NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

December 30, 2024

James G. Scott, Director
Centers for Medicare & Medicaid Services
Kansas City Regional Operations Group
Division of Medicaid Field Operations-North
601 East 12th Street, Suite 355
Kansas City, Missouri 64106-2898

RE: Nebraska State Plan Amendment NE 24-0032

Dear Mr. Scott:

Enclosed please find the above referenced amendment to the Nebraska State Plan regarding the submission of a 1915(i) for adults with serious mental illness.

The Division of Medicaid and Long-Term Care sent notice on November 18, 2024 (attached) to the federally recognized Native American Tribes and Indian Health Programs within the State of Nebraska to discuss the impact 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 Matthew Ahern at Mattthew.Ahern@nebraska.gov or 402-430-7621. For submittal questions, please contact Dawn Kastens at Dawn.Kastens@nebraska.gov or 531-893-3779.

Sincerely,

Matthew Ahern, Deputy Director
Division of Medicaid and Long-Term Care
Department of Health and Human Services

cc: Tyson Christensen

Enclosures

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 — 0032

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
April 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 2025 $ 9,608,177
b. FFY 2026 $ 19,010,536

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Att. 3.1-i, Pgs 1-50 (new); Att. 4.19-B Pgs 1&2 (new); Att.2.2-A, Pgs 1-3 (new)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
Serious Mental Illness

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

12. TYPED NAME
Matthew Ahern

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

14. DATE SUBMITTED
December 30, 2024

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

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

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):*

Transitional Support Services, Supported Housing for Individuals with Serious Mental Illness (SH-SMI), Supported Employment Extended Services (ES)

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:*

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)*:	
	☒	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 Division of Behavioral Health (DBH)
☐	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):

The Division of Medicaid and Long-Term Care (MLTC) is the primary entity responsible for conducting and overseeing all administrative functions (numbers one through ten) of the Serious Mental Illness (SMI) 1915(i) State plan option. MLTC delegates the following functions to the Division of Behavioral Health (DBH):

- Eligibility and enrollment functions (numbers one and two).
- Review of participant service plans (number three).
- Operationalization of qualified provider enrollment activities (number six).
- Execution of Medicaid provider agreements and rules (number seven).
- Development of policies and procedures governing the State plan HCBS benefit (number nine).
- Quality assurance and improvement activities (number ten).

Certain administrative and operational functions are delegated to Nebraska's six Regional Behavioral Health Authorities (RBHAs), who are local non-state entities. The RBHAs, with oversight and assistance from MLTC and DBH, hold or share responsibility for:

- HCBS enrollment (number one).
- Eligibility evaluations (number two).
- Quality assurance activities (number ten).

RBHAs are statutorily limited from direct service provisioning.

(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):*

The Division of Medicaid and Long-Term Care (MLTC) has established conflict of interest standards within policies and procedures. These policies and procedures mirror long-standing conflict of interest standards incorporated within other home and community-based services waivers operated by the Division of Behavioral Health (DBH).

All eligibility and enrollment functions are performed by individuals staffed within DBH. Eligibility and enrollment functions are separate from all service planning and case coordination, which is the responsibility of the Targeted Case Managers. Should DBH become aware of a potential conflict of interest between eligibility and enrollment or Targeted Case Management staff, DBH will reassign the eligibility or case worker to mitigate the potential conflict. MLTC holds final responsibility for assuring the potential conflict is managed within established policies and procedures.

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	January 2025	December 2025	1,700
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 Behavioral Health (DBH)

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):*

Division of Behavioral Health (DBH) personnel perform the initial evaluation of level of need (LON). Waiver Services Specialists (WSS) complete the initial evaluation and are required to have a Bachelor's degree and professional experience in education, psychology, social work, sociology, human services, or a related field and experience in services or programs for individuals with serious mental illness.

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 initial evaluation process is conducted by a DBH Waiver Services Specialist (WSS). The initial eligibility process is completed by DBH personnel through the administration of the State-approved functional needs assessment instrument. The State-approved functional needs assessment instrument is completed through interviews of the individual and care team, as specified by the individual. The annual reevaluation process is conducted by WSS staff. The same level of need (LON) criteria as specified in box 5, are required to meet reevaluation standards. The process for the annual reevaluation includes completion of a new State-approved functional needs assessment instrument, review of the individual service plan; and Medicaid eligibility status. When eligible, the individual is maintained on the State plan option. When the participant is not eligible, because they do not meet the specified LON, the individual is removed from the waiver and the waiver case is closed. Individuals who are determined not eligible for waiver services receive written notification of their ineligibility via a notice of decision and are then eligible for a fair hearing under the state regulations when they believe the eligibility determination was made in error or the LON determination is not accurate.

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):*

The State has developed eligibility criteria in accordance with 42 CFR 441.715.

In addition to meeting the Target Group Eligibility Criteria, the individual must also meet the following Needs-Based HCBS eligibility criteria:

- *Is 19 years or older; and*
- *Is Medicaid eligible; and*
- *Meet Nebraska's definition an adult with a Serious Mental Illness as defined in Nebraska Revised Statute 44-792; and*
- *Has an assessed need to require support in two or more areas of instrumental activities of daily living, due to limitations posed by their Serious Mental Illness, based on the State's approved functional needs assessment instrument for services covered under the 1915i State Plan Option; or*
- *Is institutionalized, or is at risk of institutionalization, or placement in an assisted living facility, based on their Serious Mental Illness diagnosis, as determined by the State's approved functional needs assessment instrument.*

Note: the individual must meet the needs-based criteria above (which are less than the inpatient level of care) and does not need to currently require an inpatient level of care for enrollment. This program does not exclude individuals needing institutional levels of care from enrolling. A history of hospitalization alone does not qualify someone for inpatient admission.

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)
The State has developed eligibility criteria in accordance with 42 CFR 441.715. In addition to meeting the Target Group Eligibility Criteria, the individual must also meet the following Needs-Based HCBS eligibility criteria: • *Is 19 years or older; and*	**For children**: The level of care assessor gathers information using the interRAI Pediatric Home Care Assessment (PEDS-HC) to assess medical conditions and treatment, Activities of Daily Living (ADLs), and other considerations including behavior, communication, hearing, and vision. Children are evaluated based on the following pathways:	The following waiver eligibility criteria, which is the same as the state's ICF/DD level of care criteria, are assessed to initially determine, or evaluate, whether an individual needs services through the waiver. a. Self-care in six activities of daily living; b. Receptive and Expressive Language; c. Learning; d. Mobility; e. Self-direction;	

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
• *Is Medicaid eligible; and* • *Meet Nebraska's definition an adult with a Serious Mental Illness as defined in Nebraska Revised Statute 44-792; and* • *Has an assessed need to require support in two or more areas of instrumental activities of daily living, due to limitations posed by their Serious Mental Illness, based on the State's approved functional needs assessment instrument for services covered under the 1915i State Plan Option; or* • *Is institutionalized, or at risk of institutionalization, or placement in an assisted living facility, based on their Serious Mental Illness diagnosis, as determined by the State's approved functional needs assessment instrument.* Note: the individual must meet the needs-based criteria above (which are less than the inpatient level of care) and does not need to currently	Children age 17 or younger must have the following assessed limitations to meet nursing facility level of care (NF LOC) eligibility within the following categories: 1. Children age 0-47 Months: To be eligible, the child must have needs related to a minimum of one defined medical condition or treatment as listed in 471 NAC Chapter 43; and 2. Children age 48 months through 17 years: Nursing facility level of care (NF LOC) eligibility can be met in one of three ways: a. At least one medical condition or treatment need; b. Limitations in at least six activities of daily living (ADL); or c. Limitations in at least four activities of daily living (ADL) and at the presence of least two other considerations. **For adults**: The level of care assessor gathers information using the interRAI Home Care Assessment (interRAI-HC) to assess ADLs, risk factors, medical conditions and interventions, and	f. Capacity for Independent Living; g. Social Skills and Personality; and h. Economic Self-sufficiency.	

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
require an inpatient level of care for enrollment. This program does not exclude individuals needing institutional levels of care from enrolling. A history of hospitalization alone does not qualify someone for inpatient admission.	cognitive function. Adults age 18 and older are evaluated on the following pathways: 1. A limitation in at least three ADLs and one or more risk factors; 2. A limitation in at least three ADLs and one or more medical conditions or treatments; 3. A limitation in at least three ADLs and one or more areas of cognitive limitation; or 4. A limitation in at least one ADLs and at least one risk factor and at least one area of cognitive limitation.		

*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 Serious Mental Illness (SMI) 1915(i) State plan option is targeted to individuals who are Medicaid eligible, 19 years of age or older, and meet the Nebraska statutory requirements for SMI as specified in Nebraska Revised Code.

☐ **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: The minimum frequency for the provision of a 1915(i) State plan service is 90 days. Enrollment to the 1915(i) will remain available to the individual during periods of hospitalization (acute and temporary short-term stabilization), rehabilitation, and incarceration. During these periods 1915(i) services will not be available, unless otherwise specified by the service definitions included herein. A request to keep enrollment in the 1915(i) beyond 90 days for a participant must be based on critical health or safety concerns and other relevant factors, and is subject to approval by the Division of Behavioral Health (DBH). In all instances, Targeted Case Managers will make monthly contact with all individuals on their caseload, to ensure that services are provided as outlined in the person-centered plan, and in accordance with service requirements. This monitoring will continue when services are provided less than monthly.

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.)

The State will follow all components of the Centers for Medicare & Medicaid Services (CMS)-approved home and community-based (HCBS) settings transition plan. The transition plan was first approved by CMS in July 2019, and later revised in July 2022, for all 1915(c) waivers operated by the Division of Behavioral Health (DBH).

Specific to the 1915(i) Serious Mental Illness (SMI) State plan option, individuals are authorized to receive approved 1915(i) State plan services in community-settings provided by community-based providers. Individuals enrolled in the 1915(i) may reside in individual or family-owned homes, provider-controlled group homes, housing accessed through federal and state vouchers or through rental agreements, established in accordance with Nebraska state regulations. Providers of 1915(i) State plan services will only be authorized and enrolled as Medicaid providers when satisfying all provider qualifications as specified herein.

Unless otherwise noted within service definitions as approved under this 1915(i) State plan option, 1915(i) State plan services are prohibited from being provided to individuals who are institutionalized in a setting licensed by the Division of Public Health as a facility or institution under Nebraska Administrative Code and Statute.

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):*

Division of Behavioral Health (DBH) personnel perform the initial evaluation of level of need (LON). Waiver Services Specialists (WSS) complete the initial evaluation and are required to have a Bachelor's degree and professional experience in education, psychology, social work, sociology, human services, or a related field and experience in services or programs for individuals with serious mental illness.

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):*

Person-centered service planning is the responsibility of targeted case management (TCM). Qualifications for TCM providers serving individuals enrolled in the 1915(i) State plan option are as follows:

1. Be 20 years of age or older, and at least two years older than the individual for whom they support.
2. Have a high school diploma or equivalent, and must have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis demonstrated by at least one of the following:
    a. Bachelor's degree or higher in psychology, sociology, or a related field (preferred); or
    b. One year of coursework in the human services field; or
3. Two years of recovery experience with demonstrated skills in the treatment of individuals with a behavioral health diagnosis.

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 individual's targeted case manager provides support to the individual to actively lead in the development of their service plan. The individual also has the option to direct their targeted case manager to facilitate the service plan development meeting so the individual may actively participate as a team member.

a. **The supports and written information which are made available to the participant to direct and be actively engaged in the service plan development process**:

Prior to the service plan meeting(s), the targeted case manager works with the individual to coordinate invitations for their service plan meetings, dates, times, and locations. The process of coordinating invitations includes the individual's input for who to invite, times and locations of convenience to the individual, and the inclusion of remote meetings when feasible to enhance full and active engagement for all.

Service planning teams are comprised of people who care about and know the individual. The development process is a collaborative process between the individual, targeted case manager, and people chosen by the individual. The process provides necessary information and support to ensure the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. It reflects cultural considerations and communication needs of the individual.

The individual is present, is encouraged and assisted to participate in every aspect of their service planning as fully as they are able and choose to do so. The individual, targeted case manager, service provider(s), and other persons chosen by the individual (e.g. advocates, family members, and friends) participate in the service plan process or parts of the service plan process. Written information available for review prior to the development meeting includes available 1915(i) State plan services, the 1915(i) serious mental illness (SMI) Policy Manual, and fact sheet for the 1915(i) SMI State plan program developed by the Division of Behavioral Health (DBH), assessments to identify needs, personal goals, service preferences, and identification of health and safety risks. The individual directs the development and updates the plan. The individual's service planning team signs the service plan to indicate their participation in supporting the individual in developing a plan according their hopes and dreams.

b. **The participant's authority to determine who is included in the process**:

Persons involved in the planning process will be determined by the individual, but must at least include the individual, representatives of their prospective 1915(i) State plan service provider(s), and the targeted case manager. The individual may raise an objection to a particular provider representative and the service plan.

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):*

Nebraska's 1915(i) State plan services for individuals with serious mental illness (SMI) are voluntary, both for the individual and the provider. Choice of providers and services is based on mutual consent. Nebraska has regulations and processes in place to ensure individuals are provided information about 1915(i) State plan services and providers to facilitate informed decisions. Regional Behavioral Health Authority (RBHA) and Department of Health and Human Services (DHHS) offices are located throughout Nebraska to provide a statewide system of service coordination. The DHHS public website includes information about the responsibilities of the RBHAs and Division of Behavioral Health (DBH), service coordination and targeted case management, services funded by DHHS programs, certified 1915(i) SMI agency and independent providers, as well as links to other resources for individuals and families.

The targeted case manager provides the individual with information about and website addresses or links to local community services and supports, service coordination, services funded by DHHS and DBH, currently certified 1915(i) SMI agency and independent providers. Information about local community services and supports, and how to access available services are provided to participants who are determined to be eligible for 1915(i) SMI services at the time of eligibility determination and ongoing thereafter at service plan meetings, and more frequently as needed. Targeted case managers will assist the individual to arrange interviews with potential providers, and may assist the individual to arrange tours of potential 1915(i) providers.

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):*

The Division of Medicaid and Long-Term Care (MLTC) is the State Medicaid Agency for Nebraska, and the DBH is the division responsible for the operation of the 1915(i) SMI State plan option.

At a minimum, the team, led by the Targeted Case Manager, comes together annually to develop the service plan, and semi-annually to review the service plan. The service plan is updated during the semi-annual service plan meeting, and when circumstances occur and/or needs change the service plan may be updated following discussion and agreement via an in-person, electronic, or written communication. All functions related to service plan approval are completed by Targeted Case Manager. Targeted Case Managers are required to maintain copies of all service plans in an electronic database, access to which is provided to MLTC and DBH personnel for the purposes of conducting administrative oversight activities.

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: Transitional Support Services

Service Definition (Scope):

Transitional Support Services include two components that may be authorized by a Department of Health and Human Services (DHHS) or community provider care coordinator. The two components are supportive transitions counseling (1) and transitional one-time funding (2).

1. **Transitional supportive services** is dedicated to providing targeted outreach, engagement, and education to individuals currently residing in an institutional placement but are interested in, or actively seeking, enrollment into the community-based 1915(i) State plan option. The goal of transitional supportive counseling is to provide individuals with information about community-based settings and service options to support the choice to:

    a. Transition to independent community-based housing, which may be provisioned through the 1915(i) State plan supported housing service.

    b. Access an array of community-based services included through the 1915(i) State plan, Medicaid State plan, or locally funded Regional Behavioral Health Authority (RBHA) services.

    Transitional supportive counseling will be made available to individuals transitioning to a community-based setting prior to the availability of targeted case management services (TCM), as described in Supplement 1 to Attachment 3.1-A of Nebraska's Medicaid State plan. Afterwards, support for transitioning to a community-based setting will be reimbursed through TCM.

    Transitional supportive counseling will be provided only by DHHS or community provider care coordination staff.

2. **Transitional one-time funding** supports services and household set-up expenses not otherwise provided through the 1915(i) State plan option or through the Medicaid State plan to enable an individual participant to have opportunities for full membership in home and community-based services. Transitional one-time funding is non-recurring to support basic household set-up expenses needed for individuals transitioning from a Nebraska institution to a community-based residence where the person is directly responsible for his or her own living expenses.

    a. Institutional settings from which an individual may transition may include but are not limited to: licensed psychiatric hospitals, licensed short-term rehabilitation centers, nursing facilities, institutions for mental disease, intermediate care facilities for individuals with developmental disabilities, qualified residential treatment programs, and psychiatric residential treatment facilities.

    b. Transitional one-time funding may include essential furniture, furnishings, window coverings, food preparation items and bed/bath linens, security deposits, basic utility (i.e., water, gas, and electricity) fees or deposits, or moving expenses. Funds cannot be used to pay a rental deposit or rent, or for personal care items, food, clothing, or items and services which are not essential to supporting the move or ensuring a successful transition.

c. Transitional one-time funding may be approved when the individual does not have the funds to purchase the item or service, or the item or service is not available through another source, including relatives, friends, or any other source.

d. Transitional one-time funding has a life-time cap of $1,500. A critical health or safety service request that exceeds the limit is subject to available funding and approval by the Department of Health and Human Services (DHHS).

Transitional one-time funding may only be provided by DHHS.

Providers of Transitional Support Services will hold responsibility for coordinating with other 1915(i) State Plan service providers, as appropriate.

Transitional Support Services will be made available to an individual based on referrals from institutional settings, targeted case managers, individuals, family members, and/or other members of the community on behalf of an individual. Federal financial participation for this service will only be submitted by the Division of Medicaid and Long-Term Care (MLTC) when an individual successfully transitions to a community-based placement, and is enrolled in the 1915(i) SMI State plan option. Otherwise, reimbursement for this service will be claimed as an administrative cost under the Medicaid program.

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

To access either component of Transitional Support Services, individuals must meet the following conditions:

1. Currently residing in a qualifying institutional setting.
2. Have been referred to a provider of Transitional Support Services.
3. Individual is determined to be eligible to enrollment in the 1915(i) State plan waiver upon discharge to the community.
4. Individual will be discharged to a living arrangement in a community-based setting where they are directly responsible for living expenses.

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):*

To access either component of Transitional Support Services, individuals must meet the following conditions:

1. Currently residing in a qualifying institutional setting.
2. Have been referred to a provider of Transitional Support Services.
3. Individual is determined to be eligible to enrollment in the 1915(i) State plan option upon discharge to the community.
4. Individual will be discharged to a living arrangement in a community-based setting where they are directly responsible for living expenses.
5. Transitional one-time funding has a life-time cap of $1,500. A critical health or safety service request that exceeds the limit is subject to available funding and approval by DHHS.

Eligible individuals will have access to transitional one-time funding, regardless of utilization of the transitional supportive counseling component. Transitional supportive counseling will only be made available to individuals, prior to their eligibility to access targeted case management (TCM) services through the Medicaid State plan.

☐ Medically needy *(specify limits):*

☒	To access either component of Transitional Support Services, individuals must meet the following conditions: 1. Currently residing in a qualifying institutional setting. 2. Have been referred to a provider of Transitional Support Services. 3. Individual is determined to be eligible for enrollment in the 1915(i) State plan option upon discharge to the community. 4. Individual will be discharged to a living arrangement in a community-based setting where they are directly responsible for living expenses. 5. Transitional one-time funding has a life-time cap of $1,500. A critical health or safety service request that exceeds the limit is subject to available funding and approval by DHHS. Eligible individuals will have access to transitional one-time funding, regardless of utilization of the transitional supportive counseling component. Transitional supportive counseling will only be made available to individuals, prior to their eligibility to access TCM services through the Medicaid State plan.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Department of Health and Human Services (DHHS) – Care Coordinator	None	None	A provider of the Transitional Support Service must: • Hold an active Medicaid provider agreement. • Be 20 years of age or older, and at least two years older than the individual for whom they support. • Have a high school diploma or equivalent, and must have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis demonstrated by at least one of the following: o Bachelor's degree or higher in psychology, sociology, or a related field (preferred); or o One year of coursework in the human services field. • Two years of recovery experience with demonstrated skills in the treatment of individuals with a behavioral health diagnosis. • Have computer skills and access to the technology needed to navigate the state-mandated web-based case management system. • Be authorized to work in the United States. • Not be a legally responsible individual or guardian to the individual.

			• Meet all required DHHS policies and applicable law and regulations.
Community Provider – Care Coordinator	None	None	A provider of the Transitional Support Service must: • Hold an active Medicaid provider agreement. • Be 20 years of age or older, and at least two years older than the individual for whom they support. • Have a high school diploma or equivalent, and must have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis demonstrated by at least one of the following: o Bachelor's degree or higher in psychology, sociology, or a related field (preferred); or o One year of coursework in the human services field. • Two years of recovery experience with demonstrated skills in the treatment of individuals with a behavioral health diagnosis. • Have computer skills and access to the technology needed to navigate the state-mandated web-based case management system. • Be authorized to work in the United States. • Not be a legally responsible individual or guardian to the individual. Meet all required DHHS policies and applicable law and regulations.

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):*
Department of Health and Human Services (DHHS)	Division of Medicaid and Long-Term Care (MLTC)	Program compliance, including revalidation annually, is completed by MLTC.
Community Provider – Care Coordinator	MLTC	Program compliance, including revalidation annually, is completed by MLTC.

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:	Supported Housing for Individuals with Serious Mental Illness (SH-SMI)

Service Definition (Scope)*:*

SH-SMI is defined as a coordinated network of services serving individuals who have had a history of housing instability, related to their behavioral health diagnosis. SH-SMI serves individuals transitioning back to the community from an institutional setting, as well as individuals who are already living in a non-institutional setting, who are homeless, or who are at risk of homelessness.

SH-SMI has two integrated components, which work together to support an individual's housing needs in the short and long-term.

1. **Tenancy supports** is dedicated to providing individuals with education and building self-advocacy to find and maintain housing in the community. Tenancy supports are both the pre-tenancy and tenancy supports required for individuals to locate housing that will meet not only their behavioral health needs, but provide them with a community that supports their whole person. Tenancy supports include the following:

    a. Housing coordination with the Targeted Case Manager to use assessment results from the State-approved functional needs assessment instrument to determine: an individual's housing preferences, appropriate referrals to the full array of housing services available in the State, and potential barriers to the successful maintenance of housing.

    b. Assistance with housing application process and housing search.

    c. Evaluation of located housing units to determine safety and move-in readiness.

    d. Arranging for and supporting the transition to the new housing unit.

    e. Peer support designed to identify and address behaviors specific to the individual's diagnosis which may impact their ability to live sustainability in the community.

    f. Education and training on individual housing rights, and the role of the landlord.

2. **Safe at Home** is the SH-SMI component designed to provide individuals with staffing to support assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), for the purpose of maintaining housing and the greatest degree of independence possible. Safe at Home also includes the provision of personal care, health maintenance activities (not including those activities to be conducted under the license of a registered nurse or licensed practical nurse), supervision, and protective oversight, as determined through the State-approved functional needs assessment instrument. Documentation of the specific role of Safe at Home must be included in the person-centered service plan.

    Safe at Home's skill development may be authorized only for individuals enrolled in the 1915(i) State plan option, and does not extend to the assistance of ADLs or IADLs for roommates or family members not enrolled in the 1915(i). Safe at Home may be provided in a staffing ratio of up to no more than 1:3.

    Safe at Home may include:

a. 24/7 staffed residential care when provided by a Division of Behavioral Health (DBH)) Agency provider of Residential Habilitation – Continuous Group Home and/or an Independent contractor of Shared Living Services, contracting with a DBH Agency.

b. Intermittent supports when provided by a DBH Agency provider of Independent Living Services.

Safe at Home is not authorized to be provided during "sleep" hours when provided by a DBH Agency Provider of Independent Living services.

Neither component of the 1915(i) SH-SMI service includes skilled nursing supports, nor does SH-SMI reimburse for room and board.

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

To be eligible to receive Supported Housing for Individuals with Serious Mental Illness (SH-SMI), individuals must meet the following conditions:

1. Have an assessed need for SH-SMI services as determined by the State-approved functional needs assessment instrument.

2. Be transitioning to a setting that meets all requirements of the home and community-based settings requirements, as enumerated in Code of Federal Regulations §441.710 State plan home and community-based services under section 1915(i) of the Act.

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):*

To be eligible to receive SH-SMI, individuals must an assessed need for SH-SMI services as determined by the State-approved functional needs assessment instrument.

Tenancy supports may only be available to an individual for up to 12-months following transition to a community-based setting, but may be re-authorized by the Targeted Case Manager during periods of transitions between institutions and community-based settings.

Safe at Home is reimbursed on a daily rate, when provided by a Division of Behavioral Health (DBH) Agency provider or an Independent Contractor of Continuous Group Home or Shared Living services, respectively. If less than 10 hours a day are provided by DBH providers/contractors of Continuous Group Home or Shared Living services, services will result in reimbursement at half the daily rate.

Safe at Home is reimbursed on an hourly basis, when provided by a DBH/DD provider of Independent Living services.

There are no maximum limits to the Safe at Home component of SH-SMI.

Safe at Home is not authorized to be provided during "sleep" hours when provided by a DBH/DD Agency Provider of Independent Living services. Reimbursement for room and board is

	prohibited.
☒	Medically needy *(specify limits):*
	To be eligible to receive SH-SMI, individuals must have an assessed need for SH-SMI services as determined by the State-approved functional needs assessment instrument. Tenancy supports may only be available to an individual for up to 12-months following transition to a community-based setting, but may be re-authorized by the Targeted Case Manager during periods of transitions between institutions and community-based settings. Safe at Home is reimbursed on a daily rate, when provided by a Division of Behavioral Health (DBH) Agency provider or an Independent Contractor of Continuous Group Home or Shared Living services, respectively. If less than 10 hours a day are provided by DBH/DD providers/contractors of Continuous Group Home or Shared Living services, services will result in reimbursement at half the daily rate Safe at Home is reimbursed on an hourly basis, when provided by a DBH/DD provider of Independent Living services. There are no maximum limits to the Safe at Home component of SH-SMI. Safe at Home is not authorized to be provided during "sleep" hours when provided by a DBH/DD Agency Provider of Independent Living services. Reimbursement for room and board is prohibited.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Division of Behavioral Health (DBH) Agency	N/A	Certification by Division of Public Health (DPH) in accordance with applicable state laws and regulations.	An agency provider of Supported Housing for Individuals with Serious Mental Illness (SH-SMI) must: • Hold an active Medicaid provider agreement. • Adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement. • Have computer skills and access to the technology needed to navigate the state-mandated web-based case management system. • Be authorized to work in the United States. • Must have back-up staff designated who meet all training requirements as identified by the DBH/DD. • Have training in the following areas and maintain evidence of current certificate of completion from an accredited source, when applicable or upon request: abuse, neglect, exploitation and state law reporting requirements and prevention; cardiopulmonary resuscitation; and basic first aid. • Not be a legally responsible individual or guardian to the individual. • Not be an employee of the Department of Health and Human Services (DHHS), unless approved by DHHS as compliant with DHHS policy and applicable law and regulation. • Meet all required DHHS policies and applicable law and regulations. Direct care staff must: • Be 20 years of age or older, and at least two years older than the individual for whom they support. • Have a high school diploma or equivalent, and must have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis demonstrated by at least one of the following: o Bachelor's degree or higher in

			psychology, sociology, or a related field (preferred); or o One year of coursework in the human services field; or o Two years of recovery experience with demonstrated skills in the treatment of individuals with a behavioral health diagnosis.

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):*
Division of Behavioral Health (DBH) Agency	Division of Public Health (DPH) personnel in combination with the designated provider screening and enrollment vendor.	The program compliance is verified through the annual or biennial DPH certification survey process. The provider screening and enrollment vendor ensures revalidation of agency is completed annually and re-enrollment is completed 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: Supported Employment Extended Services (ES)

Service Definition (Scope):

Supported Employment ES is provided to individuals who have indicated achieving a goal of sustainable, competitive, integrated employment within their person-centered service plan. Supported Employment ES supports individuals, who because of their disability, need intensive, sometimes on-going support, to maintain an individual job in competitive or customized employment or self-employment, in an integrated work setting in the general workforce. Individuals eligible to utilize Supported Employment ES under the 1915(i) State plan option will have reached stabilized competitive integrated employment through Vocational Rehabilitation Supported Employment services.

The activities of Supported Employment ES will help individuals achieve and sustain competitive integrated employment and recovery following their transition from Vocational Rehabilitation Supported Employment. Supported Employment ES provided through the 1915i State plan option helps individuals to maintain and advance in individual employment absent the provision of supports, and are consistent with the individual's strengths, abilities, interests, and informed choice. Transition from Vocational Rehabilitation Supported Employment services to Supported Employment ES requires that the individual has met their goal of stable competitive employment, while still requiring or benefiting from recovery and rehabilitation supports to maintain stable community-based competitive employment. The nature of Supported Employment ES is similar to job stabilization with the level of intensity and frequency of contacts and interventions gradually reduced.

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

Individuals authorized to receive Supported Employment ES will be compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by a person without a disability. Reimbursement is made only for the adaptations, teaching and supervision required by individuals receiving Supported Employment ES services because of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting. 1915(i) funds cannot be used to compensate or supplement an individual's wages.

Federal financial participation must not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Payments made to an employer to encourage or subsidize the employer's participation in a Supported Employment ES program;

2. Payments passed through to users of Supported Employment ES programs; or

3. Payments for training not directly related to a participant's Supported Employment ES program.

This service must not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan or Vocational Rehabilitation. Documentation must include that the individual:

- Does not have an open case with Vocational Rehabilitation; or

- Has reached Stabilized Employment through the Vocational Rehabilitation Supported Employment services; and
- Has completed a job stability report or similar forms with the Supported Employment Specialist.

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

Supported Employment Extended Services (ES) is available to all individuals with documentation in their person-centered service plan indicating achieving a goal of competitive, integrated employment. Supported Employment ES is available to individuals who are currently employed, but may need additional support to remain employed, due to their disability. Individuals may access Supported Employment ES through the 1915(i) State plan option when the individual:

- Does not have an open case with Vocational Rehabilitation; or
- Has reached Stabilized Employment through the Vocational Rehabilitation Supported Employment services; and
- Has completed a job stability report or similar forms with the Supported Employment Specialist.

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):*

Supported Employment ES is available to all participates with documentation in their person-centered service plan indicating achieving a goal of competitive, integrated employment. Supported Employment ES is available to individuals who are currently employed, but may need additional support to remain employed, due to their disability. Individuals may access Supported Employment ES through the 1915(i) State plan option when the individual:

- Does not have an open case with Vocational Rehabilitation; or
- Has reached Stabilized Employment through the Vocational Rehabilitation Supported Employment services; and
- Has completed a job stability report or similar forms with the Supported Employment Specialist.

☒ Medically needy *(specify limits):*

Supported Employment ES is available to all participates with documentation in their person-centered service plan indicating achieving a goal of competitive, integrated employment. Supported Employment ES is available to individuals who are currently employed, but may need additional support to remain employed, due to their disability. Individuals may access Supported Employment ES through the 1915(i) State plan option when the individual:

- Does not have an open case with Vocational Rehabilitation; or
- Has reached Stabilized Employment through the Vocational Rehabilitation Supported Employment services; and
- Has completed a job stability report or similar forms with the Supported Employment Specialist.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Division of Behavioral Health (DBH) Agency	N/A	Certification by Division of Public Health (DPH) in accordance with applicable state laws and regulations.	An agency provider of Supported Employment for Individuals with Serious Mental Illness (Supported Employment ES) must: • Hold an active Medicaid provider agreement. • Adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement. • Have computer skills and access to the technology needed to navigate the state-mandated web-based case management system. • Be authorized to work in the United States. • Have training in the following areas and maintain evidence of current certificate of completion from an accredited source, when applicable or upon request: abuse, neglect, exploitation and state law reporting requirements and prevention; cardiopulmonary resuscitation; and basic first aid. • Not be a legally responsible individual or guardian to the individual. • Not be an employee of the Department of Health and Human Services (DHHS), unless approved by DHHS as compliant with DHHS policy and applicable law and regulation. • Meet all required DHHS policies and applicable law and regulations. Direct care staff must: • Be 20 years of age or older, and at least two years older than the individual for whom they support. • Have a high school diploma or equivalent, and must have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis demonstrated by at least one of the following: o Bachelor's degree or higher in psychology, sociology, or a related field (preferred); or o One year of coursework in the

			human services field; or o Two years of recovery experience with demonstrated skills in the treatment of individuals with a behavioral health diagnosis.
Independent Individual – Habilitative Services	N/A	N/A	An independent individual provider of Supported Employment ES must: • Hold an active Medicaid provider agreement. • Adhere to standards as described in the Division of Medicaid and Long-Term Care Service Provider Agreement. • Be 20 years of age or older, and at least two years older than the individual for whom they support. • Have a high school diploma or equivalent, and must have demonstrated skills and competencies in treatment with individuals with a behavioral health diagnosis demonstrated by at least one of the following: o Bachelor's degree or higher in psychology, sociology, or a related field (preferred); or o One year of coursework in the human services field; or o Two years of recovery experience with demonstrated skills in the treatment of individuals with a behavioral health diagnosis. • Have computer skills and access to the technology needed to navigate the state-mandated web-based case management system. • Be authorized to work in the United States. • Have training in the following areas and maintain evidence of current certificate of completion from an accredited source, when applicable or upon request: abuse, neglect, exploitation and state law reporting requirements and prevention; cardiopulmonary resuscitation; and basic first aid. • Not be a legally responsible individual or guardian to the

			individual. • Not be an employee of DHHS, unless approved by DHHS as compliant with DHHS policy and applicable law and regulation. • Meet all required DHHS policies and applicable law and regulations.

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):*
Division of Behavioral Health (DBH) Agency	Division of Public Health (DPH) personnel in combination with the designated provider screening and enrollment vendor.	The program compliance is verified through the annual or biennial DPH certification survey process. The provider screening and enrollment vendor ensures revalidation of agency is completed annually and re-enrollment is completed every five years.
Independent Individual – Habilitative Services	DPH personnel in combination with the designated provider screening and enrollment vendor.	The program compliance is verified through the annual or biennial DPH certification survey process. The provider screening and enrollment vendor ensures revalidation of agency is completed annually and re-enrollment is completed 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 – The state does not allow payments for State plan home and community-based services, approved under this 1915(i), furnished by relatives, legally responsible individuals, and legal guardians.

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):*
	Only individuals eligible to receive transitional one-time funding under the Transitional Support Services are eligible to self-direct services.

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):*

The Division of Behavioral Health (DBH) embraces a person-centered self-directed philosophy, designed to focus on what is important to individuals, and provide choice when determining the services and supports needed to maximize independence. The case manager is actively involved in supporting self-direction. The case manager supports self-direction by meeting with the participant to facilitate discussion of the participant's budget, the self-directed services available, and the rights and responsibilities associated with choosing self-directed services.

Opportunities for self-direction are available to participants who are eligible to receive the transitional one-time funding component under Transitional Support Services. This service is directed by the participant to support transitions back to community-based settings.

The Internal Revenue Service (IRS) has approved DHHS to be appointed the Fiscal/Employer agent as a means to ensure all requisite IRS rules are being followed. DHHS provides the following services in this capacity: Manage and direct the disbursement of funds contained in the participant's budget; Performing fiscal accounting and making expenditure reports to the participant and state authorities. Information regarding IRS related responsibilities is explained verbally and in writing to the participant and provider.

3. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness 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
Transitional Support Services	☐	☒

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):*

1915(i) State plan services are voluntary services for individuals. Each participant can choose services and the providers to meet their needs and preferences. The authorization of funding for services to a particular provider or providers is mutually agreed upon, and either entity can end participation.

Nebraska state regulation allows the Division of Behavioral Health (DBH) to deny or end funding of specific services when:

1. A participant's needs are not being met through 1915(i) State plan services or intensity of services and supports does not reflect the level of need for this waiver;
2. The participant has failed to cooperate with, or refused the services funded by DBH; or,
3. The participant's service plan has not been implemented. The decision to end funding may be based on case manager monitoring, review of the service plan, critical incident reports, and assessment of risk to the participant and community, or complaint investigations conducted by DBH personnel.

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.):*
	Budget authority is only available to individuals eligible to receive transitional one-time funding under the Transitional Support Services approved under this 1915(i) State plan option. The maximum lifetime allowable funding amount is $1,500. Transitional one-time funding needs are based on the results of the State-approved functional needs assessment instrument, which is also used to determine the level of need for this 1915(i) State plan option. Individuals have the ability to determine how and where to spend the authorized amount of one-time funding under Transitional Support Services. The individual's case manager will make available all policies regarding use of one-time funding during the initial and re-evaluation periods, and will document discussion regarding budget authority and self-direction in the person-centered service plan. Publicly available information is found on the Department of Health and Human Services website.
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*
	Safeguards have been established to prevent the premature depletion of the participant's budget or address potential service delivery problems associated with budget over-utilization. The Division of Behavioral Health (DBH) is responsible for ensuring the implementation of safeguards developed for the participants who are self-directing. The state-mandated web-based case management system tracks budget utilization and provides monthly reports for service coordination, management, and administrative personnel. DBH and the vendor of the state-mandated web-based case management system have developed rules within the system to highlight possible over-utilization. When potential over-utilization is identified, the participant and case manager discuss and manage adjustments to the authorized amounts.

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	1a. Service plans address assessed needs of 1915(i) recipients.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed that reflect the individual's assessed needs (including health and safety risk factors). **Numerator**: Number of service plans reviewed that reflect the individual's assessed needs (including health and safety risk factors) **Denominator:** Number of service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	**Data Source:** Record reviews, off-site **Sample Size:** Less than 100%, representative sample with a 95% confidence level within +/- 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**Agency responsible:** Division of Behavioral Health (DBH))
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	1b. Service plans are updated at least annually.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of individuals reviewed whose person-centered plans were reviewed and revised on or before the annual review date. **Numerator**: Number of individuals reviewed whose person-centered plans were reviewed and revised on or before the annual review date. **Denominator:** Number of individuals reviewed.
Discovery Activity *(Source of Data & sample size)*	**Data Source:** Record reviews, off-site **Sample Size:** Less than 100%, representative sample with a 95% confidence level within +/- 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**Agency responsible:** Division of Behavioral Health (DBH))
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	1c. Service plans document the individual's choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	**Performance measure 1:** Number and percent of individuals reviewed whose case management files document an annual choice of 1915(i) State plan services. **Numerator**: Number and percent of individuals reviewed whose case management files document an annual choice of 1915(i) State plan services. **Denominator:** Number of individuals whose case management files were reviewed. **Performance measure 2:** Number and percent of individuals reviewed whose case management files document an annual choice of 1915(i) State plan service providers. **Numerator:** Number of participants reviewed whose case management files document an annual choice of 1915(i) State plan service providers. **Denominator:** Number of individuals whose case management files were reviewed.
Discovery Activity *(Source of Data & sample size)*	**For both performance measures listed under 1c:** **Data Source:** Record reviews, offsite **Sample Size:** Less than 100%, representative sample with a 95% confidence level within +/- 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**For both performance measures listed under 1c:** **Agency responsible:** DBH
Frequency	**For both performance measures listed under 1c:** Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**For both performance measures listed under 1c:** DBH
Frequency *(of Analysis and Aggregation)*	**For both performance measures listed under 1c:** Quarterly

Requirement	2a. An evaluation for 1915(i) State plan home and community-based services (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 new 1915(i) State plan HCBS applicants, with a reasonable indication of need, for whom an eligibility evaluation was provided **Numerator**: Number of new 1915(i) State plan HCBS applicants, with a reasonable indication of need, for whom an eligibility evaluation was provided. **Denominator:** Number of new 1915(i) State plan HCBS applicants with a reasonable indication of need.
Discovery Activity *(Source of Data & sample size)*	**Data Source:** Electronic database **Sample Size:** 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**Agency responsible:** Division of Behavioral Health (DBH))
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Monthly, quarterly

Requirement	2b. The process 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 initial/annual level of need (LON) assessments in which LON criteria were appropriately applied according to the approved State plan. **Numerator**: Number of initial/annual LON assessments in which LON criteria were applied according to the approved State plan. **Denominator:** Number of initial/annual LON assessments.
Discovery Activity *(Source of Data & sample size)*	**Data Source:** Electronic database **Sample Size:** 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**Agency responsible:** Division of Behavioral Health (DBH))
Frequency	Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	2c. 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) home and community based services.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of 1915(i) enrolled individuals who are re-evaluated for eligibility at least annually, or more frequently, as specified in the approved State plan. **Numerator**: Number of 1915(i) enrolled individuals who were re-evaluated for eligibility at least annually, or more frequently, as specified in the approved State plan. **Denominator:** Number of individuals enrolled in the 1915(i) State plan.
Discovery Activity *(Source of Data & sample size)*	**Data Source:** Electronic database **Sample Size:** 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**Agency responsible:** Division of Behavioral Health (DBH))
Frequency	Continuously
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	3. Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	**Performance measure 1:** Number and percent of newly enrolled 1915(i) State plan providers who initially met state defined qualifications for their certification and/or licensure type, prior to providing 1915(i) State plan services. **Numerator**: Number of newly enrolled 1915(i) State plan providers who initially met state defined qualifications for their certification and/or licensure type, prior to providing 1915(i) State plan services. **Denominator:** Number of new 1915(i) providers providing services that were reviewed. **Performance measure 2:** Number and percent of enrolled 1915(i) State plan providers who meet state defined qualifications for their certification and/or licensure type, at the annual screening. **Numerator**: Number of enrolled 1915(i) State plan providers who meet state defined qualifications for their certification and/or licensure type, at the annual screening. **Denominator:** Number of enrolled 1915(i) providers providing 1915(i) services that had an annual screening that were reviewed.
Discovery Activity *(Source of Data & sample size)*	**For both performance measures listed under 3:** **Data Source:** Record reviews, off-site **Sample Size:** Less than 100%, representative sample with a 95% confidence level within +/- 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**For both performance measures listed under 3:** **Agency responsible:** Division of Behavioral Health (DBH))
Frequency	**For both performance measures listed under 3:** Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**For both performance measures listed under 3:** DBH

Frequency *(of Analysis and Aggregation)*	**For both performance measures listed under 3:** Quarterly

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 setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with HCBS setting requirements. **Numerator**: Number of setting assessments completed where the provider was either compliant or progressing toward a plan for compliance with HCBS setting requirements **Denominator:** Number of setting assessments completed
Discovery Activity *(Source of Data & sample size)*	**Data Source:** Electronic database **Sample Size:** 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**Agency responsible:** Division of Behavioral Health (DBH))
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DBH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	5. The State Medicaid Agency retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of annual reports submitted by the Division of Medicaid and Long-Term Care (MLTC) to the Centers for Medicare and Medicaid Services (CMS), timely. **Numerator**: Number of annual reports submitted to CMS timely. **Denominator:** Number of annual reports due.
Discovery Activity *(Source of Data & sample size)*	**Data Source:** Annual report submissions **Sample Size:** 100% review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**Agency responsible:** MLTC
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MLTC
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	6. The State Medicaid Agency maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	
Discovery Evidence *(Performance Measure)*	**Performance measure 1:** Number and percent of paid claims reviewed that were paid in accordance with the authorized services documented on reviewed service plans. **Numerator**: Number of paid claims reviewed that were paid in accordance with the authorized services documented on reviewed service plans. **Denominator:** Number of paid claims reviewed. **Performance measure 2:** Number and percent of paid claims reviewed that were supported by documentation that services were rendered. **Numerator**: Number of paid claims reviewed that were supported by documentation that services were rendered. **Denominator:** Number of paid claims reviewed.
Discovery Activity *(Source of Data & sample size)*	**For both performance measures listed under 6:** **Data Source:** Records review, on and off-site, Electronic database **Sample Size:** Less than 100%, representative sample with a 95% confidence level within +/- 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**For both performance measures listed under 6:** **Agency responsible:** Division of Medicaid and Long-Term Care (MLTC)
Frequency	**For both performance measures listed under 6:** Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**For both performance measures listed under 6:** MLTC
Frequency *(of Analysis and Aggregation)*	**For both performance measures listed under 6:** Quarterly

Requirement	7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	**Performance measure 1:** Number and percent of individuals reviewed who received information/education about how to identify and report abuse, neglect, and exploitation. **Numerator**: Number of individuals reviewed who received information/education about how to identify and report abuse, neglect, and exploitation. **Denominator:** Number of individuals reviewed. **Performance measure 2:** Number and percent of abuse, neglect, exploitation incidents that were reported by provider in the incident management system as required by Division of Behavioral Health (DBH)) policies and approved 1915(i) State plan amendment. **Numerator**: Number of abuse, neglect, exploitation incidents that were reported by provider in the incident management system as required by DBH policies and approved 1915(i) State plan amendment. **Denominator:** Number of abuse, neglect, and exploitation incidents reviewed. **Performance measure 3:** Number and percent of reportable incidents reviewed that were reported by provider timely in the state incident management system as specified in DBH policies. **Numerator**: Number of reportable incidents reviewed that were reported by provider timely in the state incident management system as specified in DBH policies. **Denominator:** Number of reportable incidents reviewed. **Performance measure 4:** Number and percent of substantiated abuse/neglect/exploitation critical incidents reviewed where the resolution was completed as required by DBH policies. **Numerator**: Number of substantiated abuse, neglect, and exploitation critical incidents reviewed where the resolution was completed as required by DBH policies. **Denominator:** Number of substantiated abuse, neglect, and exploitation critical incidents reviewed.
Discovery Activity *(Source of Data & sample size)*	**For all performance measures listed under 7:** **Data Source:** Record reviews, off-site/electronic database **Sample Size:** Less than 100%, representative sample with a 95% confidence level within +/- 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	**For all performance measures listed under 7:** **Agency responsible:** Division of Behavioral Health (DBH))

Frequency	**For all performance measures listed under 7:** Continuously and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	**For all performance measures listed under 7:** DBH
Frequency *(of Analysis and Aggregation)*	**For all performance measures listed under 7:** Quarterly

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

The Division of Behavioral Health (DBH) Quality Improvement (QI) Strategy uses an evidence-based tiered approach, which includes a number of activities and processes at both the local and state levels. This system has been developed to discover whether the federal waiver assurances are being met, to remediate identified problems, and to carry out quality improvement.

The DBH QI efforts for 1915(i) State plan services are coordinated through the DBH QI Committee comprised of (at a minimum), representatives from DBH Central Office, Division of Medicaid and Long-Term Care (MLTC), and the Regional Behavioral Health Authorities (RBHAs). The QI Committee meets at least quarterly and reviews data and reports including, but not limited to, statewide monitoring, critical incidents, complaints and investigations, 1915(i) State plan performance measures, service utilization, post-payment claims, and certification surveys to identify trends and consider statewide changes to support service improvement.

The continuing efforts are to oversee and refine the formal design and implementation of QI systems allowing for systematic oversight of services across the state by the QI Committee, while ensuring utility of the information at the local level. A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The minutes of QI Committee quarterly meetings document review of reports and data, identification of areas of concern, and recommendations and assignment of tasks for remediation, both to address identified issues and to proactively decrease the likelihood of similar problems occurring in the future. A continuous evaluation component is built into the system for evaluation of utility, information received, and effectiveness of strategies.

2. Roles and Responsibilities

DBH is responsible for monitoring and assessing system design changes, collecting and analyzing information, determining whether the waiver requirements and assurances are met, ensuring remediation, and planning system improvement activities. The DBH Director and DBH personnel are responsible for coordinating the development, implementation and monitoring of any system design changes. The DBH Director works closely with the DBH QI Committee to assure the appropriate identified priority system issues are developed, implemented, and monitored to assure system change occurs.

The QI Committee receives reports and information and provides/shares feedback and support to the RBHAs. DBH makes all meeting minutes and reports available to the Medicaid Director for their review. DBH Central Office personnel design and monitor services, including specific performance related to service and remediation. Discovery methods under DBH Central Office are expenditure and utilization monitoring; technical assistance; professional research, observation and insight; and analysis of data sources.

The DBH QI personnel provide systemic review of program outcomes and standards compliance to establish continuous improvement. Both DDD Central Office and QI personnel are involved in discovery related to, complaints, incident reports, and data collection and analysis. In addition to DBH Central Office and QI personnel, a contracted quality improvement organization (QIO)-entity is also involved in the discovery, data collection, and reporting related to mortality review. The contracted QIO compiles and produces reports related to mortality reviews, which are analyzed by DBH personnel, DBH administration and the QI Committee. QI reports include data from mortality review, appeals, supervisory file review, Central Office file review, critical incident, state-mandated web-based case management system reports, post-payment claims, and service authorizations. These reports are compiled by DBH personnel and analyzed by the DBH administration and the QI Committee at least annually and as needed. When a provider is cited during certification review or complaint investigation and it is determined a plan of improvement is required, DBH and MLTC personnel monitor the plan of improvement to assure completion.

3. Frequency

Data is reviewed on at least a quarterly basis through the QI Committee. Appropriate recommendations, action plans, and follow-up are documented in the QI Committee minutes.

4. Method for Evaluating Effectiveness of System Changes

Quality improvement (QI), program management, and administrative personnel in the Division of Behavioral Health (DBH) evaluate the effectiveness of the 1915(i) State plan QI system on an ongoing basis.

Quality improvement strategies stratify information for each 1915(c) waiver and 1915(i) State plan, as well as services funded by state general funds only. The Division of Medicaid and Long-Term Care (MLTC) oversees the implementation of the 1915(i) State plan and all identified State plan system issues are relayed to MLTC personnel responsible for services under 1915(i). System design change recommendations will be made to MLTC before implementation.

The evaluation of DBH's QI strategy involves assessing the effectiveness of the system in improving the quality of services as well as comparing the system to best practices. When efforts to improve the quality of services are not effective, additional analyses are conducted to identify weaknesses in the current QI strategy. These analyses aid in identifying potential changes to improve the efficacy of the overall system.

In addition, the QI Committee provides an additional review of the effectiveness of the QI strategy and makes recommendations for improvement. The QI strategy is evaluated on various levels in a systematic basis. Information reviewed by the QI Committee is reviewed to assess the reliability and thus, validity of the information being presented each time a committee meeting is held. There is also a self-correcting nature based on strategies used to effect systems change. As the QI strategy has become more mature, the development of remediation strategies becomes influenced by the history of prior efforts. The historical access to and cooperation with various levels of personnel and resources as well as the efficacy of historical strategies all influence the development of new remediation strategies. The QI strategies are evaluated at a minimum once during the waiver period and prior to renewal. Just as the assumption is that services can always be improved, the same concept also holds with the QI strategy. Efforts are continually made to identify areas of improvement. These include modifying data collection systems to reduce error and increase the validity of the information gathered, developing additional monitoring systems to ensure the maintenance of system improvements, and eliciting additional feedback from agencies and providers regarding QI issues. New technology also leads to system changes and improvements in QI strategies. As new and updated web applications become available, data and processes for gathering and analyzing data are reviewed, which may lead to new strategies.

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)

Transitional Support Services:

The rate for Transitional Support services was established by comparing the 1915(i) service definition to similar covered Medicaid and 1915(c) waiver services. Medicaid will pay the lower of: the provider's submitted charge; or the maximum allowable fee established by the Division of Medicaid and Long-Term Care (MLTC).

Payment for the transitional one-time funding component has a lifetime cap of $1,500, and is aligned with similarly available services under the 1915(c) Comprehensive Developmental Disability (CDD) and Developmental Disabilities Adult Day (DDAD) waivers.

Supported Housing for Individuals with Serious Mental Illness (SH-SMI):

The rate for SH-SMI was established by comparing the 1915(i) service definition to similar covered Medicaid and 1915(c) waiver services. Medicaid will pay the lower of: the provider's submitted charge; or the maximum allowable fee established by the Division of Medicaid and Long-Term Care (MLTC).

Safe at Home is reimbursed on a daily rate, when provided by a Division of Behavioral Health (DBH) Agency provider or an Independent Contractor of Continuous Group Home or Shared Living services, respectively. If less than 10 hours a day are provided by DBH providers/contractors of Continuous Group Home or Shared Living services, services will result in reimbursement at half the daily rate

Safe at Home is reimbursed on an hourly basis, when provided by a DBH provider of Independent Living services.

There are no maximum limits to the Safe at Home component of SH-SMI.

Safe at Home is not authorized to be provided during "sleep" hours when provided by a DBH Agency Provider of Independent Living services.

Reimbursement for room and board is prohibited.

Supported Employment for Individuals with Serious Mental Illness (Supported Employment ES):

The rate for Supported Employment ES was established by comparing the 1915(i) service definition to similar covered Medicaid and 1915(c) waiver services. Medicaid will pay the lower of: the provider's submitted charge; or the maximum allowable fee established by MLTC.

Non-medical transportation to and from the employment site is not a reimbursable activity under Supported Employment ES.

Reimbursement is made only for the adaptations, teaching and supervision required by individuals receiving Supported Employment ES services because of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting. 1915(i) funds cannot be used to compensate or supplement an individual's wages.

Federal financial participation must not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Payments made to an employer to encourage or subsidize the employer's participation in a Supported Employment ES program;

2. Payments passed through to users of Supported Employment ES programs; or

3. Payments for training not directly related to a participant's Supported Employment ES program.

This service must not overlap with, supplant, or duplicate other comparable services provided through the Medicaid State Plan or Vocational Rehabilitation. Documentation must include that the individual:

- Does not have an open case with Vocational Rehabilitation; or
- Has reached Stabilized Employment through the Vocational Rehabilitation Supported Employment services; and
- Has completed a job stability report or similar forms with the Supported Employment Specialist.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☒ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

1. For the qualified pregnant women and children (1902)(a)(10)(A)(i)(III), the poverty level pregnant women and children (1902(a)(10)(A)(i)(IV), (VI) and (VII)), the optional groups of children under age 21 and caretaker relatives (1902(a)(10)(A)(ii)(I)), and pregnant women under 1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(A), declared winnings, interest, and dividends of less than $10 per month are excluded as income.

2. For the qualified pregnant women and children (1902)(a)(10)(A)(i)(III), the poverty level pregnant women and children (1902(a)(10)(A)(i)(IV), (VI) and (VII)), the optional groups of children under age 21 and caretaker relatives (1902(a)(10)(A)(ii)(I)), and pregnant women under 1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(A), and the medically needy (1902(a)(10)(C)(i)(III), effective November 1, 2002, disregard $100 of gross earned income per working individual as a work-related expense deduction in determining countable income.

3. For Working Disabled individuals as defined in Section (1902)(a)(10)(A)(ii)(XIII) of the Act, the following income standard applies: Disregard all earnings plus unearned income contingent upon a trial work period (such as a Social Security Trial Work Periods). In determining eligibility for SSI in the individual eligibility determination required under Section 4733 of the Balanced Budget Act.

4. For pregnant women under 1902(a)(10)(A)(ii)(IX) and 1902 (l)(1)(A) of the Act, disregard the amount of income between 150% FPL and 185% FPL.

5. For persons eligible as Qualified Medicare Beneficiaries1902(a)(10)(E)(i) and1905(p)(1), the Specified Low-Income Beneficiaries 1902(a)(10)(E)(iii), the Qualifying Individuals 1902(a)(10)(E)(iv), the Working Disabled 1902(a)(10)(ii)(XIII) and the Aged and Disabled 1902(a)(10)(A)(ii)(X) disregard the amount of income equal to the monthly premiums paid for private/commercially available health insurance plans.

6. For Working Disabled individuals as defined in Section 1902(a)(10)(A)(iii)(XIII) of the Act, the following more liberal resource methodology applies: Disregard an additional $2,000 per individual for a total of $4,000 per individual and an additional $3,000 per couple for a total of $6,000 per couple. The purpose of this additional resource disregard is to aid in achieving self-sufficiency.

☐OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* ___%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, and Baltimore, Maryland 21244-1850.