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State/Territory Name: Nebraska

State Plan Amendment (SPA) #: 24-0005

This file contains the following documents in the order listed:

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

December 19, 2024

Drew Gonshorowski
State Medicaid Director
Division of Medicaid and Long-Term Care
PO Box 95026
Lincoln NE 68509-5026

RE: Nebraska Initial SPA NE-24-0005 and 1915(b) Waiver Amendment NE-0003.R13.02

Dear Director Gonshorowski:

The Centers for Medicare & Medicaid Services (CMS) is approving Nebraska's request to amend its state plan to add a new 1915(i) home and community-based services (HCBS) benefit, transmittal number NE-24-0005, titled Therapeutic Family Care Crisis Support Services program. CMS conducted the review of the state's submittal according to statutory requirements in Title XIX of the Social Security Act and relevant federal regulations. Enclosed is a copy of the approved state plan amendment (SPA).

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved state plan amendment. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

It is important to note that CMS' approval of the 1915(i) action solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, §504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

Concurrently, CMS is approving Nebraska's request to amend its 1915(b) Waiver, CMS control number NE-0003.R13.02, titled Heritage Health. This waiver allows Nebraska to provide crisis maintenance and response, and mobile crisis services targeted to children placed in foster care with complex behavioral health needs. Beginning January 1, 2025, the 1915(b) waiver is concurrent with a new 1915(i) State Plan home and community-based services program. This 1915(b) waiver is authorized under section(s) 1915(b)(1), 1915(b)(2), 1915(b)(3), 1915(b)(4) of the Social Security Act and provides a waiver of the following section[s] of Title XIX:

- Section 1902(a)(1) Statewideness
- Section 1902(a)(10)(B) Comparability
- Section 1902(a)(23) Freedom of Choice

Our decision is based on the evidence submitted to CMS demonstrating that the state's proposal is consistent with the purposes of the Medicaid program, will meet all the statutory and regulatory requirements for assuring beneficiaries' access to and quality of services, and will be a cost-effective means of providing services to enrollees under this waiver.

The state has elected to target the population who can receive §1915(i) State Plan HCBS. The SPA is effective for five years beginning January 1, 2025, through December 31, 2030. The state must submit a renewal application to CMS no later than July 1, 2030, that is at least 180 days prior to the end of the 1915(i)-approval period.

The SPA operates concurrently with the 1915(b) Heritage Health waiver that will expire September 30, 2027. The state may request to renew the 1915(b) waiver. Nebraska's request to renew the 1915(b) waiver should be submitted to CMS no later than July 2, 2027, that is at least 90 days prior to the end of the 1915(b)-approval period. The renewal application will need to provide evidence and documentation of satisfactory performance and oversight.

We appreciate the cooperation and effort provided by you and your staff during the review of these concurrent actions. If you have any questions concerning this information, please contact Rhonda Wells at (816) 426-6486 or via email at Rhonda.Wells@cms.hhs.gov for the 1915(i) SPA or Hira Mirza at (212) 616-2339 or via email at Hira.Mirza@cms.hhs.gov for the 1915(b) Waiver.

Sincerely,

[redacted]

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

[redacted]

Bill Brooks, Director
Division of Managed Care Operations

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0005

2. STATE: NE

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT ☒ XIX ☐ XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 441.700-441.745, Section 1915(i) of the Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 949,795
b. FFY 2025 $ 1,883,226

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i, Pgs 1-41 (new); Att. 4.19-B, Pgs 1&2 (new)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Click or tap here to enter text.

9. SUBJECT OF AMENDMENT
Therapeutic Family Care Program

10. GOVERNOR'S REVIEW *(Check One)*
○ GOVERNOR'S OFFICE REPORTED NO COMMENT
○ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
○ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
◉ OTHER, AS SPECIFIED:
Governor has waived review

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Matthew Ahern

13. TITLE
Interim Director, Division of Medicaid & Long-Term Care

14. DATE SUBMITTED
December 28, 2023

15. RETURN TO
Dawn Kastens
Division of Medicaid & Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

FOR CMS USE ONLY

16. DATE RECEIVED
December 28, 2023

17. DATE APPROVED
December 19, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2025

19. SIGNATURE OF APPROVIN
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director

22. REMARKS

FORM CMS-179 (09/24)

1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Therapeutic Family Care (TFC) Crisis Support Services

- Crisis Service Maintenance and Response
- Mobile Crisis

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

○	**Not applicable**
◉	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☑	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
	Nebraska has a previously approved 1915(b) waiver (titled Heritage Health). Nebraska has submitted amendment (NE-003.R13.02) to the waiver to align with the new services in this 1915(i).

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

☑	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)

	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*			
☐	**A program authorized under §1115 of the Act.** *Specify the program*:			

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

⊙	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	⊙	The Medical Assistance Unit *(name of unit)*:	Division of Medicaid and Long-Term Care (MLTC)
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
○	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☑	☐	☐
2 Eligibility evaluation	☑	☑	☐	☐
3 Review of participant service plans	☑	☑	☐	☐
4 Prior authorization of State plan HCBS	☑	☐	☐	☐
5 Utilization management	☑	☑	☑	☐
6 Qualified provider enrollment	☑	☐	☑	☐
7 Execution of Medicaid provider agreement	☑	☐	☑	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☐	☐
10 Quality assurance and quality improvement activities	☑	☑	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

1. Individual State plan HCBS enrollment: Division of Child and Family Services (DCFS)
2. Eligibility evaluation: DCFS
3. Review of participant service plans: DCFS
4. Prior authorization of State plan HCBS: N/A
5. Utilization management: Division of Medicaid and Long-Term Care (MLTC), Managed Care Organizations (MCO)
6. Qualified provider enrollment: MLTC Provider Enrollment Contractor, MCO (credential and contract)
7. Execution of Medicaid provider agreement: MLTC Provider Enrollment Contractor
8. Establishment of a consistent rate methodology for each State plan HCBS: MLTC
9. Rules, policies, procedures, and information development governing the State plan HCBS benefit: MLTC, DCFS
10. Quality assurance and quality improvement activities: MLTC, MCO

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	1/1/2025	12/31/2025	525
Year 2			
Year 3			
Year 4			
Year 5			

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☑ The State does not provide State plan HCBS to the medically needy.

☐ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○ Directly by the Medicaid agency

⊙	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	Division of Child and Family Services

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The Division of Child and Family Services is a division within Nebraska's Department of Health and Human Services. The persons performing the function are employees of the Single State Agency of Nebraska Department of Health and Human Services. Medicaid authority is 42 CFR 430.10 AT-79-29. SMA delegates the responsibility for performing evaluations and reevaluations to these authorities. TFC Care Coordinators must maintain an active license or certification in good standing by the Nebraska Department of Health and Human Services in one of the following health professions:

- Licensed Independent Mental Health Practitioner (LIMHP) or Licensed Mental Health Practitioner (LMHP)
- Clinical Program Manager (LIMPH, LMHP, CMSW, RN)
- Master Social Worker or Certified Master Social Worker (CMSW)
- Registered Nurse

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The TFC Care Coordinator will be responsible for conducting an initial 1915(i) eligibility evaluation within 14 days of notification that the individual is eligible to be evaluated for this 1915(i) benefit.The eligibility evaluation includes a comprehensive individualized assessment that is conducted either face-to-face or through telehealth technology using the Child and Adolescent Functional Assessment Scale tool (CAFAS®) or Preschool and Early Childhood Functional Assessment Scale (PECFAS®), based on age.

The CAFAS and PECFAS both assess the individual's need for assistance with day-to-day functioning in specified sub-domains using the following scale:

- Severe (severe or incapacitation)
- Moderate (major or persistent)
- Mild (significant problems or distress); and
- Minimal or No Impairment

- The PECFAS consists of the following subdomains: School/Daycare, Home, Community, Behavior Toward Others, Moods/Emotions, Self-Harmful Behavior, and Thinking/Communication; and
- The CAFAS consists of the following domains : School, Home, Community, Behavior Toward Others, Moods and Emotions, Self-Harmful Behavior, Substance Use, and Thinking.

The state agency has sign-on or user access to the technology where the assessments reside. The state reviewer reviews the completed assessment and any additional documentation used to determine that the individual meets the needs-based criteria, including risk factors, and target groups.

Eligibility reevaluations will be conducted at a minimum every six months, or earlier if a significant change in the behavior or function of the child/youth is identified. The evaluation and reevaluation process follow the same procedure.

4. ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Children in the TFC target group ages 4-6 are eligible for TFC services if they need assistance with managing major or persistent disruptive behaviors due to an assessed moderate impairment as determined by the PECFAS assessment. Needs include requiring verbal direction in how to use coping skills or how to manage thoughts and feelings to modify specific non-age appropriate behaviors in one of the following domains:

- Behavior Towards Others; or
- Moods; or
- Self-Harm; or
- Thinking.

Children and youth in the TFC target group ages 7-18 are eligible for TFC services if they demonstrate a need for assistance, due to an impairment, in the following domains. Needs include requiring verbal direction in how to use coping skills or how to manage thoughts and feelings to modify specific non-age appropriate behaviors in one of the following domains:

- School/Work; or
- Home; or
- Behavior towards Others; or
- Moods/Emotions; or
- Self-Harm; or
- Substance Use; or
- Thinking; or

Individuals eligible for TFC must score at least one of the following on a CAFAS

- A total score of 80+, across multiple domains, which indicates a need for assistance due to a mild impairment; or
- A minimum score of 40, which indicates a need for assistance in at least two domains due to a moderate impairment; or
- A minimum score of 30, which indicates a need for assistance in at least one domain due to a severe impairment.

In addition to meeting the functional needs-based criteria as assessed by the PECFAS and CAFAS, the individual must meet the following risk factor:

- Determined by the Nebraska Caregiver Responsibility (NCR) tool to be at least a Tier 4, which indicates that the individual is at risk of losing placement with foster families and has no other options for placement or housing;

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Children in the TFC target group ages 4-6 are eligible for TFC services if they need assistance with managing major or persistent disruptive behaviors due to an assessed moderate impairment as determined by the PECFAS assessment. Needs include requiring verbal direction in how to use coping skills or how to manage thoughts and feelings to modify specific non-age appropriate behaviors in one of the following domains: • Behavior Towards Others; or • Moods; or • Self-Harm; or • Thinking. Children and youth in the TFC target group ages 7-18 are eligible for TFC services if they demonstrate a need for assistance due to an impairment in the following domains. Needs include requiring verbal direction in how to use coping skills or how to manage thoughts and feelings to modify specific non-age appropriate behaviors in one of the following domains:	ACTIVITIES OF DAILY LIVING (ADL) FOR CHILDREN AGE 48 MONTHS THROUGH 17 YEARS. Activities in daily living (ADL) are considered a limitation when the child, due to their physical disabilities, requires hands-on assistance from another person on a daily basis, or supervision, monitoring, or direction to complete the age appropriate tasks associated with two or more activities of daily living (ADL) defined in this section. For the purposes of this section, the term "ability" must be interpreted to include the physical ability, cognitive ability, age appropriateness, and endurance necessary to complete identified activities. The following activities of daily living (ADL) are considered for nursing facility level of care (NF LOC) eligibility: (1) Bathing; (2) Dressing; (3) Personal Hygiene;	Nebraska Medicaid applies the following criteria to determine the appropriateness of intermediate care facility for individuals with developmental disabilities (ICF/DD) services on admission and at each subsequent review: (1) The individual has a diagnosis of an intellectual disability or a related condition, which has been confirmed by prior diagnostic evaluations and standardized tests and sources independent of the intermediate care facility for individuals with developmental disabilities (ICF/DD); and (2) The individual can benefit from active treatment as defined in 42 CFR 483.440(a) and 471 NAC 31-002. In addition, the following criteria apply: (a) The individual has a related condition and the independent qualified intellectual disabilities professional (QIDP) assessment identifies the	The individual demonstrates severe and persistent symptoms and functional impairments consistent with a Diagnostic and Statistical Manual (DSM), current edition, diagnosis that requires 24 hour residential/inpatient psychiatric treatment under the direction of a physician. The individual's symptoms/severe functional impairments include at least one of the following: • Suicidal/homicidal ideation • Substance use disorder that meets American Society of Addiction Medicine (ASAM), current edition, level of care 3.7 • Persistent or medically significant self-injury behaviors • A pattern of physical and verbal aggression • Significant eating disorder symptoms • Severe mood instability • Psychotic symptoms

• School/Work; or • Home; or • Behavior towards Others; or • Moods/Emotions; or • Self-Harm; or • Substance Use;or • Thinking Individuals eligible for TFC must score at least one of the following on a CAFAS • A total score of 80+, across multiple domains, which indicates a need for assistance due to a mild impairment; or • A minimum score of 40, which indicates a need for assistance in at least two domains due to a moderate impairment: or • A minimum score of 30, which indicates a need for assistance in at least one domain due to a severe impairment. In addition to meeting the functional needs-based criteria as assessed by the PECFAS and CAFAS, the individual must meet the following risk factor:	(4) Eating; (5) Mobility; (6) Toileting; or (7) Transferring. The needs based criteria for NF LOC is the child requiring hand-on assistance on a daily basis or an adult to provide assistance, exceeding the range of activities which would ordinarily be performed to the child with the following: (1) Bathing; (2) Dressing; (3) Personal Hygiene; (4) Eating; (5) Mobility; (6) Toileting; or (7) Transferring.	related condition has resulted in substantial functional limitations in three or more of the following areas of major life skills: self-care, receptive and expressive language, learning, mobility, self-direction, or capacity for independent living. These substantial functional limitations indicate that the individual needs a combination of individually planned and coordinated special interdisciplinary care, a continuous active treatment program, treatment, and other services which are lifelong or of extended duration. (b) A Medicaid-eligible individual has a dual diagnosis of developmental disability or a related condition and a mental illness. The developmental disability or related condition has been verified as the primary diagnosis by both an independent qualified intellectual disabilities professional (QIDP) and a mental health professional in	• Sexually harmful behaviors The needs-based criteria for hospital level of care is the individual needs assistance from a nurse 24/7.

• Determined by the Nebraska Caregiver Responsibility (NCR) tool to be at least a Tier 4, which indicates that the individual is at risk of losing placement with foster families and has no other options for placement or housing		which their scope of practice allows them to diagnose mental illness: (i) Historically there is evidence of missed developmental stages, due to developmental disability or a related condition; (ii) There is remission in the mental illness, and it does not interfere with intellectual functioning and participation in training programs; and (iii) The diagnosis of developmental disability or a related condition takes precedence over the diagnosis of mental illness; and (c) When the individual does not have substantial functional limitations in selfcare skills, the individual must have substantial functional limitations in at least the life skill area for capacity for independent living along with two other life skill areas.	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the

state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The TFC Program targets children and youth from 4 years of age up to and including age 18 who have complex physical health, mental health and/or substance use disorders.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: 1	
ii.	**Frequency of services**. The state requires (select one):	
	⊙	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and*

community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

TFC Crisis Support Services will be furnished to children and youth aged 4 through 18 who reside and receive HCBS in a home in the community. These settings are the private homes of foster parents who meet and maintain Nebraska Department of Health and Human Services housing requirements for issuance of a foster care license. Prior to enrollment, CFS will conduct site visits to ensure the homes are compliant with all Federal HCBS settings requirements from 42 CFR 441.710(a) (1)-(2). DCFS provides the state the home assessments to ensure placement meets HCBS setting criteria provided by the state. State will complete a desk review of all new DCFS settings. Settings that fail to meet the settings criteria will not be able to be billed. To ensure that all settings meet all the requirements in the future, providers will be trained and educated on setting requirements and site visits will occur at least once per month for youth in Intensive Plus and for youth in the Specialized level of foster care placement.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

   The following health professionals will be responsible for face-to-face assessments:
   - Licensed Independent Mental Health Practitioner (LIMHP) or Licensed Mental Health Practitioner (LMHP)
   - Psychologist
   - Clinical Program Manager
   - Master Social Worker or Certified Master Social Worker
   - Registered Nurse

   Training/skill requirements for people doing the independent assessments:
   - TFC program and HCBS waiver components and requirements
   - Child Abuse and Neglect 101
   - Understanding of Nebraska Foster Care system and service array
   - Trauma Informed Care
   - Understanding of all Nebraska DHHS programs and services as well as Behavioral Health Regions
   - Any required training/certification for assessment tool(s) chosen for TFC program

5. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The following health professionals will be responsible for developing the person-centered service plan:

- Licensed Independent Mental Health Practitioner (LIMHP) or Licensed Mental Health Practitioner (LMHP)
- Psychologist
- Clinical Program Manager
- Master Social Worker or Certified Master Social Worker
- Registered Nurse

Training/skill requirements for people responsible for person-centered service plan development:

- TFC program and HCBS waiver components and requirements
- Child Abuse and Neglect 101
- Understanding of Nebraska Foster Care system and service array
- Trauma Informed Care
- Understanding of all Nebraska DHHS programs and services as well as Behavioral Health Regions
- Any required training/certification for assessment tool(s) chosen for TFC program
- Family Engagement Skills
- De-escalation skills

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The participant and family will be informed verbally and in writing about the services available in the State Plan HCBS benefit at the time they make the choice to receive 1915(i) services. Following a person-centered philosophy, the parent(s) or legal guardian, youth and family members are the primary decision makers in the care of their family. The parent(s) or legal guardian, youth and family members, and formal and informal supports, constitute the Child and Family Team (CFT). The TFC Care Coordinator will, with the participant and family:

- identify needs that they will work on in the planning process;
- determine who will attend team meetings;
- contact potential CFT members, and
    - provide them with an overview of the care coordination process, and
    - discuss expectations for the first CFT meeting;
- conduct an initial assessment of strengths of the participant, their family members and potential CFT members.

The TFC Care Coordinator is responsible for working with the participant, family, and CFT to develop the care coordination plan through the process outlined below.

Within 72 business hours of notification of enrollment in the TFC program, the TFC Care Coordinator contacts the participant and family to schedule the initial meeting. At the meeting, the TFC Care Coordinator will:

(a) Administer the appropriate assessments;
(b) Work with the participant and family to develop an initial crisis plan;
(c) Execute signing of releases of information and all necessary consents;

(d) Provide an overview of the TFC program.

The CFT, will determine the family vision which will guide the planning process; identify strengths of the entire team; be notified of the needs that the team will be working on; determine outcome statements for meeting identified needs; determine the specific services and supports required to achieve the goals identified in the care coordination plan; create a mission statement that the team generates and commits to following; identify the responsible person(s) for each of the strategies in the care coordination plan; review and update the crisis plan; and meet at least every 30 days to coordinate the implementation of the care coordination plan and update the care coordination plan as necessary.

The plan must also address the methods used to ensure the active participation of the participant and/or the legally responsible person and others to develop such goals and to identify the steps or actions each CFT member will take to respond to the assessed service needs of the participant. This will be demonstrated by the CFT members signing and dating the care coordination plan and any updates made to the plan.

During the evaluation and/or re-evaluation, if the state reviewer sees there is a need identified in the assessment that does not have a corresponding action indicated in the care plan, the state reviewer will contact the care coordinator and have them amend the care plan to address the outstanding need.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Upon enrollment, the TFC Care Coordinator will provide a list of the available providers of 1915(i) services and the participant and family will be offered opportunity to select one. The choice of provider will be documented in the care coordination plan and the provider will be notified. MLTC will maintain the provider list.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

MLTC will delegate approval of the care coordination plan to the Operating Agency: DCFS. The TFC Care Coordinators will develop the care coordination plans and obtain approval from the TFC Care Coordination Supervisor. MLTC retains the responsibility for oversight of the care coordination plans and will conduct ongoing sample reviews to ensure plans have been developed with applicable policies and procedures, and plans ensure health and welfare of waiver participants.

9. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☑	Operating agency	☐	Case manager
☐	Other (*specify):*				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Crisis Service Maintenance and Response

Service Definition (Scope):

- TFC Crisis Service Maintenance and Response (TFC CSMR) must provide a phone line that is answered by a live voice 24 hours a day, every day of the year and can link the individual to a licensed behavioral health professional, law enforcement, and other emergency services. TFC CSMR is designed to assist individuals enrolled in the TFC Program and their foster parents in pre-crisis or crisis situations related to a behavioral health problem. TFC CSMR may be notified of a pre-crisis or crisis situation either through a verbal report of a current behavioral health pre-crisis or crisis or verbal request for assistance with the pre-crisis or crisis.

  The desired outcome is de-escalation of the pre-crisis or crisis, ensuring safety and making the necessary linkages.
  The provider will:
  - Perform brief screening of the intensity of the situation.
  - Work with the participant and family unit toward immediate relief of distress in pre-crisis and crisis situations; reduction of the risk of escalation of a crisis; arrangements for emergency onsite responses when necessary; and referral to appropriate services when other or additional intervention is required.
  - Calls to the phone line continue until the pre-crisis or crisis is resolved or a licensed behavioral health professional, law enforcement, or other emergency service is deemed necessary and arrives to offer assistance or the caller voluntarily ends the call.
  - Provide access to a licensed clinician when needed.
  - Establish involvement of law enforcement and other emergency services as needed.
  - Provide education on when and how to access the TFC 24-Hour Crisis Support phone line.
  - Use linguistically appropriate approaches when necessary.
  - Provide access to Nebraska Relay Service or TDD and ensure staff are appropriately trained in the utilization of the service.
  - Provide a minimum of once-a-month contact; if no crisis call is received in the span of 30 days, an outreach phone call must be made to proactively assess for any service needs.

  Providers are expected to have the following qualified mental health professionals and resources available to support the crisis support phone line:
  - Direct Care Staff trained to recognize and respond to a behavioral health crisis using trauma informed care, de-escalation strategies, and harm reduction, AND;
  - Peer Support or Community Treatment Aide trained to recognize and respond to a behavioral health crisis, AND;
  - On staff or consultative agreement with a Licensed Clinician;
  - Direct link to law enforcement and other emergency services.

  Personal recovery experience and personal experience with the foster care system preferred for all positions.

Licensed clinicians may include:

- Psychiatrist
- Physician
- Advanced practice registered nurse (APRN)
- Psychologist
- Provisionally licensed psychologist
- Physician Assistant (PA)
- Licensed Independent Mental Health Practitioner (LIMHP)*
- Licensed mental health practitioner (LMHP)*
- Provisionally licensed mental health practitioner (PLMHP)*
- All staff must be educated and trained in crisis intervention and crisis stabilization

**LIMHP, LMHP, and PLMHPs providing this service must have the equivalent of one year of full-time experience in direct child and/or adolescent services, ASD or DD services.*

All staff are required to work within their scope of practice to provide mental health, substance use, or co-occurring mental health and substance use disorder treatment. The CSMR team maintains relationships with community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care organizations.

When a provider is enrolled in Medicaid, they are required to sign a Service Provider Agreement, which states that they will comply with state and federal laws, including privacy and confidentiality requirements.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Crisis Support Services (TFC)	None	None	Any organization or agency that has, and can maintain, the necessary individually licensed behavioral health providers is eligible to perform the service. Per the service definitions, the Crisis Support Services (TFC) provider must have an

			array of the following clinically licensed individuals on staff: • Psychiatrist • Physician • Advanced practice registered nurse (APRN) • Psychologist • Provisionally licensed psychologist • Physician Assistant (PA) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed mental health practitioner (LMHP) • Provisionally licensed mental health practitioner (PLMHP) *Licensed by the Nebraska Division of Public Health in accordance with the Nebraska Uniform Credentialing Act.* Providers enrolled as Crisis Support Services (TFC) provider will be required to provide both the Crisis Service Maintenance and Response and Mobile Crisis services.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Crisis Support Services (TFC)	MLTC Provider Enrollment Contractor, Managed Care Organizations	At least every five years

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Mobile Crisis

Service Definition (Scope):

- TFC Mobile Crisis is designed to use natural supports and resources to manage and resolve an immediate mental health or substance use disorder crisis in the least restrictive

environment by creating and implementing a crisis intervention plan with the participant and family. This service is delivered in-person in the individual's home or community setting and is available 24 hours a day, every day of the year. The desired outcome is resolution of the crisis, ensuring safety and making the necessary referrals and linkages.

The mobile crisis team consists of a minimum of two team members. The team members include a direct service worker who is in-person and a licensed clinician who is available either in-person or via telehealth, with the individual(s) in crisis ideally one hour from the time of dispatch (two hours in rural and frontier settings), with response time not to exceed three hours. Upon contact, the Mobile Crisis team conducts an evaluation, including brief mental health status and substance use disorder screening, that must include at least one of the following: SBQR, ASQ, CAGE-AID, or CSSRS to ensure the individual is assessed for suicidality, homicidally, substance use disorder, and current symptoms.
The Mobile Crisis team will also:

- Develop the Brown-Stanley Safety Plan with the individual and support system.
- Provide mental health and/or substance use disorder interventions and crisis management.
- Provide linkage to information and referrals including appropriate community based mental health and/or substance use disorder services.
- Ensure consultation and/or referral to hospital emergency personnel, law enforcement, and community agencies as needed.
- Provide post crisis follow-up support with the first attempt made within 24 hours and 3 total attempts made within 72 hours including crisis disposition (review of the case and additional referrals for the participant and family if needed)
- Arrange for alternatives to psychiatric hospitalization if appropriate.

A licensed clinician must be available at all times to provide support, guidance, and direction to the Mobile Crisis team. The clinician must respond within 30 minutes of contact by the team member(s). The Mobile Crisis team member(s) may indicate a need for the clinician to arrive in-person. Non-licensed Certified Peer Support Specialists and Direct Care Staff must be accompanied by another staff member until they have completed all training. All services must be culturally sensitive.

Providers are expected to have the following qualified mental health professionals available to support the Mobile Crisis service:

- Direct Care Staff trained to recognize and respond to a behavioral health crisis, OR;
- Peer Support or Community Treatment Aide trained to recognize and respond to a behavioral health crisis, AND;
- On staff or consultative agreement with a Licensed Clinician.
- Direct link to law enforcement and other emergency services.
- Personal recovery experience preferred for all positions
- Personal experience with the foster care system preferred for all positions
- One or more staff may respond to a crisis and must include or have access to a Licensed Clinician 24/7.

Licensed Clinicians may Include:

- Psychiatrist
- Physician

- Advanced practice registered nurse (APRN)
- Psychologist
- Provisionally licensed psychologist
- Licensed Physician Assistant (PA)
- Licensed Independent Mental Health Practitioner (LIMHP)*
- Licensed mental health practitioner (LMHP)*
- Provisionally licensed mental health practitioner (PLMHP)*

**LIMHP, LMHP, and PLMHPs providing this service must have the equivalent of one year of full-time experience in direct child and/or adolescent services, ASD or DD services.*

All staff who respond on-site must be trained in:

- CPR and First Aid
- QPR/AMSR/CAM
- Diversity training
- Accessing interpretation services
- Opioid Overdose Safety (Narcan)
- Trauma Informed Services, De-Escalation Strategies and Harm Reduction
- Mental Health First Aid (All non-licensed staff)
- SBQR and ASQ
- CAGE-AID
- CSSRS
- Brown-Stanley Safety Plan
- CALM – Counseling Access to Lethal Means
- Mobile Crisis teams that provide services to youth must complete youth specific training such as adolescent development, working with DCFS involved youth, or Emergency Protective Custody alternatives for youth 18 years and under.

All staff are required to work within their scope of practice to provide mental health, substance use, or co-occurring mental health and substance use disorder treatment. Personal recovery experience is preferred for all positions.

The Mobile Crisis service continues until the crisis intervention plan for the individual and foster family is developed and implemented, or the crisis is resolved, and the individual can safely remain in the foster family or is transferred to a safe and least-restrictive setting for ongoing care.

The mobile crisis team maintains relationships with relevant community partners, including behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care organizations.

When a provider is enrolled in Medicaid, they are required to sign a Service Provider Agreement which states that they will comply with state and federal laws, including privacy and confidentiality requirements.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

- Based on information received during a call to the crisis phone line, Mobile Crisis will be dispatched if the individual exhibits or requires one or more of the following:

- active crisis symptoms consistent with current DSM diagnoses
- potential for risk of harm to self or others if support is not provided
- prompt, in-person crisis evaluation and intervention are needed
- at risk of being placed in Emergency Protective Custody and/or hospitalized if support is not provided

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Crisis Support Services (TFC)	None	None	Any organization or agency that has, and can maintain, the necessary individually licensed behavioral health providers is eligible to perform the service. Per the service definitions, the Crisis Support Services (TFC) provider must have an array of the following clinically licensed individuals on staff: • Psychiatrist • Physician • Advanced practice registered nurse (APRN) • Psychologist • Provisionally licensed psychologist • Physician Assistant (PA) • Licensed Independent Mental Health Practitioner (LIMHP) • Licensed mental health practitioner (LMHP) • Provisionally licensed mental health practitioner (PLMHP) *Licensed by the Nebraska Division of Public Health in accordance with the Nebraska Uniform Credentialing Act.*

			Providers enrolled as Crisis Support Services (TFC) provider will be required to provide both the Crisis Service Maintenance and Response and Mobile Crisis services.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Crisis Support Services (TFC)	MLTC Provider Enrollment Contractor, Managed Care Organizations	At least every five years

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Not applicable

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction**. (*Select one):*

◉	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. **Limited Implementation of Participant-Direction**. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. **Participant-Directed Services**. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. **Financial Management.** (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. **Opportunities for Participant-Direction**

a. **Participant–Employer Authority** (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

○	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. **Participant–Budget Authority** (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

○ The state does not offer opportunity for participants to direct a budget.
○ Participants may elect Participant–Budget Authority.
Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	1.a) ***Service plans address assessed needs of 1915(i) recipients.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed that adequately address the assessed needs of 1915(i) recipients. Numerator = Number of service plans reviewed that adequately address the assessed needs of 1915(i) recipients. Denominator = Total number of service plans reviewed.
Discovery Activity	Source of data: Record review of 1915(i) participant case records. Sample size: A representative sample of the total population with a 90% confidence level and +/-5% margin of error.

(Source of Data & sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency (SMA)
Frequency	Bi-annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will collect, analyze, and aggregate the data. Deficiencies will be remediated through a quarterly, or earlier if indicated, Quality Improvement Team (QIT) meeting including SMA and DCFS. SMA will remediate any issue or non-compliance within 30 calendar days.
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be developed by DCFS, as applicable, and provided to SMA within 30 calendar days. SMA will then respond in 30 calendar days for a total of 60 calendar days.

Requirement	***1.b) Service plans are updated annually***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans that are updated at least once in the last 12 months. Numerator = Number of service plans reviewed that are updated at least once in the last 12 months. Denominator = Total number of service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	Source of data: Record review of 1915(i) participant case records. Sample size: A representative sample of the total population with a 90% confidence level and +/-5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
Frequency	Bi-annually

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will collect, analyze, and aggregate the data. Deficiencies will be remediated through a quarterly, or earlier if indicated, QIT meeting including SMA and DCFS. SMA will remediate any issue or non-compliance within 30 calendar days.
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be developed by DCFS, as applicable, and provided to SMA within 30 calendar days. SMA will then respond in 30 calendar days for a total of 60 calendar days.

Requirement	***1.c) Service plans document choice of services and providers***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed that indicate 1915(i) recipients were given a choice when selecting services and providers. Numerator = Number of service plans reviewed that indicate 1915(i) recipients were given a choice when selecting services and providers. Denominator = Total number of service plans reviewed
Discovery Activity *(Source of Data & sample size)*	Source of data: Record review of 1915(i) participant case records. Sample size: A representative sample of the total population with a 90% confidence level and +/-5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
Frequency	Bi-annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will collect, analyze, and aggregate the data. Deficiencies will be remediated through a quarterly, or earlier if indicated, QIT meeting including SMA and DCFS. SMA will remediate any issue or non-compliance within 30 calendar days.

Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be developed by DCFS, as applicable, and provided to SMA within 30 calendar days. SMA will then respond in 30 calendar days for a total of 60 calendar days.

Requirement	***2. (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of individuals newly identified as being in the target group who had an eligibility evaluation for the TFC 1915(i) HCBS benefit Numerator: Number of individuals newly identified as being in the target group who had an eligibility evaluation for the TFC 1915(i) HCBS benefit Denominator: Number of individuals newly identified as belonging to the target group
Discovery Activity *(Source of Data & sample size)*	Source of data: Record review of 1915(i) participant case records. Sample size: A representative sample of the total population with a 90% confidence level and +/-5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
Frequency	Bi-annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will collect, analyze, and aggregate the data. Deficiencies will be remediated through a quarterly, or more frequent if indicated, QIT meeting including SMA and DCFS. SMA will remediate any issue or non-compliance within 30 calendar days.
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be developed by DCFS, as applicable, and provided to SMA within 30 calendar days. SMA will then respond in 30 calendar days for a total of 60 calendar days.

Requirement	**2. (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately**
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of reviewed 1915(i) eligibility evaluations that were completed by appropriately applying the processes and instruments approved in the 1915(i) HCBS state plan amendment. Numerator = Number of reviewed 1915(i) evaluations that were completed by appropriately applying the processes and instruments approved in the 1915(i) HCBS state plan amendment. Denominator = Total number of 1915(i) evaluations reviewed
	Discovery Activity *(Source of Data & sample size)*	Source of data: Record review of 1915(i) participant case records. Sample size: A representative sample of the total population with a 90% confidence level and +/-5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Bi-annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will collect, analyze, and aggregate the data. Deficiencies will be remediated through a quarterly, or earlier if indicated, QIT meeting including SMA and DCFS. SMA will remediate any issue or non-compliance within 30 calendar days.
	Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be developed by DCFS, as applicable, and provided to SMA within 30 calendar days. SMA will then respond in 30 calendar days for a total of 60 calendar days.

Requirement	**2. (c) the 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percentage of enrolled recipients whose 1915 (i) benefit Needs Based eligibility Criteria, was reevaluated annually. Numerator: Number of enrolled recipients whose Needs Based Criteria was reevaluated annually; Denominator: Number of enrolled recipients reviewed.

Discovery Activity *(Source of Data & sample size)*	Source of data: Record review of 1915(i) participant case records. Sample size: A representative sample of the total population with a 90% confidence level and +/-5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
Frequency	Bi-annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will collect, analyze, and aggregate the data. Deficiencies will be remediated through a quarterly, or earlier if indicated, QIT meeting including SMA and DCFS. SMA will remediate any issue or non-compliance within 30 calendar days.
Frequency *(of Analysis and Aggregation)*	Analysis and aggregation are ongoing. If a corrective action plan is needed it must be developed by DCFS, as applicable, and provided to SMA within 30 calendar days. SMA will then respond in 30 calendar days for a total of 60 calendar days.

Requirement	**3. Providers meet required qualifications.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of 1915(i) service providers who meet the SMA's enrollment standards, as required, prior to providing 1915(i) services. Numerator: Number of 1915(i) service providers who meet the SMA's enrollment standards, as required, prior to providing 1915(i) services. Denominator: Total number of 1915(i) service providers reviewed.
Discovery Activity *(Source of Data & sample size)*	Source of data: Record review of 1915(i) participant case records. Sample size: A representative sample of the total population with a 90% confidence level and +/-5% margin of error
Monitoring Responsibilities	SMA Provider Enrollment Unit Contracted MCOs

(Agency or entity that conducts discovery activities)	
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA Provider Enrollment Unit will verify licensure of individual providers upon application for enrollment. The individual providers will also be required to be credentialed with the Managed Care Organizations. The MCOs will be responsible for re-verification on a schedule commensurate with their standard operation procedures.
Frequency *(of Analysis and Aggregation)*	Ongoing and annually

Requirement	**4. Settings meet the home and community-based setting requirements as specified in this State plan amendment and in accordance with 42 Code of Federal Regulations 441.710(a)(1) and (2).**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of settings that meet the HCBS requirements. Numerator: Number of settings that meet HCBS requirements Denominator: Total number of medical records reviewed.
Discovery Activity *(Source of Data & sample size)*	Source of data: Record review of 1915(i) participant case records. Sample size: A representative sample of the total population with a 90% confidence level and +/-5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Contracted MCOs.
Frequency	Annually.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates*	The MCOs will be responsible for monitoring and remediation commensurate with their standard operation procedures.

	remediation activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***5. The SMA retains authority and responsibility for program operations and oversight.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of issues identified in QI monitoring reports that were remediated as required by SMA. Numerator = Number of issues identified in QI monitoring reports that were remediated as required by SMA. Denominator = Total number of issues identified. NOTE: the QI Monitoring reports summarize the performance measures for Requirements 1 and 2.
	Discovery Activity *(Source of Data & sample size)*	Source of data: Record review of 1915(i) participant case records. Sample size: 100% of monitoring reports are reviewed
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will collect, analyze, and aggregate the data. Deficiencies will be remediated through a quarterly, or earlier if indicated, QIT meeting including SMA and DCFS. SMA will remediate any issue or non-compliance within 30 calendar days.
	Frequency	Annually

	(of Analysis and Aggregation)	

Requirement		***6) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) recipients by qualified providers.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of claims for 1915(i) services that providers submitted in compliance with the billing guidelines. Numerator: Number of claims for 1915(i) services that providers submitted in compliance with the billing guidelines. Denominator: Number of claims reviewed.
	Discovery Activity *(Source of Data & sample size)*	Source of data: Record review of 1915(i) participant case records. Sample size: A representative sample of the total claims received during the reporting period with a 90% confidence level and +/-5% margin of error
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency (SMA) Quality Assurance (QA) Unit, Fiscal Unit and Contracted MCOs
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the quarterly QIT meeting.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

Requirement	***7. (a) The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.***
Discovery	

Discovery Evidence *(Performance Measure)*	Number and percent of case records that demonstrate 1915(i) recipients who receive information/ or education about how to report abuse, neglect, exploitation and other critical incidents. N: Number of recipients records which demonstrate 1915(i) recipients who received information or education about how to report abuse, neglect, exploitation and other critical incidents. D: Number of case records of 1915(i) recipients reviewed.
Discovery Activity *(Source of Data & sample size)*	Source of data: Record review of 1915(i) participant case records. Sample size: A representative sample of the total population with a 90% confidence level and +/-5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
Frequency	Bi-annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. During initial and annual assessment, the 1915 (i) recipient will be educated on how to submit an incident report, be provided with a list of contacts for reporting such incidents and sign the acknowledgment form. The acknowledgment form will be kept in the participant case file for supervisor review quarterly and for SMA QA review bi-annually.
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

Requirement	***7.(b) The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incident reviews or investigations that were initiated regarding abuse, neglect, exploitation, and other critical incidents. Numerator: Number of incident reviews or investigations that were initiated regarding abuse, neglect, exploitation, and other critical incidents as required by DCFS. Denominator: Number of incident reports received.

Discovery Activity *(Source of Data & sample size)*	Data related to investigations is collected from the Nebraska Child Welfare System Source of data: Record review of 1915(i) participant case records. Sample size: A representative sample of the total population with a 90% confidence level and +/-5% margin of error.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DCFS
Frequency	Ongoing with Annual Report
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DCFS Analytics, Planning and Evaluation team is responsible for collecting and analyzing the data. DCFS will remediate any issue or non-compliance within 30 days.
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

Requirement	***7.(c) The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incident reviews/investigations involving abuse, neglect, exploitation, and other critical incidents that were completed by the DCFS. Numerator: Number of incident reviews/investigations involving abuse, neglect, exploitation, and other critical incidents that were completed by DCFS Denominator: Number of incidents reviewed.
Discovery Activity *(Source of Data & sample size)*	Source of data: Record review of 1915(i) participant case records. Sample size: A representative sample of the total population with a 90% confidence level and +/-5% margin of error
Monitoring Responsibilities	DCFS

	(Agency or entity that conducts discovery activities)	
	Frequency	Ongoing with Annual Report
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DCFS Analytics, Planning and Evaluation team is responsible for collecting and analyzing the data. DCFS will remediate any issue or non-compliance within 30 days.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

On an ongoing basis, the SMA QA Unit, led by a staff RN and including support staff as needed, will collaborate in a Quality Improvement Team (QIT) that includes DCFS and the MCOs when appropriate. The QIT will assess performance and identify quality improvements needed to ensure required performance measures are met or exceeded. Monthly QIT meetings will be held to review performance on all measures, and to determine remediation and mitigation efforts for measures below 86% using CMS guidelines.

Such guidelines include, but are not limited to, identifying probable cause, development of interventions to improve performances, trend analysis on performance measures, etc. The SMA QA Unit will conduct educational trainings on how to perform participant case and provider reviews, as needed. Provider reviews will be tracked, and deficiencies flagged. Depending on the deficiency, referrals are sent to an appropriate state agency for review and corrective action plan as appropriate.

Care coordination plans and related records are housed in a database which generates reports needed for SMA QA Unit participant case reviews. Upon application for enrollment as a Nebraska Medicaid Provider, provider records are reviewed and verified by the SMA Provider Enrollment Unit. Electronic submission of claims is done through MMIS, which has built-in edits to ensure claims are processed correctly and appropriately.

2. Roles and Responsibilities

The SMA QA unit will complete reviews of the performance measures outlined above excluding provider reviews which are conducted by a contracted MCOs.

3. Frequency

The QIT meets at least quarterly to review performance measures, identify deficiencies, discuss remediations on deficiencies found prior review periods, and discuss the changes ~~as~~ needed ~~to the~~ for process and systemic improvement. The Quality Improvement Strategy is evaluated in its entirety prior to the 5-year renewal.

4. Method for Evaluating Effectiveness of System Changes

During QIT meetings, trend analysis is conducted on:

- remediation efforts to determine effectiveness and
- performance measures to ensure continual improvement.

As trends develop, specific changes that are needed will be identified and monitored to ensure that issues are remedied.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (specify below)
	Crisis Service Maintenance and Response Nebraska began by estimating the number of kids and expected utilization of the service to determine the estimated capacity necessary to provide the service. Nebraska also looked at which types of staff (and their general reimbursement) would primarily participate in the delivery of the service. From there the state developed a per member per month rate (and pro-rata per diem, when applicable, such as partial service months) to reimburse consistent with the estimated service capacity and staffing required. The Crisis Service Maintenance and Response daily/monthly rate will be adjusted at the beginning of each new State Fiscal Year by the legislatively appropriated rate percentage update allocated to Mental Health Substance Abuse providers.

	Mobile Crisis Response Nebraska developed the rate for this service by completing a market analysis of other payers' rates for this service, and similar (i.e. crisis) services. Nebraska incorporated a blended approach of established State Medicaid rates, namely those who are like peer (i.e. border) States into its established Mobile Crisis Response rate. Nebraska has also adopted a tiered rate structure by provider class, where the higher the licensure level the clinicians are who are rendering the service, the higher the reimbursement. Each level of reimbursement by provider class will be identified using a unique modifier combination with the procedure code. The Mobile Crisis Response rates will be adjusted at the beginning of each new State Fiscal Year by the legislatively appropriated rate percentage update allocated to Mental Health Substance Abuse providers.