by the billing practitioner.
  - Ensure the device used to collect and transmit the data meets the definition of a medical device as defined by the FDA.
  - Collect remote monitoring data for at least 16 out of 30 days.
  - Use Health Maintenance Monitoring to monitor an acute care or chronic condition.

Health Maintenance Monitoring may be provided by auxiliary personnel under the general supervision of the billing practitioner.

Rates:
- Rates are reviewed annually at the time the provider’s annual agreement is scheduled to end.
- Rates are established based on the usual and customary rates that are not more than the provider would charge a private paying individual.
- The equipment rental is a separate billing item depending on the device.
- Electronic Monitoring billing includes:
  - A first month of initial enrollment including Remote Patient Monitoring (RPM) device setup and the delivery of participant education on using the device and receiving RPM services.

o A base monthly payment for monitoring participant data transmitted from the RPM device and ongoing management of the device.
o A monthly payment for spending 20 minutes communicating with the participant or a caregiver about the transmitted data and changes to the care management plan.
o An additional monthly payment if communication with a participant or caregiver exceeds 20 minutes but is less than 40 minutes.
o If communication requires 40 or more minutes, provide an additional — and final — monthly payment. There are no additional payments for communication of 1 hour or more.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health Maintenance Monitoring

Provider Category:

Agency

Provider Type:

Independent Agency - Health Maintenance Monitoring Agency

Provider Qualifications

License *(specify):*

175 NAC Health Care Facilities and Services Licensure.

Interpretation of data and any teaching or coaching of the participant and guardian must be done by a Registered Nurse (RN), Nurse Practitioner (NP), Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Medical Doctor (MD) or Doctors of Osteopathy (DO).

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

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

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

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

Agency provider employees and back-up staffing delivering direct services and supports must:
- Meet and adhere to all applicable employment standards established by the hiring agency;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
  - Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - Cardiopulmonary resuscitation; and
  - Basic first aid;
- Be authorized to work in the United States;
- Not be a legally responsible individual or guardian to the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

Providers of Health Maintenance Monitoring must:
- Employ or contract with a healthcare provider with the required qualification or license of a registered nurse (RN), physician, physician's assistant (PA), or advanced practice nurse (APRN) to provide the following, according to participant need:
  - Health assessments;
  - Nursing services;
  - Review and interpret participant data;
  - Report to the supervising practitioner who is directly providing care and treatment for their medical condition;
  - Complete necessary records;
  - Provide teaching and coaching as necessary to the recipient and guardian; and
  - Analyze data and develop and document interventions by qualified staff based on the information and data reported.
- For remote monitoring, the provider must:
  - Deliver, provide, maintain, repair, or replace equipment, supplies, and accessories, and ensure proper functioning when connected to the participant’s existing internet, cell, or phone services.
  - This may be done remotely as long as all routine requests are resolved within 3 business days.
  - Train the participant and caregiver in the use of the equipment.
  - Electronically collect and automatically uploaded all physiologic data to a secure location where the data can be available for analysis and interpretation by the billing practitioner.
  - Ensure the device used to collect and transmit the data meets the definition of a medical device as defined by the FDA.
  - Collect remote monitoring data for at least 16 out of 30 days.
  - Use Health Maintenance Monitoring to monitor an acute care or chronic condition.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home Modifications are physical adaptations to the participant's private home or to the family's home, when living with their family. Home modifications are necessary to ensure the health, welfare, and safety of the participant, or necessary to enable the participant to function with greater independence in their own participant-directed private home or in the family's home, thereby decreasing their need for assistance from paid and natural supports because of limitations due to disability.

Home Modifications are provided within the current foundation of the residence. Such modifications may include, but are not limited to, the installation of ramps, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems necessary to accommodate the modifications. Adaptations adding to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Approvable adaptations do not include adaptations or improvements to the home of general utility, and are not of direct medical or remedial benefit to the participant. The participant's home must not present a health and safety risk to the participant other than what is corrected by the approved home adaptations. Home Modifications will not be approved to adapt living arrangements for a residence owned or leased, operated or controlled by a provider of waiver services.

Home Modifications may be self-directed.

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

DDD may require an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate Medicaid enrolled professional providers. DDD may use a third party to assess the proposed modification and need for the adaptation to ensure cost effectiveness and quality of product. This assessment will be funded by the Environmental Modification Assessment service, and will be reimbursed separately.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Proof of renter's insurance or homeowner's insurance may be requested.

Evidence of application to secure government-subsidized housing through U.S. Department of Housing and Urban Development or other Economic Assistance programs may be requested.

Providers shall not exceed their charges to the general public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to the participants who would otherwise qualify for the discount.

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

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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
Individual	Independent Individual - Non-Habilitative Services
Agency	Independent Agency, Department of Education, Companies for Specialized Equipment, Supplies, Home Repair

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

Independent Individual - Non-Habilitative Services

Provider Qualifications

License *(specify):*

All general contractors or vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license.

Certificate *(specify):*

All general contractors or vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate certifications.

Other Standard *(specify):*

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

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

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

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

A provider of this service must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. Appropriately licensed/certified persons shall make or oversee all modifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Agency

Provider Type:

Independent Agency, Department of Education, Companies for Specialized Equipment, Supplies, Home Repair

Provider Qualifications

License *(specify):*

All general contractors or vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license.

Certificate *(specify):*

All general contractors or vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate certifications.

Other Standard *(specify):*

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

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

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

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

A provider of this service must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. Appropriately licensed/certified persons shall make or oversee all modifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Homemaker

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Homemaker service is the performance of the general household activities, such as meal preparation, laundry services, errands, and routine household care, when the participant regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. This service does not include direct care or supervision.

Homemaker may be self-directed.

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

Homemaker has an annual cap of 520 hours.

Homemaker cannot be provided to participants receiving Independent Living, Continuous Home, Host Home, Shared Living, and Youth Continuous Home.

Homemaker cannot duplicate or replace other supports available to the participant, including natural supports.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Homemaker is reimbursed at an hourly unit and the provider must use Electronic Visit Verification (EVV).

Transportation is not included in the reimbursement rate.

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

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

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Agency
Individual	Independent Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Independent Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

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

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

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

All providers delivering this service must have the computer skills and access to the technology needed to navigate the Electronic Visit Verification (EVV) system.

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Independent Individual

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

Independent providers, acting as legal guardians, must be approved by DDD Central Office to provide this service.

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

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

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

All providers delivering this service must have the computer skills and access to the technology needed to navigate the Electronic Visit Verification (EVV) system.

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR Â§440.180(b)(9), the State requests the authority to provide the following additional service

not specified in statute.

Service Title:

Host Home

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Host Home is delivered in a private home owned or leased as the sole residence by an individual, couple, or a family chosen by the participant, and who is an employee of the provider agency authorized to provide the service. The Host Home employee and the participant live together in the host home and the participant shares daily life with the Host Home family in their home and community.

All Host Home options include adaptive skill development of activities of daily living (ADLs), such as personal grooming and cleanliness, laundry, bed making and household chores, eating and the preparation of food, inclusive community activities, transportation, and the social and leisure skill development necessary to enable the participant to live in the most integrated setting appropriate to their needs. This service also includes the provision of personal care, health maintenance activities, supervision, and protective oversight.

When a participant is admitted to an in-patient, acute care hospital, due to a critical health or safety concern, this service can be provided. Support includes habilitation to maintain learned skills, implementation of behavioral support, if needed, and assistance with ADLs to support the participant's treatment and recovery. This level of support will assist the participant to not regress or lose learned skills they had before or while they were in an in-patient, acute care hospital.

This service is provided to meet needs of the participant that are not met through the provision of acute care hospital services. This service is in addition to, and may not substitute for, or are not duplicative of, the services the acute care hospital is obligated to provide. This service will be used to ensure smooth transition between acute care setting and community-based setting and to preserve the participant's functional abilities. When authorized this service must be identified in the participant's person-centered service plan.

Prior to discharge the person-centered plan (PCP) will be updated to reflect the participant's needs and supports for transition back to the community-based setting.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

When a portion of this service is delivered remotely, the following conditions apply:

- The total combined hours for remote supports may not exceed a weekly amount of 10 hours. A participant can choose to receive a portion of this service remotely, but cannot replace all in-person assistance. The majority of the service provided each week must be provided in-person.
- The provider is responsible for ensuring technologies used to deliver remote supports comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534.
- Remote supports will be delivered in a way that respects the privacy of the individual and are not intended to monitor ADLs. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- Use of remote supports will be addressed in the participant's PCP and the provider must have a plan and/or policies to ensure the participant's rights of privacy, dignity, and respect.
- Use of remote supports must be a person-centered decision and facilitate community integration, not risk leading to the isolation of the participant from the community or from interacting with other people.
- Use of remote supports is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in person services if they choose. The decision to use remote supports as a portion of the service array must be clearly documented in the participant's PCP and assure that the participant's needs must be able to be met by supports that can be provided remotely.
- The state is requiring provider's to be responsible for ongoing training of the participant and direct support staff in use of the remote support devices.
- Providers are required to develop a policies and procedures which include:
  - Identifying whether health and safety needs can be addressed safely via remote supports;
  - Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA compliance of the technology used for remote support;
  - Obtaining written informed consent from the participant, guardian (if applicable), and any others potentially impacted by provision of remote supports, and maintaining records of these consents;
  - A backup person for when in-person support is needed;

o A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
o Ongoing training for direct support staff.

When a portion of this service is delivered via electronic health maintenance monitoring, the following conditions apply:
• Participants receiving Health Maintenance Monitoring must be under the supervision of a treating physician, physician's assistant, or advanced practice nurse who is directly providing care and treatment for their medical condition and not merely engaged to authorize the monitoring service.
• Electronic Health Maintenance Monitoring requires the participant or guardian to have the capability to utilize any monitoring tools involved or shall include the regular presence of an individual in the home who can utilize the involved monitoring tools and have the internet or cellular internet connection necessary to accommodate any needed remote patient monitoring equipment in the home.
• Health Maintenance Monitoring will be addressed in the participant's PCP and include the frequency, duration, and schedule of each health monitoring task including the criteria for abnormal findings and when to consult the participant's doctor.
• Health Maintenance Monitoring will be delivered in a way that respects the privacy of the individual and is not intended to monitor ADLs. Video cameras/monitors are not permitted in bedrooms and bathrooms.
• The use of Health Maintenance Monitoring is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose.
• The participant or guardian must consent to receive the monitoring service and is responsible for the oversight and supervision of the monitoring.
• The participant's residence must have space for all program equipment and full transmission capability.
• The provider maintains a participant's record supporting the medical necessity of the service, all transmissions and subsequent reviews received from the participant, and how the data transmitted from the participant is being utilized in the continuous development and implementation of the participant's care.
• Health care providers performing a telehealth or digital health service shall, as appropriate for the service, provider, and participant, utilize the following modalities of communication delivered over a secure communications connection that complies with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA):
o Live or real-time audio and video asynchronous telehealth technology;
o Asynchronous store-and-forward telehealth technology;
o Remote patient monitoring using wireless devices, wearable sensors, or health monitors, such as:
o Heart rhythm with an electrocardiogram (ECG), respiration, blood oxygen level (SpO2), non-invasive blood pressure (NIBP), glucose monitor weight, apnea monitors, specialized monitors for dementia and temperature.
o Audio-only telecommunications systems;
o Clinical text chat technology; and
o Medication dispensing and monitoring.
• Health Maintenance Monitoring can be used to monitor the following:
o Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.
o Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
o Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes.
o Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes.
• Interpretation of data and any teaching or coaching of the participant and guardian must be done by a Registered Nurse (RN), Nurse Practitioner (NP), Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Medical Doctor (MD) or Doctors of Osteopathy (DO).
• Providers are required to develop policies and procedures which include:
o Identifying whether health and safety needs can be addressed safely via health maintenance monitoring;
o Assurance of the participants' rights to privacy, dignity, and respect, and the HIPAA compliance of the technology used for health maintenance monitoring;
o A plan for how to respond to abnormal findings and when to consult the participant's doctor.
o A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-

site support; and
- Ongoing training for direct support staff.

Host Home may not be self-directed.

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

Host Home is only available to participants aged 19 and older. Exceptions may be requested for participants aged 18 and under and will be subject to DDD Central Office approval.

Placement is limited to those individuals that demonstrate any of the following assessed risks as determined by the State's approved functional needs assessment: Behavioral/Harm to Self and Others; and Lack of natural supports for appropriate supervision and monitoring, based on the care needs of the participant; or Residential instability in the last two years. If requested, a clinical review of a participant's unique needs may be conducted to determine if Host Home is appropriate if not otherwise indicated by the State's approved functional needs assessment. A participant's needs are assessed using the state-approved functional needs assessment tool, and further informed through person-centered planning conversations as delineated in Appendix D of this waiver application.

Host Home is provided in a residential setting and must meet all federal standards for home and community-based settings.

A DD agency provider cannot own or lease the home in which Host Home is provided.

Host Home may be provided for up to 3 participants, based on the participants' assessed needs when approved by DDD Central Office.

Host Home is reimbursed at a daily rate. The provider must be in the residence with the participant, providing a combination of habilitation, supports, protective oversight, and supervision for a minimum of 10 hours in a 24 hour period 12:00am - 11:59pm for the provider to bill a daily rate. When the provider is in the residence with the participant, providing a combination of habilitation, supports, protective oversight, and supervision for any amount of time less than 10 hours in a 24 hour period 12:00am - 11:59pm, the provider will be paid at half of the daily rate.

Participants receiving Host Home daily rate cannot receive Continuous Home, Shared Living, Independent Living, or Supported Family Living on the same day.

Participants receiving Host Home cannot receive Respite, LRI Personal Care, and Homemaker.

Transportation required in the provision of Host Home is included in the rate. Non-medical transportation to the site at which Host Home begins is included in the rate. Non-medical transportation from the site at which Host Home ends is included in the rate.

During awake hours, the Host Home employee must provide supervision as indicated by assessed needs and as documented in the participant's service plan. Overnight, the Host Home employee may be asleep, but must be present and available to respond immediately to the individuals' needs and emergencies.

The regular rate may be billed for Host Home even when, during a portion of the time being billed, the service is provided by back-up staff in place of the DD agency provider Host Home employee. Reimbursement for the time provided by the back-up staff will be negotiated between the DD agency provider or Host Home employee and paid out of the billed rate.

Back-up staff must be chosen by the participant, documented in participant's service plan, and must meet all provider qualifications. The amount of back-up staff hours is limited to not more than 360 hours per annual budget year. The 360 hours were determined based on historical and actual data of participants receiving respite living with unpaid caregivers in their family homes, and the limitation of hours has historically addressed the health and welfare of waiver participants. If a participant's needs cannot be met within the established number of hours, the participant's team will meet to determine what alternatives may be available, such as another type of residential setting. If alternatives are unavailable, additional developmental disabilities funding could be requested through the established exception process . The provider is responsible for tracking the use of the 360 hours and will document the utilization of hours in the state mandated electronic case management system.

A lease, residency agreement or other form of written agreement will be in place for each participant receiving a Host Home service. The participant has, at a minimum, the same responsibilities, and protections from eviction that tenants have under the landlord/tenant laws of the state, county, city, or other designated entity.

Medicaid payment may not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

The rate tiers for this service are determined based upon needs identified in the Objective Assessment Process.

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

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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	DD Agency - Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Host Home

Provider Category:

Agency

Provider Type:

DD Agency - Habilitative Services

Provider Qualifications

License *(specify):*

A license is required for each Host Home setting with 4 or more participants. Title 175 Nebraska Administrative Code 3-000.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with the designated provider screening enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Independent Living

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Independent Living is provided in the participant's private home and the community, not in a residence owned or leased, operated or controlled by a provider. A participant can choose to receive a portion of this service virtually. The participant lives alone or with housemates and is responsible for rent, utilities, and food.

Independent Living is a habilitative service providing individually tailored intermittent supports for a waiver participant, which assists with the acquisition, retention, or improvement in skills related to living in the community. Independent Living includes adaptive skill development of daily living activities, such as personal grooming and cleanliness, laundry, bed making and household chores as well as, eating and the preparation of food, inclusive community activities, transportation, and the social and leisure skill development necessary to enable the participant to live in the most integrated setting appropriate to their needs. Providers of Independent Living generally do not perform these activities for the participant, except when not performing the activities poses a risk to the participant's health and safety.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

When a portion of this service is delivered virtually, the following conditions apply:

- The total combined hours for virtual supports may not exceed a weekly amount of 10 hours and is included as part of the currently existing limit of 35 hours per week of services provided during the day. A participant can choose to receive a portion of this service virtually, but cannot replace all in-person assistance. The majority of the service provided each week must be provided in-person.
- A participant can choose to receive a portion of this service virtually but it cannot replace all in-person assistance. Most of the service provided each week must be provided in-person.
- The provider is responsible for ensuring technologies used to deliver virtual supports comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534.
- Virtual supports will be delivered in a way that respects the privacy of the individual and is not intended to monitor ADL's. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- Use of virtual supports will be addressed in the participant's person-centered plan and the provider must have a plan and/or policies to ensure the participant's rights of privacy, dignity, and respect.
- Use of virtual supports must be a person-centered decision and facilitate community integration, not risk leading to the isolation of the participant from the community or from interacting with other people.
- Use of virtual supports is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose. The decision to use virtual supports as a portion of the service array must be clearly documented in the participant's person-centered plan and assure that the participant's needs must be able to be met by supports that can be provided virtually.
- The state is requiring provider's to be responsible for ongoing training of the participant and direct support staff in use of the virtual support devices.
- Providers are required to develop a policies and procedures which include:
  - Identifying whether health and safety needs can be addressed safely via virtual supports;
  - Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA compliance of the technology used for virtual support;
  - Obtaining written informed consent from the participant, guardian (if applicable), and any others potentially impacted by provision of virtual supports, and maintaining records of these consents;
  - A backup person for when in-person support is needed;
  - A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
  - Ongoing training for direct support staff.

Independent Living may be self-directed.

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

Independent Living is available for participants who are 19 years and older.

Independent Living is provided in the participant's private home, not a provider operated or controlled residence.

Independent Living may be provided for up to one, two, or three participants, based on the participants' assessed needs.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Independent Living is provided to an awake participant who requires less than 24 hours of support a day.

Independent Living is reimbursed at an hourly rate. Independent Living cannot exceed a weekly amount of 70 hours. A week is defined as 12:00 AM Monday through 11:59 PM Sunday.

The rate structure for this service is determined based on the group size. Group sizes of 1, 2, or 3 are based on the participant's assessed needs.

Independent Living requires the provider use Electronic Visit Verification (EVV).

Participants receiving Independent Living cannot receive Continuous Home, Host Home, Shared Living, Youth Continuous Home, Behavioral In-Home Habilitation, Medical In-Home Habilitation, or Supported Family Living.

Participants receiving Independent Living cannot have an active service authorization for Respite.

Transportation required in the provision of Independent Living is included in the rate. Non-medical transportation to the site at which Independent Living begins is not included in the rate. Non-medical transportation from the site at which Independent Living ends is not included in the rate.

Independent Living may be provided by a relative or legal guardian but not a legally responsible individual.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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	DD Agency
Individual	Independent Individual - Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Independent Living

Provider Category:

Agency

Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

All providers delivering this service must have the computer skills and access to the technology needed to navigate the Electronic Visit Verification (EVV) system.

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Independent Living

Provider Category:

Individual

Provider Type:

Independent Individual - Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

Independent providers, acting as legal guardians, must be approved by DDD Central Office to provide this service.

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

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

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

All providers delivering this service must have the computer skills and access to the technology needed to navigate the Electronic Visit Verification (EVV) system.

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

LRI Personal Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

LRI Personal Care is a service for participants of all ages which includes assistance with Activities of Daily Living (ADLs) and/or health-related tasks and may include Instrumental Activities of Daily Living (IADLs) provided in a person's home and other community settings.

This service offers a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance will take the form of hands-on assistance to perform a task. These services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by state law.

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

This service may not be self-directed.

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

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

Transportation is not included in this service.

LRI Personal Care requires provider use of Electronic Visit Verification (EVV).

A participant cannot be authorized to receive this service at times that overlap with any other service.

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

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

Personal care services that can be covered under the state plan should be furnished to waiver participants under the age of 21 as services required under EPSDT.

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

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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	DD Agency
Individual	Independent Individual - Non-Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: LRI Personal Care

Provider Category:

Agency

Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

Home Health Aide Service license as found in 175 NAC 14.

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

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

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

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

All providers delivering this service must have the computer skills and access to the technology needed to navigate the Electronic Visit Verification (EVV) system.

Agency provider employees and back-up staffing delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be authorized to work in the United States;
• Be 19 years of age or older; and
• Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with the designated provider screening enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: LRI Personal Care

Provider Category:

Individual

Provider Type:

Independent Individual - Non-Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

Independent providers must be approved by DDD Central Office to provide this service.

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

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

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

All providers delivering this service must have the computer skills and access to the technology needed to navigate the Electronic Visit Verification (EVV) system.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Medical In-Home Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Medical In-Home Habilitation is a short-term habilitative service provided to waiver participants who have a chronic or severe medical condition that prevents them from fully participating in community activities or employment opportunities, or have recently been hospitalized and are continuing to recover in their residence, and their medical needs prevent them from participating in community activities or employment opportunities. Medical In-Home Habilitation is provided to participants who are unable to remain alone during the hours that they would otherwise be away from their residence.

Services are based on the current needs and capabilities of the participant, and based on discharge orders and ongoing oversight by a Registered Nurse or higher medical degree employed by the DD provider. Medical In-Home Habilitation includes adaptive skill development or refining of daily living activities, such as personal grooming and cleanliness, laundry, bed making and household chores, and eating and the preparation of food. This service also includes the provision of personal care, health maintenance activities, supervision, and protective oversight.

Individual programs must be specific and measurable and updated when not yielding progress, and data must be tracked and analyzed for trends. Monthly summary reports on progress or lack of progress must be made available upon request.

When a participant is admitted to an in-patient, acute care hospital, due to a critical health or safety concern, Medical In-Home Habilitation can be provided. Support includes habilitation to maintain learned skills, implementation of behavioral support, if needed, and assistance with daily living activities to support the participant’s treatment and recovery. This level of support will assist the participant to not regress or lose learned skills they had before or while they were in an in-patient, acute care hospital.

This service is provided to meet needs of the participant that are not met through the provision of acute care hospital services. This service is in addition to, and may not substitute for or are not duplicative of, the services the acute care hospital is obligated to provide. This service will be used to ensure smooth transition between acute care setting and community-based setting and to preserve the participant’s functional abilities. When authorized this service must be identified in the participant’s person-centered service plan.

Prior to discharge the person-centered plan will be updated to reflect the participant’s needs and supports for transition back to the community based setting.

Medical In-Home Habilitation may not be self-directed.

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

Medical In-Home Habilitation must be provided in the participant's residence. The provider must be in the residence with the participant, providing service during daytime hours, as documented in the service plan.

Medical In-Home Habilitation is limited to 90 calendar days. Additional days must receive DDD Central Office approval.

Medical In-Home Habilitation is only available to participants receiving Continuous Home, Host Home, Shared Living, or Youth Continuous Home.

Medical In-Home Habilitation is not available to participants receiving Independent Living or Supported Family Living.

The amount of prior authorized services is based on the participant's need as periodically assessed by the state clinical team, and documented in the service plan, and within the participant's approved annual budget.

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

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

The total combined hours for this service may not exceed a weekly average amount of 35 hours and a maximum of 152 hours per month. A week is defined as 12:00am Monday through 11:59pm Sunday.

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	DD Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medical In-Home Habilitation

Provider Category:
Agency
Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

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

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

Personal Emergency Response System (PERS) cannot be authorized for a participant who resides in a residence that is provider-owned, provider-operated or provider-controlled, unless a transition plan for the participant is submitted, and outlines how PERS will assist the participant to move to a less restrictive setting within 6 months. If there is no transition plan, PERS cannot be authorized for a participant receiving Continuous Habilitation, Host Home, Shared Living, or Youth Continuous Home.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

PERS is reimbursed as a monthly rental fee or as a one-time installation fee.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Independent Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

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

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

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

Agency provider employees and back-up staffing delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be authorized to work in the United States;
• Be 19 years of age or older;
• Not be a person legally responsible for the participant;
• Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation;
• Ensure response is provided 24 hours per day, 7 days per week;
• Furnish replacement PERS unit within 24 hours of malfunction of original unit;
• Ensure monthly testing of PERS unit; and
• Update responder contacts semi-annually.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Remote Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Remote Supports is the use of technology for a provider to assist a participant from another location via live two-way communication. It allows a provider to monitor a participant's health and safety without being physically present through equipment such as sensors and alerts that generate real-time data.
Communication with the remote supports staff is through live or real-time audio and/or video asynchronous communication technology. Staff must be available for in-person assistance at any time during remote supports service when needed.

Remote supports are provided in the participant's private home and the community, not in a setting owned or leased, operated, or controlled by a provider.
Equipment used to meet this requirement must include one or more of the following systems: motion sensing system, radio frequency identification, live video feed, live audio feed, GPS Tracking, web-based monitoring system, or a device that otherwise meets the requirement for two-way communication.
Individual interactions with support staff can be scheduled, requested on-demand, or triggered by a device alert in the remote supports equipment system based on the participant's needs as documented in the person-centered plan (PCP).

Remote supports are used to promote the individual's independence, increase self-determination, and build self-reliance, and confidence which decreases reliance on paid staff for activities in the home and community. Services are provided in community-based settings in a manner that contributes to the service recipient's independence, self-sufficiency, community inclusion, and well-being.
Remote Supports are not used for surveillance of an individual. Electronic support systems using on-demand video and/or web cameras, or other technology are only available on an individual, case-by-case basis when an individual requests the service, and the need for each activity under Remote Supports is identified during participant assessment and included in the PCP. When video equipment is utilized, the data system shall track all utilization of the equipment including who activated it, when it was activated, and how long it was active. When cameras are utilized, they may not be placed in or provide a view of private spaces such as bedrooms and bathrooms.

The person-centered planning team will ensure the participant understands the technology use, provides information for choosing remote or in-person services, and understands privacy protections in the approved plan before the consent is signed."

The participant receiving Remote Supports and each person who lives with the individual shall consent in writing after being fully informed of what Remote Supports entails including, but not limited to, that the remote supports staff will observe their activities and/or listen to their conversations in the residence, where in the residence the Remote Supports will take place. If the individual or a person who lives with the individual has a guardian, the guardian shall consent in writing. The individual's Service Coordinator shall attach a copy of each signed consent form to the PCP The Service Coordinator and providers will share responsibility for monitoring privacy concerns.
The need for each activity under Remote Support must be identified during participant assessment and included in the PCP. The PCP will include the frequency, duration, and schedule of each remote support task including the criteria for response, backup plan, and emergencies. What is being monitored, for what purpose, what technology is used, who is responsible for the activity, and their location.
Remote support technology may only be used with the full consent of the individual and their guardian to ensure the individual's rights are being respected. The participant (or guardian) can revoke their consent at any time.

Remote Supports service will include the following components:
Consultation: Individuals interested in Remote Supports must be assessed by their provider, with input from the PCP team for risk using an assessment for Remote Supports and must be provided information to ensure an informed choice about the use of equipment versus in-home support staff.

Equipment: The type of equipment and where it will be placed depends upon the needs and wishes of the individual and their guardian (if applicable) and will also depend upon the company selected by the individual or guardian (if applicable) to provide the equipment. The installation of video equipment in the home will be done at the direction of the individual. If the home is shared with others the equipment will be installed in such a manner that it does not invade others' privacy. The equipment is controlled by the individual and can be turned on or off as needed. Remote Supports cannot be accessed to purchase video monitors or cameras to be placed in bedrooms or bathrooms. Video monitors or cameras may not record video or audio feeds.

Service Delivery: The monthly implementation of service and monitoring of the technology equipment and

individual as necessary. The remote support provider will provide education and training that aids an individual in the use of technology equipment as well as training for the individual's family members, guardian, staff, or other persons who provide natural support or paid services, employ the individual, or who are otherwise substantially involved in activities being supported by the remote support technology equipment or service delivery. Technology support may include, when necessary, coordination with complementary therapies or interventions and adjustments to existing assistive technology to ensure its ongoing effectiveness. Remote Support is provided to the participant in a way to maintain as much independence and privacy as possible. The provider must have safeguards and backup systems such as batteries and generators for the electronic devices in place at the base and the individual's residential living site(s) in the event of electrical outages. The provider must have backup procedures for system failure (e.g. prolonged power outage), fire or weather emergency, individual medical issue, or personal emergency in place and detailed in writing for each site utilizing the system as well as in each individual's PCP. The person-centered plan must specify the person to be contacted and at least two backup persons who will be responsible for responding to these situations and when in-person supports are needed by traveling to the individual's living sites(s). The Person-centered plan team will document a backup plan in the PCP for when a crisis or emergency occurs. In emergencies, staff should call 911, backup plans should be person-centered to meet the historical and potential future needs of the participant.

All electronic device vendors must provide equipment approved by the Federal Communication Commission and the equipment must meet the Underwriters Laboratories, Inc., standard for home health care signaling equipment. The Underwriters Laboratories, Inc., listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard.

Remote Supports requires the participant or guardian to have the capability to utilize any monitoring tools involved or shall include the regular presence of an individual in the home who can utilize the involved monitoring tools and have the internet or cellular internet connection necessary to accommodate any needed remote patient monitoring equipment in the home.

The emergency response activator must be able to be activated in such a way that the individual can independently activate the system regardless of the person's visual, hearing, or physical support needs.

Any assistive technology device must not interfere with typical cellular or landline telephonic utilization. An initial installation fee is covered, as well as ongoing monthly rental charges, subscriptions, upkeep, and maintenance of the devices.

Remote monitoring will meet HIPAA requirements and the methodology will be accepted by the state's HIPAA compliance officer.

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

The provider is responsible for ensuring technologies used to deliver Remote Supports comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534.

Remote Supports may not be authorized at times that overlap with Continuous Home, Host Home, Shared Living, or Youth Continuous Home.

Remote Supports will be delivered in a way that respects the privacy of the individual and is not intended to monitor activities of daily living. Video cameras/monitors are not permitted in bedrooms and bathrooms.

The use of remote supports will be addressed in the participant's person-centered plan and the provider must have a plan and policies to ensure the participant's rights of privacy, dignity, and respect.

The use of remote supports must be a person-centered decision and facilitate community integration, not risk leading to the isolation of the participant from the community or from interacting with other people.

The use of remote supports is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose. The decision to use remote supports as a portion of the service array must be documented in the participant's person-centered plan and ensure that the participant's needs must be able to be met by supports that can be provided remotely.

The state is requiring providers to:
o Deliver, provide, maintain, repair, or replace equipment, supplies, and accessories, and ensure proper functioning when connected to the participant's existing internet, cell, or phone services.
o This may be done remotely as long as all routine requests are resolved within three business days.

This service cannot be provided during school hours set by the local school district. The limitations include public education programs funded under the Individuals with Disabilities Education Act (IDEA). Regular school hours and days apply for a child who receives home schooling. Remote Supports will not be authorized for the hours outlined in the school district's days and hours of regular attendance.

The originating site must have space for all program equipment and full transmission capability.

Remote Supports cannot be authorized at times that overlap with any other waiver service that includes supervision.

Remote Supports may be provided by a relative but not a legal guardian or legally responsible individual.

Providers are required to develop policies and procedures which include:
o Assurance of the participants' rights to privacy, dignity, and respect are maintained, including the HIPAA compliance of the technology used for remote supports.
o Obtaining written informed consent from the participant, guardian (if applicable), and any others potentially impacted by the provision of remote supports and maintaining records of these consents.
o Ensuring continuous coverage of remote supports including in-person supports or contacting EMS if needed.
o Instructing the participant and caregiver in the use of the equipment.
o Ongoing coaching of the participant in the use of the remote supports devices.
o Ongoing training for support staff.
o Completing necessary records of monitoring events.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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	Agency - Non-Habilitative Services
Individual	Independent Individual - Non-Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Agency - Non-Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

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

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

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

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

For remote monitoring, the provider must:
• Deliver, provide, maintain, repair, or replace equipment, supplies, and accessories, and ensure proper functioning when connected to the participant's existing internet, cell, or phone services.
• This may be done remotely as long as all routine requests are resolved within 3 business days.
• Train the participant and caregiver in the use of the equipment.
• Electronically collect and automatically uploaded all physiologic data to a secure location where the data can be available for analysis and interpretation by the billing practitioner.
• Ensure the device used to collect and transmit the data meets the definition of a medical device as defined by the FDA.
• Collect remote monitoring data for at least 16 out of 30 days.
• Use Health Maintenance Monitoring to monitor an acute care or chronic condition.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with the designated provider screening enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Individual

Provider Type:

Independent Individual - Non-Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

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

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

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

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

For remote monitoring, the provider must:
• Deliver, provide, maintain, repair, or replace equipment, supplies, and accessories, and ensure proper functioning when connected to the participant's existing internet, cell, or phone services.
• This may be done remotely as long as all routine requests are resolved within 3 business days.
• Train the participant and caregiver in the use of the equipment.
• Electronically collect and automatically uploaded all physiologic data to a secure location where the data can be available for analysis and interpretation by the billing practitioner.
• Ensure the device used to collect and transmit the data meets the definition of a medical device as defined by the FDA.
• Collect remote monitoring data for at least 16 out of 30 days.
• Use Health Maintenance Monitoring to monitor an acute care or chronic condition.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Shared Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Shared Living is delivered in a private home owned or leased by an individual, couple, or a family chosen by the participant, and who is an independent contractor of the provider agency authorized to deliver direct services and support. The Shared Living contractor and the participant live together in the sole residence and the participant shares daily life with the Shared Living family in their home and community.

Shared Living includes adaptive skill development of activities of daily living, such as personal grooming and cleanliness, laundry, bed making and household chores, eating and the preparation of food, inclusive community activities, transportation, and the social and leisure skill development necessary to enable the participant to live in the most integrated setting appropriate to their needs. This service also includes the provision of personal care, health maintenance activities, supervision, and protective oversight.

When a participant is admitted to an in-patient, acute care hospital, due to a critical health or safety concern, this service can be provided. Support includes habilitation to maintain learned skills, implementation of behavioral support, if needed, and assistance with activities of daily living to support the participant's treatment and recovery. This level of support will assist the participant to not regress or lose learned skills they had before they were in an in-patient, acute care hospital .

This service is provided to meet needs of the participant that are not met through the provision of acute care hospital services. This service is in addition to, and may not substitute for, or are not duplicative of, the services the acute care hospital is obligated to provide. This service will be used to ensure smooth transition between acute care setting and community-based setting and to preserve the participant's functional abilities. When authorized, this service must be identified in the participant's person-centered service plan.

Prior to discharge, the person-centered plan (PCP) will be updated to reflect the participant's needs and supports for transition back to the community-based setting.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

When a portion of this service is delivered remotely, the following conditions apply:
- The total combined hours for remote supports may not exceed a weekly amount of 10 hours. A participant can choose to receive a portion of this service remotely, but cannot replace all in-person assistance. The majority of the service provided each week must be provided in-person.
- A participant can choose to receive a portion of this service remotely but it cannot replace all in-person assistance. Most of the service provided each week must be provided in-person.
- The provider is responsible for ensuring technologies used to deliver remote supports comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534.
- Remote supports will be delivered in a way that respects the privacy of the individual and are not intended to monitor ADLs. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- Use of remote supports will be addressed in the participant's PCP and the provider must have a plan and/or policies to ensure the participant's rights of privacy, dignity, and respect.
- Use of remote supports must be a person-centered decision and facilitate community integration, not risk leading to the isolation of the participant from the community or from interacting with other people.
- Use of remote supports is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in person services if they choose. The decision to use remote supports as a portion of the service array must be clearly documented in the participant's PCP and assure that the participant's needs must be able to be met by supports that can be provided remotely.
- The state is requiring provider's to be responsible for ongoing training of the participant and direct support staff in use of the remote support devices.
- Providers are required to develop a policies and procedures which include:
  - Identifying whether health and safety needs can be addressed safely via remote supports;
  - Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA compliance of the technology used for remote support;
  - Obtaining written informed consent from the participant, guardian (if applicable), and any others potentially

impacted by provision of remote supports, and maintaining records of these consents;
- o A backup person for when in-person support is needed;
- o A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
- o Ongoing training for direct support staff.

When a portion of this service is delivered via electronic health maintenance monitoring, the following conditions apply:
- Participants receiving Health Maintenance Monitoring must be under the supervision of a treating physician, physician's assistant, or advanced practice nurse who is directly providing care and treatment for their medical condition and not merely engaged to authorize the monitoring service.
- Electronic Health Maintenance Monitoring requires the participant or guardian to have the capability to utilize any monitoring tools involved or shall include the regular presence of an individual in the home who can utilize the involved monitoring tools and have the internet or cellular internet connection necessary to accommodate any needed remote patient monitoring equipment in the home.
- Health Maintenance Monitoring will be addressed in the participant's PCP and include the frequency, duration, and schedule of each health monitoring task including the criteria for abnormal findings and when to consult the participant's doctor.
- Health Maintenance Monitoring will be delivered in a way that respects the privacy of the individual and is not intended to monitor ADLs. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- The use of Health Maintenance Monitoring is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose.
- The participant or guardian must consent to receive the monitoring service and is responsible for the oversight and supervision of the monitoring.
- The participant's residence must have space for all program equipment and full transmission capability.
- The provider maintains a participant's record supporting the medical necessity of the service, all transmissions and subsequent reviews received from the participant, and how the data transmitted from the participant is being utilized in the continuous development and implementation of the participant's care.
- Health care providers performing a telehealth or digital health service shall, as appropriate for the service, provider, and participant, utilize the following modalities of communication delivered over a secure communications connection that complies with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA):
  - o Live or real-time audio and video asynchronous telehealth technology;
  - o Asynchronous store-and-forward telehealth technology;
  - o Remote patient monitoring using wireless devices, wearable sensors, or health monitors, such as:
  - o Heart rhythm with an electrocardiogram (ECG), respiration, blood oxygen level (SpO2), non-invasive blood pressure (NIBP), glucose monitor weight, apnea monitors, specialized monitors for dementia and temperature.
  - o Audio-only telecommunications systems;
  - o Clinical text chat technology; and
  - o Medication dispensing and monitoring.
- Health Maintenance Monitoring can be used to monitor the following:
  - o Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.
  - o Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
  - o Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes.
  - o Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes.
- Interpretation of data and any teaching or coaching of the participant and guardian must be done by a Registered Nurse (RN), Nurse Practitioner (NP), Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Medical Doctor (MD) or Doctors of Osteopathy (DO).
- Providers are required to develop policies and procedures which include:
  - o Identifying whether health and safety needs can be addressed safely via health maintenance monitoring;
  - o Assurance of the participants' rights to privacy, dignity, and respect, and the HIPAA compliance of the technology used for health maintenance monitoring;

- A plan for how to respond to abnormal findings and when to consult the participant's doctor.
- A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
- Ongoing training for direct support staff.

Shared Living may not be self-directed.

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

Shared living is only available to participants aged 19 and older. Exceptions may be requested for participants aged 18 and under and will be subject to DDD Central Office approval.

Placement is limited to those individuals that demonstrate any of the following assessed risks as determined by the State's approved functional needs assessment: Behavioral/Harm to Self and Others; and Lack of natural supports for appropriate supervision and monitoring, based on the care needs of the participant; or Residential instability in the last two years. If requested, a clinical review of a participant's unique needs may be conducted to determine if Shared Living is appropriate if not otherwise indicated by the State's approved functional needs assessment. A participant's needs are assessed using the state-approved functional needs assessment tool, and further informed through person-centered planning conversations as delineated in Appendix D of this waiver application.

Shared Living is provided in a residential setting and must meet all federal standards for home and community-based settings.

Day services must not be provided by the Shared Living provider.

A DD agency provider cannot own or lease the home in which Shared Living is provided.

The total number of state funded individuals (including participants served in the waiver) living in the home, is based on the participant's assessed need but cannot exceed two unless approved by DDD Central Office.

Shared Living is reimbursed at a daily rate. The provider must be in the residence with the participant, providing a combination of habilitation, supports, protective oversight, and supervision for a minimum of 10 hours in a 24 hour period 12:00am - 11:59pm for the provider to bill a daily rate. When the provider is in the residence with the participant, providing a combination of habilitation, supports, protective oversight, and supervision for any amount of time less than 10 hours in a 24 hour period 12:00am - 11:59pm, the provider will be paid at half of the daily rate.

Participants receiving Shared Living daily rate cannot receive Host Home, Continuous Home, Independent Living, or Supported Family Living on the same day.

Participants receiving Shared Living cannot receive Respite, LRI Personal Care, and Homemaker.

Transportation required in the provision of Shared Living is included in the rate. Non-medical transportation to the site at which Shared Living begins is included in the rate. Non-medical transportation from the site at which Shared Living ends is included in the rate.

During awake hours, the Shared Living independent contractor must provide supervision as indicated by assessed needs and as documented in the participant's service plan. Overnight, the Shared Living independent contractor may be asleep, but must be present and available to respond immediately to the individuals' needs and emergencies.

The regular rate may be billed for Shared Living even when, during a portion of the time being billed, the service is provided by back-up staff in place of the DD agency provider Shared Living independent contractor. Reimbursement for the time provided by the back-up staff will be negotiated between the DD agency provider or Shared Living independent contractor and paid out of the billed rate.

Back-up staff must be chosen by the participant, documented in participant's service plan, and must meet all provider qualifications.

The amount of back-up staff hours is limited to not more than 360 hours per annual budget year. The 360 hours were determined based on historical and actual data of participants receiving respite living with unpaid caregivers in their family homes, and the limitation of hours has historically addressed the health and welfare of waiver participants. If a participant's needs cannot be met within the established number of hours, the participant's team will meet to determine what alternatives may be available, such as another type of residential setting. If alternatives are unavailable, additional developmental disabilities funding could be requested through the established exception process. The provider is responsible for tracking the use of the 360 hours and will document the utilization of hours in the state mandated electronic case management system.

A lease, residency agreement or other form of written agreement will be in place for each participant receiving a Shared Living service. The participant has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant laws of the state, county, city, or other designated entity.

Medicaid payment may not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

The rate tiers for this service are determined based upon needs identified in the Objective Assessment Process.

Shared Living may be provided by a relative or legal guardian but not a legally responsible individual.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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	DD Agency - Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Shared Living

Provider Category:

Agency

Provider Type:

DD Agency - Habilitative Services

Provider Qualifications

License *(specify):*

No license required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with the designated provider screening enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Small Group Vocational Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Small Group Vocational Support is a habilitative service provided in community business or industry settings for single participants or small groups of participants.Generally, participants are a member of a team, at a single competitive employment site in a community business or industry or a mobile crew. Habilitative teaching, supervision, and ongoing supports are provided by a specially trained on-site supervisor, who is an employee of the DD agency provider.

Small Group Vocational Support is not competitive integrated employment and does not include services provided in facility-based work settings. Services typically take place at a work site of a competitive employer where a group of participants with disabilities are working and supervised by staff from the DD agency provider holding a contract with the competitive employer. Participants receiving Small Group Vocational Support are not employees of the community business or industry. The participants remain under the provider's service delivery system.

Small Group Vocational Support may also include mobile crews and other small business-based workgroups of participants with disabilities receiving services in integrated employment sites in the community. The outcome of this service is to gain payment for work experience leading to further career development and individual integrated community-based employment for which a participant is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by people without disabilities.

Small Group Vocational Support may include the acquisition of work skills, appropriate work behavior, and the behavioral and adaptive skills necessary to enable the participant to attain or maintain their maximum inclusion and personal accomplishment in the working community. Small Group Vocational Support may include services not specifically related to job skill development to enable the waiver participant to be successful in integrating into the job setting. Small Group Vocational Support must be provided in a manner promoting integration into the workplace and interaction between participants and people without disabilities in those workplaces. This service also includes the provision of personal care, health maintenance activities, supervision, and protective oversight.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

Small Group Vocational Support may not be self-directed.

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

The participant must first be referred to Vocational Rehabilitation and determined ineligible for Vocational Rehabilitation before this service can be authorized. Another referral can be made to Vocational Rehabilitation at any time.

This service must be discontinued upon the participant obtaining competitive integrated employment.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Small Group Vocational Support is reimbursed at an hourly unit.

Waiver funds cannot be used to compensate or supplement a participant's wages.

Transportation required in the provision of Small Group Vocational Support is included in the rate. Non-medical transportation to the site at which Small Group Vocational Support begins is not included in the rate. Non-medical transportation from the site at which Enclave ends is not included in the rate.

Small Group Vocational Support may be provided by a relative but not a legal guardian or legally responsible individual.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

Documentation must be maintained in the service coordination file for each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services).

Federal financial participation must not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
o Payments made to an employer to encourage or subsidize the employer's participation in Small Group Vocational Support;
o Payments passed through to users of Small Group Vocational Support; or
o Payments for training not directly related to a participant's employment skills development.

This service must not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan or HCBS Waiver service, including EPSDT.

The total combined hours for day services may not exceed a weekly amount of 35 hours. A week is defined as 12:00am Monday through 11:59pm Sunday.

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	DD Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Small Group Vocational Support

Provider Category:

Agency

Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Employment - Follow Along

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported Employment – Follow-Along is one-to-one formalized intermittent teaching and supports to enable a participant who is paid at or above the federal minimum wage to maintain employment in an integrated community employment setting. Intermittent support may be provided on-site, remotely, and through phone calls between provider staff and the participant's employer staff, followed up with face-to-face contact with the participant to reinforce and stabilize job placement. Services must be furnished consistent with the participant's service plan.

Supported Employment – Follow-Along includes observation and monitoring of the participant at the work site a minimum of twice a month to ascertain the success of the job placement and when needed, the provision of habilitative short-term job skill teaching at the work site to help maintain employment. Supported Employment – Follow-Along includes facilitation of natural supports at the work site and advocating with the participant, but only with persons at the employment site (e.g., employers, co-workers, customers) and only for purposes directly related to employment

A participant may receive Supported Employment – Follow-Along for working in an integrated community work environment where more than half of other employees who work around the participant do not have disabilities.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

Supported Employment – Follow-Along Services may be self-directed.

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

Supported Employment – Follow-Along does not include activities taking place in a group, i.e. work crews or Prevocational; public relations; community education; in-service meetings; staff development; department meetings; or any other non-participant specific activities, such as a job coach completing the work instead of the participant.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Supported Employment – Follow-Along is reimbursed at an hourly rate.

Supported Employment – Follow-Along is limited to not more than 25 hours annually and must be a combination of communication with the employer and face-to-face participant support.

A provider of Supported Employment – Follow-Along cannot be the employer of the participant to whom they provide Supported Employment – Follow-Along.

Waiver funds cannot be used to compensate or supplement a participant's wages.

Transportation required in the provision of Supported Employment – Follow-Along is included in the rate. Non-medical transportation to the site at which Supported Employment – Follow-Along begins is not included in the rate. Non-medical transportation from the site where Supported Employment – Follow-Along ends is not included in the rate.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

For each participant receiving this service, and on the wait list under a program funded under section 110 of the Rehabilitation Act of 1973 (Vocational Rehabilitation Services), documentation must be maintained in the service coordination file. Documentation must include that the participant is on the Vocational Rehabilitation Services wait list, and the service is not available due to the program's wait list.

Federal financial participation must not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
o Payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
o Payments passed through to users of supported employment programs; or
o Payments for training not directly related to a participant's supported employment program.

Supported Employment - Follow-Along may be provided by a relative but not a legal guardian or legally responsible individual.

This service must not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan or HCBS Waiver service, including EPSDT, or Vocational Rehabilitation.

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	DD Agency
Individual	Independent Individual - Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment - Follow Along

Provider Category:

Agency

Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment - Follow Along

Provider Category:

Individual

Provider Type:

Independent Individual - Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

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

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

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

A provider of this service must:

- Complete all provider enrollment requirements;
- Have necessary education and experience, and provide evidence upon request:
  - o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
  - o Have four or more years of professional experience in the provision of habilitative services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
  - o Have any combination of education and experience identified above equaling four years or more;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - o Cardiopulmonary resuscitation; and
  - o Basic first aid;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Family Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported Family Living is provided to the participant in the participant's private family home, not in a provider-owned or leased, operated or controlled setting. A participant can choose to receive a portion of this service virtually. The participant lives with relatives in their private family home.

Supported Family Living is a habilitative service providing individually tailored intermittent teaching and supports to assist with the acquisition, retention, or improvement in skills related to living in the community. Supported Family Living includes adaptive skill development of daily living activities, such as personal grooming and cleanliness, laundry, bed making and household chores, as well as eating and the preparation of food, inclusive community activities, transportation, and the social and leisure skill development necessary to enable the participant to live in the most integrated setting appropriate to their needs. Providers of Supported Family Living generally do not perform these activities for the participant, except when not performing the activities poses a risk to the participant's health and safety.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

When a portion of this service is delivered virtually, the following conditions apply:

- The total combined hours for virtual supports may not exceed a weekly amount of 10 hours and is included as part of the currently existing limit of 35 hours per week of services provided during the day. A participant can choose to receive a portion of this service virtually, but cannot replace all in-person assistance. The majority of the service provided each week must be provided in-person.
- A participant can choose to receive a portion of this service virtually but it cannot replace all in-person assistance. Most of the service provided each week must be provided in-person.
- The provider is responsible for ensuring technologies used to deliver virtual supports comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, and 45 CFR section 164.102 to section 164.534.
- Virtual supports will be delivered in a way that respects the privacy of the individual and is not intended to monitor ADL's. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- Use of virtual supports will be addressed in the participant's person-centered plan and the provider must have a plan and/or policies to ensure the participant's rights of privacy, dignity, and respect.
- Use of virtual supports must be a person-centered decision and facilitate community integration, not risk leading to the isolation of the participant from the community or from interacting with other people.
- Use of virtual supports is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose. The decision to use virtual supports as a portion of the service array must be clearly documented in the participant's person-centered plan and assure that the participant's needs must be able to be met by supports that can be provided virtually.
- The state is requiring provider's to be responsible for ongoing training of the participant and direct support staff in use of the virtual support devices.
- Providers are required to develop a policies and procedures which include:
  - Identifying whether health and safety needs can be addressed safely via virtual supports;
  - Assurance of the participants' rights to privacy and dignity and respect are maintained, including the HIPAA compliance of the technology used for virtual support;
  - Obtaining written informed consent from the participant, guardian (if applicable), and any others potentially impacted by provision of virtual supports, and maintaining records of these consents;
  - A backup person for when in-person support is needed;
  - A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
  - Ongoing training for direct support staff.

Supported Family Living may be self-directed.

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

Supported Family Living is provided to an awake participant who requires less than 24-hours of support a day. Personal care activities that only require verbal cueing may be performed remotely, but cannot be performed in lieu of the provision of habilitation and needed supervision. Personal care activities must be documented and accessible in the state-mandated web-based case management system or submitted to the service coordinator and DDD at the frequency approved in the service plan.

Supported Family Living may be provided to one, two, or three participants, based on the participants' assessed needs.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Supported Family Living is reimbursed at an hourly rate and the provider must use Electronic Visit Verification (EVV).

Supported Family Living cannot exceed a weekly amount of 70 hours. A week is defined as 12:00am Monday through 11:59pm Sunday.

The rate structure for this service is determined based on the group size. Group sizes of one, two, or three are based on the participant's assessed needs.

Participants receiving Supported Family Living cannot receive Behavioral In-Home Habilitation, Independent Living, or Medical In-home Habilitation.

Participants receiving Supported Family Living cannot receive Continuous Home daily rate, Host Home daily rate, Shared Living daily rate, or Youth Continuous Home on the same day.

Transportation required in the provision of Supported Family Living is included in the rate. Non-medical transportation to the site at which Supported Family Living begins is not included in the rate. Non-medical transportation from the site at which Supported Family Living ends is not included in the rate.

Supported Family Living may be provided by a relative or legal guardian but not a legally responsible individual.

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

This service cannot overlap with, replace, or duplicate other similar services provided through the Medicaid State Plan or HCBS Waiver service, including EPSDT.

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	DD Agency

Provider Category	Provider Type Title
Individual	Independent Individual - Habilitative Services
Agency	Independent Agency - Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Family Living

Provider Category:

Agency

Provider Type:

DD Agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

All providers delivering this service must have the computer skills and access to the technology needed to navigate the Electronic Visit Verification (EVV) system.

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. §§ 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

The program compliance is verified through the annual or biennial DD certification survey process. The provider screening and enrollment vendor ensures revalidation of agency is completed annually and re-enrollment is completed every five years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Family Living

Provider Category:

Individual

Provider Type:

Independent Individual - Habilitative Services

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

Independent providers, acting as legal guardians, must be approved by DDD Central Office to provide this service.

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

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

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

All providers delivering this service must have the computer skills and access to the technology needed to navigate the Electronic Visit Verification (EVV) system.

A provider of this service must:

- Complete all provider enrollment requirements;
- Have necessary education and experience, and provide evidence upon request:
  - o Have a Bachelor's degree or equivalent coursework/training in: education, psychology, social work, sociology, human services, or a related field; OR
  - o Have four or more years of professional experience in the provision of habilitative services for persons with intellectual or other developmental disabilities (IDD), or in habilitative program writing and program data collection/analysis, or four or more years of life experience in teaching and supporting an individual with IDD; OR
  - o Have any combination of education and experience identified above equaling four years or more;
- Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable, or upon request:
  - o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
  - o Cardiopulmonary resuscitation; and
  - o Basic first aid;
- Be age 19 or older and authorized to work in the United States;
- Not be a person legally responsible for the participant; and
- Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation.

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. §§ 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Family Living

Provider Category:

Agency

Provider Type:

Independent Agency - Habilitative Services

Provider Qualifications

License *(specify):*

In accordance with 391 NAC Children's Services Licensing or 474 NAC Social Services for Families, Children, and Youth.

Certificate *(specify):*

No certification is required.

Other Standard *(specify):*

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

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

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

All providers delivering this service must have the computer skills and access to the technology needed to navigate the Electronic Visit Verification (EVV) system.

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. §§ 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transitional Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transitional Services are services and household set-up expenses not otherwise provided through this waiver or through the Medicaid State Plan to enable a participant to have opportunities for full membership in home and community-based services.

Transitional Services are non-recurring basic household set-up expenses needed for participants transitioning from a Nebraska institution to a private residence where the person is directly responsible for his or her own living expenses to remove the identified barriers or risks for the success of the transition. Facilities considered institutions for Transitional Services are Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Nursing facilities, and Institutions for Mental Disease. Transitional Services may include essential furniture, furnishings, window coverings, food preparation items and bed/bath linens, security deposits, basic utility (i.e., water, gas, and electricity) fees or deposits, or moving expenses. Funds cannot be used to pay a rental deposit or rent. Transitional Services may be approved when the participant does not have the funds to purchase the item or service, or the item or service is not available through another source, including relatives, friends, or any other source. Transitional Services will not be approved for a residence owned or leased, operated or controlled by a provider of waiver services.

Transitional Services may be self-directed.

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

Transitional Services have a participant budget cap of $1,500. A critical health or safety service request that exceeds the limit is subject to available waiver funding and approval by DDD.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Transitional Services are authorized for direct reimbursement to the vendor.

Medicaid funds may not be used to pay rent.

An application must be submitted to DHHS-CFS Economic Support Unit for assistance prior to utilization of this service.

Transitional Services cannot be used for personal care items (toiletries or things used for daily hygiene), food, or clothing, or items and services which are not essential to supporting the move or ensuring a successful transition.

Providers shall not exceed their charges to the general public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) shall apply the same discount to the participants who would otherwise qualify for the discount.

Transitional Services may be provided by a relative but not a legal guardian or legally responsible individual.

This service cannot overlap with, replace, or duplicate other similar services provided through the Medicaid State Plan or HCBS Waiver service, including EPSDT, or Money Follows the Person.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transitional Services

Provider Category:

Agency

Provider Type:

Independent Agency - Non-Habilitative

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transitional Services

Provider Category:

Individual

Provider Type:

Independent Individual - Non-Habilitative

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation

HCBS Taxonomy:

Category 1: 15 Non-Medical Transportation

Sub-Category 1: 15010 non-medical transportation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Transportation is a service designed to foster greater independence and personal choice. Transportation enables participants to gain access to waiver services, community activities, and resources, as specified by the participant's service plan. Transportation services are not intended to replace formal or informal transportation options, like the use of natural supports.

Transportation may be self-directed.

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

This service does not include transportation to the site at which Child Day Habilitation begins and from the site at which Child Day Habilitation ends.

Transportation is provided for a waiver participant to get to and from a location only using the most direct route.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Transportation is reimbursed per mile or cost of a bus pass.

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

Agency provider mileage rate must not exceed the rate of reimbursement pursuant to Neb. Rev. Stat. §81-1176 multiplied by three.

Individual Independent provider mileage rate is paid at the mileage rate of reimbursement pursuant to Neb. Rev. Stat. §81-1176.

The public transportation rate must not exceed purchase price by the public.

This service must not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan, HCBS Waiver service, or other federal and state transportation programs.

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	Agency - Public Service Commission Exempt Transportation Provider
Agency	Agency - Certified Commerical Carrier/Common Carrier
Individual	Individual - Individual Tranportation Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Agency - Public Service Commission Exempt Transportation Provider

Provider Qualifications

License *(specify):*

Provider must have a valid driver's license. Neb. Rev. Stat. §60-484.

Certificate *(specify):*

No certification is required. Neb. Rev. Stat. §§75-301 - 322, 291 NAC 3-002.

Other Standard *(specify):*

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

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

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

Agency provider employees and back-up staffing delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be authorized to work in the United States;
• Be 19 years of age or older;
• Not be a person legally responsible for the participant;
• Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation;
• Ensure drivers possess a current and valid driver's license;
• Maintain the minimum vehicle insurance coverage as required by state law;
• Ensure drivers have not had his/her driver/chauffeur's license revoked within the past three years; and
• Meet and adhere to all applicable employment standards established by the hiring agency.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements.

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Agency - Certified Commerical Carrier/Common Carrier

Provider Qualifications

License *(specify):*

Provider must have a valid driver's license. Neb. Rev. Stat. §60-484.

Certificate *(specify):*

Certificate of Authority issued by the Nebraska Public Service Commission. Neb. Rev. Stat. §§75-301 - 322.

Other Standard *(specify):*

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

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

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

Agency provider employees and back-up staffing delivering direct services and supports must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be authorized to work in the United States;
• Be 19 years of age or older;
• Not be a person legally responsible for the participant;
• Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation;
• Ensure drivers possess a current and valid driver's license;
• Maintain the minimum vehicle insurance coverage as required by state law;
• Ensure drivers have not had his/her driver/chauffeur's license revoked within the past three years; and
• Meet and adhere to all applicable employment standards established by the hiring agency.

The provider must have internet access for immediate adherence to applicable record-keeping and billing requirements.

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Individual - Individual Tranportation Provider

Provider Qualifications

License *(specify):*

Provider must have a valid driver's license. Neb. Rev. Stat. §60-484

Certificate *(specify):*

No certificate is required.

Other Standard *(specify):*

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

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

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

A provider delivering this service must:
• Meet and adhere to all applicable employment standards established by the hiring agency;
• Have training in the following areas, and provide evidence of current certificate of completion from an accredited source, when applicable or upon request:
o Abuse, neglect, and exploitation and state law reporting requirements and prevention;
o Cardiopulmonary resuscitation; and
o Basic first aid;
• Be authorized to work in the United States;
• Be 19 years of age or older;
• Not be a person legally responsible for the participant;
• Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation;
• Ensure drivers possess a current and valid driver's license;
• Maintain the minimum vehicle insurance coverage as required by state law; and
• Ensure drivers have not had his/her driver/chauffeur's license revoked within the past three years.

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Vehicle Modifications are adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle Modifications are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant.

The following are specifically excluded:
1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant.
2. Purchase or lease of a vehicle.
3. Purchase of existing adaptations or adaptations in process.
4. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
5. Adaptations to automobiles or vans owned or leased, operated or controlled by providers of waiver services.

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

DDD Central Office may require an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate Medicaid enrolled professional providers. DDD may use a third party to assess the proposed modification and need for the modification to ensure cost effectiveness and quality of product. This assessment will be funded by the Environmental Modification Assessment service, and will be reimbursed separately.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

Proof of vehicle insurance may be requested.

Providers must not exceed their charges to the public when billing the waiver. A provider who offers a discount to certain individuals (for example, students, senior citizens, etc.) must apply the same discount to the participants who would otherwise qualify for the discount.

When the vehicle is leased, the modification is transferrable to the next vehicle.

This service must not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan or HCBS Waiver service, including EPSDT.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Agency/Business; Department of Education Vocational Rehabilitation Assistive Technology Partnership; Companies for Specialized Equipment; Businesses for Vehicle Adaptions

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Independent Agency/Business; Department of Education Vocational Rehabilitation Assistive Technology Partnership; Companies for Specialized Equipment; Businesses for Vehicle Adaptions

Provider Qualifications

License *(specify):*

All vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license.

Certificate *(specify):*

All vendors must meet all applicable federal, state, and local laws and regulations, including maintaining appropriate certifications.

Other Standard *(specify):*

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

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

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

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

A provider of this service must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. Appropriately licensed/certified persons shall make or oversee all modifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with designated provider screening and enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Youth Continuous Home

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Youth Continuous Home is a habilitative service which is delivered in a provider-owned or leased, operated, or controlled residential setting and provided by agency provider shift staff not living in the setting. Youth Continuous Home consists of individually tailored continuous supports to assist with the acquisition, retention, or improvement in skills not yet mastered which will lead to more independence for the participant to reside in the most integrated setting appropriate to their needs.

Youth Continuous Home includes adaptive skill development of activities of daily living (ADLs), such as personal grooming and cleanliness, laundry, bed making and household chores, eating and the preparation of food, inclusive community activities, transportation, and the social and leisure skill development necessary to enable the participant to live in the most integrated setting appropriate to their needs. This service also includes the provision of personal care, health maintenance activities, supervision, and protective oversight.

When a participant is admitted to an in-patient, acute care hospital, due to a critical health or safety concern, this service can be provided. Support includes habilitation to maintain learned skills, implementation of behavioral support, if needed, and assistance with daily living activities to support the participant's treatment and recovery. This level of support will assist the participant to not regress or lose learned skills they had before they were in an in-patient, acute care hospital.

This service is provided to meet needs of the participant that are not met through the provision of acute care hospital services. This service is in addition to, and may not substitute for, or are not duplicative of, the services the acute care hospital is obligated to provide. This service will be used to ensure smooth transition between acute care setting and community-based setting and to preserve the participant's functional abilities. When authorized this service must be identified in the participant's person-centered service plan.

Prior to discharge the person-centered plan (PCP) will be updated to reflect the participant's needs and supports for transition back to the community-based setting.

Individual habilitation programs must be specific and measurable and updated when not yielding progress. Data must be analyzed at least monthly to determine the effectiveness of the programming and to identify trends. Monthly summary reports on progress or lack of progress must be made available in the state-mandated web-based case management system.

When a portion of this service is delivered via electronic health maintenance monitoring, the following conditions apply:

- Participants receiving Health Maintenance Monitoring must be under the supervision of a treating physician, physician's assistant, or advanced practice nurse who is directly providing care and treatment for their medical condition and not merely engaged to authorize the monitoring service.
- Electronic Health Maintenance Monitoring requires the participant or guardian to have the capability to utilize any monitoring tools involved or shall include the regular presence of an individual in the home who can utilize the involved monitoring tools and have the internet or cellular internet connection necessary to accommodate any needed remote patient monitoring equipment in the home.
- Health Maintenance Monitoring will be addressed in the participant's PCP and include the frequency, duration, and schedule of each health monitoring task including the criteria for abnormal findings and when to consult the participant's doctor.
- Health Maintenance Monitoring will be delivered in a way that respects the privacy of the individual and is not intended to monitor ADLs. Video cameras/monitors are not permitted in bedrooms and bathrooms.
- The use of Health Maintenance Monitoring is a person-centered decision that must only be authorized in circumstances in which the individual's health and safety would not be at risk, and the person must still have the option of in-person services if they choose.
- The participant or guardian must consent to receive the monitoring service and is responsible for the oversight and supervision of the monitoring.
- The participant's residence must have space for all program equipment and full transmission capability.
- The provider maintains a participant's record supporting the medical necessity of the service, all transmissions and subsequent reviews received from the participant, and how the data transmitted from the participant is being utilized in the continuous development and implementation of the participant's care.
- Health care providers performing a telehealth or digital health service shall, as appropriate for the service, provider, and participant, utilize the following modalities of communication delivered over a secure communications connection that complies with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA):

- o Live or real-time audio and video asynchronous telehealth technology;
- o Asynchronous store-and-forward telehealth technology;
- o Remote patient monitoring using wireless devices, wearable sensors, or health monitors, such as:
- o Heart rhythm with an electrocardiogram (ECG), respiration, blood oxygen level (SpO2), non-invasive blood pressure (NIBP), glucose monitor weight, apnea monitors, specialized monitors for dementia and temperature.
- o Audio-only telecommunications systems;
- o Clinical text chat technology; and
- o Medication dispensing and monitoring.

• Health Maintenance Monitoring can be used to monitor the following:

- o Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.
- o Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
- o Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes.
- o Remote physiologic monitoring treatment management services, clinical staff/physician/ other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes.

• Interpretation of data and any teaching or coaching of the participant and guardian must be done by a Registered Nurse (RN), Nurse Practitioner (NP), Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Medical Doctor (MD) or Doctors of Osteopathy (DO).

• Providers are required to develop policies and procedures which include:

- o Identifying whether health and safety needs can be addressed safely via health maintenance monitoring;
- o Assurance of the participants' rights to privacy, dignity, and respect, and the HIPAA compliance of the technology used for health maintenance monitoring;
- o A plan for how to respond to abnormal findings and when to consult the participant's doctor.
- o A plan for contacting EMS if the participant experiences an emergency during remote support or requires on-site support; and
- o Ongoing training for direct support staff.

Youth Continuous Home may not be self-directed.

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

Youth Continuous Home is only available to participants aged 18 years and younger.

Placement is limited to those individuals that demonstrate any of the following assessed risks as determined by the State's approved functional needs assessment: Behavioral/Harm to Self and Others; and Lack of natural supports for appropriate supervision and monitoring, based on the care needs of the participant; or Residential instability in the last two years. If requested, a clinical review of a participant's unique needs may be conducted to determine if Youth Continuous Home is appropriate if not otherwise indicated by the State's approved functional needs assessment. A participant's needs are assessed using the state-approved functional needs assessment tool, and further informed through person-centered planning conversations as delineated in Appendix D of this waiver application.

Youth Continuous Home cannot be approved for more than 12 months in a 3-year period without approval from DDD Central Office.

Youth Continuous Home is provided in a residential setting and must meet all federal standards for home and community-based settings.

Youth Continuous Home may be provided to no more than 3 participants in the residence at the same time, unless the residence is licensed as a Center for the Developmentally Disabled.

Participants receiving Youth Continuous Home daily rate cannot receive, Continuous Home, Host Home, Shared Living, Independent Living or Supported Family Living on the same day.

Participants receiving Youth Continuous Home cannot receive Respite, LRI Personal Care, and Homemaker.

Youth Continuous Home is reimbursed at a daily rate. The provider must be in the residence with the participant, providing a combination of habilitation, supports, protective oversight, and supervision for a minimum of 10 hours in a 24 hour period 12:00am - 11:59pm for the provider to bill a daily rate. When the provider is in the residence with the participant, providing a combination of habilitation, supports, protective oversight, and supervision for any amount of time less than 10 hours in a 24 hour period 12:00am - 11:59pm, the provider will be paid at half of the daily rate.

Participants receiving Youth Continuous Home daily rate cannot receive In-Home Residential services, which sunset ninety days following the approval of this amendment.

Transportation required in the provision of Youth Continuous Home is included in the rate. Non-medical transportation to the site at which Youth Continuous Home begins is included in the rate. Non-medical transportation from the site at which Youth Continuous home ends is included in the rate.

The provider agency is responsible for staffing Youth Continuous Home.

A lease, residency agreement or other form of written agreement will be in place for each participant receiving a Youth Continuous Home service. The participant has, at a minimum, the same responsibilities, and protections from eviction that tenants have under the landlord/tenant laws of the state, county, city, or other designated entity.

Medicaid payment may not be made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

The amount of prior authorized services is based on the participant's need as documented in the service plan, and within the participant's approved annual budget.

The rate tiers for this service are determined based upon needs identified in the Objective Assessment Process.

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

This service shall exclude any services available through public education programs funded under the Individuals with Disabilities Education Act (IDEA). This includes services not otherwise available through public education programs in the participant's local school district, including after school supervision and daytime services when

school is not in session (i.e. summer breaks and/or scheduled school holidays, in-service days, etc.). Services cannot be provided during the school hours set by the local school district. Regular school hours and days apply for a child who receives home schooling.

This service must not overlap with, supplant, or duplicate other comparable services provided through Medicaid State Plan or HCBS Waiver service, including EPSDT.

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	DD Agency - Habilitative Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Youth Continuous Home

Provider Category:

Agency

Provider Type:

DD Agency - Habilitative Services

Provider Qualifications

License *(specify):*

A license is required for each Youth Continuous Home setting with 4 or more participants. Title 175 Nebraska Administrative Code 3-000.

Certificate *(specify):*

Certification by DHHS in accordance with applicable state laws and regulations. Neb. Rev. Stat. §§83-1201 - 83-1226 – Developmental Disabilities Services Act.

Other Standard *(specify):*

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

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

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

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

All guardians delivering direct services and supports must comply with Neb. Rev. Stat. § 30-2627.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS agency personnel in combination with the designated provider screening enrollment vendor.

Frequency of Verification:

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

Appendix C: Participant Services

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

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

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

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §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:

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

DDD will ensure that service delivery system staff continue to receive training on person-centered planning philosophy and practice, which supports federal HCBS setting requirements, and includes the empowerment of the individual to fully understand the range of options available to them and their rights in making individual choices. Training will emphasize an individual's right to select where they live and to receive services from the full array of available options, including services and supports in their own or family homes.

Appendix C: Participant Services

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

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

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

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

The requirement of obtaining background and/or criminal history is outlined in Neb. Rev. Statute 83-1217(9) and below.In this waiver, DDD uses the term “background checks” to refer to criminal history investigations, background investigations, and abuse and other registry screenings.

a) The types of positions for which such investigations must be conducted: The background checks are conducted by DHHS staff or a vendor under contract with DHHS, upon a request initiated by an independent provider or certified DD agency. All waiver providers who will provide direct contact services and supports, and any household member of an independent provider or agency-associated individual contracted provider, if services will be provided in the provider’s home, undergo the background checks. Certified DD agency providers must complete annual background checks on each employee or contractor associated with the DD agency that has direct contact with participants served by the agency. Initial background checks must be initiated by certified DD agency providers within ten calendar days of their employment and annually thereafter to verify a staff person or associated individual contracted provider is not on the background check and registry lists. Employees who provide direct support services may not work alone with participants until the results of the background checks are reviewed by the provider.

b) The scope of such investigations: The state and federal registry checks consist of a review of the following:
NDEN - Nebraska Data Exchange Network for state and federal law enforcement history.
SOR - Nebraska State Patrol Sex Offender Registry.
DHHS APS and CPS Central Registries for any substantiated reports of adult or child exploitation, neglect, and abuse (physical, verbal, psychological or sexual), and if applicable, verification from other states they have lived in of their criminal history including any APS/CPS registry information from the other states.
OIG LEIE - Office of Inspector General List of Excluded Individuals and Entities.
SAM - System for Award Management, formerly the Excluded Parties List System (EPLS).
SSDMF - Social Security Death Master File.
NPPES - National Plan and Provider Enumeration System.
MCSIS - Medicaid and CHIP Information Sharing System.
PECOS - Provider Enrollment, Chain, and Ownership System.
SAVE - Systematic Alien Verification for Entitlements Program.
NMEP - Nebraska list of excluded parties.

c) The process for ensuring that mandatory investigations have been conducted: On-site surveys, or certification review activities, conducted annually or biennially by DHHS staff ensure that required background checks have been conducted by the DD agency provider. Provider management personnel are interviewed and a sample of records is reviewed to confirm that background checks were completed on all employee and associated individual contracted providers. In addition, DHHS staff review documentation of provider hiring decisions to verify adherence to applicable state regulations. Annual or biennial on-site certification review activities are the same activities and the frequency is based on the provider’s certification status, which is either a one-year certification or a two-year certification. In addition, DHHS staff review records to ensure that certified providers are in compliance with state laws that apply to using non-licensed persons providing medications and providing non-complex nursing interventions as delegated through the Nurse Practice Act to ensure their competency.

Background checks are completed initially for each individual independent provider that has direct contact with participants as a part of the Medicaid enrollment process and are completed prior to an approval and authorization to deliver waiver services. Background checks are completed annually for each individual independent provider that has direct contact with participants. Independent provider background check compliance is completed annually and the provider enrollment broker ensures that revalidation is completed annually and re-enrollment is completed every 5 years.

Once the background checks are completed on potential independent providers, the contracted vendor notifies DHHS staff by e-mail and electronically transfers the enrollment data. The vendor will notify DHHS if a potential provider fails a screening or background check and designated DHHS staff will issue a denial letter to the potential provider. The electronic enrollment data contains the verification and dates that the abuse registry checks were completed and is stored in perpetuity.

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):

In this waiver, DDD uses the term “background checks” to refer to criminal history investigations, background investigations, and abuse and other registry screenings.

a) The entity (entities) responsible for maintaining the abuse registry: The DHHS Adult Protective Services (APS) and Child Protective Services (CPS) Central Registries are maintained by employees of DHHS.

b) The types of positions for which abuse registry screenings must be conducted.
State service coordination employees and all waiver providers who will provide direct contact services and supports, and any household member of an independent provider or agency-associated individual contracted provider if services will be provided in the provider’s home undergo the background checks listed in C-2-a above and the following registry checks:
• SOR - Nebraska State Patrol Sex Offender Registry
• DHHS APS and CPS Central Registries for any substantiated reports of adult or child exploitation, neglect, and abuse (physical, verbal, psychological or sexual), and if applicable, verification from other states they have lived in of their criminal history including any APS/CPS registry information from the other states

The background checks, are conducted by DHHS staff or a vendor under contract with DHHS, upon a request initiated by an independent provider or certified DD agency. Initial background checks must be initiated by certified DD agency providers within ten calendar days of their employment and annually thereafter to verify a staff person or associated individual contracted provider is not on the background check and registry lists. Employees who provide direct support services may not work alone with participants until the results of the background checks are reviewed by the provider. Background checks on state service coordination employees are completed prior to the first day of employment.

c) The process for ensuring that mandatory screenings have been conducted.
On-site surveys, or certification review activities, conducted annually or biennially by DHHS staff ensure that required background checks have been conducted by the DD agency provider. Provider management personnel are interviewed and a sample of records is reviewed to confirm that background checks were completed on all employee and associated individual contracted providers. In addition, DHHS staff review documentation of provider hiring decisions to verify adherence to applicable state regulations. Annual or biennial on-site certification review activities are the same activities and the frequency is based on the provider’s certification status, which is either a one-year certification or a two-year certification. In addition, DHHS staff review records to ensure that certified providers are in compliance with state laws that apply to using non-licensed persons providing medications and providing non-complex nursing interventions as delegated through the Nurse Practice Act to ensure their competency.

Background checks are completed initially for each individual independent provider that has direct contact with participants as a part of the Medicaid enrollment process and are completed prior to an approval and authorization to deliver waiver services. Background checks are completed annually for each individual independent provider that has direct contact with participants. Independent provider background check compliance is completed annually and the provider enrollment vendor ensures that revalidation is completed annually and re-enrollment is completed every 5 years.

Once the background checks are completed on potential providers, the contracted vendor notifies DHHS staff by e-mail and electronically transfers the enrollment data. The vendor will notify DHHS if a potential provider fails a criminal history investigation, background investigation, or abuse and other registry screenings, and designated DHHS staff will issue a denial letter to the potential provider. The electronic enrollment data contains the verification and dates that the background checks were completed and is stored in perpetuity. A provider agreement is not issued prior to completion of the criminal history investigations, background investigations, and abuse and other registry screenings.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law 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.*

A Legally Responsible Individual (LRI) is defined as the natural or adoptive parents of a minor child or spouse of the waiver participant. A legally responsible individual is limited in service provision to the LRI Personal Care Service for services identified in the Nebraska Extraordinary Care tool. When the LRI Personal Care Service is provided by an independent provider, it must be deemed to be in best interest of the participant with prior approval from DDD Central Office. Payments for services rendered will be made according to services outlined in the participant's individual service plan and will be monitored as outlined in Appendix D-2.

Provider agencies may hire LRIs to provide waiver services when the individual is qualified and trained to provide the service in accordance with provider standards outlined in Appendix C-1/C-3. Provider agencies must provide supervision and oversight of employees and ensure claims are submitted only for services rendered and for the services, activities, and supports specified in the service plan.

The State makes payment to LRIs when it is determined the individual meets and maintains all standards and requirements outlined in applicable state regulations.

Payment to any LRI is only made when the service provided is not a function the LRI would normally provide for the participant, without charge, due to the usual relationship among family members; and, the service would otherwise need to be provided by a qualified provider. The provision of services by the legally responsible individual is determined through documented team discussion during the planning process, on a case-by-case situation by the participant's service plan team.

The provision of services is monitored by the participant's state service coordination personnel. Service coordination personnel monitor, at a minimum on a quarterly basis, services are furnished and paid as specified in the service plan. To ensure the provision of services is in the best interest of the participant, the service plan must be developed and monitored by a service coordinator without a conflict of interest to the LRI, and the plan must document services do not duplicate similar services, natural supports, or services otherwise available to the participant.

Designated DDD personnel ensure payments are made only for services rendered by prior authorization of all services based on the participant's needs and by reviewing submitted billing documentation.

To ensure the provision of services is in the best interest of the participant, the service plan must be developed and monitored by a service coordinator without a conflict of interest to the LRI provider, and the plan must document services do not duplicate similar services, natural supports, or services otherwise available to the participant.

The State does not make payments to members of the participant's immediate household for home modifications, respite, and homemaker services; or for activities or supervision when a payment is made by a source other than Medicaid.

Waiver services are not intended to duplicate or replace other services or supports (paid or unpaid) which are available to the participant.

The following controls are employed in the state-mandated web-based case management system to ensure payments are made only for services rendered:
- The need for the service is documented in the service plan;
- The provider is a Medicaid provider and enrolled prior to the delivery of waiver services;
- DHHS personnel have prior authorized each waiver service to be delivered;
- At the time services are delivered, documentation is completed by the provider to support the delivery of the service, such as, but not limited to electronic recording of time in and time out and habilitation data;
- A claim and when applicable, supporting documentation, is electronically submitted to DHHS for approval and processing;
- An Explanation of Payment is issued electronically; and
- Edits are in place in the electronic systems.

☐ **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.*

A relative legal guardian is defined as a court appointed legal guardian of a participant who is also the spouse, adult child, parent, or other relative of the participant. Relatives are defined as any person related to the participant by blood or marriage to the third degree of consanguinity, including a foster parent, foster child, stepparent, stepchild, and adopted children and their adoptive parents, per Neb. Rev. Stat § 49-1443.01. In the case of an Indian child, relative is defined in Neb. Rev. Stat. § 43-1503. Payment may only be made to relatives who are not legally responsible for the participant.

Relative legal guardians and non-legally responsible participant relatives may provide services. Any potential provider meeting general and specific service standards has the right to be a provider. Relative legal guardians and non-legally responsible participant relatives may provide services as specified in the service definitions, scope, and limitations in accordance with provider standards outlined in Appendix C-1/C-3. Non-legally responsible relatives may provide all waiver services except for the following: Consultative Assessment, Environmental Modification Assessment, Personal Emergency Response System (PERS), and Vehicle Modification. Relative Legal Guardians may provide the following services: Continuous Home, Host Home, Shared Living, Youth Continuous Home, Independent Living, Shared Living, Prevocational, Adult Day Retirement, Adult Day Health, Child Day Habilitation, Community Integration, Day Supports, Homemaker, and Transportation.

Provider agencies may hire participant relative legal guardians and non-legally responsible relatives to provide waiver services when the relative legal guardian or relative is qualified and trained to provide the service in accordance with provider standards outlined in Appendix C-1/C-3. Provider agencies must provide supervision and oversight of employees and ensure claims are submitted only for services rendered and for the services, activities, and supports specified in the service plan.

The State makes payment to relative legal guardians and non-legally responsible participant relatives when it is determined the provider meets and maintains all standards and requirements outlined in applicable state regulations.

Payment to any relative legal guardian and non-legally responsible participant relative provider is only made when the service provided is not a function the relative legal guardian or non-legally responsible participant relative would normally provide for the participant, without charge, due to the usual relationship among family members; and, the service would otherwise need to be provided by a qualified provider. The provision of services by the relative legal guardian or non-legally responsible participant relative is determined through documented team discussion during the planning process, on a case-by-case situation by the participant’s service plan team. The provision of services is monitored by the participant’s state DDD service coordination personnel.

Service coordination personnel monitor, at a minimum on a quarterly basis, services are furnished and paid as specified in the service plan.

To ensure the provision of services is in the best interest of the participant, the service plan must be developed and monitored by a service coordinator without a conflict of interest to the relative provider, and the plan must document services do not duplicate similar services, natural supports, or services otherwise available to the participant.

Designated DDD Personnel ensure payments are made only for services rendered by prior authorization of all services based on the participant’s needs and by reviewing submitted billing documentation.

The State does not make payments to members of the participant’s immediate household for home modifications, respite, and homemaker services; to a legally responsible relative or guardian; or for activities or supervision when a payment is made by a source other than Medicaid.

There are no additional limitations on the amount of services just because the provider is a relative legal guardian or a non-legally responsible relative.

Waiver services are not intended to duplicate or replace other services or supports (paid or unpaid) which are available to the participant.

The following controls are employed in the state-mandated web-based case management system to ensure payments are made only for services rendered:
• The need for the service is documented in the service plan;

• The provider is a Medicaid provider and enrolled prior to the delivery of waiver services;
• DHHS personnel have prior authorized each waiver service to be delivered;
• At the time services are delivered, documentation is completed by the provider to support the delivery of the service, such as, but not limited to electronic recording of time in and time out and habilitation data;
• A claim and when applicable, supporting documentation, is electronically submitted to DHHS for approval and processing;
• An Explanation of Payment is issued electronically; and
• Edits are in place in the electronic systems.

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

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

○ **Other policy.**

Specify:

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

All willing and qualified providers have the opportunity to enroll as waiver service providers. DD waiver services are provided by agencies, which successfully completed an enrollment process through DHHS and through the contracted enrollment provider broker.

The enrollment and certification requirements and procedures, and established timeframes are readily available to prospective DD agency providers on the DHHS public website.

Information for becoming an independent provider can be obtained from the waiver participant or DHHS personnel as well as on the DHHS public website.

Separate Agency Provider Orientation and Independent Provider Orientation are offered monthly and presented by DDD Central Office.

The participant interviews the potential provider to determine whether the provider will meet their needs. The potential provider is referred to DHHS personnel for enrollment. All willing and qualified independent providers can enroll.

DHHS personnel and a vendor under contract with DHHS are responsible for enrolling independent providers as waiver providers. Within two business days of receipt of a referral, DHHS personnel enter the referral into the provider data management system for the enrollment process. An application number needed for access to the vendor web portal for enrollment is generated and a referral packet is sent to the potential provider. The referral packet includes billing information, the MC-19 Service Provider Agreement, an application number, and instructions on how to use the contracted vendor's web portal to enroll. The referral cover letter advises the potential provider of the need to provide verification from other states they have lived in of their criminal history including any APS/CPS registry information from the other states. Verifications of education/experience, CPR/First Aid, proof of age and a driver's license (as applicable) are also required. The completed MC-19 and all verifications, including out of state background checks must be uploaded into the vendor's web portal before the provider can enroll. The potential provider completes the enrollment process with the contracted vendor on line or, when requested, on paper. The vendor notifies the referring DHHS personnel by e-mail and electronically transfers the enrollment data to DHHS. Within ten business days, DHHS personnel notify the prospective independent service provider and complete the approval process.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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:
A.1 # & % of new enrolled licensed/certified providers that met licensure/certification standards and adhere to other standards prior to providing waiver services. N = # of new enrolled lic/cert. providers that met lic/cert., and other standards prior to providing waiver services. D = # of reviewed new enrolled lic/cert. providers providing waiver services.

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 level 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:
A.2 # & % of enrolled licensed/certified providers providing waiver services that met required licensure/certification standards at certification review. N = # of enrolled lic/cert providers providing waiver services that met required licensure/certification standards at certification review. D = # of all lic/cert providers due for certification review providing waiver services that were 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 level 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.

Performance Measure:
B.1 # and % of new enrolled non-licensed/non-cert providers that initially met rq'd provider standards, specified in the waiver, prior to providing wvr svcs. N=# new enrolled non-licensed/non-cert providers that initially met provider standards, specified in the waiver, prior to providing wvr services. D=# all new non-licensed/non-certified providers providing services that were 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 level 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:
B.2. # and % of enrolled non-licensed/non-certified providers providing waiver srvs that met provider standards as specified in the waiver at annual screening. N= # of enrolled non-lic/non-cert providers providing wvr srvs that met provider standards as specified in the wvr at annual review. D= # of all non-lic/non-cert providers providing srvs that had an annual screening that were 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 level 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**

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

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:
C.1 #&% of licensed/certified providers providing waiver services who met training requirements as specified in state regs and the waiver at the cert review. N: # lic/cert providers providing waiver services who met training requirements as specified in state regs and the waiver at the cert review. D: # of reviewed lic/cert providers who had cert review.

Data Source (Select one):
Training verification records
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 level 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:

C.2 # & % of enrolled non-licensed/non-certified providers who met the training requirements as specified in state regs and approved waiver at their annual review.
N: # of enrolled non-licensed/non-certified providers who met the training requirements as specified in state regs and approved waiver at their annual review.
D: # of reviewed non-lic/non-cert providers that had their annual review.

Data Source (Select one):
Training verification records
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 level 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.

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

Activities for the determination of compliance with the above sub-assurances and performance measures are completed by DHHS staff and a vendor under contract with DHHS. The sample size for this review is determined by:
1) Using the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50% OR
2) Using a risk-based quality control sampling plan based on MIL-STD-1916 or ANSI/ASQ Z1.4.

Monitoring of the delivery of services is conducted by the SC, with input from the participant and/or representative when, applicable.

Enrollment of qualified providers is completed by DHHS staff and the contracted vendor. DHHS has the ultimate responsibility for enrolling qualified providers and the execution of Medicaid provider agreements. Each DD agency provider is certified prior to delivering waiver services in accordance with state regulations and re-certified annually or biennially, based on the provider's certification status.

All providers of waiver services must be Medicaid providers, as described in the Title 471 regulations, and adhere to the same general conditions and standards. The provider enrollment broker ensures that revalidation is completed annually and re-enrollment is completed every 5 years.

Failure to meet the regulatory requirements may result in termination or suspension of the provider agreement. Signing the provider agreement does not constitute employment.

Once DHHS approves the provider (Medicaid provider agreement and authorizations in place), web-based training for the provider is available, based on the provider type (independent or agency) and service type. Once enrolled, each independent provider of participant directed services is trained and directed by the waiver participant and/or their families.

The DDD QI committee meets quarterly and reviews the performance measure and other quality and compliance data. Recommendations are made for action by appropriate parties, including DHHS-DD management, members of the committee, and other DHHS staff. The QI activities of DHHS-DD and results of reports are communicated by DHHS to provider organizations, the DHHS-DD Advisory Committee, the Nebraska DD Planning Council, and to participants, families, and other interested parties. See Appendix H for additional information on the State's quality improvement strategies.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs 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 local and state levels have been developed to discover whether the 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 quality management strategies for addressing individual problems related to qualified providers are completed at the local level.

When an issue with performance of an independent provider is identified, a plan to address the issue may be discussed by the SC with the participant, depending on the issues that need to be addressed, and documented by the SC. The participant may address the provider or may ask their SC to assist in addressing the concerns or issues with the provider. The SC will follow through with the participant or on behalf of the participant until the issue is resolved. The issue, discussion, and resolution are documented and retained in the state-mandated web-based case management system.

The SC is responsible for facilitation and development of the service plan and then monitoring the implementation of each service plan in its entirety quarterly in addition to the ongoing monitoring of the service plan which may involve specific areas of the service plan within each monitoring session. The monitoring data are documented and retained in the state mandated web-based case management system.

Monitoring mechanisms include:
1. A review of all components of the service plan to ensure delivery of services as specified by the service plan;
2. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team if a change in the service plan is necessary; and
3. A semi-annual review of the service plan by the SC and the service plan team. The team reviews progress, implementation of the service plan, and the need for any revisions to the service plan.

Waiver participants may ask for assistance from their SC in communicating to their independent providers their expectations, compliments, areas that need improvement, concerns, unacceptable practices, etc. The SC may increase monitoring activities, participate in discussions with the participant and provider, provide talking points, facilitate revisions to the service plan, or, upon direction from the participant, terminate the authorizations for that provider.

When a pattern of inappropriate or inaccurate claims is detected, a referral is made to the DHHS Program Integrity Unit.

The quality management strategies for reviewing qualified providers are completed at the state level. The CBS QI Committee meets on a quarterly basis and reviews aggregate data for local, district, or statewide monitoring and certification to identify trends related to specific individual and agency providers and recommends resolution and/or changes that will support service improvement.

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 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.

a) The waiver services to which the limit to the prospective budget amount applies: The state has developed and implemented a methodology to determine a specific budget amount uniquely assigned to each waiver participant. The assigned budget amount constitutes a limit on the overall amount of services, which may be authorized in the service plan. The limit on the maximum dollar amount of waiver services for each specific participant is individually objectively assessed and is a realistic estimate of the expected amount of services waiver participants are likely to require. The individual budget amount (IBA) is the total annual funding amount available to the participant per their waiver year and is determined by DDD personnel. The assigned amount is determined before the development of the participant's service plan. The process for the determination of the individual budget amount is described in a printable public guidance document posted on the DDD public web page, and is available in printed format at local offices. Each participant's budget amount and specific IBA is not disclosed as part of public inspection.

b) The basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies used to determine the amount of the limit to which a participant's services are subject: The determination of prospective individual budget amounts for participants is determined using the 'Objective Assessment Process' or OAP as stated in statute and regulations. Funding is assigned based on an objective assessment of each person's abilities, to provide for equitable distribution of funding based on each person's assessed needs. Geographic factors do not affect the budget amount and the participant location is not factored into the objective assessment process.

The ICF/IID level of care assessment tool is used to ascertain each participant's skills, abilities, and needs. DDD personnel completes the ICF/IID level of care assessment with input from the participant's teachers, para-educators, family members, and provider staff, as appropriate, as well as a review of substantiating documentation to support tabulated responses. Substantiating documentation includes but is not limited to medical reports, psychological evaluations, critical incident data, and programmatic data. The ICF/IID level of care assessment tool is completed for persons new to services and annually thereafter.

The participant's service coordinator is informed of the prospective IBA and shares this amount with the participant at the time of initiation of DD waiver services and in the development of the service plan via the service budget authorizations.

c) How the limit will be adjusted over the course of the waiver period: The prospective individual budget amount is adjusted during the period the waiver is in effect. The limit will be adjusted to take into account cost increases, and the methodology will be periodically re-evaluated in light of changes in utilization patterns or other factors. The participant's IBA will be adjusted when the ICF/IID level of care assessment score results in a change in the level of service need or sooner when a new assessment is required due to changes in the participant's health and welfare needs.

d) Provisions for adjusting or making exceptions to the maximum annual budget based on participant health and welfare needs or other factors specified by the state. The IBA is adjusted based on the result of the ICF/IID level of care assessment score. Completion of a new assessment may be requested sooner when a waiver participant's needs have changed and cannot be safely met with funding solely based on the current prospective IBA. Based on input from the participant, provider, and guardian, when applicable, the team may submit a clinical rationale and supporting documentation to request re-evaluation.

Alternative compliance to the funding tier may be requested when a waiver participant's needs cannot be safely met with funding solely based on the ICF/IID level of care assessment score. When applicable, the team may submit a rationale for consideration to alternative compliance to the participant's ICF/IID level of care assessment score and identified IBA. A clinical review will be completed based on the alternative compliance request.

e) The safeguards in effect when the amount of the limit is insufficient to meet a participant's needs: The State has established the following safeguards to avoid an adverse impact on the participant:

• Additional requests for services would be evaluated by DDD Central Office to determine whether there is a critical health or safety need and if so, would be approved based on available waiver funding. When no additional waiver funding is available, that is the expenditures have exceeded cost neutrality for the waiver, the following safeguards would be applied;

• The participant is assisted in locating and obtaining other non-waiver services to assist in meeting their needs; or
• The participant may be referred to apply for another waiver to accommodate the participant's needs.

f) How participants are notified of the amount of the limit: Participants are notified in writing by DDD personnel of their individual budget amount as well as the dollar limits of waiver services at the time of initiation of DD waiver services and in the development of the service plan via a new individual budget amount. The written notice is mailed and includes hearing rights information.

☐ **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.

1. At the time of submission of this waiver application, all settings, specifically all Residential Habilitation settings including group homes, centers for the developmentally disabled (CDDs), host homes, and shared living homes and Adult Day Service sites including workshops, hubs, enclaves and all other locations where day services occur, and private homes, will be monitored through monthly reviews of person-centered plans with participants and at annual and semi-annual review meetings facilitated by Services Coordinators. The DDD quality team monitors settings for safety, environmental factors, personal well-being, and issues related to community integration through a combination of a random, stratified sampling strategy as well as targeted assessment when necessary. Settings may be selected for targeted assessment for any number of reasons including previous settings assessment results, consumer or public concern regarding compliance with the final rule, or other issues. All settings types utilized by this waiver currently exist within the HCBS system and have previously been validated and continue to be monitored for compliance with the Final Settings Rule. No settings, currently identified, have been identified as requiring heightened scrutiny review.

2. Nebraska's monitoring efforts will occur at the individual, provider, and state levels. All settings, including private homes, are continually monitored through monthly reviews of person-centered plans with participants and at annual review and semi-annual meetings facilitated by service coordinators, which include Home & Community-based Services (HCBS) settings criteria in the monitoring process.

Monitoring efforts at the individual level include a review of person-centered service plans. Relevant forms include indicators of compliance with the HCBS final rule. DDD will ensure that service delivery system staff continue to receive training on person-centered planning philosophy and practice, including the empowerment of the individual to fully understand the range of options available to them and their rights in making individual choices. Training will emphasize an individual's right to select where they live and to receive services from the full array of available options, including services and supports in their own or family homes.

The trainings will include curricula on supporting informed choice and identifying areas that providers must address. Guidance will be provided to service coordinators on how to educate individuals about person-centered philosophy and practice, which supports federal HCBS setting requirements. It will also include rights, protections, person-centered thinking, and community membership.
Monitoring efforts at the provider level for all provider-owned, operated, or controlled settings include ensuring current providers maintain compliance. Licensing, certification, and/or service delivery system staff will be critical to ensuring compliance of providers. Strategies to ensure ongoing compliance will include:
1. Ongoing licensing inspections and certification reviews by appropriate staff; and
2. Ongoing HCBS setting compliance monitoring to ensure that settings continue to comply with the HCBS regulations.

At the State level, DDD will ensure staff members are appropriately trained on the HCBS regulations and expectations. DDD works with Department of Public Health (DPH) licensure and certification staff to reduce duplication of effort in each Division's survey process.

DDD staff will conduct ongoing monitoring for all provider-owned, operated, or controlled settings through the use of file reviews and also through the annual provider review process, to assure continuous monitoring and improvement. All provider-owned, operated, or controlled settings are monitored for all parts of the HCBS Final Rule. This will include determining the sample sizes to ensure providers are complying with HCBS regulations on an ongoing basis.

DDD staff will also actively monitor the provision of services and supports identified in the participant service plan at a frequency and intensity that ensures needs are met and that any necessary revisions to the service plan are completed. This includes monitoring individual private homes, non-licensed settings, and anywhere services are received.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Support Plan, hereafter referred to as service plan.

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

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

In this waiver, “participant” means the individual receiving waiver services and any person legally authorized to act on behalf of the participant.

Developmental Disabilities (DD) Service Coordination is responsible to coordinate and oversee the delivery of effective services for participants through assessment, service plan development, referral, and monitoring activities. A SC, utilizing the team process, coordinates related activities to help a participant obtain needed habilitation services, medical, social, vocational rehabilitation services, educational providers, or other programs and services. The SC may make referrals to providers for needed services and schedule appointments for the participant. The SC completes monitoring and follow-up activities with the participant, family members, providers, or other entities to ensure the service plan is effectively implemented and adequately addresses the needs of the participant, and whether there are changes in the needs or status of the participant warranting to make necessary adjustments in the service plan and service arrangements with providers. The SC serves as a liaison for the participant with service providers and the community. DD Service Coordination is provided as Targeted Case Management under the Medicaid State Plan.

The qualifications of a Service Coordinator are:

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

2. Knowledge of: current practices in the field of community-based services for persons with intellectual disabilities and other developmental disabilities; person-centered planning; Americans with Disability Act (ADA) standards; self-direction; community integration; the principles of social role valorization; provision of habilitation services; positive behavioral supports; and, statutes and regulations pertaining to delivery of services for participants; and

3. Knowledge of: program resources/services available in Nebraska for persons with intellectual and other developmental disabilities; the objectives, philosophies, and functions of the Division of Developmental Disabilities (DDD); regulations governing the authorization, delivery of, and payment of community-based developmental disabilities services; Department of Education regulations; Vocational Rehabilitation services; State statutes regarding persons with disabilities; and DHHS programs, such as Protection and Safety and economic assistance programs; and

4. Ability to: mobilize resources to meet participant needs; communicate effectively to exchange information; develop working relationships with participants, their families, interdisciplinary team members, agency representatives, independent providers, and advocates or advocacy groups; analyze behavioral and habilitative data; monitor services and supports provided; apply Department of Health and Human Services (DHHS) program rules, policies, and procedures; and organize, evaluate and address program/operational data.

☐ **Social Worker**
Specify qualifications:

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The participant's SC provides support to the participant to actively lead in the development of their service plan. The participant also has the option to direct their SC to facilitate the service plan development meeting so the participant may actively participate as a team member.

a) The supports and written information which are made available to the participant to direct and be actively engaged in the service plan development process: Prior to the service plan meeting(s), the SC works with the participant to coordinate invitations for their service plan meetings, dates, times, and locations. The process of coordinating invitations includes the participant's input for who to invite, times and locations of convenience to the participant, and the inclusion of remote meetings when feasible to enhance full and active engagement for all.

Service planning teams are comprised of people who know and care about the participant. The participant and their family, the SC, service provider(s), and other persons chosen by the participant (e.g., advocates, natural supports, and friends) participate in the service plan process or parts of the process.

The process provides necessary information and support to ensure the participant and family direct their service plan meeting to the maximum extent possible and are empowered to make informed choices and decisions. The planning process reflects the cultural considerations and communication needs of the participant and the family. The participant is encouraged and assisted to participate in every aspect of their service planning meeting as fully as they are able and choose to do so.

The participant and their family direct the development and any updates to the person-centered service plan, and others sign to indicate their participation and agreement in supporting the participant in developing a person-centered service plan according to their hopes and dreams in living the life they choose for themselves.

b) The participant's authority to determine who is included in the process: Persons involved in the planning process will be determined by the participant, but must at least include the participant, representatives of their prospective DD provider(s), and the SC. The participant may raise an objection to a particular provider representative and the service plan team must attempt to accommodate the objection while allowing participation by provider representatives.

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) Who develops the plan, who participates in the process, and the timing of the plan:
Persons eligible for waiver services have a service plan developed prior to the authorization of the initial service package and annually thereafter. Service planning begins immediately following approval of the waiver slot with an Individual Family Meeting (IFM) with the participant. The purpose of this pre-service planning meeting is to gather information about what is important to and for the participant and what supports they need to be safe and healthy while leading the life of their choosing. This meeting is also the opportunity for the SC to explain the participant's individual budget amount and the available service array, including provider options. After the IFM is held, the team meets to develop the service plan. This person-centered plan is individually tailored to address the unique preferences and needs of the participant. The purpose of the annual service plan meeting is to determine waiver and non-waiver services, interventions, strategies, and supports to be provided to assist the participant to achieve their plan for the future, or personal goals.

Members in the planning process are determined by the participant but must at least include the participant, the SC, and DD agency provider representatives when agency-directed services are provided or independent providers when self-directed services are provided. The SC is responsible for scheduling concurrent remote and/or in-person service plan meetings, coordinating, and documenting the service plan meetings, and facilitating the participation of all team members by request of the participant. The SC elicits and records facts and information from other team members, advocates with the participant, encourages team members to explore differences, and discovers areas of agreement so consensus can be reached. The SC documents the service plan and the specific responsibilities of each team member with regard to implementation of services, supports, and strategies, and adheres to the electronic processes for service plan development and authorization. Meetings are scheduled at a time and place which accommodates the needs of the participant. Dates for regularly scheduled service plan meetings are scheduled well in advance to assure attendance by all team members. The participant or any other team member of the interdisciplinary team may request a team meeting at any time.

Each participant also directs, with supports as needed, their semi-annual service plan meeting. The purpose of the semi-annual service plan meeting is to review the implementation of the annual service plan, document the participant's future plans and personal goals, explore how the team can assist the participant to achieve those goals, determine information needed to develop appropriate supports for achieving the participant's future plans, assign responsibility for gathering information, and review any other issues impacting the participant's life.

b) The types of assessments, which are conducted to support the service plan development process, including securing information about participant needs, preferences, goals, and health status: The service plan must identify the needs, goals and preferences of the participant and specify how those needs, goals and preferences will be addressed. In order to accomplish that, assessments to evaluate the participant's strengths, capacities, and areas needing growth to support the service plan development are determined by the team. These may include, but are not limited to, the ICF/IID institutional level of care assessment tool, psychiatric reports, psychological reports and assessments conducted by the provider to further their knowledge of the participant's skills and abilities (e.g., vocational, medication administration, home living skills, communicative intent of behavior, etc.).

Health and welfare is addressed through a variety of assessments, which may be completed by the provider, SC, the Education System, and Medical Professionals. Assessments include, but are not limited to, the ICF/IID institutional level of care assessment tools, multidisciplinary reports, Individual Education Plan reports, medical evaluations, health screens, health assessments, and incident reports.

c) How the participant is informed of the services available under the waiver: The participant is informed of available services under the waiver prior to the initial plan development and annually thereafter at the IFM meeting.

Additionally, materials, such as the Participant Guide for Self-Direction, is provided by the SC to the participant about services offered under the waiver program; the participant rights and obligations; due process rights; providers' roles and responsibilities; for applicable participant-directed service options - how to hire, fire and direct providers; and claims review and verification processes. The written materials are provided to each participant and include an introduction to services; the roles and responsibilities of the participant, service coordination, and provider; and service definitions. The information also includes information about rights, responsibilities, and risks; developing a service plan; finding providers, resources of approved and available providers; hiring providers; training providers; working with providers; personal safety; and reviewing the service plan; the standards and qualifications providers are

expected to meet; an introduction for providers, standards for specific services; and information on authorization and

billing.

General information regarding service planning and service options are also available on the DHHS public website, within the Division of Developmental Disabilities tab, and by contacting DDD Central Office. However, the primary source of information for participants and families is received directly from service coordination, both verbally and in written form, when requested as described above, prior to entry into waiver services and annually thereafter.

d) How the plan development process ensures the service plan addresses participant goals, needs (including health care needs), and preferences: Prior to waiver entrance, the participant and an interdisciplinary team develop a detailed annual service plan through assessment, discussion, consensus, and assignment of responsibilities. This must include identification of services and supports to be provided under the waiver program, as well as services and supports to be provided by other non-Medicaid resources. The annual plan includes, as appropriate:

- Employment goals and strategies when the youth is at least 16 years of age;
- Medical information;
- Nutritional considerations;
- As applicable, physical nutritional management plans;
- As applicable, adaptive devices, including support and protective devices;
- Physical and nutritional supports;
- Medical conditions and known allergies;
- Medications;
- Rights and rights restrictions;
- Legal needs;
- Finances;
- Identification of basic and other needs, which include:
  - Physical survival
  - Physical comfort
  - Emotional well-being/happiness and personal satisfaction
  - Personal independence and self-care;
- Review of critical incidents and action needed or already taken to reduce risk of future critical incidents;
- Requested service(s);
- Identification of current providers and a plan to locate needed provider(s), when applicable;
- Description and schedule of strategies, services, and supports to be provided, taking into consideration the participant’s personal and career goals and identified needs;
- Identification of the prospective budget amount and the projected monthly cost/utilization of the services and supports to be provided, as well as services and supports to be provided by other non-DD funded resources; and
- Back-up plan, for each participant-directed service, in the event participant-directed services can’t be provided or aren’t provided as scheduled. Back-up staff must be chosen by the participant, documented in the participant’s service plan, and must meet all provider qualifications.

The service plan must identify the needs and personal preferences of the participant and specify how those needs and personal preferences will be addressed. This must include identification of services and supports to be provided under the waiver program, as well as services and supports to be provided by other non-Medicaid resources. The service plan indicates how the participant and team believe the plan will meet health and safety needs of the participant. These needs may be met by a combination of DD agency services/supports, self-directed supports, natural supports, services/supports from other DHHS programs and other services/supports from other non-Medicaid sources. If it is determined the needs cannot be met under the current plan without posing a threat to the health and safety of the participant, the participant and team will re-consider the appropriateness of the service array and funding source. This may require referral to other services or programs and the development of an alternate plan.

e) How waiver and other services are coordinated: Coordination of waiver services includes documentation, referral, and follow-up. The SC is responsible for coordination and oversight of the delivery of effective services for participants through assessment, service plan development, referral, and monitoring activities. The participant determines the level of coordination desired. The SC provides information about referrals and resources to the participant. The SC may make direct referrals and coordinate related activities to help a participant obtain needed habilitation services, medical, social, employment, educational providers, or other programs and services.

The SC makes referrals to prospective providers selected by the participant for needed services and may schedule appointments for the participant.

The SC completes service reviews and follow-up activities with the participant, providers, or other entities to ensure the service plan is effectively implemented and adequately addresses the needs of the participant, and whether there are changes in the needs or status of the participant which warrant making necessary adjustments in the service plan and service arrangements with providers. When requested, the SC may serve as a liaison for the participant with the service provider and the community.

f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan: The service plan document identifies the services and supports, schedule of delivery of services and supports, and responsibilities to implement the plan. The SCS reviews the service plan to ensure it addresses the participant's goals, needs (including health care needs), and preferences by reviewing and approving a stratified sample of annual service plans and annual budgets.

DD agency provider representatives and the participant's independent providers must participate in the development of the service plan and take the necessary steps to ensure the service plan documents the team review, discussions, and decisions. The participant may choose not to invite their independent providers to the service plan meeting, but then takes on the responsibility to communicate their applicable services and supports, schedule of delivery of services and supports, and providers' responsibilities to implement the plan to the independent providers following each service plan meeting.

The SC is responsible for reviewing the implementation of the plan by observing and documenting observations on the service review form. Service reviews are completed quarterly within the calendar year, and are scheduled at the discretion of the SC. The SC may complete service reviews: in the environment where waiver services are provided when there are reports of abuse or neglect, health and safety concerns; at the request of the participant or other team member; when a participant is moving into a different provider owned or leased, operated or controlled residential setting prior to them moving in; or any other time when the SC determines it is necessary to monitor the service delivery.

g) How and when the plan is updated, including when the participant's needs change: At a minimum, the team comes together annually to develop the service plan, and semi-annually to review the service plan. The service plan is updated during the semi-annual service plan meeting. When circumstances occur or needs change, the service plan may be updated following discussion and agreement via an in-person, electronic , or written communication. DDD does not utilize temporary or interim service plans; any changes to the service plan are done formally and with full team participation.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Assessment is required at least annually in conjunction with development of the service plan to identify the preferences, skills, and needs of the participant.
Strategies are developed by the team to address areas of risk identified through the assessment process. The SC is responsible for including the following in every service plan:

- A description and schedule of waiver services and supports to be provided, taking into consideration the participant's goals, preferences and identified needs;
- The identified provider(s);
- A back-up plan, in the event services can't be provided or aren't provided as scheduled. Back-up staff must be chosen by the participant, documented in the participant's service plan, and must meet all provider qualifications. Back-up plans may include a temporary increase in natural supports, hiring additional on-call providers, etc.;
- Documentation of how the team believes the plan will meet the health and safety needs of the participant. These needs may be met by a combination of agency and participant-directed services, supports, and strategies; natural supports; or services and supports from non-Medicaid programs.

Further assessment may be required based on the outcome of initial assessment. When the team identifies an elevated risk to the participant's health and welfare due to a medical condition, or problem behavior, additional steps must be taken to address behavioral or medical risk.

When the team has attempted to manage a behavior unsuccessfully or feel they don't have the information necessary to develop an appropriate behavior support plan, it may be appropriate to utilize Consultative Assessment, defined in Appendix C1/C3 of this waiver. The DDD Clinical Support Team (CST) may also be requested to provide consultation and recommendations when the service plan team's attempts to support the behavior have been unsuccessful or when there are concerns with unresolved medical issues.

The primary intent of Consultative Assessment and support from the CST is to help the PCP team understand the variables, which could increase risk so the service plan team can incorporate these into a habilitative behavior support plan and safety plan to reduce risk.

Should a participant be identified as having high-risk health care needs, either at entry to the DDD program or at any time during services, the need for increased support to safeguard the participant's well-being will be determined by designated clinical personnel at DDD Central Office. A referral is completed by the participant's service plan team, which may include the participant's physician, to assist the team in planning, as a guide in giving adequate consideration to health and medical factors, or at the request of DDD Central Office. If additional services are requested to support health and welfare, DDD Central Office may choose to assign clinical personnel to conduct a formal health assessment. Medical history, current medical evaluations, and a formal health assessment are considered and recommendations or direction are provided to the team regarding optimal elements to consider when selecting or preparing service environments and treatment options which will best mitigate risks identified and support the participant.

When it is determined the needs cannot be met under the current service plan without posing a threat to the health and safety of the participant or others, the team may need to re-consider the appropriateness of the participant's current waiver services. Current services and the provision of services may be adjusted or additional waiver or non-waiver services and supports will be accessed as necessary to protect the participant's health and welfare. When health and welfare needs cannot be met within the limits, adjustments, or exceptions, or a referral to another HCBS waiver, non-waiver services and supports will be determined on a case-by-case basis.

Additional funding may be requested when a participant's needs cannot be safely met with funding solely based on the ICF/IID institutional level of care assessment tools. In the event of a temporary increased service need of the participant, the amount of exception funding is determined administratively based on clinical information provided by the team.

Back up arrangements for the delivery of residential or day habilitation services by the DD agency provider are described in the provider's policies and procedures. Each agency has on-call or substitute staff available when a staff person fails to appear for work. Agency personnel have contact information for the DD agency provider's management staff who is responsible for scheduling and assigning on-call staff. Information about back-up plans for the delivery of residential or day habilitation services is provided by the DD agency provider to the participant when the DD agency provider is selected and documented in the service plan. A back-up plan is required in each participant's service plan. The need for and type of back up is discussed at the service plan meeting and documented in the service plan. Consideration is given to the natural supports which may be available to fill in and the availability of other enrolled providers who could deliver

services. Multiple independent providers may be enrolled as back up or substitute providers. Back-up staff must be chosen by the participant, documented in the participant's service plan, and must meet all provider qualifications.

DD providers are also expected to have disaster plans developed and documented so provider personnel are aware of expectations during such a time. Such plans should include where services should be provided when a disaster occurs, what necessary materials or equipment is needed for specific health or behavioral needs, and who needs to be contacted in cases of emergency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Nebraska's services for participants with intellectual or developmental disabilities are voluntary, both for the participant and the provider. Choice of providers and services is based on mutual consent. Nebraska has regulations and processes in place to ensure participants are provided information about DD services and providers to facilitate informed decisions.

DHHS offices are located throughout the state to provide a statewide system of service coordination. The DHHS public website includes information about DDD's responsibilities, service coordination, services funded by DHHS programs, certified DD agency providers, and non-certified independent providers as well as links to other resources for participants and families.

The SC provides the participant with information about and website addresses or links to local community services and supports, service coordination, services funded by DHHS and DDD, currently certified DD agency providers, and non-certified independent providers.

Information about local community services and supports, and how to access available services are provided to participants who are determined to be eligible for DD services at the time of eligibility determination and ongoing thereafter at service plan meetings and more frequently as needed.

Service Coordination personnel may assist the participant to arrange interviews with potential providers. The SC may assist the participant to arrange tours of potential DD agency providers. Participants often draw from their personal networks of family members not living in the household, friends, neighbors, teachers, paraprofessional/teacher's aides, church members, and local college students in order to select independent providers for participant-directed services.

When the participant is considering assistive technology (AT), home modifications, or vehicle modifications, the SC authorizes an approved provider to complete an Environmental Modification Assessment, defined in Appendix C1/C3 to ensure the request is functionally necessary, appropriate, based on the service definition of the applicable service, and is cost effective.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The Department of Health and Human Services (DHHS) is the State Medicaid Agency for Nebraska, and the Division of Developmental Disabilities (DDD) is a division within the Medicaid agency. At a minimum, the team, led by the DDD SC, comes together annually to develop the service plan, and semi-annually to review the service plan. The service plan is updated during the semi-annual service plan meeting, and when circumstances occur and/or needs change the service plan may be updated following discussion and agreement via an in-person, electronic, or written communication.

All functions related to service plan approval are completed by DDD personnel. All annual service plans are read and reviewed by the designated SCS upon receipt from the SC.

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) The entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare: The SC is responsible for in-person, on-site monitoring, also referred to as service reviews, of the participant's health and welfare, as well as monitoring of the implementation of the service plan. The SC also monitors to ensure the participant resides and/or receives services in a setting, which meets the HCBS regulations and requirements.

b) Service Coordination monitoring is designed to provide support to the participant and their families and allows for frequent communication through secure emails, phone calls, remote and face-to-face visits, both at their homes and at service provision sites. In addition, on-site monitoring of the provision of services is completed at least quarterly within the calendar year and is scheduled at the discretion of the SC. A standardized DDD template is used by SCs whenever they are conducting monitoring.

At least quarterly within the calendar year, a review of all components of the service plan is conducted to ensure:
a. Delivery of services, supports, and strategies in accordance with the service plan;
b. Effectiveness of habilitation programming for habilitative services;
c. Access to waiver and non-waiver services identified in the service plan;
d. Free choice of provider(s);
e. Determination services meet participant needs;
f. Effectiveness of back-up plans, when applicable and utilized;
g. Health and welfare; and
h. Other as applicable, i.e., physical nutritional management plans, adaptive devices, etc.

Follow-up and remediation process for issues discovered during monitoring:
Observations made during a review or "in passing" are documented. Concerns are discussed with the agency provider support staff working with the participant. When at any time it is noted supports or services are not being provided as noted in the service plan, the SC works directly with the provider staff on duty to reach a resolution. Anytime a concern is noted, follow-up is required. Follow-up occurs with the agency provider(s) on how to provide resolution or address the concern. The follow-up occurs by phone, secure email, remotely, or in- person. The SC documents the follow-up completed on the service review form and in the service coordination case notes. The provider has up to 14 calendar days to respond to the SC.

When determined necessary, any of the following steps may be taken:
a. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team when a change in the service plan is necessary.
b. Addressing concerns with the provision of services, including but not limited to delays in implementing any aspect of the service plan or failure to adequately implement the service plan as written.
c. When a pattern is detected of inappropriate or inaccurate claims by a provider, a referral is made to the DHHS Program Integrity Unit.

Service coordination observations during the delivery of participant-directed services are discussed with the participant, and with the provider, as appropriate, and followed through to resolution. When resolved at this level, resolution is documented on the service review form or in the SC case notes. A team meeting may be called to respond to issues and to adjust the service plan when necessary.

Should immediate safety concerns be evident, the concern is expressed verbally to appropriate personnel to prevent the participant or others from being harmed. When it is necessary for the SC to intervene to ensure the health and/or safety of the participant, such incidents are immediately discussed with the SCS. Suspected abuse or neglect is reported to DHHS Adult Protective Services and Child Protective Services as appropriate. The SC documents health and safety concerns in the case notes and complete an incident report as necessary. Please refer to Appendix G for a detailed description of DDD's critical incident management system.

Concerns which do not involve immediate threats to health and safety discovered by the SC during on- site service reviews or any other contacts is discussed with provider staff on duty to reach a resolution. When resolved at this level, the resolution is documented in the SC case note. When the issue is not resolved, the SC completes a Service Review and sends it to the agency provider staff supervisor and the SCS. A response is requested within ten days from receipt of the review.

When a written response is received, the SC reviews it to ensure the action taken will correct the problem. When the

response is deemed inadequate or no response is received, the SC contacts the person to whom the Service Review was sent to find out the status of the response. When the response is still inadequate, the SC sends the written documentation of noted concerns to their immediate supervisor. The SC reviews the issue with his/her supervisor to determine the necessity of contacting the Manager of the agency provider staff responsible for making changes or corrections to alleviate the concerns. A response from the provider within 14 days is requested when the issue has not been resolved and when a response is received, the SCS and SC review the response to ensure it meets the expectations in correcting the problem. When no response or an inadequate response is received, the SCS sends the written documentation of noted concerns to the Service District Administrator (SDA) or their designee.

The SDA or designee contacts administration of the agency provider to develop a mutually agreed-upon plan of action. When no resolution is achieved, or when trends show the problems are recurring (such as "no ongoing habilitation provided," "programs not run as written," "programs not run at all," etc.) the SDA or designee informs the DDD Central Office of the problems and works with Central Office personnel to determine what steps will be taken. Central office personnel may provide consultation/technical assistance to the DD agency provider, refer to DHHS -DDD Surveyors to perform a focused certification review specific to the delivery of services to a participant or provider setting, or initiate the complaint process described in Appendix F as necessary.

During certification reviews conducted by DHHS DD Surveyors, the service plan is reviewed using the Core Sample Record Audit and, when behavior support is a part of the service plan, the Core Sample Review Checklist will be used. Certification reviews are conducted annually, biennially, or more frequently as determined by DHHS management.

In addition, the service plan is reviewed semi-annually and updated annually to determine whether the plan developed and implemented by the team continues to meet the participant's needs. Areas reviewed include but are not limited to health, safety, habilitation, employment, community involvement, and personal goals. The service plan identifies services, supports, interventions and strategies to be provided by the DD agency providers as well as services provided by independent providers of DD services.

When non-compliance issues are identified with the agency provider that cannot be resolved, DDD management may make a referral to DHHS surveyor personnel. The types of possible actions range from citing a deficiency to termination of the agency provider by the Director of DDD. The general action taken is a citation of a deficiency and the provider must provide an acceptable plan of improvement addressing the issues cited for those participants identified in the sample as well as address the issue cited on a system level within the agency provider.

The information derived from observing the implementation of the service plan and review of the service plan is entered into a database. Designated DHHS personnel have access to the database and may query the data to identify problems and trends.

c) The frequency with which monitoring is performed: Service coordination verifies, through ongoing monitoring, the services and supports provided continues to be effective. The SC monitors the implementation of each service plan. This oversight has long been a part of the regulations, policies, and expectations regarding the role of service coordination in monitoring. In-person and on-site service reviews are conducted quarterly for each participant in services. A service review is completed quarterly within the calendar year, and is scheduled at the discretion of the SC. Ongoing in-person and on-site monitoring are conducted between the service reviews when there are reported health and safety concerns, reports of abuse or neglect and/or when requested by a team member, or any other time when the SC determines it is necessary to monitor the delivery of services. During each of these service reviews, the SC may choose to scrutinize only those items that surfaced as concerns during the previous service review to check that the concerns have been remediated. However, the SC has the ultimate and ongoing responsibility to ensure service plan implementation, health and safety, environmental factors, personal well-being, and issues related to community integration are adequate to meet the needs of the participant.

Concerns are reviewed with the local Service District Administrator and brought to the attention of DDD Central Office administration as needed.

SCs will make monthly contact with all participants or identified team members on their caseload to make sure that services are provided as outlined in the PCP. This monitoring will continue when services are provided less than monthly.

b. Monitoring Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.**

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 Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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 participantsâ 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:
A.1. Number and percent of service plans reviewed which reflect the participant's goal(s). Numerator = number of service plans reviewed which reflect the participant's goal(s); Denominator = number of service plans 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 level 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**

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

Performance Measure:
A.2. Number and percent of service plans reviewed that reflect the participant's assessed needs (including health and safety risk factors). Numerator = number of service plans reviewed that reflect the participant's assessed needs (including health and safety risk factors); Denominator = number of service plans 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 level 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 participantâs 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:
C.1. Number and percent of participants reviewed whose person-centered plans were reviewed and revised on or before the annual review date. Numerator = number of participants reviewed whose person-centered plans were reviewed and revised on or before the annual review date. Denominator = number of participants reviewed.

Data Source (Select one):
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 level 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:
C.2. Number and percent of participants reviewed whose person-centered plans were revised, as needed, to address changing needs. Numerator = number of participants reviewed whose person-centered plans were revised, as needed, to address changing needs; Denominator = number of participants whose person-centered plan required a change due to a participant's changing needs that were 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 level 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**

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

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:
D.1. # and % of participants reviewed for whom services were delivered in accordance with the type, scope, amount, duration, and frequency identified in the person-centered plan. N = # of participants reviewed for whom services were delivered in accordance with the type, scope, amount, duration, and frequency identified in the person-centered plan. D = # of participants reviewed.

Data Source (Select one):
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 level 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:
E.1. Number and percent of participants reviewed whose case management files document an annual choice of waiver services. Numerator = number of participants reviewed whose case management files document an annual choice of waiver services. Denominator = number of participants whose case management files were 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 level 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:
E.2 Number and percent of participants reviewed whose case management files document an annual choice of waiver providers. Numerator = number of participants reviewed whose case management files document an annual choice of waiver providers. Denominator = number of participants whose case management files were 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 level 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**

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

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

The SCS reviews the online initial service plan for each waiver participant to ensure it meets the waiver and regulatory standards. The process was developed to also ensure the service plan is completed in accordance with timelines and to aggregate the results to identify issues at various levels of DDD.

The SC reviews assessment information, the participant's personal goals, and the service plan to determine if the services defined flow from the assessments and personal goals.

To allow for increased state oversight of the service review process, the responses are entered into a quality database. The database allows DDD personnel responsible for quality reviews to access the information and create aggregated reports to look at the performance of individual SCs and analyze systemic trends. DDD Central Office Quality personnel annually conducts off-site file reviews of a representative sample at a confidence interval of 95% with a +/- 5% margin of error to check service plan documentation. The sample size for this review is determined by the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50%.

In addition to the ongoing monitoring of the service plan, the SC monitors the implementation of each service plan in its entirety quarterly, which may involve specific areas of the service plan within each service review.

Monitoring/service review mechanisms include:
1. A review of all components of the service plan to ensure delivery of services as specified by the service plan;
2. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team when a change in the service plan is necessary; and
3. A semi-annual review of the service plan by the SC and the service plan team. The team reviews progress, implementation of the service plan, and the need for any revisions to the service plan.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs 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.

Monitoring is completed quarterly and additionally when there are reports of abuse or neglect, health and safety concerns, at the request of the participant or any other team member, or any time when the SC determines it is necessary to monitor the service delivery.

To allow for state oversight of the monitoring process, responses on the monitoring forms are entered into a web-based database. This allows individual SCs to track issues, which are yet unresolved and provide aggregate information for SCSs, Quality personnel, and the DDD Central Office personnel. The information is useful for looking at the performance of individual SCs and providers, as well for identifying any area-wide issues. This information is reviewed and acted on, as appropriate, at the local level.

When issues or problems are discovered during monitoring, the participant's SC documents on the monitoring form a plan to address the issues identified. The plan to address issues may include a team meeting, the facilitation of sharing information between the participant, provider(s) of services, etc. A timeline to address the issues and/or a service plan team meeting date is noted on the monitoring form as well as whether the issues were resolved within the timeline.

When a pattern is detected of inappropriate or inaccurate claims, a referral is made to the DHHS Program Integrity Unit.

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)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

In this waiver, “participant” means the individual receiving Medicaid HCBS DD waiver services and any person legally authorized to act on behalf of the participant.

(a) The nature of participant-directed opportunities, known as self-directed opportunities in Nebraska, afforded to participants: The Division of Developmental Disabilities (DDD) embraces a person-centered self-directed philosophy, designed to focus on what is important for and to that participant and provide choice when determining the services and supports needed to maximize independence. The SC is actively involved in supporting self-direction. The SC supports self-direction by meeting with the participant to facilitate discussion of the participant’s budget, the self-directed services available, and the rights and responsibilities associated with choosing self-directed services. The SC may assist in locating independent providers, facilitate interviewing the prospective providers, and assist in setting up referral meetings with certified agency providers. To enhance engagement of all team members, the SC encourages and facilitates concurrent remote and in-person service plan meetings, and documents service plan meetings.

Opportunities for self-direction are available to participants who select DD waiver services listed in E-1-g. These services are directed by the participant. Self-directed services are intended to give the participant more control over the type of services received as well as control of the providers of those services. The underlying philosophy of offering self-directed services is to build upon participant strengths, build team and community relationships, and to strengthen and support informal and formal services already in place. Self-directed services must be individually tailored to address the unique preferences and needs of the participant.

(b) How participants may take advantage of these opportunities: Persons eligible for waiver services participate in the development of their service plan prior to the initiation of services and annually, or more frequently as needed, thereafter. The annual service plan meeting determines waiver and non-waiver services, interventions, strategies, and supports to be provided to assist the participant to achieve their plan, or personal goals, and to meet the participant’s needs and preferences. The purpose of the semi-annual service plan meeting is to review the implementation of the annual service plan, document any changes to the participant's needs, goals, and preferences, explore what supports are needed from the team, determine when additional information or assessment is needed, to assign responsibility for gathering information or completing assessments, and review any other issues affecting the participant's life. The participant or any other team member may request a team meeting at any time to update the service plan when circumstances or needs change. All team members, chosen by the participant, are invited to all service plan meetings.

The participant has the right and responsibility to participate to the greatest extent possible in the development and implementation of their service plan. This person-centered service plan is individually tailored to address the unique preferences and needs of the participant. Membership in the planning process is determined by the participant, but must at least include the participant, the SC, and any DD waiver service providers. The participant may take responsibility or direct the SC to be responsible for scheduling, coordinating, and chairing all service plan meetings. The SC assists the participant or directly facilitates the active participation of all team members gathered remotely and in person. The service plan must identify the needs and preferences of the participant and specify how those needs will be addressed. This must include identifying services and supports to be provided as well as other non-DDD funded resources.

Participants have the right and responsibility to select DD waiver service providers. The participant identifies potential providers and screens the providers to determine competence for provision of services, based on the participant’s needs and preferences, and experience, knowledge, and training the providers may have. The participant describes to the provider the services and supports to be delivered.

(c) The entities which support individuals who direct their services and the supports they provide: At any time, the participant can request assistance to facilitate completion of the above steps from their SC.

During the enrollment process, DHHS assists the participant by verifying citizenship status of individual independent providers. Once the provider is enrolled, and prior authorized for delivery of services, the participant directs the provider by setting the schedule and determining how services will be delivered, and based on the service plan, the type and amount of service.

The participant also has the authority to terminate the provider, by directing DDD personnel to end the authorization for the delivery of services. DDD has the option to retain the service agreement to allow other participants to utilize the enrolled provider.

The Internal Revenue Service (IRS) has approved DHHS to be appointed the Fiscal/Employer agent as a means to ensure all requisite IRS rules are being followed. DHHS provides the following services in this capacity:
1. Manage and direct the disbursement of funds contained in the participant's budget;
2. Facilitate the employment of staff by the participant by performing, as the participant's agent, such employer responsibilities as processing payroll, withholding Federal, state, and local tax and making tax payments to appropriate tax authorities; and,
3. Performing fiscal accounting and making expenditure reports to the participant and state authorities.

As a state entity, DHHS is not required to file individual forms 2678 with the IRS. Instead, DHHS devised a substitute form 2678 (DHHS form FA-65) which DHHS entitled "Appointment of DHHS as Agent for State and Federal Employment Taxes and Other Withholding Taxes for In-Home Service." This is broader than the IRS form because it also allows DHHS to handle state employment taxes. This form is maintained by the SC and kept in the participant's electronic records maintained by DDD. Information regarding IRS related responsibilities is explained verbally and in writing to the participant and provider. Under federal law, DHHS and the participant/Common Law Employer are jointly liable for employer taxes; however, neither entity is required to withhold income taxes.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☒ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to**

elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) The information about self-direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction: Information about self-direction opportunities is available to participants who are currently receiving DD waiver services as well as to anyone entering DD waiver services. Information is provided verbally and through written materials and website addresses by the SC, and is provided to the participant prior to entrance to DD waiver services and prior to the annual service plan meeting to allow sufficient time for the participant to weigh the pros and cons of self-direction and obtain additional information as necessary. Information about self-direction opportunities are available in reference materials developed by DDD, the DHHS public website, and other public communications, such as information from Nebraska Department of Education about post-high school opportunities and information developed through the Nebraska Developmental Disabilities Council.

Reference materials developed by DDD include descriptions of available DD waiver services, guidance for deciding if self-direction is right for a participant, guidance for finding, enrolling, and managing independent providers for participants who self-direct services, and guidance for providers on authorizations and submitting claims.

The DHHS public website also includes information about DDD responsibilities, service coordination, services funded by DHHS and DDD, certified DD agency providers, and non-certified independent providers, as well as links to other resources for participants, families, and any interested persons.

Reference materials developed by DDD are utilized as training tools and post-training reference guides for participants and their support systems.

(b) The entity or entities responsible for furnishing this information: The SC provides the participant information or website addresses for local community services and supports, service coordination, services funded by DHHS and DDD, currently certified DD agency providers, and non-certified independent providers.

(c) How and when this information is provided on a timely basis: The provision of written information about self-directed services and supports is an integral component of the development of the service plan. The participant's SC provides verbal and written information, as well as website addresses about self-directed services and supports to participants at entry into waiver services, annually thereafter, and as requested. The written information includes information posted on the DHHS public website related to self-direction, for those who prefer written materials or do not have access to the internet.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Selection of an advocate is voluntary, and an advocate may be chosen by the participant when the participant does not have a guardian. The responsibilities and extent of involvement in decision making by the advocate is determined by the participant and documented in the service plan. The advocate must be 19 years of age or older and can be an involved family member or trusted friend of the participant. The advocate works with the participant to make sure the advocate is fulfilling the participant's wishes and needs as desired. The advocate is authorized by the participant to make decisions on behalf of the participant, but cannot assume legal responsibilities. A person interested in becoming an advocate is screened by the participant, with assistance from their SC when desired, to ensure the advocate demonstrates a strong commitment to the participant's wellbeing and is interested in and able to carry out responsibilities as agreed upon with the participant.

The SC provides monitoring to ensure the advocate functions as agreed upon with the participant and in the best interest of the participant as part of monitoring the service plan. When the advocate serves their own interests rather than those of the participant, the SC may advise the participant and their service plan team to consider a change of advocate or, when no other advocate can be identified, advise a transfer to agency provider services. In egregious cases, DDD may report the concerns identified through SC monitoring as suspected abuse, neglect, or exploitation of a vulnerable adult.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Respite	☒	☒
Transportation	☒	☒
Transitional Services	☒	☒
Home Modifications	☒	☒
Community Integration	☒	☒
Supported Employment - Follow Along	☒	☒
Supported Employment - Individual	☒	☒
Child Day Habilitation	☒	☒

Waiver Service	Employer Authority	Budget Authority
Homemaker	☒	☒
Independent Living	☒	☒
Environmental Modification Assessment	☒	☒
Assistive Technology	☒	☒
Supported Family Living	☒	☒
Health Maintenance Monitoring	☒	☒
Consultative Assessment	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☒ **Governmental entities**

☐ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The state provides Government Fiscal/Employer Agent financial management services directly as an administrative activity.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The state has an approved cost allocation plan that includes administrative claiming for activities performed as the FMS. Medicaid and Long-Term Care, a Division within DHHS, the Medicaid Agency, is the Government Fiscal Employer Agent and claims Federal Financial Participation for the administrative activities performed as the FMS.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☐ **Other**

  Specify:

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

  Specify:

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

  Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Administrative Services (AS) State Accounting is responsible for systematically reviewing on a regular basis activities of state agencies and departments to determine adequate internal controls exist within all agencies, including DHHS, to assure proper accounting methods are employed, per Neb. Rev. Stat. §81-111(4). AS State Accounting approves a required internal control plan for financial reporting that is implemented, tested, and monitored by DHHS, which includes pre-audit functions. DHHS has an Internal Audit Division to perform internal audits along with assisting DHHS personnel in the event of a State or Federal audit.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case management in Nebraska is performed by DDD SCs and all DDD SCs are qualified to provide self-direction guidance. In addition to basic new SC training, SCs receive training on available self-directed services, such as the types/definitions of services, limits on services, authorization codes and rates, billing guidelines, budget projecting, and the referral process for enrollment of independent providers. SCs also receive the all reference materials developed by DDD as training tools.

SCs provide information to those who self-direct DD waiver services listed in E-1-g. The SC provides reference materials developed by DDD with the participant to assist the participant in understanding their responsibilities in self-direction, including hiring, training, and dismissing a provider, as well as assisting the participant to recognize potential abuse and neglect situations.

The SC informs the participant of the amount of funding available and develops the monthly budget with the participant. When determining the rate for an independent provider, the participant is informed of their annual funding allocation and the maximum rates to be considered for each service, based on the potential independent provider's experience and training, the participant's needs, and the tasks the potential provider will perform.

When the participant has not chosen their provider(s), DDD personnel may provide a list of currently enrolled independent providers for the participant to consider, and help the participant interview a potential provider when the participant requests assistance. The SC is informed by DDD Central Office when the provider is enrolled and authorized to provide services to the participant.

When requested, the SC will assist the participant in communicating their expectations to the independent provider, including when and how the services will be delivered, and addressing any performance issues, which may arise.

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite	☐
LRI Personal	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Care	
Transportation	☐
Transitional Services	☐
Vehicle Modifications	☐
Home Modifications	☐
Community Integration	☐
Supported Employment - Follow Along	☐
Medical In-Home Habilitation	☐
Benefits Counseling	☐
Supported Employment - Individual	☐
Child Day Habilitation	☐
Behavioral In-Home Habilitation	☐
Shared Living	☐
Small Group Vocational Support	☐
Host Home	☐
Remote Supports	☐
Youth Continuous Home	☐
Day Supports	☐
Adult Day	☐
Homemaker	☐
Independent Living	☐
Continuous Home	☐
Personal Emergency Response System (PERS)	☐
Environmental Modification Assessment	☐
Assistive Technology	☐
Adult Day Retirement	☐
Supported Family Living	☐
Employment Exploration	☐
Health Maintenance Monitoring	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Consultative Assessment	☐
Prevocational	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

DD waiver services are voluntary services for the participant and the provider(s). Each participant's funding amount is based on an objective assessment process, and the funding follows the participant. Each participant can choose services and the providers to meet their needs and preferences. The authorization of funding for services to a particular provider or providers is mutually agreed upon, and either entity can end participation. All DD service providers are DD waiver service providers.

Nebraska offers provider-managed services under this waiver and the NE 0394 HCBS DD Day Services Waiver for Adults. The participant may choose provider-managed services that may better meet the participant's health and safety needs. The provider-managed waiver services are delivered by certified DD agency providers and the team process is utilized to assist the participant to choose DD waiver services and providers to best meet the participant's needs. Participants can change waiver services without a gap in the provision of services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

DD state regulation allows DDD to deny or end funding of specific services when:

1. A participant's needs are not being met through waiver services or intensity of services and supports does not reflect the need for ICF/IID level of care;
2. The participant has failed to cooperate with, or refused the services funded by DDD; or,
3. The participant's service plan has not been implemented.

The decision to end funding may be based on the SC monitoring, review of the service plan, critical incident reports, and assessment of risk to the participant and community, or complaint investigations conducted by DHHS personnel.

Nebraska offers provider-managed services under this waiver and the NE 0394 HCBS DD Day Services Waiver for Adults. The participant may choose provider-managed services that may better meet the participant's health and safety needs. The provider-managed waiver services are delivered by certified DD agency providers and the team process is utilized to assist the participant to choose DD waiver services and providers to best meet the participant's needs. Participants can change waiver services without a gap in the provision of services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		1205
Year 2		1205
Year 3		1205
Year 4		1205
Year 5		1205

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The state’s method to conduct background checks does not vary from what is described in Appendix C-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☐ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The methodology for establishing the amount of the self-directed budget is the same as for provider-managed services, as fully described in Appendix C-4-a of this waiver. DDD has developed and implemented a methodology that determines a specific Individual Budget Amount (IBA) uniquely assigned to each waiver participant. The assigned IBA constitutes a limit on the overall amount of services, which may be authorized in the service plan. The limit on the maximum dollar amount of waiver services for each specific participant is individually objectively assessed and is a realistic estimate of the expected amount of services waiver participants are likely to require. The IBA is the total annual funding amount available to the participant per their waiver year and is determined by DDD personnel. The amount assigned is determined in advance of the development of the participant's service plan. The process for the determining the IBA is described in the DDD ICF Handbook and posted on the DDD public website page.

The determination of prospective IBAs for participants is determined using an Objective Assessment Process (OAP) as required in statute and regulations. Funding is assigned based on an objective assessment of each participant's abilities, to provide for equitable distribution of funding based on each participant's assessed needs. Geographic factors do not affect the budget amount and the participant location is not factored into the OAP.

The original OAP methodology was developed in 1996 and public meetings were held at that time to explain the process. The process was updated in 2008 and a document describing the methodology and its improvements was prepared and made available to the public at that time. Since then, the public has been informed of the process through public meetings and documents posted on the DHHS public website associated with rate setting improvements in 2011, 2015, 2016, 2017, 2018, and 2019.

DDD personnel complete the state mandated ICF/IID level of care assessment tool with input from the participant's teachers, para-educators, family members, and providers, as appropriate, as well as a review of substantiating documentation to support tabulated responses. Substantiating documentation includes, but is not limited to, medical reports, psychological evaluations, critical incident data, and programmatic data. The completed ICF/IID level of care assessment tool is submitted to the DDD Central Office where it is electronically entered to determine the overall score. The OAP is completed for persons new to services and re-evaluated annually.

The prospective IBA is adjusted during the period the waiver is in effect. The limit will be adjusted to take into account cost increases, and the methodology will be periodically re-evaluated in light of changes in utilization patterns or other factors.

The ICF/IID level of care assessment tool is re-evaluated annually to assess changes in a participant's needs and abilities. The IBA is adjusted based on the result of the ICF/IID level of care assessment tool score. Completion of the ICF/IID level of care assessment tool may be requested when a participant's needs have changed, which cannot be safely met with funding solely from the current IBA. Based on input from the participant, provider, and other team members, the service plan team may submit a clinical rationale and supporting documentation to DDD Central Office to request a new ICF/IID level of care assessment tool.

Alternative compliance to the funding tier may be requested when a waiver participant's needs cannot be safely met with funding solely based on the ICF/IID level of care assessment tool score. Based on input from the participant, provider, and other team members, the service plan team may submit a rationale for consideration of alternative compliance to the participant's ICF/IID level of care assessment tool score and identified funding tier. A clinical review will be completed based on the alternative compliance request.

Additional requests for services for participants are evaluated by DDD to determine if requests are related to a critical health or safety need, and if so, the request would be approved based on available waiver funding. When no additional waiver funding is available, (i.e. the expenditures have exceeded cost neutrality for the waiver), the following safeguards would be applied:
1. The participant is assisted in locating and obtaining other non-waiver services to assist in meeting their needs; or
2. The participant will be evaluated to determine if their needs and eligibility more closely align with other Nebraska HCBS waiver programs and will be assisted in the application process as deemed necessary.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant is notified in writing by DDD personnel of their IBA as well as the dollar limits of waiver services at the time of initiation of DD waiver services and prior to the development of the service plan. The participant is also notified of their service authorizations, prior to services being delivered. The written notice is mailed and includes fair hearing rights information. Questions about the right to a fair hearing are directed to the SC or the SCS. Additionally, DDD Central Office personnel are available to respond to participant questions regarding fair hearing rights and any other aspect of waiver implementation.

The participant may propose budget changes at any time, by contacting the SC. By utilizing the budget functions of the state-mandated web-based case management system, the overall impact of the proposed change is calculated and the participant is able to compare the proposed change to the current budget. The SC is responsible for documenting the change in circumstances that has impact on the participant's annual budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Safeguards have been established to prevent the premature depletion of the participant's budget or address potential service delivery problems associated with budget over-utilization. DDD is responsible for ensuring the implementation of safeguards developed for the participants who are self-directing. The state-mandated web-based case management system tracks budget utilization and provides monthly reports for service coordination, management, and administrative personnel.

DDD and the vendor of the state-mandated web-based case management system have developed rules within the system to highlight possible over-utilization. When potential over-utilization is identified, the participant and SC discuss and manage adjustments to the monthly authorized amounts and the annual individual budget amount when necessary.

Likewise, providers contact participants and SC when services are under-utilized. The SC may follow-up with monitoring, a meeting with appropriate parties, referrals to another qualified DD waiver service provider, participant education, provider re-education, or risk screenings to assess the participant's health and safety

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

In this waiver, “participant” means the individual receiving waiver services and any person legally authorized to act on behalf of the participant.

Participants are advised of their appeal rights at the time of initial eligibility by the Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) personnel and annually thereafter by their SC at the time of the Individual and Family Meeting (IFM) or annual PCP meeting. At the annual IFM or annual PCP meeting, the participant is given a Notice of Rights and Obligations to read and sign. Hearing rights are also printed on the Notice of Decision.

Participants receive and have the opportunity to dispute a Notice of Decision in any of the following circumstances:
1. The applicant is determined ineligible for NE Medicaid HCBS DD waiver services;
2. The applicant is not given the choice of Medicaid HCBS DD waiver services as an alternative to institutional care;
3. The participant’s choice of providers is denied; or
4. Services to the participant are denied, suspended, reduced, or terminated.

Participants may also appeal any action, inaction, or failure to act with reasonable promptness because:
1. Their application is denied;
2. Their application is not acted upon with reasonable promptness;
3. Their assistance or services are suspended;
4. Their assistance or services are reduced;
5. Their assistance or services are terminated;
6. Their form of payment or services is changed to be more restrictive; or
7. They think the Department's action was erroneous.

When issued, the Notice of Decision includes information about the Request for a Fair Hearing, and advises participants of their right to a hearing, the method by which to obtain a hearing, and that they may represent themselves or use an attorney, friend, or other spokesperson. This information is also posted on the DHHS public website at: www.dhhs.ne.gov/developmental_disabilities.

Designated DDD personnel complete and retain the Notice of Decision in N-FOCUS, Nebraska’s electronic local web-based system for claims processing. The Notice of Decision is mailed to the participant at least ten days prior to the action being taken, in accordance with 42 CFR 431.211.

The Notice of Decision includes an advisement that services will continue (or be reinstated) until the outcome of the fair hearing when the participant requests a hearing within ten days of the mailing of the Notice of Decision.

Request for Fair Hearing must be submitted in written hardcopy or electronic form, and submission may be done via mail, email, fax, phone, or in person at any local DHHS office. All Notices of Decision and Requests for Fair Hearing are maintained in electronic form, in accordance with the Records Retention Schedule applicable to DHHS . Fair hearing rights are provided in English and Spanish according to the language on file, which is spoken at home, and may be translated into other languages upon request.

In order to exercise the right to a hearing, the participant must file a petition with DDD. The petition may be made on a form provided by DDD for such purpose, or in another written format, which contains at least the following information:
1. The name and contact information of the petitioner (the participant’s or guardian’s name, address, and phone number, and signature);
2. The specific decision contested;
3. The date of the decision contested; and
4. Any other information the participant wants to be included at the hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

◉ **No. This Appendix does not apply**

○ **Yes. The state operates an additional dispute resolution process**

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:

Participants receiving supports through the waiver may register a grievance or complaint with DHHS. Participants are informed that filing a grievance or making a complaint is not a prerequisite or substitute for a Fair Hearing.

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 types of grievances/complaints that participants may register: Participants are advised in the annual Notice of Rights and Obligations (received at the annual Individual and Family meeting or annual service plan meeting) that filing a grievance or complaint is not a prerequisite for filing for a Fair Hearing.

Participants receiving supports through the waiver may register the following types of grievances/complaints:
1. Safety, endangerment, or welfare issues;
2. Suspicion of Medicaid fraud;
3. Violations by DDD Medicaid providers of Medicaid regulations, DDD regulations, or DDD policies;
4. Issues related to a participant's SC;
5. Difficulty with DDD Medicaid services or providers; or
6. Issues with services being provided in settings that respect participant choices, promote community integration, and uphold their right to privacy and dignity, as outlined in the HCBS Final Settings Rule.

(b) The process and timelines for addressing grievances/complaints: The grievance/complaint may be submitted via mail, email, fax, phone, or in person at any local DHHS office. DDD also has a central phone number participants can call to file a complaint or to ask questions. Participants can also write a letter and mail or fax it in to DDD. Complaints, questions, or concerns are responded to by designated DDD program personnel. Once the grievance/complaint has been resolved, designated DHHS personnel provide a written notification, when applicable, of the outcome to the complainant. Resolution of the grievance/complaint may involve working with DHHS Division partners, multiple providers, and the participant's service plan team; thus, there is no specified timeframe for the state making resolution and notifying the complainant. Designated DDD personnel are expected to take immediate steps to make resolution and notification. All grievances/complaints and outcomes are maintained in electronic form, in accordance with the Records Retention Schedule applicable to DHHS.

(c) The mechanisms used to resolve grievances/complaints: The mechanisms for resolving the complaint and preparing the response include, but are not limited to, follow-up by phone, letter, in-person or remote visits with the provider or participant, and referral to another DHHS program (e.g., Child Welfare Services, Adult Protective Services, and Medicaid Fraud Control Unit).

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).

In this waiver, “participant” means the individual receiving Medicaid HCBS DD waiver services and any person legally authorized to act on behalf of the participant and “provider” means both agency and independent providers, unless otherwise specified. The Critical Incident Management Process is used to document, track, and analyze critical events/incidents. Reports of incidents may be received from any source.

DHHS DDD defines critical events/incidents requiring an incident report to DDD as situations which may adversely affect the physical or emotional well-being of the participant; alleged or suspected cases of abuse, neglect, exploitation, or mistreatment; and emergency safety situations requiring the use of emergency safety interventions.

All instances of abuse, neglect, or exploitation must be reported to appropriate authorities to conduct a follow-up action. Appropriate authorities include DHHS-Division of Child and Family Services (Adult Protective Services, Child Protective Services), DHHS-Division of Public Health (for certified providers), and Law Enforcement.

DHHS maintains a toll-free hotline available at all times for reporting suspected or alleged abuse, neglect, and exploitation of vulnerable adults. This number is posted on the DHHS public website. DHHS also accepts reports of abuse, neglect, and exploitation by mail, email, fax, or in-person at any DHHS office.

For vulnerable persons age 18 and older, abuse, neglect, and exploitation are defined in the Adult Protective Services Act, Neb. Rev. Stat. §§28-348 - 28-387. Neb. Rev. Stat. §28-372 specifies persons required to make a report to DHHS or the appropriate law enforcement agency when abuse, neglect, or exploitation of a vulnerable adult is suspected or alleged. Regulations on Adult Protective Services can be found in Title 463 Nebraska Administrative Code (NAC).

For children age 18 and younger, abuse and neglect are defined in the Child Protection and Family Safety Act, Neb. Rev. Stat. §28-710. Neb. Rev. Stat. §28-711 requires any person to make a report to DHHS or the appropriate law enforcement agency when abuse or neglect of a child is suspected or alleged.
• Maltreatment of children constituting abuse or neglect is further defined in Title 390 of Nebraska Administrative Code (NAC).
• Medical neglect of a handicapped infant constituting abuse or neglect is further defined in 390 NAC.

For all participants in Medicaid HCBS DD waiver services, DHHS state regulation defines and prohibits provider use of physical restraint except as specified, chemical restraint, mechanical restraint, aversive stimuli, corporal punishment, seclusion, physical, emotional, and verbal abuse, denial of basic needs, discipline, implementation of an intervention on a participant by another participant, or other means of intervention that result in or are likely to result in physical injury to the participant.

Providers must report the following types of critical incidents to DDD:
- Allegation or suspicion of verbal, physical, sexual, psychological, emotional abuse, neglect, or exploitation of a child or vulnerable adult.
- Allegation or suspicion of financial exploitation.
- Misuse or unauthorized use of restrictive interventions or seclusion.
- A medication error resulting in a telephone call to, or a consultation with, a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death.
- Unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect.

Providers must also report the following incidents to the state that occurs during the delivery of services or as a result of the failure to deliver services:
- Actual or Potential Airway Obstruction
- Communicable Disease
- Emergency Situations
- Fall with Significant Injury
- Fatal 5
- Incidents Involving Emergency Personnel Requiring Emergent Response
- Infestations
- Injuries of Unknown Origin Raising Suspicion
- Injury Requiring Medical or Nursing Interventions beyond First Aid
- Misconduct not Involving Law Enforcement
- Missing Person(s)

- PRN Psychotropic Medication Usage
- Property Damage
- Suicide Attempts
- Swallowing Inedible Items
- Unplanned Hospital/Emergency Room/Urgent Care Visit
- Use of Emergency Safety Interventions
- Vehicle Accident

A verbal report must be made by the provider to DDD upon becoming aware of these incidents. Written incident reports must be submitted using the state-mandated web-based case management system within 24 hours of the verbal report to DDD. A verbal report must also be made to the participant or guardian within 24 hours of becoming aware of the incident.

Quality Improvement Organization (QIO)-like entity staff reviews all incidents in which abuse, neglect or exploitation is either suspected or substantiated. QIO-like entity staff will work with Service Coordination and/or provider staff as needed to remediate any issues to ensure appropriate resolution activities are occurring to mitigate the incident and ensure the health and safety of the participant.

The web-based case management system is also used to record all participant deaths. After receiving notification of a death, the QIO-like entity Mortality Review Nurse will triage the death to determine if the mortality review needs to be expedited due to the death being due to alleged or suspected abuse/neglect, exploitation, or criminal acts, was sudden and unexpected, or could be due to a lack of standard medical or clinical care. Expedited mortality reviews are to be completed within 45 calendar days following the triage.

If, during the mortality review triage process or review of death related information, the QIO-like entity Mortality Review Nurse discovers potential signs of abuse, neglect, or exploitation, designated DDD personnel will be informed to make them aware of any immediate concerns that might need to be addressed. All expedited mortality reviews and any non-expedited mortality reviews that require medical discretion will have a second-level review completed by the QIO-like entity Mortality Review Physician. All unexpected and unexplained deaths will be referred for review by the Mortality Review Committee. The Mortality Review Committee will forward any systemic quality improvement recommendations and/or follow-up actions to designated DDD personnel.

Agency providers must submit an aggregate report of incidents the provider has reported to DDD on a quarterly basis. The report must be received by DDD no later than 30 calendar days after the last day of each quarter. The report must include a compilation, analysis, and interpretation of data, and evidentiary examples to evaluate action taken to address critical incidents to reduce the number of incidents over time.

DDD annual reporting on the initiation of critical incident investigation, critical incident investigation and resolution, and completed corrective action plans related to critical incidents must meet a 90% minimum performance level for occurring within state-specified timeframes per the HCBS Final Settings Rule.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information concerning protections from and reporting of abuse, neglect, and exploitation is provided to each participant when entering DD waiver services and annually thereafter by their SC.This information is also available on the DHHS public website. Training is available to the public, including participants, family members, and providers on the DHHS public website.

The participant’s assigned SC must provide information on participant rights to the participant when entering DD waiver services and annually thereafter.

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.

Upon receipt of an incident report, a Service Coordination Supervisor (SCS) reviews the report to determine the appropriate response, which depends on the nature and severity of the incident and the history of the participant. All critical incidents that include a significant health and safety concern or law enforcement contact require some type of follow-up action from the SC. The type of follow-up and timeline for completion are decided in consultation between the SC and SCS.

Agency providers must complete an investigation of each reported incident. A written summary of the agency provider's investigation and action taken must be submitted via the state-mandated web-based case management system to DDD within 14 calendar days of the initial report of the incident. Timeframes for conducting and completing the investigation and informing the participant of the results of an internal investigation completed by the agency provider must be specified in the provider agency policies and procedures, and cannot exceed 14 calendar days. Any incidents reported by an agency provider involving suspected or alleged abuse, neglect, or exploitation, use of emergency safety intervention, or any other situation where violation of the participant's rights may have occurred must also be reviewed by the agency provider's rights review committee.

The DHHS Division of Children and Family Services (DHHS-CFS) Protection and Safety Unit maintains the toll-free hotline available at all times for reporting of alleged or suspected abuse, neglect, and exploitation of vulnerable adults. All reports of suspected or alleged abuse, neglect, or exploitation are screened immediately and shared with law enforcement within 24 hours of receipt.

Reports of alleged or suspected abuse, neglect, or exploitation of children or vulnerable adults are reviewed by DHHS-CFS personnel with specialized training in intake and screening. Screening criteria includes definitions of abuse, neglect, and exploitation of a vulnerable adult outlined in the Adult Protective Services Act, Neb. Rev. Stat. §§28-348-28-387 and definitions of child abuse and neglect outlined in the Child Protection and Family Safety Act, Neb. Rev. Stat. §28-710. Reports of suspected or alleged abuse, neglect, or exploitation that do not meet statutory definitions will not be accepted for investigation by DHHS-CFS.

When DHHS-CFS personnel have screened a report of suspected or alleged abuse, neglect, or exploitation, the determination to accept or not accept a report for investigation and the prioritization of accepted reports is reviewed by a DHHS-CFS supervisor to ensure screening criteria are applied accurately.

Accepted reports are prioritized and assigned for investigation. Reporting parties are notified by the DHHS-CFS personnel taking the report whether the report will be accepted and assigned to DHHS-CFS for investigation or if the report will not be accepted for investigation.

Provider reports of alleged or suspected abuse, neglect, or exploitation to the DHHS-CFS Protection and Safety Unit not accepted for investigation are electronically submitted within 24 hours of receipt to DHHS. DHHS reviews each report upon receipt to determine what action should be taken. Actions taken may include completion of a complaint investigation by DHHS, depending on the nature and circumstances of the incident. These reports are also reviewed by the assigned SC and SCS to assess the participant's safety and the need for any revision to the participant's service plan to address the reported incident.

Investigations for Abuse/Neglect/Exploitation of a Vulnerable Adult
Investigations of alleged or suspected abuse, neglect, or exploitation of vulnerable adults are performed by DHHS-CFS staff specializing in adult protective services. Accepted reports are categorized in three priorities. Investigations for all priority levels must be completed within 60 days of the report being accepted for investigation, unless there is alleged or suspected financial exploitation, which requires the investigation be completed within 90 days.
• Priority One – includes reports indicating a vulnerable adult is in immediate danger of death or life-threatening or critical harm. Face-to-face contact must be made with the victim within eight hours from the time the report was accepted for investigation. When DHHS-CFS personnel are unable to respond within the specified timeframe, they must notify law enforcement of the emergent nature of the reported abuse, neglect, or exploitation and request immediate response, and CFS personnel must make face-to-face contact with the alleged victim within 24 hours of law enforcement contact. CFS personnel may work simultaneously with law enforcement when requested.
• Priority Two – includes reports indicating a vulnerable adult is in danger of serious, but not life-threatening or critical harm. Face-to-face contact by a DHHS-CFS personnel must be made with the victim within five calendar days of the date of the report was accepted for investigation.
• Priority Three – includes reports indicating a vulnerable adult is in danger of harm that is serious, but not less serious

than Priority One or Two reports. Face-to-face contact by APS personnel or law enforcement must be made with the victim within ten calendar days of the date of the report was accepted for investigation.

Investigations for Abuse/Neglect of a Child
Investigations of allegations of abuse or neglect of children are performed by DHHS-CFS staff specializing in child protective services. Since both law enforcement agencies and DHHS-CFS have statutory obligations pertaining to child abuse/neglect cases, one agency may take the primary responsibility for some investigations and some investigations may initially be a joint effort.

Accepted reports are categorized in three priorities. Investigations for all priority levels must be completed within 30 days. When necessary, a plan will be developed and implemented to provide safety for the child during the investigation. Exceptions to the timelines for initial contact with the alleged victim may be made based on the involvement or request of law enforcement, inability to locate the alleged victim, inability to identify the alleged victim, or parental refusal to allow children to be interviewed. When law enforcement makes first contact with an alleged victim, this contact may be used as the initial contact with the alleged victim(s) when it occurs after the report is accepted for investigation and it is clear in law enforcement reports the alleged victim was seen and immediate safety concerns were addressed.
• Priority One– These are reports that may be life threatening and require immediate response. Contact must be made with the alleged victim(s) within 24 hours from the time the report was accepted for investigation. When DHHS-CFS personnel are unable to respond, they must notify law enforcement of the emergency nature of the report and request law enforcement respond immediately.
• Priority Two – Contact must be made with the alleged victim(s) within five calendar days from the date and time the report was accepted for investigation.
• Priority Three – Contact must be made with the alleged victim(s) within ten calendar days from the date and time the report was accepted for investigation.

Provider reports of alleged or suspected abuse, neglect, or exploitation to the CFS Protection and Safety Unit not accepted for investigation are electronically submitted within 24 hours of receipt to DHHS. DHHS reviews each report upon receipt to determine what action should be taken. Actions taken may include the completion of a complaint investigation by DHHS, depending on the nature and circumstances of the incident. These reports are also reviewed by the assigned SC and SCS to assess the participant's safety and the need for any revision to the participant's service plan to address the reported incident.

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.

DDD is responsible for overseeing the reporting of and response to critical incidents. All critical incidents are entered into the state-mandated web-based case management system and are subject to DHHS review and analysis at any time. DDD reserves the right to request additional review of any critical incident. There may be immediate follow-up of individual events.

CFS personnel are also responsible for the oversight of critical incident management. At least annually, CFS provides to DDD information about reports of abuse, neglect, or exploitation involving DD waiver service participants made to CFS. Data is obtained and analyzed on waiver participants involved in reports of alleged or suspected abuse, neglect, or exploitation. The data includes demographic information, types of abuse/neglect reported, and the findings of investigations.

CFS and DDD collaborate to identify strategies to reduce the number of critical incidents and to coordinate on both a system-wide and participant-specific basis. Examples of these strategies include training of CFS personnel about the Medicaid HCBS DD waivers, and training of DDD personnel about abuse, neglect, and exploitation and the functions of CFS.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Restraint is defined as any physical hold, device, or chemical substance that restricts, or is meant to restrict, the movement or normal function of a portion of the participant's body, or to control the behavior of a participant. Devices used to provide support for the achievement of functional body position or proper balance, and devices used for specific medical and surgical (as distinguished from behavioral) treatment are not to be considered as restraint.

Physical restraint is defined as any physical hold that restricts, or is meant to restrict, the movement or normal functioning of a participant. Physical restraint is prohibited except when used as an emergency safety intervention.

Emergency safety intervention is defined as the use of physical restraint or separation as an immediate response to an emergency safety situation. Emergency safety intervention can be used in a situation in which the participant or others are in immediate jeopardy or significant danger of physical harm. These situations are typically unpredictable, unusual, and not reoccurring. Emergency safety intervention should be used as a last resort when other interventions have not been successful. Separation used in emergency safety intervention may include physical restraint to separate a participant from an item, an area, or a person, or separation of the participant to a specific room or area, as long as the separation is not seclusion as defined in DDD state regulation.

Mechanical restraint is defined as any device, material, object, or equipment that is attached or adjacent to the participant's body that restricts freedom of movement or normal access to the body. Mechanical restraint does not include use of acceptable child safety products, use of car safety systems, or safeguarding equipment ordered by a physician or healthcare provider and approved by the support plan team. Use of mechanical restraint is prohibited by DDD state regulation.

Chemical restraint is defined as a drug or medication used for discipline or convenience and not required to treat medical symptoms. Use of chemical restraint is prohibited by DDD state regulation. Routine use of psychotropic medication as prescribed by a physician is not chemical restraint. Use of PRN psychotropic medications prescribed by a physician is not a chemical restraint when used as prescribed, and not used as discipline or for the convenience of the provider.

All providers of DD waiver services are required to document any allowed use of emergency safety intervention, any prohibited use of physical, mechanical, or chemical restraint, and any injury to a participant caused by use of restraint in an incident report submitted to DDD in the state-mandated web-based case management system. All use of emergency safety intervention must be reviewed by the participant's PCP team.

Following submission of an incident report to DDD, agency providers must complete an investigation and submit a summary of the investigation and any follow-up action taken to DDD through the state-mandated web-based case management system. The investigation must review whether restraint was used in compliance with state regulations pertaining to use of restraint and the policies and safeguards outlined in this waiver. All use of emergency safety intervention must also be reviewed by the agency provider's rights review committee to ensure emergency safety intervention was used appropriately and was not a prohibited use of physical or mechanical restraint.

Agency providers must develop policies and procedures for use of restraints, which are consistent with DDD state regulation. DDD state regulation states that any intervention that is likely to result in injury to a participant is prohibited. Provider policies and procedures must also include a QI system, monitor for use of restraint in compliance with provider policies and procedures and DDD state regulation.

Agency providers are responsible for providing training and assessing competency of employees providing direct support to participants in approved emergency safety intervention techniques as identified in the agency provider's policies and procedures and in positive support techniques to avoid use of restraint. Training and verification of competency must be conducted by persons who are qualified by education, training, or expertise in the topic being trained. The agency provider must maintain documentation in each employee's personnel record, which reflects training and demonstration of competency were successfully completed.

Independent providers work at the direction of the participant, and must complete any training in the areas of positive behavior support and use of restraint and emergency safety intervention required by the participant. The independent provider must follow any expectations of the participant responsible for self-direction as to what type of emergency safety intervention the provider is permitted to use, if any.

Independent providers must follow all applicable regulations in use of restraints, but are not required to have written policies and procedures or a QI system.

Monitoring for unauthorized or inappropriate use of emergency safety intervention, or physical, chemical, or mechanical restraint, and monitoring to ensure compliance with all applicable laws and regulations includes the following:
• On-site certification review;
• Review of critical incident reports;
• DDD service coordination monitoring;
• Complaint investigations; and
• Quality Improvement review

Any allowed use of restraint is a rights restriction. All requirements and safeguards outlined in section G-2-b pertaining to use of rights restrictions applies to allowed use of restraint.

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

DHHS is responsible for overseeing the use of restraints and ensuring all safeguards and applicable statutes and regulations are followed.

On-Site Certification Review
Initial and ongoing certification of agency providers is the responsibility of DHHS, and includes on-site scheduled and unscheduled certification review.

During initial provider enrollment, the provider's policies, procedures, and actual practices are reviewed to ensure compliance with all applicable state regulations.
The provider's capacity to support participants with behavioral challenges is assessed and DHHS personnel monitor for any unauthorized use of restraint. The provider must also have an internal quality review system and a rights review committee, with written policies and procedures for these processes in compliance with applicable regulation. When DHHS personnel finds policies and procedures that do not comply with regulatory requirements, due to prohibited intervention techniques, an insufficient quality review system, an inadequate review committee, etc., the provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DHHS prior to providing DD waiver services to participants.

Detection of unauthorized or inappropriate use of restraints may also occur through ongoing on-site certification review. During certification review, a random sample of participants served by the provider is chosen based on the total number of participants in the provider's services, and delivery of service and agency systems are reviewed.

The frequency of on-site certification reviews is based on each provider's current certification standing. Annual or biennial on-site certification reviews are scheduled in advance, but a focused review to address issues found through other oversight activities can occur at any time and may be unannounced. Walk-through activities are unannounced.

Review of Critical Incidents
All providers of DD waiver services are required to report any allowed use of emergency safety intervention, any prohibited use of physical, mechanical, or chemical restraint, and any injury to a participant caused by use of restraint to DDD through the state-mandated web-based case management system. Following submission of an incident report, agency providers must complete an investigation and submit a report on the investigation and any follow-up action taken to DDD through the state-mandated web-based case management system. The provider's internal investigation may reveal unauthorized use, overuse, inappropriate use, or ineffective use of restraint.

All incident reports are reviewed by a DDD SCS within one business day to determine what follow-up is needed. Follow-up may include review of the incident by the participant's service plan team, consultation with the provider to discuss concerns or gather additional information, or referral to DDD administration for additional review. Incidents and concerns forwarded to DDD administration from service coordination are reviewed to determine what follow-up may be appropriate. Follow-up may include DDD complaint investigation, consultation with the provider, referral to DHHS for complaint investigation or certification review, or referral to CFS when abuse, neglect, or exploitation is suspected.

When it is determined a restraint has been used in a manner that is prohibited or inappropriate, actions taken by DHHS could include disciplinary action outlined in DHHS state regulation. Refer to G-1 for additional information on management of critical incidents.

Service Coordination Monitoring
DDD SCs complete service monitoring for all participants at least quarterly, which may detect unauthorized use of restraints. Service monitoring is intended to review the implementation of each participant's service plan through direct observation of participants during service provision and review of records kept by providers. Observations are documented on a checklist and entered into an electronic database. In addition, the SC makes monthly contacts with participants or identified PCP team members, which may include unannounced visits to the participant's residential or day service locations. When any concerns related to prohibited or inappropriate use of restraint are identified during service monitoring or other contacts, the SC

will consult with provider staff and review participant files to determine what action should be taken to resolve the issue.

Complaint Investigations
DHHS completes investigations of complaints submitted, which could include complaints related to prohibited or inappropriate use of restraint. Complaint investigations and any on-site review required may be unannounced and take place whenever investigation is necessary and appropriate.

Quality Improvement Review
DDD completes quality improvement review of service provision through off-site records review and on-site observation. These reviews may detect prohibited or inappropriate use of restraint.

Off-site records review includes review of service plans, provider program documentation, incident reports, and other records on a monthly basis for a randomly selected sample. When potential concerns are identified through off-site records review, concerns may be communicated to DDD administration, the assigned SC, or DHHS for further action or investigation, or reported to CFS when abuse, neglect, or exploitation is suspected.

On-site reviews are intended to review the implementation of a participant's service plan through direct observation of participants during service provision and review of records kept by providers. When any concerns related to prohibited or inappropriate use of restraint are identified during service monitoring or other contacts, the reviewing DD personnel will consult with provider staff and review participant documentation to determine what action should be taken to resolve the issue.

Quality improvement review also includes mortality review for all deaths of DD waiver service participants. These reviews would detect whether death occurred due to prohibited or inappropriate use of restraint. When concerns related to prohibited or inappropriate use of restraint are discovered during mortality review, this information is referred to DDD administration for follow-up or referral to other divisions of DHHS when appropriate.

Data analysis
The frequency of the oversight activities varies by activity, and is specified for each activity outlined in this section. Data from all oversight activities is gathered and analyzed to identify state-wide trends and patterns, and to develop and support QI strategies.

A summary of certification activities completed by DHHS is submitted to DDD. Comparison to previous certification reviews of each provider can be made to identify any trends or patterns specific to each provider.

On a quarterly basis, the DDD QI Committee reviews aggregated reports compiled from various monitoring activities including off-site records review, on-site observations, and mortality review. These reports include concerns identified during these monitoring activties.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Participants in DD waiver services are entitled to the same human and legal rights guaranteed to all citizens as outlined in federal and state laws and constitutions. These rights include, but are not limited to, right to be treated with dignity and respect, right to privacy, right to autonomy, freedom of choice, freedom of access to other people, places, and activities, and freedom of movement.

Any intervention, support, or practice that limits a participant's rights is a rights restriction. Any allowed use of restraint is considered a rights restriction. Rights restrictions may be implemented by DD waiver service providers at the direction of the participant's service plan team, under the following conditions:
• Restrictions must only be used to address genuine and immediate risk to the health or safety of the participant or others, or risk the participant may commit a violation of any federal, state, or local laws or ordinances.
• Rights must not be treated as privileges.
• Rights must not be limited without due process. For restrictions implemented by DD waiver service providers at the direction of the service plan team, due process includes team approval, informed consent of the participant, and agency provider rights review committee approval, when the restriction will be implemented by an agency provider.

To the fullest extent possible, a participant's rights must not be limited or restricted. When a restrictive intervention is considered:
• Restrictive interventions used for one participant must not affect other participants receiving services in the same setting when possible.
• Restrictive interventions must not be used as punishment, for the convenience of staff, due to shortage of staff, as a substitute for habilitation or as an element of a positive behavior support plan (BSP).
• Restrictive interventions must be the least restrictive and intrusive intervention needed to mitigate the identified risk.
• There must be a goal of reducing or eliminating the restriction.
• There must be habilitation or supports to reduce the need for the restriction.
• Prior to proposing a restrictive measure, there must be documented evidence that other, less restrictive methods have been regularly applied and were not successful in addressing the identified risk.
• The restrictive intervention must be safe for the participant.
• All restrictions implemented by a DD waiver service provider at the direction of the service plan team must be documented in the service plan.

Use of psychotropic medication may be a rights restriction. When psychotropic medication is prescribed by a physician acting within their scope of practice to treat a clinically recognized diagnosis of a mental disorder or medical condition when other interventions have been determined to be unsuccessful by the prescribing physician, use of psychotropic medication is not a rights restriction. Other use of psychotropic medication, including use to modify a participant's behavior when there is no diagnosed medical condition or mental disorder, is a rights restriction. This criterion also applies to use of PRN psychotropic medication. Use of PRN psychotropic medication is permitted, but must not be used for the purpose of discipline or convenience of the provider. Additional safeguards for use and administration of PRN psychotropic medication (for both restrictive and non-restrictive use) can be found in section G-3-c-ii.

The service plan must document service plan team approval for the use of the restriction, with the following information:
• Description of the restriction, including how the restriction is to be implemented and under what circumstances;
• Rationale for use of the restriction, including the risk the restriction is intended to mitigate;
• Interventions previously attempted and determined to be ineffective;
• Summary of the risks posed by the restriction itself, including the limitation to the participant's rights, and risk the restriction is intended to mitigate, and a comparison of all risks to ensure the risk being mitigated outweighs the risk of the restriction itself;
• Positive habilitation to support reduction of the restriction;
• Plan and criteria for reduction or elimination of the restriction;
• Frequency the participant's service plan team will review the effectiveness of the plan, not less than every six months; and
• Date of last review by the agency provider's rights review committee (not required when a restriction will

only be used by independent providers).

For restrictions involving psychotropic medication, the service plan must also include:
• Name(s) of medication
• Dosage(s) of medication
• Date of last review by prescribing physician and timeframe of recommended follow-up
• Summary of service plan team review of the medication to ensure the medication used is the lowest therapeutic dose to meet the participant's needs and the medication does not interfere with the participant's ability to participate in habilitation and activities of daily living.

For all restrictions used to mitigate an identified risk for the participant, there must be a safety plan or protocol developed by the service plan team, which describes:
• The safety risk(s) being addressed by the restriction(s) and the safety plan/protocol;
• Circumstances under which the restriction(s) should be used;
• Instruction for how staff should implement the restriction(s);
• Any other non-restrictive supports or interventions, which should be used to address identified risks.

For all restrictions used to mitigate an identified risk for the participant, there must be habilitation or supports to reduce the need for the restriction and support the participant to gain skills or abilities needed to mitigate the identified risk. Habilitation or supports can be provided in various ways, depending upon needs of the participant related to the risk being addressed. The following should be considered in development of habilitation and supports:
• When a restriction is being used to address risk related to identified behaviors of concern, a positive behavior support plan (BSP) must be implemented to support the participant to gain skills to reduce the behaviors causing the identified risk requiring a restriction.
• When a restriction is being used to address a risk related to a lack of adaptive skills, a formal habilitation program must be implemented to support the participant to build the adaptive skills needed to mitigate the identified risk.
• When a restriction is being used to address a risk related to a participant's medical needs or physical disabilities, supports to reduce the need for the restriction may include the physician treating the participant, any medical/nursing care available from the provider agency, any medications prescribed, or any therapies provided to improve the participant's medical condition or physical abilities.

When a behavior support plan is required to address behavioral needs requiring use of restrictive interventions, the BSP must meet the following criteria:
• The BSP must be developed based on a functional behavioral assessment (FBA) which identifies the function of the behavior for the participant and recommends interventions and supports to address the behaviors of concern.
• The FBA used to develop the BSP must be completed by a licensed psychologist, advanced practice registered nurse (APRN), licensed independent mental health practitioner (LIMHP), or a board-certified behavioral analyst (BCBA). The BSP may be written by a non-professional, and when this occurs, the BSP must be reviewed by the participant's PCP team and the professional who completed the FBA to ensure the BSP is consistent with the recommendations in the FBA.
• The BSP describes the identified behaviors of concern and any identified antecedents and precursor behaviors to the behaviors of concern.
• The BSP includes instruction for staff in responding to precursor behaviors or behaviors of concern when they occur and teaching positive replacement behavior for the identified behavior of concern.
• The BSP must include data collection to measure frequency of behaviors of concern and progress in teaching positive replacement behavior.
• The BSP must not include use of restraint or restrictive interventions. These interventions are documented in the safety plan.

All providers of DD waiver services are required to document any allowed use of emergency safety intervention, which may include alternative strategies to avoid the use of restraints, in an incident report submitted to DDD in the state-mandated web-based case management system. All use of emergency safety intervention must be reviewed by the participant's PCP team.

Agency providers must have written policies and procedures for the use of interventions, supports, or practices limiting or restricting a participant's rights, and for the formation of a rights review committee. All policies and procedures must be consistent with DHHS state regulation. Provider policies and procedures must also include a QI system as specified in DHHS state regulation, which would monitor to ensure use of rights restrictions in compliance with provider policies and procedures and DHHS state regulation.

Agency providers must obtain written informed consent from the participant for authorization to use a restriction. Emergency verbal consent may be requested when there is an urgent need to implement a restriction prior to requesting written consent. The written informed consent or emergency verbal consent must be obtained prior to implementation of the restriction. Independent providers are not required to obtain written informed consent for use of restrictions, as they work at the direction of the participant who employs them, and a participant would not direct an independent provider to use an intervention they do not consent or agree to.

Agency providers must have a rights review committee, which is responsible for protecting participant rights by monitoring the provider's practices. The rights review committee must give approval for any rights restriction used by the agency provider. Interim approval can be requested from a designee of a committee when there is an urgent need to implement a restriction prior to getting approval from the full committee. Interim or full committee approval must be given prior to use of a rights restriction.
• The rights review committee must meet at least semi-annually.
• Add documentation to case management system.
• After initial approval, rights restrictions involving use of psychotropic medication must be approved by the rights review committee semi-annually, and all other rights restrictions must be approved annually.
• Members of the rights review committee must be free from conflict of interest and ensure confidentiality of participant information. At least half the rights review committee members must be participants, participant family, or other interested persons who are not employees or subcontractors of the agency provider.

Agency providers must ensure employees responsible for using interventions, supports, or practices limiting or restricting a participant's rights are educated and trained as required in DHHS state regulation. This training includes participant rights, confidentiality, and positive behavior support, approved methods of restraint, habilitation, and participant safety protocols (as applicable). The agency provider must ensure staff receive training and demonstrate competencies under the guidance of an already trained and proficient staff member prior to working alone with participants. The provider must document in each employee's personnel record when required orientation and training was completed and competency was demonstrated.

Monitoring for unauthorized or inappropriate use of restrictions, and monitoring to ensure compliance with all applicable laws and regulations includes the following:
• On-site certification review;
• DDD Service Coordination monitoring;
• Complaint investigations; and
• Quality Improvement review

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DHHS is responsible for overseeing the use of rights restrictions and ensuring all safeguards are followed.

On-Site Certification Review
Initial and ongoing certification of agency providers is the responsibility of DHHS, and includes on-site scheduled and unscheduled certification review.

During initial provider enrollment, the agency provider's policies, procedures, and actual practices are reviewed to ensure compliance with all applicable state regulations. The provider's capacity to support participants with behavioral challenges is assessed and DHHS personnel monitor for any unauthorized or inappropriate use of restrictions. The provider must also have an internal quality review system and a rights review committee, with written policies and procedures for these processes in compliance with applicable regulation. When DHHS personnel find policies and procedures do not comply with regulatory requirements, due to prohibited intervention techniques, an insufficient quality review system, an inadequate Review Committee, etc., the provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DHHS prior to providing DD waiver services to participants.

Detection of unauthorized or inappropriate use of restrictions may also occur through ongoing on-site certification review. During certification review, a random sample of participants served by the provider is chosen based on the total number of participants in the provider's services, and delivery of service and agency systems are reviewed.

The frequency of on-site certification reviews is based on each provider's current certification standing. Annual or biennial on-site certification reviews are scheduled in advance, but a focused review to address issues found through other oversight activities can occur at any time and may be unannounced. Walk-through activities are unannounced.

Service Coordination Monitoring
DDD SCs complete service monitoring, also referred to as service reviews, for all participants at least quarterly which may detect unauthorized or inappropriate use of restrictions. Service reviews are intended to review the implementation of each participant's service plan through direct observation of participants during service provision and review of records kept by providers. Observations are documented on a checklist and entered into an electronic database. In addition, the SC makes monthly contacts with participants, which may include unannounced visits to the participant's residential or day service locations. When any concerns related to prohibited or inappropriate use of restrictions are identified during service monitoring or other contacts, the SC consults with provider staff and review participant files to determine what action should be taken to resolve the issue.

Complaint Investigations
DHHS completes investigations of complaints submitted, which could include complaints related to unauthorized or inappropriate use of restrictions. Complaint investigations and any on-site review required may be unannounced and take place whenever investigation is necessary and appropriate.

Quality Improvement Review
DDD completes quality improvement review of service provision through off-site records review and on-site observation. These reviews may detect unauthorized or inappropriate use of restrictions.

Off-site records review includes review of service plans, provider program documentation, and other records on a monthly basis for a randomly selected sample. When potential concerns are identified through off-site records review, concerns may be communicated to DDD Central Office personnel, the assigned SC, or designated DHHS personnel, for further action or investigation, or reported to CFS when abuse, neglect, or exploitation is suspected.

On-site reviews are intended to review the implementation of a participant's service plan through direct observation of participants during service provision and review of records kept by providers. When any concerns related to unauthorized or inappropriate use of restrictions are identified during service monitoring or other contacts, the reviewing DD personnel will consult with provider staff and review participant

documentation to determine what action should be taken to resolve the issue.

Data analysis
The frequency of the oversight activities varies by activity and is specified for each activity outlined in this section. Data from all oversight activities is gathered and analyzed to identify statewide trends and patterns, and to develop and support QI strategies.

A summary of certification activities is submitted to DDD. Comparison to previous certification reviews of each provider can be made to identify any trends or patterns specific to each provider.

On a quarterly basis, the DDD QI Committee reviews aggregated reports compiled from various monitoring activities including off-site records review and on-site observations. These reports include any concerns identified during the monitoring activities.

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:

Seclusion is defined as the involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from having contact with others or leaving. Seclusion is prohibited.

Separation is permitted as emergency safety intervention, and any separation used must not meet the definition of seclusion.

DHHS monitors for unauthorized use of seclusion. Monitoring is described in detail in section G-2-a-ii, as the processes for monitoring for unauthorized use of seclusion are the same as those used to monitor for unauthorized or inappropriate use of restraint.

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

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

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

Appendix G: Participant Safeguards

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

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

a. Applicability. Select one:

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

b. Medication Management and Follow-Up

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

DD provider agencies have ongoing responsibility to ensure medications administered by provider staff are provided in compliance with applicable state statutes and regulations, including the Medication Aide Act, Neb. Rev. Stat. §§71-6718 - 71-6743, and 172 NAC. These statutes and regulations do not govern self-administration of medication or administration of medication by a caregiver or service provider not employed or subcontracted by a certified DD provider agency. Participants choosing to self-direct DD waiver services by employing independent providers are responsible for all oversight of medication provision by the providers the participants employ.

Medications administered by certified DD provider agencies may be administered by a medical professional acting within their scope of practice, or by a certified medication aide as delegated by a licensed medical professional who is permitted to administer medication and delegate medication administration within their scope of practice.

Psychotropic medications may be used and administered by providers of DD waiver services in compliance with safeguards outlined in this section and in sections G-2-a and G-2-b of this waiver.

Medical professionals prescribing medication to participants are responsible for monitoring participant medication regimens. The medical professional prescribing medication determines the frequency of their monitoring, based on the circumstances, including the participant's diagnoses and current condition, the type of medication, the length of time the medication is prescribed, other medications the participant is prescribed, monitoring for the intended effect of the medication, or other factors.

Monitoring the appropriateness of each medication individually and in relation to other prescribed medications is the responsibility of the medical professional who prescribes each medication and the pharmacist who fills the prescriptions.

DD agency providers must maintain a medication administration record (MAR) for all participants receiving medications administered by the provider. These records must be kept in the state-mandated web-based case management system.

DD providers monitor administration of medication through documenting and reporting relevant information whenever the participant receives medical attention or treatment with provider support to the participant and the medical professional delegating responsibility for medication administration to a licensed medication aide (if applicable). Relevant information includes:
• Inappropriate storage conditions for medications;
• Adverse reactions or side effects to medications experienced by the participant;
• Medication administration errors; and
• Observation of the symptoms the medication is prescribed to treat.

Licensed medical professionals (typically registered nurses) whose scope of practice allows delegation of medication administration are responsible for monitoring medication administration by medication aides, at a frequency determined by the delegating medical professional and the DD agency provider. Delegation is based on the willingness and ability of the participant to be involved in management of their own care, the stability of the participant's condition, the experience and competency of the medication aide, and the level of nursing judgment required for medication administration. The licensed medical professionals are employees of the DD provider agency or professionals who have entered into a contract with the DD provider.

Delegating medical professional and DD provider agency monitoring may include observation of the administration of medication or treatment, review of records relating to medication provision or treatment, review of incident reports related to medication or treatment errors, retraining medication aides, and ongoing observation.

When the prescribed medication is a rights restriction as specified in section G-2-b of this waiver appendix, the agency provider rights review committee reviews use of the medication at least semi-annually. Data from behavior support plans and staff observation of any behavioral or mental health symptoms the medication is prescribed to treat are reported to the rights review committee to facilitate this review.

DD agency providers must have policies and procedures for the provision of medications in compliance with applicable state regulation. This includes policies and procedures for internal quality improvement including frequency of QI monitoring. The agency provider QI monitoring includes review of medication errors to identify inappropriate or concerning practices, and follow-up action to reduce or prevent medication administration errors, such as retraining medication aides, review of provider procedures or practices, or disciplinary action.

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

DHHS is responsible for oversight of DD agency provider compliance with all state statutes and regulations applicable to medication administration. The administration of medication is a regulated activity as a method to ensure participant medications are managed and administered appropriately. DHHS monitors the administration of medications through review of DD agency provider policies and procedures during the initial certification process and on-site certification review activities.

When DHHS personnel finds policies and procedures do not comply with regulatory requirements, such as an insufficient QI system, inadequate incident reporting and follow-up, etc., the prospective agency provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit.

During on-site certification review, which may be unannounced or scheduled, service delivery and agency systems are reviewed. A random sample of participants served by the agency provider is chosen based on the total number of participants in the provider's services. From this certification review, DHHS personnel assess whether participants are receiving medication from medication aides in accordance with physician orders and applicable state statute and regulation. When this evaluation identifies any inappropriate or prohibited practices, DHHS cites deficient practice and the provider agency must submit a formal plan of improvement addressing citations. The plan of improvement must be approved by DHHS, and when the plan is insufficient, the provider must correct the plan and resubmit.

Medication aides must be certified through DHHS and recertified as required by Neb. Rev. Stat. §§71-6718 – 71-6743. Medication aides may participate in the physical act of medication provision and related documentation as delegated by a licensed medical professional. Unlicensed persons, including medication aides, may assist with monitoring therapeutic effects of medication, under some conditions.

DHHS Division of Public Health (DPH) oversees the regulatory requirements for certification of medication aides through maintenance of the Medication Aide Registry. The training requirements for certification of medication aides, outlined in 172 NAC, include DPH approved medication aide examinations and procedures. The competency exam must assess the competency standards identified in 172 NAC. These topics include:
1.Maintaining confidentiality;
2.Compliance with a participant'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 participant, 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.Compliance with limitations and conditions under which a medication aide may provide medications;
9.Having knowledge of abuse and neglect reporting requirements; and
10.Compliance with every participant's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property.

Upon successful completion of a medication aide training course, the applicant for certification must pass a competency test in order to be placed on the Medication Aide Registry. All medication aide certifications expire two years from the date of issue and the applicant must renew their registration to continue to be on the Medication Aide Registry.

DHHS personnel are responsible for ongoing monitoring of the performance of medication aides employed by the certified agency providers. When a complaint involving the performance of a medication aide is received by the DHHS, the MAR information for medication administered by the medication aide is reviewed for compliance with the state statute and regulation. When DHHS discovers a medication aide is not performing their duties in compliance with the state statute and regulation, the medication aide is removed from the Medication Aide Registry.

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).

Certified DD agency providers are responsible for monitoring medication administered by provider employees and ensuring medication is administered in compliance with applicable state statutes and regulations, including the Medication Aide Act, Neb. Rev. Stat. §§71-6718 - 71-6743 and 172 NAC.

Any certified DD agency provider staff or subcontractor administering medication to participants must be licensed medical professionals or certified medication aides. Medication aides are certified to administer medication under the direction and monitoring of:
• A licensed medical professional whose scope of practice allows medication administration;
• A participant with capability and capacity to make informed decisions about medications (i.e. self-administration); or
• A caretaker of the participant. Caretaker means a parent, foster parent, family member, friend, or guardian who has current, first-hand knowledge of a participant's health status and medications being administered, and has consistent and frequent interaction with the participant. A caretaker provides direction and monitoring and has capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication. This would not include an employee or subcontractor of a facility, school, provider agency, or other entity, or a guardian or family member of a participant who does not live in the same residence.

When a participant is able to self-administer their medication, the agency provider is not responsible for administration of or monitoring of these medications. The participant must meet the following criteria to be considered capable of self-administration of medication:
• Participant is 19 years of age or older;
• Participant is capable of completing the physical act of taking or applying a dose of a medication;
• Participant is capable of taking or applying the medication according to a prescription or recommended protocol;
• Participant has the capacity to observe and monitor for desired effects, side effects, interactions, and contraindications of the medication, and take appropriate action based on those observations;
• Participant receives no assistance in any way from another person for any activity related to medication administration.

The service plan team must evaluate a participant's ability to self-administer medication, and determine the level of assistance needed for medication administration.

For participants without the capability and capacity to make informed decision about medications and for whom there is no caretaker, a licensed medical professional must accept responsibility for direction and monitoring of medication administration. The Nurse Practice Act, Neb. Rev. Stat. §§71-1132 - 71-1132 and 172 NAC outlines the medical professional's responsibility and accountability for nursing actions delegated, directed, or assigned to be performed by others, and all requirements for documentation and oversight.

DHHS state regulation specifies direction and monitoring of medication administration by medication aides will be completed on an ongoing basis. The DD agency provider must have policies and procedures in place for monitoring medication administration by medication aides.

When the medication being administered is classified as a psychotropic medication, and it is being administered on a PRN (as needed) basis by certified agency provider staff, the following additional requirements must be met:
• PRN psychotropic medications must be prescribed by a licensed medical professional acting within their scope of practice.
• PRN psychotropic medication must not be used as discipline or for convenience, as use for these purposes is chemical restraint.
o PRN psychotropic medication cannot be routinely prescribed in advance of or upon admission to a provider's services.
o PRN psychotropic medication must be prescribed based on clinical need, and not prescribed in advance of anticipated need.
• PRN psychotropic medication must only be used as last resort when other behavioral and medical interventions have been attempted and determined to be unsuccessful by the prescribing physician acting within their scope of practice.
• Use of medications classified as antipsychotics as PRN psychotropic medication must only be prescribed to treat acute symptoms of a diagnosed mental disorder, prescriptions must be time limited, and use should only continue

for the shortest amount of time necessary.
• The prescribing physician must specify:
o Indications for use of the PRN psychotropic medication
o Comprehensive instruction for administration, when a PRN psychotropic medication is prescribed with a dosage range or can be administered through more than one route, including the order and frequency in which different doses or routes should be administered and specifying the lowest possible dose must be given first.
o Whether use of PRN psychotropic medication added to any other prescribed medication may constitute a high dose outside of standard clinical recommendations.
• Each use of PRN psychotropic medication must be reviewed by the PCP team. When PRN psychotropic medication is used more than weekly, the PCP team must review the first use within seven days and at least every seven days thereafter while medication continues to be used more often than weekly. This review must be documented.
• The participant or legal guardian must give specific informed consent for psychotropic medication to be administered on a PRN basis.
• The medication administration record (MAR) must contain the following information:
o All instruction for administration given by the prescribing physician, including dose, indications, frequency.
o Potential side effects of any PRN psychotropic medication must be documented in the MAR in non-technical terms to notify staff.
o When prescribed PRN psychotropic medication can be administered via different routes (i.e. both intramuscularly and orally), the different routes must be documented separately in the MAR as maximum dosage for each route is different.
o All PRN psychotropic medication administered must be documented in the MAR.
• MAR information for the last 30 days must be provided to any physician treating the patient.
• When PRN psychotropic medication is administered, the participant must be monitored by a licensed nurse or other medical professional for response to treatment, including adverse reactions, side effects, and physical health.
• Each use of PRN psychotropic medication must be reported by the provider to DDD as a critical incident as specified in section G-1-b of this waiver appendix.

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

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

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

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

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

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

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

Medication errors are any errors in the five “rights” of medication provision, or inaccurate or incomplete documentation of medication name, dose, route, or time administered.

Medication errors must be reported to the person responsible for directing and monitoring administration of medication.

Medication errors that result in injury, serious illness, hospitalization, or death must be reported as critical incidents to DDD and are monitored and reviewed through the required incident reporting process described in section G-1 of this appendix.

Medication errors suspected to be abuse or neglect must be reported to CFS or law enforcement, as well as to DDD as a critical incident.

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.

DHHS is responsible for oversight of DD agency provider compliance with all state statutes and regulations pertaining to medication administration. The administration of medication is a regulated activity as a method to ensure participant medications are managed and administered appropriately. DHHS monitors the administration of medications through review of DD agency provider policies and procedures during the initial certification process and on-site certification review activities.

When DHHS personnel finds policies and procedures do not comply with regulatory requirements, such as an insufficient QI system, inadequate incident reporting and follow-up, etc., the prospective provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit.

During on-site certification reviews, which may be unannounced or scheduled, service delivery and agency systems are reviewed. A random sample of participants served by the provider is chosen based on the total number of participants in the provider's services. From this certification review, DHHS personnel assess whether participants are receiving medication from medication aides in accordance with physician orders and applicable state statute and regulation. When this evaluation identifies any inappropriate or prohibited practices, DHHS cites deficient practice and the agency provider must submit a formal plan of improvement addressing citations. The plan of improvement must be approved by DHHS, and when the plan is insufficient, the provider must correct the plan and resubmit.

DPH oversees the regulatory requirements for certification of medication aides through maintenance of the Medication Aide Registry. The training requirements for certification of medication aides, outlined in 172 NAC, include DPH approved medication aide examinations and procedures. The competency exam must assess the competency standards identified in 172 NAC.

Upon successful completion of a medication aide training course, the applicant for certification must pass a competency test in order to be placed on the Medication Aide Registry. All medication aide certifications expire two years from the date of issue and the applicant must renew their registration to continue to be on the Medication Aide Registry.

DHHS personnel are responsible for ongoing monitoring of the performance of medication aides employed by the certified agency providers. When a complaint involving the performance of a medication aide is received by the DHHS, the MAR information for medication administered by the medication aide is reviewed for compliance with the state statute and regulation. When DHHS discovers a medication aide is not performing their duties in compliance with the state statute and regulation, the medication aide is removed from the Medication Aide Registry.

DDD monitors medication errors resulting in injury, serious illness, or hospitalization and use of PRN psychotropic medication through the critical incident monitoring process outlined in section G-1.

Data from monitoring completed by DHHS through certification review and complaint investigation and monitoring completed by DDD through critical incident reporting is reviewed by the DDD QI Committee at least semi-annually. Data is used to identify trends or patterns and to make recommendations of improvement strategies.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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:
A.1. # and % of participants reviewed who received information/education about how to identify & report abuse, neglect exploitation & other critical incidents. N: # of participants reviewed who received info/education about how to id & report abuse, neglect exploitation & other critical incidents; D: # 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 level 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:
A.2 # & % of abuse, neglect, exploitation (ANE) and unexplained death incidents that were reported by provider in the incident management system as required by DD policies and approved waiver. Numerator: # of ANE & unexplained death incidents that were rptd by prvdr in the incident mgt system as required by DD policies and approved waiver. D: # of ANE & unexplained death incidents reviewed.

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

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

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

Performance Measure:
A.3. Number and percent of reportable incidents reviewed that were reported by provider timely in the state incident management system as specified in DDD policies. N = Number of reportable incidents reviewed that were reported by provider timely in the state incident management system as specified in DDD policies. D = Number of reportable incidents 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 Level 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:
A.4. # and % of substantiated abuse/neglect/exploitation (ANE) & unexplained death critical incidents (CI) reviewed where the CI resolution was completed as required by DDD policies. N: # of substantiated ANE & unexplained death critical incidents reviewed where the CI resolution was completed as required by DDD policies. D: # of substantiated ANE & unexplained death critical incidents 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 level with +/- 5% margin 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**

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

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:
B.1. Number and percent of new service coordinators who receive training on their responsibilities as mandated reporters of abuse and neglect. Numerator- Number of new service coordinators who receive training on their responsibilities as mandated reporters of abuse and neglect Denominator- Total number of new service coordinators.

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

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

B.2. Number and percent of critical incident trends where systemic intervention was implemented. Numerator: Number of critical incident trends where systemic intervention was implemented. Denominator: Number of critical incident trends.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

Performance Measure:
Number and percent of non death related Critical Incident reports completed with appropriate waiver resolution activity. Numerator = number of non death related Critical Incident reports completed with appropriate waiver resolution activity; Denominator = number of non death related Critical Incident reports.

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

Responsible Party for data collection/generation *(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:

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:
C1 #&% of incident reports regarding use of unallowable restraint that document an investigation & actions were taken to address incident in accordance with DDD policies. N:# of incident reports re use of unallowable restraint that document an investigation & actions were taken to address the incident in accordance with DDD policies.D:# of incident reports re use of unallowable restraint reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level 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:
C.2. Number and percent of incident reports that document restraints were used in accordance with DDD Emergency Safety Intervention (ESI) policies. Numerator: Number of incident reports that document restraints were used in accordance with DDD ESI policies. Denominator: Number of incident reports that document that restraints were used that were reviewed.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level 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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
C.3. Number and percent of service plans reviewed that document all restrictive interventions in use. Numerator: Number of service plans reviewed with no unidentified rights restrictions. Denominator: Number of service plans that were 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 level 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:
C4 # & % of expected restriction safeguards present in reviewed service plans.
Numerator: # of restriction safeguards present in reviewed service plans.
Denominator: # of restriction safeguards expected to be present in reviewed service plans.

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 level 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:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
C5 #&% of service plans with restrictive intervention to address safety concern for behavior that has a behavioral assessment admin according to DDD policies & procedures. N:# of service plans w restrictive interv to address safety concern for behavior that has a behavioral assess admin according to DDD pol & proc. D:# of plans reviewed with restrictive interv to address behavioral safety concern.

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 level 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:
D.1. Number and percent of case management files reviewed where the participant's health care status was assessed at the initial or annual review. Numerator = Number of case management files reviewed where the participant's health care status was assessed at the initial or annual review. Denominator = Number of case management files 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 level 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**

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

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.

Strategies employed by DHHS to discover and identify problems or issues within the waiver program including agencies responsible and timelines are summarized in sections G-1-b, G-1-d, G-1-e, G-2-a-ii, G-2-b-ii, G-3-b-ii, G-3-c-iii, and G-3-c-iv.

The sample size for this review is determined by the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50%.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs 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.

DDD has processes in place to address specific problems upon discovery.

Providers are required by state statute to report any suspected or alleged abuse, neglect, or exploitation of participants to CFS and/or law enforcement. Reports of alleged or suspected abuse, neglect, or exploitation of participants made to CFS that do not meet statutory definitions of abuse, neglect or exploitation are shared with DHHS within 24 hours of receipt. DHHS personnel review the information and determine what action should be taken.

Critical incidents are reported through the state-mandated web-based case management system. DDD reviews a sample of reportable incidents for compliance with state policies. These findings are trended and analyzed to determine what remediation to apply.

In addition, providers submit a report quarterly to DDD summarizing critical incidents for the quarter and actions taken on both a participant and provider-wide level to address the issue and decrease the likelihood of future incidents.

Data is summarized and reviewed by the DDD QI Committee quarterly. The summarized data from service plan reviews is shared with service coordination personnel. The implementation data summary is shared with service coordination, providers, and DDD Central Office personnel.

Providers are required by state statute to report any suspected or alleged abuse, neglect, or exploitation of participants to CFS or law enforcement. Reports of alleged or suspected abuse, neglect, or exploitation of participants made to CFS that do not meet statutory definitions of abuse, neglect or exploitation are shared with DHHS within 24 hours of receipt. DHHS personnel review the information and determine what action should be taken.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Semi-Annually or more often as determined by the DDD Director

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 Medicaid Home and Community-Based Services (HCBS) Waivers quality improvement (QI) strategy is to ensure the health and safety of participants through continuous participant-focused monitoring and improvement by implementing and sustaining a system of quality management and improvement strategies.

The DDD QI Strategy 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.

The DDD quality improvement (QI) efforts for DDD waiver services are coordinated through the DDD Quality Improvement (QI) Committee comprised of (at a minimum), representatives from DDD Central Office, DHHS Medicaid (MLTC), and DDD Service Coordination. The QI Committee meets at least quarterly and reviews data and reports including, but not limited to, statewide monitoring, critical incidents, complaints and investigations, Medicaid HCBS waiver performance measures, service utilization, post-payment claims, and certification surveys to identify trends and consider statewide changes to support service improvement.

The continuing efforts are to oversee and refine the formal design and implementation of QI systems allowing for systematic oversight of services across the state by the QI Committee, while ensuring utility of the information at the local level. A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The minutes of QI Committee quarterly meetings document review of reports and data, identification of areas of concern, and recommendations and assignment of tasks for remediation, both to address identified issues and to proactively decrease the likelihood of similar problems occurring in the future. A continuous evaluation component is built into the system for evaluation of utility, information received, and effectiveness of strategies.

The QI Committee receives reports and information and provides/shares feedback and support to DDD service coordination. DDD makes all meeting minutes and reports available to the Medicaid Director for their review.

DDD Central Office personnel design and monitor services, including specific performance related to service and remediation. Discovery methods under DDD Central Office are expenditure and utilization monitoring; technical assistance; professional research, observation and insight; and analysis of data sources.

The DDD QI personnel provide systemic review of program outcomes and standards compliance to establish continuous improvement. Discovery methods under QI include reviewing electronic participant data, conducting file reviews, National Core Indicators (NCI) participant surveys, and oversight of field office supervisory efforts. For reviews completed using a representative sample, the sample size is determined by using the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50%.

Both DDD Central Office and QI personnel are involved in discovery related to, complaints, incident reports, and data collection and analysis. In addition to DDD Central Office and QI personnel, a contracted QIO-entity is also involved in the discovery, data collection, and reporting related to mortality review and critical incidents. The contracted QIO-like entity compiles and produces reports, which are analyzed by DDD personnel, DDD administration and the QI Committee. QI reports include data from mortality review, appeals, supervisory file review, Central Office file review, critical incident, state-mandated web-based case management system reports, post-payment claims, and service authorizations. These reports are compiled by DDD personnel and analyzed by the DDD administration and the QI Committee at least annually and as needed. When a provider is cited during certification review or complaint investigation and it is determined a plan of improvement is required, DHHS personnel monitor the plan of improvement to assure completion.

In order to assure protections, services, and supports on a systems level, DHHS has established a formal certification and review process in accordance with state regulations and Medicaid HCBS waiver requirements for provider agencies offering DD waiver services. This certification process includes certification and service reviews of certified agency providers and programs by DHHS surveyors in accordance with a one-year or two-year certifications issued by DHHS. The purpose of the reviews is to identify gaps and weaknesses, as well as strengths, in services provided on a statewide level. In order to ensure continued certification as an agency provider of DD waiver services, when providers are cited during certification review or complaint investigations, a formal plan of correction may be required to ensure remediation of circumstances leading to citation that must

be addressed. On an ongoing basis, critical incidents and complaints associated with certified providers, which have been reported to DDD, are reviewed and appropriate levels of follow-up are conducted.

Quality improvement for the purpose of statewide systemic program enhancement occurs through a variety of activities, including:
• Training and staff development may be offered or required for DDD personnel to remediate identified issues, inform and educate staff on changing regulations, policies, procedures, etc., and to provide opportunities for continued staff growth and education.
• Development of policy and operational guidelines to revise or clarify existing program expectations, or communicate new program expectations as needed for continuous program improvement.
• Development of informational materials, including written guidance for DDD personnel and providers and reference materials for current or prospective participants and the public.
• Researching national trends and best practices in the field of developmental disabilities and applying information gathered to continuous quality improvement activities or recommendations.
• Remediation of specific issues by DDD personnel. DDD personnel involved in remediation activities may vary, depending on the nature and scope of the identified issue.
• The DDD QI Strategy outlines a structured process for continuous assessment, monitoring, measuring, and evaluating operational and person-centered outcomes of DD waiver service delivery. The QI Strategy also outlines DDD collaboration with other DHHS divisions and the Governor’s Advisory Committee on Developmental Disabilities for continuous quality improvement.

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: More frequently as determined by DDD.

b. System Design Changes

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

DDD is responsible for monitoring and assessing system design changes, collecting and analyzing information, determining whether the waiver requirements and assurances are met, ensuring remediation, and planning system improvement activities. The DDD Director and DDD personnel are responsible for coordinating the development, implementation and monitoring of any system design changes. The DDD Director works closely with the DDD QI Committee 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. System design change recommendations will be made available to MLTC before implementation.

As described in section H-a-i of this waiver, DDD has in place a QI system including monitoring for issues and remediation of identified concerns. In turn, this process leads to system improvement. This is an ongoing, circular system with components of design, discovery, remediation, and operational improvement. DDD QI personnel, in consultation with the DDD Director, review the QI strategies on an ongoing basis, but no less frequently than quarterly, to adjust program outcomes, determine the need to modify data sources and to develop other methods to evaluate progress and services.

DDD QI personnel fulfill the lead role in guiding this improvement along with input from DDD service coordination, DDD Central Office personnel, and other divisions of DHHS. Specific activities are as follows:

a. Process of Aggregating Data and Monitoring Data Trends
The majority of waiver Performance Measure data is aggregated through queries from the state-mandated web-based case management system and electronic records where data is entered directly by the worker or reporter.

For data not entered directly into a system, data is derived from individual source documents such as audits of files or certification reports and manually tabulated as necessary.

In addition to Medicaid HCBS DD waiver performance measure data, the following data points are monitored on a quarterly basis:
• Service coordination timelines;
• Wait list management and timelines;
• Service authorizations; and
• Prevention of incidents.

b. Report Formats
Quality reports include mortality review data, supervisory file review data, critical incident data, electronic participant data system reports, post-payment claims data, and service authorization data. These reports reflect information via graphs, tables, and narratives. QI Committee minutes display meeting topics and discussion, as well as action plans or follow-up categorized by performance measures.

c. Communicating Results
Aggregate data is shared through the QI Committee with DDD administration, service coordination, and other stakeholders. Data reports are submitted as requested to CMS representatives. Quality data is presented at stakeholder meetings (e.g., Nebraska Association of Service Providers, DD Council, DD Advisory Committee, and DHHS HCBS stakeholder meetings).

d. Using Data for Implementing Improvement
Data is reviewed on at least a quarterly basis through the QI Committee. Appropriate recommendations, action plans, and follow-up are documented in the QI Committee minutes.

e. Assessment of the Effectiveness of the QI Process
Evaluations of the effectiveness of the QI process are done by analyzing remediation activities, determining if timelines and outcomes are being met, and the success level in addressing the original concern. Effectiveness is also measured through the relevancy of collected data in providing useful information on the timeliness and quality of services provided through waiver services; data is not collected for its own sake but rather to measure areas requiring maintenance of effort or improvement in service operations and delivery.

The DDD administration is responsible for coordination of monitoring and analysis of system design changes.

The administration works in conjunction with the QI Committee and the DDD personnel to develop methods of evaluation when implementing system design changes. The QI Strategy goals define the outcome desired as a function of the system change and to allow the gathering of data and other information related to the state of affairs prior to the system change.

In cases where this is not practicable, efforts are made to develop alternate strategies to capture information post hoc allowing a determination of whether the outcome was met. In those cases, it is more difficult to attribute the outcome measurement directly to the systems changes than when adequate baseline measures can be compared to measures taken following the system change.

An example of the development and monitoring of systems changes strategies was the decision to utilize a contracted vendor web-based case management system for budgeting, case management, and reporting incidents. The use of the web-based application and electronic records has improved the methods of data collection and aggregation.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Quality improvement (QI), program management, and administrative personnel in DDD evaluate the effectiveness of the waiver QI system on an ongoing basis. Quality improvement strategies stratify information for each respective waiver for all services funded by DDD, including the services offered under the Medicaid HCBS DD waivers 0394 and 4154, as well as services funded by state general funds only. MLTC oversees the implementation of the Medicaid State Plan and all identified State Plan system issues are relayed to MLTC personnel responsible for services under the Medicaid State Plan. System design change recommendations will be made to MLTC before implementation.

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

The QI strategy is evaluated on various levels in a systematic basis. Information reviewed by the QI Committee is reviewed to assess the reliability and thus, validity of the information being presented each time a committee meeting is held.

There is also a self-correcting nature based on strategies used to effect systems change. As the QI strategy has become more mature, the development of remediation strategies becomes influenced by the history of prior efforts. The historical access to and cooperation with various levels of personnel and resources as well as the efficacy of historical strategies all influence the development of new remediation strategies. The QI strategies are evaluated at a minimum once during the waiver period and prior to renewal.

Just as the assumption is that services can always be improved, the same concept also holds with the QI strategy. Efforts are continually 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 QI issues. New technology also leads to system changes and improvements in QI strategies. As new and updated web applications become available, data and processes for gathering and analyzing data are reviewed, which may lead to new strategies.

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).*

Financial accountability and integrity are joint responsibilities of the Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) with assistance from, Medicaid and Long-Term Care (MLTC), and the DHHS Financial Services unit.

DDD is responsible to ensure the integrity of the service authorization and claims processes. DDD staff authorizes services using a state-mandated web-based case management system which edits individual claims, suspends inaccurate claims, and tracks the participant's utilization of waiver services.

The DDD Program Accuracy Specialists are responsible for conducting the post payment reviews quarterly, using the random sampling noted below.
The sampling plan used for these Performance Measures is as follows.
1) A file is produced with all paid claims processed in the prior month.
2) Forty claims are randomly selected for review.
3) Annually, this results in approximately 144,000 paid claims in population and 480 inspected.

The Raosoft sample size calculator indicates a sample size of 384 would be required to achieve the 95/5/50 sample for a population of 144,000.

For the post-payment reviews, all paid claims are included in the population from which the random sample is drawn. Any claim processed in the prior month can become part of the sample and is equally likely to be selected. Claims for all services are audited in the same manner. Onsite reviews are not conducted for claims reviewed with this process.

When overpayments are discovered, the provider is contacted and given the opportunity to provide additional information to substantiate their claim. The additional information is reviewed and the provider is notified of findings, which can include the requirement to initiate repayment of funds.

The state-mandated web-based case management system identifies inaccurate authorizations, claims and trending data, and DDD supervisory and management personnel utilize this data to determine follow-up with service coordination personnel to correct errors in service authorizations or conduct monitoring activities to determine whether authorizations are sufficiently linked to service delivery. This data may also lead DDD personnel to conduct financial reviews of provider claims when concern is raised through monitoring, certification activities by DHHS Surveyors, or complaint investigations.

The DHHS Financial Services unit operates the cost allocation plan, prepares and monitors budget projections for MLTC and DDD, prepares federal and state reports as required, and prepares the CMS-64 reports.

(a) Describe the requirements concerning the independent audit of provider agencies: DD agency providers are required to contract with a certified public accountant for an annual independent audit of financial operations. The scope of this independent audit includes a review of the accounting systems of the agency in order to assess whether the financial statements provide an accurate representation of its financial position and are free from material misstatement.

Audit reports are submitted to DDD and are reviewed by an analyst for any audit findings or exceptions, which might affect State payments by or for the provider.

Agency providers with annual operating budgets of less than $200,000 are not required to provide an audit report. However, these providers are required to retain financial and statistical records to support and document all claims.

Services delivered by independent providers, rather than agency providers do not require an independent audit. Independent providers are required to retain financial and statistical records to support and document all claims.

(b) Describe 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: Claims for all services are audited in the same manner. Medicaid HCBS DD waiver providers submit billings through a state-mandated web-based case management system. A pre-audit of all provider claims is completed to assure the accuracy of coding and billing. Supporting electronic documentation, including electronic recording of time-in and time-out, program data records, or other documentation as determined by DDD must be available to DDD upon request. The provider must maintain electronic or paper records and documentation in sufficient detail to allow DDD program accuracy personnel to verify delivery of service to participants as certified on the electronic claim.

Audits of provider claims may be conducted in response to concerns raised by a review of electronic data, trending reports, complaints, or certification reviews. DDD central office personnel will review documentation to support the claim for services. This documentation may include, but is not limited to, the provider claim, electronic recording of time-in and time-out, service authorizations, electronic service utilization data, and the service plan. When issues are found which may be considered fraudulent claims; those issues are referred to the DHHS Medicaid Surveillance and Utilization Review Unit, or the Medicaid Fraud Control Unit of the Nebraska Department of Justice Office of the Attorney General.

DDD also conducts internal quality assurance activities related to the use of funding. Billing and authorization data is queried monthly to track trends in costs and service use by area, provider and statewide. These quality assurance activities are not a random sample review. They refer to reports that the Division produces internally that track/trend service utilization and for internal control of compliance to service limitations in the waiver (e.g. making sure there is compliance to weekly service limits such as the 35 hour/week limit applicable to day services).

Nebraska does not review all claims. For its quality assurance activities, Nebraska reviews a statistically valid random sample.
• Post-audit activities associated with audits of provider claims occur as needed.
• Post-audit activities associated with quality assurance activities occur quarterly.
• Post-audit activities associated with the monthly queries to track trends occur as needed.
• Post-audit activities associated with Financial Services tracking occurs as needed.
• Post-audit activities associated with Auditor of Public Accounts audits occur annually.

Financial Services track the use of Medicaid funding and provide monthly updates on the use of Medicaid HCBS DD waiver funding relative to the budgeted amounts. This aids DHHS-DD in determining the efficacy of efforts to enhance our monitoring and oversight of the use of waiver funding.

(c) Describe the agency (or agencies) responsible for conducting the financial audit program: The Nebraska Auditor of Public Accounts (APA) and DHHS are responsible for conducting these financial audits. The APA is responsible for conducting the periodic independent audit of the waiver program under the provisions of the Single Audit Act. The APA conducts the audits on an annual basis.

The state implemented an Electronic Visit Verification System in January 2021. The following services are subject to EVV:
- Supported Family Living
- Independent Living
- Respite
- LRI Personal Care
- Homemaker

Providers are required to use the EVV system. EVV data collected is used to monitor the State's financial integrity and accountability as an element of the post payment review processes."

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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:
A.1. Number and percent of paid claims reviewed that 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):*
Other
If 'Other' is selected, specify:
Records review, on and off site; Electronic database

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level 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:
A.2. Number and percent of paid claims reviewed that were supported by documentation that services were rendered. Numerator: Number of paid claims reviewed that were supported by documentation that services were rendered. Denominator: Number of paid claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Record reviews: on and off site; Electronic database

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

☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level 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:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

b. Sub-assurance: The state 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:
B.1. Number and percent of paid claims reviewed that were paid in accordance with the rate methodology specified in the approved waiver. Numerator = Number of paid claims reviewed that were paid in accordance with the rate methodology specified in the approved waiver. Denominator = Number of paid claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Record reviews, on and off site; Electronic database

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level 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.*

Quarterly off-site file reviews are conducted by DHHS-DD program accuracy staff (PAS). This review is conducted on a sample of files to ensure activities are being applied correctly, and that reviews and remediation activities are completed as assigned. The sample size for this review is determined by the calculation tool provided by Raosoft, Inc. (http://www.raosoft.com/samplesize.html) assuming a 95% confidence level, a 5% margin of error, and a response distribution of 50%. PAS are responsible for reporting all individual problems requiring remediation identified during discovery processes to supervisory staff. This information is summarized and reviewed by the DHHS-DD Quality Improvement Committee (QIC) quarterly.

An independent statewide single audit of DHHS is conducted by the State APA office on an annual basis following each state fiscal year (July 1 - June 30). This is an audit of the financial statements of the governmental activities, the business-type activities, the aggregate discreetly presented component units, each major fund, and the aggregate remaining fund information of the State of Nebraska. The final report includes APA's findings, DHHS management responses and corrective action plans, if applicable. Financial services staff respond to findings related to the State's accounting systems. DHHS-DD staff responds to findings related to review of randomly selected participant waiver files.

The APA reviews the waiver files for compliance with the state's regulations. The APA reviews the State's electronic information systems for inclusion of the waiver consent form, service plan, and waiver evaluation or reevaluation worksheets. The APA office also reviews the electronic claim and service authorization that corresponds with the service dates being tested. The authorization and billing documents are checked for accuracy of service codes and service rates, as well as for agreement with the service plan documentation. Please see Appendix I-1, I-2-b, I-2-d, I-3, and I-5 for additional information on strategies employed by the state for checks and balances and discovery of systemic issues.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the Stateâs 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 participant's DHHS-DD SC has primary responsibility for discovery and remediation of individual problems. Discovery processes include: monitoring; conducting supervisory file reviews; reviewing incidents; and following up on complaints.

Participants are notified in writing or electronically of the authorized funding amount at the time of choosing a provider and in the development of the service plan. Checks and balances described in sections I-1, I-2, and I-3 are in place to assure accurate authorizations. The team determines the provider, amount, and type of services needed. The participant's SC authorizes the services. When discrepancies are found, designated DHHS-DD staff take action to correct errors in the authorization, such as correcting the provider, service type, service amount, and/or dates of services. A pre-audit of all provider claims is completed to assure the accuracy of coding and claim.

The continuing efforts are to oversee and refine the formal design and implementation of quality improvement systems that allow for systematic oversight of services across the state by the QIC, while ensuring utility of the information at the local service coordination level. Quarterly reporting has been developed to ensure regular review of the results of the various QI functions. The report shows an empirical data review of results and recommendations for remediation, both to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future.

ii. Remediation Data Aggregation

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

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

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

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).*

Current rates for services on this waiver were last reviewed in 2017. Since that time, annual rate increases for agency and self-directed individual independent providers have been provided through the appropriations process of the Nebraska State Legislature. Reimbursement is based on Fee-For-Service rates for all services with the exception of Assistive Technology, Environmental Modification Assessment, Home Modification and Vehicle Modification, Personal Emergency Response System (PERS) and Transitional Services. Current and historical fee schedules are available to the public at the following url: https://dhhs.ne.gov/Pages/DD-Provider-Ratesand-Fee-Schedules.aspx

CMS approved the renewal of this waiver in 2017 with the condition the state complete a comprehensive rate methodology study. In December 2016, DDD contracted with Optumas Consulting to develop a rate methodology process for fee-for-service rates for DDD's HCBS waivers. DDD built the proposed rates by estimating the total costs incurred by providers to deliver DD services. Each DD service has its own individual rate model. The models begin with an estimate of the cost of direct labor required to provide the specific service. The rate which accounts for the total cost of the service is determined by applying factors to this direct labor cost.

Rate factors were determined by a few mechanisms including the review of actual costs documented in the general ledgers (GL) of the accounting systems of 12 providers. The GL data reviewed included actual revenue and expense data for a representative sample of DD service providers for Nebraska state fiscal year 2016 (July 1, 2015 – June 30, 2016.

DDD commenced the review in March 2017 and completed it in September 2017. All costs were categorized into the rate factors and care was taken to identify unallowable expenses, including room and board and fundraising expenses, and exclude these from consideration in the rate factors. Other activities used for determining rate factors were completed concurrently with the GL review and included: a staff training survey administered to members of the Provider Advisory Group (PAG); a review of payroll data; submitted by a representative sample of 12 providers; and a residential group home staffing survey.

These reviews were conducted for the purpose of studying and, when necessary, rebasing provider rates. DDD intends to perform comparable reviews on an on-going, periodic basis for the purpose of determining the adequacy of rates. DDD intends to study rates and, when necessary, rebase rates at least every five years but may rebase more frequent depending on availability of resources.

The methodology for estimating the direct labor cost and all factors in the rate model are explained below:
1) Direct Labor Cost:
The cost of direct labor for each service is based on the staffing requirements for the service and the classification of the employee. For each classification, an appropriate employment classification from the 2016 Bureau of Labor Statistics (BLS) was selected. Most of the services use the classification of Social and Human Service Assistants for direct-care staff. Wages are inflated from the BLS data using the Consumer Price Index to account for inflation from the time when this data was collected to the anticipated implementation of this rate model.

2) Employee Related Expenses (ERE):
This includes costs associated with employees of DD agency providers. These costs include FICA, retirement, unemployment compensation, health/dental/life insurance, and short and long-term disability insurance. The ERE factor is based on actual costs in general ledger (GL) data submitted by providers.

3) Availability Factor:
This factor compensates agency providers for paid direct-care staff time for non-billable activities including recordkeeping, reporting, training, and meetings. Additionally, it also compensates agency providers for paid time off for direct staff (holidays, sick, vacation) and overtime hours. The factor is based on payroll data submitted by a representative sample of DD service providers for Nebraska state fiscal year 2016 and a training survey administered to the PAG.

4) Mileage:
This factor compensates providers for mileage while transporting the participant as part of waiver services. The rate is based on the 2018 rate published by the Internal Revenue Service for reimbursement of employees for personal vehicle usage.

5) Program Support:
This factor is intended to cover the supports around direct-care specific to the provision of services (as opposed to

general and administrative expenses). Examples include clinical supports, nursing costs, and rent/maintenance associated with a building used for the delivery of service. It does not include costs for staff who have direct contact with the waiver participant as these costs are accounted for in the direct labor cost component. This factor was estimated based on GL data submitted by providers.
Rent expenses included in the rate model were categorized based on how they were recorded in the GL data. For buildings that housed both program activities and support staff, the expense was split into program support and administration.

6) Administration:
This factor is intended to cover general and administrative expenses for the providers. These include indirect costs such as rent/depreciation, salaries and benefits, and background checks for staff for functions such as human resources, finance and accounting, and quality improvement. This factor was estimated based on GL data submitted by providers.

DDD solicited feedback from stakeholders via three structured mechanisms:
1) Establishment of a Provider Advisory Group (PAG) consisting of agency DD service providers
This group consisted of 12 Agency providers who volunteered to provide feedback to DDD during the rate development process. DDD solicited feedback from the PAG via recurring meetings and requests for feedback following major milestones in the rate development process (e.g. introduction of new service definitions, presentation of draft rate models, etc.). The feedback provided by the PAG helped to inform assumptions in the rate model including staffing ratios in group homes, training requirements for direct-care staff, and "sloping" (i.e. adjusting the magnitude) of factors in the rate model for tiered services based on participant acuity level.
2) Independent Provider Meetings
Meetings were held with Independent Providers on March 27, 2018. Two sessions (afternoon and evening) were held to provide flexibility for attending these meetings. Independent providers could attend in-person in Lincoln, NE or via WebEx. DDD presented draft rate methodology and service definitions and solicited feedback in these sessions.
3) Public Stakeholder Meeting
A two-hour public stakeholder meeting was held on June 19, 2018. Participants in this meeting included parents and guardians of waiver participants, service providers, and representatives from advocacy groups for individuals with DD. The meeting provided an opportunity to present information about the rate development process and solicit feedback on the process.
Additional details on how DDD solicits public input can be found in Main Section 6-I.
DDD developed rates specific to independent providers for self-directed services based on stakeholder feedback and the goal of providing participants with additional options. DDD established independent provider rates for self-directed services to reflect additional habilitation opportunities for self-directed services and provider qualifications for habilitative services. The rate models for independent providers have different assumptions to compensate for differences compared to agency providers. The ERE, staff availability factor, mileage, administration and program support factors are all lower for independent providers.

The ERE factor for independent providers is set lower to cover only FICA taxes. The staff availability factor includes allowances for only training, attending service plan meetings, and recordkeeping/reporting requirements. The mileage factor assumes lower transportation expenses incurred than agency providers. The administration factor is intended to cover only basic requirements for billing of services and electronic case management, such as an internet and phone connection.

Some services incorporate a tiered rate structure to compensate providers based on the acuity of the participant. The following services have tiered rates: Day Supports, Community Integration, Child Day Habilitation, Continuous Home, Host Home, Shared Living, and Youth Continuous Home. The reimbursement for these services is tiered based on the participant's level of service need as determined by the ICF/IID level of care assessment tool.

Rate factors are adjusted for tiered services to account for different costs within the tiers. The assumed staffing ratios for direct labor are lowest for the basic tier and are increased to one-to-one for the behavioral risk tier, including overnight hours. Program support, administration, and the wage percentile of the BLS classification are also graduated to account for the different cost structures within the tiers.

Other services have rate structures to accommodate service delivery one-on-one or in a group setting. This structure provides waiver participants the flexibility to purchase the services in a group setting at a lower cost. Prevocational, Independent Living, and Supported Family Living services are structured with both individual and group rates. Rates for

these services are adjusted by changing the assumed staffing ratio for direct labor based on the setting.
The service rates do not differ geographically. The state considered the need for rate differences by geographical region in the 2018 rate study and concluded that this was not necessary. Rates established in accordance with this methodology may be adjusted at the direction of the Nebraska State Legislature.

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

Basic: Individuals who meet LOC with minimal supervision and support needs. Individuals at this level do not require 24 hour care.
Intermediate: Individuals who meet LOC with moderate supervision and support needs. Individuals at this level do not require 24 hour care.
High: Individuals who meet LOC with high supervision and support needs. Individuals at this level require 24-hour care.
Advanced: Individuals who meet LOC with high supervision and support needs as well as behavioral and/or medical complexities. Individuals at this level require 24-hour care.
Risk: Individuals who meet LOC with high supervision and support needs, as well as behavioral or medical complexities. Individuals at this level require 24-hour care in specialized environments. Individuals in this tier may require 2:1 or 3:1 supervision for safety.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Billings flow from providers to the State's claims translator and downloaded to the State's electronic local web-based service system, N-FOCUS, which is a component of MMIS, and are not routed through intermediary entities. Services are prior authorized and sent electronically to the provider in a state mandated web-based case management system. Service data, including the time at which services begin and end and the service delivery location, is recorded in the attendance module and a claim is generated through the state mandated web-based case management system by providers and are electronically submitted for claims processing following the delivery of services.
During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services are authorized. During nightly payments processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher, which is then sent to the state's accounting system, the Nebraska Information System (NIS). All claims are routed through the State's electronic local web-based service system, a recognized component of MMIS, and are subsequently sent to the NIS, the accounting system for the State of Nebraska.
The program under which a claim is paid is stored on each individual service authorization and electronically transferred to the claim. For each program, a separate account is maintained from which to debit the federal and state shares based on the date of payment. Those account tables are maintained over time. When the payment is made, all claims for the same program are then summarized on a voucher and submitted to NIS. The state's electronic local web-based service system stores the timestamp and user ID for all new or updated information related to this process. Federal funds are drawn from the designated accounts at the time an approved claim is set to Paid status and sent to the NIS. Claims are processed on a daily basis.
Direct billing of waiver services is provided to the State. Claims made to Medicaid are documented on the CMS-64 on a quarterly basis.
The state collects overpayments to Medicaid providers pursuant to 471 NAC § 3-002.08. The Medicaid Financial Responsibility (MFR) unit of DHHS Financial Services is responsible for processing and collecting overpayments for Medicaid provider claims.
An overpayment is established when a claim is revised in the state-mandated web-based case management system to lower the number of billable units. This revision can be done by either the provider or the state. The claim revision generates an overpayment in the N-FOCUS system, which creates an Accounts/Receivables (A/R) account to monitor the collection of the overpayment. A demand letter is sent to the provider to provide notification of the establishment of the A/R. The provider may remit payment via check or have the A/R satisfied via recoupment from future payments. Collections made via both check/cash remittance and recoupments are recorded to the general ledger and account for federal funds in claims for Federal Financial Participation (FFP).

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

a) Claims for payment are made only when the participant was eligible for a Medicaid waiver payment on the date of service.
DD waiver services must be prior authorized before payment is made. Authorizations are based upon a determination by designated DHHS-DD staff that the participant meets waiver eligibility criteria, that the services are identified in the approved service plan, and that the services are not available for funding through programs funded under section 602 (16) or (17) of the Individuals with Disabilities Education Act (P.L. 94 - 142) or section 110 of the Rehabilitation Act of 1973.

b) Claims for payment are made only when the service was included in the participant's approved service plan.
The authorization and payment process includes the following steps:

1. *DD-waiver eligibility of the participant is determined.*
2. *DD waiver services are identified in the service plan.*
3. *DD waiver service authorization, also known as the budget authorization, is completed, indicating approved waiver services, waiver provider(s), dates of service, and authorized units of service.*
4. *Authorization is entered into in a state mandated web-based case management system used for budget authorization, claims processing, and case management and then sent to the state's electronic local web-based service system.*
5. *Upon verification through the state mandated web-based case management system, claims are electronically submitted to state's electronic local web-based service system for processing. Edits in the state mandated web-based case management system verify participant and provider eligibility, dates of service, units of service, and rates.*
6. *Claims are generated based on service data entered by providers.*

c) Claims for payment are made only when the services were provided.
DD waiver providers submit billings through a state mandated web-based case management system. A pre-audit of all provider claims is completed to assure the accuracy of coding and billing. Supporting electronic documentation, including electronic recording of time-in and time-out, program data records, or other documentation as determined by DHHS-DD must be available to DHHS-DD staff upon request. An electronic signature is acceptable.

The billing validation process verifies that the participant was eligible for Medicaid waiver payment on the date of service.

The state collects overpayments to Medicaid providers pursuant to 471 NAC § 3-002.08. The Medicaid Financial Responsibility (MFR) unit of DHHS Financial Services is responsible for processing and collecting overpayments for Medicaid provider claims.

An overpayment is established when a claim is revised in Therap to lower the number of billable units. This revision can be done by either the provider or the state. The claim revision generates an overpayment in the NFOCUS system which creates an Accounts/Receivables (A/R) account in NFOCUS to monitor the collection of the overpayment. A demand letter is sent to the provider to provide notification of the establishment of the A/R. The provider may remit payment via check or have the A/R satisfied via recoupment from future payments. Collections made via both check/cash remittance and recoupments are recorded to the general ledger and account for federal funds in claims for Federal Financial Participation (FFP).

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.

The state will make a supplemental payment as one-time payments based on the proportion of total agency provider claims paid for services rendered from March 1 to May 30, 2024. These supplemental payments will be provided only to agency providers of waiver services, using unallocated ARP funding to cover the non-Federal share. Providers eligible for these supplemental payments will retain 100% of the total computable expenditure claimed by the state to CMS.

As part of its requirements under Tribal Notice and Public Input, DHHS-DDD posted the draft waiver amendment application to its public website and conducted a public comment presentation via webinar on September 12, 2024 regarding requested waiver changes including information regarding the methodology and basis of the supplemental payment.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Vocational Rehabilitation Services within the Department of Education is a state government agency. Vocational Rehabilitation Services is an independent Medicaid HCBS DD waiver provider of Assistive Technology, Home Modifications, Vehicle Modifications, and Environmental Modification Assessment, and receive the same rates as all providers for those services.

In Nebraska, some agency providers are public providers established by County Commissioners under interlocal agreements. Both private and public agency providers deliver the same DD waiver services, and the payment to these public providers does not differ from the amount paid to private providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The state establishes the rates for waiver services furnished in residential settings and those rates do not include any costs for room and board. The providers bill according to the established rates.

The service rates reflect the exclusion of Medicaid payment for room and board for services that are delivered in residential settings.

As noted in Appendix I-2-A, the state identified unallowable expenses, including room and board expenses, in the general ledger data furnished by providers for the purpose of rebasing rates. These expenses were categorized separately as unallowable and not considered for any of the factors described in the rate methodology.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	45578.98	8996.00	54574.98	195925.00	8820.00	204745.00	150170.02
2	41869.09	9177.00	51046.09	199844.00	8996.00	208840.00	157793.91
3	41760.45	9360.00	51120.45	203840.00	9176.00	213016.00	161895.55
4	42673.81	9548.00	52221.81	207917.00	9360.00	217277.00	165055.19
5	46356.30	9739.00	56095.30	212076.00	9547.00	221623.00	165527.70

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	4300	4300
Year 2	4500	4500
Year 3	5200	5200
Year 4	5200	5200
Year 5	5200	5200

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Average length of stay on the waiver is based off of waiver 4154's most recent 372 submitted report for dates between 3/1/2022-2/28/2023. The ALOS was 313.3.

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:*

Estimates for cost per units are based on utilization in Waiver year 3 for dates between 6/1/2019-5/31/2020. Estimates for waiver years are based on actual paid claims data with dates of service from waiver year 3 (6/1/2019-5/31/2020) actuals. Number of units are based on utilization in Waiver year three (6/1/2019-5/31/2020).A 2% increase is assumed for each year.

Estimates for number of users in waiver years 1 & 2 are based on utilization in waiver year 3 for dates between 6/1/2019-5/31/2020. Estimates for waiver years 3-5, have been updated to reflect a proportional increase in the number of users based on the increased waiver capacity. It is assumed that participants will continue to utilize services at the same rate and proportionality even with an increase in the overall number of participants.

Estimates are based on actual paid claims data with dates of service from 6/1/2019 to 5/31/2020 that was year 3 of the data that was submitted to CMS.

1) Average estimated rates for tiered services is based on the proportion of participants in each tier of waiver year 3 (reporting period 6/1/2019-5/31/2020).

2) A 2% price increase is assumed for each year. The 2% price increase represents an estimate for cost of living increases appropriated to the program by the Nebraska State Legislature. These have historical been set close to the overall change in the Consumer Price Index which has been trending around 2% per year. This waiver does not cover the cost of prescribed drugs and therefore Factor D does not include any costs for prescription drugs. Prescription drugs are covered as a State Plan service.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is based on actual acute care expenditures for individuals on the waiver during the Waiver year 3 for dates between 6/1/2019-5/31/2020. The average cost for acute care for the reported year 3 was $ $8,996. Price increases of 2.0% were included for each year.
A 2% price increase is assumed for each year. The 2% price increase represents an estimate for cost of living increases appropriated to the program by the Nebraska State Legislature. These have historical been set close to the overall change in the Consumer Price Index which has been trending around 2% per year. This waiver does not cover the cost of prescribed drugs and therefore Factor D does not include any costs for prescription drugs. Prescription drugs are covered as a State Plan service.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The average cost of institutional care per ICF-DD recipient was based on actual expenditures in Waiver year 3 for dates of service between 6/1/2019-5/31/2020. The average cost for the year was $195,925
Price increases of 2% were included for each year.
The 2% price increase represents an estimate for cost of living increases appropriated to the program by the Nebraska State Legislature. These have historical been set close to the overall change in the Consumer Price Index which has been trending around 2% per year.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is based on actual acute care expenditures for individuals in an ICF-DD in Waiver year 3 for dates of service between 6/1/2019-5/31/2020. The average cost for acute care for this waiver year was $8820. Price increases of 2% were included for each year.

The 2% price increase represents an estimate for cost of living increases appropriated to the program by the Nebraska State Legislature. These have historical been set close to the overall change in the Consumer Price Index which has been trending around 2% per year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Continuous Home	
Prevocational	
Respite	
Supported Employment - Individual	
Adult Day Retirement	
Adult Day	
Assistive Technology	
Behavioral In-Home Habilitation	
Benefits Counseling	
Child Day Habilitation	
Community Integration	
Consultative Assessment	
Day Supports	
Employment Exploration	
Environmental Modification Assessment	
Health Maintenance Monitoring	
Home Modifications	
Homemaker	
Host Home	
Independent Living	
LRI Personal Care	
Medical In-Home Habilitation	
Personal Emergency Response System (PERS)	
Remote Supports	
Shared Living	
Small Group Vocational Support	
Supported Employment - Follow Along	
Supported Family Living	
Transitional Services	
Transportation	
Vehicle Modifications	
Youth Continuous Home	

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
Continuous Home Total:						**50625405.00**
Continuous, Daily	Day	1161	153.00	285.00	**50625405.00**	
Continuous, Partial Day	Partial Day	0	0.00	0.01	**0.00**	
Prevocational Total:						**396710.41**
Prevocational Services, Agency, Large Group	Hour	11	327.00	16.91	**60825.27**	
Prevocational Services, Agency, Small Group	Hour	22	71.00	9.39	**14667.18**	
Prevocation Services, Independent, 1:1	Hour	7	17.00	41.00	**4879.00**	
Prevocational Services, Agency, 1:1	Hour	129	58.00	42.28	**316338.96**	
Respite Total:						**523840.00**
Respite, Agency, Daily	Day	69	10.00	177.00	**122130.00**	
Respite, Independent, Quarter Hour	Quarter Hour	96	265.00	3.00	**76320.00**	
Respite, Independent, Daily	Day	58	14.00	109.00	**88508.00**	
Respite, Agency, Hourly	Hour	66	43.00	24.00	**68112.00**	
Respite, Agency, Quarter Hour	Quarter Hour	105	157.00	4.00	**65940.00**	
Respite, Independent, Hourly	Hour	113	70.00	13.00	**102830.00**	
Supported Employment - Individual Total:						**3872750.00**
Supported Employment - Individual, Agency	Hour	482	172.00	43.00	**3564872.00**	
Supported Employment - Individual, Independent	Hour	46	291.00	23.00	**307878.00**	
Adult Day Retirement Total:						**0.00**
Daily	Day	0	0.00	191.00	**0.00**	
Hourly	Hour	0	0.00	26.00	**0.00**	
Adult Day Total:						**464486.00**

GRAND TOTAL:	**195989601.41**
Total Estimated Unduplicated Participants:	**4300**
Factor D (Divide total by number of participants):	**45578.98**
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services	Hour	86	491.00	11.00	464486.00	
Assistive Technology Total:						2342.00
Assistive Technology	Occurrence	1	1.00	2342.00	2342.00	
Behavioral In-Home Habilitation Total:						0.00
Agency, Hourly	Hour	0	0.00	0.01	0.00	
Behavioral In-Home Habilitation	Hour	0	0.00	0.01	0.00	
Benefits Counseling Total:						0.00
Benefits Counseling	0	0	0.00	0.01	0.00	
Child Day Habilitation Total:						0.00
Child Day Habilitation	Hour	0	0.00	0.01	0.00	
Community Integration Total:						36274714.00
Habilitative Community Inclusion, Agency, Hourly	Hour	2410	455.00	24.00	26317200.00	
Habilitative Community Inclusion, Agency, Daily	Day	1302	41.00	167.00	8914794.00	
Habilitative Community Inclusion, Independent, Hourly	Hour	152	343.00	20.00	1042720.00	
Consultative Assessment Total:						726880.00
Consultative Assessment	Hour	590	11.00	112.00	726880.00	
Day Supports Total:						35850168.00
Habilitative Workshop, Agency, Hourly	Hour	2406	661.00	18.00	28626588.00	
Habilitative Workshop, Agency, Daily	Day	1470	39.00	126.00	7223580.00	
Employment Exploration Total:						0.00
Employment Exploration	0	0	0.00	0.01	0.00	
Environmental Modification Assessment Total:						12000.00

GRAND TOTAL:	195989601.41
Total Estimated Unduplicated Participants:	4300
Factor D (Divide total by number of participants):	45578.98
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modification Assessment	Occurrence	12	1.00	1000.00	12000.00	
Health Maintenance Monitoring Total:						0.00
Installation (One-time) Fee	0	0	0.00	0.01	0.00	
On-going Monthly Fee	0	0	0.00	0.01	0.00	
Home Modifications Total:						59400.00
Home Modification	Occurrence	18	1.00	3300.00	59400.00	
Homemaker Total:						22539.00
Homemaker, Independent	Hour	11	186.00	11.00	22506.00	
Homemaker, Agency	Hour	1	3.00	11.00	33.00	
Host Home Total:						172935.00
Host Home, Daily	Day	15	63.00	183.00	172935.00	
Host Home, Partial Day	Partial Day	0	0.00	0.01	0.00	
Independent Living Total:						8058306.00
Independent Living, Independent, 1:1	Hour	127	514.00	20.00	1305560.00	
Independent Living, Agency, 1:1	Hour	635	335.00	30.00	6381750.00	
Independent Living, Agency, Small Group	Hour	104	183.00	16.00	304512.00	
Independent Living, Independent, Small Group	Hour	11	50.00	10.00	5500.00	
Independent Living, Agency, Large Group	Hour	21	264.00	11.00	60984.00	
Independent Living, Independent, Large Group	Hour	0	0.00	0.01	0.00	
LRI Personal Care Total:						3227250.00
Agency	Hour	250	520.00	23.17	3012100.00	
Individual	Hour	25	520.00	16.55	215150.00	

GRAND TOTAL:	195989601.41
Total Estimated Unduplicated Participants:	4300
Factor D (Divide total by number of participants):	45578.98
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical In-Home Habilitation Total:						**81016.00**
Agency, Hourly	Hour	19	164.00	26.00	**81016.00**	
Personal Emergency Response System (PERS) Total:						**8660.00**
Installation (One-time) Fee	Occurrence	3	4.00	31.00	**372.00**	
Ongoing Monthly Fee	Month	28	8.00	37.00	**8288.00**	
Remote Supports Total:						**0.00**
Installation (One-time) Fee	0	0	0.00	0.01	**0.00**	
On-going Monthly Fee	0	0	0.00	0.01	**0.00**	
Shared Living Total:						**45754500.00**
Shared Living, Day	Day	1298	150.00	235.00	**45754500.00**	
Shared Living, Partial Day	Partial Day	0	0.00	0.01	**0.00**	
Small Group Vocational Support Total:						**1381072.00**
Supported Employment - Enclave	Hour	0	0.00	0.01	**0.00**	
Enclave, Agency	Hour	304	413.00	11.00	**1381072.00**	
Supported Employment - Follow Along Total:						**45268.00**
Supported Employment - Follow Along, Agency, Hourly	Hour	62	9.00	43.00	**23994.00**	
Supported Employment - Follow Along, Agency, Quarter Hour	Quarter Hour	74	21.00	10.00	**15540.00**	
Supported Employment - Follow Along, Independent, Quarter Hour	Quarter Hour	3	213.00	6.00	**3834.00**	
Supported Employment - Follow Along, Independent, Hourly	Hour	4	19.00	25.00	**1900.00**	
Supported Family Living Total:						**5529354.00**

GRAND TOTAL:	**195989601.41**
Total Estimated Unduplicated Participants:	**4300**
Factor D (Divide total by number of participants):	**45578.98**
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Family Living, Independent, Group	Hour	3	191.00	10.00	5730.00	
Supported Family Living, Agency, 1:1	Hour	586	234.00	26.00	3565224.00	
Supported Family Living, Agency, Group	Hour	34	42.00	15.00	21420.00	
Supported Family Living, Independent, 1:1	Hour	211	459.00	20.00	1936980.00	
Transitional Services Total:						0.00
Transitional Services - Occurrence	Occurrence	0	0.00	0.01	0.00	
Transportation Total:						2363956.00
Transportation, Independent	Mile	36	2397.00	1.00	86292.00	
Transportation, Agency	Mile	872	1306.00	2.00	2277664.00	
Transportation, Other	Occurrence	0	0.00	0.01	0.00	
Vehicle Modifications Total:						100000.00
Vehicle Modifications	Occurrence	10	1.00	10000.00	100000.00	
Youth Continuous Home Total:						436050.00
Youth Continuous Home	Day	10	153.00	285.00	436050.00	

GRAND TOTAL:	195989601.41
Total Estimated Unduplicated Participants:	4300
Factor D (Divide total by number of participants):	45578.98
Average Length of Stay on the Waiver:	349

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
Continuous Home Total:						**46895112.00**
Continuous, Daily	Day	1161	153.00	264.00	**46895112.00**	
Continuous, Partial Day	Partial Day	0	0.00	0.01	**0.00**	
Prevocational Total:						**404808.45**
Prevocational Services, Agency, Large Group	Hour	11	327.00	17.28	**62156.16**	
Prevocational Services, Agency, Small Group	Hour	22	71.00	9.58	**14963.96**	
Prevocation Services, Independent, 1:1	Hour	7	17.00	41.93	**4989.67**	
Prevocational Services, Agency, 1:1	Hour	129	58.00	43.13	**322698.66**	
Respite Total:						**523840.00**
Respite, Agency, Daily	Day	69	10.00	177.00	**122130.00**	
Respite, Independent, Quarter Hour	Quarter Hour	96	265.00	3.00	**76320.00**	
Respite, Independent, Daily	Day	58	14.00	109.00	**88508.00**	
Respite, Agency, Hourly	Hour	66	43.00	24.00	**68112.00**	
Respite, Agency, Quarter Hour	Quarter Hour	105	157.00	4.00	**65940.00**	
Respite, Independent, Hourly	Hour	113	70.00	13.00	**102830.00**	
Supported Employment - Individual Total:						**3872750.00**
Supported Employment - Individual, Agency	Hour	482	172.00	43.00	**3564872.00**	
Supported Employment - Individual, Independent	Hour	46	291.00	23.00	**307878.00**	
Adult Day Retirement Total:						**0.00**
Daily	Day	0	0.00	0.01	**0.00**	
Hourly	Hour	0	0.00	0.01	**0.00**	
Adult Day Total:						**464486.00**

GRAND TOTAL:	**188410896.45**
Total Estimated Unduplicated Participants:	**4500**
Factor D (Divide total by number of participants):	**41869.09**
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services	Hour	86	491.00	11.00	464486.00	
Assistive Technology Total:						2342.00
Assistive Technology	Occurrence	1	1.00	2342.00	2342.00	
Behavioral In-Home Habilitation Total:						0.00
Agency, Hourly	Hour	0	0.00	0.01	0.00	
Behavioral In-Home Habilitation	Hour	0	0.00	0.01	0.00	
Benefits Counseling Total:						0.00
Benefits Counseling	0	0	0.00	0.01	0.00	
Child Day Habilitation Total:						0.00
Child Day Habilitation	Hour	0	0.00	0.01	0.00	
Community Integration Total:						36274714.00
Habilitative Community Inclusion, Agency, Hourly	Hour	2410	455.00	24.00	26317200.00	
Habilitative Community Inclusion, Agency, Daily	Day	1302	41.00	167.00	8914794.00	
Habilitative Community Inclusion, Independent, Hourly	Hour	152	343.00	20.00	1042720.00	
Consultative Assessment Total:						726880.00
Consultative Assessment	Hour	590	11.00	112.00	726880.00	
Day Supports Total:						35850168.00
Habilitative Workshop, Agency, Hourly	Hour	2406	661.00	18.00	28626588.00	
Habilitative Workshop, Agency, Daily	Day	1470	39.00	126.00	7223580.00	
Employment Exploration Total:						0.00
Employment Exploration	0	0	0.00	0.01	0.00	
Environmental Modification Assessment Total:						12000.00

GRAND TOTAL:	188410896.45
Total Estimated Unduplicated Participants:	4500
Factor D (Divide total by number of participants):	41869.09
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modification Assessment	Occurrence	12	1.00	1000.00	12000.00	
Health Maintenance Monitoring Total:						0.00
Installation (One-time) Fee	0	0	0.00	0.01	0.00	
On-going Monthly Fee	0	0	0.00	0.01	0.00	
Home Modifications Total:						59400.00
Home Modification	Occurrence	18	1.00	3300.00	59400.00	
Homemaker Total:						22539.00
Homemaker, Independent	Hour	11	186.00	11.00	22506.00	
Homemaker, Agency	Hour	1	3.00	11.00	33.00	
Host Home Total:						159705.00
Host Home, Daily	Day	15	63.00	169.00	159705.00	
Host Home, Partial Day	Partial Day	0	0.00	0.01	0.00	
Independent Living Total:						8058306.00
Independent Living, Independent, 1:1	Hour	127	514.00	20.00	1305560.00	
Independent Living, Agency, 1:1	Hour	635	335.00	30.00	6381750.00	
Independent Living, Agency, Small Group	Hour	104	183.00	16.00	304512.00	
Independent Living, Independent, Small Group	Hour	11	50.00	10.00	5500.00	
Independent Living, Agency, Large Group	Hour	21	264.00	11.00	60984.00	
Independent Living, Independent, Large Group	Hour	0	0.00	0.01	0.00	
LRI Personal Care Total:						3324620.00
Agency	Hour	250	520.00	23.87	3103100.00	
Individual	Hour	25	520.00	17.04	221520.00	

GRAND TOTAL:	188410896.45
Total Estimated Unduplicated Participants:	4500
Factor D (Divide total by number of participants):	41869.09
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical In-Home Habilitation Total:						**81016.00**
Agency, Hourly	Hour	19	164.00	26.00	**81016.00**	
Personal Emergency Response System (PERS) Total:						**8660.00**
Installation (One-time) Fee	Occurrence	3	4.00	31.00	**372.00**	
Ongoing Monthly Fee	Month	28	8.00	37.00	**8288.00**	
Remote Supports Total:						**0.00**
Installation (One-time) Fee	0	0	0.00	0.01	**0.00**	
On-going Monthly Fee	0	0	0.00	0.01	**0.00**	
Shared Living Total:						**42249900.00**
Shared Living, Day	Day	1298	150.00	217.00	**42249900.00**	
Shared Living, Partial Day	Partial Day	0	0.00	0.01	**0.00**	
Small Group Vocational Support Total:						**1381072.00**
Supported Employment - Enclave	Hour	0	0.00	0.01	**0.00**	
Enclave, Agency	Hour	304	413.00	11.00	**1381072.00**	
Supported Employment - Follow Along Total:						**45268.00**
Supported Employment - Follow Along, Agency, Hourly	Hour	62	9.00	43.00	**23994.00**	
Supported Employment - Follow Along, Agency, Quarter Hour	Quarter Hour	74	21.00	10.00	**15540.00**	
Supported Employment - Follow Along, Independent, Quarter Hour	Quarter Hour	3	213.00	6.00	**3834.00**	
Supported Employment - Follow Along, Independent, Hourly	Hour	4	19.00	25.00	**1900.00**	
Supported Family Living Total:						**5529354.00**

GRAND TOTAL:	**188410896.45**
Total Estimated Unduplicated Participants:	**4500**
Factor D (Divide total by number of participants):	**41869.09**
Average Length of Stay on the Waiver:	349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Family Living, Independent, Group	Hour	3	191.00	10.00	5730.00	
Supported Family Living, Agency, 1:1	Hour	586	234.00	26.00	3565224.00	
Supported Family Living, Agency, Group	Hour	34	42.00	15.00	21420.00	
Supported Family Living, Independent, 1:1	Hour	211	459.00	20.00	1936980.00	
Transitional Services Total:						0.00
Transitional Services - Occurrence	Occurrence	0	0.00	0.01	0.00	
Transportation Total:						2363956.00
Transportation, Independent	Mile	36	2397.00	1.00	86292.00	
Transportation, Agency	Mile	872	1306.00	2.00	2277664.00	
Transportation, Other	Occurrence	0	0.00	0.01	0.00	
Vehicle Modifications Total:						100000.00
Vehicle Modifications	Occurrence	10	1.00	10000.00	100000.00	
Youth Continuous Home Total:						0.00
Youth Continuous Home	Day	0	0.00	0.01	0.00	

GRAND TOTAL:	188410896.45
Total Estimated Unduplicated Participants:	4500
Factor D (Divide total by number of participants):	41869.09
Average Length of Stay on the Waiver:	349

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
Continuous Home Total:						**48671442.00**
Continuous, Daily	Day	1161	153.00	274.00	**48671442.00**	
Continuous, Partial Day	Partial Day	0	0.00	0.01	**0.00**	
Prevocational Total:						**485815.70**
Prevocational Services, Agency, Large Group	Hour	13	327.00	17.59	**74775.09**	
Prevocational Services, Agency, Small Group	Hour	25	71.00	9.77	**17341.75**	
Prevocation Services, Independent, 1:1	Hour	8	17.00	43.62	**5932.32**	
Prevocational Services, Agency, 1:1	Hour	149	58.00	44.87	**387766.54**	
Respite Total:						**647442.00**
Respite, Agency, Daily	Day	80	10.00	184.00	**147200.00**	
Respite, Independent, Quarter Hour	Quarter Hour	111	265.00	3.00	**88245.00**	
Respite, Independent, Daily	Day	67	14.00	114.00	**106932.00**	
Respite, Agency, Hourly	Hour	76	43.00	25.00	**81700.00**	
Respite, Agency, Quarter Hour	Quarter Hour	121	157.00	5.00	**94985.00**	
Respite, Independent, Hourly	Hour	131	70.00	14.00	**128380.00**	
Supported Employment - Individual Total:						**4681332.00**
Supported Employment - Individual, Agency	Hour	557	172.00	45.00	**4311180.00**	
Supported Employment - Individual, Independent	Hour	53	291.00	24.00	**370152.00**	
Adult Day Retirement Total:						**4844000.00**
Daily	Day	80	200.00	184.00	**2944000.00**	
Hourly	Hour	76	1000.00	25.00	**1900000.00**	
Adult Day Total:						**583308.00**

GRAND TOTAL:	**217154347.70**
Total Estimated Unduplicated Participants:	**5200**
Factor D (Divide total by number of participants):	**41760.45**
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services	Hour	99	491.00	12.00	583308.00	
Assistive Technology Total:						2437.00
Assistive Technology	Occurrence	1	1.00	2437.00	2437.00	
Behavioral In-Home Habilitation Total:						0.00
Agency, Hourly	Hour	0	0.00	0.01	0.00	
Behavioral In-Home Habilitation	Hour	0	0.00	0.01	0.00	
Benefits Counseling Total:						17948.00
Benefits Counseling	Hour	20	20.00	44.87	17948.00	
Child Day Habilitation Total:						0.00
Child Day Habilitation	Hour	0	0.00	0.01	0.00	
Community Integration Total:						43623405.00
Habilitative Community Inclusion, Agency, Hourly	Hour	2785	455.00	25.00	31679375.00	
Habilitative Community Inclusion, Agency, Daily	Day	1505	41.00	174.00	10736670.00	
Habilitative Community Inclusion, Independent, Hourly	Hour	176	343.00	20.00	1207360.00	
Consultative Assessment Total:						870232.00
Consultative Assessment	Hour	682	11.00	116.00	870232.00	
Day Supports Total:						43660472.00
Habilitative Workshop, Agency, Hourly	Hour	2780	661.00	19.00	34914020.00	
Habilitative Workshop, Agency, Daily	Day	1699	39.00	132.00	8746452.00	
Employment Exploration Total:						17590.00
Employment Exploration	Hour	25	40.00	17.59	17590.00	
Environmental Modification Assessment Total:						14000.00

GRAND TOTAL:	217154347.70
Total Estimated Unduplicated Participants:	5200
Factor D (Divide total by number of participants):	41760.45
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modification Assessment	Occurrence	14	1.00	1000.00	14000.00	
Health Maintenance Monitoring Total:						10112.00
Installation (One-time) Fee	Occurance	3	4.00	32.00	384.00	
On-going Monthly Fee	Month	32	8.00	38.00	9728.00	
Home Modifications Total:						69300.00
Home Modification	Occurrence	21	1.00	3300.00	69300.00	
Homemaker Total:						29049.00
Homemaker, Independent	Hour	13	186.00	12.00	29016.00	
Homemaker, Agency	Hour	1	3.00	11.00	33.00	
Host Home Total:						166320.00
Host Home, Daily	Day	15	63.00	176.00	166320.00	
Host Home, Partial Day	Partial Day	0	0.00	0.01	0.00	
Independent Living Total:						9659474.00
Independent Living, Independent, 1:1	Hour	147	514.00	21.00	1586718.00	
Independent Living, Agency, 1:1	Hour	734	335.00	31.00	7622590.00	
Independent Living, Agency, Small Group	Hour	120	183.00	17.00	373320.00	
Independent Living, Independent, Small Group	Hour	13	50.00	11.00	7150.00	
Independent Living, Agency, Large Group	Hour	24	264.00	11.00	69696.00	
Independent Living, Independent, Large Group	Hour	0	0.00	0.01	0.00	
LRI Personal Care Total:						2624830.00
Agency	Hour	200	520.00	23.17	2409680.00	
Individual	Hour	25	520.00	16.55	215150.00	

GRAND TOTAL:	217154347.70
Total Estimated Unduplicated Participants:	5200
Factor D (Divide total by number of participants):	41760.45
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical In-Home Habilitation Total:						**97416.00**
Agency, Hourly	Hour	22	164.00	27.00	**97416.00**	
Personal Emergency Response System (PERS) Total:						**10112.00**
Installation (One-time) Fee	Occurrence	3	4.00	32.00	**384.00**	
Ongoing Monthly Fee	Month	32	8.00	38.00	**9728.00**	
Remote Supports Total:						**10112.00**
Installation (One-time) Fee	Occurance	3	4.00	32.00	**384.00**	
On-going Monthly Fee	Month	32	8.00	38.00	**9728.00**	
Shared Living Total:						**44002200.00**
Shared Living, Day	Day	1298	150.00	226.00	**44002200.00**	
Shared Living, Partial Day	Partial Day	0	0.00	0.01	**0.00**	
Small Group Vocational Support Total:						**1739556.00**
Supported Employment - Enclave	Hour	0	0.00	0.01	**0.00**	
Enclave, Agency	Hour	351	413.00	12.00	**1739556.00**	
Supported Employment - Follow Along Total:						**55321.00**
Supported Employment - Follow Along, Agency, Hourly	Hour	72	9.00	44.00	**28512.00**	
Supported Employment - Follow Along, Agency, Quarter Hour	Quarter Hour	86	21.00	11.00	**19866.00**	
Supported Employment - Follow Along, Independent, Quarter Hour	Quarter Hour	3	213.00	7.00	**4473.00**	
Supported Employment - Follow Along, Independent, Hourly	Hour	5	19.00	26.00	**2470.00**	
Supported Family Living Total:						**6659502.00**

GRAND TOTAL:	**217154347.70**
Total Estimated Unduplicated Participants:	**5200**
Factor D (Divide total by number of participants):	**41760.45**
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Family Living, Independent, Group	Hour	3	191.00	10.00	5730.00	
Supported Family Living, Agency, 1:1	Hour	677	234.00	27.00	4277286.00	
Supported Family Living, Agency, Group	Hour	39	42.00	15.00	24570.00	
Supported Family Living, Independent, 1:1	Hour	244	459.00	21.00	2351916.00	
Transitional Services Total:						0.00
Transitional Services - Occurrence	Occurrence	0	0.00	0.01	0.00	
Transportation Total:						2733570.00
Transportation, Independent	Mile	42	2397.00	1.00	100674.00	
Transportation, Agency	Mile	1008	1306.00	2.00	2632896.00	
Transportation, Other	Occurrence	0	0.00	0.01	0.00	
Vehicle Modifications Total:						120000.00
Vehicle Modifications	Occurrence	12	1.00	10000.00	120000.00	
Youth Continuous Home Total:						1048050.00
Youth Continuous Home	Day	25	153.00	274.00	1048050.00	

GRAND TOTAL:	217154347.70
Total Estimated Unduplicated Participants:	5200
Factor D (Divide total by number of participants):	41760.45
Average Length of Stay on the Waiver:	313

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
Continuous Home Total:						**49737240.00**
Continuous, Daily	Day	1161	153.00	280.00	**49737240.00**	
Continuous, Partial Day	Partial Day	0	0.00	0.01	**0.00**	
Prevocational Total:						**487683.31**
Prevocational Services, Agency, Large Group	Hour	13	327.00	17.95	**76305.45**	
Prevocational Services, Agency, Small Group	Hour	25	71.00	9.96	**17679.00**	
Prevocation Services, Independent, 1:1	Hour	8	17.00	43.62	**5932.32**	
Prevocational Services, Agency, 1:1	Hour	149	58.00	44.87	**387766.54**	
Respite Total:						**651718.00**
Respite, Agency, Daily	Day	80	10.00	187.00	**149600.00**	
Respite, Independent, Quarter Hour	Quarter Hour	111	265.00	3.00	**88245.00**	
Respite, Independent, Daily	Day	67	14.00	116.00	**108808.00**	
Respite, Agency, Hourly	Hour	76	43.00	25.00	**81700.00**	
Respite, Agency, Quarter Hour	Quarter Hour	121	157.00	5.00	**94985.00**	
Respite, Independent, Hourly	Hour	131	70.00	14.00	**128380.00**	
Supported Employment - Individual Total:						**4792559.00**
Supported Employment - Individual, Agency	Hour	557	172.00	46.00	**4406984.00**	
Supported Employment - Individual, Independent	Hour	53	291.00	25.00	**385575.00**	
Adult Day Retirement Total:						**4844000.00**
Daily	Day	80	200.00	184.00	**2944000.00**	
Hourly	Hour	76	1000.00	25.00	**1900000.00**	
Adult Day Total:						**583308.00**

GRAND TOTAL:	**221903800.31**
Total Estimated Unduplicated Participants:	**5200**
Factor D (Divide total by number of participants):	**42673.81**
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services	Hour	99	491.00	12.00	583308.00	
Assistive Technology Total:						2486.00
Assistive Technology	Occurrence	1	1.00	2486.00	2486.00	
Behavioral In-Home Habilitation Total:						0.00
Agency, Hourly	Hour	0	0.00	0.01	0.00	
Behavioral In-Home Habilitation	Hour	0	0.00	0.01	0.00	
Benefits Counseling Total:						18308.00
Benefits Counseling	Hour	20	20.00	45.77	18308.00	
Child Day Habilitation Total:						0.00
Child Day Habilitation	Hour	0	0.00	0.01	0.00	
Community Integration Total:						43930593.00
Habilitative Community Inclusion, Agency, Hourly	Hour	2785	455.00	25.00	31679375.00	
Habilitative Community Inclusion, Agency, Daily	Daily	1505	41.00	178.00	10983490.00	
Habilitative Community Inclusion, Independent, Hourly	Hour	176	343.00	21.00	1267728.00	
Consultative Assessment Total:						892738.00
Consultative Assessment	Hour	682	11.00	119.00	892738.00	
Day Supports Total:						45630574.00
Habilitative Workshop, Agency, Hourly	Hour	2780	661.00	20.00	36751600.00	
Habilitative Workshop, Agency, Daily	Day	1699	39.00	134.00	8878974.00	
Employment Exploration Total:						17940.00
Employment Exploration	Hour	25	40.00	17.94	17940.00	
Environmental Modification Assessment Total:						14000.00

GRAND TOTAL:	221903800.31
Total Estimated Unduplicated Participants:	5200
Factor D (Divide total by number of participants):	42673.81
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modification Assessment	Occurrence	14	1.00	1000.00	14000.00	
Health Maintenance Monitoring Total:						10380.00
Installation (One-time) Fee	Occurrence	3	4.00	33.00	396.00	
On-going Monthly Fee	Month	32	8.00	39.00	9984.00	
Home Modifications Total:						69300.00
Home Modification	Occurrence	21	1.00	3300.00	69300.00	
Homemaker Total:						29052.00
Homemaker, Independent	Hour	13	186.00	12.00	29016.00	
Homemaker, Agency	Hour	1	3.00	12.00	36.00	
Host Home Total:						170100.00
Host Home, Daily	Day	15	63.00	180.00	170100.00	
Host Home, Partial Day	Partial Day	0	0.00	0.01	0.00	
Independent Living Total:						9905364.00
Independent Living, Independent, 1:1	Hour	147	514.00	21.00	1586718.00	
Independent Living, Agency, 1:1	Hour	734	335.00	32.00	7868480.00	
Independent Living, Agency, Small Group	Hour	120	183.00	17.00	373320.00	
Independent Living, Independent, Small Group	Hour	13	50.00	11.00	7150.00	
Independent Living, Agency, Large Group	Hour	24	264.00	11.00	69696.00	
Independent Living, Independent, Large Group	Hour	0	0.00	0.01	0.00	
LRI Personal Care Total:						2676960.00
Agency	Hour	200	520.00	23.63	2457520.00	
Individual	Hour	25	520.00	16.88	219440.00	

GRAND TOTAL:	221903800.31
Total Estimated Unduplicated Participants:	5200
Factor D (Divide total by number of participants):	42673.81
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical In-Home Habilitation Total:						**97416.00**
Agency, Hourly	Hour	22	164.00	27.00	**97416.00**	
Personal Emergency Response System (PERS) Total:						**10380.00**
Installation (One-time) Fee	Occurrence	3	4.00	33.00	**396.00**	
Ongoing Monthly Fee	Month	32	8.00	39.00	**9984.00**	
Remote Supports Total:						**10380.00**
Installation (One-time) Fee	Occurrence	3	4.00	33.00	**396.00**	
On-going Monthly Fee	Month	32	8.00	39.00	**9984.00**	
Shared Living Total:						**44781000.00**
Shared Living, Day	Day	1298	150.00	230.00	**44781000.00**	
Shared Living, Partial Day	Partial Day	0	0.00	0.01	**0.00**	
Small Group Vocational Support Total:						**1739556.00**
Supported Employment - Enclave	Hour	0	0.00	0.01	**0.00**	
Enclave, Agency	Hour	351	413.00	12.00	**1739556.00**	
Supported Employment - Follow Along Total:						**56064.00**
Supported Employment - Follow Along, Agency, Hourly	Hour	72	9.00	45.00	**29160.00**	
Supported Employment - Follow Along, Agency, Quarter Hour	Quarter Hour	86	21.00	11.00	**19866.00**	
Supported Employment - Follow Along, Independent, Quarter Hour	Quarter Hour	3	213.00	7.00	**4473.00**	
Supported Employment - Follow Along, Independent, Hourly	Hour	5	19.00	27.00	**2565.00**	
Supported Family Living Total:						**6820131.00**

GRAND TOTAL:	**221903800.31**
Total Estimated Unduplicated Participants:	**5200**
Factor D (Divide total by number of participants):	**42673.81**
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Family Living, Independent, Group	Hour	3	191.00	11.00	6303.00	
Supported Family Living, Agency, 1:1	Hour	677	234.00	28.00	4435704.00	
Supported Family Living, Agency, Group	Hour	39	42.00	16.00	26208.00	
Supported Family Living, Independent, 1:1	Hour	244	459.00	21.00	2351916.00	
Transitional Services Total:						0.00
Transitional Services - Occurrence	Occurrence	0	0.00	0.01	0.00	
Transportation Total:						2733570.00
Transportation, Independent	Mile	42	2397.00	1.00	100674.00	
Transportation, Agency	Mile	1008	1306.00	2.00	2632896.00	
Transportation, Other	Occurrence	0	0.00	0.01	0.00	
Vehicle Modifications Total:						120000.00
Vehicle Modifications	Occurrence	12	1.00	10000.00	120000.00	
Youth Continuous Home Total:						1071000.00
Youth Continuous Home	Day	25	153.00	280.00	1071000.00	

GRAND TOTAL:	221903800.31
Total Estimated Unduplicated Participants:	5200
Factor D (Divide total by number of participants):	42673.81
Average Length of Stay on the Waiver:	313

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
Continuous Home Total:						**58517910.00**
Continuous, Daily	Day	1342	153.00	285.00	**58517910.00**	
Continuous, Partial Day	Partial Day	0	0.00	0.01	**0.00**	
Prevocational Total:						**497422.28**
Prevocational Services, Agency, Large Group	Hour	13	327.00	18.30	**77793.30**	
Prevocational Services, Agency, Small Group	Hour	25	71.00	10.16	**18034.00**	
Prevocation Services, Independent, 1:1	Hour	8	17.00	44.49	**6050.64**	
Prevocational Services, Agency, 1:1	Hour	149	58.00	45.77	**395544.34**	
Respite Total:						**660062.00**
Respite, Agency, Daily	Day	80	10.00	191.00	**152800.00**	
Respite, Independent, Quarter Hour	Quarter Hour	111	265.00	3.00	**88245.00**	
Respite, Independent, Daily	Day	67	14.00	118.00	**110684.00**	
Respite, Agency, Hourly	Hour	76	43.00	26.00	**84968.00**	
Respite, Agency, Quarter Hour	Quarter Hour	121	157.00	5.00	**94985.00**	
Respite, Independent, Hourly	Hour	131	70.00	14.00	**128380.00**	
Supported Employment - Individual Total:						**4888363.00**
Supported Employment - Individual, Agency	Hour	557	172.00	47.00	**4502788.00**	
Supported Employment - Individual, Independent	Hour	53	291.00	25.00	**385575.00**	
Adult Day Retirement Total:						**4882000.00**
Daily	Day	80	200.00	184.00	**2944000.00**	
Hourly	Hour	76	1000.00	25.50	**1938000.00**	
Adult Day Total:						**583308.00**

GRAND TOTAL:	**241052767.28**
Total Estimated Unduplicated Participants:	**5200**
Factor D (Divide total by number of participants):	**46356.30**
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services	Hour	99	491.00	12.00	583308.00	
Assistive Technology Total:						2535.00
Assistive Technology	Occurrence	1	1.00	2535.00	2535.00	
Behavioral In-Home Habilitation Total:						0.00
Agency, Hourly	Hour	0	0.00	0.01	0.00	
Behavioral In-Home Habilitation	Hour	0	0.00	0.01	0.00	
Benefits Counseling Total:						18676.00
Benefits Counseling	Hour	20	20.00	46.69	18676.00	
Child Day Habilitation Total:						0.00
Child Day Habilitation	Hour	0	0.00	0.01	0.00	
Community Integration Total:						45382883.00
Habilitative Community Inclusion, Agency, Hourly	Hour	2785	455.00	26.00	32946550.00	
Habilitative Community Inclusion, Agency, Daily	Day	1505	41.00	181.00	11168605.00	
Habilitative Community Inclusion, Independent, Hourly	Hour	176	343.00	21.00	1267728.00	
Consultative Assessment Total:						907742.00
Consultative Assessment	Hour	682	11.00	121.00	907742.00	
Day Supports Total:						45829357.00
Habilitative Workshop, Agency, Hourly	Hour	2780	661.00	20.00	36751600.00	
Habilitative Workshop, Agency, Daily	Day	1699	39.00	137.00	9077757.00	
Employment Exploration Total:						18300.00
Employment Exploration	Hour	25	40.00	18.30	18300.00	
Environmental Modification Assessment Total:						14000.00

GRAND TOTAL:	241052767.28
Total Estimated Unduplicated Participants:	5200
Factor D (Divide total by number of participants):	46356.30
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modification Assessment	Occurrence	14	1.00	1000.00	14000.00	
Health Maintenance Monitoring Total:						10648.00
Installation (One-time) Fee	Occurrence	3	4.00	34.00	408.00	
On-going Monthly Fee	Month	32	8.00	40.00	10240.00	
Home Modifications Total:						69300.00
Home Modification	Occurrence	21	1.00	3300.00	69300.00	
Homemaker Total:						29052.00
Homemaker, Independent	Hour	13	186.00	12.00	29016.00	
Homemaker, Agency	Hour	1	3.00	12.00	36.00	
Host Home Total:						195993.00
Host Home, Daily	Day	17	63.00	183.00	195993.00	
Host Home, Partial Day	Partial Day	0	0.00	0.01	0.00	
Independent Living Total:						9987258.00
Independent Living, Independent, 1:1	Hour	147	514.00	22.00	1662276.00	
Independent Living, Agency, 1:1	Hour	734	335.00	32.00	7868480.00	
Independent Living, Agency, Small Group	Hour	120	183.00	17.00	373320.00	
Independent Living, Independent, Small Group	Hour	13	50.00	11.00	7150.00	
Independent Living, Agency, Large Group	Hour	24	264.00	12.00	76032.00	
Independent Living, Independent, Large Group	Hour	0	0.00	0.01	0.00	
LRI Personal Care Total:						2730130.00
Agency	Hour	200	520.00	24.10	2506400.00	
Individual	Hour	25	520.00	17.21	223730.00	

GRAND TOTAL:	241052767.28
Total Estimated Unduplicated Participants:	5200
Factor D (Divide total by number of participants):	46356.30
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medical In-Home Habilitation Total:						**101024.00**
Agency, Hourly	Hour	22	164.00	28.00	**101024.00**	
Personal Emergency Response System (PERS) Total:						**10648.00**
Installation (One-time) Fee	Occurrence	3	4.00	34.00	**408.00**	
Ongoing Monthly Fee	Month	32	8.00	40.00	**10240.00**	
Remote Supports Total:						**10648.00**
Installation (One-time) Fee	Occurrence	3	4.00	34.00	**408.00**	
On-going Monthly Fee	Month	32	8.00	40.00	**10240.00**	
Shared Living Total:						**52875000.00**
Shared Living, Day	Day	1500	150.00	235.00	**52875000.00**	
Shared Living, Partial Day	Partial Day	0	0.00	0.01	**0.00**	
Small Group Vocational Support Total:						**1739556.00**
Supported Employment - Enclave	Hour	0	0.00	0.01	**0.00**	
Enclave, Agency	Hour	351	413.00	12.00	**1739556.00**	
Supported Employment - Follow Along Total:						**56712.00**
Supported Employment - Follow Along, Agency, Hourly	Hour	72	9.00	46.00	**29808.00**	
Supported Employment - Follow Along, Agency, Quarter Hour	Quarter Hour	86	21.00	11.00	**19866.00**	
Supported Employment - Follow Along, Independent, Quarter Hour	Quarter Hour	3	213.00	7.00	**4473.00**	
Supported Employment - Follow Along, Independent, Hourly	Hour	5	19.00	27.00	**2565.00**	
Supported Family Living Total:						**7090545.00**

GRAND TOTAL:	**241052767.28**
Total Estimated Unduplicated Participants:	**5200**
Factor D (Divide total by number of participants):	**46356.30**
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Family Living, Independent, Group	Hour	3	191.00	11.00	6303.00	
Supported Family Living, Agency, 1:1	Hour	677	234.00	29.00	4594122.00	
Supported Family Living, Agency, Group	Hour	39	42.00	16.00	26208.00	
Supported Family Living, Independent, 1:1	Hour	244	459.00	22.00	2463912.00	
Transitional Services Total:						0.00
Transitional Services - Occurrence	Occurrence	0	0.00	0.01	0.00	
Transportation Total:						2733570.00
Transportation, Independent	Mile	42	2397.00	1.00	100674.00	
Transportation, Agency	Mile	1008	1306.00	2.00	2632896.00	
Transportation, Other	Occurrence	0	0.00	0.01	0.00	
Vehicle Modifications Total:						120000.00
Vehicle Modifications	Occurrence	12	1.00	10000.00	120000.00	
Youth Continuous Home Total:						1090125.00
Youth Continuous Home	Day	25	153.00	285.00	1090125.00	

GRAND TOTAL:	241052767.28
Total Estimated Unduplicated Participants:	5200
Factor D (Divide total by number of participants):	46356.30
Average Length of Stay on the Waiver:	313