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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

Restricting access to Functional Behavior Assessments (FBAs) by relying on Managed Care Organizations as the primary pathway is unrealistic and unsafe. Although FBAs may technically be billable through MCOs, restrictive credentialing requirements and multi-year waitlists make this option inaccessible for many individuals who need immediate behavioral support.

When FBAs and behavior supports are delayed or denied, behavior escalates. This results in more injuries, crisis calls, hospitalizations, staff turnover, placement failures, and emergency interventions, all of which cost significantly more than preventative behavioral services. Limiting FBAs does not reduce spending; it shifts costs into crisis systems and puts individuals at risk. This approach is not sustainable and should be reconsidered. You are compromising the health of a very vulnerable population who needs support and advocacy. This is very sad and I urge to to reflect on the message are you sending.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

Tyra

Last Name

Kelce

City & State

Omaha, NE

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 10, 2026

Subject: Public Comment – Preserve CDD Comprehensive Waiver Funding

To Nebraska DHHS Leadership,

I respectfully submit this public comment urging the department not to reduce funding or services under the CDD Comprehensive Waiver.

This waiver supports individuals with complex medical and behavioral needs. It ensures proper staffing, supervision, health monitoring, and daily living assistance. Without adequate funding, families will face unsafe gaps in care.

For many individuals, including my loved one, overnight supervision and consistent staffing are medically and behaviorally necessary. Funding reductions would not decrease needs — they would only shift the burden onto exhausted families and emergency systems.

The Comprehensive Waiver prevents institutional placement. It prevents crisis stabilization admissions. It prevents hospitalizations. It keeps people stable in their communities.

Please do not weaken a system that is already carefully structured around medical necessity and individualized assessments.

Nebraska can be fiscally responsible without compromising safety.

Respectfully submitted,
Cody Kampschneider

[redacted]
horn, NE 68022

OMAHA NE 680
26 FEB 2026 PM 2 L

DDD Public Comments
PO Box 98947
301 Centennial Mall
South; Lincoln, NE 68509

68508-252901

Public Comment Opposing the Discontinuation of Consultative Assessment Services and the Proposed Transition Process Nebraska Department of Health and Human Services – Division of Developmental Disabilities

February 26, 2026

Thank you for the opportunity to provide public comment on the proposed elimination of Consultative Assessment (CA) Services and the associated Transition Process within the Nebraska Department of Health and Human Services Division of Developmental Disabilities (DDD). I strongly oppose both the discontinuation of CONSULTATIVE ASSESSMENT and the proposed transition plan, as together they would undermine clinical quality, safety, and the continuity of care for Nebraskans with intellectual and Developmental Disabilities (IDD).

I. Opposition to Eliminating Consultative Assessment (CA) Services

1. Eliminating CONSULTATIVE ASSESSMENT Conflicts with Eligibility Requirements and Whole-Person Care

To qualify for Developmental Disabilities (DD) services in Nebraska, individuals must have a DSM-V / ICD-10 diagnosis. Intellectual and developmental disabilities—including mild, moderate, and severe intellectual disabilities and autism—are classified under F-codes and frequently co-occur with additional mental health conditions such as impulse control disorders, anxiety, depression, bipolar disorder, schizophrenia, or PTSD. These conditions often manifest as self-harm, aggression, property destruction, or other high-risk behaviors. Given that mental health diagnoses are inherent to eligibility, removing the clinical supports designed to assess and respond to these needs is negligent and clinically unsound. Without CA, agencies would be expected to manage complex mental health and behavioral needs without the oversight and intervention that keep participants and caregivers safe.

2. DHHS Manual Requirements Cannot Be Upheld Without CA

Multiple components of the DHHS Manual (e.g., Section 1.10 A, B1, B2, B4, B5, B6) presume the presence of clinical services to realize person-centered, whole-person care. If CONSULTATIVE ASSESSMENT is removed, those mandates become neither enforceable nor achievable; providers cannot credibly offer person-centered care while the division removes the very clinical infrastructure required to meet mental health and behavioral needs.

3. Community Mental Health Providers Are Not Equipped at Scale for DD Populations

There is a longstanding shortage of outpatient mental health providers trained to serve individuals with Intellectual and Developmental Disabilities. Agencies have relied on in-house clinicians through Consultative Assessment, to provide immediate behavioral intervention, coping-skills training, risk assessment, crisis mitigation, and staff coaching.

Without CA, individuals will face waitlists, access barriers, and a scarcity of providers capable of addressing complex cognitive, behavioral, and communication needs, creating a statewide access-to-care crisis. As noted by the Division during this Public Comment Period the largest managed care organization is not actively accepting new clinicians to provide services identified in the transition plan. Not only are managed care organizations not equipped to facilitate such a transition, accessibility to Functional Behavior Assessments will be impossible due to licensing restrictions and endorsements, making this transition plan completely inadequate to support our state's most vulnerable population.

4. Assigning Clinical Tasks to Non-Clinical Staff is Unsafe and Unprofessional

Expecting Direct Support Professionals or any unlicensed staff to complete Safety Plans, Functional Behavioral Assessments (FBAs), or Behavior Support Plans (BSPs) ***undermines standards of care and scope-of-practice safeguards. The depth of training and clinical judgment required for these activities cannot be reassigned to non-licensed staff without jeopardizing client safety.***

5. Nebraska Medicaid Requirements Contradict the Proposed Change

Nebraska Medicaid requires that FBAs be completed by licensed clinicians (e.g., licensed psychologists; Licensed Independent Mental Health Practitioners (LIMHPs)—often with Board Certified Behavior Analyst (BCBA) credentials—or doctoral/masters-level BCBAs under supervision). These guidelines further require assessment in the natural environment, consideration of situational variables and caregiver practices, and clinically informed development of Behavior Intervention Plans (BIPs). Nebraska already has very few LIMHPs with BCBA credentials, creating a capacity gap that CONSULTATIVE ASSESSMENT currently helps mitigate. Eliminating CONSULTATIVE ASSESSMENT would leave the state unable to meet its own standards for FBA completion and clinical plan development.

6. No Data-Driven Rationale Presented for Reversing Clinical Requirements

DHHS previously established licensure requirements for FBA/BSP processes based on evidence of necessity. The proposal now suggests these responsibilities can be assumed by any agency staff. There is zero fidelity, quality, or outcomes data supporting this reversal. A policy change of this magnitude must be justified by rigorous evidence—not convenience nor statewide budget reduction initiatives at the expense of a vulnerable population.

7. The Proposal Breaks the Required Link Between FBA and BSP

DHHS guidance states the FBA is the basis of the BSP and that a BSP is required when risky behaviors or restrictive interventions are present, with CONSULTATIVE ASSESSMENT historically providing BSP development, implementation, and staff training. Under the proposed changes, only "Risk" level clients would receive an FBA. Many others (Intermediate/High/Advanced) would not have access to the same level of care, and therefore not receive data driven, functionally based assessments due having unqualified

and unlicensed staff assuming this responsibility. The consequences of this approach will result in an increase in the need for exception requests due to inadequate behavioral intervention and oversight.

II. Opposition to the Proposed Transition Process

The Transition Process proposes discontinuing CONSULTATIVE ASSESSMENT effective July 1, 2026, and shifting to internally created BSPs supported by training, resources, and optional consultation with the Clinical State Team (CST). While the language emphasizes person-centered, data-driven, and outcome-oriented plans, the process lacks the infrastructure and workforce capacity to achieve these aims.

1. Timeline and Workforce Readiness Are Unrealistic

It is unrealistic to expect agencies within the proposed timeframe to build internal capacity to produce clinically sound BSPs. Many agencies face high turnover and already manage heavy administrative burdens and this plan does not specify the nature, depth, duration, or verification of the 'expanded training and resources' that are supposed to replace ongoing clinical services.

2. Reliance on 'Existing Evaluation Tools' and 'Clinical Judgment' Is Misplaced

The transition language encourages integrating risk, strengths, and needs assessments using 'existing evaluation tools or clinical judgment.' Many providers do not have validated tools or standardized frameworks, and ***'clinical judgment' cannot be delegated to non-clinicians***. Eliminating CONSULTATIVE ASSESSMENT removes the very professionals who have supplied this judgment for years.

3. No Mechanism Ensures Person-Centered, Data-Driven, Outcome-Oriented Plans

The plan sets aspirational requirements without providing standardized training, fidelity checks, clinical oversight, quality metrics, monitoring, or enforcement mechanisms. Requirements without infrastructure do not constitute accountability and will not yield consistent, safe practice as this plan no longer provides funding for this level of support and oversight.

4. Habilitative Supports Cannot Replace Clinical Assessment

Coordinating with other habilitative supports is valuable but not a substitute for clinical assessment and treatment planning. Habilitative services are not licensed to assess or diagnose mental-health-driven behaviors and cannot implement evidence-based interventions without clinical direction.

5. The Clinical State Team (CST) Cannot Absorb the Loss of CA

CST provides consultation and guidance but does not deliver ongoing, direct clinical services at the scale required to replace CA. Consultation cannot substitute for routine

assessment, BSP development, crisis mitigation, or iterative treatment planning across the entire system. Not only is band-with an issue, but the Clinical State Team has no understanding of the whole person in the environment which they receive supports, nor are they directly accessible in any form of crisis or behavior in the moment. The removal of agency capacity to fund a clinician will place unsurmountable burden on the CST.

6. High-Risk Individuals Will Lose Critical Clinical Oversight

Individuals with aggression, self-injury, property destruction, sexually inappropriate behavior, elopement, and co-occurring mental health conditions require continuous clinical oversight. Training alone and provider-created plans without licensed clinical involvement are insufficient to ensure safety and effective intervention.

Lack of adequate funding will drive an increase in termination of services for individuals displaying maladaptive behaviors, resulting in vulnerable individuals moving from agency to agency due to lack of financial resources and clinical support.

7. The Transition Plan Risks Non-Compliance with Medicaid Standards

Nebraska Medicaid standards require licensed professionals for FBAs and clinically informed plan components. The transition plan does not explain how compliance will be maintained, how licensed capacity will be ensured, or how enforcement will occur—exposing the state and providers to regulatory and liability risks.

III. Recommendations

• Withdraw the proposed elimination of CONSULTATIVE ASSESSMENT Services and engage stakeholders (providers, families, clinicians, and individuals served) in a formal workgroup to co-develop any future changes.

• If changes are pursued, adopt a phased approach with clearly defined milestones, statewide training curricula, supervised practice, and fidelity monitoring by licensed clinicians.

• Invest in workforce development: incentives for LIMHPs, psychologists, and BCBAs to specialize in IDD; loan repayment; clinical internships and supervision pipelines within DD agencies.

• Codify minimum clinical standards for FBA/BSP (qualifications, assessment settings, required data elements, team participation) and require documented clinical oversight.

• Maintain access to CONSULTATIVE ASSESSMENT or an equivalent reimbursable clinical service that provides on-site assessment, plan development, staff training, crisis mitigation, and ongoing review.

IV. Conclusion

The proposed elimination of CONSULTATIVE ASSESSMENT Services and the accompanying transition plan are misaligned with Medicaid rules, DHHS guidance, clinical best practices, and the needs of the IDD population. Proceeding would reduce access to clinically appropriate care, increase risk for individuals and staff, create compliance challenges, and erode person-centered, whole-person care. I respectfully urge DHHS to withdraw the proposal and instead strengthen access to qualified clinical professionals within DD services.

Respectfully submitted,

William Ehegartner
CEO, 360 Community Services

Public Comment Regarding Proposed Changes to BSP and FBA Requirements

Dear Leadership Team,

I am submitting this public comment to express significant concerns regarding Nebraska DHHS's proposed changes effective 7/1/2026 related to Behavior Support Plans (BSPs) and Functional Behavior Assessments (FBAs).

As outlined, DHHS plans to discontinue Consultative Assessment services, remove the requirement that BSPs be developed or reviewed by a licensed clinician such as a BCBA, and eliminate the requirement that BSPs be functionally linked to an FBA. Under the proposed framework, an FBA would only be completed if the service planning team— which may not include any qualified clinician—determines that one is "necessary."

While I understand the goal of increasing provider access and flexibility, these changes raise serious concerns related to ethical practice, clinical effectiveness, and participant safety. BSPs are inherently assessment-based interventions. Decoupling BSP development from required functional assessment and licensed clinical oversight significantly weakens safeguards that ensure plans are data-driven, functionally accurate, and responsive to changes in behavior, health, environment, or support needs.

From an Applied Behavior Analysis perspective, and consistent with widely accepted professional ethics and best practices, effective behavior support requires accurate identification of behavioral function, functionally equivalent replacement skills, and ongoing evaluation by individuals with appropriate training. Allowing BSPs to be developed without required assessment or qualified clinical judgment increases the risk of ineffective interventions, escalation of challenging behavior, and unnecessary or overly restrictive safety strategies.

Additionally, reliance on undefined "clinical judgment" by teams that may not include trained clinicians introduces ambiguity, reduces accountability, and creates variability in plan quality across providers. This places both participants and providers at increased risk.

I respectfully urge DHHS to reconsider these changes and retain requirements for qualified clinician involvement and functional assessment when BSPs are developed or revised. Preserving these safeguards is critical to ensuring person-centered, ethical, and effective behavioral supports within the HCBS system.

Thank you for the opportunity to provide public comment and for considering these concerns.

Respectfully,
Matt Dennis, BCBA

From: [redacted]
To: DHHS HCBS Public Comments
Subject: §1915(c) HCBS Waiver Amendment
Date: Tuesday, February 24, 2026 7:32:33 PM

I respectfully submit this comment for CMS review of Nebraska's proposed §1915(c) HCBS waiver amendment. I am raising a formal objection to the proposed removal of Consultative Assessment Services (CAS) based on concerns related to participant health and welfare, access to medically necessary services, and internal inconsistency with prior DHHS determinations regarding the necessity of CAS.

The assertion that CAS is duplicative of services available through Managed Care Organizations (MCOs) is not supported by evidence and is inconsistent with DHHS's own waiver documentation and service definitions.

Mischaracterization of CAS as "Duplicative"
Nebraska DHHS has stated that Consultative Assessment Services are duplicative because Functional Behavior Assessments (FBAs) are available through MCOs and updated Behavior Support Plan (BSP) requirements. This characterization is inaccurate.

In the **DDD Waivers Service Summary issued in July 2025**, DHHS explicitly stated: **"Consultative Assessment is necessary to improve the participant's independence and inclusion in their community."**

This statement reflects DHHS's formal determination, made less than a year ago, that CAS is a necessary waiver service with a distinct role in supporting participant outcomes. A service identified as *necessary* to improve independence and community inclusion cannot simultaneously be deemed duplicative without new clinical evidence demonstrating that its full function is replicated, accessible, and operationally equivalent elsewhere. No such evidence has been presented.

CAS was not a one-time assessment service. It functioned as a waiver-integrated, consultative model that translated behavioral assessment into real-world implementation through ongoing observation, coaching, and system coordination across home, day, and community settings. These functions are not replicated by MCO-based ABA assessments or BSP documentation requirements.

Side-by-Side: DHHS Statements vs. Proposed Amendment

DHHS Prior Position (July 2025)	Current Amendment Claim
CAS is **necessary** to improve independence and community inclusion	CAS is **duplicative**
CAS supports **real-world implementation**across waiver settings	FBAs are limited to **clinical or eligibility-based models**
CAS provides **ongoing consultative support**	Assessment becomes **episodic or documentation-driven**
CAS supports **adults regardless of ABA**	Access depends on **MCO networks and ABA**

eligibility	criteria
CAS prevents escalation and placement disruption	Replacement model is **reactive and risk-tier dependent**

Failure to Meet CMS Equivalency Standards
A service may only be considered duplicative if its removal preserves:

- **Equivalent access**
- **Equivalent scope**
- **Equivalent timeliness**
- **Equivalent outcomes**

The proposed replacement fails on all four criteria.

MCO-based FBAs are constrained by credentialing requirements, network availability, age limitations, and waitlists. Updated BSP requirements do not provide assessment, consultation, staff training, or implementation support. A service that exists in theory but is inaccessible in practice is not an equivalent replacement under CMS standards.

CMS Waiver Assurance Concerns
Appendix C – Participant Safeguards / Health & Welfare
Under Appendix C assurances, the state must ensure that participants are protected from harm and that risks are proactively addressed. CAS functioned as the waiver's primary prevention mechanism for behavioral escalation. Removing this service increases foreseeable risk of:

- Behavioral crises
- Emergency intervention
- Law enforcement involvement
- Placement disruption

Appendix G – Service Delivery & Access
Appendix G requires states to demonstrate that services are sufficient in amount, duration, and scope to meet assessed needs. The proposed amendment removes the only waiver-based behavioral consultative service without demonstrating:

- Network adequacy
- Timely access standards
- Continuity of care
- Coverage for adults not eligible for ABA

This constitutes a reduction in service capacity rather than an administrative substitution.

Cost and System Impact
Consultative Assessment Services are cost-avoidant. The cost of proactive behavioral consultation is significantly lower than the downstream costs of:

- Emergency room visits and psychiatric hospitalization
- Crisis services and emergency staffing
- Law enforcement involvement
- High-cost residential placements
- Incident investigations, staff injuries, and retraining

Eliminating CAS does not eliminate the need for behavioral support. It shifts costs to more expensive, reactive systems and undermines long-term stability.

Formal Request to CMS

Until Nebraska DHHS demonstrates, through data, enforceable access standards, and operational safeguards, that participants will retain timely, equivalent access to the full scope of consultative behavioral supports previously provided by CAS, this amendment should not be approved.

Approval under current conditions would be inconsistent with CMS requirements related to:

- Health and welfare protections
- Service sufficiency and access
- HCBS principles of prevention and least restrictive support

Closing

A service that DHHS previously identified as **necessary to improve independence and community inclusion** cannot be reclassified as **duplicative** without evidence that its full function, accessibility, and outcomes are preserved. Removing CAS without an equivalent replacement places participants, providers, and caregivers at increased risk and conflicts with the core purpose of the §1915(c) waiver.

I respectfully urge CMS to require corrective action or deny approval of this amendment as written.

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Comment

I am writing to formally oppose the proposed removal of Consultative Assessment Services, commonly referred to as Functional Behavior Assessments (FBAs), from Nebraska's §1915(c) Home and Community-Based Services (HCBS) waivers and to raise serious concerns about the lack of transparency surrounding this decision.

Governor Pillen and DHHS leadership have publicly stated that Consultative Assessment Services, including Functional Behavior Assessments (FBAs), are duplicative and already available through Managed Care Organization (MCO)–based Applied Behavior Analysis (ABA) benefits. This statement is misleading. In practice, FBAs are not operationally accessible through MCOs for adult DD waiver participants. Licensed independent clinicians consistently report they cannot bill MCOs for FBAs, and DHHS has provided no written guidance, billing codes, or documentation to support this claim.

Stakeholders have repeatedly requested clarification and proof of an operational MCO billing pathway for FBAs. These requests have gone unanswered. If this pathway truly exists, DHHS should be able to clearly document it. The absence of written guidance strongly suggests it does not function in practice.

FBAs are preventative services that reduce crises, hospitalizations, law enforcement involvement, and placement disruptions. Removing them does not eliminate need; it shifts responsibility to more expensive and less effective crisis systems.

Claiming FBAs remain available while eliminating the only functional funding mechanism constitutes misrepresentation. The proposed removal of Consultative Assessment Services should be withdrawn. At minimum, DHHS must publicly demonstrate in writing how FBAs can be timely accessed and reimbursed through MCOs for adult DD waiver participants before eliminating the waiver service.

Lives, safety, and long-term costs are at stake. This decision warrants immediate reconsideration.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

Andrea

Last Name

Witte

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 24, 2026

Hands of Heartland, LLC
209 Galvin Rd N
Bellevue, NE 68005

February 18, 2026

Nebraska Department of Health and Human Services
Division of Developmental Disabilities
DDD Public Comments
PO BOX 98947
301 Centennial Mall South
Lincoln, NE 68509

Re: Public Comment – Proposed Amendments to CDD (NE.4154) and DDAD (NE.0394) Waivers

Dear Director and Division Leadership:

On behalf of Hands of Heartland, I am submitting formal comments regarding the proposed amendments to the Comprehensive Developmental Disabilities (CDD) Waiver (NE.4154) and the Developmental Disabilities Adult Day (DDAD) Waiver (NE.0394), specifically the removal of the Functional Behavior Assessment (FBA) requirement conducted by a licensed professional.

HOH has invested more than $1 million over the past several years to build and strengthen behavioral support services across our organization. This investment reflects our commitment to ensuring individuals receive clinically sound, person-centered, and least restrictive behavioral interventions. The proposed removal of the FBA requirement significantly undermines these efforts and presents serious risks to individuals served, providers, and the broader HCBS system.

A Functional Behavior Assessment is the guiding and foundational component in the development of a Behavior Support Plan (BSP). Without a licensed professional conducting a systematic functional analysis, it is not possible to reliably identify antecedents, behavioral functions, maintaining variables, or underlying skill deficits. In the absence of this clinical process, interventions become assumption-based rather than data-driven, increasing the likelihood of ineffective supports, escalation of behaviors, and service instability.

We are particularly concerned about the following:

- High probability that FBAs will not be completed if they are no longer required by DHHS.
- Funding for FBAs will not be guaranteed, and authorization through Managed Care

Hands of Heartland

Organizations (MCOs) will likely result in denials or delays. Transitioning approval authority from the state to MCOs significantly increases the risk that necessary FBAs will not be authorized.
• Diminished quality of BSPs developed without an FBA or prepared by untrained, unlicensed professionals.
• The proposed analysis tool (FAST), referenced during the public comment meeting, is opinion-based and does not replace a formal functional assessment conducted by a licensed clinician.
• No clear plan for training, clinical oversight, or ongoing support from the state clinical team for unlicensed staff expected to prepare BSPs after June 30, 2026.
• Lack of clinical oversight to evaluate progress and determine whether behavior interventions are effective or require modification.

An essential component of the FBA process is the development of a fading plan to ensure individuals are maintained on the least restrictive measures possible. Without proper clinical assessment and oversight, there is significant risk of excessive restrictions and potential rights violations. Removing the FBA requirement does not adequately consider participant safety, dignity, or long-term outcomes.

The likely consequences of eliminating access to FBAs include:

• Increased behavioral hospitalizations and emergency room visits.
• Increased staff injuries and turnover due to inadequate training and support.
• Decreased staff skill development, as licensed clinicians will no longer provide structured training based on FBA findings.
• Lack of structured guidance for safety plans, which are developed through the FBA process.
• BSPs becoming generic rather than individualized and person-centered.
• Providers being less inclined to pursue FBAs for individuals classified as non-risk level, even when clinically indicated.
• Potential negative impact to inteRAI assessments due to the absence of FBA documentation for assessors, resulting in miscalculation of needs, service levels, and funding.
• Increased notices served to individuals when providers are unable to safely support them, leading to displacement.
• Elevated risk of post-institutional participants failing in community placements due to poorly developed BSPs.
• Increased administrative burden for providers with licensed clinicians who must apply for approval with multiple MCOs, particularly where provider panels are full or closed.

Eliminating access to FBAs removes a critical, proactive, and cost-effective tool. FBAs support preventative planning and reduce the need for costly crisis interventions, hospitalization, and placement changes. Allowing providers to continue utilizing qualified consulting services for FBAs protects service quality, participant safety, and long-term fiscal responsibility within Nebraska's HCBS system.

Hands of Heartland

We respectfully urge DHHS to maintain the requirement for Functional Behavior Assessments conducted by licensed professionals and to ensure continued funding and access to these services under both the CDD and DDAD waivers.

Thank you for the opportunity to provide comment. We would welcome continued dialogue regarding these concerns and want to work with DHHS to develop solutions that are fiscally responsible while maintaining high quality services.

Respectfully submitted,

Signed by:
Angie Huber
4F9FB54AF28746B...

Dr. Angie Huber
Director of Behavioral Supports
Hands of Heartland
ahuber@handsofheartland.com

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DDD Public Comment Form

undefined

Comment

As a clinician who at times evaluates and treats individua with severe disabilities and traumatic brain injuries, I am deeply concerned that implementing a monetary cap on the A&D/TBI Waiver would undermine safe, community-based care. The needs of this population vary widely and can fluctuate significantly over time due to medical complications, behavioral health challenges, or neurological changes. A preset funding ceiling would not account for these realities and could result in reduced services, caregiver burnout, preventable hospitalizations, or premature institutionalization. In my professional judgment, individualized assessments—not arbitrary financial limits—must guide care planning. Preserving flexibility within the waiver is essential to protecting patient health, maintaining community integration, and avoiding higher long-term costs to the state. I respectfully urge DHHS to reject any proposal that imposes a monetary cap on this critical program.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Submitted on Feb 16, 2026

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DDD Public Comment Form

undefined

Comment

I am writing to urge you to protect the CDD and DDAD Medicaid Waiver including reimbursement for consultative assessment services as budget and policy decisions move forward.

Consultative assessment services prevent crisis, reduce institutionalization, and save the state money. Any changes should be guided by clinical evidence and expert testimony on downstream impacts. Please ensure that families, caregivers, and professionals are fully heard before advancing policies that could destabilize vulnerable individuals, agencies who oversee services, and caregivers.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 2, 2026

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DDD Public Comment Form

undefined

Comment

I am writing to express serious concern regarding the proposed removal of the Consultative Assessment Service from the DDAD (NE.0394) and CDD (NE.4154) waivers.

Functional Behavioral Assessments and Behavior Support Plan (BSP) development require specialized training in behavioral assessment, data interpretation, and evidence-based intervention design. Eliminating a distinct consultative assessment service creates substantial risk to service quality, participant safety, and clinical accountability.

The proposed waiver language does not specify required credentials, licensure, or competency standards for individuals who will complete behavioral assessments or develop BSPs. Without explicit requirements, individuals with complex behavioral needs may receive plans developed by staff without adequate clinical preparation, increasing the likelihood of ineffective or harmful interventions.

Removal of the Consultative Assessment Service should not move forward. If the Department proceeds despite these concerns, the waiver must clearly establish:

• Minimum qualifications for BSP authors
• Required training and competency standards
• Ongoing clinical supervision expectations
• Guaranteed access to independent clinical consultation for high-risk or complex cases

Absent these protections, elimination of Consultative Assessment will significantly weaken behavioral service infrastructure and undermine person-centered, safe, and effective care.

Thank you for the opportunity to provide public comment.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 3, 2026

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DDD Public Comment Form

undefined

Comment

I am writing to express serious concern regarding the proposed removal of the Consultative Assessment Service from the DDAD (NE.0394) and CDD (NE.4154) waivers.

Functional Behavioral Assessments and Behavior Support Plan (BSP) development require specialized training in behavioral assessment, data interpretation, and evidence-based intervention design. Eliminating a distinct consultative assessment service creates substantial risk to service quality, participant safety, and clinical accountability.

The proposed waiver language does not specify required credentials, licensure, or competency standards for individuals who will complete behavioral assessments or develop BSPs. Without explicit requirements, individuals with complex behavioral needs may receive plans developed by staff without adequate clinical preparation, increasing the likelihood of ineffective or harmful interventions.

Removal of the Consultative Assessment Service should not move forward. If the Department proceeds despite these concerns, the waiver must clearly establish:

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• Required training and competency standards
• Ongoing clinical supervision expectations
• Guaranteed access to independent clinical consultation for high-risk or complex cases

Absent these protections, elimination of Consultative Assessment will significantly weaken behavioral service infrastructure and undermine person-centered, safe, and effective care.

Thank you for the opportunity to provide public comment.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

Submitted on Feb 3, 2026

Proposed CDD/DDAD Waiver Amendments — Critical Concerns

Dear Members of the Division of Developmental Disabilities:

I am writing to express grave concerns about the proposed amendments to the Comprehensive Developmental Disabilities (CDD) and Disabled and Developmentally Disabled Aid (DDAD) waivers, set to take effect July 1, 2026. While I understand the Division's position that federal law necessitates shifting Functional Behavioral Assessment (FBA) costs to Managed Care Organizations (MCOs), the proposed implementation creates serious legal, clinical, and access problems that will ultimately harm the very families this program is designed to serve.

Critical Legal and Safety Concerns

First, the proposed policy does not resolve a fundamental legal problem: Nebraska law requires FBAs before Behavior Support Plans (BSPs), yet the Division proposes to implement BSPs without FBAs using templates. Templates cannot resolve this regulatory violation, this requires a legislative fix, not merely a policy workaround. More troubling, even if this practice were legalized, it replaces clinical expertise with administrative checklists, creating serious safety risks for individuals with complex behavioral needs.

Second, you are dismantling the very program that created your success story. Consultative Assessments helped Nebraska eliminate an eight-year waitlist, moving more than 3,000 families off the registry by 2025. Now you propose removing the exact tool that made this achievement possible. The irony is profound: by eliminating the consultative FBA model, you risk recreating the waitlist you worked so hard to eliminate.

The Fundamental Change That Will Eliminate Provider Participation
Under the previous model, clinicians could complete a consultative FBA—delivering a comprehensive report after approximately 10 hours of assessment work, then exiting the case. The new model fundamentally changes this relationship. FBAs will now require full client onboarding with ongoing clinical supervision responsibilities tied to billing code 97155. This transforms what was a time-limited consultation into a permanent treatment relationship.

The result is predictable: clinicians are already refusing these cases. They will not accept permanent liability for outcomes they cannot control, with no clear exit strategy from the professional relationship.

The State Ward Crisis
This problem becomes acute with state wards. Clinicians will not accept state ward cases because onboarding creates:

- Liability for outcomes they cannot control, including placement decisions and DHHS case management actions
- Complex consent and authorization processes that change with every county or MCO transition
- A permanent on-call expert role with no professional exit pathway

The MCO Network Reality
The Division's assumption that MCO networks can absorb this demand ignores on-the-ground realities:

- Agencies will not accept FBA-only referrals because they are not financially viable
- Families must independently locate credentialed clinicians within MCO networks—a significant barrier, particularly in rural Nebraska
- Generic managed care clinicians lack developmental disability-specific expertise
- The result will be a care desert for our most vulnerable populations

The Numbers Tell the Story
Consider what the data reveals:

- **Only 11% utilization:** Of 3,100 families offered funding, only 339 (11%) actually receive services—not because they don't need them, but because providers do not exist
- **DHHS's own admission:** Without major changes, the state may have to re-implement a waiting list.
- **Provider exodus:** At $13 per hour reimbursement rates, qualified clinicians are already scarce—making FBAs a permanent liability commitment will eliminate remaining willing providers
- **InterRAI fallout:** 17% of current waiver users had funding reduced under the new assessment tool, with families now scrambling through appeals while being shunted to the Family Support Waiver's inadequate $10,000 annual cap

The Cost Reality You're Not Addressing
Program costs rose from $91 million in 2016 to $383 million in 2025. The proposed solution? Cut clinical services that prevent crises. The actual result will be more expensive: emergency interventions, institutionalizations, law enforcement involvement, and eventual comprehensive waiver enrollment at much higher cost. This isn't sustainability, it's cost-shifting that guarantees worse outcomes at greater eventual expense.

What Must Happen Before Implementation
Before moving forward with these amendments, the Division must:

1. Resolve legal contradictions regarding BSPs without FBAs through legislative amendment, not administrative workaround
2. Verify actual MCO network capacity to absorb demand—not merely assume it exists on paper
3. Provide concrete transition support beyond templates that cannot substitute for clinical judgment
4. Address provider reimbursement rates to prevent complete provider exodus
5. Create exit pathways for clinicians doing consultative FBAs to avoid permanent liability without authority
6. Ensure developmental disability-specific clinical expertise within MCO networks, not generic behavioral health providers

Conclusion
You eliminated the registry by providing adequate assessments through Consultative Assessment services. Professionalizing FBAs into permanent treatment relationships will reduce providers'

willingness to serve high-need cases—the exact population most dependent on these services. Your policy creates the access barriers it claims to solve.

I urge you: do not resurrect the waitlist by removing the tool that eliminated it. Nebraska families with loved ones who have developmental disabilities deserve better than a policy that prioritizes budget shifting over clinical safety and access to care.

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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

Critical Legal Concern: The proposal to allow BSPs withc FBAs directly contradicts Nebraska regulations. Creating BSPs without FBAs—even with DDD-provided templates—remains illegal under current state law. The legality issue is not about formatting, but about professional requirements and assessment foundation. This policy cannot be implemented without first changing state regulations.

Practical Implementation Issues:
1. MCO Clinician Access: The claim that MCOs "provide" credentialed clinicians is misleading. Agencies and families must locate these professionals themselves within the MCO network, creating significant access barriers, especially in rural areas.
2. Service Coordinator Role: While DDD Service Coordinators can assist in identifying clinicians, this adds workload without guaranteeing availability or timely services.
3. Agency Clinician Reality: The explanation of why agencies use external clinicians is accurate, but this makes the removal of Consultative Assessment more problematic—it eliminates a known pathway without ensuring MCO networks can absorb the demand.

The "State Ward Crisis" Clinicians won't accept state wards because onboarding means:
- Liability for outcomes they can't control (placements, DHHS decisions)
- Complex consent/authorization across county/MCO changes
- Becoming permanent "on-call" expert with no exit strategy

Recommendation: Before implementing these changes, DDD must:
- Resolve the legal contradiction regarding BSPs without FBAs
- Verify adequate MCO network capacity
- Provide concrete transition support beyond templates

These changes require regulatory amendments and infrastructure verification, not just policy updates.

Attach Files

CDD-DDAD-CriticalWaiverConcerns.docx

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 3, 2026

Proposed CDD/DDAD Waiver Amendments — Critical Concerns

Dear Members of the Division of Developmental Disabilities:

I am writing to express grave concerns about the proposed amendments to the Comprehensive Developmental Disabilities (CDD) and Disabled and Developmentally Disabled Aid (DDAD) waivers, set to take effect July 1, 2026. While I understand the Division's position that federal law necessitates shifting Functional Behavioral Assessment (FBA) costs to Managed Care Organizations (MCOs), the proposed implementation creates serious legal, clinical, and access problems that will ultimately harm the very families this program is designed to serve.

Critical Legal and Safety Concerns

First, the proposed policy does not resolve a fundamental legal problem: Nebraska law requires FBAs before Behavior Support Plans (BSPs), yet the Division proposes to implement BSPs without FBAs using templates. Templates cannot resolve this regulatory violation, this requires a legislative fix, not merely a policy workaround. More troubling, even if this practice were legalized, it replaces clinical expertise with administrative checklists, creating serious safety risks for individuals with complex behavioral needs.

Second, you are dismantling the very program that created your success story. Consultative Assessments helped Nebraska eliminate an eight-year waitlist, moving more than 3,000 families off the registry by 2025. Now you propose removing the exact tool that made this achievement possible. The irony is profound: by eliminating the consultative FBA model, you risk recreating the waitlist you worked so hard to eliminate.

The Fundamental Change That Will Eliminate Provider Participation
Under the previous model, clinicians could complete a consultative FBA—delivering a comprehensive report after approximately 10 hours of assessment work, then exiting the case. The new model fundamentally changes this relationship. FBAs will now require full client onboarding with ongoing clinical supervision responsibilities tied to billing code 97155. This transforms what was a time-limited consultation into a permanent treatment relationship.

The result is predictable: clinicians are already refusing these cases. They will not accept permanent liability for outcomes they cannot control, with no clear exit strategy from the professional relationship.

The State Ward Crisis
This problem becomes acute with state wards. Clinicians will not accept state ward cases because onboarding creates:

- Liability for outcomes they cannot control, including placement decisions and DHHS case management actions
- Complex consent and authorization processes that change with every county or MCO transition
- A permanent on-call expert role with no professional exit pathway

The MCO Network Reality
The Division's assumption that MCO networks can absorb this demand ignores on-the-ground realities:

- Agencies will not accept FBA-only referrals because they are not financially viable
- Families must independently locate credentialed clinicians within MCO networks—a significant barrier, particularly in rural Nebraska
- Generic managed care clinicians lack developmental disability-specific expertise
- The result will be a care desert for our most vulnerable populations

The Numbers Tell the Story
Consider what the data reveals:

- **Only 11% utilization:** Of 3,100 families offered funding, only 339 (11%) actually receive services—not because they don't need them, but because providers do not exist
- **DHHS's own admission:** Without major changes, the state may have to re-implement a waiting list.
- **Provider exodus:** At $13 per hour reimbursement rates, qualified clinicians are already scarce—making FBAs a permanent liability commitment will eliminate remaining willing providers
- **InterRAI fallout:** 17% of current waiver users had funding reduced under the new assessment tool, with families now scrambling through appeals while being shunted to the Family Support Waiver's inadequate $10,000 annual cap

The Cost Reality You're Not Addressing
Program costs rose from $91 million in 2016 to $383 million in 2025. The proposed solution? Cut clinical services that prevent crises. The actual result will be more expensive: emergency interventions, institutionalizations, law enforcement involvement, and eventual comprehensive waiver enrollment at much higher cost. This isn't sustainability, it's cost-shifting that guarantees worse outcomes at greater eventual expense.

What Must Happen Before Implementation
Before moving forward with these amendments, the Division must:

1. Resolve legal contradictions regarding BSPs without FBAs through legislative amendment, not administrative workaround
2. Verify actual MCO network capacity to absorb demand—not merely assume it exists on paper
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Conclusion
You eliminated the registry by providing adequate assessments through Consultative Assessment services. Professionalizing FBAs into permanent treatment relationships will reduce providers'

willingness to serve high-need cases—the exact population most dependent on these services. Your policy creates the access barriers it claims to solve.

I urge you: do not resurrect the waitlist by removing the tool that eliminated it. Nebraska families with loved ones who have developmental disabilities deserve better than a policy that prioritizes budget shifting over clinical safety and access to care.

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Comment

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2. Service Coordinator Role: While DDD Service Coordinators can assist in identifying clinicians, this adds workload without guaranteeing availability or timely services.

3. Agency Clinician Reality: The explanation of why agencies use external clinicians is accurate, but this makes the removal of Consultative Assessment more problematic—it eliminates a known pathway without ensuring MCO networks can absorb the demand.

4. The "State Ward Crisis" Clinicians won't accept state wards because onboarding means:
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Recommendation: Before implementing these changes, DDD must:
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Attach Files

CDD-DDAD-CriticalWaiverConcerns.docx

Tell us about yourself! I am...

An Organization- A company, organization, or government agency

Organization Name

Anonymous

Organization Type

Company or Provider

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 3, 2026

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DDD Public Comment Form

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Name

Anonymous

Comment

I am reaching out to emphasize the importance of protecting the CDD and DDAD Medicaid Waiver, particularly regarding the reimbursement for consultative assessment services, as we navigate upcoming budget and policy decisions.

These consultative assessment services play a crucial role in preventing crises, minimizing institutionalization, and ultimately saving the state significant funds. I urge you to ensure that any changes are based on solid clinical evidence and expert insights, considering the broader implications they may have. It is vital that we take the voices of families, caregivers, and professionals into account to avoid policies that could destabilize those who are most vulnerable, as well as the agencies that support them.

Thank you for your attention to this critical matter. I truly appreciate your consideration and ongoing support!

Sincerely,
J.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

DDAD- DD Adult Day Waiver AD- Aged and Disabled Waiver

Submitted on Feb 8, 2026

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DDD Public Comment Form

undefined

Comment

I am writing to strongly urge you to protect the CDD and DDAD Medicaid Waivers, including continued reimbursement for consultative assessment services, as budget and policy decisions are considered.

These services prevent crisis, reduce reliance on institutional care, and ultimately save the state money. Any proposed changes should be grounded in clinical evidence and informed by expert input on long-term impacts, with meaningful consideration given to families, caregivers, and providers who would be directly affected.

The proposal assumes providers can replace consultative assessments through training and internal plan development. This is unrealistic given current workforce shortages, increasing participant acuity, and the specialized clinical expertise required to assess high-risk behaviors. Eliminating FBAs shifts responsibility and risk onto providers, caregivers, and participants rather than strengthening the support system.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 9, 2026

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DDD Public Comment Form

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Comment

Restricting access to timely Functional Behavior Assessments (FBAs) by limiting them to Managed Care Organization (MCO) billing pathways will have serious negative consequences for individuals with disabilities, providers, and the State of Nebraska. Although it has been stated that FBAs may be accessed through MCOs, this does not reflect current reality. Restrictive and inconsistent MCO credentialing requirements exclude many qualified clinicians, resulting in multi-year waitlists and widespread inaccessibility. For individuals experiencing active behavioral challenges, these delays are unsafe, clinically inappropriate, and unethical.
When individuals do not receive timely behavioral assessment and intervention, behavior predictably escalates. Unsafe behaviors increase, including aggression, elopement, self-injury, and property destruction. Injuries, emergency interventions, caregiver burnout, staff turnover, and placement failures rise. This is not theoretical; it is consistently documented and observed in practice.
From a fiscal standpoint, restricting FBAs is counterproductive and irresponsible. There will not be real cost savings it will only shift and increase costs to other departments. Preventative behavioral assessment costs are far less than emergency room visits, hospitalizations, crisis services, law enforcement involvement, high-cost placements, incident investigations, and staff injury claims. When behavioral support is removed, systems shift from preventive to reactive, driving costs up and outcomes down. Policies that restrict FBAs do not eliminate the need for behavioral support; they shift the burden to emergency systems, families, and frontline staff. This approach undermines safety, stability, and long-term outcomes and should be reconsidered.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

Submitted on Feb 11, 2026

DDD Public Comment Form

undefined

Comment

The State of Nebraska has requested approval of an amendment to its §1915(c) Home and Community-Based Services (HCBS) waiver to remove consultative assessment services, commonly referred to as Functional Behavior Assessments (FBAs). DHHS has indicated that these services are “duplicative,” asserting they can be accessed and billed through Managed Care Organizations (MCOs). Stakeholders report that, in practice, this billing pathway is not operational. Licensed Independent clinicians have indicated they are unable to successfully bill MCOs for FBAs, and documentation confirming reimbursement pathways has not been provided, though they’ve contacted DHHS multiple times to get this information. Additionally, individuals seeking FBAs through MCO networks are reportedly experiencing significant delays, with some wait times exceeding two years. For individuals experiencing active behavioral challenges, such delays are clinically inappropriate and pose safety risks.

When timely behavioral assessment and intervention are unavailable:
* Unsafe behaviors increase in frequency and intensity
* Emergency interventions and hospitalizations rise
* Caregiver burnout and staff turnover accelerate
* Residential and community placements destabilize

Preventive behavioral assessment is significantly less costly than crisis response. Delays in assessment shift costs to:
* Emergency departments
* Crisis stabilization units
* Law enforcement
* High-cost residential placements
* Incident investigations and staff injury claims

Removing consultative behavioral assessments from the waiver does not eliminate the need for services. It shifts the burden to crisis systems, families, and frontline providers, increasing both risk and long-term cost. This amendment warrants careful reconsideration to protect safety, stability, and fiscal responsibility.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 11, 2026

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DDD Public Comment Form

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Comment

I oppose the proposed amendment to Nebraska's §1915(c) HCBS waiver removing consultative behavioral assessment services on the basis that they are duplicative and available through Managed Care Organizations (MCOs).

While the State has indicated that Functional Behavior Assessments (FBAs) can be accessed through MCO billing pathways, providers and families report significant barriers in practice, including limited provider networks, credentialing restrictions, lack of clear reimbursement guidance, and substantial delays in accessing assessments. As a result, timely behavioral assessment is often unavailable.

For individuals with active behavioral challenges, delayed or inaccessible assessment places health and safety at risk. When preventive behavioral supports are unavailable, escalation is predictable, leading to increased emergency interventions, placement instability, staff burnout, and higher-cost services.

Preventive behavioral assessment is far less costly than crisis response, hospitalization, or placement failure. Eliminating waiver-based assessment does not remove the need for behavioral support; it shifts costs to more reactive systems.

Under §1915(c) assurances, the State must ensure access to necessary services and protect participant health and welfare. I respectfully urge reconsideration of this amendment.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

Submitted on Feb 17, 2026

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DDD Public Comment Form

undefined

Comment

Nebraska is eliminating the DD Waiver Consultative Assessment service this July (per Draft). That service allo LIMHPs, APRNs, psychologists, and BCBAs to complete and bill for Functional Behavioral Assessments (FBAs).
Going forward, FBAs are being moved into the ABA benefit. Under that definition, only BCBAs (Licensed Behavior Analysts), or psychologists/physicians with ABA training, can bill for the assessment.
This will exclude LIMHPs/APRNS/PA's from completing FBAs in a service dessert and effectively remove this service. A review of the MCO's revealed that not only was the Consultative Assessment changed to ABA Assessment there is no criterion for adults. Removing the Consultative Assessment Waiver removes critical clinical oversight for the development of Behavior Support Plans (now will be provided by agency providers, not a clinician "with support from the States clinical team - which will not be sufficient) even within the draft it relies on language such as "clinical judgement" but by removing LIMHPs/APRNs from this process the state is shifting assessments that include danger to self, and to others to agency providers who are not licensed clinicians - ergo - no clinical judgement. This is categorically out of scope of practice and limiting this function to BCBAs only - who are unable to diagnose - is a disservice to this population and to those who support the DD community - and in many ways, out of the BCBA scope of practice unless they have a dual LIMHP/PhD/PsyD, etc. This will increase the population not receiving medically necessary care, while also siloing who is able to provide the care, and in many instances those who provide it will be acting out of their scope and training. I petition the State and others that this is not a road we want to go down.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

DDAD- DD Adult Day Waiver

CDD- Comprehensive Waiver

Submitted on Feb 19, 2026

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DDD Public Comment Form

undefined

Comment

I wish parents that send only the best of the best of the best self-advocates in the 60-70 IQ range, would also include advocates of the IQ of around 40 like my young adult. It is disheartening that Tony Greene thinks these adults all have the same ability.

A good example is the Sheltering Tree provider agencies that a couple of parents received funding to build a few of these apartment type living arrangements do not provide services to fix meals for people, put necessary adults to bed at night, out of bed in the morning, help get these adults dressed, hair &teeth brushed, wash face,take baths, serve breakfast, etc. for all these daily duties from Medicaid providers. My adult kid wouldn't make it out the door in time to meet their transportation van, fix their own food etc. It would be nice if these services could be provided. My adult has gone thru numerous Shared Living Providers (SLP's) and would be nice if they could live in 1 home, without moving every several months, getting use to new families, who keep burning out on this job. We started out having someone come to the house to care for him, but those people don't want to do it for a limited few hours before & after Day Service ends around 3:30p.m.and then have to have someone come back to get them showered, hair and teeth brushed, menstrual hygiene (monthly) and occasional poop accidents necessitating clean up clothing furniture, carpet, floors, toilets, sink and the other mess that comes with that, and into bed nightly. These adults shouldn;t have to be shipped off to sterile institutions a few hours away from family for these services. Sheltering Tree concept is great idea, but needs to have fulltime staff help with meals,messes,clothes washing messes, etc. Someone's needed on staff to prep meals including lunch bags for day service, but staffing to one individual is not worth a careprovider's time to work a couple hours early morning, in the evening, and after Day Service daily.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

DDAD- DD Adult Day Waiver

CDD- Comprehensive Waiver

Submitted on Feb 19, 2026

To whom it may concern,

I am writing today to express concern regarding the proposed elimination of the Consultative Assessment Service Waiver code. As an employee of a DD provider who has clinicians on staff, I have seen nothing but benefit from having the ability to provide the FBA as a service in-house. Those who have been able to utilize our clinicians are able to have much more tangible access to the professional. We have been able to implement much more cohesive behavior support plans and provide better training for caregivers on how to adhere to strategies outlined in plans so that data can be useful. Throughout this month, I have been summarizing some of my concerns as follows:

MYTH #1: ***"Teams will just need to write a really good behavior support plan, but an FBA is not necessary in most cases." – Tony Green, 2/17/2026, NASP call***

FACT:
Teams are not responsible for writing Behavior Support Plans. In practice, BSPs are completed by program writers, agency coordinators, or in the best-case scenario, qualified clinicians. This means, a person who has more than one provider agency could have multiple interpretations and approaches for management of challenging behavior. This inherently reduces effectiveness of teaching strategies, as consistency of structured responses is a key component of an effective first tier of support.

Additionally, team members rarely possess the specialized training, certification, or educational background needed to independently develop effective, data-driven behavioral programming—especially for complex or specialized supports. Many team members are former DSPs or managers from other backgrounds, but not necessarily people who have had training specific to this type of program development. Putting the development of the behavior assessment and/or behavior support plan back on the provider in many cases is parallel to asking a K-5 teacher to write an IEP without having SPED credentialing.

Behavior cannot be accurately understood through guesswork. For example, what appears to be "attention-seeking" might actually be a desire to escape a demanding task, avoid overstimulation, or access a preferred activity. Without a full FBA—including multiple data sources—it is impossible to confidently determine the true function of a behavior.

Creating a BSP without an FBA results in intervention plans based on assumptions rather than evidence, increasing the likelihood that supports will be ineffective or even counterproductive. Best practice requires a qualified professional to conduct a comprehensive FBA *before* designing any intervention at all levels, not just for those with highest risk.

Tony's statement regarding the proposed change indicates that the Department is aware that obtaining an FBA will become more challenging for participants, if they are in favor of teams just bypassing the formal process of obtaining one.

MYTH #2: ***"Observing the individual in one setting provides enough information to complete an FBA."***

FACT:
Observations are valuable, but they represent only one component of a high-quality FBA. A thorough adult FBA integrates *multiple* sources of both broad and specific data:

- **Broad data:** medical and mental health information, communication abilities, trauma history, environmental stressors, life events, prior interventions, and medication history.
- **Specific behavioral data:** patterns regarding where, when, with whom, and under what circumstances behaviors occur, as well as how others respond.

This information is collected through interviews, record reviews, incident data, direct observation across settings, and communication with all providers involved.

Problem: When individuals receive services from multiple providers, the absence of clinical oversight often leads to BSPs that contradict one another. Without cohesive, clinically guided plans, cohesiveness of support is less likely to be achieved for that participant.

MYTH #3: ***"Once you know the function of the behavior, the goal is simply to eliminate it."***

FACT:
All behavior serves a purpose. Ethical practice does not focus on suppressing challenging behavior; it focuses on teaching appropriate, functional alternatives that meet the same need.

For example, if an individual uses disruptive behavior to escape overwhelming situations, a BSP should teach and reinforce replacement behaviors such as:

- requesting a break,
- using a break card,
- communicating discomfort in an agreed-upon way.

PBIS principles—uniquely required for Nebraska DD providers through Mandt training in addition to the standard Relational/Technical Mandt curriculum utilized by most other organizations in Nebraska—emphasize proactive teaching and reinforcement. Without an FBA, teams cannot effectively adhere to PBIS practices, placing providers at odds with expectations from DHHS.

MYTH #4: ***"Only behavior specialists or clinicians are responsible for implementing the BSP."***

FACT:
All staff who support the individual share responsibility for implementing the BSP. Effective behavior support requires consistency across every environment where the person interacts with others—home, day programs, community outings, transportation, or workplaces.

Clinicians are essential in guiding staff training, providing oversight, and ensuring fidelity of implementation. Providers using the Consultative Assessment Services waiver have demonstrated improved outcomes when clinicians develop assessments, create replacement-behavior instruction plans, and train teams directly in contrast to those clinicians who complete an assessment as a one-time service without knowing the person as in depth as the waiver service option allows.

MYTH #5: ***"FBAs and BSPs are only necessary for severe or dangerous behaviors, or only for individuals receiving risk services."***

FACT:
FBAs and BSPs are beneficial for *any* behavior that limits a person's quality of life, independence, or access to the community—even when behaviors are not severe. In reality, individuals with dangerous behaviors may not be placed on risk tiers, leaving providers without support if FBAs become more difficult to access. Early intervention prevents escalation, reduces frustration for individuals and staff, and improves long-term outcomes. Crisis-level behavior should never be the threshold for support.

MYTH #6: ***"The MCO will pay for an FBA when needed."***

FACT:
To date, waiver participants and providers have not received clear or actionable information about how the MCO will

approve or fund FBAs. Providers have been told to request an FBA through the assigned case worker, yet guidance is lacking regarding:

- the likelihood of service approval,
- who is eligible or available to complete FBAs,
- what prior authorization processes are required,
- how providers can assist in facilitating access.

These gaps are particularly concerning given Nebraska's ongoing clinician shortage, especially among professionals credentialed to complete FBAs. Creating additional barriers to accessing clinical services harms participants and restricts providers' ability to offer safe, evidence-based support.

The **UNMC Behavioral Health Education Licensed Behavioral Health Workforce Report (2025)** highlights significant workforce shortages statewide—further limiting the practicality of relying solely on MCO-connected clinicians.

Conclusion

FBAs and BSPs are not bureaucratic hurdles—they are essential tools for ensuring safe, ethical, person-centered supports. Their effectiveness depends on clinical expertise, comprehensive data collection, and collaborative implementation. Reducing access to FBAs, shifting responsibility to under-trained teams, or relying on unclear MCO processes puts individuals and providers at risk and contradicts established best practices and regulatory expectations.

Ensuring that FBAs and BSPs remain accessible, clinically guided, and thoroughly implemented is essential for protecting participant safety, supporting provider success, and maintaining high-quality services across Nebraska. Allowing clinicians with specialized training—not only in the FBA process, but also in the field of intellectual and developmental disabilities—to continue providing these services under an already approved and successfully functioning waiver code is an efficient and responsible use of Nebraska's resources. Because this is a niche yet highly beneficial service, the best outcomes for participants occur when clinicians work directly within the developmental disabilities system. This level of expertise and consistency is far more achievable when providers are able to hire, supervise, and train clinicians in-house, ensuring alignment with agency practices, participant needs, and required service models. Maintaining the MCO as an optional pathway for specific circumstances may offer flexibility, but relying on it as the primary or sole mechanism for accessing FBAs creates unnecessary barriers and risks leaving participants without timely, appropriate support.

Remaining Questions/Action-Items to make the elimination of this waiver code more reasonable.

1) Will MCO-enrolled clinicians be knowledgeable in disability services and trained on Title 404 regulations?

- Title 404 governs Developmental Disabilities (DD) services and sets certification/core requirements for DD *providers*. It does not directly certify MCO network clinicians. However, DD agency and independent providers serving waiver participants must comply with Title 404 Chapter 4 (certification) and Chapter 5 (core requirements), including policies, staff training, restrictive measures rules, and rights protections.
- Implication for MCO clinicians: MCO network clinicians (e.g., psychologists, LIMHPs, BCBAs) must meet *Medicaid/MLTC provider* standards and scope-of-practice rules for behavioral health, but there is no public requirement that they receive *Title 404-specific training.* Nebraska Total Care's FBA guidance, for example, requires that FBAs be completed by fully licensed clinicians enrolled with MLTC (psychologists, LIMHPs with BCBA, BCBAs under appropriate supervision), but not that they be Title 404-trained. NE Total Care ABA Behavior Assessments & Plans

Actionable step: Require clinicians to demonstrate knowledge in HCBS/404 Regulations

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2) Will the MCO pay for these services for *adults*?

Historically I've seen approvals for children only.

- Commercial/State-regulated insurance: Nebraska's autism insurance mandate (LB 254) requires coverage of ABA and related behavioral treatments for individuals with autism under age 21. That statute does not create a right to ABA coverage for adults in commercial plans. NE Statute - LB 254
- Medicaid (Heritage Health MCOs): DHHS maintains behavioral health service definitions, including Applied Behavior Analysis (ABA) and an ABA behavior identification assessment. These definitions are being updated and actively managed by MLTC; however, the program communications and provider bulletins have been framed largely around children/ASD. Coverage determinations hinge on medical necessity and the specific service definition in effect. DHHS Behavioral Health Definitions, DHHS - Provider Bulletin 25-02
- Recent rate/policy context: Nebraska implemented significant ABA reimbursement changes in 2025 and finalized ABA service definitions in Feb 2025—both developments primarily discussed in the context of pediatric ASD services. This doesn't *categorically* exclude adults on Medicaid, but in practice, MCOs may tightly apply indications to ASD-focused definitions. bhbusiness.com - NE Rolls Out Steep Cuts to ABA Services, DHHS - ABA Medicaid Service Definitions

The concern: For adult members, payment is not *guaranteed* and may depend on diagnosis, medical necessity, and whether the requested service fits the current Medicaid ABA or other behavioral health service definition. Pre-authorization with clear adult-focused clinical rationales is essential. DHHS - Medicaid Behavioral Health Definitions

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3) Are MCO-enrolled clinicians accepting adults, or are they mostly specialized in kids with autism?

- Nebraska's Heritage Health has three statewide MCOs (Molina, Nebraska Total Care, UnitedHealthcare) and provider finder tools. However, neither of these tools have clear search features to categorize qualified clinicians who are also offering the service of FBA/ABA to Adults. Anecdotally, I have worked with many LIMHPs who have never written an FBA. This is problematic and not accessible to those needing this service the most – most likely this will result in the provider or the participant/guardian having to do direct outreach to locate a clinician. DHHS - MLTC Provider Finder, NE Heritage Health Provider Search

Actionable step: Create better search fields to allow providers and participants to filter by a list of professionals specifically offering this service.

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4) Are the clinicians we're told to use aware of this shift? What if we can't get one on board—especially for unsafe behaviors not on a risk tier?

- MCO clinicians are not automatically "put on notice" about DD waiver workflow changes. Communication typically occurs via MLTC provider bulletins, MCO provider updates, and case-by-case care coordination. Has this occurred and do MCO clinicians have awareness and anticipation of this change so they can be prepared to accommodate a potential increase in referrals?

Actionable step: Have an escalation path if no clinician engages with the request and a formal process established for requesting an FBA through the MCO prior to elimination of the CAS Waiver code. Or, keep the CAS Waiver code as the primary pathway, but begin increasing accessibility of this service through the MCO to determine success first.

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5) What training will be provided/required so programs are written effectively? Why will it work better this time?

- DHHS DD has provider-facing resources for FBA, BSP, and Safety Plans, including an FBA template, FBA/BSP checklists, and training content (e.g., PEARLS/Proactive Treatment Interaction) that align plans with Medicaid behavioral health expectations. These tools explicitly say they meet requirements in Heritage Health behavioral health definitions, but Nebraska also has specific requirements on credentialing needed to be able to implement these strategies formally. Title 404 Chapter 4/5 require DD providers to have policies, training, and quality processes—this anchors provider accountability for correct plan development and implementation (e.g., restrictive measures, rights, documentation). However, providers lack education and credentialing to be able to complete these tools.

What's still missing: I don't see a new, formal statewide training mandate (e.g., a DHHS directive requiring all providers to complete specific coursework) published since the most recent Title 404 update (Chapter 4 amended Sept 17, 2024). If the Department intends a new training program for behavior services, it has not been posted publicly in the DD Providers training area as of today.

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6) Historically we haven't been able to obtain FBAs for adults through an MCO. "We're working on it with MLTC" isn't enough, especially if a waiver code is being eliminated.

- Currently I can not find any DHHS/MLTC instruction that explicitly states "adult FBAs must be covered under MCO X/Y/Z regardless of diagnosis". If such a change is being contemplated, it should appear in a formal MLTC bulletin or waiver amendment notice; I do not see that publicly posted.

Recommended assurance-seeking steps from the Department (before any code is sunset):

1. Request a written position from Medicaid that CPT codes 97151 and 97152 (ABA Definitions - DHHS) will cover *adult* services
2. If the Department intends to eliminate a waiver code, provide a formal bulletin (or the State Plan/Waiver amendment reference) and the transition plan that guarantees continuity of care and adult access pathways.

Thank you for your consideration,

Respectfully submitted 2/24/2026

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

DDD Public Comment Form

undefined

Comment

Subject: Formal Objection to Waiver Amendments NE.41 and NE.0394 – Removal of Consultative Assessments
To the Division of Developmental Disabilities,
I am writing to formally object to the proposed elimination of the DD Waiver Consultative Assessment service. Transitioning Functional Behavioral Assessments (FBAs) exclusively to the ABA benefit creates a critical service gap that directly threatens the health and welfare of participants, particularly adults over 21.
1. Violation of Health and Welfare Assurances: Under 42 C.F.R. § 441.302, the state must ensure the health and welfare of waiver participants. By removing consultative assessments for the adult population, the state is effectively eliminating the only mechanism many high-needs adults have for behavioral stabilization.
2. Lack of Provider Capacity: The ABA benefit is predominantly utilized by pediatric providers. There is a documented "service desert" for BCBAs who accept adult Medicaid patients in Nebraska. Without accessible providers, this change is not a "transition" but a total loss of service.
3. Risk of Institutionalization: Without regular FBAs to update safety protocols, individuals with complex behavioral needs face a high risk of losing their community-based residential placements. This will lead to an increase in emergency room visits, law enforcement intervention, and avoidable institutionalization in higher-cost settings.
Requested Action: I urge DHHS to withdraw this amendment or maintain the Consultative Assessment service for individuals over the age of 21.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

Submitted on Feb 24, 2026

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

DDD Public Comment Form

undefined

Comment

I urge the State to preserve Consultative Assessment Services (CAS), including Functional Behavior Assessme (FBAs), within the CDD and DDAD Medicaid Waivers.

Recent guidance suggesting clinicians can transition CAS billing to Managed Care Organizations is inaccurate. Under the proposed changes, FBAs would be limited to an ABA billing pathway, excluding many qualified providers (including LIMHPs, APRNs, and PAs) and effectively eliminating access for many adults age 21+ with DD/ID. This will worsen an existing service shortage and create multi-year waitlists.

Many waiver participants have complex mental health, trauma, and medical needs. Excluding clinicians with mental health expertise risks oversimplifying behavior and producing ineffective or inappropriate interventions.

FBAs are preventative and cost-effective. Without timely assessment, behavioral needs escalate, leading to crisis response, hospitalization, law enforcement involvement, placement disruption, and higher long-term costs.

I strongly urge the State to maintain CAS within the DD waivers and ensure changes are guided by clinical evidence and stakeholder input, not policies that destabilize vulnerable individuals.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

A

Last Name

Concerned citizen

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 24, 2026

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

Remove Appendix C to the proposed CDD Waiver NE.4154. I believe this will negatively impact the care and services that are decided based off the Consultative Assessment Service and FBA's. With the evolving behaviors of some of the participants changing from semi-annual to annual meetings doesn't seem to be in the best interest of all parties. This waiver is aimed at reducing the level of care for some of our most vulnerable citizens. The DHHS is attempting to eliminate professional Consultative Assessment Services and FBA's and bring them in house and performed by "trained" employees not professionals. The participants should be getting the best assessments and FBA's to achieve the best care. The State of Nebraska should not have government employees dictating level of care of for anyone especially the developmentally disabled. The State should not be moving to the socialized medicine policies of other countries. The approval of this waiver and others are exactly the direction the DHHS specifically the Division of Developmental Disabilities is moving to. The lower quality of information gathered (Consultative Assessments and FBA's) equals lower quality of care. Performing assessments and creating FBA's is how my wife makes a living. Approval of this waiver will greatly impact our lives along with other tax paying citizens in our state. One of the many functions of the DHHS is to assist with the quality of care and life of our most vulnerable population. This is not a business nor should be treated as such. The DHHS mission statement is Helping people live better lives. Tax breaks and incentives given by the state to the fortunate should not lower the quality of life for our citizens with disabilities. The current system in place provides for the best level of care and outcomes. The proposed waivers seem to undermine that. Remove appendix C.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

Submitted on Feb 24, 2026

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DDD Public Comment Form

undefined

Comment

I am writing to oppose the proposed removal of Consultative Assessment Services, commonly referred to as Functional Behavior Assessments (FBAs), from Nebraska's §1915(c) Home and Community-Based Services (HCBS) waivers and to express concern regarding the lack of transparency surrounding this proposal.

State leadership has asserted that FBAs are not being eliminated but shifted to Managed Care Organization (MCO) billing pathways. This statement is a lie. In practice, FBAs are not operationally accessible through MCOs for adult Developmental Disabilities waiver participants. Licensed independent clinicians report they cannot bill MCOs for FBAs, and DHHS has provided no written guidance, billing codes, or documentation demonstrating that an equivalent, functioning pathway exists.

Despite repeated requests from stakeholders, DHHS has not provided clarification or proof of an operational MCO billing mechanism. If such a pathway exists, it should be clearly documented. The absence of written guidance suggests it does not function in practice.

FBAs provide objective, data-driven information regarding behavioral risk, staffing needs, and service intensity that standardized assessments alone may not fully capture. They are preventative services that reduce crises, hospitalizations, law enforcement involvement, and placement disruptions. Removing access to FBAs does not eliminate behavioral need; it shifts responsibility to more costly and less effective crisis systems.

Claiming FBAs remain available while removing the only functional funding mechanism undermines transparency and informed decision-making. For these reasons, the proposed removal of Consultative Assessment Services should be withdrawn, or DHHS should first demonstrate, in writing, how FBAs can be timely accessed and reimbursed through MCOs for adult DD waiver participants.

Lives, safety, and long-term costs are at stake, and this decision warrants reconsideration.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 24, 2026

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DDD Public Comment Form

undefined

Comment

The removal of currently provided consultive assessment service (CAS) from the waivers will decrease the level of oversight and support from Clinical staff for participants, putting those with behavioral and mental health concerns at further risk of escalation to the point of crisis. Further, if CAS behavior support is not as accessible to participants, the pressure for other supports (risk providers, higher level of funding for participants, inpatient psychiatric facilities, the State's Clinical Support and Crisis Stabilization Teams, exception funding, and the few MCO-enrolled Clinicians in the state) will be drastically higher. The current CAS services help the person learn skills that promote their personal success and gain independence as a member of their community. Lowering access to this vital service will directly impact the quality of life for many Nebraskans, as well as putting people with both disabilities and major mental health disorders at further risk due to decreasing access to mental health and behavioral support. Furthermore, having non-clinical persons being responsible for writing assessments, intervention plans and Behavior Support Plans (BSPs) not only will strain their already stressful workload, but jeopardizes the participant of having non-function-based or mental health informed interventions being implemented, causing further harm.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 25, 2026

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

Dear CMS HCBS Waiver Review Team,

Please accept the attached public comment regarding Nebraska's proposed amendment to remove Consultative Assessment Services (CAS) from the DD §1915(c) waiver.

This comment raises concerns related to Appendix C (Health and Welfare) and Appendix G (Service Delivery and Access), and includes a side-by-side service capacity comparison (Exhibit A).

I respectfully request that this comment be included in the official CMS waiver review record.

Thank you for your consideration.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 25, 2026

NEBRASKA
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DDD Public Comment Form

undefined

Comment

I oppose the proposed amendment eliminating Consultative Behavioral Assessments (Functional Behavioral Assessments, or FBAs) from Nebraska's §1915(c) HCBS waiver.
The amendment states that FBAs are duplicative because they may be billed through Managed Care Organizations (MCOs) or completed by the participant's team. However, in practice, Licensed Independent clinicians cannot reliably bill MCOs for this service. While psychologists may technically bill, reimbursement rates for FBAs are substantially lower than standard therapy or psychological service rates, creating little incentive for providers to offer this time-intensive service. As a result, access and provider capacity are likely to decrease.
Shifting responsibility to internal teams removes independent clinical oversight. Comprehensive FBAs require specialized expertise in behavioral assessment, data analysis, and treatment planning that cannot be replicated through general team training alone.
Under §1915(c) waiver assurances, states must ensure participant health and welfare and maintain sufficient provider capacity. Eliminating consultative assessments without a clearly operational, accessible alternative pathway raises concerns regarding:

- Network adequacy
- Timely access to medically necessary services
- Protection of participant health and safety

Without preventive behavioral assessment, crisis utilization increases, placements destabilize, and higher-cost services are required.
For these reasons, I respectfully urge CMS to carefully evaluate whether this amendment maintains compliance with §1915(c) health and welfare assurances before approval.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 25, 2026

NEBRASKA
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DDD Public Comment Form

undefined

Comment

FBA's are not covered under the MCOs. The ABA benefit is only for people under 21. The state reported on the public presentation that people who need an FBA can have this service billed through the MCO's. This is demonstrably false since all 3 MCO's restrict this to BCBAs and do not extend the benefit to adults. This creates a healthcare dessert that is unfair to our population. By limiting the FBA to only people on the Risk Tier you also eliminate a whole population who should have BSP's and Safety Plans developed and or informed by medical professionals completed by agency providers who would be acting outside of their scope. This is dangerous and people will get hurt. This is a service gap.

Tell us about yourself! I am...

An Organization- A company, organization, or government agency

Organization Name

FBA's

Organization Type

Company or Provider

Waiver

AD- Aged and Disabled Waiver

Submitted on Mar 3, 2026

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

removing FBAs from APRN's and moving it into the "ABA benefit" creates a "service desert" for the over-21 population who no longer have access to school-based supports. This directly creates a service gap in the state of Nebraska. One that had previously been closed. BCBAs cannot diagnose, do not have authority to provide anything beyond the limited ABA modality, and misses many of the clinical realities that a more advanced provider would identify. This will be a disaster for Nebraska population with disabilities and create a Service Gap.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

AD- Aged and Disabled Waiver

Submitted on Mar 3, 2026

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

DDD Public Comment Form

undefined

Comment

I oppose Governor Pillen's new assessments that reclassify and take away support for those with severe cognitive abilities.
The new assessments appear to exclude decades of professional and medical evaluations. Lowering the funding tiers makes it financially impossible for Shared Living Providers to afford certified backup workers. I am requesting that you do not lower the funding tiers. If someone has been unable to take medication on their own, prepare meals by themself, and make arrangements for transportation for 43 years, that doesn't suddenly change when new assessments reclassify their abilities.
Thank you for your consideration.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

DDAD- DD Adult Day Waiver

CDD- Comprehensive Waiver

Submitted on Mar 9, 2026

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I am writing to urge you to protect the CDD and DDAD Medicaid Waiver including reimbursement for consultative assessment services as budget and policy decisions move forward.

Consultative assessment services prevent crisis, reduce institutionalization, and save the state money. Any changes should be guided by clinical evidence and expert testimony on downstream impacts. Please ensure that families, caregivers, and professionals are fully heard before advancing policies that could destabilize vulnerable individuals, agencies who oversee services, and caregivers.

In addition to this, Medicaid is already decreasing ABA therapy hours per year.

Tell us about yourself! I am...

Anonymous- A person who does not want their name associated with the comment

Waiver

CDD- Comprehensive Waiver

Submitted on Feb 2, 2026

4433 S 70th Street,Suite 200
Lincoln NE 68516
(402) 471-6400 - GoApace.com

To: Director Tony Green & members of the Department of Developmental Disabilities
From: Matt Kasik, Chief Executive Officer of Apace
Date: February 25, 2026
Subject: Public Comment on Proposed Comprehensive DD Waiver Revisions

Director Green,

On behalf of Apace, Nebraska's largest provider of services for individuals with intellectual and developmental disabilities, I appreciate the opportunity to comment on the proposed revisions to the Comprehensive DD Waiver.

1. Functional Behavioral Assessments (FBAs) and Clinical Consultation Are Essential Services

Functional Behavioral Assessments (FBAs) are not optional or peripheral services - they are foundational to supporting individuals with complex behavioral and mental health needs. FBAs are conducted by trained clinicians who evaluate the historical, medical, environmental, and social influences affecting a person's behavior. These assessments:

- Identify the function of behaviors
- Recommend evidence-based behavior modification strategies
- Mitigate risks related to aggression or self-injury
- Ensure interventions are ethical and least restrictive
- Support developmentally appropriate programming
- Provide caregiver training and oversight

Through Consultative Assessment Services (CAS), clinicians also develop Behavior Support Plans (BSPs), safety plans, individualized behavioral protocols, and provide ongoing training and supervision to staff. The current system allows providers to respond quickly when someone begins to escalate behaviorally. That responsiveness prevents crises, protects staff, and most importantly, preserves the individual's ability to live in the least restrictive environment possible. These should not be completed by non-clinical staff, which is what the department has proposed by making this change.

2. Transitioning to MCO-Controlled ABA Assessments Will Reduce Access and Increase Delays

The proposed shift to Managed Care Organization (MCO)-controlled ABA assessments raises serious concerns.

Reduced clinical hours. The CMS "ABA Assessment" model typically authorizes significantly fewer hours, estimated at roughly one-quarter of what CAS allows. That reduction limits a clinician's ability to properly observe, gather history, collaborate with caregivers, and develop thoughtful recommendations. It also does not clearly include training hours, which are critical to successful implementation.
Narrow population focus. ABA services primarily target individuals with Autism. Many individuals with intellectual and developmental disabilities who do not carry an Autism diagnosis rely on CAS today. There is significant concern that they may no longer qualify under the new structure.
Existing workforce shortages. Current waitlists for FBAs can range from six months to several years due to limited clinician availability. MCOs contract with a smaller pool of clinicians, further restricting access. LIMHPs, who currently complete a substantial portion of CAS consultation, are not uniformly able to contract through MCOs for ABA assessment services.

4433 S 70th Street,Suite 200
Lincoln NE 68516
(402) 471-6400 - GoApace.com

Apace hired its own clinicians specifically because wait times were unacceptable. If MCOs do not credential our clinicians, we will return to a system where participants wait months - or years - for essential behavioral support.

3. Apace's Experience with MCOs Raises Serious Operational Concerns

Apace already works with MCOs for Non-Emergency Medical Transportation (NEMT). That experience has been extraordinarily difficult, marked by delays, administrative burden, and constant appeals. Under the current waiver structure, we can resolve behavioral concerns quickly and collaboratively. Under an MCO-controlled model, every referral risks becoming a negotiation. Every request could become a fight.

When behavioral services are delayed, behaviors escalate. When behaviors escalate, safety risks increase. When safety risks increase, people lose placements.

The current system allows for quick resolution. The proposed structure inserts friction at precisely the moment speed matters most.

4. Removal of CAS Will Increase System-Wide Costs and Risk

Reducing access to clinical behavioral support will not eliminate need - it will shift cost and increase risk.

Without timely CAS support, we will see:

- Increased behavioral crises
- Greater reliance on risk providers
- Escalations to higher funding tiers
- Increased use of inpatient psychiatric facilities
- Greater demand on State Clinical Support and Crisis Stabilization Teams
- More exception funding requests

Ironically, the removal of preventive behavioral services will drive greater dependence and higher overall system costs.

CAS services promote skill-building, independence, and community stability. Removing or restricting them moves the system in the opposite direction.

5. Budget Transparency Concerns

The state has characterized this change as a reduction within the DD services budget. However, there appears to be no corresponding credit or cost shift reflected in Medicaid's budget. If these dollars do not follow the service into Medicaid, that raises a serious concern: that this is not a restructuring - it is a reduction.

Given the vulnerability of this population, reductions in clinical behavioral support should be clearly disclosed, not structurally obscured.

Conclusion

Behavioral and consultative services are not ancillary supports. They are preventative, protective, and foundational.

4433 S 70th Street,Suite 200
Lincoln NE 68516
(402) 471-6400 - GoApace.com

The current waiver structure allows providers to act quickly, clinically, and collaboratively in response to emerging behavioral needs. Moving these services into an MCO-controlled model is likely to increase delays, reduce access, create administrative conflict, and ultimately place participants and staff at greater risk.

We respectfully urge the Department to reconsider these revisions or, at minimum:

- Ensure adequate assessment hours
- Guarantee inclusion of individuals with I/DD who do not have Autism
- Allow provider-employed clinicians to continue delivering services
- Ensure budget transparency regarding any reductions

Nebraska's DD system works best when it prioritizes responsiveness, prevention, and person-centered care. These revisions move us further from that goal.

Thank you for your consideration.

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

DDD Public Comment Form

undefined

Comment

I respectfully request that the Centers for Medicare & Medicaid Services (CMS) require additional documentation prior to approving this waiver amendment.
Under §1915(c) of the Social Security Act and 42 CFR §441.302, states must provide assurances that necessary services are furnished in a manner that protects participant health and welfare, ensures sufficient provider capacity, and maintains timely access to medically necessary services.
To date, publicly available amendment materials do not include:
* Network adequacy data demonstrating sufficient Managed Care Organization (MCO) provider capacity to deliver behavioral assessments;
* Average wait times for Functional Behavioral Assessments (FBAs) through MCO pathways;
* Reimbursement rate analysis demonstrating sustainability for provider participation;
* Fiscal modeling comparing preventive behavioral assessment costs to crisis-related Medicaid expenditures;
* Documentation explaining how internal team-based plan development provides equivalent clinical rigor and oversight to independent consultative behavioral assessment.
Without this information, it is unclear how elimination of waiver-funded FBAs maintains compliance with required assurances related to health and welfare protections, service sufficiency, and provider qualifications.
Preventive behavioral assessment reduces crisis utilization and associated Medicaid costs. Removal of this service without documented equivalent access pathways may increase emergency department use, psychiatric hospitalization, and high-acuity service expenditures while weakening participant safeguards.
CMS should require formal documentation addressing these gaps before approving this amendment.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

Benjamin

Last Name

Hiser

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 15, 2026

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I am adamantly requesting that the state to reconsider ending consultative assessment and FBAs through HCBS. I have been in the field long enough to remember when Consultative Assessment was not around. Agencies had such poor behavioral management competency. That incompetency directly increased instances of inappropriate inpatient hospitalizations, police contacts, and institutionalization. This was a problem that was identified years ago, with CA being the solution.

Having clinicians involved in individuals care drastically decreased these costly items and increased the agency's ability to manage high behavioral individuals internally. The knowledge that clinicians have brought to the table has led to Nebraska experiencing an overall higher rate of competency when managing difficult individuals. Having a clinician available to provide ongoing consultation to the team has helped not with just the particular situation but also has increased the overall knowledge base of providers to ensure positive behavioral supports are safe and effective for all individuals in service.

Lack of competency that will come from taking clinicians out of the equation will eventually swing the pendulum back to the caregivers in the state being less competent to manage high behaviors. This is what ultimately led to the DOJ being involved at BSDC, to individuals being abused, and higher costs for the state in terms of inappropriate acute hospitalizations, inappropriate police contact, and institutionalization.

Having clinicians involved was a solution to a problem. Taking away this solution will just lead us back to the same, costly problem.

This solution is working. Why change it? The cost is minimal compared to the savings.

Tell us about yourself! I am...

An Organization- A company, organization, or government agency

Email

[redacted]

Phone

[redacted]

First Name

BDmello

City & State

Omaha, NE

Organization Name

Compassionate Services and Consulting

Organization Type

Company or Provider

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Jan 26, 2026

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

DDD Public Comment Form

undefined

Comment

Eliminating consultative services is a huge mistake. These disabled people are evaluated by trained professionals for the level of care they require and in which manner it is rendered. Removing these services means removing highly trained professionals from their positions, not only costing their professions, but also costing the individuals a fair evaluation for much needed services.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

Email

[redacted]

First Name

Brandon

Last Name

Bergmeier

City & State

Virginia, Nebraska

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Jan 26, 2026

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

DDD Public Comment Form

undefined

Comment

The proposed changes from Nebraska DHHS would allow Behavior Support Plans to be created without licensed clinicians and without requiring a Functional Behavioral Assessment, which raises serious concerns about safety, effectiveness, and the rights of the individuals receiving services. Clinicians such as BCBAs are specifically trained to design ethical, person-centered replacement behaviors that respect an individual's autonomy and right to take reasonable risks, rather than relying on outdated approaches that focus on "task compliance" or controlling behavior for staff convenience. Without this clinical oversight, there is a real risk that teams may unintentionally revert to more punitive, compliance-driven strategies that do not address the true reasons behind someone's behavior and may limit personal choice or dignity. Trained clinicians help ensure that supports are based on understanding the individual, teaching meaningful skills, and promoting independence—not enforcing rigid expectations. Removing these safeguards could lead to inconsistent practices across providers and reduce the quality of care for people who rely on these services. For these reasons, it is important for the DHHS to seriously reconsider these changes for the purposes of supporting standards that protect the well-being, rights, and dignity of the individuals served.

Tell us about yourself! I am...

An Organization- A company, organization, or government agency

Email

[redacted]

Phone

[redacted]

City & State

Omaha, NE

Organization Name

ABA Behavior Consulting

Organization Type

Company or Provider

Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 5, 2026

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

DDD Public Comment Form

undefined

Comment

I oppose the proposed amendment eliminating Consultat Behavioral Assessments (Functional Behavioral Assessments, or FBAs) from Nebraska's §1915(c) HCBS waiver. FBAs are detailed, individualized behavioral evaluations completed by trained specialists. They help families understand:
Why behaviors are happening
What triggers escalation
What prevention strategies work
How to support social skills and learning
Without FBAs:
Families may wait years for behavioral assessment through insurance or MCO systems.
Teams may be asked to create plans without specialized behavioral expertise.
Crisis situations may increase before help is available.
This change does not remove behavioral needs. It shifts responsibility to families, direct support staff, and emergency systems.
When preventive assessment is unavailable, the likely outcomes include:
Increased emergency room visits
Psychiatric hospitalizations
Law enforcement involvement
Placement instability
Caregiver burnout
Eliminating consultative assessments without a clearly operational, accessible alternative pathway raises concerns regarding:
Network adequacy
Timely access to medically necessary services
Protection of participant health and safety
Without preventive behavioral assessment, crisis utilization increases, placements destabilize, and higher-cost services are required. FBAs are prevention. Prevention protects families, providers, and the state budget. If you care about protecting vulnerable individuals and keeping families stable in their communities, this amendment deserves careful reconsideration.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

Email

[redacted]

Phone

[redacted]

First Name

Bridget

Last Name

Bates

City & State

Omaha

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 14, 2026

Archived: Tuesday, February 3, 2026 3:05:3 PM
From: [redacted]
Sent: Tuesday, February 3, 2026 10:25:3 AM
To: DHHS HCBS Public Comments
Subject: Consultative Assessment Services
Importance: Normal

You don't often get email from [redacted] Learn why this is important

I am writing to urge you to protect the CDD and DDAD Medicaid Waiver including reimbursement for consultative assessment services as budget and policy decisions move forward.

Consultative assessment services prevent crisis, reduce institutionalization, and save the state money. Any changes should be guided by clinical evidence and expert testimony on downstream impacts. Please ensure that families, caregivers, and professionals are fully heard before advancing policies that could destabilize vulnerable individuals, agencies who oversee services, and caregivers.

I appreciate your consideration.

Cami Erb

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I oppose these.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

Carmen

Last Name

Manhart

City & State

Omaha Nebraska

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 17, 2026

A **Functional Behavior Assessment (FBA)** or **Applied Behavior Analysis (ABA) assessment** is essential for individuals with developmental disabilities because it forms the foundation of an **accurate, ethical, and effective Behavior Support Plan (BSP)**. The quality and success of this process depends heavily on the assessment being completed by a **trained and qualified professional**.

1. Accurate identification of the function of behavior
Challenging behaviors serve specific functions (e.g., access to attention, escape from demands, sensory regulation, etc.). A trained professional has the expertise to systematically analyze data, differentiate between similar behaviors with different functions, and avoid common misinterpretations that can lead to ineffective or harmful interventions.

2. Clinical expertise and ethical decision-making
Professionals trained in FBA/ABA adhere to ethical standards, evidence-based practices, and legal requirements. This ensures interventions are developmentally appropriate, culturally responsive, and aligned with the principles of least restrictive and most positive support. Accurate assessment helps avoid unnecessary punitive, restrictive, or intrusive practices. Instead, it supports evidence-based, positive behavior supports that respect dignity and autonomy while prioritizing safety.

3. Individualized, person-centered assessment
A qualified professional considers multiple variables, including communication abilities, cognitive functioning, medical and mental health factors, trauma history, environmental influences, and skill deficits. This comprehensive approach prevents oversimplification and supports truly individualized planning.

4. Valid data collection and analysis
Trained professionals use reliable assessment methods—such as direct observation, functional analysis, caregiver interviews, and data-based decision-making—to ensure conclusions are accurate. Proper data interpretation is critical for identifying patterns, triggers, and maintaining consequences of behavior.

5. Effective prevention and skill-building strategies
With expert assessment, the resulting Behavior Support Plan emphasizes proactive strategies, environmental modifications, and the teaching of functionally equivalent replacement behaviors. This moves support beyond behavior reduction toward meaningful skill development and improved quality of life.

6. Consistency and collaboration across settings
A trained assessor can translate assessment findings into clear, actionable strategies and train caregivers, educators, and support staff to implement them consistently across environments, increasing the likelihood of success.

7. Ongoing monitoring and professional judgment
Behavior is dynamic. Qualified professionals are trained to monitor progress, analyze data

trends, and make necessary adjustments to the Behavior Support Plan, ensuring it remains effective as the individual's needs change.

In summary:
Having an FBA or ABA assessment completed by a **trained professional** is critical to ensuring the Behavior Support Plan is accurate, ethical, and effective. Professional expertise ensures behaviors are understood within their full context, interventions are evidence-based and humane, and individuals with developmental disabilities receive support that promotes safety, skill development, autonomy, and long-term positive outcomes.

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Name

Incoming form answer

Comment

While I understand moving the FBA (to be referred to as an ABA assessment going forward) from the waiver to insurance as a payee, I have significant concerns about how this will actually work going forward. Even though all three of the MCOs may be on board with this, many individuals have other insurances as their primary (or even secondary) insurances such as Medicare, Tricare, etc.
I do not see in this plan a clearly outlined process that addresses this without leaving many individuals without access to an important assessment process. Stating that "staff have a pretty good idea of what is motivating a client" is not data, it is just guessing.
It is not good practice, much less best practice, to implement these changes without having a written, strategic plan in place beforehand to move these services from an individual's waiver to an insurance company. Please see the attached file for further information.

Attach Files

A Functional Behavior Assessment (FBA) or Applied Behavior Analysis (ABA) assessment is essential for individuals with developmental disabilities .pdf

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

Email

[redacted]

Phone

 [redacted]

First Name

Carol

Last Name

Salber, LIMHP

City & State

Omaha, NE

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 6, 2026

From: [redacted]
Subject: Concerns regarding the new InterRAI system
Date: Thursday, February 19, 2026 5:18:03 PM

> You don't often get email from [redacted]. Learn why this is important

Hello,

I am a Nebraskan homeowner, educator, and former special education teacher. I am very concerned to hear about the new assessment processes of the InterRAI system. I am highly concerned that it will harm those with disabilities that impact daily life by not allowing them to get the support they need. It will hurt those with disabilities who are still capable of working, as they will lose the chance of getting an income and growing in their independence. It will also impact the caregivers who face drastic pay cuts that will force them to get other jobs, in turn weakening the level of care they are able to give.

Thank you,
Caylin Choquette

To Whom it May Concern,

My name is Chelsea Sedlacek-Bergmeier, and for over 10 years, I have worked in various capacities with individuals who live with developmental disabilities in the state of Nebraska. Currently, I collaborate directly with these individuals, as well as their families, guardians, staff, and care coordinators, by providing what is referred to by the Nebraska Department of Health and Human Services Division of Developmental Disabilities (DHHS-DD) as Consultative Assessment Services (CAS).

This service provides a multitude of independence-facilitating methods, including Functional Behavioral Assessment (FBA), to encompass a person's supervision and support needs while giving professional recommendations for behavior modification interventions, behavioral risk and aggressive behavior mitigation support, mental health support, developmentally appropriate programming, and training for caregivers.

These services help the person learn skills that promote their personal success and gain independence as a member of their community. I have worked with countless individuals who live with developmental and intellectual disabilities and are likewise Nebraska taxpayers, earning credible wages working in public spaces across the state.

Nebraska continues to face a statewide shortage of behavioral health clinicians across licensure types and service settings. This shortage has impacted access to assessment, psychotherapy, and clinical oversight for those with I/DD, while increasing demands on the professionals currently providing care. Individuals seeking clinicians with appropriate training and experience frequently encounter waitlists of six months or longer, which can delay needed services and significantly affect client well-being and quality of life.

The removal of CAS from the current waiver will cut the number of available and experienced Clinicians to complete FBAs and other much-needed CAS supports significantly; MCOs often have a limit of the number of Clinicians they will partner with, limiting the number of available Clinicians further. Lowering access to this vital service will directly impact the quality of life for many Nebraskans, as well as putting people with both developmental or intellectual disabilities and major mental health disorders at further risk due to decreasing access to mental health and behavioral support. Increases in pressure on the State Clinical Team, Exception Funding Requests due to escalating maladaptive behaviors and mental health symptoms, as well as decreased independence for those with these needs are all results of discontinuing this service through the state of Nebraska.

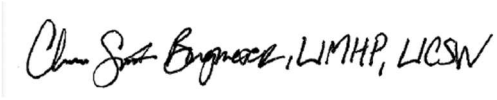
Updated guidance from DHHS-DD on the expectations of Behavior Support Plans, or BSPs, is also changing. Though these programs are still expected to follow regulations for ethical compliance, including (but not limited to) no aversive interventions, agency staff members will

be asked to complete these programs using functionally matched replacement behaviors. Caregivers and administration in these agencies are at significant risk of burnout, not having a broad range of training available, as well as heavy workloads. Adding this to their work expectations will put a significant burden on these employees, leading to increased turnover and lower quality of work. The level of training in mental health symptoms, biological-social-psychological and sensorimotor effects on behavior for laypersons in the field is not sufficient for them to produce assessments and behavior modification plans for persons with high-risk behaviors and severe mental illness. Though typically very well intended, Coordinators and other agency staff often lack further training required for best practices.

As a Clinician, former staff and administrator, as well as an advocate for this population, I implore those who are reviewing this proposed change to the waivers to consider the vast negative effects that it will have not only on participants, but agencies, Clinicians, as well as state-provided resources such as the Clinical Team and Exception Funding Requests. Thank you for your time and consideration.

Regards,

Chelsea Sedlacek-Bergmeier, LIMHP, LICSW



Subject: Public Comment – CDD Comprehensive Waiver Safety Concerns

Members of the HHS Committee,

I am deeply concerned about any proposed reductions to the CDD Comprehensive Waiver.

Individuals served by this waiver often require:

- 24-hour supervision
- Medication management
- Behavioral support
- Medical oversight
- Assistance with activities of daily living

These are not conveniences. They are safety requirements.

Reducing funding risks inadequate staffing ratios, increased caregiver strain, and dangerous overnight gaps. The consequences could include injuries, elopement, medical emergencies, and preventable crises.

The waiver system exists because these needs are documented and assessed. Weakening it undermines the entire purpose of Nebraska's disability support structure.

Please act to ensure continued, stable funding.

Respectfully,
Christi Kampschneider

Christi Kampschneider

Omaha, Nebraska

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Please act to ensure continued, stable funding.

Respectfully,
Christi Kampschneider

Christi Kampschneider

Omaha, Nebraska

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

DDD Public Comment Form

undefined

Comment

I am writing to urge you to protect the CDD and DDAD Medicaid Waiver including reimbursement for consultative assessment services as budget and policy decisions move forward.

Consultative assessment services prevent crisis, reduce institutionalization, and save the state money. Any changes should be guided by clinical evidence and expert testimony on downstream impacts. Please ensure that families, caregivers, and professionals are fully heard before advancing policies that could destabilize vulnerable individuals, agencies who oversee services, and caregivers.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

Chrystol

Last Name

Spraling

City & State

Omaha, NE

Waiver

CDD- Comprehensive Waiver

Submitted on Feb 2, 2026

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

DDD Public Comment Form

undefined

Comment

My grandson was born with spinal muscular atrophy. He a g tube and does not eat orally. He can not walk or craw needs 24 hour care! He can not be left alone! He needs a night nurse so his parents can work! Both his parents are teachers. I don't know how they can both work if they aren't getting sleep at night! Sleep deprivation could cause numerous problems for them not to mention the people they interact with. The public is at risk when people are sleep deprived. Cutting my grandson's care puts him at risk, his family and the public! He also needs care when he goes to school. He needs care from a nurse not a paraprofessional that is not medically trained. Cognitively there is absolutely nothing wrong with my grandson and he is doing very well in school! Please do not cut his care!

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

Email

[redacted]

First Name

Clara

Last Name

Thoene

City & State

Valley

Waiver

CDD- Comprehensive Waiver

Submitted on Feb 18, 2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
8044 S 84TH ST
LAVISTA NE 68128

Case Number - [redacted]
CONTACT - [redacted]
Phone Number - [redacted]
Fax Number - [redacted]
Date of Notice - [redacted]
Mail Date - [redacted]

[redacted]

RE: [redacted]

Notice of Redetermination

~~Required documentation to complete your redetermination was received on~~ [redacted].

Based on information from the Objective Assessment Process (OAP), effective [redacted] your new annual individual budget amount (IBA) level will be:

Level
Intermediate

Comments

Level/IBA has been redetermined and has changed:
[redacted] funding for Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities (DDD) waiver services will be changed based on the recent completion of the objective assessment process. [redacted] will contact you by phone to talk about this change and how to best use the new funding to purchase DDD services.

If you have questions regarding this notice, please contact the number that is listed above or you may e-mail DHHS.DDDCommunityBasedServices@nebraska.gov to obtain additional information.

PLEASE READ THIS REGARDING YOUR RIGHTS

YOUR RIGHTS

RIGHT TO APPEAL WITHIN 90 DAYS

You have the right to appeal on any action or inaction of any state employee or official with regard to application for or receipt of services. You may appeal because your application for services is denied or is not acted upon with a reasonable promptness; your services are suspended, reduced, discontinued or terminated; your fee payment or service is changed to a more restrictive level or because you feel the action taken by the local office was erroneous. A hearing need not be granted when either state or federal law requires automatic case adjustments for classes of clients unless the reason for an individual appeal is incorrect eligibility determination.

You (or your representative) have 90 days following the date the notice of decision is mailed to request a fair hearing.

In cases of intended adverse action where the worker is required to send you timely and adequate notice, if you request an appeal hearing within ten days following the date the notice of decision is mailed, your worker shall not carry out the adverse action until a fair hearing decision is rendered. This regulation does not apply to those situations where the worker may dispense with timely notice and is only required to send you adequate notice.

This regulation in no way restricts your worker from continuing normal case activities and implementing changes to your service case that are not directly related to the appeal issue.

To file an appeal, you may contact your local social services office or the Nebraska Department of Health and Human Services. Your worker will explain the appeal procedure and assist you in completing the appeal form. The appeal request must be in writing. Once you've filed the appeal, arrangements for a hearing will be made and you will be notified of the time and place. You may represent yourself at the hearing or be represented by another person.

February 13, 2026

Dear Medicaid/DHHS:

I am offering my comments on the state's proposed changes to the CDD waiver as the father of a young adult individual receiving Medicaid Home and Community Based Services (HCBS) in Nebraska under this waiver:

> CDD Waiver Renewal Draft: Comprehensive Developmental Disabilities Services (NE.4154) Waiver
>
> (URL: https://dhhs.ne.gov/DD%20Documents/20260126-%20Draft%20NE.4154%20Comprehensive%20Developmental%20Disabilities%20Services%20Waiver.PDF)

I am not an attorney so please forgive any erroneous case citations herein, I did the best I could. As the father of an individual receiving HCBS, along with having an extensive background in developing computer software, I have a keen interest in the state's Object Assessment Process as it relates to not only my son's services under Medicaid, but all individuals who receive Home and Community Based Services in Nebraska under the 1915(c) HCBS waivers, especially those who, for whatever reason, are unwilling or unable to speak to the state's callousness in its use of the new "calculated benefit determination system" (i.e., the systems the state developed with Myers and Stauffer, meant to surreptitiously obfuscate the states purported Objective Assessment Process under Medicare regulations.)

Sincerely,

CJS (dad)

Public Comment Items

Item 1:

Page 7 of 362

Section 4: Waiver(s) Requested

4.A: Comparability:

Application:

"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."

Comment:

There is no request for waiver in the application for 42 CFR § 440.240 - Comparability of services for groups. With the state using a set of systems (e.g., interRAI ID, Case Mix Index) that are driven by hidden, non-public algorithms meant to "objectively" measure an individual's Level of Care (LOC) need and operates via predetermined programmed rules, where those rules are an interpretation of the related policies, the state's burden to provide comparability of services for groups is to ignore every individuals' specific needs! Standardized decisions regarding eligibility/allocation where certain groups and certain individuals' needs are not considered by the set of rules in the standardized system's implementation. The standardized system is a simplified model of the world that includes some scenarios, but not others – possibly biased and/or based on irrelevant data. Further, this "standardized measurement" is inherently incorrect…people are not standardized! Is this really a Person-Centered approach?! No! With the algorithm "cherry picking" what questions/answers are utilized, along with their weight, in the determination of eligibility and LOC the state is free to discriminate in a manner that is couched in technical terms, built by "experts," is "objective," and yet does all who encounter it a serious disservice.

I request that Medicare investigate how the state is utilizing the current system to categorize individuals into groups that do not fully and faithfully represent the individuals' specific needs and true LOC. In doing so, the state is artificially creating what they, at their sole discretion via an undocumented set of processes, determine to be comparable groups; these groups are by design and definition NOT equal or comparable given the state's methodology.

Item 2:

Page 13-14 of 362

Attachments

Application:

"X – Eliminating a service"

"Amendment Information for 7/1/2026:

Notification of waiver participants: The assigned Service Coordinator will notify all participants with active Consultative Assessment authorizations to identify alternative supports."

Comment:

The section does not mention that in addition to eliminating a service (presumably, this means an individual has been determined ineligible), the state, in using the same instruments for both eligibility *and* level of care determination, which includes adding or decreasing services to participants by way of an increase/decrease in the individual's Case Mix Index (CMI), and therefore their budget, derived from the instruments used in the Object Assessment Process (OAP). I request that Medicaid ensure that the state follows appropriate procedures for ALL changes to an individual's HCBS under Medicaid – increases and decreases. Courts have previously found that reducing an individual's budget is equivalent to eliminating services; therefore, both the elimination of services (i.e., ineligibility) AND reductions to LOC/CMI should be construed as equivalent actions, and the state held to the same standards in both instances.

Item 3:

Page 13-14 of 362

Attachments

Application:

"X – Eliminating a service"

"Amendment Information for 7/1/2026:

Notification of waiver participants: The assigned Service Coordinator will notify all participants with active Consultative Assessment authorizations to identify alternative supports."

Comment:

While the state does appear to be providing notification to waiver participants regarding their service determination, the notification provided by the state is woefully lacking in any detail or substance. Pursuant to 42 CFR 431.210 – Content of notice, part (b), this notice must include:

"A clear statement of the specific reasons supporting the intended action;"

However, the state fails to provide anything close to specific reasons supporting the intended action (i.e., the action of eliminating or reducing the individual's budget), other than a very generic statement [excerpt from the Notice of Redetermination received from DHHS – please see attached file: Attachment_2__Notice_of_Redetermination_Redacted.pdf for the complete, 2-page notice]:

"Based on information from the Objective Assessment Process (OAP), effective [date redacted] your new annual individual budget amount (IBA) level will be: Level - Intermediate"

In Goldberg v. Kelly, 397 U.S. 254, 267–68 (1970), the supreme court, in their decision discussing procedural due process, indicates that notices must be detailed enough that a recipient can determine, during a challenge, whether the actions are "resting on incorrect or misleading factual premises or on misapplication of rules or policies to the facts of particular cases."

I ask Medicaid, how does the excerpt from the notice (or any part thereof) in any way allow for the recipient to determine if there were any incorrect facts or misapplication of Medicare's rules and policies, let alone challenge any deficiencies thereof in a due process fair hearing?

Inadequate notice not only deprives individuals of their right to understand the decisions affecting them, but also effectively renders the appeal process meaningless! An appeal process, no matter how fair and impartial the appeal is purported to be (in this case, the hearing officer is an employee of DHHS, with that hearing officer's superior being the DDD director who approves the hearing officer's recommendation), it is fundamentally useless if the people the process is designed to serve cannot understand the decisions they are supposed to appeal. In other words, without adequate information, an individual cannot know if their rights have been violated, let alone how to contest the violation.

In multiple instances, courts, including those on appeal by state agencies, have found for the participant where the adequacy of notice was brought as an issue:

- "Unless a person is adequately informed of the reasons for denial of a legal interest, a hearing serves no purpose — and resembles more a scene from Kafka than a constitutional process." Gray Panthers v. Schweiker, 652 F.2d 146, 168-69 (D.C. Cir. 1980).
- If insufficient information is given in the department's notice, "…subsequent due process, available in the administrative review phase of the appeal, comes too late" Grijalva v. Shalala, 946 F. Supp. 747, 759 (D. Ariz. 1996) and, "…inadequate notice

renders the existence of an appeal process meaningless." Grijalva v. Shalala, 152 F.3d 1115, 1122 (9th Cir. 1998).

- Where the adequacy of notice was at issue the court pointed out that using the information the agency provided, "…it would be impossible for a recipient…to determine the accuracy of the agency's decision." Buckhanon v. Percy, 533 F. Supp. 822, 827 (D. Wis. 1982).

While I could go on citing case after case in state after state where the state Medicaid agency did not provide adequate notice, in the interest of time I will leave those out and ask that in this instance, Medicaid compel Nebraska DHHS to provide truly effective and adequate notice in their determination letters, to include, but not be limited to: specific details as to the interRAI ID results, scores, scales, and outcomes; the means, manner and methodology used to arrive at the participant's Case Mix Index (CMI) - i.e., the algorithm details (for general/non-personal information such as this, it does not seem necessary to have these details in the notice itself, but seems adequate, and at the very least, made available in a public location for the examination thereof of such public records, documentation, and information, for example, the department's website), and all other relevant information required by a participant to ascertain the validity and accuracy of the department's decision **prior to the participant's appeal and/or fair hearing**.

At this point, in order to determine whether the state has made an error or there are systemic errors present which have caused my son's funding to decrease, I have been forced to file a Freedom of Information Act request with the state of Nebraska to obtain this information. I am hopeful that the state does not claim this information to be a "Trade Secret," as other states have attempted in similar requests. Suffice it to say, no one at my son's fair hearing with the department was able to provide details or information as to how my son's funding level was determined – other than vague mentions of the use of the interRAI ID and the output from the computer; this information should be freely available to all impacted parties, particularly when they are notified of adverse action against their Medicaid HCBS…it should not require any/every participant submit a FOIA request to the state Medicaid agency/DHHS.

Item 4:

Page 13-14 of 362

Attachments

Application:

"X – Eliminating a service"

“Prior to the request to CMS to change LOC eligibility tools, DDD conducted a population impact analysis to determine the impact of the proposed change in LOC assessment tools. DDD sampled a total of 656 current waiver enrollees to evaluate if there would be a difference in their LOC eligibility determination between the Developmental Index (DI) (current assessment tool) and the interRAI ID or ChYMH-DD (proposed assessment tools). DDD found no negative impact to eligibility for all 656 individuals using the interRAI tools.

Participants found non-eligible and fair hearing rights: Based on the population impact analysis results, DDD does not anticipate any previously eligible participants, based on DI results, will be found ineligible under for LOC using the interRAI ID or ChYMH-DD. For any participant found to be ineligible to enroll on an ICF/IID waiver program, DDD will inform the participant of their fair hearing rights.”

Comment:

Similar to the previous comment, the state, in its stated impact analysis, clearly provided very specific details (“656 current waiver enrollees”) as to the impact in the sample’s eligibility for HCBS in using the proposed Level of Care (LOC) tools – the interRAIs. While the state, “found no negative impact to eligibility for all 656 individuals using the interRAI tools,” what the state, presumably in a calculated and intentional omission to hide the details, chose to NOT discuss the actual LOC/Case Mix Index (CMI) changes (reductions and increases to their individual budget) in their sample. As stated in the previous comment, a reduction in an Individual Budget Amount (IBA), where said budget changes equate to a loss or gain of services (i.e., ineligibility for the same or higher levels of care). The state appears to have concealed this information from both the public and Medicaid in their application. As such, I request that Medicaid reopen for thorough and extensive examination the state’s Objective Assessment Process, seeking to obtain any and all information that the state intentionally, or otherwise, kept out of its Medicaid waiver application(s), now and in prior filings.

Item 5:

Appendix B:

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B-6: Evaluation/Reevaluation of Level of Care

B.6.E: Level of Care Instrument(s)

Application:

"While Adults aged 21 and over use a different tool than children, 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."

Comment:

The application states the output of the determinations yielded the same results, but the application does not go into whether the outcome was for eligibility versus the determined level of care. While the eligibility may have been equivalent, the level of care for individuals already receiving services under the previous instruments versus the new instruments is vastly different – with the overall effect being that the average level of care and thus the related budgets have significantly decreased under the new instruments. Further, the state, in their piloting of the new instruments, did not release details to the public regarding the aforementioned overall average decrease in LOC/budgets, nor, to my knowledge, to Medicare in their application materials. I request that Medicare reopen the waiver application(s) in order to acquire all relevant information, including the information pertaining to the known reduction in Case Mix Index (CMI), translating into reduced Individual Budget Amounts (IBA), thus reducing a large number of individuals services.

Item 6:

Appendix B:

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B.6.F: Process for Level of Care Evaluation/Reevaluation

Application:

"The process for ICF/IID LOC evaluation includes an assessment and observation with the participant, and when needed the guardian or an individual with knowledge of the individual's functioning."

Comment:

In my son's recent interRAI ID evaluation neither he nor his guardian (his mother) were contacted by the state to initiate the evaluation. Had the day service provider not contacted his guardian, the participant and the guardian would have been excluded from the process. It seems, based on conversations with others in this community being administered the interRAI ID, this is the state's standard operating procedure – they generally and regularly seek to exclude the individual and their guardian, opting to only notify an external service provider

(e.g., day service.) The state is clearly not following their own guidelines and regulations regarding this process, let alone Medicare regulations. I request that Medicaid investigate these practices and provide oversight to ensure that Nebraska DHHS is substantively following all regulatory requirements.

Item 7:

Appendix B:

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Application:

"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."

Comment:

The application notes eligibility without mentioning the associated Level of Care (LOC)/Case Mix Index (CMI) – which determines the participant's funding level. In cases where the LOC/CMI are reduced from previous levels, with no change to the participant's overall "general" eligibility for waiver services (i.e., they are still eligible, but at a reduced funding level – this too is considered a subclassification of the participant's eligibility (per numerous court rulings) with respect to specific budgetary concerns) the state is required to perform as mentioned in the application. It is requested that Medicare ensure the same level of notification is mandated for those whose overall eligibility for waiver coverage does not change, but their LOC/CMI are impacted in such a way as to effectively disqualify the individual for current/expected levels of care.

In the matter of participants receiving written notification, please see additional comments provided herein regarding the department's complete lack of meaningful and actionable notification thereto.

Item 8:

Appendix B:

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B-6: Quality Improvement: Level of Care

B-6 A: Methods for Discovery: Level of Care Assurance/Sub-assurances

B-6 a.i.b: Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Application:

"Performance Measures"

Comment:

No details are provided herein regarding the stated performance measures. The state has sought to, and apparently continues to do so, hide this information, particularly details related to eligible participant's change in Level of Care (LOC)/Case Mix Index (CMI) from previous levels. It is assumed that the state understands publicizing the fact that they are, on average, lowering the vast majority of budgets for participants receiving HCBS is fraught with negative and dire political consequences. Regardless, I ask that Medicaid force the state to reveal these numbers and provide Medicaid with specific details regarding not only the count, but the actual magnitude (i.e., dollars) for which individuals' budgets change from year to year due to their Objective Assessment Process (OAP). The state did not make these statistics known during the piloting of the new instruments developed for their OAP with Myers and Stauffer, which coincided with the state's activities related to eliminating the waitlist for HCBS services. Unless new/more money was allocated by the legislature, which I do not believe is the case, it appears that the state knowingly developed the algorithms used in their OAP to produce a reduced budget outlay for those already receiving HCBS, factoring in the "savings" derived from the widespread reduction in LOC/CMI and participants' budget, using those monies to "magically" eliminate the state's funding waitlist for HCBS in an outwardly political move, despite the negative consequences to those already receiving funding. It is therefore requested that Medicaid require the state to fully elucidate their "Performance Measures" related to levels of care of enrolled participants that are reevaluated per waiver guidelines.

Item 9:

Appendix B:

Page 46-47 of 362

B-6 a.i.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.

Application:

Elided for brevity

Comment:

Suffice to say the state merely providing aggregate numbers of the number of Level of Care (LOC) determinations performed, using the stated "Less than 100% Review" of the available *electronic* data (Why and what is it that the state intends on leaving out of these measurements?), is meaningless to show what the sub-assurance is seeking: that the "processes and instruments described in the approved waiver are ***applied appropriately*** and according to the approved description to determine participant level of care." I request that Medicaid seek to compel the state to provide meaningful and transparent statistics, processes, and reports to ensure compliance and to prevent political and unilaterally nefarious adjustments from being made to the state's algorithm to "tweak" the Individual Budget Amounts (IBA) in a manner that lacks transparency, oversight, and regulation.

Item 10:

Appendix B:

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B-6 a.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.

Application:

"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."

Comment:

1. Herein, the state mentions reevaluating 100% of waiver participants, yet in the previous section the state seeks to only use a representative sample of data to ensure compliance and appropriate application of the processes and instruments. Why and what is it that the state intends on leaving out of these measurements, and to what end, when the state, as mentioned in this application, has access to 100% of the *electronic* data that is retained forever…why use a sample?
2. The state's application leaves out all details related to their stated annual review of the level of care assessment tool. The application only refers to the fact that all (100%) of participants are reevaluated annually, not on how it intends to discover/identify

problems/issues with the waiver program. What does the stated assessment tool review at the participant level entail and how exactly does such a narrow "review" translate into identifying issues with the overall waiver program(s)? How is it documented. Is the public provided with these details? Is Medicaid provided with a wholistic, systemic review? If the details are provided to the public and Medicaid, how/when/where are they provided? If the details are NOT provided to the public or Medicaid, why? And how can participants ensure their rights are not infringed upon due to the state's findings and any actions taken as a result of said findings? I request that Medicaid compel the state to provide specific details and procedures on strategies employed by the state to discover/identify problem/issues with the waiver program, per the application's request.

Item 11:

Appendix B:

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B-6 b: Methods for Remediation/Fixing Individual Problems

B-6 b.i.: Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Application:

"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."

Comment:

The state's application makes no mention of, per this item, "identifying systemic deficiencies." While individual problems are addressed, the state fails to provide any details as to how it intends to identify problems with its Objective Assessment Process (OAP) in a broader, more widely applicable manner. While remediating and fixing individual problems is certainly necessary, the state does not describe, even in general, how it plans to examine problems in a wholistic manner in efforts to identify systemic issues. For example, the state is currently fielding an EXTREMELY large number of appeals related to individuals Level of Care (LOC)/Case Mix Index (CMI) reductions from previous levels. It is well known that there have been 0 (zero) appeals lost by the state [per DHSS DD director's comments to a service provider regarding no one winning their appeal, during a recent community meeting] – the state is batting 1000 on interRAI ID appeals. One should expect, in a fair and just adversarial system, that a 100% winning streak is highly suspect and likely fraudulent by design. The state should not be allowed to skirt its responsibility to Medicare and the citizens receiving HCBS under Medicare in the state of Nebraska at ensuring the systems and instruments used in the OAP are valid, correct, consistent, transparent, and consistently monitored and assessed for bias, error, discrimination, and political gain. I request that Medicare compel the state to provide specific details, plans, and procedures for ensuring quality and proactively identifying systemic deficiencies.

From:	[redacted]
To:	DHHS HCBS Public Comments
Cc:	Medicareombudsman@cms.hhs.gov; ROkcmSCB@cms.hhs.gov; Gonshorowski, Drew; Sen. Christy Armendariz; info@disabilityrightsnebraska.org; Curt Safranek
Subject:	DDD Public Comment - CDD (and all other) Waivers
Date:	Friday, February 13, 2026 3:08:19 PM
Attachments:	Attachment_1_of_2__Public_Comment_1915(c)_-_January_26_through_February_25,_2026.pdf Attachment_2_of_2__Notice_of_Redetermination_Redacted.pdf Attachment_1_of_2__Public_Comment_1915(c)_-_January_26_through_February_25,_2026.pdf Attachment_2_of_2__Notice_of_Redetermination_Redacted.pdf

Dear DHHS HCBS Administration:

[Sent via email to DHHS.HCBSPublicComments@nebraska.gov]

This email contains two attachments representing my Public Comment (open January 26 through February 25, 2026) applicable to all 1915(c) Medicaid HCBS waivers, but specifically to the CDD Waiver as that is what my son receives.

Attachment 1 (Attachment_1_of_2__Public_Comment_1915(c)_-_January_26_through_February_25,_2026.pdf) - Public comments regarding Nebraska's Application for 1915(c) HCBS Waiver: Draft NE.016.04.04 - Jul 01, 2026.

Attachment 2 (Attachment_2_of_2__Notice_of_Redetermination_Redacted.pdf) - The [redacted] determination letter my son received regarding his HCBS redetermination.

Thank you for your consideration in this matter.
Curt Safranek

DEPARTMENT OF HEALTH AND HUMAN SERVICES
8044 S 84TH ST
LAVISTA NE 68128

Case Number - [redacted]
CONTACT - [redacted]
Phone Number - [redacted]
Fax Number - [redacted]
Date of Notice - [redacted]
Mail Date - [redacted]

[redacted]

RE: [redacted]

Notice of Redetermination

~~Required documentation to complete your redetermination was received on~~ [redacted].

Based on information from the Objective Assessment Process (OAP), effective [redacted] your new annual individual budget amount (IBA) level will be:

Level
Intermediate

Comments

Level/IBA has been redetermined and has changed:
[redacted] funding for Medicaid Home and Community-Based Services (HCBS) Developmental Disabilities (DDD) waiver services will be changed based on the recent completion of the objective assessment process. [redacted] will contact you by phone to talk about this change and how to best use the new funding to purchase DDD services.

If you have questions regarding this notice, please contact the number that is listed above or you may e-mail DHHS.DDDCommunityBasedServices@nebraska.gov to obtain additional information.

PLEASE READ THIS REGARDING YOUR RIGHTS

YOUR RIGHTS

RIGHT TO APPEAL WITHIN 90 DAYS

You have the right to appeal on any action or inaction of any state employee or official with regard to application for or receipt of services. You may appeal because your application for services is denied or is not acted upon with a reasonable promptness; your services are suspended, reduced, discontinued or terminated; your fee payment or service is changed to a more restrictive level or because you feel the action taken by the local office was erroneous. A hearing need not be granted when either state or federal law requires automatic case adjustments for classes of clients unless the reason for an individual appeal is incorrect eligibility determination.

You (or your representative) have 90 days following the date the notice of decision is mailed to request a fair hearing.

In cases of intended adverse action where the worker is required to send you timely and adequate notice, if you request an appeal hearing within ten days following the date the notice of decision is mailed, your worker shall not carry out the adverse action until a fair hearing decision is rendered. This regulation does not apply to those situations where the worker may dispense with timely notice and is only required to send you adequate notice.

This regulation in no way restricts your worker from continuing normal case activities and implementing changes to your service case that are not directly related to the appeal issue.

To file an appeal, you may contact your local social services office or the Nebraska Department of Health and Human Services. Your worker will explain the appeal procedure and assist you in completing the appeal form. The appeal request must be in writing. Once you've filed the appeal, arrangements for a hearing will be made and you will be notified of the time and place. You may represent yourself at the hearing or be represented by another person.

February 13, 2026

Dear Medicaid/DHHS:

I am offering my comments on the state's proposed changes to the CDD waiver as the father of a young adult individual receiving Medicaid Home and Community Based Services (HCBS) in Nebraska under this waiver:

> CDD Waiver Renewal Draft: Comprehensive Developmental Disabilities Services (NE.4154) Waiver
>
> (URL: https://dhhs.ne.gov/DD%20Documents/20260126-%20Draft%20NE.4154%20Comprehensive%20Developmental%20Disabilities%20Services%20Waiver.PDF)

I am not an attorney so please forgive any erroneous case citations herein, I did the best I could. As the father of an individual receiving HCBS, along with having an extensive background in developing computer software, I have a keen interest in the state's Object Assessment Process as it relates to not only my son's services under Medicaid, but all individuals who receive Home and Community Based Services in Nebraska under the 1915(c) HCBS waivers, especially those who, for whatever reason, are unwilling or unable to speak to the state's callousness in its use of the new "calculated benefit determination system" (i.e., the systems the state developed with Myers and Stauffer, meant to surreptitiously obfuscate the states purported Objective Assessment Process under Medicare regulations.)

Sincerely,

CJS (dad)

Public Comment Items

Item 1:

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Section 4: Waiver(s) Requested

4.A: Comparability:

Application:

"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."

Comment:

There is no request for waiver in the application for 42 CFR § 440.240 - Comparability of services for groups. With the state using a set of systems (e.g., interRAI ID, Case Mix Index) that are driven by hidden, non-public algorithms meant to "objectively" measure an individual's Level of Care (LOC) need and operates via predetermined programmed rules, where those rules are an interpretation of the related policies, the state's burden to provide comparability of services for groups is to ignore every individuals' specific needs! Standardized decisions regarding eligibility/allocation where certain groups and certain individuals' needs are not considered by the set of rules in the standardized system's implementation. The standardized system is a simplified model of the world that includes some scenarios, but not others – possibly biased and/or based on irrelevant data. Further, this "standardized measurement" is inherently incorrect…people are not standardized! Is this really a Person-Centered approach?! No! With the algorithm "cherry picking" what questions/answers are utilized, along with their weight, in the determination of eligibility and LOC the state is free to discriminate in a manner that is couched in technical terms, built by "experts," is "objective," and yet does all who encounter it a serious disservice.

I request that Medicare investigate how the state is utilizing the current system to categorize individuals into groups that do not fully and faithfully represent the individuals' specific needs and true LOC. In doing so, the state is artificially creating what they, at their sole discretion via an undocumented set of processes, determine to be comparable groups; these groups are by design and definition NOT equal or comparable given the state's methodology.

Item 2:

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Attachments

Application:

"X – Eliminating a service"

"Amendment Information for 7/1/2026:

Notification of waiver participants: The assigned Service Coordinator will notify all participants with active Consultative Assessment authorizations to identify alternative supports."

Comment:

The section does not mention that in addition to eliminating a service (presumably, this means an individual has been determined ineligible), the state, in using the same instruments for both eligibility *and* level of care determination, which includes adding or decreasing services to participants by way of an increase/decrease in the individual's Case Mix Index (CMI), and therefore their budget, derived from the instruments used in the Object Assessment Process (OAP). I request that Medicaid ensure that the state follows appropriate procedures for ALL changes to an individual's HCBS under Medicaid – increases and decreases. Courts have previously found that reducing an individual's budget is equivalent to eliminating services; therefore, both the elimination of services (i.e., ineligibility) AND reductions to LOC/CMI should be construed as equivalent actions, and the state held to the same standards in both instances.

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Attachments

Application:

"X – Eliminating a service"

"Amendment Information for 7/1/2026:

Notification of waiver participants: The assigned Service Coordinator will notify all participants with active Consultative Assessment authorizations to identify alternative supports."

Comment:

While the state does appear to be providing notification to waiver participants regarding their service determination, the notification provided by the state is woefully lacking in any detail or substance. Pursuant to 42 CFR 431.210 – Content of notice, part (b), this notice must include:

"A clear statement of the specific reasons supporting the intended action;"

However, the state fails to provide anything close to specific reasons supporting the intended action (i.e., the action of eliminating or reducing the individual's budget), other than a very generic statement [excerpt from the Notice of Redetermination received from DHHS – please see attached file: Attachment_2__Notice_of_Redetermination_Redacted.pdf for the complete, 2-page notice]:

"Based on information from the Objective Assessment Process (OAP), effective [date redacted] your new annual individual budget amount (IBA) level will be: Level - Intermediate"

In Goldberg v. Kelly, 397 U.S. 254, 267–68 (1970), the supreme court, in their decision discussing procedural due process, indicates that notices must be detailed enough that a recipient can determine, during a challenge, whether the actions are "resting on incorrect or misleading factual premises or on misapplication of rules or policies to the facts of particular cases."

I ask Medicaid, how does the excerpt from the notice (or any part thereof) in any way allow for the recipient to determine if there were any incorrect facts or misapplication of Medicare's rules and policies, let alone challenge any deficiencies thereof in a due process fair hearing?

Inadequate notice not only deprives individuals of their right to understand the decisions affecting them, but also effectively renders the appeal process meaningless! An appeal process, no matter how fair and impartial the appeal is purported to be (in this case, the hearing officer is an employee of DHHS, with that hearing officer's superior being the DDD director who approves the hearing officer's recommendation), it is fundamentally useless if the people the process is designed to serve cannot understand the decisions they are supposed to appeal. In other words, without adequate information, an individual cannot know if their rights have been violated, let alone how to contest the violation.

In multiple instances, courts, including those on appeal by state agencies, have found for the participant where the adequacy of notice was brought as an issue:

- "Unless a person is adequately informed of the reasons for denial of a legal interest, a hearing serves no purpose — and resembles more a scene from Kafka than a constitutional process." Gray Panthers v. Schweiker, 652 F.2d 146, 168-69 (D.C. Cir. 1980).
- If insufficient information is given in the department's notice, "…subsequent due process, available in the administrative review phase of the appeal, comes too late" Grijalva v. Shalala, 946 F. Supp. 747, 759 (D. Ariz. 1996) and, "…inadequate notice

renders the existence of an appeal process meaningless." Grijalva v. Shalala, 152 F.3d 1115, 1122 (9th Cir. 1998).

- Where the adequacy of notice was at issue the court pointed out that using the information the agency provided, "…it would be impossible for a recipient…to determine the accuracy of the agency's decision." Buckhanon v. Percy, 533 F. Supp. 822, 827 (D. Wis. 1982).

While I could go on citing case after case in state after state where the state Medicaid agency did not provide adequate notice, in the interest of time I will leave those out and ask that in this instance, Medicaid compel Nebraska DHHS to provide truly effective and adequate notice in their determination letters, to include, but not be limited to: specific details as to the interRAI ID results, scores, scales, and outcomes; the means, manner and methodology used to arrive at the participant's Case Mix Index (CMI) - i.e., the algorithm details (for general/non-personal information such as this, it does not seem necessary to have these details in the notice itself, but seems adequate, and at the very least, made available in a public location for the examination thereof of such public records, documentation, and information, for example, the department's website), and all other relevant information required by a participant to ascertain the validity and accuracy of the department's decision **prior to the participant's appeal and/or fair hearing**.

At this point, in order to determine whether the state has made an error or there are systemic errors present which have caused my son's funding to decrease, I have been forced to file a Freedom of Information Act request with the state of Nebraska to obtain this information. I am hopeful that the state does not claim this information to be a "Trade Secret," as other states have attempted in similar requests. Suffice it to say, no one at my son's fair hearing with the department was able to provide details or information as to how my son's funding level was determined – other than vague mentions of the use of the interRAI ID and the output from the computer; this information should be freely available to all impacted parties, particularly when they are notified of adverse action against their Medicaid HCBS…it should not require any/every participant submit a FOIA request to the state Medicaid agency/DHHS.

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Attachments

Application:

"X – Eliminating a service"

“Prior to the request to CMS to change LOC eligibility tools, DDD conducted a population impact analysis to determine the impact of the proposed change in LOC assessment tools. DDD sampled a total of 656 current waiver enrollees to evaluate if there would be a difference in their LOC eligibility determination between the Developmental Index (DI) (current assessment tool) and the interRAI ID or ChYMH-DD (proposed assessment tools). DDD found no negative impact to eligibility for all 656 individuals using the interRAI tools.

Participants found non-eligible and fair hearing rights: Based on the population impact analysis results, DDD does not anticipate any previously eligible participants, based on DI results, will be found ineligible under for LOC using the interRAI ID or ChYMH-DD. For any participant found to be ineligible to enroll on an ICF/IID waiver program, DDD will inform the participant of their fair hearing rights.”

Comment:

Similar to the previous comment, the state, in its stated impact analysis, clearly provided very specific details (“656 current waiver enrollees”) as to the impact in the sample’s eligibility for HCBS in using the proposed Level of Care (LOC) tools – the interRAIs. While the state, “found no negative impact to eligibility for all 656 individuals using the interRAI tools,” what the state, presumably in a calculated and intentional omission to hide the details, chose to NOT discuss the actual LOC/Case Mix Index (CMI) changes (reductions and increases to their individual budget) in their sample. As stated in the previous comment, a reduction in an Individual Budget Amount (IBA), where said budget changes equate to a loss or gain of services (i.e., ineligibility for the same or higher levels of care). The state appears to have concealed this information from both the public and Medicaid in their application. As such, I request that Medicaid reopen for thorough and extensive examination the state’s Objective Assessment Process, seeking to obtain any and all information that the state intentionally, or otherwise, kept out of its Medicaid waiver application(s), now and in prior filings.

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B-6: Evaluation/Reevaluation of Level of Care

B.6.E: Level of Care Instrument(s)

Application:

"While Adults aged 21 and over use a different tool than children, 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."

Comment:

The application states the output of the determinations yielded the same results, but the application does not go into whether the outcome was for eligibility versus the determined level of care. While the eligibility may have been equivalent, the level of care for individuals already receiving services under the previous instruments versus the new instruments is vastly different – with the overall effect being that the average level of care and thus the related budgets have significantly decreased under the new instruments. Further, the state, in their piloting of the new instruments, did not release details to the public regarding the aforementioned overall average decrease in LOC/budgets, nor, to my knowledge, to Medicare in their application materials. I request that Medicare reopen the waiver application(s) in order to acquire all relevant information, including the information pertaining to the known reduction in Case Mix Index (CMI), translating into reduced Individual Budget Amounts (IBA), thus reducing a large number of individuals services.

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B.6.F: Process for Level of Care Evaluation/Reevaluation

Application:

"The process for ICF/IID LOC evaluation includes an assessment and observation with the participant, and when needed the guardian or an individual with knowledge of the individual's functioning."

Comment:

In my son's recent interRAI ID evaluation neither he nor his guardian (his mother) were contacted by the state to initiate the evaluation. Had the day service provider not contacted his guardian, the participant and the guardian would have been excluded from the process. It seems, based on conversations with others in this community being administered the interRAI ID, this is the state's standard operating procedure – they generally and regularly seek to exclude the individual and their guardian, opting to only notify an external service provider

(e.g., day service.) The state is clearly not following their own guidelines and regulations regarding this process, let alone Medicare regulations. I request that Medicaid investigate these practices and provide oversight to ensure that Nebraska DHHS is substantively following all regulatory requirements.

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Application:

"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."

Comment:

The application notes eligibility without mentioning the associated Level of Care (LOC)/Case Mix Index (CMI) – which determines the participant's funding level. In cases where the LOC/CMI are reduced from previous levels, with no change to the participant's overall "general" eligibility for waiver services (i.e., they are still eligible, but at a reduced funding level – this too is considered a subclassification of the participant's eligibility (per numerous court rulings) with respect to specific budgetary concerns) the state is required to perform as mentioned in the application. It is requested that Medicare ensure the same level of notification is mandated for those whose overall eligibility for waiver coverage does not change, but their LOC/CMI are impacted in such a way as to effectively disqualify the individual for current/expected levels of care.

In the matter of participants receiving written notification, please see additional comments provided herein regarding the department's complete lack of meaningful and actionable notification thereto.

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B-6: Quality Improvement: Level of Care

B-6 A: Methods for Discovery: Level of Care Assurance/Sub-assurances

B-6 a.i.b: Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Application:

"Performance Measures"

Comment:

No details are provided herein regarding the stated performance measures. The state has sought to, and apparently continues to do so, hide this information, particularly details related to eligible participant's change in Level of Care (LOC)/Case Mix Index (CMI) from previous levels. It is assumed that the state understands publicizing the fact that they are, on average, lowering the vast majority of budgets for participants receiving HCBS is fraught with negative and dire political consequences. Regardless, I ask that Medicaid force the state to reveal these numbers and provide Medicaid with specific details regarding not only the count, but the actual magnitude (i.e., dollars) for which individuals' budgets change from year to year due to their Objective Assessment Process (OAP). The state did not make these statistics known during the piloting of the new instruments developed for their OAP with Myers and Stauffer, which coincided with the state's activities related to eliminating the waitlist for HCBS services. Unless new/more money was allocated by the legislature, which I do not believe is the case, it appears that the state knowingly developed the algorithms used in their OAP to produce a reduced budget outlay for those already receiving HCBS, factoring in the "savings" derived from the widespread reduction in LOC/CMI and participants' budget, using those monies to "magically" eliminate the state's funding waitlist for HCBS in an outwardly political move, despite the negative consequences to those already receiving funding. It is therefore requested that Medicaid require the state to fully elucidate their "Performance Measures" related to levels of care of enrolled participants that are reevaluated per waiver guidelines.

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B-6 a.i.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.

Application:

Elided for brevity

Comment:

Suffice to say the state merely providing aggregate numbers of the number of Level of Care (LOC) determinations performed, using the stated "Less than 100% Review" of the available *electronic* data (Why and what is it that the state intends on leaving out of these measurements?), is meaningless to show what the sub-assurance is seeking: that the "processes and instruments described in the approved waiver are ***applied appropriately*** and according to the approved description to determine participant level of care." I request that Medicaid seek to compel the state to provide meaningful and transparent statistics, processes, and reports to ensure compliance and to prevent political and unilaterally nefarious adjustments from being made to the state's algorithm to "tweak" the Individual Budget Amounts (IBA) in a manner that lacks transparency, oversight, and regulation.

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B-6 a.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.

Application:

"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."

Comment:

1. Herein, the state mentions reevaluating 100% of waiver participants, yet in the previous section the state seeks to only use a representative sample of data to ensure compliance and appropriate application of the processes and instruments. Why and what is it that the state intends on leaving out of these measurements, and to what end, when the state, as mentioned in this application, has access to 100% of the *electronic* data that is retained forever…why use a sample?
2. The state's application leaves out all details related to their stated annual review of the level of care assessment tool. The application only refers to the fact that all (100%) of participants are reevaluated annually, not on how it intends to discover/identify

problems/issues with the waiver program. What does the stated assessment tool review at the participant level entail and how exactly does such a narrow "review" translate into identifying issues with the overall waiver program(s)? How is it documented. Is the public provided with these details? Is Medicaid provided with a wholistic, systemic review? If the details are provided to the public and Medicaid, how/when/where are they provided? If the details are NOT provided to the public or Medicaid, why? And how can participants ensure their rights are not infringed upon due to the state's findings and any actions taken as a result of said findings? I request that Medicaid compel the state to provide specific details and procedures on strategies employed by the state to discover/identify problem/issues with the waiver program, per the application's request.

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B-6 b: Methods for Remediation/Fixing Individual Problems

B-6 b.i.: Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Application:

"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."

Comment:

The state's application makes no mention of, per this item, "identifying systemic deficiencies." While individual problems are addressed, the state fails to provide any details as to how it intends to identify problems with its Objective Assessment Process (OAP) in a broader, more widely applicable manner. While remediating and fixing individual problems is certainly necessary, the state does not describe, even in general, how it plans to examine problems in a wholistic manner in efforts to identify systemic issues. For example, the state is currently fielding an EXTREMELY large number of appeals related to individuals Level of Care (LOC)/Case Mix Index (CMI) reductions from previous levels. It is well known that there have been 0 (zero) appeals lost by the state [per DHSS DD director's comments to a service provider regarding no one winning their appeal, during a recent community meeting] – the state is batting 1000 on interRAI ID appeals. One should expect, in a fair and just adversarial system, that a 100% winning streak is highly suspect and likely fraudulent by design. The state should not be allowed to skirt its responsibility to Medicare and the citizens receiving HCBS under Medicare in the state of Nebraska at ensuring the systems and instruments used in the OAP are valid, correct, consistent, transparent, and consistently monitored and assessed for bias, error, discrimination, and political gain. I request that Medicare compel the state to provide specific details, plans, and procedures for ensuring quality and proactively identifying systemic deficiencies.

Archived: Wednesday, February 4, 2026 9:56:20 AM
From: [redacted]
Sent: Wednesday, February 4, 2026 8:23:10 AM
To: DHHS HCBS Public Comments
Subject: Public Comment
Importance: Normal

I am submitting this public comment to express significant concern regarding recent changes to the Consultative Assessment framework, specifically the removal of Functional Behavioral Assessments (FBAs) as a funded and required component informing Behavior Support Plans (BSPs).

The absence of BSPs informed by FBAs effectively places individuals without appropriate clinical training in the position of making quasi-clinical determinations at the fringe of licensed practice. FBAs are not ancillary documents; they are comprehensive, structured clinical tools that integrate behavioral data, medical and psychiatric context, environmental variables, and risk factors. Removing them from the service model undermines clinical rigor and blurs the boundary between programmatic support and licensed clinical judgment.

FBAs are fundamentally preventive in nature. When conducted appropriately, they function as an upstream safety intervention—identifying patterns of escalation, precursors to harm, and environmental risk factors before they result in injury to the individual or others. Shifting away from FBAs promotes a reactive model, in which intervention occurs only after a crisis or adverse event has already taken place. This approach increases risk rather than mitigating it.

Additionally, the removal of FBAs from the fee schedule will have predictable workforce consequences. Licensed Independent Mental Health Practitioners (LIMHPs), psychologists, and Board-Certified Behavior Analysts (BCBAs) rely on clinically grounded work that aligns with their scope of practice. Eliminating reimbursement for FBAs will incentivize these professionals to leave Nebraska for states that continue to fund evidence-based, preventive behavioral health services—further exacerbating the existing healthcare desert, particularly in rural regions.

It is also important to emphasize the value of independent FBAs. When conducted by clinicians who are not employed by the service-providing agency, FBAs offer an objective consultation focused on the safety, dignity, and long-term stability of the individual. This independence is a recognized best practice, reducing conflicts of interest and strengthening the credibility of recommendations that may involve staffing, environmental modification, or restrictive interventions.

Finally, reliance on the State's Clinical Team as a substitute for FBAs is not sufficient. Based on direct experience, the State Clinical Team is not positioned to provide practical, lay-level guidance to direct support teams at the scale required. Moreover, the volume of consultative need created by the removal of FBAs will rapidly overwhelm that team, resulting in delays, inconsistency, and reduced effectiveness across the system.

In summary, removing FBAs from the Consultative Assessment model weakens clinical oversight, increases risk, accelerates workforce attrition, and shifts the system away from prevention and toward crisis response. I strongly urge DHHS to reconsider this change and to preserve FBAs as a funded, independent, and clinically led component of behavior support planning in Nebraska.

Respectfully submitted,

Daniel Zak, EdD, LIMHP
Licensed Independent Mental Health Practitioner
Nebraska

From: [redacted]
To: DHHS HCBS Public Comments
Subject: CDD Comprehensive Waiver
Date: Friday, February 20, 2026 3:30:57 AM

> You don't often get email from [redacted]. Learn why this is important

Dear Nebraska DHHS Leadership,

I am submitting this public comment regarding the CDD Comprehensive Waiver and the use of the RAI assessment as the primary tool for determining eligibility and funding allocation.

While standardized tools can provide consistency, the RAI does not appear to capture the full scope of daily support needs experienced by individuals with intellectual and developmental disabilities. The assessment structure limits detailed explanation of behavioral variability, medical complexity, safety supervision, and fluctuating needs that occur outside of structured questioning.

When funding levels are derived primarily from this scoring system, families may experience reductions or limitations that do not accurately reflect actual care demands. This creates instability not only for individuals served, but also for providers and caregivers attempting to ensure health and safety.

I respectfully request:

Greater transparency in how RAI scoring translates into funding tiers.

Opportunities for expanded narrative input beyond fixed assessment fields.

A review of whether the RAI adequately measures complex, high-supervision needs.

Clear appeal standards that allow meaningful reconsideration when lived experience differs from assessment outcomes.

Nebraska families deserve a system that balances accountability with individualized understanding. I urge DHHS to reevaluate whether the current framework fully accomplishes that goal.

Thank you for your time and consideration.

Sincerely,

Dave Kampschneider

Nebraska Tax Payer

February 20,2026

Please Preserve Medicaid Waiver Support for My Daughter

To Whom It May Concern,

My name is Dave, and I am the father of a daughter who relies on Nebraska's Medicaid CDD Comprehensive Waiver services every single day.

I am writing to respectfully and urgently ask that you reconsider any reductions to waiver funding. These services are not extras in our daughter's life — they are the foundation that allows her to live safely, with dignity, and with stability.

Because of this waiver, she has been able to remain in her home, receive proper supervision, maintain her health, and participate in her community in a structured and supported way. The support she receives keeps her safe. It keeps her regulated. It keeps our family functioning.

If funding is reduced, her life will look very different — and not in a good way. Reduced staffing and fewer supports would mean increased medical risk, increased behavioral instability, and an overwhelming strain on our family. The structure that protects her well-being would begin to erode.

Our daughter cannot do this on her own. Individuals like her depend on consistent, trained support. These are not numbers on a spreadsheet — they are loved ones. They are sons and daughters. They deserve stability and safety.

Please carefully consider the real human impact of funding decisions. I respectfully ask that you preserve the Medicaid waiver funding that allows my daughter to continue living the life she has worked so hard to maintain.

Thank you for your time and consideration.

Sincerely,
Dave Kampschneider
Dave Kampschneider

From: [redacted]
To: DHHS HCBS Public Comments
Subject: Eliminating Consultative Behavior Assessments
Date: Saturday, February 14, 2026 8:12:52 PM

You don't often get email from [redacted] Learn why this is important

I respectfully oppose the proposed amendment to Nebraska's §1915(c) Home and Community-Based Services (HCBS) waiver that would eliminate Consultative Behavioral Assessments, commonly referred to as Functional Behavioral Assessments (FBAs). This change represents a fundamental shift away from preventive, clinically rigorous behavioral support and toward a system that relies on uncertain access pathways, reduced clinical oversight, and increased crisis response.

FBAs are not duplicative services. They provide independent, specialized behavioral analysis that cannot be replicated through general team-based planning or training alone. The proposed amendment replaces a clearly defined, waiver-funded preventive service with reliance on Managed Care Organization (MCO) billing pathways or internal team development, neither of which has been demonstrated to provide equivalent access, timeliness, or clinical rigor.

Chart: Current System vs. Proposed Change

Category	Current System (Waiver-Based FBA)	Proposed Change (Elimination of FBA Service)
Access to Assessment	Independent consultative behavioral specialist conducts FBA	Reliance on MCO billing pathways or internal team development
Clinical Expertise	Specialized behavioral assessment by trained clinician	Team-based plan development without guaranteed behavioral specialist oversight
Billing Pathway	Waiver-funded, clearly defined service	Claimed MCO billing pathway; limited evidence of reliable LI reimbursement
Provider Capacity	Dedicated waiver providers	Uncertain provider participation due to reimbursement and credentialing barriers
Timeliness	Defined waiver service timeline	Potential delays due to MCO credentialing and waitlists expanding multiple years
Objectivity	Independent external review and analysis	Internal team development; reduced independent clinical oversight
Plan Quality	Data-driven, individualized analysis	Risk of generalized or compliance-focused planning
Crisis	Preventive intervention before	Greater reliance on crisis services

Prevention	escalation	
Fiscal Impact	$2,000–$4,000 per FBA (approximate)	Higher downstream costs (ER, hospitalization, high-acuity placement)
Risk Level	Preventive and stabilizing	Increased likelihood of escalation and placement disruption

This comparison illustrates that the proposed amendment does not simply modify how behavioral plans are developed, it fundamentally weakens access to specialized behavioral expertise, reduces independent clinical oversight, and increases reliance on crisis-driven systems. Eliminating waiver-based FBAs shifts the system from prevention to reaction, placing participants, families, providers, and the state at greater risk.

Under §1915(c) waiver assurances, Nebraska is required to protect participant health and welfare, ensure provider capacity, and maintain timely access to necessary services. Without clear documentation demonstrating equivalent access, provider availability, and fiscal impact, it is difficult to conclude that these assurances will continue to be met under the proposed change.

For these reasons, I respectfully urge reconsideration of this amendment and preservation of Consultative Behavioral Assessments as a core, preventive component of Nebraska's HCBS waiver system.

Thank you for your time,
Deshawn Ferris

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I oppose the proposed removal of the Consultative Assessment Service (CAS) from Nebraska's DD waivers the assertion that Medicaid Managed Care Organization (MCO)–based Functional Behavior Assessments (FBAs), combined with revised Behavior Support Plan (BSP) requirements, provide an equivalent replacement.

CAS is a waiver-integrated, proactive service that includes cross-setting behavioral observation, intervention development and revision, and staff training aligned with ISP goals and waiver safeguards. These functions are not replicated by episodic, medically driven MCO assessments, which are frequently inaccessible to adults with developmental disabilities due to closed provider networks, long waitlists, and restrictive credentialing requirements.

Limiting FBAs to participants already identified at a Risk Tier shifts Nebraska's system from prevention to reaction. Behavioral instability often escalates before Risk Tier thresholds are met. CAS has historically supported early identification, staff coaching, and timely plan adjustments that prevent escalation to emergency services, psychiatric hospitalization, and placement disruption.

From a fiscal perspective, eliminating CAS represents a cost shift rather than a cost savings. Removing preventative behavioral consultation increases reliance on high-cost crisis responses, including emergency interventions, hospitalizations, restrictive placements, and higher staffing ratios. These downstream costs far exceed the cost of maintaining CAS.

For these reasons, I urge DHHS to retain Consultative Assessment Services to protect participant safety, provider stability, and long-term fiscal sustainability within Nebraska's DD system.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

Erin

Last Name

McCord

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 19, 2026

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I oppose the removal of Consultative Behavioral Assessments (FBAs) from Nebraska's DD HCBS waivers. The state claims FBAs are "duplicative" because they can be billed through MCOs or created internally by teams.
Why This Is a Problem
1. Billing Through MCOs Is Not Functionally Accessible
* Licensed Independent clinicians cannot reliably bill MCOs for FBAs.
* Result: Reduced provider participation and decreased access.
2. Team-Based Plans Are Not a Substitute
* FBAs require specialized behavioral expertise.
* Direct support teams are dedicated but not trained behavioral clinicians.
* Removing independent assessment removes clinical oversight and rigor.
* Teams hire independent contractors for a reason…if they felt confident enough to complete these assessments, they would.
3. It Will Increase Crisis and Costs
* FBA cost estimate: $2,000–$4,000.
* Psychiatric hospitalization: $8,000–$15,000+ per stay.
* Emergency room visits: $1,500–$3,000 each.
* High-acuity placements: $100,000+ annually per individual.
Preventive behavioral assessment avoids:
* Hospitalizations
* Law enforcement involvement
* Staff injuries and turnover
* Placement failure
4. This Is a Cost Shift, Not a Cost Savings
* Eliminating FBAs does not eliminate behavioral needs.
* It shifts costs to emergency systems and high-acuity placements.
Bottom Line
Removing FBAs:
* Reduces access to specialized behavioral expertise
* Weakens clinical oversight
* Increases crisis utilization
* Likely increases long-term Medicaid costs
Legislative Consideration
Before supporting this amendment, legislators should ask:
* Is there documented MCO provider capacity to absorb this service?
* What is the average wait time for behavioral assessment through MCOs?
* What fiscal analysis compares preventive FBA costs to crisis expenditures?
* How does this protect participant health and welfare?

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

Gabrielle

Last Name

Hiser

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 15, 2026

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

DDD Public Comment Form

undefined

Comment

Hello! I have been a clinician completing FBAs for the las years. I have seen the benefit of these assessments. The assessments help providers and individuals understand challenging and undesirable behaviors. They should be person- specific and require time to get to know the person through observations and interviews. I fear turning them over to the MCOs will not be beneficial and could prevent more providers and individuals from receiving the help that they need. No information has been provided on a timeline of reaching out to the MCOs to start the process or how long it will take for the assessments to be completed. There is also no guarantee that the people that are currently doing FBAs will be able to do ABAs in the future with the MCOs. This is very unfortunate as the clinicians, like me, know this population very well and are active in their care. What does it look like when a licensed person from the MCO completes an assessment without understanding the person or this population? Will person-specific services be able to be met?

I understand that there is a shortage of available people to complete the FBAs but is this the answer to that problem? This is not an equivalent replacement because ABA access is limited for adults, the ABA will be a reactive option and not a preventative option, and costs for crisis services will increase. Current FBAs reduce ER visits and hospitalizations and police presence with preventative measures and are individualized and person-centered. A clinician being available to the team and provider when necessary to assist with new or changes in behavior can be beneficial and cost-saving compared to having a person that is contracted through the MCO and may not be available in a timely fashion. Please consider the consequences of this change to the DD agencies and the individuals that they support and care for. Thank you.

Tell us about yourself! I am...

An Organization- A company, organization, or government agency

Email

[redacted]

Phone

 [redacted]

City & State

Omaha

Organization Name

Integrity Alliance

Organization Type

Company or Provider

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 24, 2026

From: [redacted]
To: DHHS HCBS Public Comments
Subject: Public Comment on CDD and DDAD Waiver
Date: Monday, January 26, 2026 2:10:21 PM
Attachments: gwlogotype-100-73-0-2-100black_1a4f6587-a24f-46f1-8e1e-04aa95b8692f.png
J. Blankenship Comment on Proprosed State Updates.docx

> You don't often get email from [redacted] Learn why this is important

Hi my name is Emma Meyer and I am relaying this comment on behalf of one of our clinicians regarding the updates proposed. The comment is attached below via document as well as typed here:

The Case for the Use of Licensed Independent Mental Health Practitioners for Crisis Intervention and High-Risk Behavioral Support

My name is **Jennifer Blankenship**, and I have worked as an independent provider conducting Functional Behavioral Assessments (FBAs) throughout Nebraska for the past two years. With the upcoming changes to the Medicaid waiver, I would like to offer my professional perspective to those responsible for shaping policy and service delivery for individuals with high-risk and complex behavioral needs.

Communities across Nebraska have a significant and ongoing need for clinical support from licensed mental health practitioners who are qualified not only to assess behavior but also to identify and address the underlying mental health factors that often drive high-risk or problematic behaviors. In my experience, behavioral challenges rarely stem from a single cause. Instead, they emerge from the interaction of mental health symptoms, environmental factors, family dynamics, service-system limitations, and staff responses.

Through my work supporting individuals with complex behavioral presentations, I have encountered numerous cases in which traditional behavior-only approaches were insufficient. For example, I have worked with individuals who had been diagnosed—or clearly required assessment for—paraphilic disorders. In these cases, existing Developmental Disabilities Division (DDD) policies and person-centered approaches sometimes conflicted with established best practices for treating these disorders. By providing clinical guidance, I was able to help teams understand that, given the nature of the diagnosis, increased structure and appropriate restrictions were necessary to ensure safety. I also assisted teams in identifying the appropriate assessments and developing behavior support plans that aligned with clinical standards of care.

In other cases, the primary contributors to problematic behavior were family dynamics and environmental stressors rather than skill deficits alone. By meeting directly with family members in the community, I was able to increase understanding of how these dynamics were contributing to the individual's challenges and to guide families and support teams toward more effective, sustainable interventions.

These experiences highlight the value that licensed clinicians—particularly those trained in systems therapy and in working with individuals with severe and persistent mental illness—can bring to crisis intervention and behavioral support. Such clinicians are able to offer a more comprehensive and integrated approach than behavior therapy alone, especially in situations where mental health symptoms significantly influence behavior.

I believe these types of interventions remain necessary and should be preserved within the Medicaid waiver framework. These situations can often be addressed through targeted, in-person observations; structured interviews with direct support staff and caregivers; and thorough review of existing data and records. The outcome of this process does not need to be as lengthy or resource-intensive as a full FBA and may, in many cases, be more clinically useful.

I propose a model in which the clinician provides:

- A clear written explanation of the presenting problem and the factors contributing to high-risk behaviors
- A concise, actionable plan outlining strategies to address those factors
- Training for staff and caregivers, including competency-based assessments and supporting training materials
- Periodic follow-up competency checks (for example, annually) to ensure fidelity to the intervention and prevent regression to ineffective or unsafe practices

This approach would allow for timely, clinically informed interventions that prioritize safety, effectiveness, and long-term sustainability for individuals with complex needs.

Emma Meyer
Habilitation Specialist
Goodwill Industries of Greater Nebraska, Inc.
835 South Burlington, Ste #110
Hastings, NE 68901
Phone:
Cell: 402-902-0577 | Fax: 402.463.1445
emeyer@goodwillne.org
Web: Goodwillne.org

Goodwill
Industries of Greater Nebraska, Inc.
With CARE at Our Core: Community, Accountability, Respect, and Empowerment in Action.

The Case for the Use of Licensed Independent Mental Health Practitioners for Crisis Intervention and High-Risk Behavioral Support

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- A clear written explanation of the presenting problem and the factors contributing to high-risk behaviors
- A concise, actionable plan outlining strategies to address those factors
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- Periodic follow-up competency checks (for example, annually) to ensure fidelity to the intervention and prevent regression to ineffective or unsafe practices

This approach would allow for timely, clinically informed interventions that prioritize safety, effectiveness, and long-term sustainability for individuals with complex needs.

Subject: Please Protect Funding for the CDD Comprehensive Waiver

Governor Pillen,

I am writing as a Nebraska parent and caregiver to strongly urge you not to reduce funding for the CDD Comprehensive Developmental Disabilities Waiver.

For families, this waiver is not optional. It is not extra. It is essential for safety, health, and daily stability. The services funded through this waiver allow individuals with significant disabilities to remain in their homes, receive proper supervision, and avoid unnecessary institutionalization or crisis care.

Reducing funding would not simply "tighten a budget." It would place medically vulnerable Nebraskans at risk. It would increase emergency room visits, caregiver burnout, behavioral crises, and long-term institutional costs — all of which are far more expensive than properly funding community-based supports.

Nebraska families are doing everything we can to keep our loved ones safe at home. We are not asking for more than what is necessary. We are asking that you protect what is already in place so that our sons and daughters can live with dignity and safety.

Please stand with Nebraska families. Protect the Comprehensive Waiver funding.

Respectfully,
Jake Kampschneider

Medical Complexity / Safety Risk Focus

Dear DHHS Waiver Review Committee,

I am writing during the public comment period to express concern regarding funding and tier determinations under the Comprehensive DD Waiver.

Many individuals served under this waiver experience fluctuating medical instability — including seizure-like shaking episodes, gastrointestinal incidents, fall risk during bathing, and nighttime monitoring needs. These realities require flexible and adequately funded staffing models.

When tier levels are reduced or criteria are narrowed, the result is not cost savings — it is increased emergency intervention, higher medical costs, and preventable safety incidents.

The Comprehensive Waiver must remain responsive to medical necessity, not constrained by rigid funding caps or administrative simplifications.

I respectfully request that DHHS reconsider any funding reductions and ensure that tier determinations fully reflect medical instability, two-person assist needs, and overnight supervision requirements.

Public policy must align with real-world care demands.

Sincerely,

Jeanette Jarosz

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I am writing to urge you to protect the CDD and DDAD Medicaid Waiver including reimbursement for consultative assessment services as budget and policy decisions move forward.

Consultative assessment services prevent crisis, reduce institutionalization, and save the state money. Any changes should be guided by clinical evidence and expert testimony on downstream impacts. Please ensure that families, caregivers, and professionals are fully heard before advancing policies that could destabilize vulnerable individuals, agencies who oversee services, and caregivers.

I appreciate your consideration and support!

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

Email

[redacted]

Phone

1[redacted]

First Name

Jen

Last Name

Muller

City & State

Omaha, NE

Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 10, 2026

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I strongly oppose the proposed amendment to Nebraska's §1915(c) HCBS waiver. Restricting access to timely Functional Behavior Assessments (FBAs) by limiting them to Managed Care Organization (MCO) billing pathways will have serious consequences for individuals with disabilities, providers, and the State of Nebraska.

Although it has been stated that FBAs are available through MCOs, this does not reflect current practice. Restrictive and inconsistent credentialing requirements exclude many qualified clinicians, resulting in multi-year waitlists and widespread inaccessibility. For individuals experiencing active behavioral challenges, these delays are unsafe, clinically inappropriate, and unethical.

When timely behavioral assessment and intervention are unavailable, behavior predictably escalates. Unsafe behaviors increase, emergency interventions become more frequent, caregivers and staff experience burnout, and placements destabilize or fail. These outcomes are well documented and consistently observed in practice.

From a fiscal standpoint, restricting FBAs is counterproductive. Preventive behavioral assessment costs far less than emergency room visits, hospitalizations, crisis services, law enforcement involvement, and high-cost residential placements. Limiting access to FBAs does not eliminate the need for behavioral support, it shifts the burden to more expensive, reactive systems.

Nebraska must prioritize timely, accessible, and preventive behavioral services. This proposal undermines safety, stability, and long-term outcomes and should be reconsidered with meaningful input from clinicians, providers, families, and those directly impacted.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

Email

[redacted]

Phone

 [redacted]

First Name

Jen

Last Name

Muller

City & State

Omaha, NE

Waiver

CDD- Comprehensive Waiver

[redacted]

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I oppose the proposed amendment to Nebraska's §1915(HCBS waiver that would eliminate consultative behaviora assessment services based on the claim that they are duplicative and available through Managed Care Organizations (MCOs).

Although FBAs are said to be accessible through MCO billing pathways, providers and families report significant barriers, limited network availability, and delays in obtaining timely assessments. No clear, publicly documented process demonstrates that participants will reliably access behavioral assessment services through MCOs.

For individuals experiencing behavioral challenges, timely assessment is essential to health and safety. When preventive supports are delayed, behaviors escalate. Emergency interventions increase, placements destabilize, and systems shift from proactive care to crisis response.

This results in:
Increased hospitalizations and emergency services
Greater reliance on law enforcement
Caregiver burnout and staff turnover
Higher-cost, more restrictive placements
Preventive behavioral assessment is far more cost-effective than crisis stabilization. Eliminating waiver-based services does not remove the need—it shifts costs to more expensive systems.

Under §1915(c) assurances, the state must protect participant health and welfare and ensure access to necessary services. I respectfully urge reconsideration of this amendment to ensure Nebraska's most vulnerable residents maintain access to timely, preventive behavioral supports.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

Email

[redacted]

Phone

[redacted]

First Name

Jen

Last Name

Muller

City & State

Omaha, NE

Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 24, 2026

I am writing to urge you to protect the CDD and DDAD Medicaid Waiver including reimbursement for consultative assessment services (CAS) as budget and policy decisions move forward. The elimination of consultative assessment services through the DHHS-DD wavier threatens to significantly restrict access to crisis and behavioral support for participants, family members, caregivers, and provider agencies. While many caregivers may be able to identify or hypothesize the function of a participant's behavior, most do not have access to qualified professionals with specialized education and training in diagnosis, behavior analysis, assessment methodologies, and evidence-based interventions. Reduced access to CAS will undermine person-centered planning and the development of interventions specifically designed to decrease the frequency and intensity of maladaptive behaviors. For families and caregivers supporting adults with complex mental and behavioral health needs, this reduction directly impacts safety, stability, and the ability of participants to remain successfully engaged in services with adequate behavioral supports.

As an Assessment Specialist who has assisted in completing Functional Behavioral Assessments (FBAs) for more than three years, it has been my experience that very few licensed clinicians possess both the necessary clinical and behavioral expertise along with practical experience navigating the developmental disability (DD) system. Providing consultative assessments requires a highly specialized and niche skill set, which has already resulted in a limited pool of qualified providers. Additionally, Medicaid licensure requirements for professionals authorized to complete FBAs further restrict provider availability, creating a significant workforce shortage and extensive waitlists for services. Many individuals wait years for access to FBAs and, in some cases, only become eligible after turning 21 and receiving approval for DD waiver services. Further reducing access to proactive, preventative behavioral therapies and crisis management supports is likely to result in higher long-term costs, increased funding tiers, participant behavioral crises, and more restrictions.

That said, I support the Department of Health and Human Services' goal of improving access to Behavioral Support Plans (BSPs) by expanding training and resources for agencies and caregivers in conjunction with the FBA. Currently, BSP and safety plan development hours are included in CAS reimbursement. A more effective and efficient approach may be to remove clinician reimbursement for BSP and safety plan writing and instead make this the responsibility of supporting agencies and caregivers, who often employ program writers with specific expertise in this area. This shift would reduce the number of CAS hours required from clinicians while preserving access to high-quality FBAs and consultative input, ultimately supporting both system sustainability and participant outcomes. Thank you for your consideration.

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Ingabire, Yvonne

From: [redacted]
Sent: Tuesday, February 10, 2026 9:40 AM
To: DHHS HCBS Public Comments
Subject: CDD and DDAD Waivers

You don't often get email from [redacted] Learn why this is important

I am writing to urge you to protect the CDD and DDAD Medicaid Waiver including reimbursement for consultative assessment services as budget and policy decisions move forward.

Elimination of access to consultative assessment services through DHHS will decrease person centered planning and interventions specifically designed to reduce the frequency and intensity of maladaptive behaviors. For caregivers and families caring for adults with complex mental and behavioral health needs, this directly affects safety, stability, and whether participants and caregivers have access to behavioral supports and resources to remain in services.

Consultative assessment services prevent crisis, reduce institutionalization, and save the state money. Any changes should be guided by clinical evidence and expert testimony on downstream impacts. Please ensure that families, caregivers, and professionals are fully heard before advancing policies that could destabilize vulnerable individuals, agencies who oversee services, and caregivers.

I appreciate your consideration and support!

Jen Muller
[redacted]

From: [redacted]
To: DHHS HCBS Public Comments
Subject: CDD and DDAD Waivers
Date: Tuesday, February 10, 2026 9:40:24 AM

> You don't often get email from [redacted] Learn why this is important

I am writing to urge you to protect the CDD and DDAD Medicaid Waiver including reimbursement for consultative assessment services as budget and policy decisions move forward.

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I appreciate your consideration and support!

Jen Muller
[redacted]

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

DDD Public Comment Form

undefined

Comment

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I appreciate your consideration and support!

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

Email

[redacted]

Phone

[redacted]

First Name

Jen

Last Name

Muller

City & State

Omaha, NE

Waiver

CDD- Comprehensive Waiver

Submitted on Feb 10, 2026

From: [redacted]
[redacted] DHHS HCBS Public Comments
Subject: CDD and DDAD Medicaid Waiver
Date: Tuesday, February 10, 2026 10:04:22 AM
Attachments: Public Comment.docx

> You don't often get email from [redacted]. Learn why this is important

Please see attached file for public comment.
Thanks!
Jen Muller
[redacted]

Retaining Consultative Assessment Services and Authorizing Independent LIMHP-Delivered Targeted CAS Units

Submitted by:
Independent Provider – Functional Behavioral Assessments (FBAs), Nebraska

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Executive Summary

I respectfully request that the revised Medicaid waiver **retain Consultative Assessment Services (CAS)** and explicitly authorize **targeted CAS units delivered by independent Licensed Independent Mental Health Practitioners (LIMHPs)** for crisis intervention, behavioral stabilization, staff training, and structured supervision-reduction planning. Strategic use of targeted CAS-rather than default reliance on full FBAs or ongoing high-intensity habilitative services-provides an objective, clinically informed, and cost-effective mechanism to reduce reliance on Behavioral In-Home Habilitation, Therapeutic Residential Habilitation, and exception funding while maintaining health and safety.

For purposes of this comment, "independent LIMHP" means a LIMHP **not employed by, contracted to, or otherwise affiliated with** the agency delivering the participant's ongoing residential, day, or habilitative services.

Purpose and Professional Background

I have worked as an independent provider conducting Functional Behavioral Assessments (FBAs) across Nebraska for the past two years. Through this work, I have supported individuals receiving Developmental Disabilities (DD) services who present with complex behavioral challenges frequently influenced by co-occurring mental health conditions.

With upcoming changes to the Medicaid waiver, I submit this comment to advocate for the **continued and clearly defined inclusion of LIMHPs**, specifically independent LIMHPs, as providers of targeted clinical consultation and crisis intervention when mental health factors significantly contribute to behavioral risk.

Service Needs Observed Across Nebraska Communities

Many individuals served under the waiver experience behavioral challenges that cannot be effectively addressed through habilitative or behavior-only interventions. These situations often

involve psychiatric symptoms, trauma histories, family-system dynamics, environmental stressors, or service-delivery limitations that require clinical assessment and intervention.

When teams lack access to qualified mental health clinicians, the system faces increased risk of delayed intervention, ineffective service escalation, and prolonged reliance on high-intensity supports that may not address the underlying causes of behavioral risk.

Clinical Gaps in Current Service Models

In my work, I have supported individuals who were diagnosed-or clearly required further assessment for-serious mental health conditions, including paraphilic disorders. In these cases, strictly person-centered approaches sometimes conflicted with evidence-based treatment standards, particularly when safety-driven structure and restrictions were clinically indicated. Targeted clinical consultation helped teams implement appropriate safeguards, identify needed assessments, and develop behavior support plans aligned with mental health standards, often preventing escalation to more restrictive or costly interventions.

In other cases, behavioral concerns were driven primarily by family dynamics or environmental variables rather than skill deficits alone. Targeted community-based consultation helped teams modify supports and expectations, reducing behavioral risk without prolonged high-supervision services.

These examples illustrate the need for **clinically informed, targeted intervention options** within the waiver structure.

The Role and Value of Licensed Independent Mental Health Practitioners

LIMHPs-particularly those trained in systems therapy and severe and persistent mental illness-bring essential expertise that complements behavioral services. These clinicians are able to:

- Integrate mental health, behavioral, and environmental factors into a unified clinical formulation
- Provide guidance when safety considerations require limits or structure beyond standard person-centered practices
- Support time-limited, outcome-focused interventions

This role is especially important when behaviors are driven by mental health symptoms rather than skill deficits.

Strategic Use of Consultative Assessment Services

Efficiency and Appropriate Use of CAS Units

Consultative Assessment Services are often used to support full FBAs, which typically require **30–40 units**. While FBAs are appropriate in some cases, many situations can be effectively addressed through **10–20 CAS units** focused on targeted assessment, intervention, and training.

In my experience, targeted CAS allows clinicians to:

- Rapidly identify drivers of behavioral risk
- Determine whether concerns are primarily mental-health-driven, environmental, or systems-based
- Provide practical recommendations with measurable steps
- Train staff and caregivers efficiently and verify competency

Allowing CAS to be used independently of full FBAs when clinically appropriate improves responsiveness, reduces unnecessary utilization, and promotes earlier stabilization.

Cost Effectiveness and Utilization Management

Without targeted clinical reassessment, systems often default to:

- Behavioral In-Home Habilitation
- Therapeutic Residential Habilitation
- Exception funding
- Sustained elevated supervision levels

Strategic use of CAS as an early-intervention and stabilization service can reduce reliance on these higher-intensity supports by addressing contributing factors earlier and enabling safe, structured step-down plans.

Independent Provider Requirement to Avoid Conflicts of Interest

A key safeguard of CAS is the ability to use **independent LIMHPs**-clinicians who are not financially tied to the delivery of ongoing supervision or habilitative hours. For waiver design purposes, targeted CAS should be delivered by LIMHPs who are **not employed by, contracted to, or otherwise affiliated with** the agency delivering the participant's ongoing services.

This distinction is necessary because agency-employed clinicians operate within the same organizational structure that bills for supervision and habilitation hours. Even with best intentions, that structure creates a systemic disincentive to recommend reductions in service intensity. Independent LIMHP-delivered CAS supports objective clinical reassessment,

measurable behavior-reduction planning, and ethically sound supervision reduction recommendations.

Response to Proposed Elimination of Consultative Assessment Services (Effective 7/1/2026)

The proposed amendment would discontinue CAS effective July 1, 2026 and shift BSP development toward internally created plans supported through expanded training, internal resources, and access to the Clinical State Team (CST). While the intent to strengthen provider capacity and improve access to behavioral supports is acknowledged, full elimination of CAS raises significant concerns related to clinical oversight, system incentives, and risk management.

Loss of Independent Clinical Assessment and Oversight

CAS provides an independent clinical function distinct from habilitative service delivery. Eliminating CAS removes a structured, objective assessment mechanism and replaces it with internally developed BSPs created by agencies that also bill for high-intensity services. Internal planning and training are not a substitute for independent clinical consultation in cases involving complex mental health conditions, elevated risk, or the need to safely reduce supervision.

System Incentives and Risk of Service Overutilization

When agencies develop the BSP and deliver the services identified in the plan, there is an inherent incentive to maintain service intensity without external reassessment. Eliminating CAS increases the likelihood of overreliance on Behavioral In-Home Habilitation, Therapeutic Residential Habilitation, exception funding, and prolonged elevated supervision.

Training and “Clinical Judgment” Do Not Replace Independent Assessment

While person-centered, data-driven planning is essential, internal “clinical judgment” is not equivalent to independent mental health assessment. CAS provides structured analysis, written documentation of contributing factors and risk, measurable recommendations, staff training, and objective step-down planning.

Limitations of CST as a Replacement

CST is an important resource, but it functions primarily as a secondary consultative or escalation support rather than a direct early-intervention service. CAS enables timely, localized intervention before behavioral risk escalates.

Preservation of a Behavioral Health Safety Net

CAS functions as a behavioral health safety net across Nebraska communities-bridging routine supports and crisis-level interventions. Eliminating CAS removes an early-intervention mechanism and shifts responses toward escalation rather than stabilization.

Alternative Amendment Proposal (CMS-Style Language)

Rather than eliminating CAS, I propose the following alternative approach to achieve the State's stated goals of efficiency and provider access while maintaining safeguards and cost controls:

The waiver shall retain Consultative Assessment Services (CAS) as a targeted, time-limited intervention delivered by independent qualified clinicians, including Licensed Independent Mental Health Practitioners (LIMHPs). For purposes of CAS, "independent" means the LIMHP is not employed by, contracted to, or otherwise affiliated with the agency or provider entity delivering the participant's ongoing residential, day, or habilitative services. CAS may be utilized independently of a full Functional Behavioral Assessment when clinically appropriate and shall focus on behavioral stabilization, identification of contributing mental health and environmental factors, staff training, and development of measurable plans to reduce behavior severity and supervision levels. The State recognizes CAS as a utilization-management and cost-containment strategy intended to reduce reliance on exception funding and prolonged high-intensity habilitative services, including Behavioral In-Home Habilitation and Therapeutic Residential Habilitation.

Requested Action

I respectfully request that DHHS and the waiver committee:

1. **Retain Consultative Assessment Services (CAS) in the revised waiver**
2. **Explicitly authorize targeted CAS units delivered by independent LIMHPs** (not employed by, contracted to, or otherwise affiliated with the participant's service-provider agency)
3. **Allow CAS to be used independently of full FBAs** when clinically appropriate, including targeted assessment, intervention, staff training, and competency verification within a smaller unit range
4. **Recognize CAS as a utilization-management and cost-containment strategy** to reduce reliance on Behavioral In-Home Habilitation, Therapeutic Residential Habilitation, prolonged high-supervision, and exception funding

Preserving and strengthening CAS in this manner will enhance safety, improve outcomes, and promote responsible stewardship of Medicaid resources while supporting Nebraska communities serving individuals with complex behavioral and mental health needs.

From: [redacted]
To: DHHS HCBS Public Comments
Subject: Public Comment Period - CDD and DDAD Waivers
Date: Wednesday, February 25, 2026 5:28:50 PM
Attachments: Outlook-itpaytpk.png

You don't often get email from [redacted] Learn why this is important

Hello,

I respectfully submit the following concerns regarding the proposed removal of semi-annual team meetings and consultation services.

Semi-Annual Meetings

The removal of the semi-annual meeting requirement creates a significant gap in care coordination, interdisciplinary communication, and ongoing oversight of participant needs. Semi-annual meetings are not merely administrative; they function as structured safeguards to ensure services remain appropriate, effective, and aligned with the individual's evolving needs. These meetings allow the team to continuously address any needs the participant has.

For some participants they look forward and plan their meetings, they use these as their way to talk, and have a platform of navigating their own lives and services, taking this away will be upsetting to some. This removal to some participants, can be viewed as

their voice doesn't matter in their own services.

Having a planned meeting every six months eliminates the need to have extra communication throughout the waiver year, as all members of the team know that they can just wait for the update coming meeting. So, limited to only meeting once a year, is going to create a higher amount of communication as team will discuss things as they come up, instead of waiting for upcoming meetings.

The current policy for all rights restrictions is reviewed of 6 months, all teams use the Semi-annual meetings as a critical mechanism for ensuring that rights restrictions are meaningfully reviewed, data is evaluated, and less restrictive alternatives are actively pursued. Without this structured review point, there is increased risk that restrictions could remain in place longer than clinically necessary, which would conflict with the intent of the HCBS Settings Rule's rights-based protections.

If semi-annual meetings are removed, policies related to the Human and Legal Rights Committee (HLRC) must be revised for alignment and clarity. If semi-annual meetings are removed, then alternatively, semi-annual meetings should remain mandatory whenever restrictions are in place. Another solution could be for the HLRC process to updated to where they are only reviewed annual, to align with the annual meetings.

Removal of Consultation Services

The proposed elimination of consultation services would create a significant gap in access to specialized behavioral and clinical expertise, particularly for individuals experiencing crisis or

presenting with complex needs. Consultation services often provide the assessment, data analysis, and positive behavioral support planning necessary to prevent more restrictive interventions.

Federal HCBS standards emphasize that services must optimize individual autonomy and independence and be delivered in a manner that ensures health and welfare. Removing consultation services entirely may undermine the system's ability to implement positive interventions prior to imposing restrictive measures, which runs counter to the requirement that restrictions be justified only after less intrusive methods have been attempted and documented.

Given Nebraska's already limited provider pool for specialized assessments and consultation, full elimination of this service will likely result in extended waitlists, delayed interventions, and increased risk to participants and providers. Rather than eliminating consultation services, we strongly recommend implementing an exception funding process that allows access when clinically or medically necessary. This approach would maintain fiscal oversight while preserving essential protections and ensuring continued compliance with HCBS person-centered and rights-based standards.

Thank you for your consideration,

Jennifer Viles
Director
Holistic Group Inc.

Phone Number: 402-718-6900
Fax Number: 402-763-9126

Address:
9001 Arbor St Ste 206
Omaha, NE 68124

HGI
Holistic Group, Inc.

Supporting People in Living Their Best Lives

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

DDD Public Comment Form

undefined

Comment

I urge you to protect the CDD and DDAD Medicaid Waivers, including consultative assessment services, as decisions are made regarding future funding and policy direction.

These services are essential in stabilizing individuals with complex needs, preventing crisis situations, and supporting families and caregivers. Changes should not move forward without listening to those directly impacted and understanding the real-world consequences of reduced access.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

Julia

Last Name

Dunning

City & State

Omaha, NE

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 9, 2026

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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I am writing as a parent of a child with a disability in stron opposition to the proposal to remove Consultative Assessment services from Nebraska's HCBS waiver. I was hesitant to agree to an FBA at first. I worried about what it meant and whether it would truly help. It ended up being the best thing we could have done for our child.
The level of detail included in our child's FBA was remarkable. It included detailed information specific to my child's disabilities, triggers, warning signs, what helps prevent escalation, how he learns best, and what to avoid. The consultant took time to truly understand him and tailored the FBA precisely to our child. They provided specific social skills activities and even created social scripts outlining exactly what he could say in difficult situations. Those scripts gave him confidence and gave us clarity. The team was flexible, responsive, and available when we had questions. That level of support made all the difference.
The assessment was completed in about three and a half months and if we would've had to wait 2 years, like what will happen if your proposal goes through, my child would have suffered and become so much worse, and I truly don't know know what I would have been reduced to.
Before the FBA, we worked closely with our service coordinator, vocational staff, and our family trying everything we could think of. Nothing worked. We were exhausted and felt helpless. The FBA brought expertise that our internal team could not provide. It gave us answers and direction.
Removing this service does not just change paperwork. It removes specialized, independent expertise that families desperately need. Training alone cannot replace that level of clinical skill.
These changes will harm vulnerable individuals and families like mine. FBAs bring prevention, stability, and hope. Please do not take that away. I respectfully urge you to reject this amendment.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

K

Last Name

Wood

City & State

Bellevue, NE

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 13, 2026

Dr. Katherine Bacon, Ph.D., LPC-S, NCC
[redacted]

March 3, 2026

Nebraska Legislature
Health and Human Services Committee
Nebraska State Capitol
Lincoln, Nebraska

Re: Public Comment in Support of LB 958 and Amendment 1992 – Improvements to the IDD Evaluation Process and InterRAI Assessment Implementation

Dear Members of the Health and Human Services Committee:

Thank you for the opportunity to submit comments regarding LB 958 and Amendment 1992, which address the evaluation process used to determine service eligibility and levels of support for individuals with intellectual and developmental disabilities (IDD) under Nebraska's 1915(c) Home and Community-Based Services waivers.

I write in strong support of LB 958 and the proposed amendments because these changes represent meaningful improvements to transparency, fairness, and accountability in the assessment process used to determine services for individuals with disabilities.

Personal Perspective

My support for this legislation is deeply personal.

My brother and I grew up in the Nebraska foster care system and ultimately aged out of care. When we left the system, I became my brother's legal guardian. Navigating public systems designed to assess need and determine access to services has been a central part of our lives.

Today, I am a tenured professor of professional counseling and a practicing mental health provider. Through my professional work, I see daily how critical accurate assessments and transparent service determinations are to the well-being of individuals with disabilities and their families.

The policies Nebraska adopts regarding assessment tools and appeal processes are not abstract administrative procedures. They directly affect whether real people receive the supports they need to live safely, independently, and with dignity.

Importance of Improving the Assessment Process

The use of standardized tools such as InterRAI or similar assessment systems can be valuable when implemented correctly. However, assessment tools must always be paired with skilled clinical judgment and meaningful communication with the individual being evaluated.

LB 958's provisions requiring training in clinical interviewing techniques are essential. Individuals with IDD may communicate their needs differently, require clarification of questions, or need adaptive interviewing approaches. Without proper training, assessments can easily misrepresent a person's actual functional needs.

Ensuring that staff administering these tools are trained to adapt questions, clarify responses, and understand the individual's communication style will significantly improve the accuracy and fairness of service determinations.

Transparency and Communication

Another important component of the bill is the requirement that the Department clearly communicate eligibility determinations, service tier assignments, the methodology and scoring used by the assessment tool, and appeal rights and procedures.

Families and guardians often struggle to understand how decisions about services are made. Providing clear explanations of scoring metrics, algorithms, and service tier determinations will improve trust in the system and allow individuals to make informed decisions about whether to appeal a determination.

Transparency is not simply good administrative practice—it is essential for protecting the rights of waiver participants.

Strengthening the Appeal Process

One of the most significant improvements included in the amendment is the provision allowing a waiver participant, parent, or guardian to obtain an independent evaluation during an appeal, with the cost covered by the state and the evaluation included as evidence in the hearing.

This provision is critical.

For individuals and families navigating complex systems, appealing a determination without access to an independent evaluation often creates a significant imbalance between the individual and the state. Allowing independent evaluations helps ensure that appeals are based on complete and objective information, improving both fairness and accuracy in the process.

For individuals whose services may be reduced or altered, these decisions can dramatically affect quality of life, independence, and safety. Ensuring access to independent evaluation strengthens due process and protects vulnerable individuals.

Oversight and Accountability

The reporting requirements included in LB 958 also represent a meaningful step toward legislative oversight and system accountability. Requiring the Department to report on assessment tool metrics, service tier changes, implementation challenges, and compliance with federal HCBS regulations will provide lawmakers with the information necessary to evaluate whether the system is functioning fairly and effectively.

These reporting provisions will help Nebraska identify disparities, improve implementation, and ensure that the system continues to meet the needs of waiver participants.

Why This Matters

My brother and I experienced firsthand how public systems shape the trajectory of a person's life. For individuals with disabilities, accurate assessments and fair appeal processes are not bureaucratic details—they determine access to the supports that allow people to live safely, participate in their communities, and pursue independence.

As both a family member who has navigated these systems and a professional who works within the behavioral health field, I strongly believe that LB 958 and Amendment 1992 represent thoughtful and necessary improvements to Nebraska's evaluation process.

Conclusion

I respectfully urge the Nebraska Legislature and the Health and Human Services Committee to support LB 958 and Amendment 1992. These provisions will improve the accuracy of assessments, strengthen transparency, protect the rights of waiver participants, and ensure that individuals with IDD receive fair and appropriate determinations regarding the services they need.

Thank you for your consideration and for your commitment to improving services for Nebraskans with intellectual and developmental disabilities.

Sincerely,

Katherine Bacon

Katherine Bacon, Ph.D., LPC-S, NCC

From: [redacted]
To: DHHS HCBS Public Comments
Subject: public comment_LB 958 and the pending amendment 1992
Date: Tuesday, March 3, 2026 6:38:33 PM
Attachments: Nebraska_LB958_Public_Comment_Bacon.pdf

> You don't often get email from [redacted]. Learn why this is important

Good evening, I am submitting public comment in support of LB 958 and pending amendment 1992. Please see attached letter. Thank you.

Warm regards,

Katherine Bacon

From: [redacted]
Subject: InterRAI Assessment Process and Tool
Date: Tuesday, February 24, 2026 12:32:11 PM

> You don't often get email from [redacted]. Learn why this is important

I want you to know what is happening to those with disabilities in our state.

I am the legal guardian for our 22-year-old adopted son, Erik, who has fetal alcohol spectrum disorder, autism, ADHD, hypotonia, sensory processing disorder and several other significant diagnoses. While his chronological age is 22, his developmental age is between 8-12 depending on the moment. (The InterRAI tool is limited to listing only 6 diagnoses…I guess if more are impactful, they just don't count. There is also a limit to the number of medications that can be listed.

DHHS assessed our son on August 14, 2025, near the very beginning of the time DHHS began using the InterRAI tool. I was not aware of the plan to assess him or invited to participate. Instead, the residential supervisor of the shared living group home where he was living in at the time was included. The residential supervisor present during the assessment did not have adequate advocacy skills or documentation to effectively respond factually on Erik's behalf.

I received his InterRAI summary report in December, 2025. I discovered there was a detailed report and requested that. Both were full of inaccuracies!

Erik is smart and appears capable in many ways when spending a minimal amount of time with him but he struggles with impulse control and executive functioning so decision making, planning and anticipating consequences of his actions are severely impaired.

Erik did not understand the questions which was proven when 6 months later, I read him the same questions word-for-word and audio recorded his answers.

For example, in December of 2024, Erik decided he'd like a vacation in Florida, so he called a treatment center there claiming he had alcoholism (which he did/does not). The treatment center sent an Uber to pick him up at 2 AM. He snuck out and was transported to the Eppley Airport where they flew him through the Atlanta airport to Boca Raton, Florida. When he was discovered missing from Bellevue in the morning, it was immediately reported to the police since he is a vulnerable adult who thinks at the level of a third grader. We had no idea where he was. About 9 PM, I received a call stating he was in Florida. He had been to a hospital emergency room for extensive testing and moved through 3 treatment facilities by the treatment facility. The InterRAI assessor, who was supposedly trained, listed that horribly dangerous incident as "community involvement."

As another example, Erik was removed from his biological home at 6 months old and had had 5 families before he was 3.5 years old yet they claimed he had experienced no trauma. (He scores 7/10 on the Adverse Childhood Experiences scale.)

And a final example, though there are many others, he has intentionally injured himself numerous times resulting in several hospitalizations and a mental health stay as well but the report stated he had never been hospitalized. Erik left unattended for even a few minutes can have very dangerous results.

The InterRAI is only focused in spans of 3 days for some questions and 30 days for others. Erik has behavior patterns that repeat over time. It depends on which window of time you capture whether you happened to catch those behaviors or not. It also depends on the quality of documentation provided in Therap, a program that most parents have extremely limited access to. In Erik's case they recorded only one incident when there were several of the same type. Erik's FASD, autism, ADHD, sensory processing disorder and others will not go away, They are a permanent part of his brain.

Getting corrections made is proving to be incredibly difficult and time consuming. I have spent hours providing extensive documentation on two separate occasions as well as dated photos to support my statements. There are still corrections needed. We have an appeal hearing which will be conducted over the telephone(!) on April 6. Why appeals are being conducted on the phone is a mystery but is our only choice. For us to question witnesses and such will be much more challenging than on video calls or in person.

Problems with these InterRAI assessments have been reported by over 150 families stating disabilities are minimized and inaccurately reported. I cannot allow incorrected information to become part of Erik's record and assumed to be factual. I believe a class action lawsuit is brought against Nebraska DHHS is very likely.

Thank you for your care and concern. I am most willing to answer any questions or concerns you may have.

Thank you!

[redacted]

[redacted]

02/23/2026

Public Comment on behalf of the Nebraska Council on Developmental Disabilities (NCDD)

Submitted by Kristen Larsen, Council Executive Director

Re: Amendment on the HCBS Comprehensive Developmental Disabilities Services (NE.4154) waiver and the Developmental Disabilities Day Services Waiver for Adults (NE.0394)

On behalf of the Nebraska Council on Developmental Disabilities (NCDD), I am submitting public comments on Nebraska DHHS's plan to amend the 1915(c) Medicaid and Home and Community Based Services (HCBS) Comprehensive DD and Adult Day DD waivers. Although NCDD is appointed by the Governor and administered by DHHS, we operate independently. Our comments do not necessarily reflect the views of the Governor's administration or DHHS. NCDD is a federally mandated, independent Council comprised of individuals with developmental disabilities, their families, community providers, and agency representatives who advocate for systems change and quality services.

NCDD works to ensure that individuals with developmental disabilities and their families participate in designing and accessing community services, individualized supports, and other assistance that promote self-determination, independence, productivity, and full inclusion in community life. When needed, NCDD serves as a nonpartisan source of information and advice for state policymakers and appreciates the opportunity to provide input through this DHHS public comment process.

Appendix C: Participant Services: NCDD Concerns

Removal of the consultative assessment service:

NCDD has significant concerns regarding the proposed removal of the consultative assessment service under Participant Services.

DHHS has indicated that Functional Behavior Assessments (FBA) are covered under Medicaid as Applied Behavior Analysis (ABA) assessments and are available through all three Managed Care Organizations (MCOs). Stakeholders have been told that HCBS waivers cannot cover services already available through the Medicaid State Plan.

However, there is considerable uncertainty about how providers can access these services through straight Medicaid. Even clinicians who serve as risk providers have expressed confusion. NCDD is concerned that this change could negatively impact risk services and potentially require agencies to continue delivering a level of support that is no longer easily reimbursed. Losing convenient access to professional guidance for individuals with the most intense behavioral needs would be a serious setback for DD services.

Providers offering FBA services are being encouraged to credential through the MCOs to continue serving participants. This process appears cumbersome and may lead to unintended consequences for habilitation services, particularly for individuals with challenging behaviors. The consultative assessment service has been a critical, easily accessible resource for both providers and participants. Recent reductions in Medicaid's ABA reimbursement rates have already resulted

in fewer ABA providers. Eliminating this service could make it even harder for HCBS recipients to obtain the behavioral supports necessary to thrive in community settings.

Change in Meeting Frequency: Semi-Annual to Annual:

Reducing person-centered planning (PCP) meetings from twice a year to only once annually undermines the core principles of person-centered care. This change eliminates critical opportunities for individuals to share their needs, preferences, and goals, placing their voice at risk of being overshadowed by system convenience. Limiting these discussions to a single annual meeting restricts meaningful dialogue and the ability to adjust plans as needs evolve.

Cutting back to one meeting per year removes essential chances for people to shape their own lives. Goals that seem appropriate initially often fail in practice, and without regular check-ins, individuals may remain in plans that no longer reflect who they are or what they want. Person-centered planning should be dynamic and responsive instead of a yearly formality. These meetings are among the few times when families, friends, and trusted supporters can come together to ensure decisions truly honor the person's voice. Reducing them risks turning planning into paperwork instead of a process that empowers choice and growth.

Implementing true person-centered planning through the CtLC framework has been challenging even with two meetings per year. Nebraska has made progress through collaboration with advocates and DD Division leadership, and NCDD fears that fewer meetings will halt this momentum. Often, months pass before anyone realizes a goal or service isn't effective. Reducing meeting frequency makes it even more likely that progress will slow and skill development will stall. Semi-annual meetings provide an essential opportunity for teams to refocus on what the HCBS participant truly wants to experience or achieve, rather than defaulting to what providers believe should be learned.

We appreciate the effort to streamline processes, but it's essential that efficiency does not diminish engagement or accountability. To uphold person-centered principles, we recommend exploring strategies that maintain ongoing involvement for individuals and their natural supports, ensuring meaningful input continues throughout the year rather than being limited to one annual meeting.

Appendix G: Participant Safeguards: NCDD Concern

Change to BSP Requirements: FBAs Only for Risk Tier

This change could leave individuals without timely behavioral support, particularly those not classified in a risk tier, but who still require FBAs to address significant behavioral challenges. Reduced access may lead to gaps in care and hinder progress for participants with complex needs.

The Nebraska Council on Developmental Disabilities appreciates your time in reviewing this letter and addressing the concerns raised. If you have any questions or desire additional information related to these public comments, please contact Kristen Larsen, NCDD Executive Director, at Kristen.larsen@nebraska.gov.

From:	Larsen, Kristen
To:	DHHS HCBS Public Comments
Cc:	Beth Libra ; "joe valenti"
Subject:	NCDD Public Comments on HCBS Comp and Adult Day DD Waiver amendments proposal
Date:	Monday, February 23, 2026 5:17:14 PM
Attachments:	NCDD HCBS CDD and Adult Day waiver amendment public comments Feb 2026 FINAL.pdf NCDD HCBS CDD and Adult Day waiver amendment public comments Feb 2026 FINAL.docx

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Hello,
Attached are public comments on behalf of the Nebraska Council on Developmental Disabilities regarding the state's proposed amendments to the HCBS Comprehensive Developmental Disabilities Services waiver and the Developmental Disabilities Day Services Waiver for Adults.

Please let me know if you have any questions. Thank you.

Kristen Larsen | *Executive Director, Nebraska Council on Developmental Disabilities*
PUBLIC HEALTH

Nebraska Department of Health and Human Services
OFFICE: 402-471-0143 | CELL: 402-853-4180

DHHS.ne.gov | **Facebook** | **Twitter** | **LinkedIn**

NCDD
Nebraska Council on Developmental Disabilities

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I strongly oppose the proposed removal of Consultative Assessment Services (CAS) from Nebraska's Developme Disabilities (DD) waivers and the assertion that Functional Behavior Assessments (FBAs) billed through Medicaid Managed Care Organizations (MCOs), along with updated Behavior Support Plan (BSP) requirements, are sufficient replacements.

Pillen/Corsi Claim: FBAs are duplicative. • FBAs provide independent, specialized behavioral analysis. • Team planning does not replace functional assessment. • No equivalent service remains if removed.

Pillen/Corsi Claim: FBAs can be billed through MCOs. • Licensed Independent clinicians cannot bill for FBAs. • No transparent data has been provided on network capacity or wait times, though this information has been requested from dhhs over three weeks ago.

Pillen/Corsi Claim: Participant teams can create plans. • Teams are not behavioral diagnosticians. • FBAs require data analysis, functional assessment methodology, and clinical oversight. • Removing independent review increases risk of reactive, compliance-based plans.

Pillen/Corsi Claim: This will save money. • FBA: $2,000–$4,000. • Psychiatric hospitalization: $8,000–$15,000+. • High-acuity placement: $100,000+ annually. • Prevention costs less than crisis.

Pillen/Corsi Claim: CST can manage complex cases. • CST is crisis-based and reactive. • FBAs are preventive. • Prevention reduces crisis utilization.

Core Concern: Does this amendment protect participant health and welfare under §1915(c)? They want to handle are most vulnerable adults "like a business." Just ask them.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

L

Last Name

Palmer

City & State

Omaha

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 19, 2026

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I am a parent of a child with a disability, and I strongly oppose the removal of Consultative Behavioral Assessments.
Our child's FBA was not generic. It was detailed, individualized, and tailored specifically to his disabilities, triggers, learning style, and support needs. The consultant took time to truly understand him; what escalates him, what calms him, and what actually works. It fit my child, not a template. Removing this service does not only change how plans are written, it removes clinical specialization and individual analysis. If recommendations become generic, what is the point?
We received answers and direction within months. If this amendment passes and families are forced to rely on MCOs with multi-year delays and insurance uncertainty, individuals in crisis will wait years for help. Many cannot safely wait that long. We could not have. When we explored other options, we were told insurance coverage could not be guaranteed (see Munroe Meyer's website which states that). That is not a reliable system for families already in crisis.
Before the FBA, our child's team worked tirelessly. We tried everything. Nothing created lasting change. We were exhausted and felt helpless as behaviors escalated. The FBA brought specialized expertise our team could not provide. Without it, hospitalization was a very real possibility, not only for my child, but for me as his caregiver due to the level of stress and crisis we were experiencing. That is not an exaggeration. When behaviors escalate without proper interventions, families break down and placements fail.
DHHS's proposal will harm vulnerable individuals and caregivers already stretched beyond capacity. FBAs gave our family direction and hope. Please do not take that away. I respectfully urge rejection of this amendment.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

Lane

Last Name

B

City & State

Omaha, Ne

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 19, 2026

Re: Nebraska DD §1915(c) Waiver Amendment – Removal of Consultative Assessment Services (CAS)

I am submitting this comment for CMS review because the proposed amendment raises concerns regarding compliance with §1915(c) assurances related to health and welfare, service sufficiency, and access to necessary behavioral supports.

I am writing to express serious concern regarding Nebraska's proposed amendment to remove Consultative Assessment Services (CAS) from the Developmental Disabilities (DD) §1915(c) waivers on the basis that the service is duplicative of Managed Care Organization (MCO)–based Functional Behavior Assessments (FBAs).

CAS was not duplicative of MCO-based assessments. It was a waiver-integrated, consultative service designed to prevent behavioral escalation, stabilize placements, and ensure the safe and effective implementation of Behavior Support Plans (BSPs) across real service settings. CAS provided proactive behavioral assessment, cross-setting observation, staff training and coaching, ongoing plan revision, and coordination across ISP and BSP processes; functions that are not replicated or operationally accessible through MCO-based ABA assessments or BSP documentation requirements.

The proposed amendment removes the only waiver-based behavioral consultative service without demonstrating enforceable standards for network adequacy, timely access, continuity of care, or coverage for adults who do not meet ABA eligibility criteria. As written, this represents a reduction in service capacity rather than an administrative substitution.

This raises significant concerns under CMS waiver assurances:

- Appendix C (Health and Welfare): CAS functioned as the primary prevention mechanism for behavioral escalation. Its removal increases foreseeable risk of crisis events, emergency intervention, law enforcement involvement, and placement disruption.
- Appendix G (Service Delivery and Access): The amendment does not demonstrate that remaining services are sufficient in amount, duration, or scope to meet assessed behavioral needs.

Further, Nebraska DHHS's own July 2025 DD Waiver Service Summary states that "Consultative Assessment is necessary to improve the participant's independence and inclusion in their community." Reclassifying CAS as duplicative directly contradicts this determination without evidence that its full function, accessibility, or outcomes are preserved.

Absent evidence that the full scope, accessibility, and preventive function of CAS are preserved, approval of this amendment would be inconsistent with CMS requirements under §1915(c).

Exhibit A: CAS vs. Proposed Replacement — Service Capacity Comparison

Domain	CAS (DD Waiver)	MCO FBA / ABA Assessment	BSP-Only Model
Primary Purpose	Prevention, stabilization, implementation	Clinical assessment tied to ABA eligibility	Compliance and documentation

	support		
Timing	Proactive (before crisis)	Delayed (waitlists, eligibility)	Post-incident response
Access	Any age or diagnosis	Limited by MCO networks	None
Providers	Multidisciplinary	ABA credentialed only	None
Settings Observed	Home, day, community	Often clinic-based	None
Ongoing Consultation	Yes	No	No
Staff Training	Included and funded	Not included	Not included
Plan Follow-Through	Built-in	Fragmented	Absent
Risk Impact	Reduces escalation and crisis	Delayed access increases risk	Crisis-driven response

Requested CMS Action: Require corrective action or deny approval of the amendment unless and until Nebraska demonstrates a fully equivalent, operational replacement for CAS.

From: [redacted]
Subject: Nebraska DD §1915(c) Waiver Amendment
Date: Wednesday, February 25, 2026 3:14:35 PM
Attachments: CAS Letter 1.pdf

You don't often get email from [redacted] Learn why this is important

I am submitting this comment for CMS review because the proposed amendment raises concerns regarding compliance with §1915(c) assurances related to health and welfare, service sufficiency, and access to necessary behavioral supports.

I am writing to express serious concern regarding Nebraska's proposed amendment to remove Consultative Assessment Services (CAS) from the Developmental Disabilities (DD) §1915(c) waivers on the basis that the service is duplicative of Managed Care Organization (MCO)–based Functional Behavior Assessments (FBAs).

CAS was not duplicative of MCO-based assessments. It was a waiver-integrated, consultative service designed to prevent behavioral escalation, stabilize placements, and ensure the safe and effective implementation of Behavior Support Plans (BSPs) across real service settings. CAS provided proactive behavioral assessment, cross-setting observation, staff training and coaching, ongoing plan revision, and coordination across ISP and BSP processes; functions that are not replicated or operationally accessible through MCO-based ABA assessments or BSP documentation requirements.

The proposed amendment removes the only waiver-based behavioral consultative service without demonstrating enforceable standards for network adequacy, timely access, continuity of care, or coverage for adults who do not meet ABA eligibility criteria. As written, this represents a reduction in service capacity rather than an administrative substitution.

This raises significant concerns under CMS waiver assurances:

- Appendix C (Health and Welfare): CAS functioned as the primary prevention mechanism for behavioral escalation. Its removal increases foreseeable risk of crisis events, emergency intervention, law enforcement involvement, and placement disruption.
- Appendix G (Service Delivery and Access): The amendment does not demonstrate that remaining services are sufficient in amount, duration, or scope to meet assessed behavioral needs.

Further, Nebraska DHHS's own July 2025 DD Waiver Service Summary states that "Consultative Assessment is necessary to improve the participant's independence and inclusion in their community." Reclassifying CAS as duplicative directly contradicts this determination without evidence that its full function, accessibility, or outcomes are preserved.

Absent evidence that the full scope, accessibility, and preventive function of CAS are preserved, approval of this amendment would be inconsistent with CMS requirements under §1915(c).

Exhibit A: CAS vs. Proposed Replacement — Service Capacity Comparison

Domain	CAS (DD Waiver)	MCO FBA / ABA Assessment	BSP-Only Model
Primary Purpose	Prevention, stabilization, implementation support	Clinical assessment tied to ABA eligibility	Compliance and documentation
Timing	Proactive (before crisis)	Delayed (waitlists, eligibility)	Post-incident response
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		networks	
Providers	Multidisciplinary	ABA credentialed only	None
Settings Observed	Home, day, community	Often clinic-based	None
Ongoing Consultation	Yes	No	No
Staff Training	Included and funded	Not included	Not included
Plan Follow-Through	Built-in	Fragmented	Absent
Risk Impact	Reduces escalation and crisis	Delayed access increases risk	Crisis-driven response

Requested CMS Action: Require corrective action or deny approval of the amendment unless and until Nebraska demonstrates a fully equivalent, operational replacement for CAS.

February 20, 2026

Public Comment – CDD Comprehensive Waiver and RAI Assessment Concerns

To Whom It May Concern,

I am writing as a Nebraska parent and caregiver of an individual served under the CDD Comprehensive Waiver. I respectfully ask that DHHS take a serious look at the limitations of the current RAI assessment process.

The RAI tool does not fully capture the daily realities of caring for a loved one with complex needs. A standardized form cannot adequately reflect the unpredictability, medical fragility, supervision requirements, and safety concerns that families navigate every single day. Our loved ones are not checkboxes. Their needs are layered, dynamic, and deeply individualized.

When funding levels are tied so tightly to a scoring tool that does not allow for full narrative explanation, families feel unheard. We are asking for greater clarity, transparency, and flexibility in how needs are evaluated. We want assessments that truly reflect daily living demands — not just what can be captured in limited fields on a form.

Please consider revising the reliance on the RAI as the sole determinant of eligibility and funding range. Families deserve a process that honors lived experience and allows for meaningful input.

Thank you for providing an opportunity for public comment. We ask that our voices be heard and that thoughtful reform be considered.

Respectfully,

Mary Jo Kampschneider

Nebraska Parent and Caregiver

Personal Impact / Family Stability

Nebraska Department of Health and Human Services

Division of Developmental Disabilities

Re: Public Comment – Comprehensive DD Waiver Funding

Dear DHHS Leadership,

I am submitting this public comment regarding the proposed changes to the Comprehensive Developmental Disabilities (CDD) Waiver. I respectfully ask that DHHS reconsider any reductions or restructuring that limit funding, flexibility, or tier access for individuals with complex medical and developmental needs.

My daughter depends entirely on waiver services for her health and safety. These services are not optional supports — they are medically necessary. When funding levels are reduced or service flexibility is narrowed, the impact is immediate and serious.

Individuals with fluctuating medical conditions require dynamic staffing and responsive service models. A fixed or narrowed approach does not reflect the reality of daily care needs. Without adequate funding, families are forced into unsafe situations, increased medical risk, and caregiver burnout.

I urge DHHS to reconsider any changes that would restrict Comprehensive Waiver funding or make it harder for medically complex individuals to qualify for appropriate tiers.

These decisions affect real families in real time. Please protect the stability of Nebraska's most vulnerable citizens.

Respectfully,
Mary Jo Kampschneider

Public Comment Regarding Proposed Changes to BSP and FBA Requirements

Dear Leadership Team,

I am submitting this public comment to express significant concerns regarding Nebraska DHHS's proposed changes effective 7/1/2026 related to Behavior Support Plans (BSPs) and Functional Behavior Assessments (FBAs).

As outlined, DHHS plans to discontinue Consultative Assessment services, remove the requirement that BSPs be developed or reviewed by a licensed clinician such as a BCBA, and eliminate the requirement that BSPs be functionally linked to an FBA. Under the proposed framework, an FBA would only be completed if the service planning team—which may not include any qualified clinician—determines that one is "necessary."

While I understand the goal of increasing provider access and flexibility, these changes raise serious concerns related to ethical practice, clinical effectiveness, and participant safety. BSPs are inherently assessment-based interventions. Decoupling BSP development from required functional assessment and licensed clinical oversight significantly weakens safeguards that ensure plans are data-driven, functionally accurate, and responsive to changes in behavior, health, environment, or support needs.

From an Applied Behavior Analysis perspective, and consistent with widely accepted professional ethics and best practices, effective behavior support requires accurate identification of behavioral function, functionally equivalent replacement skills, and ongoing evaluation by individuals with appropriate training. Allowing BSPs to be developed without required assessment or qualified clinical judgment increases the risk of ineffective interventions, escalation of challenging behavior, and unnecessary or overly restrictive safety strategies.

Additionally, reliance on undefined "clinical judgment" by teams that may not include trained clinicians introduces ambiguity, reduces accountability, and creates variability in plan quality across providers. This places both participants and providers at increased risk.

I respectfully urge DHHS to reconsider these changes and retain requirements for qualified clinician involvement and functional assessment when BSPs are developed or revised. Preserving these safeguards is critical to ensuring person-centered, ethical, and effective behavioral supports within the HCBS system.

Thank you for the opportunity to provide public comment and for considering these concerns.

Respectfully,
Matt Dennis, BCBA

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I oppose the proposed amendment to Nebraska's §1915(c) HCBS waiver that would remove consultative behavioral assessment services, including Functional Behavior Assessments (FBAs), on the basis that they are duplicative and available through Managed Care Organizations (MCOs).

Although it has been stated that FBAs can be accessed through MCO billing pathways, providers report significant barriers in practice. Clear documentation outlining a functional reimbursement process has not been publicly provided, and families and providers report substantial delays when attempting to access behavioral assessment services through MCO networks.

For individuals experiencing active behavioral challenges, timely assessment is essential to health and safety. When preventive behavioral supports are delayed or unavailable, escalation is predictable. Unsafe behaviors increase, emergency interventions rise, and placements destabilize. Systems shift from proactive support to crisis response.

• The consequences are well recognized:
Increased emergency room visits and hospitalizations
• Greater reliance on crisis and law enforcement services
• Caregiver burnout and staff turnover
• Placement disruption and higher-cost services

Preventive behavioral assessment costs far less than crisis stabilization, hospitalization, or high-acuity placements. Eliminating waiver-based FBAs does not remove the need for behavioral support; it shifts the burden to more expensive and reactive systems.

Under §1915(c) assurances, states must protect participant health and welfare and ensure access to necessary services. Before this amendment is approved, there should be clear evidence that participants will maintain timely, adequate access to behavioral assessment.

Nebraska's most vulnerable residents deserve safe, accessible, and preventive behavioral supports. I respectfully urge reconsideration of this amendment.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

Mia

Last Name

Easton

City & State

Omaha, NE

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 11, 2026

Comments regarding proposed changes to Comprehensive Developmental Disabilities Services Waiver and Development Disabilities Day Services Waiver

The comments below represent the position of the Nebraska Association for Behavior Analysis (NEABA), a professional membership organization that promotes the science and practice of Applied Behavior Analysis (ABA) in the state of Nebraska. Functional Behavior Assessments (FBA) which are termed "Consultative Assessment" in these respective waivers and termed "Applied Behavior Analysis Behavior Identification Services" in the Medicaid Service Definitions and Provider Manual were empirically originated in ABA and are a core component of the required skill set of Licensed Behavior Analysts and Licensed Assistant Behavior Analysts in Nebraska. FBAs are an essential component to designing and implementing effective Behavior Support Plans (BSP). Our comments below center primarily on the proposed changes to these two services.

We recognize that the Consultative Assessment (CA) Service needs to be removed from the waivers as CMS does not allow for duplication of services and Medicaid provides for the ABA Behavior Identification Service (BIS). However, the way these two services are authorized and implemented are distinct enough that removing the CA process and relying on the BIS fundamentally changes who, when, and how FBAs are administered and subsequently who, when, and how BSPs are effectively designed, implemented, and monitored. It is imperative that DHHS ensure that accessibility to FBAs occurs whenever needed and that effective training, clinical support, and monitoring are actively provided to ensure appropriate assessments are conducted to inform design of effective BSPs.

FBA Accessibility

It is not clear that FBAs will be fully accessible to individuals across the lifespan. The most recent proposed draft of the Medicaid Policy manual for ABA BIS restricted it to Ages 0 – 20 (p. 74). In addition, the individual needs to "present with severe behaviors that cause significant impairments" (p. 74). These restrictions are concerning and indicate the many waiver service recipients would not be able to receive an FBA (BIS) when needed. There is large empirical evidence base for the effectiveness of FBAs for adults and for the efficacy of FBAs for developing BSPs to prevent severe behaviors and significant impairments. In addition, a BIS requires that an Individual Diagnostic Interview (IDI) be completed first by a licensed clinician (typically a psychologist, LIMHP, or physician) who recommends the BIS be delivered. This step could readily create time delays and waitlists for waiver service recipients in need of services, particularly if providers need to wait to refer until there are "severe behaviors." We recognize that FBAs would still be required for those individuals on the Risk tier, but it is not clear how that aligns with the MCOs admissions criteria for FBAs.

It is imperative to ensure that all the MCOs provide a seamless authorization process that is standardized across the different MCOs and is not overly restrictive so that any individual regardless of age and identified need for an FBA (BIS) may be quickly authorized to receive that service. We recommend that a clear process be outlined for providers on how to work with the MCOs to ensure successful authorizations of FBAs (BIS).

Training and Qualifications

Removing the need for an FBA (CA) and clinician with expertise in FBAs for development of BSPs leaves unclear who will be responsible for this process and what training or skill set is required to complete the assessment and BSP development. A poorly administered assessment will lead to a poorly developed BSP which will lead to increased behavior issues. Identifying the purpose or function of behavior is an essential component of any assessment in designing an effective BSP. When functional assessment is not clearly required or when the responsibility to determine the need for an FBA rests with teams that may not include trained clinicians, the risk increases for plans that are not functionally accurate or that rely on more restrictive or reactive strategies. From an ethical standpoint, individuals receiving services have the right to interventions that are:

- Based on accurate and current assessment
- Data-driven and functionally informed
- Implemented with treatment integrity
- Designed to be the least restrictive alternative

We recommend that there are clear criteria written about who is qualified and has the necessary competencies to administer an assessment and design the BSP. This should include clear qualification language in regulations indicating that FBAs, BSPs, and Safety Plans must be developed or overseen by individuals with demonstrated competence (e.g., manager/coordinator-level positions with competency-based training), rather than DSP-level staff.

In addition, there should be required, documented, competency-based training (with annual renewal) for those responsible for developing and overseeing FBAs, BSPs, and Safety Plans — similar to CPR or other safety recertifications.

Finally, there should be ongoing documented fidelity checks by the clinical team to ensure plans are implemented as written and remain effective.

Clinical Support

It is our understanding that the clinical team for the Division of Developmental Disabilities will be responsible for providing training and technical assistance and consultation for individuals with behavioral issues and service teams.

Clear guidance and training needs to be developed for providers regarding how and when to conduct assessments. Most important, clear guidance needs to be provided for providers as to

when and how to refer for an FBA. As noted, it is best to conduct and design BSPs before behavior becomes a risk or severe. Understanding when and how to do it requires expertise in assessment and function-based intervention.

Clear guidance and training needs to be provided for providers on when to seek consultation and technical assistance from the clinical team. Our concern is that many will wait until behaviors are severely problematic.

We are concerned regarding the capacity of the clinical team to meet the needs of all the individuals requiring behavioral supports being served by waivers. It is important that the Division have enough behavior analysts hired to meet the needs.

Monitoring Progress

We understand that language requiring a semi-annual meeting for person-centered planning and service delivery has been removed and only one annual meeting is required. We believe it is important to clarify for providers that anyone on a BSP should be reviewed at least semi-annually, and likely more often as proscribed by the BSP. Best practice and ethical standards support this for several reasons:

• Behavior function can shift over time due to environmental changes, staffing turnover, medical factors, psychiatric comorbidity, medication changes, and skill acquisition or regression.
• Individuals at Risk Tier by definition present behaviors with health or safety implications, which warrants proactive review rather than reactive reassessment.
• Annual updates promote early identification of function shifts and help prevent escalation that could otherwise lead to restrictive interventions or crisis-driven responses.
• Regular reassessment supports the principle of least-restrictive intervention by ensuring strategies remain accurate and preventative rather than punitive or reactive.

Likewise, the most recent draft of Medicaid Policy manual for BIS indicates an ABA reassessment be performed at 6-month intervals. We recommend that similar requirements be expected for any individual on a BSP.

We appreciate the opportunity to provide comments on these changes and your time and attention to these important issues.

Sincerely,

Nebraska Association for Behavior Analysis

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

I am shocked to hear about the proposed amendment to remove CAS from DD waivers. The FBA for my daughter was so detailed, had specific examples, and the team that created it were so responsive, helpful, and even available for questions after it was done. It helped our family so much. You people have lost your mind.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

Nicole

Last Name

P.

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 25, 2026

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

DDD Public Comment Form

undefined

Comment

FBAs are essential for individuals with developmental disabilities and behavioral or mental health needs. FBAs allow clinicians and teams to understand why behaviors occur so that supports are preventative, person-centered, and effective. Without FBAs, Behavioral Support Plans risk becoming reactive, generic, and focused on compliance rather than safety, dignity, and long-term stability. Replacing consultative assessments through training and internal plan development is unrealistic given current workforce shortages, increasing participant acuity, and the specialized clinical expertise required to assess high-risk behaviors. Eliminating FBAs shifts responsibility and risk onto providers, caregivers, and participants rather than strengthening the support system.
DHHS has indicated that FBAs may be billed through MCOs; however, this does is not true. I have also asked DHHS to provide specifics regarding where this has been successful, but have yet to hear back. Current waitlists for FBAs through MCOs already span multiple years, making this an inaccessible and unreliable alternative.
The proposed elimination directly threatens safety and placement stability for families and caregivers. When behaviors escalate without appropriate assessment and intervention, consequences include emergency responses, hospitalization, staff injury, and placement disruption, which all directly contradict the intent of HCBS waivers.
CST involvement is not a substitute for proactive consultative assessment. CST support is typically crisis-driven and occurs only after harm or instability has already occurred. FBAs are a preventative service and must remain available to reduce escalation and system failure.
You are risking harm to participants and families, as well as increased long-term costs to the state.
Please reject this amendment and maintain access to consultative assessment services.
Thank you for considering the real and human impact of this proposed change.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

First Name

Pete

Last Name

Anderson

City & State

Seward, NE

Waiver

CDD- Comprehensive Waiver

DDAD- DD Adult Day Waiver

Submitted on Feb 10, 2026

Dear DHHS Leadership,

Individuals on the Comprehensive DD Waiver often experience periods of medical stability alternating with periods of instability. The waiver must allow services to flex accordingly without penalizing families for these fluctuations.

Community inclusion and in-home PAS are not separate worlds — they are interconnected supports that shift based on medical condition.

When policy does not allow flexibility within one waiver framework, families are forced into unsafe decisions or under-supported care.

I ask DHHS to preserve funding structures that recognize fluctuating medical need and allow dynamic staffing within the Comprehensive Waiver.

One-size-fits-all tier models do not reflect real medical life.

Sincerely,
Peter Elsasser
Pete Elsasser

Long term tax payer

February 20, 2026

To the Nebraska Department of Health and Human Services:

RE: Request for Reform – CDD Waiver Funding and RAI Limitations

I am writing to strongly advocate for reform in how the CDD Comprehensive Waiver determines eligibility and funding through the RAI assessment.

The RAI is not an adequate standalone measure of an individual's real-world needs. It reduces complex human lives into numerical categories that do not fully reflect daily supervision, medical vulnerability, behavioral support requirements, or safety risks. Families are left trying to fit dynamic, round-the-clock caregiving realities into rigid assessment boxes. When funding limitations are based primarily on this tool, individuals risk being underserved. Caregivers feel silenced. Providers are constrained. The result is a system that may meet administrative benchmarks but fails to fully reflect lived experience.

We are asking for:

Expanded assessment methods beyond the RAI score.
Clear breakdowns of how funding decisions are calculated.
Greater incorporation of caregiver documentation and longitudinal evidence.
Meaningful stakeholder involvement in waiver evaluation and redesign.

Our loved ones deserve assessments that honor their complexity and funding structures that reflect true need — not just what can be captured on a form.

I respectfully request that DHHS review and revise its current approach to ensure fairness, clarity, and safety for Nebraska families.

Sincerely,

Pete Elsasser
Nebraska Taxpayer

From:	[redacted]
To:	DHHS HCBS Public Comments
Cc:	sclouse@leg.ne.gov; aspivey@leg.ne.gov; Robert Clements; Sen. Robert Dover; Sen. Myron Dorn; Sen. Machaela Cavanaugh, M.; bandersen@leg.ne.gov; Sen. Beau Ballard; Sen. Brian Hardin; Sen. Barry DeKay; Sen. Ben Hansen, B.; Dan Quick; jprokop@leg.ne.gov; Sen. Loren Lippincott; Sen. Christy Armendariz; Sen. John Cavanaugh, J.; gmeyer@leg.ne.gov; jstorm@leg.ne.gov; Sen. John Fredrickson; pstrommen@leg.ne.gov; Merv Riepe; Sen. Rick Holdcroft; vrountree@leg.ne.gov
Subject:	Public Comment – Assessment Methodology in Nebraska HCBS Waivers
Date:	Saturday, March 7, 2026 4:27:16 PM

Public Comment – Assessment Methodology in Nebraska HCBS Waivers

Thank you for the opportunity to provide public comment regarding the use of the interRAI assessment within Nebraska's Home and Community-Based Services (HCBS) waiver programs administered by the Nebraska Department of Health and Human Services.

These observations reflect both experience navigating waiver services and familiarity with long-term care assessment processes.

During legislative testimony it was stated that the interRAI assessment has been used within the Aged and Disabled Waiver since approximately 2021 as part of the eligibility evaluation process. More recently, the same assessment framework has been implemented within Developmental Disabilities waiver programs to determine service tiers or funding levels. As these uses have expanded, many participants and families have only recently become aware of the role the assessment tool plays in determining eligibility or services within waiver programs.

Because the interRAI framework is now used across multiple HCBS programs, observations from participants in different waiver populations may provide useful insight into how the assessment functions in practice.

—

Issue Summary

This comment raises several structural concerns regarding the use of the interRAI assessment within Nebraska's HCBS waiver programs:

• Annual eligibility or funding decisions may rely heavily on assessment questions based on short observation windows.
• Assessment outcomes are translated into eligibility or funding tiers through a scoring process that participants cannot easily review.
• Participants may have limited ability to challenge assessment outcomes when appeals focus primarily on whether the assessment procedure was followed rather than whether the result accurately reflects an individual's circumstances.

—

1. Short Observation Windows and Long-Term Determinations

Many interRAI questions rely on short observation windows, frequently asking about assistance provided during the last three days. While this structure may function in institutional settings where individuals are observed continuously, it can present challenges when applied to individuals living in community environments.

Assessment results may influence eligibility or service levels for extended periods of time, yet the questions often capture only a brief snapshot of circumstances. Needs that fluctuate over time or require ongoing routines to manage may not be fully reflected within a short observation window.

—

2. Supports Occurring Outside the Assessment Window

Individuals receiving services in community settings often rely on coordinated routines and supports across multiple environments throughout the year.

For example, individuals may receive consistent assistance within school environments during the academic year. If those supports occur outside the short look-back window or are not fully captured during the assessment conversation, the assessment may not reflect the level of support required to maintain stability in daily life.

In these situations, the absence of documented assistance during the look-back period does not necessarily indicate that the individual does not require support. Rather, it may reflect that the brief assessment window does not fully capture the routines, coordination, and ongoing effort required to maintain stability in community settings.

—

3. Transparency in Assessment Scoring

During legislative testimony it was described that the interRAI assessment produces a numeric score used to determine eligibility categories or funding tiers, and that elements of the scoring methodology are proprietary.

Participants and families may also have limited visibility into how responses are recorded during the assessment interview. The assessment is conducted as a structured interview in which the assessor asks questions and records responses within the assessment system. Because participants do not see the full assessment instrument or the coding structure used to record responses, it may be difficult to understand how specific information is translated into the final assessment record.

The interRAI instrument is designed to gather information through standardized questions rather than through clinical interpretation by the interviewer. In this type of

framework, the reliability of the assessment depends heavily on the structure and consistency of the interview process itself. When complex health circumstances or ongoing management routines are involved, the structured format of the questions becomes especially important to ensure that relevant information is captured accurately within the assessment.

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4. Appeals and Review

Summary information presented during legislative testimony indicated that a number of appeals have been filed regarding assessment outcomes, but none of the closed appeals during the reported period resulted in reversal of the department's determination.

Additional context regarding how appeals are resolved, including distinctions between withdrawals, dismissals, and adjudicated decisions, would help stakeholders better understand how the review process functions in practice. When assessment outcomes determine eligibility or service levels for essential supports, it is important that participants have a meaningful opportunity to address situations where assessment results may not reflect their actual circumstances.

—

5. Participation in Assessment Meetings

Community-based care frequently involves multiple caregivers and support systems. While input from individuals familiar with the participant's needs is valuable, it may not always be feasible to require the presence of specific caregivers or representatives at a single assessment meeting.

Allowing flexibility in how input is gathered may help ensure the assessment reflects the full range of supports occurring across different settings.

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Conclusion

Standardized assessments can support consistency across programs. However, when an annual determination of eligibility or services relies primarily on short observation windows and a scoring system that participants cannot easily review, it may become difficult to understand how decisions are made or how to address concerns through the review process.

Assessment tools should be designed to accurately capture an individual's needs over time within the context of community living, rather than relying on brief snapshots that may not fully reflect the ongoing supports required to maintain health, safety, and

stability.

Ensuring that assessment methodology reflects the realities of community-based care will strengthen the effectiveness and transparency of Nebraska's HCBS waiver programs.

Thank you for considering these observations.

Randi Ross
Omaha
- mother, legal guardian, advocate, neighbor

From:	[redacted]
To:	DHHS HCBS Public Comments
Cc:	aspivey@leg.ne.gov; bandersen@leg.ne.gov; Sen. Beau Ballard; Sen. Barry DeKay; Sen. Ben Hansen, B.; Sen. Brian Hardin; Sen. Christy Armendariz; Dan Quick; gmeyer@leg.ne.gov; Sen. John Cavanaugh, J.; Sen. John Fredrickson; jprokop@leg.ne.gov; jstorm@leg.ne.gov; Sen. Loren Lippincott; Sen. Machaela Cavanaugh, M.; Sen. Myron Dorn; Merv Riepe; pstrommen@leg.ne.gov; Robert Clements; Sen. Robert Dover; Sen. Rick Holdcroft; sclouse@leg.ne.gov; vrountree@leg.ne.gov
Subject:	Public Comment – NE HCBS interRAI Implementation Considerations
Date:	Sunday, March 8, 2026 1:22:34 PM

Dear DHHS Public Comment, DHHS, Appropriations & General Committees:

Public Comment – NE HCBS interRAI Implementation Considerations

After listening to recent hearing testimony and reviewing the assessment materials, I would like to offer several observations regarding implementation of the interRAI assessment system.

These comments are offered in the interest of accurate assessments, transparent decision-making, and effective legislative oversight as the transition continues.

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1. Transparency of Assessment Calculations

My concern is not the use of a standardized assessment tool itself, but the lack of transparency in how assessment responses are converted into funding determinations.

Nebraska is using public Medicaid funds to implement a system owned by a private company, yet the methodology used to determine publicly funded service levels appears largely inaccessible to participants, families, providers, and the public. When public programs determine access to essential supports, the calculation methods driving those decisions should be transparent and subject to meaningful public review.

Without visibility into how assessment scores translate into service levels, participants cannot reasonably understand or challenge determinations affecting their services.

This raises a fundamental public accountability concern. Publicly funded service determinations should not rely on proprietary calculations that are not subject to meaningful public oversight.

At a minimum, participants should be able to review how their assessment responses translate into their individual determination, and policymakers should have sufficient transparency to evaluate the methodology for purposes of public oversight.

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2. Clinical Interpretation of Assessment Items

In reviewing the assessment instrument, I noticed that some items reference clinical indicators such as BUN or creatinine ratio. These are laboratory values typically found in medical records rather than information participants or families would reasonably be expected to know or interpret.

When assessments rely solely on a verbal interview conducted by a non-clinical assessor, important medical context may be missed even when participants answer questions honestly. For example, a participant receiving dialysis several times each week may not identify that care as a “doctor visit,” despite its clear clinical significance.

For participants with complex medical needs, the assessment process could benefit from a brief clinical verification step to ensure medically relevant information is accurately captured. This could be implemented in a limited and

practical way, such as:

- a short telehealth consultation with a nurse or clinician during the initial assessment, and

- a similar brief review following hospital discharge or other significant events to ensure oversight of participant health & welfare.

Even a short 10–15 minute video consultation at these key points could help confirm critical medical information. Involving a licensed clinician for limited verification would provide an additional layer of professional review to ensure complex medical information is accurately interpreted and documented.

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3. Clarification Regarding Changes in Service Tiers

Recent discussions regarding implementation of the interRAI system have referenced significant movement in participant service tiers, with substantial numbers of individuals shifting both upward and downward.

Testimony suggested that some of this movement may reflect long gaps between prior assessments—sometimes two years or more. If so, it would be helpful to understand whether these changes reflect overdue reassessments, changes in participant needs, or differences between the previous assessment system and the current interRAI methodology.

Because these changes directly affect services for participants and families, I respectfully request that reporting during the transition distinguish among these factors so policymakers can better understand what is driving the changes. Tracking these categories from the beginning of implementation would provide useful context for evaluating the system's performance for purposes of legislative oversight.

Thank you for your attention to these issues and for the work being done to ensure Nebraska's service systems function safely and transparently for the individuals who depend on them.

Sincerely,

Randi Ross
Omaha, Nebraska
Mom, Registered Nurse, LG, advocate, neighbor

From:	[redacted]
To:	DHHS HCBS Public Comments
Cc:	aspivey@leg.ne.gov; bandersen@leg.ne.gov; Sen. Beau Ballard; Sen. Barry DeKay; Sen. Ben Hansen, B.; Sen. Brian Hardin; Sen. Christy Armendariz; Dan Quick; gmeyer@leg.ne.gov; Sen. John Cavanaugh, J.; Sen. John Fredrickson; jprokop@leg.ne.gov; jstorm@leg.ne.gov; Sen. Loren Lippincott; Sen. Machaela Cavanaugh, M.; Sen. Myron Dorn; Merv Riepe; pstrommen@leg.ne.gov; Robert Clements; Sen. Robert Dover; Sen. Rick Holdcroft; sclouse@leg.ne.gov; vrountree@leg.ne.gov
Subject:	Public Comment: Nebraska HCBS Budgeting Structure and Exception Policy
Date:	Sunday, March 8, 2026 8:58:43 PM

Public Comment: Nebraska HCBS Budgeting Structure and Exception Policy

Thank you for the opportunity to provide comments regarding the implementation of assessment-based budgeting and related policy changes affecting Nebraska's HCBS waiver programs. These comments focus on how several structural elements of the proposed approach may interact within the overall planning framework.

HCBS programs operate within a framework that combines responsible stewardship of public funds with person-centered planning to ensure that services reflect the individualized needs of participants. The following comments address how certain structural elements of the proposed budgeting approach may interact with that framework.

Because these policies relate to how service plans are developed and implemented in practice, I respectfully offer these observations to support clarity regarding how the program structure will operate within the person-centered planning framework that guides HCBS programs.

—

1. Assessment-Generated Budgets and Service Planning

The current system increasingly relies on an assessment tool [interRAI assessment instrument] to generate a participant budget amount directly from the assessment score. In practice, this means the assessment produces a budget first, and the service plan must then be developed within that amount.

Assessment tools can provide useful information about typical support needs and spending patterns, and benchmark figures can be valuable for program planning. However, when the budgeting figure is established before the service planning process begins, that figure can unintentionally become the starting point for the service plan.

Establishing a predetermined budget amount prior to service planning may influence the planning process in either direction:

• If the amount is lower than the services required, needed supports may be difficult to include.
• If the amount exceeds the services actually needed, planners may still feel pressure to align the plan with the available funding rather than beginning from a neutral assessment of needs.

For these reasons, it may be helpful to ensure that benchmark tools inform the planning process while allowing service plans themselves to be built from the individual's identified needs.

—

2. Reduction in Exception Funding

The State of Nebraska Biennial Budget FY2025–26 and FY2026–27, as Proposed by the Appropriations Committee, 109th Legislature – Second Session (March 2026), Agency 25, Program 424, includes a line item titled:

"AD Waiver Reduction and Reduce Exception Funding."

The budget identifies reductions of:

$14,118,676 in General Funds and $17,179,653 in federal funds in FY2026–27.

The accompanying fiscal note explains that these reductions are:

“pursuant to agency expectations of reduced exception funding based on changes to how the program is implemented, specifically caps on budget with limited exceptions.”

Exception processes often serve as an important mechanism for addressing situations where standard budgeting models do not fully reflect the individual needs of a participant.

—

3. Interaction of Budgeting Model and Exception Policy

Taken together, the assessment-generated budgeting model and the proposed reduction in exception funding raise an important implementation question.

Because benchmark-based budgeting models are designed to reflect typical support patterns, individual circumstances will naturally vary around those benchmarks. In practice, some participants may require fewer services than the benchmark suggests, while others may require more.

Maintaining appropriate flexibility within the planning framework helps ensure that normal variation can be accommodated while still preserving fiscal predictability within the program.

When assessment-generated budgets and reduced exception flexibility occur at the same time, it raises an important policy question about how the system will continue to accommodate normal variation in participant needs while maintaining a person-centered planning framework.

—

Broader HCBS Policy Context

HCBS programs have historically been structured to expand community-based options and reduce reliance on more restrictive service models. As budgeting and planning structures evolve, it may be helpful to consider how those changes interact with the broader policy goal; including the objective of supporting individuals in the most integrated community settings appropriate to their needs.

—

Closing

I respectfully request clarification on how the proposed structure will ensure that service planning continues to reflect individualized needs in a manner consistent with the person-centered planning principles that guide HCBS programs.

Thank you for allowing me to comment on our HCBS waivers,

Randi Ross - Nebraska mother, LG, advocate, neighbor

Subject: Waiver Funding Prevents Higher State Costs

To Nebraska Budget and Policy Decision Makers,

I respectfully urge you to preserve funding for the CDD Comprehensive Waiver.

Cutting community-based disability services does not eliminate costs. It transfers them to:

- Emergency rooms
- Law enforcement
- Psychiatric facilities
- State institutions

Institutional and crisis care are significantly more expensive than preventative, structured community services.

Waiver funding is not excess spending. It is preventative investment.

When properly funded, the system works. Individuals remain stable. Families remain intact. Crises are avoided.

Reducing funding creates instability — and instability is far more costly to the state.

Please choose prevention over crisis response.

Respectfully,
Renee Kampschneider

Renee Kampschneider

Tax payer

From: [redacted]
To: DHHS HCBS Public Comments
Subject: CDD Waiver Cap Comments
Date: Monday, February 16, 2026 2:46:00 PM

You don't often get email from [redacted] Learn why this is important

DHHS.HCBSPublicComments@nebraska.gov

We are writing to oppose changes to the CDD Waiver. Lack of transparency is glaring. It is so difficult to find the summary of changes. We can't wade through 350 pages of bureaucratic paperwork.

Our most vulnerable citizens should be well taken care of, not have their services cut. It is a matter of life and death for many if proposed cuts take place. The proposed caps are too low. The formula for figuring the nursing home rate is flawed. Nursing homes are understaffed. If the formula is based on expenditures of nursing homes divided by number of patients, the result is too low because it includes cost for too few caregivers. Expenditures do not include profit. Of course, it is too low!

Our grandson requires nursing home level of care, 24/7. He has lived as high of quality of life and health as possible in our daughter's home for 16 years. It has been a constant struggle to keep enough Medicaid services, an unnecessary stress on our single daughter, who adopted our grandson from foster care. She must work. She needs to sleep. She needs at least an LPN during those hours to care for our grandson.

Respite for our daughter is supposed to be provided thru waiver, but it is impossible for agencies to hire people to work with the disabled for $17/hour, which is what Hands of the Heartland agency pays for respite. Who wants to change diapers on a 17-year-old and clean up slobber and mucous for the same wage as flipping burgers?

Please do not go forward with decreasing the cap on CDD Waiver. We know our grandson's care is expensive, due to his severe disability. Multiple layers of agencies administer benefits and siphon off too many dollars that should go to the disabled. Only a fraction of Medicaid dollars trickles down for our grandson's actual care. Cutting funding for the disabled is not the place to cut the DHHS budget.

Ron and Linda Lindquist
[redacted]

Prevention of Crisis / Cost-to-State Argument

Dear Nebraska DHHS,

Proposed changes to Comprehensive DD Waiver funding risk creating the very crises the waiver system was designed to prevent.

When medically complex individuals lose appropriate tier funding:

- Hospitalizations increase
- Emergency interventions rise
- Families collapse under unsustainable care demands
- Long-term state costs grow significantly

Preventative, community-based waiver services are far less expensive than institutional or emergency care.

The Comprehensive Waiver exists to keep individuals safe in their homes and communities. Reducing funding or limiting tier flexibility undermines that mission.

I strongly urge DHHS to reconsider any changes that reduce access, restrict tier levels, or narrow definitions of medical necessity.

Protecting funding now prevents greater costs later.

Respectfully,

Sandy Elsasser

February 20, 2026

To the Nebraska Department of Health and Human Services:

RE: Request for Reform – CDD Waiver Funding and RAI Limitations

I am writing to strongly advocate for reform in how the CDD Comprehensive Waiver determines eligibility and funding through the RAI assessment.

The RAI is not an adequate standalone measure of an individual's real-world needs. It reduces complex human lives into numerical categories that do not fully reflect daily supervision, medical vulnerability, behavioral support requirements, or safety risks. Families are left trying to fit dynamic, round-the-clock caregiving realities into rigid assessment boxes. When funding limitations are based primarily on this tool, individuals risk being underserved. Caregivers feel silenced. Providers are constrained. The result is a system that may meet administrative benchmarks but fails to fully reflect lived experience.

We are asking for:

- Expanded assessment methods beyond the RAI score.
- Clear breakdowns of how funding decisions are calculated.
- Greater incorporation of caregiver documentation and longitudinal evidence.
- Meaningful stakeholder involvement in waiver evaluation and redesign.

Our loved ones deserve assessments that honor their complexity and funding structures that reflect true need — not just what can be captured on a form.

I respectfully request that DHHS review and revise its current approach to ensure fairness, clarity, and safety for Nebraska families.

Sincerely,

Sandy Elsasser

Sandy Elsasser
Nebraska Taxpayer

From: [redacted]
To: DHHS HCBS Public Comments
Subject: 1115 Waiver Comment
Date: Monday, March 2, 2026 3:54:43 PM

3/2/26

The move to reduce Nebraska's period of Medicaid retro eligibility from three months to zero months is a cost shifting move by DHHS to reduce their budget by shifting the expenses from Medicaid to hospitals, clinics, and nursing facilities. I've been in healthcare for over 30 years and this is an unjust move by the department. Budgets are tight for everyone but this will put some people out of business or worse. The worse being they will not longer accepted Medicaid patients. Our skilled nursing facility has already been moving away from the care of a large Medicaid population in order to survive.

Scott Bahe, MHA, NHA
Gothenburg, NE

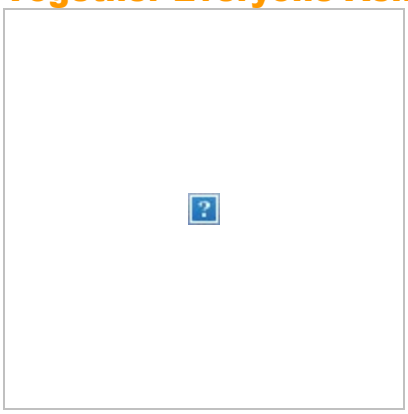
From: [redacted]
To: DHHS HCBS Public Comments
Subject: comments
Date: Monday, February 2, 2026 9:42:45 AM

> You don't often get email from s[redacted] Learn why this is important

I am writing to urge you to protect the CDD and DDAD Medicaid Waiver including reimbursement for consultative assessment services as budget and policy decisions move forward.

Consultative assessment services prevent crisis, reduce institutionalization, and save the state money. Any changes should be guided by clinical evidence and expert testimony on downstream impacts. Please ensure that families, caregivers, and professionals are fully heard before advancing policies that could destabilize vulnerable individuals, agencies who oversee services, and caregivers.

Sylvester GBEKIN
Owner / CFO/ HR
Office: 531-375-5829 / Cell: 402-779-1882
sylvester@teamdds.org
287 N 115th street , Omaha Ne, 68154
Together Everyone Achieves More (TEAM) LLC



From: [redacted]
To: DHHS HCBS Public Comments
Date: Tuesday, March 3, 2026 9:23:20 AM

[You don't often get email from [redacted]. Learn why this is important at https://aka.ms/LearnAboutSenderIdentification]

Please do not vote in the new proposed changes for help for disabled people. It is a complete lie to reevaluate a clients level to lower it just to save money. My nephew was rated could cook his own meals… he is at a 3 year old level. Devious way to say money on the backs of the disabled. And no fair way to object. You take Seth for a day and tell me he could cook a meal or take his own medication.
Teresa Rogers
Sent from my iPhone

TRACY MULLER
COUNSELING SERVICES

Tracy Muller Counseling Services
9802 Nicholas Street, Ste. 305
Omaha, NE 68114

(402)301-7367
connect@tracymullercounselingservices.com
www.tracymullercounselingservices.com

February 1, 2026

I am writing to urge you to protect the CDD and DDAD Medicaid Waiver including reimbursement for consultative assessment services (CAS) as budget and policy decisions move forward. The elimination of consultative assessment services through the DHHS-DD wavier threatens to significantly restrict access to crisis and behavioral support for participants, family members, caregivers, and provider agencies. While many caregivers may be able to identify or hypothesize the function of a participant's behavior, most do not have access to qualified professionals with specialized education and training in diagnosis, behavior analysis, assessment methodologies, and evidence-based interventions. Reduced access to CAS will undermine person-centered planning and the development of interventions specifically designed to decrease the frequency and intensity of maladaptive behaviors. For families and caregivers supporting adults with complex mental and behavioral health needs, this reduction directly impacts safety, stability, and the ability of participants to remain successfully engaged in services with adequate behavioral supports.

As a clinician who has completed Functional Behavioral Assessments (FBAs) for more than ten years, it has been my experience that very few licensed clinicians possess both the necessary clinical and behavioral expertise along with practical experience navigating the developmental disability (DD) system. Providing consultative assessments requires a highly specialized and niche skill set, which has already resulted in a limited pool of qualified providers. Additionally, Medicaid licensure requirements for professionals authorized to complete FBAs further restrict provider availability, creating a significant workforce shortage and extensive waitlists for services. Many individuals wait years for access to FBAs and, in some cases, only become eligible after turning 21 and receiving approval for DD waiver services. Further reducing access to proactive, preventative behavioral therapies and crisis management supports is likely to result in higher long-term costs, increased funding tiers, participant behavioral crises, and more restrictions.

That said, I support the Department of Health and Human Services' goal of improving access to Behavioral Support Plans (BSPs) by expanding training and resources for agencies and caregivers in conjunction with the FBA. Currently, BSP and safety plan development hours are included in CAS reimbursement. A more effective and efficient approach may be to remove clinician reimbursement for BSP and safety plan writing and instead make this the responsibility of supporting agencies and caregivers, who often employ program writers with specific expertise in this area. This shift would reduce the number of CAS hours required from clinicians while preserving access to high-quality FBAs and consultative input, ultimately supporting both system sustainability and participant outcomes. Thank you for your consideration.

Tracy Muller, LIMHP

Tracy Muller
Licensed Intendent Mental Health Practitioner (LIMHP) #1670

From: [redacted]
To: DHHS HCBS Public Comments
Subject: Public Comment CDD and DDAD Waiver
Date: Tuesday, February 24, 2026 2:48:43 PM

I am writing to respectfully urge you to preserve the CDD and DDAD Medicaid Waiver programs, including reimbursement for Consultative Assessment Services (CAS), as budgetary and policy decisions move forward. During recent informational Zoom meetings regarding elimination of CAS services, DHHS representatives advised stakeholders that Licensed Independent Mental Health Practitioners (LIMHPs) currently providing CAS through DHHS would be able to credential and bill through Managed Care Organizations (MCOs). This information is inaccurate. Under the proposed transition, Functional Behavioral Assessments (FBAs) would be billed as an Applied Behavior Analysis (ABA) benefit which subsequently excludes LIMHPs, APRNs, and PAs from completing FBAs. Doing so would further exacerbate an existing service desert and effectively eliminate access to this service for individuals age 21 and older who receive DD/ID services.

While ABA providers play an important role in behavior modification, their training does not include education or clinical expertise required to assess, comprehend, or treat complex mental health disorders. Mental health conditions have a significant impact on an individual's level of functioning and engagement in maladaptive behaviors. Excluding clinicians with specialized mental health training from the FBA process risks oversimplifying behaviors that may be rooted in co-occurring psychiatric conditions. This broader clinical lens allows for a more accurate and individualized understanding of behavior as well as more person centered interventions that include mental health implications.

On average, the current reimbursement rate for Functional Behavioral Assessments (FBAs) is approximately 32% lower per hour than the rate I receive in private practice as a clinician holding a master's degree and LIMHP licensure. Medicaid reimburses FBAs at the same rate as DHHS; however, they impose more advanced degree and licensure requirements for providers. Eligible Medicaid providers include:

- Psychiatrist with training in Applied Behavior Analysis (ABA)
- Physician with training in ABA
- Psychologist with training in ABA
- Provisionally Licensed Psychologist with training in ABA
- Licensed Behavior Analyst (LBA)

This structure creates a significant misalignment between credentialing standards and reimbursement. Highly trained professionals, including doctoral level clinicians, are required to accept significantly reduced compensation to provide FBAs. Additionally, most psychiatrists and physicians do not have training in Applied Behavior Analysis (ABA) because physicians and psychiatrists emphasize diagnostic classification and medication management targeting internal mechanisms, whereas ABA centers on behavioral assessment and environmental interventions designed to produce measurable behavior change.

Medicaid's current eligibility requirements for providers in addition to reimbursement disparities undermine workforce sustainability by discouraging qualified providers from offering this service,

limiting recruitment of new clinicians into waiver work and accelerating provider attrition. For these reasons, participants requesting FBAs from Medicaid providers experience significant delays in assessment, interruptions in services, and increased risk of behavioral escalation. The current waitlist for an FBA assessment through Medicaid is several years. These delays disproportionately affect individuals with complex needs who rely on specialized behavioral expertise.

FBAs are preventative and cost avoidant services. When behavioral needs are not assessed and addressed appropriately at the outset, the system often incurs far greater downstream costs, including crisis response, emergency department utilization, psychiatric hospitalization, law enforcement involvement, placement disruption, and higher levels of staffing care. Investing adequately in assessment services reduces these avoidable expenditures and supports long term system stability.

Utilizing qualified providers who incorporate a participant's mental health needs into the FBA process is a critical component to ensuring recommended interventions are not only effective in theory but also clinically appropriate and practical in real time application.

For these reasons, I strongly encourage you to maintain coverage and reimbursement for Consultative Assessment Services within the CDD and DDAD Medicaid Waivers to ensure that individuals with DD/ID continue to receive comprehensive, clinically informed, and person centered supports and guidance. Any potential changes should be guided by clinical evidence and expert testimony on downstream impacts. It is imperative that family, caregivers, and professionals are fully heard before advancing policies that could destabilize vulnerable individuals.

Thank you,
Tracy Muller

[redacted]

[redacted]

Omaha, NE 68114

[redacted]

[redacted]

[redacted]

From: [redacted]
To: DHHS HCBS Public Comments
Subject: CDD and DDAD waiver public comment
Date: Wednesday, February 25, 2026 9:13:30 AM

You don't often get email from [redacted] Learn why this is important

I am writing to urge you to protect the CDD and DDAD Medicaid Waiver including reimbursement for consultative assessment services (CAS) as budget and policy decisions move forward.

The purpose of a Functional Behavioral Assessment (FBA) is to provide interdisciplinary team members with the information necessary to develop effective Behavior Support Plans (BSPs) and safety plans. These plans are designed to anticipate, prevent, and appropriately respond to behaviors that may otherwise disrupt a participant's environment or compromise health and safety.

FBAs play a foundational role in the development of BSPs and safety plans. They generate objective, data driven insights that allow interventions to be individualized and responsive to each participant's unique needs. By identifying the function of behavior and the environmental variables contributing to it, agencies are better equipped to implement targeted, evidence based strategies. BSPs typically outline the specific supports, environmental modifications, skill building strategies, and teaching methods necessary to promote positive behavioral outcomes. When interventions are grounded in a high quality FBA, participants experience improved stability, increased skill acquisition, and enhanced independence.

Effective behavior support planning reduces downstream system costs. Proactive, function based interventions decrease reliance on crisis response services, emergency department utilization, psychiatric hospitalization, law enforcement involvement, placement disruptions, and the need for higher levels of staffing or restrictive interventions.

Unfortunately, most DD/ID provider agencies are not able to employ licensed professionals with specialized education and training in diagnosis, behavior analysis, assessment methodology, and evidence based intervention design. As a result, agencies rely on Consultative Assessment Services (CAS) to provide the necessary clinical expertise to conduct FBAs and recommend appropriate, function based interventions.

That said, I understand and support the Department of Health and Human Services' goal of improving access to high quality Behavioral Support Plans by expanding training and resources for agencies and caregivers. Currently, BSP and safety plan development hours are included in CAS reimbursement. Since the content of the FBA is utilized to create the BSP and safety plan, a more cost efficient approach may be to preserve clinician reimbursement for conducting the FBAs and providing consultative expertise, while shifting responsibility for drafting the written

BSP and safety plan to provider agencies, many of whom employ program writers with expertise in plan development.

This adjustment would reduce the number of reimbursable CAS hours required while maintaining access to high quality assessments and clinical guidance. Such an approach supports fiscal responsibility without compromising participant safety or outcomes.

For these reasons, I strongly encourage you to maintain coverage and reimbursement for Consultative Assessment Services within the CDD and DDAD Medicaid Waivers to ensure that individuals with DD/ID continue to receive comprehensive, clinically informed, and person centered supports and guidance. Any potential changes should be guided by clinical evidence and expert testimony on downstream impacts. It is imperative that family, caregivers, and professionals are fully heard before advancing policies that could destabilize vulnerable individuals.

Thank you for your consideration.
Tracy Muller

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

DDD Public Comment Form

undefined

Comment

It was my understanding from the zoom presentation regarding proposed CAS changes that LIMHPs are going to be able to bill MCOs for FBAs for individuals over 21 years old. My credentialing company reached out to NTC, Molina, and United following the zoom meeting to start the credentialing process. United reported that they do not reimburse for CPT code 97151 and they were also told that NTC and United are closed to new therapists. Additionally, after several phone calls to each MCO and a review of any documentation that I could find indicates that the only licensed clinicians allowed to bill 97151 include:

- Psychiatrist with training in ABA
- Physician with training in ABA
- Psychologist with training in ABA
- Provisionally licensed psychologist with training in ABA
- Licensed Behavior Analyst (LBA)

I have also seen information that an LIMHP can bill if they also have BCBA credentials, which to my knowledge is pretty rare if not non-existent. I also reached out on some of my local community clinician groups and to some of my contacts at non-profits who I used to work with to inquire about other LIMHPs that have successfully billed MCOs for FBA services. Only one LIMHP reported billing MCOs for FBA services, which was completed under the supervision of a psychologist and the MCOs eventually recouped the reimbursement due to services not being solely provided by the psychologist.

All this to say, am I understanding MCO licensure requirements correctly and if so, is there a specific contact at any of the MCOs that would be helpful in guiding next steps specifically related to FBA services? I am willing to get credentialed with the MCOs and learn the billing process but I feel like the consistent response has been that I do not meet credentialing requirements for this service under the MCOs.

Tell us about yourself! I am...

An Individual- Yourself or another person whom you represent with their consent

Email

[redacted]

Phone

 [redacted]

First Name

Tracy

Last Name

Muller

City & State

Omaha, NE

Waiver

CDD- Comprehensive Waiver DDAD- DD Adult Day Waiver

Submitted on Feb 1, 2026

Ingabire, Yvonne

From: [redacted]
Sent: Tuesday, February 24, 2026 2:48 PM
To: DHHS HCBS Public Comments
Subject: Public Comment CDD and DDAD Waiver

I am writing to respectfully urge you to preserve the CDD and DDAD Medicaid Waiver programs, including reimbursement for Consultative Assessment Services (CAS), as budgetary and policy decisions move forward. During recent informational Zoom meetings regarding elimination of CAS services, DHHS representatives advised stakeholders that Licensed Independent Mental Health Practitioners (LIMHPs) currently providing CAS through DHHS would be able to credential and bill through Managed Care Organizations (MCOs). This information is inaccurate. Under the proposed transition, Functional Behavioral Assessments (FBAs) would be billed as an Applied Behavior Analysis (ABA) benefit which subsequently excludes LIMHPs, APRNs, and PAs from completing FBAs. Doing so would further exacerbate an existing service desert and effectively eliminate access to this service for individuals age 21 and older who receive DD/ID services.

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This structure creates a significant misalignment between credentialing standards and reimbursement. Highly trained professionals, including doctoral level clinicians, are required to accept significantly reduced compensation to provide FBAs. Additionally, most psychiatrists and physicians do not have training in Applied Behavior Analysis (ABA) because physicians and psychiatrists emphasize diagnostic classification and

medication management targeting internal mechanisms, whereas ABA centers on behavioral assessment and environmental interventions designed to produce measurable behavior change.

Medicaid's current eligibility requirements for providers in addition to reimbursement disparities undermine workforce sustainability by discouraging qualified providers from offering this service,

limiting recruitment of new clinicians into waiver work and accelerating provider attrition. For these reasons, participants requesting FBAs from Medicaid providers experience significant delays in assessment, interruptions in services, and increased risk of behavioral escalation. The current waitlist for an FBA assessment through Medicaid is several years. These delays disproportionately affect individuals with complex needs who rely on specialized behavioral expertise.

FBAs are preventative and cost avoidant services. When behavioral needs are not assessed and addressed appropriately at the outset, the system often incurs far greater downstream costs, including crisis response, emergency department utilization, psychiatric hospitalization, law enforcement involvement, placement disruption, and higher levels of staffing care. Investing adequately in assessment services reduces these avoidable expenditures and supports long term system stability.

Utilizing qualified providers who incorporate a participant's mental health needs into the FBA process is a critical component to ensuring recommended interventions are not only effective in theory but also clinically appropriate and practical in real time application.

For these reasons, I strongly encourage you to maintain coverage and reimbursement for Consultative Assessment Services within the CDD and DDAD Medicaid Waivers to ensure that individuals with DD/ID continue to receive comprehensive, clinically informed, and person centered supports and guidance. Any potential changes should be guided by clinical evidence and expert testimony on downstream impacts. It is imperative that family, caregivers, and professionals are fully heard before advancing policies that could destabilize vulnerable individuals.

Thank you,
Tracy Muller

[redacted]

[redacted]

From: [redacted]
Sent: Wednesday, February 25, 2026 9:13 AM
To: DHHS HCBS Public Comments
Subject: CDD and DDAD waiver public comment

You don't often get email from [redacted] Learn why this is important

I am writing to urge you to protect the CDD and DDAD Medicaid Waiver including reimbursement for consultative assessment services (CAS) as budget and policy decisions move forward.

The purpose of a Functional Behavioral Assessment (FBA) is to provide interdisciplinary team members with the information necessary to develop effective Behavior Support Plans (BSPs) and safety plans. These plans are designed to anticipate, prevent, and appropriately respond to behaviors that may otherwise disrupt a participant's environment or compromise health and safety.

FBAs play a foundational role in the development of BSPs and safety plans. They generate objective, data driven insights that allow interventions to be individualized and responsive to each participant's unique needs. By identifying the function of behavior and the environmental variables contributing to it, agencies are better equipped to implement targeted, evidence based strategies. BSPs typically outline the specific supports, environmental modifications, skill building strategies, and teaching methods necessary to promote positive behavioral outcomes. When interventions are grounded in a high quality FBA, participants experience improved stability, increased skill acquisition, and enhanced independence.

Effective behavior support planning reduces downstream system costs. Proactive, function based interventions decrease reliance on crisis response services, emergency department utilization, psychiatric hospitalization, law enforcement involvement, placement disruptions, and the need for higher levels of staffing or restrictive interventions.

Unfortunately, most DD/ID provider agencies are not able to employ licensed professionals with specialized education and training in diagnosis, behavior analysis, assessment methodology, and evidence based intervention design. As a result, agencies rely on Consultative Assessment Services (CAS) to provide the necessary clinical expertise to conduct FBAs and recommend appropriate, function based interventions.

That said, I understand and support the Department of Health and Human Services' goal of improving access to high quality Behavioral Support Plans by expanding training and resources for agencies and caregivers. Currently, BSP and safety plan development hours are included in CAS reimbursement. Since the content of the FBA is utilized to create the BSP and safety plan, a more cost efficient approach may be to preserve clinician reimbursement for conducting the FBAs and providing consultative expertise, while shifting responsibility for drafting the written BSP and safety plan to provider agencies, many of whom employ program writers with expertise in plan development.

This adjustment would reduce the number of reimbursable CAS hours required while maintaining access to high quality assessments and clinical guidance. Such an approach supports fiscal responsibility without compromising participant safety or outcomes.

For these reasons, I strongly encourage you to maintain coverage and reimbursement for Consultative Assessment Services within the CDD and DDAD Medicaid Waivers to ensure that individuals with DD/ID continue to receive comprehensive, clinically informed, and person centered supports and guidance. Any potential changes should be guided by clinical evidence and expert testimony on downstream impacts. It is imperative that family, caregivers, and professionals are fully heard before advancing policies that could destabilize vulnerable individuals.

Thank you for your consideration.

Tracy Muller

[redacted]