DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

June 25, 2025

Drew Gonshorowski
Director of Medicaid & Long Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South, 3rd Floor PO Box 95026
Lincoln, NE 68509

Dear Director Gonshorowski:

The Centers for Medicare & Medicaid Services (CMS) is approving Nebraska's request to extend its Medicaid section 1115(a) demonstration entitled "Nebraska Substance Use Disorder (SUD) Program Section 1115(a) Demonstration" (Project Number 11-W-10025/7), in accordance with section 1115(a) of the Social Security Act (the Act). With this approval, the demonstration will be effective July 1, 2025, until June 30, 2030, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

CMS has determined that the Nebraska SUD Program Section 1115(a) Demonstration is likely to assist in promoting the objectives of Medicaid by increasing access to high-quality, clinically appropriate treatment to beneficiaries with a SUD while they are short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Disease (IMD). This approval is in alignment with State Medicaid Director Letter #17-003 RE: Strategies to Address the Opioid Epidemic.[1] and will continue the authority from the 2019 demonstration approval without any changes.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

Extent and Scope of the Demonstration Extension

Approval of this demonstration extension will allow Nebraska to continue to provide residential treatment services for individuals who are primarily receiving treatment and withdrawal management for SUD who are short-term residents in facilities that meet the definition of an IMD. This will ensure that a broad continuum of care is available to those with SUD in Nebraska.

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

Budget Neutrality

CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration.[2] The demonstration extension is projected to be budget neutral to the federal government. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). The state will be held to the budget neutrality monitoring and reporting requirements as outlined in the STCs.

Rebasing Without Waiver Baseline

Under this extension, for existing Medicaid Expenditure Groups (MEGs) that were implemented, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period) by using a weighted average of the state's historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs. The projected demonstration expenditures associated with each MEG in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Mid-Course Correction

CMS has also updated its approach to mid-course corrections to budget neutrality calculations in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Monitoring and Evaluation

Consistent with the demonstration STCs, the state submitted its draft Interim Evaluation Report for the prior demonstration approval period with the extension application. The evaluation

[2] https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html

findings from the Interim Evaluation Report demonstrate notable progress toward the demonstration goals. For example, compared to the pre-demonstration period, findings suggest that the number of providers delivering SUD services, as well as the percentage of beneficiaries with SUD who received SUD treatment increased during the demonstration approval period. The evaluation report noted mixed evidence on quality of care. The analysis showed an increase in the rates of adherence to and retention in treatment for SUD, as well as a decrease in the average number of emergency department visits for SUD from the pre-implementation baseline period. However, other quality of care measures trended opposite the desired direction, including a decline in the rate of treatment initiation within 14 days of a new SUD diagnosis and an increase in the 30-day readmission rate for SUD.

With this extension of the demonstration, the state is required to continue conducting systematic monitoring and robust evaluation of the demonstration, per applicable CMS guidance and technical assistance. In collaboration with CMS, the state must undertake demonstration monitoring, including reporting of relevant metrics data and narrative details describing progress with implementation of all components of the demonstration. In addition, the state is also required to conduct an independent mid-point assessment of the demonstration, as described in the STCs, to support identifying risks and vulnerabilities and subsequent mitigation strategies.

The state is required to conduct an evaluation of the demonstration to support a comprehensive assessment of whether the demonstration components are effective in producing the desired outcomes for its beneficiaries and providers, as well as the state's overall Medicaid program. The demonstration evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components, as described in the STCs.

Consideration of Public Comments

The federal comment period for the state's application opened on October 20, 2023, and closed on November 19, 2023. CMS received three comments, two of which were not related to the demonstration, and one of which was supportive of the demonstration extension.

CMS has concluded that extending the Nebraska Substance Use Disorder (SUD) Program Section 1115(a) Demonstration, is likely to promote the objectives of Medicaid.

Other Information

CMS's approval of this demonstration is conditioned upon compliance with the enclosed set of expenditure authorities and STCs defining the nature, character and extent of anticipated federal involvement in the demonstration. The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer for this demonstration is Shelby Higgins, who is available to answer any questions concerning your section 1115 demonstration and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850

Email: Shelby.Higgins@cms.hhs.gov

If you have questions regarding this approval, please contact Karen LLanos, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Karen.Llanos@cms.hhs.gov.

Sincerely,

[redacted]

Drew Snyder
Deputy Administrator and Director

Enclosure

cc: Tyson Christensen, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-10025/7

TITLE: Nebraska Substance Use Disorder Program Section 1115(a) Demonstration

AWARDEE: Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by Nebraska for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from July 1, 2025 through June 30, 2030, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Nebraska to operate the above-identified section 1115(a) demonstration.

Title XIX Expenditure Authority:

1. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-10025/7

TITLE: Nebraska Substance Use Disorder Program Section 1115(a) Demonstration

AWARDEE: Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the Nebraska Substance Use Disorder Program section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional expenditure authorities, nor expand upon those separately granted.

These STCs related to the programs for those populations affected by the demonstration are effective from July 1, 2025 to June 30, 2030 unless otherwise specified.

The STCs have been arranged into the following subject areas:

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	SUD Implementation Plan
Attachment B	SUD Evaluation Design (Reserved)

2. PROGRAM DESCRIPTION AND OBJECTIVES

In this demonstration, the state will maintain and enhance access to opioid use disorder (OUD) and other substance use disorder (SUD) services and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment of Medicaid beneficiaries with SUD. This demonstration will provide the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SUD while they are short-term residents in residential and inpatient treatment settings that qualify as an IMD. It will also support state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT), and improve access to a continuum of SUD evidence-based services at varied levels of intensity, including withdrawal management services.

During the demonstration period, the state seeks to achieve the following goals:

1	Increase rates of identification, initiation, and engagement in treatment for SUD
2	Increase adherence to and retention in treatment
3	Reduce overdose deaths, particularly those due to opioids
4	Reduce utilization of emergency departments and inpatient hospitals settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
5	Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate
6	Improve access to care for physical health conditions among beneficiaries with SUD

3. GENERAL PROGRAM REQUIREMENTS

3.1. Compliance with Federal Non-Discrimination Statutes. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy. All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. Changes in Medicaid and CHIP Law, Regulation, and Policy. The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. State Plan Amendments. The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, expect as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual monitoring reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. Extension of the Demonstration. States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(d)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable advance notice requirements and fair hearing rights described at 42 CFR 431, Subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payments rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.13. Federal Financial Participation. No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. Common Rule Exemption. The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(d)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. Eligibility Groups Affected by the Demonstration. Under the demonstration, there is no change to Medicaid eligibility and the standards and methodologies for eligibility remain set forth under the state plan.

5. DEMONSTRATION PROGRAM AND BENEFITS

5.1. SUD Program Benefits. The demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD. The state will aim for a statewide average length of stay of 30 days or less in residential treatment settings.

Under this demonstration beneficiaries will have access to high quality, evidence-based OUD/SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing chronic care for these conditions in cost-effective community-based settings.

5.2. SUD Implementation Plan and Health IT Plan.

a. The state's SUD Implementation Plan, initially approved for the period from July 9, 2019 through June 30, 2025, remains in effect for the approval period from July 1, 2025 through June 30, 2030, and is affixed to the STCs as Attachment A. Any future modifications to the approved Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral. The approved SUD Implementation Plan describes the strategic approach and a detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD demonstration project:

i. *Access to Critical Levels of Care for OUD and other SUDs.* Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management, within 12-24 months of demonstration approval;

ii. *Use of Evidence-based SUD-specific Patient Placement Criteria.* Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of demonstration approval;

iii. *Patient Placement.* Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;

iv. *Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.* Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Nebraska administrative code. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

v. *Standards of Care.* Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence- based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

vi. *Standards of Care.* Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;

vii. *Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD.* An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of demonstration approval;

viii. *Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD.* Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. *Improved Care Coordination and Transitions between Levels of Care.* Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and

supports following stays in these facilities within 24 months of demonstration approval.

x. *SUD Health IT Plan.* Implementation of a Substance Use Disorder Health Information Technology Plan which describes technology that will support the aims of the demonstration. Further information which describes the milestones and metrics as detailed in STC 5.2(b) and Attachment A.

b. SUD Health Information Technology Plan ("Health IT Plan"). The SUD Health IT Plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable Health IT Plan(s), to be included as a section(s) of the associated Implementation Plan (see STC 5.2(a)), to develop infrastructure and capabilities consistent with the requirements outlined in the SUD demonstration-type. The state's Health IT Plan, initially approved for the period from July 9, 2019 through June 30, 2025, remains in effect for the approval period from July 1, 2025 through June 30, 2030, and is affixed to the STCs as Attachment A.

The Health IT Plan describes how technology can support outcomes through care coordination; linkages to public health and prescription drug monitoring programs; establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR 433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 42 CFR part 170, subpart B.

i. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines and report on its progress to CMS within its Annual Report (see STC 8.5).

ii. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory – Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

iii. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards.

iv. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170

but included in the ISA, the state should use the federally recognized ISA standards.

v. Components of the Health IT Plan include:

1. The Health IT Plan must describe the state's alignment with Section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP).[1]
2. The Health IT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] States should favor procurement strategies that incorporate qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in RX Check for Interstate data sharing.
3. The Health IT Plan will describe how technology will support substance use disorder prevention and treatment outcomes described by the demonstration.
4. In developing the SUD Health IT Plan, states should use the following resources.

- States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).
- States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.
- States should review the Office of the National Coordinator's Interoperability Standards Advisory (https://www.healthit.gov/isa) for information on appropriate standards which may not be required per 42 CFR part 170,

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[2] *Ibid.*

subpart B for enhanced funding, but still should be considered industry standards per 42 CFR 433.112(b)(12).

5.3. Unallowable Expenditures Under the SUD Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

6. COST SHARING

6.1. Cost Sharing. Cost sharing requirements under the demonstration will not differ from the approved Medicaid State Plan.

7. DELIVERY SYSTEM

7.1. Delivery System. Nebraska's delivery system will continue to be the Heritage Health Medicaid managed care program that utilizes capitated Medicaid MCOs to provide state plan and 1915(b) authorized behavioral health services. Heritage Health will continue to operate as approved in DHHS' 1915(b) waiver.

8. MONITORING AND REPORTING REQUIREMENTS

8.1. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement. The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state must submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

8.2. Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones as evidenced by reporting on the milestones in the Annual Monitoring Report. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

8.3. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs unless CMS and the state mutually agree to another timeline.

8.4. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115 demonstration, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

8.5. Monitoring Reports. The state must submit one Annual Report each demonstration year (DY) that is due no later than 180 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. See 42 CFR 431.420(d)(1)-(2).

The Annual Monitoring Reports will include all required elements as per 42 CFR 431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Report must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and must be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The Annual Monitoring Report must provide sufficient information to document key operations and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by individuals; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Annual Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's milestones. Per 42 CFR 431.428, the Annual Monitoring Report must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and overall cost of care, and access to care, as applicable. This should also include the results of beneficiary satisfaction

or experience of care surveys, if conducted, as well as grievances and appeals. The Annual Monitoring Report must provide detailed information about deviations from CMS's applicable metrics technical specifications, relevant methodology, plans for phasing in metrics, and data or reporting issues for applicable metrics, in alignment with CMS guidance and technical assistance.

The state and CMS will work collaboratively to finalize the list of metrics to be reported on in the Annual Monitoring Report. The demonstration's monitoring metrics must cover categories to include, but not be limited to eligibility, utilization of services, quality of care and health outcomes, and grievances and appeals. The state must report these metrics for all demonstration populations. Demonstration monitoring reporting does not duplicate or replace reporting requirements for other authorities, such as Home and Community Based Services and Managed Care authorities.

In addition, the state is expected to report monitoring metrics for the following demonstration initiative, as described below and per applicable CMS guidance:

i. For the SUD component, the state's monitoring must cover metrics in alignment with CMS guidance and the demonstration's milestones as outlined in the SUD State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMD #17-003).

The reporting of these monitoring metrics may also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography) and by demonstration component, as appropriate. Subpopulation reporting can support identifying any gaps in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population.

c. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Annual Monitoring Report must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

8.6. SUD Mid-Point Assessment. The state must contract with an independent entity (herein referred to as the Independent Assessor) to conduct an independent Mid-Point Assessment and submit to CMS by May 31, 2028. This timeline will allow for the Mid-Point Assessment to capture approximately the first two and a half years of program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning, and execution of the Mid-Point Assessment, the state must require that the

Independent Assessor consult with key stakeholders such as, representatives of MCOs, health care providers, beneficiaries, community groups, and other key partners.

a. The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations. If requested, the state must brief CMS on the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

b. Elements of the Mid-Point Assessment must include:

    i. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plan;

    ii. A determination of factors that affected achievement on the milestones and performance metric gap closures to date;

    iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

    iv. For milestones or targets identified by the Independent Assessor as at medium to high risk of not being met, recommendations for adjustments in the state's Implementation Plan, or to other pertinent factors that the state can influence that will support improvement.

8.7. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS might withdraw an authority, as described in STC 3.10, if metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals and desired directionality, and the state has not implemented corrective action, and the circumstances described in STC 3.10 are met. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

8.8. Close-Out Report. Within 120 calendar days after the expiration of the demonstration the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 9.7 and 9.8, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out Report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 8.1.

8.9. Monitoring Calls. CMS will convene, no less frequently than quarterly, monitoring calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operations and implementation which align with the state's demonstration monitoring reports, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, eligibility and access, and progress on evaluation activities.

b. These calls will follow the structure of and focus on the topics in the Annual Monitoring Report.

c. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

d. The state and CMS will jointly develop the agenda for the calls.

8.10. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website.

The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

9. EVALUATION OF THE DEMONSTRATION

9.1. Cooperation with Federal Evaluators and Learning Collaborative. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f). This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 8.1.

9.2. Independent Evaluator. The state must use an independent entity (herein referred to as the Independent Evaluator) to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The Independent Evaluator must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

9.3. Evaluation Design. The state must submit, for CMS comment and approval, an Evaluation Design with implementation timeline no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with the STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as

establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the Independent Evaluator in the development of the Evaluation Design. The Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 9.7 and 9.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the state and CMS. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

9.4. Evaluation Design Approval and Updates. The state must submit to CMS a revised Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the Evaluation Design, the document will be posted to Medicaid.gov. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each Annual Monitoring Report. Once CMS approves the Evaluation Design, if the state wishes to make changes and the changes are substantial in scope, the state must submit a revised Evaluation Design to CMS for approval; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in an Annual Monitoring Report.

9.5. Evaluation Questions and Hypotheses. Consistent with the STCs and applicable CMS guidance, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include the Consumer Assessment of Health Care Providers and Systems (CAHPS), the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to

as the Child and Adult Core Sets, the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum (NQF).

The state must develop robust evaluation questions and hypotheses related to each demonstration initiative, and per applicable CMS guidance. Specifically:

a. Hypotheses for the SUD component of the demonstration must align with the goals of the program, including increasing rates of identification and initiation of and engagement in treatment as well as adherence to and retention in treatment, reducing overdose deaths, reducing utilization of emergency departments and inpatient hospitalizations as well as readmissions to the same or higher level of care, and improving access to care for physical health conditions.

As part of its evaluation efforts, the state must also conduct an overall demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experiences with access to and quality of care. To better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state may collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography). Such stratified data analyses can provide a fuller understanding of gaps in access to and quality of care and health outcomes and help inform how the demonstration's various policies support improving outcomes.

9.6. Evaluation Budget. A budget for the evaluations must be provided with the Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS

finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

9.7. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). The draft Interim Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

a. The Interim Evaluation Reports will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expires prior to the overall demonstration's expiration date and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for the extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. When applying for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment. If the state does not request an extension for the demonstration, the Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

9.8. Summative Evaluation Report. The state must submit to CMS a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance

a. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

b. Once approved by CMS, the state must post the final Summative Report to the state's Medicaid website within 30 calendar days.

9.9. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration initiatives, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

9.10. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, or the Summative Evaluation Report.

9.11. Public Access. The state shall post the final documents (e.g., Annual Monitoring Report, Close out Report, Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

9.12. Additional Publications and Presentations. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration, over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

10. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

10.1. Allowable Expenditures. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

10.2. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

10.3. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms, and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

10.4. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

10.5. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR 447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

10.6. Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

10.7. State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 8.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

10.8. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 11:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

10.9. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

10.10. Medicaid Expenditure Groups. Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and

other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 1: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
SUD Waiver Demonstration - ABD	Hypo 1	X		X	All medical assistance expenditures during an IMD stay month for Aged, Blind and Disabled beneficiaries.
SUD Waiver Demonstration - DUAL	Hypo 1	X		X	All medical assistance expenditures during an IMD stay month for Dual Eligible beneficiaries
SUD Waiver Demonstration - FAM	Hypo 1	X		X	All medical assistance expenditures during an IMD stay month for Families beneficiaries
SUD 1115 Demonstration – EXP	Hypo 1	X		X	All medical assistance expenditures during an IMD stay month for the Expansion population

10.11. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-10025/7). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements**. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements

must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. To assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 11, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** The state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64,

consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 2: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SUD Waiver Demonstration - ABD	All medical assistance expenditures during an IMD stay month for Aged, Blind and Disabled beneficiaries.	STC 5.3	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/19	6/30/30
SUD Waiver Demonstration - DUAL	All medical assistance expenditures during an IMD stay month for Dual Eligible beneficiaries.	STC 5.3	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/19	6/30/30
SUD Waiver Demonstration - FAM	All medical assistance expenditures during an IMD stay month for Families beneficiaries	STC 5.3	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/19	6/30/30
SUD 1115 Demonstration – EXP	All medical assistance expenditures during an IMD stay month for the Expansion population	STC 5.3	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/21	6/30/30

10.12. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 3: Demonstration Years		
Demonstration Year 7	July 1, 2025, to June 30, 2026	12 months
Demonstration Year 8	July 1, 2026, to June 30, 2027	12 months
Demonstration Year 9	July 1, 2027, to June 30, 2028	12 months
Demonstration Year 10	July 1, 2028, to June 30, 2029	12 months
Demonstration Year 11	July 1, 2029, to June 30, 2030	12 months

10.13. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in section 11. CMS will provide technical assistance, upon request.[3]

10.14. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

10.15. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

[3] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

10.16. Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 10.16.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. After acknowledging receipt of the request, CMS will determine

whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

    i. Provider rate increases that are anticipated to further strengthen access to care;

    ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

    iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

    iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

    v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

    vi. High-cost innovative medical treatments that states are required to cover; or,

    vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

    i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

    ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-

covered service or population and that is likely to further strengthen access to care.

11. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

11.1. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of one Hypothetical Budget Neutrality Test, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

11.2. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1, Master MEG Chart and Table 2, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

11.3. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

11.4. Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests, including "Supplemental". Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

11.5. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid State Plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical;" such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

11.6. Hypothetical Budget Neutrality Test 1: SUD Initiative. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 4: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 1	DY 2	DY 3	DY 4	DY 5
SUD Waiver Demonstration - ABD	PC	Both	5%	$2,420.28	$2,541.29	$2,668.35	$2,801.77	$2,941.86

SUD Waiver Demonstration - DUAL	PC	Both	5%	$362.16	$380.27	$399.28	$419.24	$440.20
SUD Waiver Demonstration - FAM	PC	Both	4.8%	$747.52	$783.40	$821.00	$860.41	$901.71
SUD 1115 Demonstration – EXP	PC	Both	5.2%	$1,072.43	$1,128.20	$1,186.87	$1,248.59	$1,313,52

11.7. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

11.8. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from July 1, 2025 to June 30, 2030. If at the end of the demonstration approval period the Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the demonstration period, the budget neutrality test shall be based on the time elapsed through the termination date.

11.9. Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 5: Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 7	Cumulative budget neutrality limit plus:	2.0 percent

DY 7 through DY 8	Cumulative budget neutrality limit plus:	1.5 percent
DY 7 through DY 9	Cumulative budget neutrality limit plus:	1.0 percent
DY 7 through DY 10	Cumulative budget neutrality limit plus:	0.5 percent
DY 7 through DY 11	Cumulative budget neutrality limit plus:	0.0 percent

12. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 6: Schedule of Deliverables for the Demonstration Period

Date	Deliverable	STC
30 calendar days after approval date	State acceptance of demonstration STCs, and Expenditure Authorities	Approval letter
180 calendar days after approval date	Evaluation Design	STC 9.3
May 31, 2028	SUD Mid-Point Assessment	STC 8.6
One year prior to the expiration of the demonstration	Draft Interim Evaluation Report	STC 9.7
60 days after receipt of CMS comments	Final Interim Evaluation Report	STC 9.7
Within 18 months after approval period ends	Draft Summative Evaluation Report	STC 9.8
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 9.8
Quarterly Deliverable: Due 60 calendar days after the end of each quarter	Quarterly Budget Neutrality Reports	STC 10.13
Annual Deliverable - Due 180 calendar days after the end of each demonstration year	Annual Monitoring Report	STC 8.5

ATTACHMENT A
SUD Implementation Plan

NEBRASKA MEDICAID 1115 SUBSTANCE USE DISORDER DEMONSTRATION

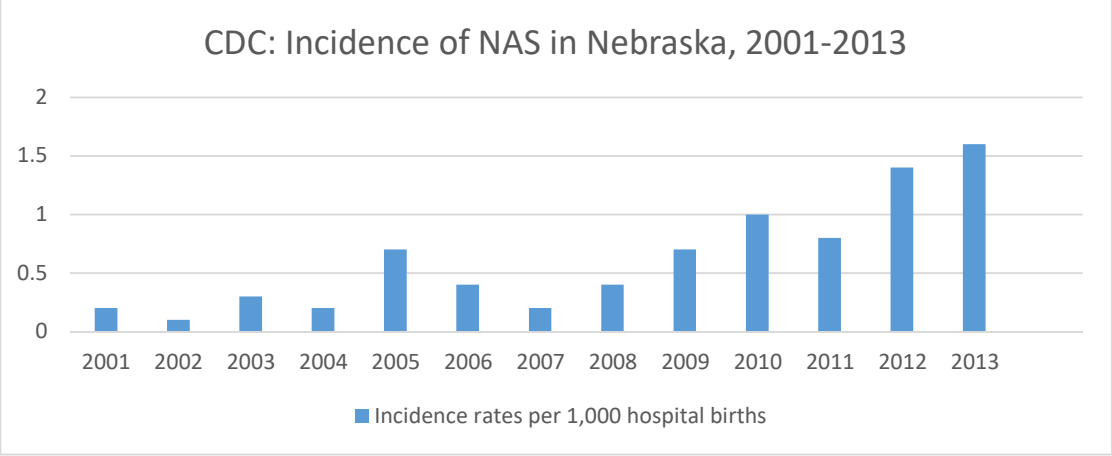
IMPLEMENTATION PLAN PROTOCOL

INTRODUCTION

The United States is facing a public health crisis brought on by the abuse of prescription and illicit opioids. According to the National Institutes of Health, more than 130 Americans die from opioid overdoses every day.[1] In 2016, over 63,000 Americans died as a result of drug overdose, 42,200 of which were attributed to opioids.[2] The surge in opioid-related overdose deaths was significant enough to contribute to a decline in overall life expectancy in the U.S. for the second year in a row. This is the first time since the 1960s that U.S. life expectancy has declined over consecutive years.[3]

According to the CDC, Nebraska's drug overdose death rate was 6.9-11 per 100,000 people in 2017.[4] The State is also experiencing an increase in newborns exhibiting drug withdrawal symptoms. Data from the Centers for Disease Control and Prevention (CDC) indicates an increase in Nebraska in the rate of neonatal abstinence syndrome (NAS). As illustrated in Figure 1, incidents of NAS have grown at an annual rate of .1 per 1,000 hospital births from .2 per 1,000 in 2001 to 1.6 per 1,000 in 2013.[5]

Figure 1. Neonatal Abstinence Syndrome (NAS) in Nebraska



[1] National Institutes of Health, Opioid Overdose Crises, January 2019. Available at: https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis#one

[2] Centers for Disease Control and Prevention, Drug Overdose Deaths in the United States, 1999–2016, December 2017. Available at: https://www.cdc.gov/nchs/data/databriefs/db294.pdf

[3] Life Expectancy Drops Again As Opioid Deaths Surge In U.S., National Public Radio, December 21, 2017. Available at: https://www.npr.org/sections/health-shots/2017/12/21/572080314/life-expectancy-drops-again-as-opioid-deaths-surge-in-u-s

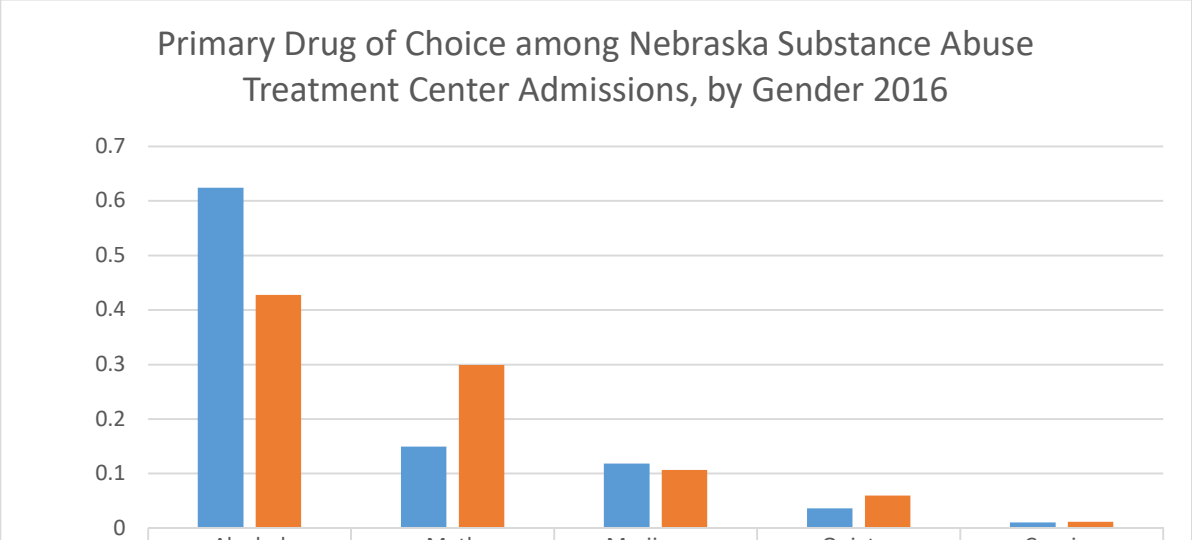
[4] CDC: Drug Overdose Deaths: https://www.cdc.gov/drugoverdose/data/statedeaths.html

[5] Ko JY, Patrick SW, Tong VT, Patel R, Lind JN, Barfield WD. Incidence of Neonatal Abstinence Syndrome — 28 States, 1999–2013. MMWR Morb Mortal Wkly Rep 2016; 65:799–802. DOI: http://dx.doi.org/10.15585/mmwr.mm6531a2.

While Nebraska has not experienced the type of public health crisis afflicting other states as a result of prescription and illicit opioid abuse, the state is still feeling the impact of the national epidemic. Opioid overdoses were responsible for 59 deaths in Nebraska in 2017.[6]

Nebraskans, including those participating in the Medicaid program, continue to struggle with a variety of substance use challenges including opioids. Figure 2 illustrates the drug of choice identified by individuals admitted to Substance Abuse Treatment Centers (SATC) in 2016.

Figure 2. Nebraska Primary Drug of Choice



	Alcohol	Meth	Marijuana	Opiates	Cocaine
Male	0.623975912	0.149639381	0.118128983	0.036412016	0.010503466
Female	0.427695139	0.299187241	0.106425395	0.059806778	0.011808005

Note: Excludes admissions in which the drug of choice information was not reported
Source: Centralized Data System, Nebraska Division of Behavioral Health

The Nebraska Medicaid program's continuum of substance use disorders (SUD) services reflects the experience of the state's population. Consequently, that continuum addresses the areas of highest current need which includes most prominently alcohol and methamphetamine abuse.

Due to Nebraska currently experiencing a lower public health impact related to opioid use disorder (OUD) including fewer overdose deaths when compared to the national trend, the Nebraska Department of Health and Human Services' (DHHS) OUD initiatives focus on the prevention of opioid addiction, through interventions such as the state's Prescription Drug Monitoring Program (PDMP)[7] and

[6] DHHS Receives Additional $10.9 Million for Opioid Prevention and Response. Available at: http://dhhs.ne.gov/News%20Release%20Archive/DHHS%20Receives%20Additional%20$10.9%20Million%20for%20Opioid%20Prevention%20and%20Response.pdf

[7] DHHS Launches Additional Enhancements to Prescription Drug Monitoring Program, January 8, 2018. Available at: http://dhhs.ne.gov/News%20Release%20Archive/DHHS%20Launches%20Additional%20Enhancements%20to%20Prescription%20Drug%20Monitoring%20Program%20%20.pdf

through the State Targeted Response (STR) Grant for Opioid Treatment,[8] the State Opioid Response (SOR) Grant, and targeted interventions implemented by the Medicaid program.

The PDMP in Nebraska, led by the DHHS Division of Public Health (DPH), is a robust initiative with well-defined measurable goals in place in order to address OUD in the state. The strategies in place are intended to increase provider use of the PDMP, provide education to healthcare professions on safe pain management without excessive opioid prescription, and educating the public on Naloxone to save lives. More detail on these strategies and how they impact Medicaid members will be reviewed in Milestone 5.

The STR Grant was awarded to the DHHS Division of Behavioral Health (DBH) in May 2017, and ended April 30, 2019. The grant was utilized to increase Nebraskan's access to clinically appropriate evidence-based practices for the prevention and treatment of OUD with the goal of reducing overdose related deaths for citizens through increasing access to Naloxone and providing additional education and training opportunities for service providers. The SOR Grant, which began October 1, 2018 and extends to September 30, 2020, continues and expands upon the efforts of the STR grant. Further detail on the strategies of these grants and how those strategies impact access to treatment for Medicaid beneficiaries will be reviewed throughout this plan.

PROGRAM OVERVIEW

The Nebraska Medicaid Program provides health coverage to approximately 240,000 residents. In any given month, 10 to 12 percent of the state's population is eligible for Medicaid. Over 98 percent of Medicaid enrollees are served through the State's managed care delivery system.

On January 1, 2017, Nebraska Medicaid launched Heritage Health, a new managed care program that integrates physical health, behavioral health, and pharmacy services into a single, statewide, comprehensive delivery system. The objectives of Heritage Health include:

- Improved health outcomes;
- Enhanced integration of services and quality of care;
- Emphasis on person-centered care, including enhanced preventive and care management services;
- Reduced rates of costly and avoidable care; and
- Improved financially sustainable system.

Nebraska Medicaid contracts with three health plans for the administration of the Heritage Health program: Nebraska Total Care (Centene), UnitedHealthCare Community Plan, and WellCare of Nebraska.

A driving force behind the creation of Heritage Health was the desire to improve care coordination and simplify service delivery for Medicaid members. Prior to the launch of Heritage Health, a member struggling with substance use, physical health problems, and mental health conditions who also required prescription drugs navigated three separate programs in order to receive the full array of benefits and services the individual required. Through the integration of Medicaid services, Heritage

[8] State Targeted Response (STR) Opioid Crisis Grant, January 5, 2018. Available at: http://dhhs.ne.gov/Reports/State%20Targeted%20Response%20to%20Opioid%20Crisis%20Fact%20Sheet%20-%202017.pdf

Health removes barriers to addressing all the health needs of each member with a streamlined, person-centered approach.

The Nebraska Medicaid program is also in the development process for a new data warehouse and business intelligence technology platform. Development for this Data Management and Analytics (DMA) project began in February of 2018 and is scheduled for go-live in 2019. The new DMA platform will have a positive impact on this demonstration, allowing for more detailed data collection and reporting. For example, currently contracted Heritage Health plans submit pharmacy encounter data based on Nebraska's proprietary pharmacy encounter format. The proprietary format is necessitated by the limitations of the state's legacy MMIS system. With the completion of the DMA project, Heritage Health plans will submit encounter data utilizing a NCPDP standard transaction format. The NCPDP standard format will provide the Nebraska Medicaid program with significantly more information about each pharmacy encounter than is currently captured within the proprietary format.

The State believes participation in the demonstration program outlined by CMS will allow the state to build on the recent delivery system reforms and DHHS-wide SUD initiatives identified in this Implementation Plan.

MILESTONE 1: ACCESS TO CRITICAL LEVELS OF CARE FOR OUD AND OTHER SUDs

Milestone Criteria:

Coverage of: a) outpatient; b) intensive outpatient services; c) medication-assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the state); d) intensive levels of care in residential and inpatient settings; and e) medically supervised withdrawal management. This milestone must be met within 12 to 24 months of demonstration approval or other timeframe in accordance with the special terms and conditions (STC).

Current State:

The Nebraska Medicaid program currently provides a range of SUD services at multiple levels of care identified for this Milestone. Table 1 is a listing of services available at these levels of care. Nebraska recognizes the importance of having services available at critical care levels in order to provide eligible individuals the medically appropriate treatment while also ensuring an efficient and effective use of Medicaid program resources.

In June 2017, the state expanded its continuum of community-focused behavioral health services by adding coverage for Peer Support.[9] Nebraska Medicaid also currently offers non-methadone medication-assisted treatment (MAT) including coverage for naloxone delivered as an injectable or spray, buprenorphine, Suboxone (buprenorphine/naloxone), and Vivitrol (naltrexone).[10]

[9] State Plan Amendment NE-16-0009. Available at: https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NE/NE-16-0009.pdf

[10] Nebraska Medicaid Preferred Drug List (PDL). March 1, 2018. Available at: https://nebraska.fhsc.com/downloads/PDL/NE_PDL-20180301.pdf

Nebraska Regulations, Nebraska DHHS Title 471 Chapter 20, Psychiatric Services for Individuals Age 21 and Older, requires covered substance use treatment be provided when it is medically necessary[11]. Nebraska contracts with the MCO's to determine their criteria for medical necessity, and requires that criteria be based on valid clinical guidelines and assessments. All guidelines are to be reviewed by Nebraska Medicaid to assure that applicable federal, state, and contractual requirements are met.

Table 1 lists out the SUD specific services and links to the corresponding service definitions. Each of these definitions list out the providers qualified to deliver the service. If the qualifications for any of these provider types require a license to practice this oversight is managed by DPH. The qualifications of each license type are listed in detail in State Regulations, Title 172. The licensing requirements for the provider types providing these services will be reviewed in further detail for Milestone 3.

Table 1: Nebraska Medicaid SUD Services by ASAM Level of Care

ASAM Level	Services	Service Definition	Authority
1	ASA COMMUNITY SUPPORT – LEVEL 1: ADULT SUBSTANCE USE DISORDER	http://dhhs.ne.gov/Behavioral Health Service Definitions/Adult Substance Abuse Community Support.pdf	1915(b)
1	OUTPATIENT GROUP THERAPY - LEVEL 1: ADULT SUBSTANCE USE DISORDER	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Substance%20Abuse%20Group%20Therapy-Level%201.pdf	1915(b)
1	ASA OUTPATIENT INDIVIDUAL THERAPY– LEVEL 1: ADULT SUBSTANCE USE DISORDER	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Substance%20Abuse%20Individual%20Therapy.pdf	1915(b)
1	ASA OUTPATIENT FAMILY THERAPY - LEVEL 1: SUBSTANCE USE DISORDER	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Substance%20Abuse%20Family%20Therapy.pdf	1915(b)
2.1	INTENSIVE OUTPATIENT – LEVEL 2.1: ADULT SUBSTANCE USE DISORDER	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Substance%20Abuse%20Intensive%20Outpatient.pdf	1915(b)
2.5	ADULT SUBSTANCE USE DISORDER DAY TREATMENT ADULT ASAM LEVEL 2.5	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Substance%20Abuse%20Day%20Treatment%20Level%202.5.pdf	1915(b)
3.1	HALFWAY HOUSE - LEVEL 3.1: ADULT SUBSTANCE USE DISORDER	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Substance%20Abuse%20Halfway%20House.pdf	1915(b)
3.2	SOCIAL DETOXIFICATION – LEVEL 3.2 ADULT SUBSTANCE USE DISORDER	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Su	1915(b)

[11] 471 NAC 20: http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-20.pdf

ASAM Level	Services	Service Definition	Authority
		bstance%20Abuse%20Detoxification-Level%203.2.pdf	
3.3	ASA INTERMEDIATE RESIDENTIAL (CO-OCCURRING DIAGNOSIS CAPABLE) – LEVEL 3.3	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Substance%20Abuse%20Intermediate%20Residential.pdf	1915(b)
3.3	THERAPEUTIC COMMUNITY (CO-OCCURRING DIAGNOSIS CAPABLE) ASAM LEVEL 3.3	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Substance%20Abuse%20Therapeutic%20Community.pdf	1915(b)
3.5	SHORT TERM RESIDENTIAL (CO-OCCURRING DIAGNOSIS CAPABLE) – LEVEL 3.5 ADULT SUBSTANCE USE DISORDER	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Substance%20Abuse%20Short%20Term%20Residential%20(Dual%20Diagnosis).pdf	1915(b)
3.5	DUAL DISORDER RESIDENTIAL (CO-OCCURRING DIAGNOSIS-ENHANCED) – LEVEL 3.5 ADULT SUBSTANCE USE DISORDER	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Substance%20Abuse%20Dual%20Disorder%20Residential.pdf	1915(b)
OTHER	ANNUAL SUPERVISION of the MEDICAID ELIGIBLE INDIVIDUAL BY A PSYCHOLOGIST OR AN LIMHP	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Annual%20Supervision%20by%20Licensed%20Independent%20or%20Psychologist.pdf	State Plan Attachment 3.1-A Item 6d Page 1 of 2
OTHER	SUBSTANCE USE DISORDER ADDENDUM – ADULT	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Substance%20Abuse%20Addendum.pdf	1915(b)
OTHER	ADULT SUBSTANCE USE DISORDER ASSESSMENT	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Adult%20Substance%20Abuse%20Assessment.pdf	1915(b)
OTHER	FAMILY ASSESSMENT	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Family%20Assessment.pdf	1915(b)
OTHER	OBSERVATION ROOM	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Observation%20Room.pdf	1915(b)
OTHER	PEER SUPPORT	http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Peer%20Support.pdf	State Plan: Attachment 3.1-A Item 13d, Page 5b

Future State:

Nebraska Medicaid will submit a State Plan Amendment to request authority to cover medically monitored intensive inpatient withdrawal management for adults at ASAM level 3.7-WM in order to meet the service coverage requirements of this milestone.

In order to further align the state's SUD service continuum with CMS's objectives for this program and in recognition of the requirements of Section 1006 of the Support Act[12], Nebraska Medicaid will submit a State Plan Amendment to request authority to cover methadone for MAT.

Nebraska Medicaid will also continue to monitor contracted MCOs for compliance with the existing contract requirements regarding covered services to ensure the full SUD continuum of care is available to members.

Summary of Actions Needed:

Implementation Action Item	Timeline
Submit a State Plan Amendment to request authority to cover medically monitored intensive inpatient withdrawal management for adults at ASAM level 3.7-WM	12- 24 months
Submit a State Plan Amendment to request authority to cover methadone for MAT.	12-24 months

MILESTONE 2: WIDESPREAD USE OF EVIDENCE-BASED, SUD-SPECIFIC PATIENT PLACEMENT CRITERIA

Milestone Criteria:

1. Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and
2. Contracted MCOs must have a utilization management approach such that: a) beneficiaries have access to SUD services at the appropriate level of care; b) interventions are appropriate for the diagnosis and level of care; and c) there is an independent process for reviewing placement in residential treatment settings.

This milestone must be met within 12 to 24 months of demonstration approval or other timeframe in accordance with the STCs.

Current State:

The Nebraska MCO contracts include the expectation that substance abuse treatment services will be appropriate to a member's level of need and that services are available when needed. The service definitions for SUD treatment provided in Table 1 include ASAM criteria and other screening tools used to assess and treat SUD. ASAM standards were utilized in the development of these service definitions. Providers must adhere to the requirements of these service definitions, which will assure the individual meets the diagnostic criteria for a substance use-related disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders (current version) as well as each of the six ASAM dimensional criteria for admission. With the exception of assessment, individual therapy, group therapy, and family therapy, all plans require the services listed in Table 1 be authorized prior to their initiation, which will

[12] SUPPORT for Patients and Communities Act, Section 1006. Available at: https://www.congress.gov/bill/115th-congress/house-bill/6/text#toc-H54D9809005834B7FAEC1764B725A2970

assure medical necessity requirements have been met by the provider. Medicaid SUD services are also required to be recovery-based, and the MCO must ensure that "active treatment" is provided to each member, meaning that a member receiving these services will have an individual plan of care in which the member participates and shows progress.

All contracted MCOs must have a utilization management program in place that complies with Federal utilization control requirements, including the certification of need and recertification of need for continued inpatient settings, including psychiatric residential treatment facilities, and as described in 42 CFR 438. The description of this program must be submitted to MLTC annually, and must include procedures for service authorizations, concurrent review, extensions of lengths of stay, and retrospective reviews for all covered services.

MCOs are required to have procedures in place for concurrent review of inpatient services in order to monitor the medical necessity of the need for a continued stay. The concurrent review system must include provisions for multiple day approvals when the episode of care is reasonably expected to last more than one day, based on the medical necessity determination.

An additional required aspect of the utilization management program is for the MCO to develop and implement retrospective UR functions for examining trends, issues, and problems in utilization, particularly over- and under-utilization that may need to be addressed including retrospective and peer reviews of a sample of network providers to ensure that the services furnished by network providers were provided to members, were appropriate and medically necessary, and were authorized and billed in accordance with the MCO's requirements.

The MCOs have all provided a Utilization Management program plan annually throughout the current contract, as required. All submitted plans have been reviewed and meet these contract requirements.

Each MCO is required to maintain up to date clinical practice guidelines in accordance with 42 CFR 438.236(b) which are maintained on the MCO's public website. Each MCO also submits to Nebraska Medicaid for review and approval the MCO's policies and procedures for treatment guidelines and utilization management approaches. Nebraska does not mandate that the MCOs follow a specific clinical guideline, but it is required that each MCO create and maintain a Clinical Advisory Committee. This committee provides input for the MCO into all policies, procedures, and practices associated with the MCO's utilization management criteria, to ensure that criteria reflect up-to-date standards consistent with research, requirements for evidence-based practices, and community practice standards in the State. It is also required that the MCO's clinical guidelines be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. All three of the currently contracted MCOs utilize guidelines published by the American Psychiatric Association in 2006[13] in regard to their treatment for substance abuse disorders. These guidelines stress the importance of using the American Society of Addiction Medicine (ASAM) patient placement criteria when determining the level of care needed for the patient.

[13] American Psychiatric Association Practice Guideline for the Treatment of Patients with Substance Use Disorders, 2nd edition (2006)
http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf

Future State:

Nebraska Medicaid will continue to monitor contracted MCOs for their compliance with the existing contract requirements regarding access to behavioral health services that are appropriate to the level of need. It is recognized that while each of the MCOs has utilization management policies and procedures that meet this milestone, not all aspects of this milestone are explicitly stated within the contract. Nebraska Medicaid will update contract language to include a requirement that assessment tools used when authorizing or reviewing inpatient stays be based on evidence based clinical treatment guidelines and which assure that requirements of all service definitions, including those found in Table 1, are met. Utilization Management policies and procedures for each of the contracted MCOs will need to specifically address how the requirements of the service definitions are met. Additionally, Nebraska Medicaid will update contract language to require that a concurrent review of care provided to members receiving inpatient residential SUD treatment include an evaluation of each case against established criteria such as national clinical guidelines.

Nebraska Medicaid also proposes to include SUD treatment specific requirements to the existing annual audit tool used to review all contracted MCOs' compliance with this new contract language.

Summary of Actions Needed:

Implementation Action Item	Timeline
Update contract language to reflect specific requirements for utilization management and level of care assessments.	12- 24 months

MILESTONE 3: USE OF NATIONALLY RECOGNIZED, EVIDENCE-BASED, SUD PROGRAM STANDARDS TO SET RESIDENTIAL TREATMENT PROVIDER QUALIFICATIONS

Milestone Criteria:

1. Implementation of residential treatment provider qualifications in licensure requirements, program authorities and policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria, or other nationally recognized, evidence- based SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings.
2. Implementation of state process for reviewing residential treatment providers to assure compliance with these standards.
3. Residential treatment facilities offer MAT on-site or facilitate access off-site.

This milestone must be met within 12 to 24 months of demonstration approval or other timeframe in accordance with the STCs.

Current State:

DPH is the entity which assures that residential treatment providers for SUD services meet provider qualifications through the process of licensure. This process assures these providers are practicing in a

setting appropriate to their license. Nebraska DHHS Title 172 -- Professional and Occupational Licensure contains regulations that govern the practitioner licensing requirements, fees, standards of conduct, practice guidelines, and training standards.

DPH is also the entity which assures that facilities for SUD treatment, licensed as a Mental Health and Substance Use (MHSU) Treatment Center, meet facility licensing qualifications. Nebraska DHHS Title 175 Chapter 18, Health Care Facilities and Services Licensure, Substance Abuse Treatment Centers, http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-175/Chapter-18.pdf, and Title 175 Chapter 19, Mental Health Centers, http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-175/Chapter-19.pdf, contain regulations that govern the facilities standards of operation, care and treatment. The State statutes relating to substance abuse treatment centers which guide licensing requirements are found here, http://dhhs.ne.gov/licensure/Documents/Facilities-HealthCareFacilities.pdf, and they include the Health Care Facility Licensure Act and Health Care Quality Improvement Act.

Alcohol and Drug Counselors are one type of provider in the State of Nebraska who provide SUD services that are outlined in Milestone 1 of this plan. The DPH Licensing regulations define an Alcohol and Drug Counselor as an individual who provides the 12 core functions of screening, intake, orientation, assessment, treatment planning, counseling (individual, group and significant others), case management, crisis intervention, client education, referral, reports and recordkeeping and consultation with other professionals in regard to client treatment and services. These core functions are in accordance with the International Certification & Reciprocity Consortium (IC&RC) requirements for alcohol and other drug abuse (AODA). The complete definition and licensing requirements for this provider type are explained in Nebraska DHHS Title 172 Chapter 15, Licensure of Alcohol and Drug Counselors, located here: http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-172/Chapter-015.pdf.

Mental Health Practitioners and Clinical Social Workers who provide SUD related services are licensed by DPH, and their licensing requirements can be found in Nebraska DHHS Title 172 Chapter 94, Licensure of Mental Health Practitioners and the Certification of Marriage and Family Therapists, Professional Counselors and Social Workers: http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-172/Chapter-094.pdf .

Dispensing Buprenorphine in Nebraska requires certification through the United States Drug Enforcement Administration (DEA). Dispensers must meet state licensing requirements before applying for DEA registration. The DEA will not issue a certification if the state license has been revoked or rescinded. Nebraska has promotions in place to expand the delivery of required training in order to increase the number of waiver qualified Buprenorphine prescribers, see milestone 4 for additional details on activities and goals related to increasing this number.

Nebraska Medicaid has included in the contract for MCOs language specific to their obligation in assuring all Medicaid providers have been appropriately licensed or certified, and are operating within their scope of practice.

In all its contracts with health care professionals, the MCO must comply with the requirements specified in 42 CFR 438.214, 438.610, 455.104, 455.105, 455.106, and 1002.3, which include selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. The MCO must utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom/which it contracts or employs and who fall within its scope of authority and action.
The MCO must re-credential each provider a minimum of every three years, taking into consideration various forms of data, including but not limited to grievances, results of quality reviews, results of member satisfaction surveys, and utilization management information. The MCO must communicate with Nebraska Medicaid, DBH, and DPH regarding incidents or audits that potentially affect provider licensure for any applicable provider types.

The Nebraska Medicaid Service Definitions in Table 1 contain information regarding the service expectations, hours of operation, and staffing requirements for the different types of residential treatment facilities in Nebraska. These service definitions were developed utilizing ASAM standards. Through the utilization management procedures detailed in Milestone 2 of this plan, Nebraska Medicaid assures that the standards found within service definitions are met.

Currently, residential providers utilize abstinence-based care models and the State is unaware of any residential providers offering MAT onsite or facilitating offsite access to MAT. One purpose of the DBH Nebraska Opioid STR and SOR Initiatives is to increase Nebraskans' access to clinically appropriate evidence-based practices for treatment of their opioid use disorder, and a method being used to support this goal is increasing the number of practitioners trained on MAT. DBH held a MAT Summit in 2017[14] which had a goal of promoting and expanding use of MAT. An Opioid Summit was held March 2019 in order to continue to provide educational opportunities and increase access to MAT. An additional method supported through the DBH grant efforts to promote provider education for MAT is Project ECHO which is reviewed in detail in Milestone 4.

Future State:

Over the next 24 months, Nebraska will work on promoting a shift in perspective among residential providers to integrate facilitation of MAT into their programmatic requirements and utilization. Residential providers will be required expand their treatment methods by either offering MAT onsite or facilitating access to MAT off-site. This requirement will be built into applicable service definitions listed in Table 1, and rates will be reviewed based on these updates. Because Nebraska's current residential providers practice within abstinence-based care models, this shift will require extensive outreach and additional education opportunities.

Nebraska Medicaid will update contract language to require the MCOs to develop training material to be provided for MHSU Treatment Centers which supports this perspective shift. These educational initiatives will seek to continue to eliminate stereotyping associated with MAT. Educational initiatives

[14] MAT Summit News Release: http://dhhs.ne.gov/News%20Release%20Archive/Medication-Assisted%20Treatment%20(MAT)%20Summit%20in%20August.pdf

will also include state and federal guidance associated with MAT. Substance Abuse and Mental Health Services Administration (SAMHSA) materials will be utilized to provide education to these facilities.

In order to further support the ability of residential providers to offer or facilitate MAT, Nebraska Medicaid is adding coverage of methadone for MAT through a State Plan Amendment as detailed in the future state section of Milestone 1.

Nebraska Medicaid will update contract language to include a requirement that the MCOs perform reviews of residential treatment providers to assure all standards regarding service type and expectations, hours of care, and staffing requirements, not currently reviewed through their current or proposed utilization management procedures detailed in Milestone 2, are met. Nebraska Medicaid will continue to monitor contracted MCOs for their compliance with the existing contract requirements regarding licensure and certification to assure providers meet standards for SUD provider qualifications.

Summary of Actions Needed:

Implementation Action Item	Timeline
Update contract language to require provider education regarding the requirements to facilitate MAT onsite or off site, and on benefits of MAT accessibility, to begin a shift in perspective toward acceptance of MAT as a complementary treatment.	24 months
Update service descriptions to require access to MAT.	24 Months
Update contract language to require reviews of residential treatment providers to assure the types of services, hours of clinical care, and credentials of staff for residential treatment settings are performed according to ASAM Criteria, or other nationally recognized, evidence- based SUD-specific program standards.	24 Months

MILESTONE 4: SUFFICIENT PROVIDER CAPACITY AT EACH LEVEL OF CARE, INCLUDING MAT

Milestone Criteria:

Assess the availability and capacity of providers throughout the state, enrolled in Medicaid, who accept patients in the Milestone 1 critical levels of care: a) outpatient; b) intensive outpatient services; c) medication-assisted treatment (medications as well as counseling and other services); d) intensive levels of care in residential and inpatient settings; and e) medically supervised withdrawal management. This milestone must be met within 12 months of demonstration approval or other timeframe in accordance with the STCs.

Current State:

Care Delivery Infrastructure

Nebraska's publicly funded behavioral health system is anchored by a network of six local regions. The regions contract with local programs to provide public inpatient, outpatient, emergency community mental health, and substance use disorder services. Medicaid managed care plans are required to collaborate with DBH and the local behavioral health regions in the establishment and maintenance of the plans' provider networks.

As of March 2018, Nebraska had just over 20 licensed Mental Health Centers with a capacity of nearly 500 licensed beds and approximately 100 licensed Substance Abuse Treatment Centers with a capacity of over 800 beds.

The state has over 200 Medicaid-enrolled fully licensed Alcohol and Drug Counselors and about 100 Provisionally Licensed Alcohol and Drug Counselors.

There are approximately 1,700 Licensed Mental Health Professionals and Licensed Clinical Social Workers enrolled to serve Medicaid beneficiaries.

Access to Care Monitoring

Nebraska Medicaid currently monitors provider capacity through MCO reporting. MCO's are required to provide quarterly network access reports that assess member access to care.

Current MCO contractual access standards for behavioral health are as follows:

- **Inpatient/Residential Services**: MCOs must, at a minimum, contract with behavioral health inpatient and residential service providers with sufficient locations to allow members to travel by car or other transit provider and return home within a single day in rural and frontier areas. If it is determined by Nebraska Medicaid that no inpatient providers are available within the access requirements, the MCO must develop alternative plans for accessing comparable levels of care, instead of these services, subject to approval by Nebraska Medicaid.

- **Outpatient Services:** MCOs must, at a minimum, contract with an adequate number of behavioral health outpatient assessment and treatment providers to meet the needs of its members and offer a choice of providers. The MCO must provide adequate choice within 30 miles of members' personal residences in urban areas; a minimum of two providers within 45 miles of members' personal residences in rural counties, and a minimum of two providers within 60 miles of members' personal residences in frontier counties. If the rural or frontier requirements cannot be met because of a lack of behavioral health providers in those counties, the MCO must utilize telehealth options.

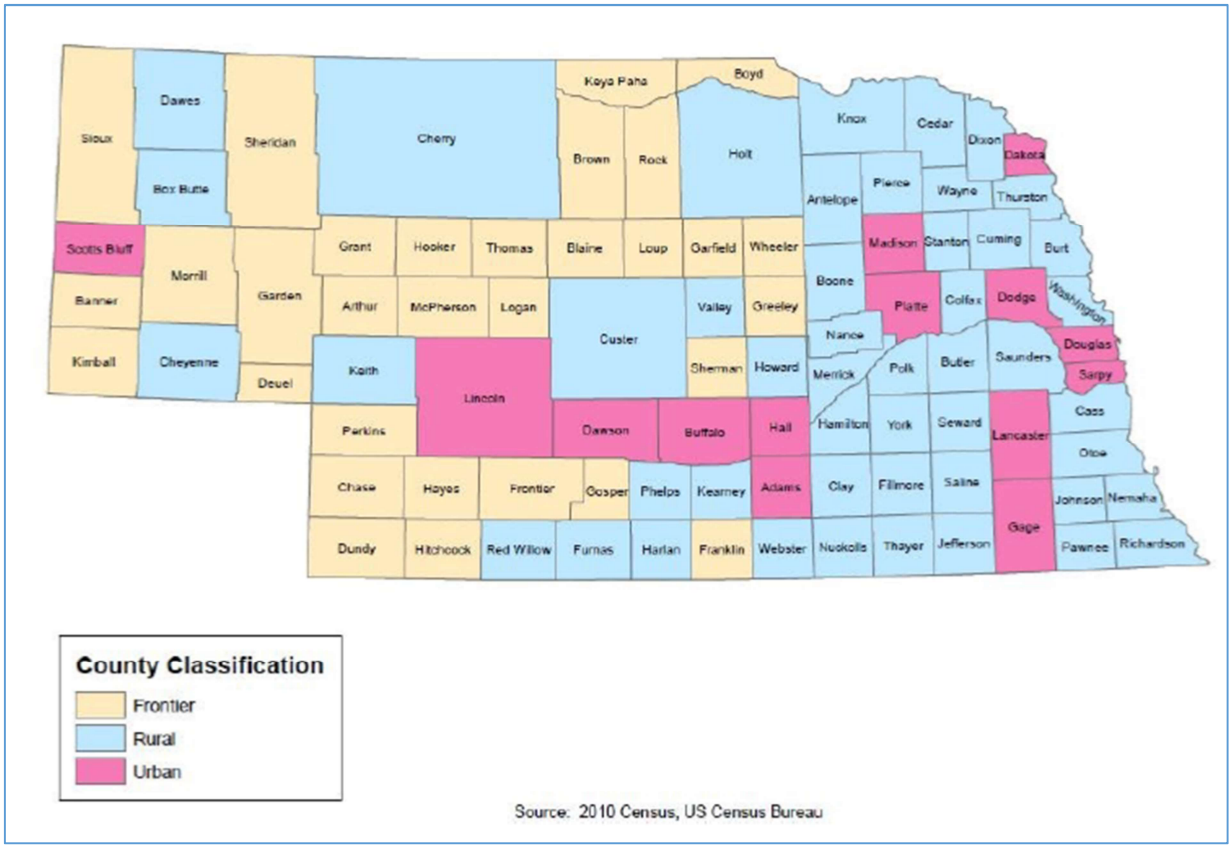
The reporting template for Geographic Access Standards can be found on the Heritage Health Reporting Templates webpage at: http://dhhs.ne.gov/Pages/Heritage-Health-Plan-Reporting-Templates.aspx

As of the submission of this Implementation Plan, the direct link to the current Geographic Access Standards report template can be located at: http://dhhs.ne.gov/Medicaid%20Health%20Plan%20Reporting%20Templates/Geographic%20Access%20Standards.xls

As illustrated in the template, MCOs are currently required to report county-level behavioral health inpatient and outpatient treatment access on the tabs entitled “BH Inpatient and Residential Service” and “BH Outpatient Assessment and Treatment.”

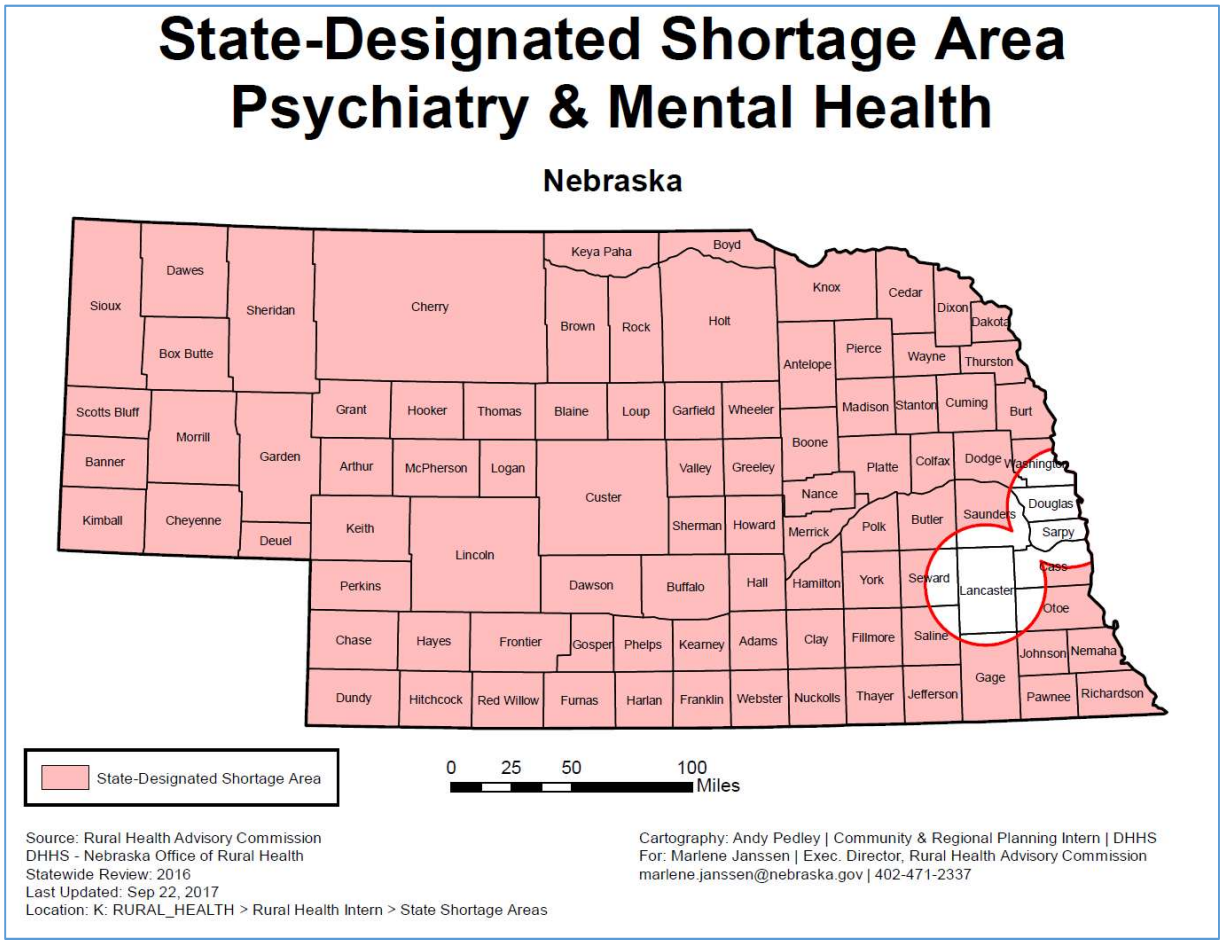
Current Nebraska Medicaid access standards and the Division’s assessment of MCO compliance with those standards must take into account the state’s rural profile. In Nebraska, challenges to accessing care for Medicaid eligible individuals are primarily driven by geographic factors. Nebraska ranks 45th in population density with 23.8 persons per square mile. As illustrated in Figure 3, of the State’s ninety-three (93) counties, forty-eight (48) are considered “rural” and thirty-one (31) are considered “frontier” for purposes of establishing managed care access standards.

Figure 3 - Nebraska Counties Classified by Urban, Rural, or Frontier Status



The geographic challenges impeding access to care for Medicaid-eligible individuals are similar to challenges facing the general Nebraska patient population. As illustrated in Figure 4, access to behavioral health services in all areas other than the state’s two largest metropolitan areas is limited.

Figure 4 - State-Designated Shortage Area – Psychiatry and Mental Health



Nebraska's STR and SOR grants for opioid treatment are being utilized by DBH in part to expand the State's ability to meet the needs of those who are experiencing OUD. To do this, strategies have been implemented to address provider capacity.[15]

In March 2018, Nebraska had 46 providers enrolled in Medicaid who have received a certification to dispense buprenorphine. As of February 2019, the number of dispensers with this certification has grown to 52 providers. One goal of the STR and SOR grants centers on increasing the availability of prescribers certified to prescribe Buprenorphine. The grants provide additional access to the targeted training needed for certification to Nebraska prescribers. At the MAT Summit, mentioned in Milestone 3, DBH provided four of the eight required training hours (for physicians).

With the new SOR grant, these training opportunities will continue with plans being made for Grand Rounds-style mentoring for newly certified prescribers from experts in the field of MAT, along with a "train the trainer" opportunity to expand the number of individuals available to provide live training for

[15] Nebraska DHHS Business Plan July 2018 – June 2019. Pg. 24. Available at: http://dhhs.ne.gov/Documents/BusinessPlan2018-2019.pdf

buprenorphine certification. While this certification is not currently a requirement of Nebraska providers, continued education is available and being promoted through this grant.

Another resource being made available to Nebraska providers through the STR and SOR grants is Project ECHO (Extension for Community Healthcare Outcomes) which connects local providers with specialist mentors at an academic medical center. Project ECHO is a telementoring system which allows educational access for healthcare providers in rural and underserved communities. Scheduled videoconferencing sessions are open to providers, including but not limited to physicians, nurses, physician assistants, behavioral health practitioners, peer support specialists, and pharmacists, and include a 15 minute SUD treatment specific presentation. The remainder of the Project ECHO session is focused on real world consultations, not including protected health information, where the specialist mentors are able to provide recommendations for best practices. Through these sessions the local providers develop their skills and competency to serve individuals with substance use disorders and pain management challenges.[16] The June 2018 through April 2019 schedule with topics of discussion can be found at: https://www.unmc.edu/bhecn/_documents/didactic-schedule-2018-20194-003.pdf. These sessions are continuing to be scheduled, with events planned for 2019 on topics such as wavier certification, methadone, naloxone, and how to assist with locating social support.

An additional DBH STR Grant strategy is the development of an addiction medicine fellowship. This initiative is being developed in partnership with the University of Nebraska Medical Center and will ensure Nebraska providers are equipped to treat substance use disorders and physical health needs of patients. This specialty training program will provide fellows with experience in the prevention, clinical evaluation, treatment, and long-term monitoring of substance-related disorders. The fellowship will engage Nebraska providers and assist in embedding evidenced based practices for SUD treatment into the physical health arena. The SOR grant continues to fund this effort in Nebraska.

Future State:

Going forward, Nebraska Medicaid will implement new reporting requirements focused on SUD provider capacity for critical ASAM levels of care, including the number of participating providers accepting new patients by level of care and those that offer MAT. MCOs will be required to address improving access to SUD services in the MCOs' annual network development plans.

A specific element Nebraska Medicaid will require MCOs to address in network development is increasing incorporation of telehealth in expanding SUD treatment. A recent study in Health Affairs[17] found that while the use of "tele-SUD" increased relatively rapidly over the study years 2010-2017, the overall rates of tele-SUD utilization remained low. The study also noted that regulatory and reimbursement barriers are factors in limiting tele-SUD utilization.

[16] DHHS, UNMC Team Up to Launch Statewide Education Model for Substance Use Disorder: http://dhhs.ne.gov/News Release Archive/DHHS, UNMC Team Up to Launch Statewide Education Model for Substance Use Disorder.pdf

[17] How is Telemedicine Being Used in Opioid and Other Substance Use Disorder Treatment? Health Affairs, Vol. 37, No. 12 https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05134

Nebraska Medicaid has been proactive in recognizing state-level telehealth barriers and has worked to expand the availability and utilization of telehealth for physical and behavioral health services. On January 1, 2017, Nebraska Medicaid implemented new telehealth regulations that expanded Medicaid-covered telehealth services to include billing for telemonitoring and the originating site fee. With this recent regulatory service expansion, Nebraska Medicaid believes that the state has laid a policy foundation for increased utilization of telehealth services including tele-SUD.

Summary of Actions Needed:

Implementation Action Item	Timeline
Add SUD specific provider capacity reporting requirements which include the number of participating providers accepting new patients by level of care and those that offer MAT	12 Months
Expanded telehealth reporting requirements	12 Months

MILESTONE 5: IMPLEMENTATION OF COMPREHENSIVE TREATMENT AND PREVENTION STRATEGIES TO ADDRESS OPIOID ABUSE AND OUD

Milestone Criteria:

1. Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse.
2. Expanded coverage of, and access to, naloxone for overdose reversal.
3. Implementation of strategies to increase utilization and improve functionality, of prescription drug monitoring programs. This includes enhancing the health IT functionality to support PDMP interoperability and enhancing and/or supporting clinicians in their usage of the state's PDMP.

This milestone may be met over the course of the demonstration.

Current State:

Nebraska Medicaid has a Drug Utilization Review (DUR) Program, through the Nebraska Pharmacists Association. In January 2019 the DUR Board announced that in response to the national opioid crisis, Nebraska Medicaid is implementing total daily dose limits of opioids,[18] in alignment with CDC and FDA guidelines. The limit implemented is 300 MME per day, and the board has created a timeline for the continued lowering of this daily limit. By June of 2021, the daily limit will be set at 90 MME per day. There is also in place a restriction for opioid naïve patients that limits those patients to a 7 day prescription at 90 MME per day.

Nebraska Medicaid staff work with all contracted MCOs to ensure the MCOs have policies and procedures in place which follow State guidelines and facilitate the implementation of opioid prescribing guidelines and limits. The MCOs are required to utilize the Nebraska Medicaid Preferred Drug List (https://nebraska.fhsc.com/downloads/PDL/NE_PDL-20190301.pdf in order to determine prescription coverage. Nebraska's PDL includes requirements for prior authorization depending on the class of drugs. The MCOs also utilize Drug Limitations document

[18] Nebraska Medicaid DUR Matters Volume 14, Issue 1, January 2019
https://www.npharm.org//Files/DUR/Newsletters/DUR%20Matters%20Newslettter%20Jan%202019%20Email.pdf

(https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf) which can be updated by Nebraska Medicaid as CDC and FDA guidelines are modified.

In October 2017, DHHS released the Nebraska Pain Management Guidance Document, a comprehensive opioid prescribing resource for prescribers, to assist in meeting the program objective of ensuring prescription drugs are used for medically appropriate purposes. This resource was created by a diverse task force including practicing clinicians, medical directors, psychiatrists, emergency department providers, pain medicine specialists, anesthesiologists, and public health professionals.
The goal of the document is to provide "real-world tools and advice to practicing clinicians as they seek to comply with national standards." The guidelines outlined in the document align with the CDC Guidelines for Chronic Pain released March 2016 and build off best practices as identified through CDC guidance and similar initiatives in other states.

The Nebraska Medicaid program understands the importance of naloxone for overdose reversal and covers it, with a prescription, as an injectable or spray. Nebraska has legislation in place, Neb. Rev. Stat. §§ 28-470 (https://nebraskalegislature.gov/laws/statutes.php?statute=28-470) and 28-405 (https://nebraskalegislature.gov/laws/statutes.php?statute=28-405) which impacts how naloxone is dispensed in Nebraska. Neb. Rev. Stat. §§ 28-470 allows a health professional who is authorized to prescribe or dispense naloxone to prescribe, administer or dispense naloxone without being subject to administrative action or criminal prosecution. If a prescription is desired, The *Nebraska Naloxone Standing Order* signed by the Chief Medical Officer and Director of the DPH, can be used, pursuant to Neb. Rev. Stat. §§ 38-2840 (https://nebraskalegislature.gov/laws/statutes.php?statute=38-2840).

DBH has initiatives underway, through the STR and SOR grants, to increase access to naloxone. Through DBH regional contracts, funding is available in order to provide naloxone kits to high risk clients. The DPH has a public health campaign, along with a provider education campaign, centered on Naloxone. For providers, education centers on how to identify patients who need naloxone, how to administer the drug, and how to talk with the patient about naloxone. Training is also available to first responders on how to use naloxone to save lives. The SOR grant has also assisted in funding the production of an opioid public education video which addresses how to respond in the event of an opioid overdose so that naloxone can be utilized, along with how to properly dispose of opioid prescriptions when the medication is no longer needed.[19] Through the *Nebraska Naloxone Standing Order*, DBH has been able to supply providers, first responders and those with OUD with 1740 naloxone kits.

The Nebraska Legislature established the state's Prescription Drug Monitoring Program (PDMP) in 2011. The PDMP is overseen by DPH in coordination with the Nebraska Health Information Initiative (NeHII). The primary objectives of the PDMP are to prevent the misuse of prescribed controlled substances, allow prescribers and dispensers to monitor the care and treatment of patients for whom such a prescription drug is prescribed, and to ensure that such prescription drugs are used for medically appropriate purposes.

Nebraska's PDMP was further strengthened in 2016 with the passage of LB 471. Beginning on January 1, 2017, LB 471 required that all dispensed prescriptions for controlled substances must be reported to the

[19] Community Partners Opioid Awareness Video
https://www.youtube.com/watch?v=MC71wrMsQfE#action=share

PDMP. By January 1, 2018, all prescription information must be reported to the prescription drug monitoring system maintained by the PDMP.[20] On January 1, 2018, Nebraska became the first state to require reporting of all dispensed prescription drugs to the PDMP.

As of December 7, 2018, Nebraska's PDMP has 44.6% of licensed Nebraska prescribers and dispensers with addresses in Nebraska, Kansas, Missouri, Iowa, South Dakota, Wyoming, and Colorado registered to access and use the Nebraska PDMP database. DPH continues to focus on increasing PDMP healthcare provider registrations. As of November 30, 2018, 100% of Nebraska licensed community pharmacies and mail-service pharmacies are registered or reporting to the Nebraska PDMP.

The intent of the PDMP tool is to aid providers in making treatment decisions with a more robust medical history of their patient, thus aiding and improving the quality and safety of patient care. Enhancements are continuously being developed with the help of end-users to increase efficiency, decrease impact to workflow, and to provide an effective tool for providers when treating patients. Additional information regarding the Health IT functionality and interoperability of Nebraska's PDMP will be reviewed in Attachment A.

Future State:

The Nebraska Medicaid program will continue to work with internal and external partners to enhance the existing programing and initiatives to ensure that they evolve as the opioid crisis evolves in Nebraska.

Summary of Actions Needed:

There are no anticipated actions needed by Nebraska for fulfillment of this milestone.

MILESTONE 6: IMPROVED CARE COORDINATION AND TRANSITIONS BETWEEN LEVELS OF CARE

Milestone Criteria:

Implementation of policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities, and coordination of care for co-occurring physical and mental health conditions. This milestone must be met within 12 to 24 months of demonstration approval or other timeframe in accordance with the STCs.

Current State:

The MCOs are required through contracts with the Nebraska Medicaid program to develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members.

At enrollment, MCO's are required to complete a health assessment on all members to determine if the member could benefit from care management. MCOs must also conduct ongoing predictive modeling to identify members who may need care management evaluation. Member substance use is a component of both the initial assessment and the ongoing predictive evaluation.

[20] LB 471 (2016) PDMP Provisions https://nebraskalegislature.gov/FloorDocs/104/PDF/Final/LB471.pdf

For general care management requirements, the MCOs are to maintain principles of care which are specific to those who have both medical and behavioral health needs. These principles, stated in the MCO contracts, include implementing a system of care which is comprehensive, evidence-informed, and incorporates continuous quality improvement. The requirements specifically address the need to integrate substance use disorders into a member's comprehensive care plan. All providers who serve a member with behavioral and medical health care needs must have access to all relevant clinical information in order to create a holistic and impactful treatment plan.

Additional care management requirements includes discharge planning, assistance in locating community links and social supports to improve outcomes for members, and continuity of care to promote communication between the members providers to assist in transition between levels of care.

The MCOs must submit to Nebraska Medicaid their policies and procedures regarding how the MCO will implement Nebraska's care coordination contract requirements. Any updates to those policies and procedures must also be submitted for approval before the implementation of any changes. In addition, Nebraska Medicaid monitors MCO compliance by reviewing reports such as a quarterly report for members in care management and monthly reports for members with restricted services. Nebraska also performs an annual audit on all MCOs which includes a review of care management files to ensure compliance.

The definitions of the services at the ASAM 3 level of care, found in Table 1, direct that a plan for patient discharge will be included in that individuals treatment plan, to be reviewed every 30 days or more often as needed. Through the utilization management process detailed in Milestone 2 of this plan, along with the facility review process detailed in Milestone 3, assurance of the completion of a discharge plan is completed. The individuals discharge or move to a different level of care is to be assessed based on ASAM criteria. Through utilization management processes, carried out by MCOs and detailed in Milestone 2 of this plan, and facility review processes, detailed in Milestone 3, providers are held accountable to meeting the requirements of this service definition.

DPH Regulations 175 NAC 18, which guide the licensing requirements for the substance use treatment carried out at MHSU Treatment Centers and described with additional detail in Milestone 2 of this Plan, require additional discharge criteria to be established by facility providing services. The facility must establish discharge criteria and use those criteria in developing an appropriate plan for discharge jointly with the client. The discharge plan must include: 1. A relapse prevention plan, which includes triggers and interventions for client to activate; 2. The client's plan for follow up, continuing care, or other post care and treatment services; 3. Documentation of referrals made for the client by the facility; 4. The client's plan to further his/her recovery; 5. The client's signature and the date; and 6. A treatment summary that will be completed no later than 30 days after the client's discharge. The summary must include a description of the client's progress under his or her ISP, the reason for discharge, and any recommendations to the client. DPH requires this documentation for every inpatient stay, and through their survey process this is reviewed to assure compliance.

Future State:

Nebraska Medicaid will continue to monitor contracted MCOs for compliance with the existing care management contract requirements in order to ensure members' health care issues are being

monitored appropriately. Current MCO contract requirements do not detail requirements for the inclusion of policies that link beneficiaries, especially those with OUD, with community-based services and supports following inpatient stays in treatment facilities, including specific timeframes for Care Management contact post discharge from an inpatient stay related to an SUD. It is proposed that contract language will be updated to create clear expectations on member follow-up.

Nebraska Medicaid also proposes to include Care Management SUD treatment follow up specific requirements to the existing annual audit tool used to review all contracted MCOs compliance with this new contract language.

Summary of Actions Needed:

Implementation Action Item	Timeline
Update contract language to reflect specific requirements for Care Management follow up after SUD treatment discharge.	12- 24 months

NEBRASKA MEDICAID 1115 SUBSTANCE USE DISORDER DEMONSTRATION

Attachment A – Health IT Plan

Part 1: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

Table 1: Strategies to Increase Utilization and Improve Functionality of Nebraska's PDMP

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criterion 1: Enhanced interstate data sharing in order to better track patient specific prescription data	The Nebraska PDMP was established by Neb. Rev. Stat. §§ 71-2454, 71-2455 and 71-2456, which does not allow for Nebraska to participate in interstate data sharing data to other states. However, Nebraska does allow for prescribers or dispensers that have a treatment relationship with a Nebraskan to request access to the Nebraska PDMP. The Nebraska Health Information Initiative (NeHII) includes a Health Information Exchange (HIE), and the Nebraska PDMP is housed on this platform. Nebraska has an enhanced connectivity between the states PDMP and any statewide, regional or local health information exchange. If a prescriber is utilizing the HIE they can query the PDMP directly from the HIE page without the need to exit and research the patient. Additionally, this functionality allows for single sign-on access to EHRs Through Nebraska's HIE, medication history information is available to all payers, including Medicaid. Medication history follows federal rules, regulations, and law around viewing patient information. Nebraska statute requires the reporting of all dispensed prescriptions no matter how they are paid for. Medication history provided to payers does not include cash/self-pay information for federal compliance.	The Nebraska PDMP team is currently developing the infrastructure needed for unidirectional (receiving) data sharing at this time. Preliminary discussions with Nebraska's contiguous states are occurring to prepare for unidirectional sharing. State law currently governs the PDMP's ability to engage in bidirectional interstate data sharing agreements. Future interstate data sharing arrangements will require legislative approval. In January 2019, LB 556 was introduced to amend Neb. Rev.	The Nebraska PDMP team is developing the infrastructure and setting up agreements so that unidirectional sharing can begin within the next calendar year. For bidirectional sharing, if current proposed legislation passes the Nebraska PDMP team is prepared to adjust in order to be able to ensure that bidirectional sharing with other states is also setup within the next calendar year.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		Stat. §§ 71-2454 to allow for data sharing with other PDMP programs along with entities including State and regional health information exchanges.	
Criterion 2: Enhanced "ease of use" for prescribers and other state and federal stakeholders	State Statute requires all dispensed prescriptions for controlled substances must be reported to the PDMP. Beginning on January 1, 2017, all dispensed controlled substances were required to be reported daily. Additionally, beginning on January 1, 2018, all prescription information must be reported to the PDMP, also on a daily basis. On January 1, 2018, Nebraska became the first state to require reporting of all dispensed prescription drugs to the PDMP. To enhance the PDMP for use by prescribers, the Nebraska PDMP has the Drug Safety Advisory Group that includes key partners and stakeholder involvement. During the development phase for the database this group convened quarterly in order to determine what enhancements will increase the ease of use, increase PDMP utilization, and decrease disruption to daily workflow. Key partners and stakeholders for the PDMP are the Division of Behavioral Health (DBH), Nebraska Hospital Association (NHA), Nebraska Medical Association (NMA), Nebraska Pharmacists Association (NPA), the Nebraska State Patrol, along with the Nebraska Medicaid Program.	The Drug Safety Advisory Group continues to meet quarterly to discuss future enhancements and other ways to increase the utilization of the system by medical providers. The upcoming enhancements that have been requested are interstate data sharing and a designee management system. See criteria 1 for details on interstate sharing. The purpose of the designee management system is to help streamline the registration process and to ensure the integrity of the system.	The interstate sharing system and designee management systems are slated to be implemented within the next calendar year.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criterion 3: Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange.	See Criteria 1 response	See Criteria 1 response.	See Criteria 1 response.
Criterion 4: Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns.	In October 2017, DHHS released the Nebraska Pain Management Guidance Document, a comprehensive opioid prescribing resource for prescribers, to assist in meeting the program objective of ensuring prescription drugs are used for medically appropriate purposes. This resource was created by a diverse task force including practicing clinicians, medical directors, psychiatrists, emergency department providers, pain medicine specialists, anesthesiologists, and public health professionals. The goal of the document is to provide "real-world tools and advice to practicing clinicians as they seek to comply with national standards." The guidelines outlined in the document align with the CDC Guidelines for Chronic Pain released March 2016 and build off best practices as identified through CDC guidance and similar initiatives in other states. The development of the prescriber's patient dashboard and its continual enhancements has been central to improving PDMP workflow. Within the functionality of this dashboard, users are allowed to save patients to their physician or prescriber profile, giving them access to easily review their patients regularly. By having high risk patients on a prescriber dashboard, they are quickly aware of any alerts that are associated with one of these patients. The alert types which have been developed for this system are centered on patient actions that could be considered high risk, especially when risks are combined. The current possible alerts are: • overlapping dispensed opioids and benzodiazepines alert;	There are no anticipated actions needed by Nebraska for fulfillment of this criteria.	No actions necessary.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	• multiple prescriber episodes (patients receiving opioid prescriptions from more than one prescriber and having them dispensed at more than one pharmacy) alert; • a risk score alert Thus, this functionality takes multiple alerts combined and brings the situation to the attention of prescribers when patients are at increased risk of an opioid related adverse event. Depending on the situation, as risk thresholds associated with the alert are met or passed, the alert is given a color to give the prescriber additional visual guidance as to the severity of the current situation. When visiting that patient's profile, all of the alerts associated are clear and color coded and can be expanded for detailed information on the events taking place. Within the alert, the prescriber is also given direct links to pertinent sections of the Nebraska Pain Management Guidance document, along with direct links to the CDC's MME calculator, as applicable.		
Criterion 5: Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP	The PDMP patient dashboard includes patient matching processes. Because of variations in how names may be maintained in medical records for different medical practices, the dashboard allows patient histories to be combined into a single profile instead of by each variation in patient name, including nick names. When a prescriber searches for a patient only the first 2 letters of the last name and first letter of the first name are required to begin a search. There are options for a cross name search when a patient has, for example, a first name that could be mistakenly identified as a last name. These search features allow for name or date of birth errors to be accounted for. Upon search results, the prescriber is given a selection of patient matches and they are given a "pick list" selection of the names they believe to be the same individual and after confirmation they are able to combine records for individual patients on their dashboard. This search can then be saved and added to the prescriber's patient dashboard to allow for a quick query for that patient in the future.	There are no anticipated actions needed by Nebraska for fulfillment of this criteria.	No actions necessary.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criterion 6: Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow.	As a part of the DHHS July 2018-July 2019 Business Plan http://dhhs.ne.gov/Documents/BusinessPlan.pdf the following are deliverables in place for Nebraska's PDMP program: Increase the number of new registered healthcare providers to 40% of those licensed (met and exceeded by December 2018), educate healthcare providers on Nebraska pain management guidance education, continue training healthcare providers on access and use of PDMP system in high burden areas and statewide, and continue to convene Drug Safety Advisory Group.	There are no anticipated actions needed by Nebraska for fulfillment of this criteria.	No actions necessary.
Criterion 7: Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription.	Once the user is reviewing the medication history of their patient they have additional functionality in how they view these medications. Due to the volume of medications possible, there are filters and sorting options in place. In Nebraska, options include • timeframes (3, 6, 9, 12 month periods); • view controlled only; • controlled/non-controlled separated; or all dispensed medication together; • sorting by date; and • roll-up features by drug and strength to quickly view overall medications dispensed to the patient. This control over information allows for the user to easily review the patient's historical use of controlled substances before they choose to prescribe.	There are no anticipated actions needed by Nebraska for fulfillment of this criteria.	No actions necessary.
Criterion 8: Enhance the master patient index (MPI) or master data management service (MDMS) in support of SUD care delivery.	See Criteria 5 response	There are no anticipated actions needed by Nebraska for fulfillment of this criteria.	No actions necessary.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criterion 9: Leverage the above functionalities/capabilities/supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids.	See Criteria 1, 2, 4, 5 and 7 responses	There are no anticipated actions needed by Nebraska for fulfillment of this criteria.	No actions necessary.

Part 2: Attestation

Statement 1: Indicate whether the state has sufficient health IT infrastructure/"ecosystem" at every appropriate level to achieve the goals of the demonstration.

Nebraska Medicaid is currently working with Deloitte Consulting LLP to build a more advanced data warehouse and decision support system to be utilized at the State level, described in further detail in Statement 2 below. Through its contracts with Medicaid health plans, Nebraska Medicaid is able to leverage the MCO's existing health IT infrastructure to the benefit of members and providers. This existing infrastructure assists in meeting existing and future contract requirements, as detailed in this application's Implementation Plan, so that the demonstration goals can be met.

Nebraska Medicaid and its contracted MCOs have implemented several of the Health IT examples cited by CMS.

In order to assure that Nebraska Medicaid members are accessing care needed for their treatment, contracted MCOs utilize identity management tools. These tools are critical not only to assuring that Medicaid is accessing real-time data for individuals when processing claims, it also assists in monitoring an individual's claim information to track trends in their care. These trends can assist in the establishment of care management plans when a member's health care needs change.

In order to support adherence to and retention in treatment, all contracted MCO's have smartphone apps which are made available to members in order to improve participation in their health care. Capabilities of these apps may include: assistance in locating providers or urgent care centers, options to contact their plan within the app, and checkup alerts. Specific to SUD treatment, one of the health plans utilizes a "recovery app" with trigger alerts and a visual journal, along with a directory of phone numbers to assist in locating an AA meeting near their current location. Through this app they can also add friends, share meetings, and track their progress in recovery.

Nebraska recognizes the importance of provider connectivity to Health Information Systems in the prevention of overdose deaths. As further described in Table 1, Nebraska's PDMP is housed on Nebraska's Health information Exchange (HIE) and can be queried directly from the HIE. Nebraska's PDMP has 44.6% of licensed Nebraska prescribers and dispensers with addresses in Nebraska, Kansas, Missouri, Iowa, South Dakota, Wyoming, and Colorado registered to access and use the Nebraska PDMP database. As of November 30, 2018, 100% of Nebraska licensed community pharmacies and mail-service pharmacies are registered or reporting to the Nebraska PDMP.

Provider capacity for behavioral health services is a challenge in Nebraska due to the state's rural profile. One way that Nebraska Medicaid is addressing this is through the coverage of services provided through telehealth. Nebraska Medicaid has been proactive in recognizing state-level telehealth barriers and has worked to expand the availability and utilization of telehealth for physical and behavioral health services. On January 1, 2017, Nebraska Medicaid implemented new telehealth regulations that expanded Medicaid-covered telehealth services to include billing for telemonitoring and the originating site fee. With this recent regulatory service expansion, Nebraska Medicaid believes that the state has laid a policy foundation for increased utilization of telehealth services including tele-SUD.

As described further in Table 1, Nebraska's PDMP includes tools for providers which are in place to assist in the tracking of high risk individuals. Prescribers can receive alerts for what could be considered high risk behavior, and links within the alert to clinical guidelines that correspond directly to a member's current risk level or need. This functionality can not only prevent the need for a higher level of care due to the early detection of high risk behavior, but it can also be a tool for managing patients through their SUD recovery.

Care management for all contracted health plans is centered on Whole Person Care. In order to meet all of the care needs of members, MCOs utilize predictive modeling technology which can identify risk levels for care management, and by accessing member data can develop individualized risk profiles and identify trends. From there, members can be targeted for specific care management programs which are appropriate for their health conditions and social circumstances. By fully identifying the risks and the individual needs of each member, care management systems assist in the coordination of care through each level of treatment, and can connect members with community resources.

Statement 2: Indicate whether the state's SUD Health IT Plan is "aligned with the state's broader State Medicaid Health IT Plan (SMHP) and if applicable, the state's Behavioral Health (BH) Health IT Plan".

Nebraska Medicaid's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan.

Nebraska Medicaid is currently replacing its data warehouse and decision support system with an updated data warehouse and business intelligence technology platform. Nebraska Medicaid contracted with Deloitte Consulting LLP to implement their HealthInteractive solution. The DMA project, which successfully began in February 2018, has been on schedule through 2018 and is scheduled for go-live in June 2019.

A key component of the DMA project is the enhancement of the state's encounter acceptance and processing capabilities. Improvements to this process directly impact the implementation of the 1115 SUD waiver and the reporting required over the course of the demonstration. Based on the ongoing discussions between Nebraska and CMS in regards to the state's demonstration application, Nebraska Medicaid believes the implementation calendar for the HealthInteractive solution closely aligns with the timetable for CMS's potential approval of the 1115 SUD demonstration. Therefore, Nebraska Medicaid anticipates that the enhancements made to data collection and analysis through the implementation of HealthInteractive will positively impact waiver implementation and monitoring from the beginning of the demonstration. Furthermore, Nebraska Medicaid believes that future enhancements enabled by the HealthInteractive platform will only further improve Nebraska's ability to meet the milestones established by CMS.

A specific enhancement that will directly impact the state's SUD monitoring and policy development is illustrated by refinements to the Medicaid pharmacy encounter process. Currently contracted Heritage Health plans submit pharmacy encounter data based on Nebraska's proprietary pharmacy encounter format. The proprietary format is necessitated by the limitations of the state's legacy MMIS system. With the completion of the DMA project, Heritage Health plans will submit encounter data utilizing a NCPDP standard transaction format. The NCPDP standard format will provide the Nebraska Medicaid program with significantly more information about each pharmacy encounter than is currently captured within the proprietary format.

Part 3: Advancing Interoperability using Health IT Standards

Statement 3: Indicate that the state will include appropriate standards reference in the ONC Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B in subsequent MCO contract amendments or Medicaid funded MCO/Health Care Plan re-procurements.

Nebraska Medicaid will include appropriate standards, as referenced in the ONC Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B, in subsequent MCO contract amendments and MCO re-procurements.

Through contract requirements, implementation of the State's Medicaid Health IT Plan[1], continued participation in other Nebraska health information initiatives, and shared learning with the parent companies and other state affiliates of contracted MCOs, Nebraska Medicaid believes MCOs can achieve implementation of applicable interoperability standards.

All currently contracted Nebraska Medicaid MCOs are participating in coordinated Admission, Discharge, Transfer initiatives either in Nebraska or in other Medicaid markets in which the MCO's parent company operates. For example, the Office of the National Coordinator for Health Information Technology recently highlighted state managed care Health IT initiatives which included references to the utilization of ADT for behavioral health services by the Tennessee affiliate of one of Nebraska's currently contracted health plans.[2]

Parent companies of currently contracted Nebraska Medicaid MCOs have also operationalized other ISA examples cited by CMS in its Attachment A template. For example, the Georgia affiliate of one of Nebraska's currently contracted health plans was instrumental in the eventual implementation of Consolidated-Clinical Document Architecture (C-CDA) transactions by the Georgia Health Information Network.

[1] State Medicaid Health Information Technology Plan: http://dhhs.ne.gov/medicaid/Documents/State%20Medicaid%20Health%20Information%20Technology%20Plan.pdf

[2] Office of the National Coordinator for Health Information Technology: "Tennessee Empowering MCO Providers: Increasing Health IT Functionality Reducing Reporting Burden." Page 12. Link available at: https://www.healthit.gov/sites/default/files/2018-12/TennesseeEmpoweringMCOProviders.pdf

ATTACHMENT B
SUD Evaluation Design (Reserved)