

May 18, 2011

James G. Scott  
Associate Regional Administrator  
for Medicaid and Children's Health Operations  
Centers for Medicare & Medicaid Services  
601 East 12<sup>th</sup> Street, Suite 235  
Kansas City, Missouri 64106

RE: Nebraska SPA #11-10 – Children's Mental Health and Substance Abuse Services

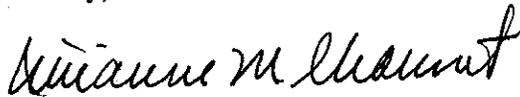
Dear Mr. Scott:

Enclosed please find the above referenced amendment to the Nebraska State Plan regarding Children's Mental Health and Substance Abuse Services and our response to the Standard Funding Questions. This amendment is part of the provisions outlined in the Nebraska Child Behavioral Health Compliance Plan submitted to CMS December 17, 2010. We have also submitted concurrent SPA #11-13 to NIRT regarding these services.

Prior to submitting this State Plan Amendment, the Division of Medicaid and Long-Term Care sought consultation from federally recognized Native American Tribes and Indian Health Programs within the State of Nebraska to discuss the impact that the proposed State Plan Amendment might have, if any, on the Tribes. No comments were received.

If you have content questions, please feel free to contact Margaret Van Dyke, 402-471-1608, [margaret.vandyke@nebraska.gov](mailto:margaret.vandyke@nebraska.gov) or for submittal questions, Pat Taft, 402-471-7787, [pat.taft@nebraska.gov](mailto:pat.taft@nebraska.gov).

Sincerely,



Vivianne M. Chaumont, Director  
Division of Medicaid and Long-Term Care  
Department of Health and Human Services

cc: Gail Brown Stevenson

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: 11-10	2. STATE Nebraska
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2011	

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN                       AMENDMENT TO BE CONSIDERED AS NEW PLAN                       AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: a. FFY 2011                      \$0 b. FFY 2012                      \$0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 3.1-A, page 7 Attachment 3.1-A, Item 4b, pp 7-25 Attachment 3.1-A, Item 16 Attachment 3.1-B, page 6 Attachment 4.19-B, Item 4b, pp 2,3 Attachment 4.19-B, Item 16, page 2	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Attachment 3.1-A, page 7 Attachment 3.1-A, Item 4b, pp 7-11 Attachment 3.1-A, Item 16 Attachment 3.1-B, page 6 Attachment 4.19-B, Item 4b, pp 2,3 Attachment 4.19-B, Item 16, page 2

10. SUBJECT OF AMENDMENT:  
Children's Mental Health and Substance Abuse Services

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT                       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED                      Governor has waived review  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Patricia (Pat) Taft Division of Medicaid & Long-Term Care Nebraska Department of Health & Human Services 301 Centennial Mall South Lincoln, NE 68509
13. TYPED NAME: Vivianne M. Chaumont	
14. TITLE: Director, Division of Medicaid and Long-Term Care	
15. DATE SUBMITTED: May 18, 2011	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:	18. DATE APPROVED:
--------------------	--------------------

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE  
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. Services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a) (31) (A), to be in need of such care.  
 Provided       No limitations       With limitations\*  
 Not provided.
16. Inpatient psychiatric facility services for individuals under 22 years of age.  
 Provided:       No limitations       With limitations\*  
 Not provided.
17. Nurse-midwife services.  
 Provided:       No limitations       With limitations\*  
 Not provided.
18. Hospice care (in accordance with section 1905(o) of the Act).  
 Provided:       No limitations        
With limitations\*  
 Not provided.

\*Description provided on attachment.

---

TN No. 11-10

Approval Date \_\_\_\_\_ Effective Date \_\_\_\_\_

Supersedes

TN No. MS-04-02

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS FOUND

---

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES FOR CHILDREN AND ADOLESCENTS COVERED UNDER EPSDT:

Medicaid covers certain mental health and substance abuse (MH/SA) services as part of the HEALTHCHECK (EPSDT) benefit.

Licensed Mental Health Practitioner (LMHP) - 42 CFR 440.60 - Other Licensed Practitioners

The following mental health and substance abuse practitioners who are licensed in the State of Nebraska to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license may be enrolled as an individual provider of mental health/substance abuse services. The following individuals are licensed to practice: Licensed Alcohol and Drug Counselor who is an individual licensed by the Nebraska Health and Human Services.

Prior authorization is required for some services while other services have an initial authorization for level of benefit and must receive authorization prior to service delivery for medically necessary outpatient psychotherapy or substance abuse treatment services which exceed any established service limit. All services provided while a person is a resident of an IMD are considered content of the institutional service and not otherwise reimbursable by Medicaid.

A unit of service is defined according to the CPT and HCPCS approved code set unless otherwise specified.

Medicaid and/or its designee does not permit separate billing of mileage and conference fees for home-based family therapy providers of outpatient psychiatric services. Those costs are assumed to be covered in the rates.

Telehealth:

Services provided by licensed mental health and substance abuse practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations.

---

TN No. 11-10  
Supersedes  
TN No. MS-00-06

Approval Date \_\_\_\_\_ Effective Date \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF CONDITIONS  
FOUND

---

Rehabilitation Services - 42 CFR 440.130(d)

The following explanation and limitations apply to the rehabilitation services listed below:

- Day Treatment/Intensive Outpatient Service by Direct Care Staff Member
- Community Treatment Aide
- Professional Resource Family Care
- Therapeutic Group Home

These rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible children with significant functional impairments resulting from an identified mental health or substance abuse diagnosis. The recommendation of medical necessity for these rehabilitative services shall be determined by a licensed psychologist, licensed independent mental health practitioner (LIMHP) or physician who is acting within the scope of his/her professional license and applicable state law, to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level.

Limitations:

Services are subject to prior approval. Services shall be medically necessary and shall be recommended by a psychologist, LIMHP or physician according to an individualized treatment plan, which addresses the child's assessed needs. A Pretreatment Assessment (PTA) is a comprehensive assessment completed prior to determining a need for rehabilitation services. The PTA identifies the clinical need for treatment and the most effective treatment intervention/level of care to meet the medical necessity needs of the client. If the client is recommended for a rehabilitation service, the Pretreatment Assessment document shall accompany the referral information to the rehabilitation program provider.

---

TN No. 11-10

Supersedes

TN No. MS-00-06

Approval Date \_\_\_\_\_ Effective Date \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

The activities included in the service shall be intended to achieve identified treatment plan goals or objectives. The recommendations of the licensed supervising practitioner following the Initial Diagnostic Interview serves as the treatment plan until the comprehensive treatment plan is developed. The comprehensive treatment plan should be developed in a person-centered manner with the active participation of the individual, family and providers and be based on the individual's condition and the standards of practice for the provision of these specific rehabilitative services. The treatment plan should identify the medical or remedial services intended to reduce the identified condition as well as the anticipated outcomes of the individual. The treatment plan shall specify the frequency, amount and duration of services. The treatment plan shall be signed by the psychologist, licensed mental health practitioner or physician responsible for developing the plan. The plan will specify a timeline for reevaluation of the plan that is at least an annual redetermination. The reevaluation should involve the individual, family and providers and include a reevaluation of the plan to determine whether services have contributed to meeting the stated goals. A new treatment plan should be developed if there is no measureable reduction of disability or restoration of functional level. The new plan should identify a different rehabilitation strategy with revised goals and services. Only one rehabilitation service may be authorized or provided to a single child on any given day (e.g., a child cannot receive both CTA and Intensive Outpatient on the same day) without prior authorization.

Anyone providing substance abuse or mental health services must meet the training requirements outlined by Medicaid and/or its designee, in addition to any required scope of practice license required for the facility or agency to practice in the State of Nebraska. Providers shall maintain case records that include a copy of the treatment plan, the name of the individual, dates of services provided, nature, content and units of rehabilitation services provided, and progress made toward functional improvement and goals in the treatment plan.

---

TN No. 11-10  
Supersedes  
TN No. 10-18

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

Medical necessity of the services is determined by a licensed mental health practitioner or physician conducting an assessment consistent with state law, regulation and policy. Services provided at a work site shall not be job tasks oriented. Any services or components of services of which the basic nature is to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, child care, and laundry services) are not covered. Services cannot be provided in an Institution for Mental Disease (IMD). Room and board is excluded from any rates provided in a residential setting. Evidence-based Practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by Medicaid and/or its designee.

Services provided to children and youth shall include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination shall be documented in the youth's medical record. Services may be provided at an office-based facility, in the community or in the individual's place of residence as outlined in the Plan of Care. Transportation of children is not included in rehabilitation rates. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual are not eligible for Medicaid reimbursement.

Rehabilitation services shall be offered to all children who need them regardless of their living arrangements, including foster care status. Children covered by Medicaid, including their parents and guardians, shall be able to choose any willing and qualified provider of services (e.g., not limited to foster care parents). Medically necessary rehabilitation services for an eligible child shall be provided by qualified Medicaid providers distinct from the placement of a child and excluding room and board. Rehabilitation services may not be provided in an Institution for Mental Disease.

---

TN No. 11-10  
Supersedes  
TN No. 10-18

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

Rehabilitation services may not include reimbursement for other services to which an eligible individual has been referred, including foster care programs and services such as, but not limited to, the following:

- (1) Research gathering and completion of documentation required by the foster care program
- (2) Assessing adoption placements
- (3) Recruiting or interviewing potential foster care parents
- (4) Serving legal papers
- (5) Home investigations
- (6) Providing transportation
- (7) Administering foster care subsidies
- (8) Making placement arrangements

A unit of service is defined according to the HCPCS approved code set unless otherwise specified.

Definitions:

The services are defined as follows:

1. Treatment in Day Treatment and Intensive Outpatient Service (IOP) by Direct Care Staff

Day Treatment and Intensive Outpatient services are services that are part of a continuum of care to prevent inpatient services and/or to facilitate the movement of the client from an inpatient setting (in a hospital or PRTF) service to a status in which the client is capable of functioning within the community with less frequent contact with the mental health or substance abuse provider. These services shall lead to an attainment of specific goals through a group of individualized treatment interventions and services.

---

TN No. 11-10  
Supersedes  
TN No. MS-00-06

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

Individualized treatment shall provide the basis for transitioning a child/adolescent to a less intense level of care if additional services are clinically necessary. Individualized treatment is based upon an active treatment plan reviewed every 30 days after it is finalized and a specific plan for discharge from Day Treatment when the treatment goals have been met. Treatment services may be appropriately used to transition a client from higher levels of care and may be provided for clients at risk of needing more intensive care than traditional weekly outpatient treatment services. Direct Care Staff perform the following functions:

- A. Provide psychoeducational activities and interventions to support youth in developing social, therapeutic, and other independent living skills as appropriate. Psychoeducational therapy services may include but are not limited to:
  - (1) Crisis Intervention Plan and Aftercare Planning
  - (2) Social Skills Building
  - (3) Life Survival Skills
  - (4) Substance Abuse Prevention Intervention
  - (5) Self-care services
  - (6) Medication education and medication compliance groups
  - (7) Health care issues group (may include nutrition, hygiene, personal wellness)
- B. Implement the treatment plan and discharge plan for each child
- C. Provide continual care to youth in the program
- D. Report all crisis or emergency situations to the program/clinical director or to the program's designee in the absence of the program/clinical director
- E. Understand the program's philosophy regarding behavior management and apply its philosophy in daily interactions with the clients in care

---

TN No. 11-10

Supersedes

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

TN No. New page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

Provider Qualifications:

Agencies shall be certified by Medicaid and/or its designee. Agencies shall be licensed by the State of Nebraska for substance abuse service delivery if substance abuse treatment is delivered. Each agency will employ program/clinical directors to supervise direct care staff consistent with State licensure, accreditation, and regulations including co-occurring conditions. The direct care staff shall have a bachelor's degree or higher in psychology, sociology, or related human service field, but two years of course work in the human services field and two years experience/training with demonstrated skills and competencies in treatment of youth with mental illness is acceptable. These requirements for direct care staff become effective for staff hired on or after the effective date of this policy. Direct care staff:

- (1) Shall complete the initial program training and successfully complete the agency's competency check. In addition, each staff shall have demonstrated skill and competency in the treatment of clients with mental health and substance abuse disorders prior to delivery of services.
- (2) Shall pass child abuse check, Adult abuse registry and motor vehicle screens
- (3) Shall complete specific training for behavioral management and update the training as required by the program
- (4) Shall understand de-escalation techniques and demonstrate the ability to implement those techniques effectively

Unit of Service: 15-minute unit for unlicensed direct care staff.

Limitations:

Agency providers cannot receive Medicaid reimbursement for treatment services provided to clients who live in any institution and are transported to the program. When a Medicaid beneficiary is receiving room and board services for therapeutic group home, Professional Resource Family Care, hospital or PRTF services, the client may not participate in day treatment or intensive outpatient services.

---

TN No. 11-10  
Supersedes  
TN No. New page

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

Payment is not available for services for clients:

- (1) Living in institutions
- (2) Whose needs are social or educational and may be met through a less structured program
- (3) Whose primary diagnosis and functional impairment is acutely psychiatric in nature and whose condition is not stable enough to allow them to participate in and benefit from the program
- (4) Whose behavior may be very disruptive and/or harmful to other program participants or staff members
- (5) Whose program is designed to provide applied behavioral analysis (ABA) to alter behaviors for clients whose primary symptoms and dysfunctions are due to a developmental disorder and the client's referral information supports that the client cannot participate and benefit from the services
- (6) Educational services are not eligible for payment by the Medicaid Program, and do not apply towards the hours of treatment services. Providers shall be familiar with each child/adolescent's IEP and coordinate with the youth and the youth's school to achieve the IEP. Educational services may not be the primary reason for admission or treatment. Academic educational services, when required by law, shall be available.

Limit of 750 hours of Day Treatment and IOP direct care staff billing per calendar year. The overall program may generally only bill for 6 hours a day for day treatment and 3 hours per day for intensive outpatient services. The number of hours per day shall be determined by the specific clinical needs of the client and by the level of acuity of the client. Medicaid and/or its designee may prior authorize treatment in excess of these guidelines if medically necessary. Licensed practitioners will bill separately from unlicensed practitioners for the time spent in direct therapy per direct therapy coding under the Other Licensed Practitioner Section of the State Plan.

---

TN No. 11-10  
Supersedes  
TN No. New page

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

Licensed and unlicensed practitioners may not bill for the same time. Clinical supervision costs for unlicensed practitioners are built into the unlicensed direct care practitioner rate. Medicaid and/or its designee shall prior authorize the number of hours of treatment per client need and periodically review the medical need for continued treatment services. The program shall identify an on-call system of licensed practitioners available for crisis management when the client is not in the program's scheduled hours and/or the program is not in session. Programs shall identify a coverage Supervising Practitioner to serve the program in the unforeseen absence of the designated Supervising Practitioner due to illness or vacations.

Day Treatment Direct Care Staff time may only be billed in an office-based facility with a well organized supportive therapeutic environment for youth in order that youth can apply the goals of their individualized, active treatment plan and achieve progress in accomplishing those goals. Clients whose symptoms includes uncontrolled disruptive behavior shall have de-escalation and anger management identified in the initial treatment plan and measures shall be taken to aggressively enforce and manage those behaviors at the earliest time possible. Day Treatment workers shall be aware of safety issues unique to each child and provide safety intervention within the milieu. Procedures such as seclusion and restraint to manage the treatment milieu are not permitted in Day Treatment programs. Treatment Plans shall be developed within 10 days of admission to the Day Treatment program.

Intensive Outpatient Direct Care Staff time may only be billed in an office-based facility providing group-based, non-residential, intensive outpatient mental health/substance abuse treatment services in conjunction with psychotherapy services and substance abuse counseling services provided by licensed practitioners. Treatment Plans shall be developed within 14 days of admission to the IOP program.

2. Community Treatment Aide (CTA) Community Treatment Aide (CTA) services are supportive, and psycho-educational interventions provided primarily in the client's natural environment. Natural environment primarily is the client's home but may also include a foster home, school, or other appropriate community locations conducive for the delivery of CTA services per the service.

---

TN No. 11-10

Supersedes

TN No. New page

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

CTA services shall be expected to improve the client's level of functioning within their environment to enhance the client and caregiver's ability to manage the client's primary mental health and substance abuse related symptoms. The service is delivered by a highly skilled, educated and trained non-licensed (paraprofessional) staff person under the direction and supervision of a licensed practitioner who simultaneously provides family and individual therapy on a regular basis to the client and the client's caregiver/family. Community Treatment Aide (CTA) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. Activities included shall be intended to achieve the identified goals or objectives as set forth in the individual's individualized treatment plan.

The intent of CTA is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. CTA is a face-to-face intervention with the individual present. Services may be provided individually and in a family setting. A majority of CTA contacts shall occur in community locations where the person lives, works, attends school, and/or socializes. A CTA provider performs the following functions:

- (A) Provides training and rehabilitation of basic personal care and activities of daily living through training the youth and the usual caregiver
- (B) Promotes improvement in the youth's social skills and relationship skills through training and education of the youth and the usual caregiver
- (C) Teaches and instructs the caregiver in crisis and de-escalation techniques
- (D) Teaches and models appropriate behavioral treatment interventions and techniques for the youth and the youth's caregiver
- (E) Teaches and models appropriate coping skills to manage dysfunctional behavior for the youth's caregiver
- (F) Provides information about medication compliance and relapse prevention and reports to her/his supervising licensed mental health practitioner
- (G) Teaches and models proper and effective parenting practice

Unit of Service: 15 minute unit for unlicensed direct care staff.

---

TN No. 11-10

Supersedes

TN No. New page

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

Provider Qualifications:

Agencies shall be certified by Medicaid and/or its designee. Each agency will employ licensed program/clinical directors to supervise direct care staff consistent with State licensure. CTA staff shall have a bachelor's degree in psychology, social work, child development or related field and equivalent of one year of full-time work experience or graduate studies in direct child/adolescent services or mental health and/or substance abuse services or high school degree and two years post high school education in the human services field and have two years full time work experience in direct child/adolescent services or mental health and/or substance abuse services. The CTA staff shall be employed/contracted within the same agency as the therapist/licensed practitioner providing psychotherapy services to the client and the client's family. The CTA staff shall be certified in the State of Nebraska to provide the service, which includes criminal, abuse/neglect registry and professional background checks, and completion of a state approved standardized basic training program.

Limitations:

Limit of 750 hours of CTA per calendar year. This limit can be exceeded when medically necessary through prior authorization. The CTA provider shall receive regularly scheduled clinical supervision from a licensed Program/Clinical Director meeting the qualifications of a licensed mental health practitioner, registered nurse (RN), APRN, LIMHP, or a psychologist with experience regarding this specialized mental health service. A licensed practitioner which may include a licensed psychiatrist, psychologist, LIMHP, LMHP and APRN (large agency CTA programs may also include provisionally licensed psychologists and provisionally licensed mental health practitioners as therapists) shall be available at all times for supervision of the CTA staff, guiding the active treatment plan implementation in the home/living environment, co-signing all CTA progress notes and continuous and ongoing assessment of the active treatment plan to assure that the clinical needs of the youth/parent/caregiver are met. This includes transitioning the client to other treatment and care settings as necessary.

---

TN No. 11-10  
Supersedes  
TN No. New page

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

3. Professional Resource Family Care

Professional Resource Family Care is intended to provide short-term and intensive supportive resources for the youth and his/her family. The intent of this service is to provide a crisis stabilization option for the family in order to avoid psychiatric inpatient and institutional treatment of the youth by responding to potential crisis situations through the utilization of a co-parenting approach provided in a surrogate family setting. The goal will be to support the youth and family in ways that will address current acute and/or chronic mental health needs and coordinate a successful return to the family setting at the earliest possible time. During the time the professional resource family is supporting the youth, there is regular contact with the family to prepare for the youth's return and his/her ongoing needs as part of the family. It is expected that the youth, family and professional resource family are integral members of the youth's individual treatment team. A professional resource family performs the following functions:

- (A) Promotes improvement in the youth's social skills and family and peer relationship skills through training and education of the youth and the biological parents/youth's primary caregiver
- (B) Teaches and instructs the caregiver in crisis and de-escalation techniques
- (C) Teaches and models appropriate behavioral treatment interventions and techniques for the youth and the youth's biological parents/youth's primary caregiver
- (D) Teaches and models appropriate coping skills to manage dysfunctional behavior for the youth's biological parents/youth's primary caregiver
- (E) Teaches and models proper and effective parenting practice to biological parents/youth's primary caregiver
- (F) Provides information about medication compliance and relapse prevention and reports to her/his supervising licensed mental health practitioner
- (G) Provides training and rehabilitation of basic personal care and activities of daily living through training the youth and the usual biological parents/youth's primary caregiver
- (H) Assists the youth to develop positive peer relationships
- (I) Works with the biological parents/youth's primary caregiver to explore community resources in the child and families' natural setting

---

TN No. 11-10

Supersedes

TN No. New page

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

Provider Qualifications:

Agencies shall be licensed by the State of Nebraska as a Child Placing Agency and accredited by a national accrediting body. Each agency will employ licensed program/clinical directors to supervise direct care staff consistent with State licensure. The agency will also employ Professional Resource Families Care staff with the following qualifications:

- (1) Have a high school diploma or equivalent
- (2) Be 21 years of age and have a minimum of 2 years experience working with children, 2 years education in the human service field or a combination of work experience and education with one year of education substituting for one year of experience
- (3) Complete training according to a curriculum approved by State prior to providing the service
- (4) Pass child abuse check, Adult abuse registry and motor vehicle screens
- (5) Each surrogate family setting shall have a Foster Family license by the State. Each PRFC practitioner shall be supported by a Child Placing Agency with appropriate clinical supervision, training and staffing.
- (6) Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively

Unit of Service: Day unit for unlicensed direct care staff.

Limitations:

PRFC services require prior authorization. The duration of services is prior authorized. Additional days can be authorized with prior approval from Medicaid and/or its designee. Each direct care staff may only care for one child in treatment unless an exception is granted by Medicaid and/or its designee.

Services provided to children and youth shall include communication and coordination with the family and/or legal guardian. Coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination shall be documented in the youth's medical record.

---

TN No. 11-10

Supersedes

TN No. New page

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

PRFC services may not be provided simultaneously with ThGH care and do not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost as charity care. Treatment Plans shall be developed within 7 days of admission to the PRFC program and reviewed every 14 days thereafter.

PRFC service staff shall receive ongoing and regular clinical supervision through a Child Placing Agency by a person meeting the qualifications of a psychiatrist or psychologist with experience regarding this specialized mental health service, and such supervision shall be available at all times to provide back up, support, and/or consultation.

Direct care by licensed individuals is billed separately from the PRFC services per diem treatment rate for unlicensed practitioners, which does not include room and board.

4. Therapeutic Group Home

Therapeutic Group Homes (ThGHs) provide a community-based residential service in a home-like setting of no greater than eight beds under the supervision and program oversight of a psychiatrist or psychologist. The treatment should be targeted to support the development of adaptive and functional behaviors that will enable the child or adolescent to remain successfully in his/her home and community, and to regularly attend and participate in work, school or training. ThGHs deliver an array of clinical and related services within the home including psychiatric supports, integration with community resources and skill-building taught within the context of the home-like setting. ThGH treatment shall target reducing the severity of the behavioral health issue that was identified as the reason for admission. Most often, targeted behaviors will relate directly to the child or adolescent's ability to function successfully in the home and school environment (e.g., compliance with reasonable behavioral expectations; safe behavior and appropriate responses to social cues and conflicts).

---

TN No. 11-10  
Supersedes  
TN No. New page

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

Treatment shall:

- (A) Focus on reducing the behavior and symptoms of the psychiatric disorder that necessitated the removal of the child or adolescent from his/her usual living situation
- (B) Decrease problem behavior and increase developmentally-appropriate, normative and pro-social behavior in children and adolescents who are in need of out-of-home placement
- (C) Transition child or adolescent from therapeutic group home to home or community based living with outpatient treatment (e.g., individual and family therapy) if necessary.

ThGH services are utilized when less intensive levels of treatment shall have been determined to be unsafe, unsuccessful or unavailable. The child shall require active treatment on an individualized active treatment plan that would not be able to be provided at a less restrictive level of care is being provided on a 24-hour basis with licensed program/clinical directors supervising the behavioral health staff. The treatment plan shall be developed within 7 days of admission and reviewed every 14 days thereafter. The setting shall be ideally situated to allow ongoing participation of the child's family. The child or adolescent shall attend a school in the community (e.g., a school integrated with children not from the institution and not on the institution's campus). In this setting, the child or adolescent remains involved in community-based activities and may attend a community educational, vocational program or other treatment setting.

ThGHs provide twenty-four hours/day, seven days/week structured and supportive living environment. Care coordination is provided to plan and arrange access to a range of educational and therapeutic services. Psychotropic medications should be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability, when appropriate and relevant. Screening and assessment is required upon admission and every 14 days thereafter to track progress and revise the treatment plan to address any lack of progress and to monitor for current medical problems and concomitant substance use issues.

---

TN No. 11-10  
Supersedes  
TN No. New page

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

The individualized, strengths-based services and supports:

- (1) Are identified in partnership with the child or adolescent and the family and support system, to the extent possible, and if developmentally appropriate
- (2) Are based on both clinical and functional assessments
- (3) Are clinically monitored and coordinated, with 24-hour availability
- (4) Are implemented with oversight from a licensed mental health professional
- (5) Assist with the development of skills for daily living and support success in community settings, including home and school

The ThGH is required to coordinate with the child or adolescent's community resources, with the goal of transitioning the youth out of the program as soon as possible and appropriate. Discharge planning begins upon admission with concrete plans for the child to transition back into the community beginning within the first week of admission with clear action steps and target dates outlined in the treatment plan. The treatment plan shall include behaviorally-measurable discharge goals.

For treatment planning, the program shall use a standardized assessment and treatment planning tool such as the Child and Adolescent Needs and Strengths. The assessment protocol shall differentiate across life domains, as well as risk and protective factors, sufficiently so that a treatment plan can be tailored to the areas related to the presenting problems of each youth and their family in order to ensure targeted treatment. The tool should also allow tracking of progress over time. The specific tools and approaches used by each program shall be specified in the program description and are subject to approval by the State. In addition, the program shall ensure that requirements for pretreatment assessment are met prior to treatment commencing.

For service delivery, the program shall incorporate at least two research-based approaches including either Evidence-Based Practices (EBPs) or ASAM pertinent to the sub-populations of ThGH clients to be served by the specific program. The specific research-based models to be used should be incorporated into the program description and submitted to the State for approval. All research-based programming in ThGH settings must be approved by the State.

---

TN No. 11-10  
Supersedes  
TN No. New page

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

Annually, facilities shall submit documentation demonstrating compliance with fidelity monitoring for at least two research-based approaches (e.g., EBP and/or ASAM). The State shall approve the auditing body providing the fidelity monitoring. ThGH facilities may specialize and provide care for sexually deviant behaviors, substance abuse, or dually diagnosed individuals. If a program provides care to any of these categories of youth, the program shall submit documentation regarding the appropriateness of the research-based approaches. For milieu management, all programs should also incorporate some form of research-based, trauma-informed programming and training, if the primary research-based treatment model used by the program does not.

Provider Qualifications: A Therapeutic Group Home shall be nationally accredited and licensed as a mental health center or substance abuse treatment center by the Nebraska Health and Human Services System and may not exceed eight beds unless grandfathered. ThGH staff shall be supervised by a licensed psychiatrist or psychologist (supervising practitioner) with experience in the research-based treatments used in the facility. Staff includes paraprofessional, master's and bachelor's level staff supervised by a psychologist or psychiatrist. At least 21 hours of active treatment per week for each child is required to be provided by qualified staff (e.g., having a certification in the EBPs selected by the facility and/or licensed practitioners operating under their scope of practice in Nebraska and meeting ThGH licensure requirements), consistent with each child's treatment plan and meeting assessed needs. All staff not licensed shall have provider qualifications meeting at least the following:

- (1) Have a high school diploma or equivalent
- (2) Be 21 years of age and have a minimum of 2 years experience working with children, 2 years education in the human service field or a combination of work experience and education with one year of education substituting for one year of experience
- (3) Complete training according to a curriculum approved by the State prior to providing the service
- (4) Pass child abuse check, Adult abuse registry and motor vehicle screens
- (5) Be certified in: First Aid, CPR, Crisis Prevention / Management
- (6) Understand de-escalation techniques and demonstrate the ability to implement those techniques effectively

---

TN No. 11-10  
Supersedes  
TN No. New page

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of youth treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix and the consistent presence and availability of professional staff. In addition, staffing schedules should ensure the presence and availability of professional staff on nights and weekends, when parents are available to participate in family therapy and to provide input on the treatment of their child.

Unit of Service: Day unit for unlicensed direct care staff.

Limitations:

All licensed staff including psychiatrists, psychologists, Licensed Independent Mental Health Practitioners, Licensed Mental Health Practitioners, Provisionally Licensed Mental Health Practitioners, Advanced Practice Registered Nurses, and Licensed Alcohol and Drug Counselors bill for their services separately under the approved State Plan for Other Licensed Practitioners, Item 6d or EPSDT Other Licensed Practitioners. A psychiatrist or psychologist shall be the supervising practitioner and shall provide twenty-four (24) hour, on-call coverage seven (7) days a week. The psychologist or psychiatrist shall see the client at least once, prescribe the type of care provided, and, if the services are not time-limited by the prescription, review the need for continued care every 14 days. Although the psychologist or psychiatrist does not have to be on the premises when his/her client is receiving covered services, the supervising practitioner shall assume professional responsibility for the services provided and assure that the services are medically appropriate. Therapy (individual, group and family, whenever possible) and ongoing psychiatric assessment and intervention (by a psychiatrist) are required of ThGH, but provided and billed separately by licensed practitioners for direct time spent.

ThGHs are located in residential communities in order to facilitate community integration through public education, recreation and maintenance of family connections. The facility is expected to provide recreational activities for all enrolled children but not use Medicaid funding for payment of such non-Medicaid activities.

---

TN No. 11-10

Supersedes

TN No. New page

Approval Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT OF  
CONDITIONS FOUND

---

ThGHs may not be Institutions for Mental Disease. Each organization owning Therapeutic Group Homes shall ensure that the definitions of institutions are observed and that in no instance does the operation of multiple ThGH facilities constitute operation of an Institution of Mental Disease. All new construction, newly acquired property or facility or new provider organization shall comply with facility bed limitations not to exceed eight beds. Existing facilities may not add beds if the bed total would exceed eight beds in the facility. A waiver up to a maximum of 16 beds may be granted for existing facilities of greater than eight beds at the existing capacity not to exceed 16 beds in the institution until alterations of the existing facility are made. Any physical plant alterations of existing facilities shall be completed in a manner to comply with the eight bed per facility limit (i.e., renovations of existing facilities exceeding eight beds shall include a reduction in the bed capacity to eight beds).

Average Length of stay ranges from 14 days to 6 months. ThGH programs focusing on transition or short-term crisis are typically in the 14 to 30 day range. Discharge will be based on the child no longer making adequate improvement in this facility (and another facility is being recommended) or the child no longer having medical necessity at this level of care. Continued ThGH stay should be based on a clinical expectation that continued treatment in the ThGH can reasonably be expected to achieve treatment goals and improve or stabilize the child or adolescent's behavior, such that this level of care will no longer be needed and the child or adolescent can return to the community. Transition should occur to a more appropriate level of care (either more or less restrictive) if the child or adolescent is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care (e.g., child or adolescent's behavior and/or safety needs requires a more restrictive level of care, or alternatively, child or adolescent's behavior is linked to family functioning and can be better addressed through a family/home-based treatment).

---

TN No. 11-10

Supersedes

Approval Date \_\_\_\_\_ Effective Date \_\_\_\_\_

TN No. New page

ATTACHMENT 3.1-A  
Item 16  
Applies to both  
Categorically and  
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

LIMITATIONS- INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER  
AGE 21

---

This page is left blank

---

TN No. 11-10  
Supersedes  
TN No. MS-06-01

Approval Date \_\_\_\_\_

Effective Date \_\_\_\_\_

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): All covered groups

---

c. Intermediate care facility services

Provided       No limitations       With limitations\*

15. Services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a) (31) (A), to be in need of such care.

Provided       No limitations       With limitations\*  
 Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Provided:       No limitations       With limitations\*  
 Not provided.

17. Nurse-midwife services.

Provided:       No limitations       With limitations\*  
 Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

Provided:       No limitations       With limitations\*  
 Not provided.

\*Description provided on attachment.

---

TN No. 11-10    Approval Date \_\_\_\_\_    Effective Date \_\_\_\_\_  
Supersedes  
TN No. MS-04-02

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

---

Medicaid reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

Medicaid may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

Other services covered as EPSDT follow-up services will be paid according to currently established payment methodologies, i.e., inpatient hospital treatment for substance abuse treatment services will be paid according to the methodology in Attachment 4.19-A.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rates for the comparable in-person service.

Payment for Telehealth Transmission costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

Medicaid reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission shall be in compliance with the quality standards for real time, two-way interactive audiovisual transmission as set forth in state regulations as amended.

---

TN No. 11-10  
Supersedes  
TN No. 11-06

Approved \_\_\_\_\_ Effective \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Reimbursement for services is based upon a Medicaid fee schedule established by the State of Nebraska. Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual practitioners and the fee schedule and any annual/periodic adjustments to the fee schedule are published at <http://www.dhhs.ne.gov/med/provhome.htm> (Division of Medicaid and Long-Term Care website). The above mentioned fee schedule is applicable to all services reimbursed via a fee schedule. The agency's rates were set as of July 1, 2011 and are effective for services provided on or after that date.

If a Medicare fee exists for a defined covered procedure code, then Nebraska will set licensed practitioner rates at a percentage of the 2011 Medicare rate set.

Where Medicare fees do not exist for a covered code, rates will be developed using a market-based pricing methodology as described below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the Plan are available to individuals at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(30) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

The market-based pricing methodology will be composed of provider cost modeling for four key components: direct care salary expenses, employee related expenses, program indirect expenses and administrative expenses. The analysis includes national compensation studies for Nebraska to determine the appropriate wage or salary expense for the direct care worker providing each service based on the staffing requirements and roles and responsibilities of the worker, published information related to employee related expenses and other notable cost components and cost data and fees from similar State Medicaid programs. The following list outlines the major components of the cost model to be used in fee development:

- (1) Staffing Assumptions and Staff Wages
- (2) Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- (3) Program-Related Expenses (e.g., supplies)
- (4) Provider Overhead Expenses
- (5) Program Billable Units

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

TN # 11-10  
Supersedes  
TN # 10-18

Approved \_\_\_\_\_ Effective \_\_\_\_\_

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

---

(This page is left blank)

---

Transmittal # 11-10  
Supersedes  
Transmittal # MS-00-06

Approved \_\_\_\_\_

Effective \_\_\_\_\_

Nebraska SPA #11-10  
CHILDREN'S BEHAVIORAL HEALTH SERVICES

Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

**Providers receive and retain the full Medicaid payment.**

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
  - (i) a complete list of the names of entities transferring or certifying funds;
  - (ii) the operational nature of the entity (state, county, city, other);
  - (iii) the total amounts transferred or certified by each entity;
  - (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
  - (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

**The State share of the payment for each Medicaid service is through appropriations from the Legislature to the Medicaid agency.**

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

**No supplemental or enhanced payment is made.**

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

**The inpatient hospital psychiatric services for individuals age 20 and younger is paid through a fee schedule. The fee schedule payment does not exceed the providers reasonable cost of providing the service.**

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

**No payment exceeds the provider's reasonable cost of providing services.**

D11132B  
(5-12-11)