Project Narrative

RURAL HEALTH NEEDS AND TARGET POPULATION

Nebraska is the definition of rural. Nearly 95% of the State's counties are defined as rural or frontier according to the Health Resources and Services Administration (HRSA) definition and United States Census Bureau population density, respectively. Nebraska has one major interstate that crosses east to west through the middle of the State and the drive takes nearly 8 hours. There is a central highway that crosses from north to south which is a mix of two-lane and four-lane sections. The interstate and central highway intersect in York, Nebraska which is nearly 3 hours from the north border, 3 hours from the south border, 2.5 hours from the east border, and nearly 5.5 hours and 6 hours to the west and southwest borders. Crossing into Nebraska on the east border, the furthest one can drive before you are in a rural county is only 70 miles. Due to workforce shortages and care deserts, a pregnant woman may need to drive over two hours just for a routine clinic visit and a complex diabetic patient needing to see an endocrinologist may need to drive over four hours. The roads to access those physicians are often two-lane roads with no hard shoulder on the side of the road. In the summer months temperatures can reach a heat index of over 105 degrees F, and wind-chill can reach -15 degrees F in winter months, making trips to the doctor dangerous for elderly patients. More than one-third of Nebraskans live in these rural and frontier areas with critical workforce shortages and limited access to family practice physicians, specialty care providers such as obstetricians, and behavioral health services.

Heart disease, cancer, and diabetes are all in the top ten leading causes of death and the high chronic disease burden in Nebraska, combined with a health care system that relies on the status quo of mainly face-to-face visits, creates an environment primed for a failing health care

infrastructure. In addition to health care access challenges, over 36% of Nebraska adults are clinically obese and 28% of adolescents are considered overweight or obese. Intensifying the situation, 48 of 93 counties meet the criteria for a food desert and a larger number have limited access to fresh foods.

Nebraska has the collective will to address health care issues in rural and frontier counties, and as an agricultural State, it is uniquely situated to address rural health care challenges. Partnerships between the agricultural and health care sectors can tackle the dichotomy of circumstances plaguing Midwesterners today: obesity in the midst of food deserts, lack of maternal care in the center of a heartland that is committed to family values, and an increasing interest among citizens in consumer-facing technology in a population that is aging. Nebraska aims to create a prevention-first and technology-enabled, sustainable health care system that will close care gaps, increase access, and develop health care workforce pipelines.

This will be accomplished through the strong partnerships that exist between the Nebraska Department of Health and Human Services (DHHS), health care provider associations, schools, farmers, ranchers, local extension offices, and other State agencies. This also includes partnerships with the four federally recognized Tribes in Nebraska – Omaha Tribe of Nebraska, Ponca Tribe of Nebraska, Santee Sioux Tribe of Nebraska, and Winnebago Tribe of Nebraska – as well as other tribal communities in rural areas throughout the State. DHHS, a super agency comprised of the Division of Public Health (DPH), Division of Behavioral Health (DBH), Division of Medicaid and Long-Term Care (MLTC), Division of Children and Family Services, and Office of Economic Assistance (OEA), will be the governor-appointed State agency of the Rural Health Transformation Program (RHTP). DHHS will partner with the Rural Health Advisory Commission (RHAC), a governor-appointed commission representing rural health

care, including rural providers, medical schools, and consumers, for program oversight. Nebraska will use RHAC as the formal forum for coordination, oversight, and stakeholder engagement for RHTP.

The health and economic vitality of rural Nebraska is in jeopardy. The comprehensive transformation envisioned by the RHTP will support rural communities in addressing escalating health crises and an evolving health care innovation landscape. With RHTP, Nebraska can create a resilient, modern system that supports healthy people and thriving rural economies. A map of Nebraska's rural and frontier counties, along with the counties' corresponding Federal Information Processing Standards (FIPS) codes is Figure 1 in the Other Supporting Documentation section.

RURAL DEMOGRAPHICS: Nebraska is a geographically large, predominantly rural State spanning 77,000 square miles with 88 of its 93 counties are classified as rural or designated as frontier, and of our 1.96 million residents, 37% reside in the rural or frontier areas.[1] The population is aging. By 2030 the number of residents over 65 is projected to grow by nearly 30%.[2,3]

Agriculture is a primary industry in rural Nebraska, producing high-quality food products that feed people across the world and support one in four jobs across the State.[4] The agricultural workforce struggles with access to care, occupational health risks, and behavioral health issues. While Nebraska's unemployment rate is relatively stable at 3%, one of the lowest in the country, many rural Nebraskans face economic hardship and are underemployed.[5]

Category	Statistics in Nebraska
Economic Hardship	• Rural Nebraskans have a lower per-capita income and a higher poverty rate compared to those in urban areas.[6] • In 2022, 23.8% of women aged 18-54 reported living below the Federal Poverty Level (FPL).[7]

Category	Statistics in Nebraska
	• In 2022, nearly 200,000 Nebraskan (10%) lived below the federal poverty rate, meaning about 10% of people in Nebraska live in poverty.[8] • In 2023, 287,240 people were food insecure or facing hunger, and of them, 91,930 were children.[9]
Lack of Coverage and Access	• In 2023 only 60.1% of children were adequately insured which is significantly lower than the national rate of 66.5%[10] • In 2022, 6.1% of Nebraskans lacked health insurance coverage, with 4.6% of children younger than 19 being uninsured.[11,12] • Between 2017 and 2023 Nebraska lost 57 primary care physicians, and by 2030, the number of primary care physicians is expected to decline by another 9%.[13]

HEALTH OUTCOMES: Nebraskans living in rural areas tend to be at higher risk for negative health outcomes. In 2022, 72.5% of Nebraskans living in rural areas reported being overweight or obese, a known risk factor for preventable disease including cardiovascular disease and diabetes. The suicide rate among rural Nebraskans is also higher than among urban Nebraskans, and the gap continues to widen.[14,15] In 2023, the infant mortality rate in rural Nebraska was 7.2 per 1,000 live births, higher than the national average, compared to 6.3 in large urban areas, and in 2024, 4.1% of women in rural Nebraska had pre-pregnancy hypertension compared to 3.5% in large urban areas, putting them at higher risk for pre-term birth.[16,17] Nearly 52% of Nebraska counties are maternity care deserts which means pregnant women have to drive long distances for standard prenatal care, and the lack of maternal specialists in rural areas contributes to the high mortality rate. Many children in Nebraska do not receive adequate preventive health services. Older housing with lead-based paint and lead pipes in rural areas can cause high blood lead levels, which in turn contributes to behavioral and learning issues. Early detection of high lead levels is imperative to prevent lifelong complications. In 2023, only 16.5% of rural children received a blood lead test compared to 28.2% of urban children.[18] Dental deserts are spread throughout the State. Only 62.5% of adults reported visiting a dentist or dental clinic in the last year and children living in rural areas have higher rates of tooth decay compared to children in urban areas.[19,20] Native Americans in Nebraska face significant health challenges, with rates of

inadequate prenatal care that are 2.7 times higher, depression rates that are 1.4 times higher, and sexually transmitted diseases that are 5.3 times higher compared to other populations in the State.[21]

Nebraska has experienced notable growth in its aging population. As of 2021, 16% of Nebraskans were age 65 and older, a share that is projected to grow to 20% by 2030.[22] While the proportion of Nebraska's population over age 60 is growing, the proportion under 60 is contracting.[23] Currently 35.9% of adults age 65 and older live in a rural area, higher than the national average of 24.1%.[24,25] Please see Figures 7 and 8 in the Other Supporting Documentation section for charts showing the disproportionately older population in Nebraska rural counties as compared to statewide. An aging population introduces special challenges in rural areas, especially for managing chronic conditions and age-related illnesses like dementia. Older adults often require more frequent medical visits, long-term care, and specialized services, yet rural areas face workforce shortages and limited access to facilities, exacerbated by recent nursing home closures.[26] Please see Figure 2 for a map of Primary Care Health Professional Shortage Areas (HPSAs), Figure 3 for a map of Obstetrics, Family Medicine, Dental, and Behavioral Health HPSAs, and Figure 4 for Dental HPSAs in the Other Supporting Documentation section.

HEALTH CARE ACCESS: In rural Nebraska, rural residents must travel long distances to see providers. This can become a barrier to receiving necessary care which can contribute to poor health outcomes particularly for time-sensitive conditions. Please see Figures 9-13 for maps illustrating the vast travel times for Nebraskans residing in shortage areas and care deserts, including for maternity care, mental health services, dental services, and long-term care in the Other Supporting Documentation section. These challenges are compounded by provider

shortages that impact nearly every aspect of rural health care. While real-time video telehealth offers the potential to address access gaps, nearly 22% of rural Nebraskans lack high-speed internet service.[27] Nebraska will need to be transformative in its adoption of remote patient monitoring (RPM), which requires significantly less broadband than video telehealth, in order to bring health care closer to where patients live and address gaps in care.

Category	Statistics in Nebraska
Time & Distance as a Barrier to Care	• The average rural Nebraskan lives about 130 miles (219-minute drive) from a Level I Trauma center. • The average woman of reproductive age in rural Nebraska lives about 99 miles (168-minute drive) from a perinatology specialist. • More than half of Nebraska counties are designated maternity care deserts.[28] • Nebraska only has two crisis stabilization centers. Patients needing crisis services may need to drive over 4 hours to receive specialized time-sensitive care. .[29,30]
Provider Shortages	• 66 counties are primary care shortage areas, 61 are dental shortage areas, and 88 are designated psychiatry and mental health shortage areas.[31] • 20% of physicians currently practicing in Nebraska have indicated they plan to retire within the next 10 years.[32] • 26% of counties do not have a behavioral health provider.[33] • Utilization of Nebraska's 988 Crisis line rose nearly 23% in 2025 compared to 2024, demonstrating increased demand for behavioral health services.[34]
Limited Emergency Services	• 71 counties have an ambulance desert, meaning a person is more than 25 minutes away from the nearest ambulance station. • 80% of Nebraska's Emergency Medical Services (EMS) agencies rely entirely on volunteer staff who do not receive regular wages.[35]

Please find maps of the Health Care Facilities and Ambulance Deserts and Birthing Hospital Travel Time as Figures 5 and 9 respectively in the Other Supporting Documentation section.

RURAL FACILITY FINANCIAL HEALTH: Nebraska's health care system is the definition of rural health care. Rural hospitals make up over 68% of hospitals in Nebraska as compared to 35% nationally.[36,37] Rural hospitals and clinics are part of the safety net system in Nebraska, but despite their critical role, these facilities often operate with thin margins due to lower volumes, high fixed costs (e.g., staff, equipment, facility upkeep), and payer mix challenges. The financial fragility of Critical Access Hospitals (CAHs) in Nebraska is widespread as nearly 60% ran

deficits in 2024.[3839,40] Hub-and-spoke models to right-size facility operations and ensure sustainable access to care is a key solution to solving the health care access issue in Nebraska.

Facility Type	Number of Facilities in Nebraska
Birthing Facilities	44
Critical Access Hospitals	62
Rural Health Clinics (Medicare-certified)	127
Federally Qualified Health Centers	7
Certified Community Behavioral Health Clinics	7
Indian Health Service Clinics	8

TARGET POPULATIONS AND GEOGRAPHIC AREAS: This application targets rural and frontier residents in Nebraska, particularly women of reproductive age, children and adolescents, adults with chronic preventable conditions such as diabetes and metabolic syndrome, adults over 65 and dual eligible patients, adults and children requiring dental care, individuals with unmet behavioral health needs, and families living below 200% of the FPL. Priority geographic areas include Nebraska's 88 HRSA-designated rural counties, which includes 30 frontier counties, as listed by FIPS code in the Other Supporting Documentation section of this application, tribal communities in rural areas, and counties adjacent to frontier counties and counties with tribal lands. Other target geographic areas include counties with high rates of infant and maternal mortality, EMS volunteer reliance, high health care workforce vacancy rates, and those with a lack of Supplemental Nutrition Assistance Program (SNAP) Employment and Training (E&T) programs. Additionally, this application targets counties with hospitals at risk of closure, counties with limited digital infrastructure, and counties with food, maternity, dental care, and behavioral health deserts.

RURAL HEALTH TRANSFORMATION PLAN: GOALS AND STRATEGIES

STRATEGIC GOALS ALIGNMENT AND PROGRAM KEY PERFORMANCE

OBJECTIVES: With rural residents making up a significant proportion of Nebraskans, high-

quality rural health care delivery remains essential to meeting the needs of the State. Nebraska designed its RHTP to focus on seven initiatives that align with the RHTP five strategic goals.

Nebraska RHTP Initiative	Aligned RHTP Strategic Goal(s)
Initiative 1: Make Rural Nebraska Healthy Again Through Food as Medicine	Making Rural America Healthy Again, Sustainable Access, Innovative Care
Initiative 2: Regionalized Rural Access and Navigation	Making Rural America Healthy Again, Sustainable Access, Workforce Development, Innovative Care
Initiative 3: Rural Workforce Acceleration	Workforce Development
Initiative 4: eHealth and Mobile	Sustainable Access, Workforce Development, Innovative Care
Initiative 5: Rural Emergency Behavioral Health	Sustainable Access, Innovative Care, Technology Innovation
Initiative 6: Assisted Living Facility (ALF) Special Needs Population Incentive Model	Sustainable Access, Workforce Development
Initiative 7: Nebraska Rural Health Technology Catalyst Fund and Partnership Initiative (NETECH)	Technology Innovation

Within the seven RHTP initiatives are projects that will work together to achieve the following key programmatic objectives by FY 2031: increase access to healthy whole foods to reduce risk of chronic conditions; improve recruitment and retention of health care professionals in rural communities; increase care access in rural communities through the establishment of a statewide hub-and-spoke system of regionalized care and technology-enabled services; build a continuum of behavioral health services; and modernize assisted living facilities to improve outcomes and reduce costs for individuals with complex behavioral and physical health conditions. To measure progress and impact across all initiatives throughout the funding period, Nebraska developed specific and measurable outcome metrics with baseline data and targets, as detailed in the Metrics and Evaluation Plan section of this application.

IMPROVING ACCESS AND OUTCOMES: To improve access for rural residents, Nebraska will implement regional strategies across preventive care, maternal health, community

paramedicine (CP), facility transformation, emergency behavioral health care, and the rural health care workforce pipeline. For example, Nebraska will utilize the mobile integrated health model engaging community health workers (CHW) and CP providers to deliver in-home services such as post-discharge checks, behavioral health support, and wound care, along with remote care services for chronic disease management and subacute in-home monitoring.

By increasing access to care as well as promoting healthy living, Nebraska's RHTP aims to achieve measurable improvements in rural health outcomes. For example, Nebraska will equip schools with knowledge and support to provide healthy meals for children to lower obesity risk. By increasing integrated primary care sites, which co-locate behavioral health providers in physician clinics, Nebraska will improve access to ambulatory behavioral health services before conditions reach a higher level of need. Please see more details throughout the Project Narrative, especially Initiative 1: Make Rural Nebraska Healthy Again Through Food as Medicine, Initiative 2: Regionalized Rural Access and Navigation, Initiative 4: eHealth and Mobile, and Initiative 5: Rural Emergency Behavioral Health.

PARTNERSHIPS: The current reality: Nebraska is a state that relies heavily on blended state-provider-community partnerships. In Nebraska, we collectively carry the burden of a struggling rural health care system, feel the pain of preventable outcomes when care is out of reach, and celebrate success when a community recruits a needed provider or statewide quality health scores improve. As a State, we are a mighty alliance that jumps all in when a problem is identified and work together to find solutions. Nebraska's implementation of the RHTP initiatives will be collaboration-driven, leveraging existing partnerships and developing new agreements, maximizing economies of scale, and sharing best practices in rural health care

delivery. The State's approach to collaboration and stakeholder engagement will support the success of building an interconnected infrastructure for rural communities and foster innovation.

Nebraska will sustain engagement through a formalized governance and stakeholder advisory structure that ensures ongoing participation and transparency throughout implementation. Please see more details on the partners that Nebraska will engage in each proposed initiative's Key Stakeholder section throughout this application.

WORKFORCE: Nebraska will implement a statewide "grow local" strategy that will recruit, train, and retain a robust workforce in rural areas. Nebraska will launch the Rural Workforce Acceleration program to develop and recruit vital clinical disciplines. To maintain continuous skills transfer and reinforce team-based competency, Nebraska will also establish a statewide, telehealth-enabled network that will deliver Virtual Reality/Augmented Reality (VR/AR)-based training to rural providers. Please see more detail in Initiative 3: Rural Workforce Acceleration.

TECHNOLOGY USE AND DATA-DRIVEN SOLUTIONS: Nebraska will leverage emerging technologies to achieve the goals of Making Rural Nebraska Healthy Again and sustainable access to care. The State will use data dashboards to monitor local purchasing rates of healthy whole foods by schools, nutritional quality of school menus, and student participation trends in its implementation of a statewide "School Food Learning Lab." Nebraska will leverage AI-assisted Remote Patient Monitoring (RPM), telehealth-enabled crisis response, and electronic health record (EHR)-integrated wearable sensors to proactively manage chronic diseases, reduce preventable health crises, and increase access to preventive care in rural and tribal communities. The State will evaluate new technologies using a structured framework that assesses clinical impact, usability, interoperability, sustainability, and alignment with rural and tribal needs, incorporating input from rural providers and communities through pilot testing and advisory

councils. Nebraska will use real-time, multi-level data to identify gaps, monitor outcomes, drive continuous quality improvement tailored to the unique needs of rural communities, and guide future scaling and investment decisions.

For example, Nebraska will deploy an EHR-integrated, hospital-to-home RPM option for individuals requiring, for example, prenatal and postnatal care, chronic disease management, acute care patients, and the elderly that includes continuous, multi-parameter wearable sensors (e.g., heart rate, respiratory rate, temperature) where appropriate, with AI-assisted protocols routed to clinicians, CHWs, and telehealth providers for timely intervention. Additionally, the State will employ telehealth technology to ensure all rural and frontier law enforcement agencies in the western portion of the State have access to mobile crisis providers. Nebraska will also launch NETECH to identify, vet, and support scalable health technology solutions that address critical health care access needs and sustainability challenges. Please see more details throughout the Project Narrative sections, particularly Initiative 1: Make Rural Nebraska Healthy Again Through Food as Medicine, Initiative 4: eHealth and Mobile, and Initiative 7: NETECH.

FINANCIAL SOLVENCY STRATEGIES AND CAUSE IDENTIFICATION: Nebraska's rural hospitals face significant challenges driven by low patient volumes, workforce shortages, and rising operating costs. These pressures have led many facilities to reduce essential services, worsening access to critical services for rural and frontier residents. To right-size facilities and ensure the financial sustainability of rural hospitals and providers, Nebraska will analyze data to ensure health care delivery best aligns with rural community needs and utilization trends. Nebraska's RHTP initiatives are grounded in technology-driven solutions to increase efficiency and patient capacity in existing rural facilities and promote preventive care. Leveraging transformative practices such as co-locating CHWs and patient navigators with local health

departments (LHDs) and agricultural extensions offices, along with converting CAHs at risk of closure to rural emergency hospitals, will ensure health care stays local. This approach empowers locally governed hospitals and clinics to remain independent while accessing the scale and shared expertise of a regionalized network.

On a policy level, the State will innovate its payment methodology to promote financial viability for critical services. The hub-and-spoke regionalization model will ensure Nebraskans can access necessary care. The RHTP will not be used to maintain failing hospitals. It will instead allow Nebraska to develop a regionalized health care system that leverages the strengths of larger rural facilities and aligns incentives for partnering with smaller facilities. See the table below for examples of legislative and regulatory actions related to payment and rate methodology. The State also includes additional details on how Nebraska will sustain successful initiatives in the Sustainability Plan of the application.

LEGISLATIVE AND REGULATORY ACTION: Nebraska commits to making the following legislative and regulatory actions as part of its implementation plan for the program:

Legislative or regulatory action	Timeline	Impact to quality, access, and/or cost
Require maternal/neonatal level of care designations.	Changes to regulation Title 175 Chapter 9 complete by CY 2026-2027.	Ensure that rural patients receive appropriate risk level of care to lower maternal and infant morbidity and mortality.
Enable Medicaid reimbursement for Community Paramedicine through a Medicaid State Plan Amendment (SPA) and State regulatory changes.	Submit no later than Q4 2027.	Support lowering costs for CP and lower risk of emergency department (ED) visits and hospitalizations.
Obtain legislative authority for State CHW certification.	Implement by CY2026-2027.	Minimize barriers of entry for CHWs to be certified and grow the workforce.
Create a Medicaid SPA to reimburse defined CHW services (e.g., education, navigation, integration/coaching).	Submit no later than Q4 2027.	Increase access to preventive services.

Establish statewide recognition of VR-based competencies for continuing education (CE) credit.	Achieve by end of CY2027.	Allow providers in remote areas to access immersive, standardized, high-quality education.
Establish Medicaid coverage of RPM, remote therapeutic monitoring, chronic care management, and maternal transport through a Medicaid SPA and State regulatory changes.	Draft policy/request for proposal language in CY2026. Pilot under existing codes in CY2027. Implement in CY2028.	Increase access for rural residents to receive services and increase qualified provider pool which in turn decreases hospital admissions.

OTHER REQUIRED INFORMATION

State Policies: Nebraska identified the following information for each technical score factor that has a State policy action factor. The chart includes action the State will take to ensure the strategic goals of the RHTP program are achieved.

Technical Score Factor	Current State Policy
Health and Lifestyle	Nebraska will reestablish the Presidential Fitness Test by December 31, 2028, aligned with any announced federal guidance associated with Executive Order 14327.
SNAP Waivers	Nebraska has a SNAP Food Restriction Waiver that restricts the purchase of soda and energy drinks, approved on May 19, 2025.[41]
Nutrition Continuing Medical Education (CME)	Nebraska does not currently have a requirement for nutrition to be a component of physician CME.[42]
Certificate of Need (CON)	Nebraska respectfully submits that the CMS scoring under Factor C.3 (Certificate of Need) requires review. NE's CON law applies specifically to hospital rehabilitation beds, long-term care beds, and nursing home beds (Neb. Rev. Stat. § 71-5829.03). The statutory definition of "hospital" (§ 71-419) includes psychiatric hospitals but excludes treatment centers. Psychiatric hospital beds are distinct from rehabilitation hospital beds and fall outside CON regulation. CMS appears to have assigned 15 points under Behavioral Inpatient based on the assumption that psychiatric beds require CON, which is inconsistent with Nebraska law. Similarly, the 15 points assigned under Medical Outpatient appear based on the premise that rehabilitation centers fall within the hospital definition. However, NE's CON applies exclusively to inpatient rehabilitation beds, not outpatient services. Nebraska requests a correction of its total CON score to 15 points (rather than 45), consistent with state statutory definitions. Nebraska policymakers have introduced legislation to modernize the State's certificate of need framework. The proposed bill would remove CON requirements when a non-profit hospital is sold and eliminate the CON requirement for expansion of long-term-care beds. Although these long-term-care provisions remain under consideration, Nebraska is actively addressing this policy area aimed at reducing regulatory barriers and improving rural access to essential health services.
Licensure compacts	• For Physician: Member of the Interstate Medical Licensure Compact (IMLC), serving as State of Principal License[43]

	• For Nurse: Nurse Licensure Compact (NLC) State[44] • For EMS: Licensure compact member of the EMS Compact[45] • For Psychology: Psychology Interjurisdictional Compact (PSYPACT) participating State[46] • For Physician Assistant (PA): Compact member[47]
Scope of practice	• For PAs: Moderate[48] • For Nurse Practitioners (NPs): Full scope of practice[49] • For Pharmacists: Barriers to innovation in place (0-3 points)[50] • For Dental Hygienists: Semi-restricted scope of practice (3-5 types)[51]
Short-term, limited-duration insurance (STLDI)	STLDI plans are not restricted.[52]
Remote care services[53]	• Live video: Reimbursed • Store and Forward: Not reimbursed • RPM: Reimbursed • In-State licensing requirement exception: Nebraska has licensure exceptions • Telehealth License/Registration Process: Nebraska does not have a registration process

Factor A.2: List of Certified Community Behavioral Health Clinics: As of September 1, 2025, Nebraska has seven active Certified Community Behavioral Health Clinic (CCBHC) entities. The complete list, including every active site of care and address associated with each CCBHC entity, can be found in the Other Supporting Documentation section of this application.

Factor A.7: Hospitals Receiving Medicaid Disproportionate Share Payment: In the most recent State plan rate year of 2023, 22 hospitals received a Medicaid Disproportionate Share Hospital (DSH) payment.

PROPOSED INITIATIVE 1: MAKE RURAL NEBRASKA HEALTHY AGAIN THROUGH FOOD AS MEDICINE

DESCRIPTION: Nebraska has one of the fastest rising obesity rates in the country according to the Centers for Disease Control and Prevention and ranks 10th highest in the nation for obesity rates.[54] The number of obese individuals in Nebraska would sell out the University of Nebraska's football stadium more than 8 times. Obesity rates in Nebraska are 36% for adults, which is expected to rise to 51% by 2030. Over 28% of adolescents in Nebraska are considered overweight or obese. The fastest-growing age group affected by obesity is young adults ages 25

to 34, which is also the age group most likely to be raising young children. For children, if one parent is obese, there is a 40% chance the child will be obese, and an 80% chance if both parents are obese.[55] Less than 1% of all obesity is caused by medical disorders signifying the remaining 99% is due to lifestyle choices such as eating processed foods and little to no activity.[56]

Despite agriculture being a prominent industry in Nebraska, over half of Nebraska counties meet the criteria for a food desert. This initiative aims to directly lower obesity risk and prevent the associated chronic diseases, such as diabetes or metabolic syndrome, by improving access to healthy foods, nutrition education, and promoting active living in rural communities. The initiative leverages partnerships between the agriculture sector and schools to promote healthy living through proper nutrition and access to healthy whole foods to encourage physical activity from a young age.

1.1 School Kitchen Modernization Grants: Nebraska will provide grants (with a maximum award of $100,000 per school or school district per year) to rural schools to transition their food preparation and storage infrastructure to support whole fresh foods. Eligible schools include any public or private elementary, middle, or high school in rural and frontier counties. Participating sites will be prioritized based on several criteria, including rural and frontier counties, food deserts, and poverty census data. DHHS will manage outreach, technical assistance (TA), intake, selection, contracting, verification, and payment scheduling. Eligible upgrades may include equipment such as blast chillers, salad bars, refrigeration units, scratch-cooking appliances, and greenhouses. These investments will support the transition to scratch cooking and the increased use of whole foods in school meal programs.

1.2 Regional Food Pantry Development: Nebraska will assess the landscape of food cooperatives and food pantries that procure locally grown items used in school nutrition

programs and identify readiness for partnerships with schools. For partners that score high on a readiness assessment, Nebraska will support producers, producer cooperatives', and food pantry investments toward cold storage, delivery equipment, and community gardens, including food safety supplies and equipment. The initiative will provide funding for up to 120 partners to strengthen regional and local food aggregation hubs through the development of procurement tools for producers. The initiative will also fund technology needed to maintain adequate records and data, such as food received, food distributed, food stored, households served, volunteer coordination, staffing coordination, training, safety of the location for clients and staff, food safety, and nutrition education and training. Additionally, the State will invest in developing "last mile" logistics systems to strengthen connections between participating small rural producers and local school systems through equipment to supply fresh foods, ensuring efficient and reliable food distribution.

1.3 Farm-to-School Procurement and Policy Technical Assistance (TA): The State will establish a statewide School Food Learning Lab to support school districts in revising bid specifications, vendor contracts, and menu cycles to better facilitate local food sourcing. Districts that apply will receive hands-on TA to navigate the U.S. Department of Agriculture (USDA) procurement regulations, vendor qualification processes, and food safety requirements. The initiative will support over 40 partners per year at $150,000 each.

Additionally, the State will provide TA and food infrastructure equipment to local rural farmers, ranchers, and food suppliers to develop healthy kitchen-ready products that reduce preparation burden on school kitchens. Priority will be given to those in rural and frontier counties and tribal communities that have food deserts. Eligible equipment may include trailers, forklifts, pallet jacks, packaging equipment, refrigeration units or generators, and food safety equipment.

To further streamline local procurement, the State will also develop a digital marketplace that connects Nebraska producers, food pantries, and school districts. This effort will support menu planning, vendor management, procurement tracking, and will include data dashboards to monitor local purchasing rates, nutritional quality of menus, and student participation trends.

1.4 Healthy Menu Design & Culinary Workforce Training: The State will launch a Nebraska School Nutrition Training Institute with post-secondary institutions such as the University of Nebraska-Lincoln (UNL) Extension, Metropolitan Community College Institute for the Culinary Arts and Great Plains Culinary Institute, in partnership with the Nebraska Department of Education (NDE), for cafeteria staff to receive a certification in healthy, scratch-cooking techniques and chronic-disease-prevention menu design. Nebraska will design and implement, in partnership with nutritionists, regional food services training for culinary skill building and standardized recipe development. By advancing the skills of rural and tribal school cafeteria staff, Nebraska will increase its local capacity to deliver nutritious meals that promote children's health, reduce reliance on processed foods, and reinforce prevention and chronic disease management through improved nutrition.

1.5 Nebraska Kids Fitness and Nutrition Day: Nebraska will engage school students across the State through interactive educational events that focus on healthy eating, physical activity, and wellness through hands-on activities, fitness demonstrations, and nutrition education sessions. The State will contract with University of Nebraska Kearney Physical Activity and Wellness Lab, among others, for implementation support. The programs that are developed with this initiative will establish the infrastructure for ongoing sustainability. Nebraska will also reestablish the Presidential Fitness Test by December 31, 2028, aligned with any announced federal guidance associated with Executive Order 14327.

Main Strategic Goal	Use of Funds	Technical Score Factors
Making Rural America Healthy Again Sustainable Access Innovative Care	A, D, F, J	B.2, F.2

KEY STAKEHOLDERS:

Stakeholder Category	Partners
State Leadership and Agencies	DPH, Department of Education, Department of Agriculture, OEA, MLTC, State Office of Rural Health (SORH), Department of Economic Development, Local Health Departments (LHDs), Nebraska Department of Education (NDE)
Health Care and Provider Partners	Nebraska Chapter American Academy of Pediatrics, Nebraska School Board Association
Community and Regional Stakeholders	Nebraska Christian Home Educators Association and Nebraska Homeschool; The Home Educators Network, Inc.; Chambers of Commerce; UNL Extension Offices; Nebraska School Nutrition Association; Nebraska Association of Local Health Directors (NALHD); University of Nebraska Kearney; food retailers; community leaders and city planning commissions; University of Nebraska-Lincoln (UNL) Extension; and educational institutions
Tribal partners	Tribal nations, schools, and food suppliers

OUTCOMES: Nebraska will measure the progress of this initiative by tracking the following key outcome metrics: (1) Percentage of locally sourced protein menu items, (2) Percentage of heat-and-serve items represented on menus for National School Lunch Program (NSLP)/School Breakfast Program (SBP), (3) School meal fresh food participation rates, and (4) Number of food producers that have new school purchasing agreements or navigated USDA procurement rules. Please see the Metrics and Evaluation Plan of this application for more details on the outcome metrics' baseline data, data sources, targets, timeframe and level of analysis for this initiative.

IMPACTED COUNTIES: Statewide with an emphasis on 88 HRSA-designated rural counties, tribal communities in rural areas, food deserts, and counties that lack access to fresh food. Please see the Other Supporting Documentation for their associated FIPS codes.

ESTIMATED REQUIRED FUNDING: Total annual: $22M | Total (FY26–FY31): = $110M | School Kitchen Modernization Grants: $2.5M/yr | Regional Food Pantry Development: $10M/yr

| Farm-to-School Procurement & Policy TA: $8.5M/yr | Healthy Menu Design & Culinary Workforce Training: $0.5M/yr | Nebraska Kids Fitness and Nutrition Day: $0.5M/yr.

PROPOSED INITIATIVE 2: REGIONALIZED RURAL ACCESS AND NAVIGATION

DESCRIPTION: In Nebraska, long travel times contribute to underutilization of preventive care and reduced follow-up post discharge. The status quo mindset of facilities delivering health care through the brick-and-mortar model limits access to specialists at the local level leading to delayed diagnosis and treatment of manageable diseases and inconsistent linkages to essential heath care resources. Nebraska will build a statewide hub-and-spoke system of regionalized care and navigation that ensures every rural resident can access the right care, in the right amount, at the right time, in the right place. The initiative integrates emergency response, maternal and perinatal systems, post-acute follow-up, preventive care, and local service access through five interdependent components. Together, these components address longstanding structural challenges in rural health care delivery, such as fragmented prehospital coordination, maternity care deserts, gaps in chronic disease management, care for aging adults, and underutilized facilities that could serve broader local health care needs.

The initiative will establish regionalized coordination of emergency medical and perinatal care; grow CP and telehealth-enabled response capacity; connect veteran EHRs to local EHRs to improve veteran access to local health care; repurpose local infrastructure into full-spectrum health access points; and embed CHWs with LHDs and agricultural (ag) extension offices to strengthen prevention and care navigation. The ag extension offices partner with local counties and the USDA to provide research-based information and educational programs to the public in areas including agriculture, 4-H youth development, and nutrition. They aim to provide practical

education and resources to strengthen families, communities, and businesses across Nebraska. Integrating these components increases local health care availability and diversifies revenue streams for existing facilities, which will sustain the infrastructure beyond the grant period.

2.1 EMS and Perinatal Regionalization: Nebraska has the fifth highest percentage of maternity-desert counties in the country, with about 52% of counties categorized as maternity deserts compared to the national average of 32.6%. Patients in rural areas face long transportation times and inconsistent referral pathways for care.[57] Standardized and dependable protocols for patient transfers or tele-consults will reduce perinatal morbidity and mortality, shorten transfer times, and improve the quality and consistency of care for pregnant and postpartum patients.

This initiative will organize the State's maternal and neonatal care infrastructure into a risk-appropriate regional network. To ensure patients receive timely access to advanced care Nebraska will formalize high-risk patient referral pathways from rural areas to regional specialty hubs. A statewide Maternal-Fetal Medicine (MFM) Rural Provider Pairing Program will connect primary care rural providers with obstetricians. Participating providers will review patient charts for risk factors and co-create a care plan within one week of a first visit to an obstetrician. Providers will co-manage high-risk pregnancies through secure teleconsultation and coordinated care planning. The MFM Provider Pairing Program will be piloted in the first year of funding at one rural clinic in a maternity desert using Health Insurance Portability and Accountability Act-compliant collaboration practices. The pilot will take place in a county with a high number of births occurring outside the county and will establish protocols that can be scaled to additional rural sites with on-site and/or virtual education. This allows a high-risk patient to be seen by their rural physician during pregnancy before being transferred to a specialist for delivery. The

initiative will also support recruitment of certified nurse midwives to the rural areas of the State. In order to support safe deliveries, a high-risk obstetrics (OB)/neonatal EMS transport system will be developed along a maternity desert section of I-80, a major corridor running east-west across Nebraska that spans 455 miles. Dedicated equipment, protocols, and an on-call MFM consult line will be provided for the initial pilot EMS teams. Learnings from the initial teams will provide the foundation for increasing the pilot to the rest of the east-west routes and to the north-south routes in maternity deserts across western Nebraska. Nebraska and Iowa have discussed the possibility of cross-border collaboration in this effort to improve access to specialized care.

2.2 Community Paramedicine (CP) Regionalization: In Nebraska, rural EMS are fragmented, with inconsistent medical direction, protocols, and documentation. More than 80% of EMS agencies are staffed with volunteers.[58] Many communities lack post-discharge support, chronic disease follow-up, behavioral health linkage, and treat-in-place options. Community Paramedicine (CP) is a mobile model that utilizes medical training of EMS providers to support patients with urgent and non-urgent needs. The initiative will build regional Mobile Integrated Health Care CP capacity. Through telehealth and updated clinical documentation systems, community paramedics will deliver new "treat-in-place" services, perform chronic disease follow-up, assist with high-risk patient outreach, and connect patients to alternate destinations such as primary-care clinics or behavioral-health providers. Participating EMS agencies will operate under unified regional medical direction and standardized equipment, protocols, and tiered response structures that match resources to patient acuity. EMS teams that volunteer to participate will be assessed for readiness and provided training. Advanced simulation training and VR technology will be deployed to improve workforce readiness and standardize

competencies across participating rural EMS agencies. Nebraska will also implement a statewide Emergency Medical Dispatch platform and pilot the adoption of PulsePoint, a 911-connected app that notifies users of nearby emergencies to improve response coordination. To support rural emergency needs, regional inventories of essential medical countermeasures will be established in geographically isolated areas across the State. Local implementation agencies will be responsible for cycling supplies through local health care systems. Collectively, these reforms will enable consistent service delivery, reduce unnecessary transport, and integrate EMS as a vital bridge between emergency, outpatient, and preventive care systems.

2.3 Rural Health Hubs and Statewide CHW Network: The Rural Health Hubs and Statewide CHW Network initiative will increase access to preventive care. The program will enable data-sharing across rural health care facilities and community partners by embedding CHWs within LHDs, tribal organizations, ag extension offices, or rural hospitals and facilities. Each participating LHD district will staff a minimum of 10 CHWs supported by supervisors who ensure alignment with local needs. LHDs, tribal organizations, ag extension offices, rural clinics, and rural hospitals and facilities will need to apply to participate in the program and priority will be given to areas with negative health outcomes as indicated in statewide health data. Subawardees will fund vendor partners that can provide technological solutions for seamless, bi-directional interoperability to share data and enhance care coordination. Subawardees will use technical assistance to engage payers and community partners to ensure sustainable value-based care.

CHWs will focus on connecting residents to medical homes, supporting chronic disease management through patient education and non-acute remote patient monitoring, coordinating communication between primary care physicians and behavioral health and maternal health

services, and facilitating benefits enrollment through ACCESSNebraska, Nebraska's integrated eligibility system. Standardized data-sharing agreements (Memoranda of Understanding [MOUs]/Business Associate Agreements [BAAs]) will allow rural clinics and CHWs to document referrals within hospital and clinic EHRs, and track outcomes. Nebraska will develop a formal CHW certification pathway and maintain a statewide registry, defining core competencies and specialized endorsements such as home visiting and lactation support. A statewide CHW Community of Practice (COP) will provide training, TA, and quality improvement, such as quarterly COP meetings for peer learning and resource sharing. DHHS will work with private insurance and prepare a Medicaid SPA to establish reimbursement for CHW services, ensuring long-term sustainability. The program will also provide funding for minimal modifications of existing community space to allow CHWs to be co-located in LHDs, tribal offices, ag extension offices, and rural facilities. The initiative also includes a pilot with a tribal organization to employ a market-ready tech-enabled care station for ambulatory care visits, such as OnMed.

Rural Health Hub regional collaboration initiative includes the development of approximately three regional coordination and governance (RCG) structures to evaluate health care data and identify collaboration opportunities. The RCG will be comprised of a cross-representation of health care associations and will be a non-profit with no lobbying activity. The RCG will establish regional coordination and governance structures to design and build a referral hub across the care continuum, evaluate data to detect operational efficiencies, identify opportunities for group purchasing, and strengthen cybersecurity capability. As part of the group purchasing evaluation, the RCG will determine how to jointly acquire and share a mobile imaging unit to

address unmet diagnostic needs and improve access to evidence-based preventive screenings across rural and frontier areas.

2.4 Veteran EHR Coordination: In partnership with the U.S. Department of Veterans Affairs (VA), Nebraska will implement the External Provider Scheduling (EPS) system across rural communities to ensure veterans can access timely care at their preferred location, whether at VA facilities or local rural hospitals and clinics. Currently operational in Nebraska's urban centers, EPS enables seamless scheduling between VA and community providers through shared EHR integration. EPS rollout is a priority of both Congress and the Administration, and this initiative will extend this capability up to 72 rural facilities statewide by funding the technical integration of EPS with Nebraska's rural health EHR infrastructure, connecting CAHs, Rural Health Clinics (RHCs), and other providers in rural and frontier counties. Through this connectivity, veterans will experience reduced appointment wait times and improved continuity of care, while rural providers will see more consistent patient referrals and increased VA reimbursement for community-based services. Funds will be sub-awarded to an association that represents rural CAHs and RHCs and will prioritize participating facilities by reviewing historical claims records where veterans receive care. By linking the VA system with Nebraska's regional health grid, the initiative ensures that veterans living in rural areas receive the same coordinated, high-quality care and scheduling efficiency available in urban centers.

2.5 CAH to REH Conversion: Nebraska will assist CAHs at risk of closure in converting to Rural Emergency Hospitals (REHs) to preserve access to essential health services in rural communities and stabilize rural health care infrastructure. Many CAHs across the State are facing insolvency due to declining inpatient volumes and unsustainable operating margins, placing entire communities at risk of losing their only source of local care. This initiative will

support up to ten facilities in either completing full CAH-to-REH conversions or implementing minor modifications to increase and diversify services, such as creating a co-located telehealth clinic, RPM monitoring stations, behavioral health crisis stabilization units, or subleasing space to partner hospitals to provide skilled nursing services. Funding will support facility modifications, clinical equipment, and cloud-based technology integration necessary for compliance and efficient operations under the REH model. The program will engage the Nebraska Hospital Association (NHA), Nebraska Rural Hospital Association (NRHA), and payers to ensure billing and reimbursement readiness, promoting long-term financial viability. These conversions will help retain emergency and outpatient services in vulnerable communities, establish new revenue streams for participating facilities, and sustain a rural care network that prevents service deserts after hospital closures.

Main Strategic Goal	Use of Funds	Technical Score Factors
Make Rural America Healthy Again Sustainable Access Workforce Development Innovative Care	A, C, D, E, F, G, H, I, J, K	B.1, B.2, C.1, C.2, D.1, F.1, F.2, F.3

KEY STAKEHOLDERS:

Stakeholder Category	Partners
State Leadership and Agencies	Local governments, LHDs, DHHS advisory boards
Health care and Provider Partners	Hospitals; clinics; Federally Qualified Health Centers (FQHCs); RHCs; CAHs; Nebraska Perinatal Quality Improvement Collaborative (NPQIC); perinatal hospitals and hospital regulators; obstetric, pediatric, and MFM providers; EMS agencies, training organizations, and physician medical directors; NALHD and University of Nebraska Medical Center (UNMC); rotating specialty providers; Nebraska Health Care Association; NHA; NRHA; VA facilities; nursing facilities; CHWs
Community and Regional Stakeholders	Public Safety Answering Points/dispatch and the Nebraska Public Service Commission, Medicaid Managed Care Organizations, community-based organizations, professional associations, health information technology and durable medical equipment vendors, LeadingAge Nebraska, high schools and post-secondary training programs, patient and family representatives
Tribal Partners	Tribal health organizations

OUTCOMES: Nebraska will measure the progress of this initiative by tracking the following key outcome metrics: (1) Number of maternity desert counties with newly trained perinatal providers; (2) Number of licensed community care providers (community paramedics); (3) Percentage of EMS services participating in regionalization; (4) Number of hospitals with active LHD MOU/BAA; (5) Number of veterans using EHR to schedule appointments outside the VA; and (6) Retention in services available locally for CAH facing insolvency. Please see the Metrics and Evaluation Plan of this application for more details on the outcome metrics' baseline data, data sources, targets, timeframe, and level of analysis for this initiative.

IMPACTED COUNTIES: Statewide with an emphasis on 88 HRSA-designated rural counties, tribal communities in rural areas, maternity care deserts, counties with high rates of infant and maternal mortality, and counties with CAHs at risk of closure. Please see the Other Supporting Documentation for their associated FIPS codes.

ESTIMATED REQUIRED FUNDING: Total annual: $58.5M | Total (FY26–FY31): ~$291M[59] | EMS & Perinatal Regionalization: $4M/yr | CP Regionalization: $11.1M/yr | Rural Health Hubs and Statewide CHW Network: $29.3M/yr | Veteran EHR Coordination: $2M/yr | CAH to REH Conversion: $10M/yr.

PROPOSED INITIATIVE 3: RURAL WORKFORCE ACCELERATION

DESCRIPTION: Rural Nebraska faces critical workforce shortages across primary care, OB, dental, and behavioral health. This initiative's five components directly respond to Nebraska's rural health workforce needs by establishing a statewide "grow local" strategy that will recruit, train, and retain a resilient workforce that advances whole-person health and ensures care availability.

3.1 Rural Provider Recruitment and Retention Incentive Program: The Rural Provider Recruitment and Retention Incentive Program will target recruitment and retention of highly needed clinical disciplines, post-graduation. Awards will be tied to a five-year rural service obligation at facilities that accept Medicare and Medicaid and meet an annual Medicaid access threshold. The Nebraska RHAC will maintain and update a prioritization matrix annually based on health care workforce data, which will determine eligible disciplines and jurisdictions. A RHAC subcommittee consisting of a cross-representation of health care associations will make recommendations to the RHAC for regionalized workforce priority areas in rural Nebraska. The subcommittee will be non-profit and will be prohibited from lobbying activities. Awards can include hiring incentives, training, apprenticeships, retention incentives, and stipends for relocation and will be scaled by discipline with awards ranging in amounts up to $75,000 per year. The total number of awards per year will be determined by the RHAC's evaluation of high-priority care needs based on Nebraska workforce data. If an individual is employed by a larger rural health system, scoring will account for a requirement to practice a portion of the work week in a rural health care facility. Participants must be United States citizens, hold an active Nebraska license at the time of award, and practice in a HRSA-designated rural county or a county adjacent to either a frontier county or a county with tribal lands. The program will require quarterly verification of employment in a designated shortage area, and cost sharing by local employers or other private sources. Annual payments are released after successful employment verification.

3.2 Rural VR and Skills Acceleration Network: RHTP funds will support a statewide, telehealth-enabled simulation network to bridge gaps in education and training, providing access to resources and experiences that are otherwise limited by distance, cost, or availability in rural

and frontier settings. Using portable VR/AR technology, the network delivers high-acuity, low-occurrence training directly to local providers. Content will include obstetric drills, EMS scenarios, and dental safety modules. Mobile training roadshows, regional hubs, and train-the-trainer cohorts will provide continuous skills transfer and reinforce team-based competency. Nebraska will partner with an institution of higher learning or vendor to develop this program. Rural and frontier facilities, CAHs, RHCs, LHDs, and tribal providers will be eligible for VR/AR technology deployment or hub participation.

3.3 Rural Health Care Workforce Incentive and Sustainability Model: Nebraska will implement a Rural Health Care Workforce Incentive and Sustainability Model to strengthen the rural workforce pipeline in rural and frontier communities and support SNAP clients to obtain jobs that pay a livable wage. Utilizing the SNAP E&T (employment and training) program, Nebraska will assist SNAP eligible individuals seeking careers in entry-level and advanced practice health care professions to access employment and training opportunities in rural communities. Careers examples include nurse aides, medical assistants, registered nurses, radiology technicians, phlebotomists, and other health care providers based upon statewide workforce shortage data. Participants receive a layered package of supports coordinated by the OEA and local employers including (1) supportive services such as transportation, educational materials, or tuition assistance to help health care workers gain the skills necessary to enter the health care workforce, (2) case management with a career coach to identify and guide participants through a health care career pathway, and (3) job retention assistance to ensure the participants are prepared to enter and remain in rural practice. The initiative provides a pathway for recipients of economic assistance to earn a living wage by helping them transition off the assistance program to self-sufficiency while building out the rural workforce. Regional

workforce and education partners will receive TA and resources to sustain the "grow local" workforce model. The OEA will provide partner capacity-building grants to rural SNAP E&T third party-partners over five years to run their SNAP E&T program focused on health care career pathways. Employers who participate will receive structured support, ensuring that investments in staff development translate to enduring rural workforce stability and encourage providers to practice at the top of their license. Participants must work in HRSA-designated rural counties, or counties next to frontier areas and counties with tribal communities. The initiative prioritizes high-vacancy rural facilities, frontier and tribal communities, and counties with maternity-care deserts.

3.4 School-Age Health Care Pipeline: Nebraska will support two state developed programs that expose school-age students to health care careers. uBEATS, a web-based platform developed by UNMC and University of Nebraska at Omaha (UNO), introduces students in grades 6–12 to health science and behavioral health fields by equipping teachers with modern science, technology, engineering, and math resources. With this funding, uBEATS offerings will add a new rural health series and launch a Badge and Job-Shadowing Scholarship Program linking digital learning and hands-on experience with rural health care providers. uBEATS will also launch a turnkey middle-school elective and enhance its platform's user interface and analytics to improve engagement and track learning outcomes.

Health Care Heroes League is a curriculum for youth in grades 3-6 developed by NHA and the Nebraska Health Care Foundation. The curriculum focuses on health care career exploration and hands-on learning, such as mock emergency scenarios. The funding will allow the curriculum to be provided in rural and frontier counties and tribal communities and through Educational

Service Unit (ESU) partnerships and workshops, teachers and counselors will receive professional development.

3.5 Subsidized Short-Term Provider Housing: Provider housing shortages are a major barrier to rural recruitment. Nebraska will launch a minimum 1:4 public-private cost-sharing model to help rural hospitals and clinics rent or cosmetically update housing for newly recruited providers on a short-term basis. These homes will serve as short-term or transitional residences during relocation or early service to incentivize residency training in rural areas. The program will be sustained by local philanthropic partners after the cooperative agreement ends. The program will support no less than five communities per year, prioritizing areas with the greatest workforce vacancies and demonstrated need.

Main Strategic Goal	Use of Funds	Technical Score Factors
Workforce Development	D, E, F, G, J, K	C.1, C.2, D.1, F.1

KEY STAKEHOLDERS:

Stakeholder Category	Partners
State Leadership and Agencies	DPH, SORH, MLTC, LHDs, OEA, local Workforce Innovation and Opportunity Act boards, Department of Labor, local governments
Health care and Provider Partners	NHA; RHAC; CAHs; RHCs; FQHCs; primary care, behavioral health, and dental clinics; UNMC iEXCEL, long-term care facilities, rural hospitals, Nebraska Medical Association (NMA)
Community and Regional Stakeholders	Community-based organizations (CBOs); Nursing Health Care and Emergency Responder Organization Education through Simulation (HEROES); UNMC College of Dentistry; regional EMS training agencies; ESUs; community colleges; universities; high schools; UNO; school districts; teachers, counselors, and schools; philanthropic partners; community development organizations
Tribal Partners	Tribal health organizations

OUTCOMES: Nebraska will measure the progress of this initiative by tracking the following key outcome metrics: (1) Number of rural and primary care providers; (2) Rural counties receiving at least one VR deployment annually; (3) Five-year retention among participants in

health care career pathways; (4) Number of unique uBEATS and Health Care Heroes League student participants per year (Grades 3–12); and (5) Percentage of sustainable housing available to rural workforce retained post-grant. Please see the Metrics and Evaluation Plan of this application for more details on the outcome metrics' baseline data, data sources, targets, timeframe and level of analysis for this initiative.

IMPACTED COUNTIES: Statewide with an emphasis on 88 HRSA-designated rural counties, counties with maternity care deserts, tribal communities in rural areas, high EMS volunteer reliance, workforce vacancy rates, and those with SNAP E&T programs. Please see the Other Supporting Documentation for their associated FIPS codes.

ESTIMATED REQUIRED FUNDING: Total annual: $26M | Total (FY26-FY31): 131M[60] | Rural Provider Recruitment and Retention Incentive Program: $17.7M/yr | VR Simulation: $4.8M/yr | Rural Health Care Workforce Incentive and Sustainability Model: $2M/yr | School-Age Health Care Pipeline: $500,000/yr | Short-term Subsidized Housing: $1M/yr

PROPOSED INITIATIVE 4: EHEALTH AND MOBILE ACCESS

DESCRIPTION: Rural Nebraskans face compounded barriers to preventive and timely care: maternity care deserts and inconsistent obstetric readiness; high chronic disease burden with limited follow-up and care coordination; transportation barriers for the elderly; and persistent oral health gaps that drive avoidable ED use. Distance, workforce shortages, digital divides, and fragmented systems translate to delayed detection, higher cost of care, and avoidable morbidity.

This initiative will bring access to high-quality, technology-enabled health care for rural and frontier Nebraskans by integrating mobile, remote, and eHealth solutions that meet patients where they are and empower them to make healthy choices. Through mobile clinical units,

preventive oral health teams, technology-enhanced pharmacy services, and remote care service technologies, this initiative strengthens local capacity, reduces emergency utilization, and advances Nebraska's vision to Make Rural America Healthy Again. The funds will establish the systems and infrastructure needed for sustainable and technology-enabled community-based care.

4.1 Mobile Maternal Care and Training (Mobile OB): This program will pilot and scale Mom & Baby mobile clinic services to bring essential maternal and infant care directly to Nebraska's maternity care deserts. These mobile units will deliver services such as prenatal and postpartum care, pregnancy confirmation, fetal monitoring, basic ultrasound, general health screening and disease prevention, health education, RPM monitoring, and referrals. This will bridge critical gaps in areas where access to OB care is limited. (See Figure 3 in Other Supporting Documentation section for a map of OB shortage areas.)

The project will begin by deploying three mobile clinics through LHD partnerships. Lessons learned and evaluation of outcomes will occur before adding three additional units. A regional assessment and planning phase will map service gaps across LHDs, birthing hospitals, and non-delivery facilities to determine areas of service for the mobile clinics. The initiative includes grants for OB readiness carts and creating a CE library featuring evidence-based resources and learning modules. Medicaid will evaluate the need for an unbundled OB payment.

The Readiness and Training initiative will be coordinated through Nebraska's statewide perinatal quality improvement experts, Nebraska Perinatal Quality Improvement Collaborative, with birthing facility members with proven success in reducing maternal and infant morbidity/mortality, will deliver assessments, training, support plans, and a multi-modal strategy to strengthen maternal care deserts.

These coordinated actions will strengthen maternal care capacity, reduce preventable complications, and ensure that mothers and infants in rural communities receive timely, high-quality care closer to home.

4.2 Oral Health (Nebraska Teeth Forever (NTF) and Emergency Department Diversion): This program aims to bring preventive and urgent dental care closer to rural Nebraskans by partnering with LHDs, tribal organizations, and rural communities to build community-based, mobile, and sustainable oral health infrastructure. Many rural communities lack routine dental services, resulting in untreated disease, higher long-term health costs, and preventable ED visits for dental pain (See Figure 4 in Other Supporting Documentation section for a map of dental health professional shortage areas). The initiative will fund LHD-based prevention teams, pairing Public Health Registered Dental Hygienists (PHRDHs) with CHWs to deliver care using portable dental equipment (e.g., mobile chairs, lighting, ultrasonics, and autoclave) and to establish small, permanent dental rooms within LHDs for follow-up care. Mobile dental carts will also be purchased for use by PHRDHs to bring care to isolated communities. In Nebraska, PHRDHs can practice independently and in a State with a shortage of dentists PHRDHs can address dental care gaps by providing care locally in a cost-effective way. Funding will support mobile dental units with x-ray capability to bring dental care to local access points. Access points will include schools, nursing homes, tribal communities, and community centers.

The program will strengthen Nebraska's dental workforce pipeline by introducing student rotations through the UNMC College of Dentistry and Creighton University School of Dentistry. Students will assist LHD teams in delivering preventive services and gain experience in community and public health dentistry. Tribal partners will help co-design prevention services for tribal populations, modestly upgrade facilities to increase access, and collaborate with

neighboring LHDs as needed. Outreach programs in coordination with State colleges of dentistry will offer portable dental services including exams, cleanings, x-rays, sealants, other preventive care, and limited urgent procedures such as extractions.

To reduce preventable emergency dental visits, ED Diversion subawards with UNMC, Creighton, and free or charitable clinics (such as Clinic with a Heart, Heart Ministry Center, People's City Mission, and Third City Clinic) will increase urgent care dental capacity for underserved populations. Standardized infection prevention/control TA will be embedded throughout the initiative to ensure consistency in sterilization, personal protective equipment usage, and room turnover across clinical sites.

The DPH Office of Oral Health and Dentistry will lead implementation by coordinating with LHDs, universities, tribal partners, and free clinics and provide training and site visits. These efforts will strengthen Nebraska's oral health infrastructure, reduce preventable diseases, and create equitable, sustainable access to dental care for rural and underserved residents.

4.3 Technology-Enhanced Pharmacy Services: This component will strengthen rural pharmacy access and support chronic disease management through digital tools and incentive payments. With 69 pharmacy closures since 2020 (14% of pharmacies statewide, mostly rural), this program helps community pharmacies by introducing a mobile application for medication review and adherence, and chronic disease management. Building on the Nebraska Enhanced Services Pharmacies (NESP) clinically integrated network, a statewide consortium of community pharmacies with expertise in patient-centered services, NESP will serve as a sub-awardee to lead development and implementation. NESP will enhance pharmacy services by deploying a mobile application that enables monthly medication reviews, synchronizes prescriptions, promotes adherence, and integrates with EHR systems. The application will feature automated reminders,

secure data exchange, and risk-screening algorithms that flag patients for referral to RPM or chronic disease programs. Participating pharmacists will receive payments for providing monthly medication reviews, synchronizing prescriptions, and screening high-risk patients, particularly those with diabetes, metabolic syndrome, cardiovascular disease, or hyperlipidemia, for chronic disease management. Other services will include adherence counseling, motivational interviewing, and use of multi-dose packaging or weekly medication planners to reduce barriers, such as transportation or language challenges, and lower hospitalizations related to medication non-adherence. NESP will scale to an anticipated 30 pharmacies per year, providing staff training, technical support, and quality monitoring while ensuring HIPAA and State privacy compliance. Procurement of mobile technology will occur through a vendor-neutral process. Please see Figure 6 in the Other Supporting Documentation section for a map of all independent pharmacies across the State that would be prioritized for participation by year. This initiative enhances medication adherence, lowers total health care costs, and helps sustain vital pharmacy services in Nebraska's rural and frontier communities.

4.4 Chronic Disease Management/Remote Patient Monitoring (RPM): RPM increases Nebraska's capacity to manage chronic illnesses in the community, monitor subacute patients in their home, monitor acute patients in CAHs or REHs via a larger rural hospital, and promote healthy living through personal use technology-enabled care. RPMs are transformative solutions that drive down health care costs and reshape the health care landscape. This initiative will use consumer-facing hospital-to-home FDA-cleared or FDA-approved RPM technologies that connect patients, CHWs, EMS, and clinicians through secure, data-driven tools, providing information to a provider dashboard or through an EHR. The devices deployed will depend on the patient care needs. Complex patients will receive RPM kits with blood pressure cuffs,

glucose monitors, pulse oximeters, and scales that connect directly to EHRs and patient portals with cellular options for areas lacking broadband. Chronic disease patients with acute exacerbations will receive technologies that support continuous vital sign monitoring, such as BioIntelliSense. Stable chronic disease patients, such as those with diabetes or metabolic syndrome, will receive RPMs that will provide health information directly to the patient and their provider on the impact of nutrition and activity level on current disease status. Prenatal patients can use RPM devices to be safely monitored in their home, such as INVU, Novii Patch, or Pylo. Nurses and CHWs will support device setup, provide home or telephonic check-ins, and use multilingual, low-literacy materials to ensure accessibility. CHWs will receive specialized training through community colleges and Area Health Education Centers (AHECs).

The program will also offer virtual group visits for patients with diabetes, metabolic syndrome, hypertension, congestive heart failure, and chronic obstructive pulmonary disease, allowing specialists to provide education and monitoring through telehealth hubs at LHDs, clinics, tribal health facilities, ag extension offices, CAHs, and REHs, in partnership with larger rural health care facilities. For patients that are seen by FQHCs and CCBHCs, a technology-supported risk stratified report will identify which patients are at highest risk for negative health outcomes and the FQHC or CCBHC will manage the patient with RPM or through referrals to community-based organizations (CBOs). For high-risk patients, the initiative includes continuous, multi-parameter wearable sensors that track metrics such as heart rate, respiratory rate, temperature, and activity, with AI-assisted analytics to identify risks and prompt timely clinician action. This will be especially impactful for older adults and dual-eligible patients as it is estimated that 90% of individuals over the age of 65 have one or more chronic conditions.[61]

Data may integrate with an existing statewide Health Information Exchange (HIE), which most hospitals and EDs use, or a technology-specific embedded HIE as applicable, for secure, real-time sharing and pooled monitoring. Implemented in rural clinics, FQHCs, CCBHCs, LHDs, CAHs, REHs, rural hospitals, and tribal health facilities, coordinated by DHHS, and supported by vendor-neutral technology partners, the initiative improves disease control, and reduces readmissions and ED visits. The initiative empowers rural and tribal residents to manage their health at home and includes integration of products that ensure consumers have access to their own health data, such as Blue Button 2.0.

Main Strategic Goal	Use of Funds	Technical Score Factors
Sustainable Access, Workforce Development, Innovative Care	A, C, D, E, F, G, I, J, K	B.1, B.2, C.1, D.1, E.1, E.2, F.1, F.2, F.3

KEY STAKEHOLDERS:

Stakeholder Category	Partners
State Leadership and Agencies	LHDs, Title V, DHHS Office of Oral Health & Dentistry
Health care and Provider Partners	Rural CAHs, non-birthing hospitals, FQHCs/clinics, EMS services, perinatal teams, infection prevention/control teams, rotating specialists for virtual groups free/charitable clinics (Clinic with a Heart, Heart Ministry Center, People's City Mission, Third City), professional and local health associations, and Nebraska Pharmacists Association
Community and Regional Stakeholders	NPQIC, AHEC, community colleges for CHW certificates/CE, UNMC/Creighton partners, telehealth platform vendors, HIE vendors, EHR vendors, broadband partners for community hubs, tribal health entities, CBOs, patient/family representatives, regional councils and quarterly forums, UNMC College of Dentistry, Creighton University School of Dentistry, UNMC College of Pharmacy, Creighton University College of Pharmacy
Tribal Partners	Tribal health organizations

OUTCOMES: Nebraska will measure the progress of this initiative by tracking the following key outcome metrics: (1) Percentage of rural birthing hospitals with annual OB readiness training; (2) Number of individuals who receive Nebraska Teeth Forever dental services; (3) Number of patients enrolled in the technology enhanced pharmacy services program; and (4)

Number of clinical partners actively enrolling RPM patients. Please see the Metrics and Evaluation Plan of this application for more details on the outcome metrics' baseline data, data sources, targets, timeframe and level of analysis for this initiative.

IMPACTED COUNTIES: Statewide with an emphasis on 88 HRSA-designated rural counties, counties with maternity and dental care deserts, and tribal communities in rural areas. Please see the Other Supporting Documentation for their associated FIPS codes.

ESTIMATED REQUIRED FUNDING: Total annual: $42.7M; Total (FY26-FY31): $199M. Mobile OB: $6M/yr | Oral Health: $7.6M/yr | Technology-Enhanced Pharmacy: $2M/yr | Chronic Disease Management/RPM: $27M/yr

PROPOSED INITIATIVE 5: RURAL EMERGENCY BEHAVIORAL HEALTH

DESCRIPTION: Rural emergency behavioral health will be a statewide initiative in the 88 counties that meet HRSA's definition of rural to create an integrated care model of emergency behavioral health services for opioid use disorder treatment services, other substance use disorder (SUD) treatment services, and mental health services. This initiative will create a sustainable, community-based emergency behavioral health system that improves outcomes, reduces costs, and strengthens the State's behavioral health continuum of care.

5.1 Integrated Primary Care Sites: In many rural areas, primary care physicians are the first point of contact for individuals seeking behavioral health services. Rural clinics lack access to mental health therapists, the ability to conduct appropriate screenings, or leverage telehealth options for behavioral health services. DHHS will partner with the Nebraska Medical Association (NMA) to establish new integrated rural clinics that co-locate licensed mental health professionals in physician clinics. This effort will strengthen rural primary care clinics as long-term access points for behavioral health. NMA will provide education, TA, and start-up costs to

create sustainable practices. Additionally, Nebraska will leverage best practices from relevant Center for Medicare and Medicaid Innovation (CMMI) models to strengthen and sustain integrated care sites.

5.2 Telehealth Crisis Responders for Law Enforcement: In western Nebraska, rural and frontier law enforcement agencies typically have wait times exceeding two hours when needing to consult with a behavioral health provider. Nebraska will leverage telehealth technology to ensure all rural and frontier law enforcement agencies have access to mobile crisis providers to support de-escalation and diversion from jail or emergency room levels of care. Law enforcement officers will use a mobile application and have instant access to a crisis professional, such as Avel eCare. The State will work with local crisis response agencies, telehealth vendors, and CCBHCs to deploy a comprehensive 24/7 crisis response platform for law enforcement, train rural officers in Crisis Intervention Team protocols, and integrate the program with 988 to ensure an immediate face-to-face crisis contact.

5.3 Modification of Existing Clinical Facilities for Mental Health Crisis Stabilization Centers: Nebraska will increase crisis stabilization and substance use withdrawal management capacity by retrofitting existing areas in rural hospitals, community health centers, REHs, and tribal health facilities. These community-based facilities shift care away from costly hospitals and justice systems. Through minor facility modifications and equipment enhancements, existing clinical spaces will be adapted to serve individuals experiencing behavioral health or substance use crises. The initiative will create integrated, trauma-informed crisis units that provide rapid stabilization, coordinated referrals, and follow-up care through the State's CCBHC network. These units will offer accessible alternatives to EDs and incarceration, reduce wait times, improve care coordination, and strengthen the statewide behavioral health continuum of care.

5.4 Behavioral Health Nursing Homes Pilot: Nebraska will implement a Behavioral Health Nursing Homes Pilot to build post-acute care capacity for individuals with serious mental illness and complex behavioral needs, particularly for those that are dual-eligible. This targeted investment will provide the support necessary to integrate behavioral health clinicians into existing nursing facilities. The integrated clinicians will support evidence-based behavioral health services and address safety needs with the patients. Funds will also support minimal infrastructure modifications to meet the specialized needs of behavioral health patients. Ultimately, this will strengthen the ability of nursing homes to stabilize and manage residents with aggressive or violent behaviors in a safe, therapeutic environment. This model, consistent with Centers for Medicare & Medicaid Services (CMS)-approved practices in other states, targets lengthy hospital stays, improves continuity of care, and strengthens the sustainable, community-based behavioral health continuum of care across Nebraska. This effort will also ensure that beds in acute care settings are available for other purposes such as surge capacity to support emergency response.

Main Strategic Goal	Use of Funds	Technical Score Factors
Sustainable Access, Innovative Care, Tech Innovation	D, E, F, G, H, J, K	B.1, C.1, E.1, E.2, F.1

KEY STAKEHOLDERS:

Stakeholder Category	Partners
State Leadership and Agencies	Law Enforcement Agencies, 988
Health care and Provider Partners	NMA, rural hospitals, rural primary care providers, hospitals, nonprofit providers, behavioral health partners, nursing home operators, behavioral health providers, Opioid Treatment Centers
Tribal Partners	Tribal health organizations

OUTCOMES: Nebraska will measure the progress of this initiative by tracking the following key outcome metrics: (1) Number of rural integrated clinics; (2) Number of contacts with a behavioral health provider at rural integrated clinics; (3) Number of law enforcement officers that are using the telehealth platform for crisis response in rural and frontier counties; and (4) reduction in placement times to nursing facilities for individuals in hospitals with complex behavioral health needs. Please see the Metrics and Evaluation Plan of this application for more details on the outcome metrics' baseline data, data sources, targets, timeframe and level of analysis for this initiative.

IMPACTED COUNTIES: Statewide with an emphasis on 88 HRSA-designated rural counties, tribal communities in rural areas, and counties with behavioral health and crisis care deserts. Please see the Other Supporting Documentation for their associated FIPS codes.

ESTIMATED REQUIRED FUNDING: Total annual: $12.1M | Total (FY26-FY31): 61.7M[62] | Integrated Primary Care: $1.5M/yr | Crisis Responders for Law Enforcement: $4M/yr | Crisis Stabilization Center Modifications: $4.5M/yr | Behavioral Health Nursing Homes Pilot: $2M/yr

PROPOSED INITIATIVE 6: ASSISTED LIVING FACILITY (ALF) SPECIAL NEEDS POPULATION INCENTIVE MODEL

DESCRIPTION: This initiative creates a new payment model to strengthen Nebraska's long-term care infrastructure and increase access to specialized services and community-based living options for medically complex patients in rural counties. The program provides an opportunity for an improved quality of life for individuals who are dual-eligible or aged 65 and older with dementia or Alzheimer's disease, or adults with complex medical and physical disabilities. The initiative offers 1) service add-ons and 2) targeted facility modernization grants to ALFs that serve dual-eligible or Medicaid memory care adults as well as individuals with physical

disabilities who are ages 64 and below and enrolled in the State's Section 1915(c) Aged and Disabled (AD) Waiver.

6.1 Incentive Payments for Memory Care and Complex Care: Memory care is a critical and specialized service for individuals with Alzheimer's and other dementias. It requires staff who receive extra training in dementia-specific strategies to help manage agitation and provide support. ALFs with 1915(c) AD Waiver beds will receive an incentive payment (estimated at $87/day beyond the existing per diem) for residents requiring memory or specialty medical care services. Incentive payments can be utilized by the ALFs to invest in programs and additional training for the staff, leading to long-term access to specialized care staff.

6.2 Facility Modernization Grants: ALFs will be eligible for targeted grants (≤$500,000 per site) to modify or equip facilities to safely accommodate residents with high acuity needs. This will include ventilators and other tracheostomy equipment, dementia safe door systems, room-level Hoyer lift rails, and other mobility equipment. By investing in existing rural ALF infrastructure, the initiative will make one-time equipment and safety modifications that will benefit multiple residents over time, promoting long-term, sustainable access for aging populations and individuals with comorbidities that have complex medical needs.

Nebraska will prioritize ALFs located in HRSA-designated rural, frontier, and tribal communities and promote partnerships between ALFs, CAHs, primary health clinics, RHCs, long-term care associations, and EMS to improve efficiency and sustainability and enhance access to specialty care, so residents no longer need to travel long distances for these services and can stay closer to their families and communities.

Main Strategic Goal	Use of Funds	Technical Score Factors
Sustainable Access, Workforce Development	B, G, J, K	B.1, C.1, C.2, E.1, E.2

KEY STAKEHOLDERS:

Stakeholder Category	Partners
State Leadership and Agencies	DPH, Division of Developmental Disabilities and Aging
Health care and Provider Partners	ALFs, CAHs, primary health clinics, RHCs, EMS
Community and Regional Stakeholders	Long-term care associations

OUTCOMES: Nebraska will measure the progress of this initiative by tracking the following key outcome metrics: (1) Number of memory care beds in ALFs for Medicaid recipients; (2) Number of ALF beds for Medicaid population; (3) Number of ALFs with Memory Care Units participating in the Section 1915(c) AD Waiver; and (4) Number of ALFs outfitted for complex care statewide. Please see the Metrics and Evaluation Plan of this application for more details on the outcome metrics' baseline data, data sources, targets, timeframe and level of analysis for this initiative.

IMPACTED COUNTIES: Statewide with an emphasis on 88 HRSA-designated rural counties. Please see the Other Supporting Documentation for their associated FIPS codes.

ESTIMATED REQUIRED FUNDING: Total annual: $16M | Total (FY26-FY31): $92M[63] | Service Add-on Reimbursement: $15M/yr | Facility Modernization Grants: ≈ 1M/yr

INITIATIVE 7: NEBRASKA RURAL HEALTH TECHNOLOGY CATALYST FUND AND PARTNERSHIP INITIATIVE (NETECH)

DESCRIPTION: This initiative establishes and manages NETECH, a tech catalyst fund. The program's goal is to catalyze cutting-edge, technology-driven transformation in rural health care delivery by blending public RHTP funding with private investment.

NETECH will establish a structured, transparent process for identifying, vetting, and evaluating health technology startups and scalable solutions that directly address Nebraska's rural health care needs. Potential innovations will be assessed and prioritized based on the following criteria: (1) how well they address specific needs such as improving access to care, enhancing disease management, promoting healthy living, and supporting the health care workforce; (2) ability to demonstrate a clear, measurable impact on patient health outcomes; (3) ability to leverage data and technology to help rural providers deliver care as close to a patient's home as possible; and (4) ability to support the financial stability and operational efficiency of rural hospitals and clinics.

The initiative will convene investors, health systems, tribal partners, and innovators through targeted events and matchmaking sessions that highlight opportunities to improve rural care delivery and workforce resilience. Over time, NETECH will cultivate an investment pipeline that multiplies initial RHTP seed funding with sustained private-sector co-investment.

Initial seed funding will be used to establish the initiative's operational infrastructure, conduct technology scouting and vetting, and facilitate initial public-private partnerships. Deployment will begin with pilot demonstrations in high-need regions including those with high rates of chronic disease, significant maternal care deserts, and a high proportion of older adults. Communities will be selected to provide a representative cross-section of rural Nebraska's population. This ensures the pilot's findings are generalizable to the broader rural population which is essential for scaling. Pilot projects will include milestones such as increased access to remote care, improved provider efficiency, and quantifiable reductions in avoidable hospitalizations or administrative burden. Ultimately, this program intends to position successful

technologies for acquisition by health systems, payers, or other health care entities seeking to integrate innovative solutions.

Main Strategic Goal	Use of Funds	Technical Score Factors
Tech Innovation	A, C, D, F, I, K	C.1, F.1, F.2, F.3

KEY STAKEHOLDERS:

Stakeholder Category	Partners
State Leadership and Agencies	Department of Economic Development
Health care and Provider Partners	CAHs, RHCs, FQHCs, primary care and behavioral health clinics
Community and Regional Stakeholders	Investors, startup accelerators, UNMC, CBOs
Tribal Partners	Tribal Nations

OUTCOMES: Nebraska will measure the progress of this initiative by tracking the following key outcome metrics: (1) Fund design and legal framework developed; (2) Technology pipeline established and vetted solutions identified; (3) Investor engagement and matching commitments secured; and (4) Initial deployments in pilot rural communities. Please see the Metrics and Evaluation Plan of this application for more details on the outcome metrics' baseline data, data sources, targets, timeframe and level of analysis for this initiative.

IMPACTED COUNTIES: Statewide with an emphasis on 88 HRSA-designated rural counties, tribal communities in rural areas, and counties with limited digital infrastructure and high provider shortages. Please see the Other Supporting Documentation for their associated FIPS codes.

ESTIMATED REQUIRED FUNDING: Total annual: $20M | Total (FY26-FY31): $100M

IMPLEMENTATION PLAN AND TIMELINE

Nebraska's implementation plan applies a strategic framework for each initiative, aligned to Stages 0-5: planning (Stage 0); piloting new initiatives (Stages 1); refining and scaling initiatives (Stages 2-3); advancing implementation through continuous quality improvement (Stage 4); and maintaining and sustaining effective initiatives (Stage 5). Nebraska will complete all Stage 0 planning activities by the end of FY26, positioning the State to quickly and effectively pilot, scale, and continuously improve initiatives in subsequent program years. This timeline is designed to maximize overall impact and ensure the sustainable implementation of effective initiatives interventions no later than FY31.

IMPLEMENTATION PLAN AND TIMELINE: The Gantt chart below provides an overview of key milestones for each initiative from FY26-31, including estimated timelines for legislative and regulatory actions, where applicable. A more detailed workplan can be found in the Other Supporting Documentation section of this application.

Stages	0	1-4				5
FY	2026	2027	2028	2029	2030	2031
Initiative 1: Make Rural Nebraska Healthy Again Through Food as Medicine						
Open application and make first round of awards for school kitchen modernization and food pantry infrastructure development (1.1, 1.2)						
Scale and maintain annual award cycles for school kitchen modernization (1.1)						
Launch and maintain digital marketplace for farm-to-school equipment/supplies (1.3)						
Launch and continue regional training for school culinary skill building and menu design (1.4)						
Finalize design of Nebraska Kids Fitness and Nutrition Day and partner with Department of Education on pilot (1.5)						
Launch Nebraska Kids Fitness and Nutrition Day in rural areas annually to achieve statewide implementation (1.5)						
Reestablish the Presidential Fitness Test, aligned with any announced federal guidance associated with Executive Order 14327						
Initiative 2: Regionalized Rural Access and Navigation						
Require maternal/neonatal level of care designations (2.1)						
Introduce and aim to pass legislation for CHW certification (2.2)						
Implement State regulatory change for CP coverage (2.3)						
Draft and submit SPA for CHW and CP coverage (2.2, 2.3)						
Execute go-live of EPS and VA EHR integration in 3 waves (2.4)						
Execute contract with contractors and health care supply vendors for CAH-to-REH conversions (2.5)						

Stages	0	1-4				5
FY	2026	2027	2028	2029	2030	2031
Complete CAH-to-REH modifications (2.5)						
Initiative 3: Rural Workforce Acceleration						
Launch and maintain annual award process for Rural Provider Recruitment and Retention Incentive Program (3.1)						
Establish statewide recognition of VR-based competencies for CE credit (3.2)						
Award grants to SNAP E&T third-party partners annually through FY29 (3.3)						
Transition partners to SNAP E&T 50/50 reimbursement (3.3)						
Launch middle-school elective and badge & job-shadowing scholarship (3.4)						
Launch and maintain annual award cycles for provider short-term housing (3.5)						
Initiative 4: eHealth and Mobile						
Launch and evaluate pilots of three Mom & Baby mobile clinics (4.1)						
Add one additional Mom & Baby mobile clinic per year (4.1)						
Establish agreements with LHD and launch NTF (4.2)						
Launch and increase technology-enabled pharmacy services and add 15 pharmacies per year (4.3)						
Transition effective pharmacies to shared savings model for long-term sustainability (4.3)						
Implement State regulatory change and submit SPA for coverage of RPM, remote therapeutic monitoring, chronic care management, and maternal transport (4.4)						
Initiative 5: ***Rural Emergency Behavioral Health***						
Establish and increase integrated behavioral health-primary care sites annually (5.1)						
Contract with vendor to stand-up a crisis response platform for law enforcement officers (5.2)						
Make annual awards for clinic upgrades for use as mental health crisis stabilization centers (5.3)						
Launch the behavioral health nursing home pilot in selected sites (5.5)						
Evaluate behavioral health nursing home pilot and finalize sustainability and payment recommendations (5.5)						
Initiative 6: ALF Special Needs Population Incentive Model						
Submit amendment for the 1915(c) AD Waiver to authorize reimbursement for memory care and medically complex adult services in ALFs (6.1)						
Award annual grants to ALFs for facility modifications/upgrades (6.2)						
Initiative 7: NETECH						
Finalize the legal structure and governance model for the fund						
Complete the first investment cycle, including applicant screening, due diligence, and awarding grants						
Award funding to new cohort annually						
Assist funded projects with transition planning						
All Initiatives						
Hire staff and engage external contractors where applicable						
Collect and analyze data, provide ongoing monitoring						

GOVERNANCE AND PROJECT MANAGEMENT STRUCTURE: Nebraska Department of Health and Human Services will serve as the lead agency for this initiative. Sara Morgan, DHHS Deputy Director, Health Promotion and Prevention, will serve as the Authorized Organizational Representative (AOR) for RHTP. The RHTP will leverage DHHS' strong cross-divisional partnerships to coordinate implementation and will engage key personnel from collaborating DHHS Divisions.

Nebraska will dedicate 26 full-time employees (FTEs) to RHTP, including existing staff and newly hired positions. Staff will include one Principal Investigator/Program Director, one Finance Manager (Administrator II), one Implementation Manager (Administrator II), one Contracts/Compliance manager (Administrator II), two Implementation Leads, multiple Program Managers, Coordinators, and Specialists, as well as dedicated contract management and fiscal staff. Each initiative will be staffed with an Implementation Lead to provide strategic direction, oversee project plans, and direct program operations, and Program Staff to execute initiative tasks. There will be overarching project management across initiatives facilitated by the Implementation Manager. See Organizational Chart in the Other Supporting Documentation section of this application for the staffing structure. Staffing levels will be sufficient to perform monitoring and oversight of subrecipient and contract activities.

Additionally, to promote long-term sustainability, Nebraska will engage external vendors to carry out targeted, time-limited activities that establish the foundational infrastructure upon which initiatives can expand. This includes engaging vendors to provide TA to the School Food Learning Lab (Initiative 1); design and implement a community of practice for the CHW Network (Initiative 2); and provide TA to providers participating in mobile/remote care delivery models (Initiative 4).

Nebraska will implement a structured coordination framework to ensure alignment among the Divisions and multi-sector partners throughout the program's lifecycle. DHHS will convene monthly regular cross-divisional Executive Steering Committee meetings to align priorities, share data, and coordinate policy actions. An Operating Committee comprised of the Program Director, Finance Manager, Implementation Manager, Implementation Leads, and the Contracts and Compliance Manager will meet bi-weekly to monitor implementation progress, resolve inter-workstream dependencies, and elevate decisions or issues requiring Executive Steering Committee input. Workstream teams supporting components of each initiative will meet at more frequent intervals to advance activities outlined in their workplans, address roadblocks, and ensure timely progress toward milestones. Additionally, Nebraska will leverage the existing RHAC to ensure broad stakeholder engagement, promote transparency and shared accountability, and maintain momentum toward statewide transformation goals. See the Stakeholder Engagement section of this application for more details on the role of the RHAC.

Program Oversight and Governance	Role
Governor's Rural Health Transformation Executive Steering Committee	Provides high-level strategic oversight, ensuring alignment with the Governor's priorities and statewide rural health goals.
Rural Health Advisory Commission (RHAC)	The RHAC will provide structured stakeholder engagement and input throughout program implementation, promoting transparency, accountability, and alignment with community and provider needs.
Principal Investigator / Program Director	Serves as the overall lead for the RHTP, responsible for program execution, federal reporting, and coordination across divisions and partners.
Initiative Oversight Team	
Financial Management Team	Includes the Finance Manager and the Federal Aid Administrators. This team manages fiscal and administrative operations, compliance, performance monitoring, and reporting to CMS.
Contracts and Compliance Team	The Contract/Compliance Manager and Contract Specialists will ensure effective management of subawards and vendor agreements in accordance with federal and State requirements.
Implementation Team	The Implementation Manager and two Implementation Leads will manage initiative execution. Each will oversee Health Program

	Managers, Program Coordinators, Program Specialists, and the EMS Sustainability Coordinator, supported by an Epidemiologist I to planning, implementation, and evaluation activities. These teams are embedded within DHHS divisions, ensuring operational integration with MLTC, DPH, Division of Behavioral Health (DBH), the OEA, and the SORH.

STAKEHOLDER ENGAGEMENT

ENGAGEMENT DURING THE PLANNING PROCESS: Nebraska adopted a comprehensive and collaborative approach to collect input and buy-in, bringing together State agency leaders and stakeholders representing rural and frontier communities, including health care executives, providers, community partners, and tribal leaders from all regions of the State, to shape a shared vision for transforming rural health care access, quality, and sustainability. Specific organizations represented in the RHTP planning process included:

Stakeholder Category	Partners
State Leadership and Agencies	Governor's Office, DPH, Department of Education, Division of Developmental Disabilities, RHAC, MLTC, DBH, Children and Family Services, Department of Economic Development, Department of Labor, SORH, and Medicaid Tribal Liaison
Health care and Provider Partners	CAHs, RHCs, FQHCs, community and behavioral health centers (including CCBHCs), dental and primary care associations, LHDs, Creighton University, UNMC, NHA, Nebraska Association of Behavioral Health Organizations, Nebraska Association of Service Providers, Nebraska Health Care Association, and Behavioral Health Regions
Community and Regional Stakeholders	University of Nebraska, Medicaid Beneficiary Advisory Committee, LHDs, community colleges, workforce and economic development organizations, nonprofit and CBOs, and faith-based and civic partners
Tribal Partners	Omaha Tribe of Nebraska, Ponca Tribe of Nebraska, Santee Sioux Tribe of Nebraska, and Winnebago Tribe of Nebraska, Great Plains Tribal Leaders' Health Board, Nebraska Urban Indian Health Coalition, and Indian Health Service representatives

Through a series of large stakeholder meetings, 1:1 consultations, and cross-agency working sessions, DHHS and its partners engaged hospital and clinic leaders, local public health departments, behavioral health providers, EMS, CBOs, education partners, and representatives

from Nebraska's four federally recognized Tribes. Nebraska also deployed a public website and mailbox to receive public comments.

Stakeholder feedback was vital to conceptualizing and prioritizing initiatives, ensuring buy-in for initiatives that will require stakeholder support in implementation. Stakeholders were vital in identifying implementation challenges at the design stage when they could be most efficiently addressed. More than 120 participants representing health care, education, and community partners informed the prioritization of draft initiatives and identified important data points that tell the story of rural Nebraska's health care needs. Please see additional examples of stakeholder feedback in the Community Perspectives on Nebraska's Health Care Landscape in the Other Supporting Documentation section. This participatory process reflects the State's deep commitment to collaborative planning and to ensuring the application meaningfully advances the goals of the RHTP and aligns with the Make Rural America Healthy Again strategy.

ENGAGEMENT FRAMEWORK: Engagement in program planning does not end with the submission of Nebraska's application. Feedback will directly inform RHTP performance metrics, program evaluation, and the continuous improvement process, ensuring that initiatives remain responsive to community needs. Nebraska will sustain engagement through a formalized governance and stakeholder advisory structure that ensures ongoing participation, accountability, and transparency throughout implementation. The structure will guide coordination, evaluation, and adaptation of rural health initiatives to support not only the success of the RHTP grant period but also the sustainability of initiatives and long-term health of Nebraska's rural residents.

Nebraska will leverage the existing RHAC as the formal forum for coordination, oversight, and stakeholder engagement under the RHTP.[64] Rather than establishing a new advisory committee, the State will integrate RHTP discussions into the RHAC's quarterly public meetings, which are

posted in advance and open to the public in accordance with Nebraska law. RHTP-related items will be added to each quarterly agenda to review program milestones, fund deployment, and outcome metrics. These sessions will include panels or presentations from DHHS, DHHS Tribal Liaisons, Medicaid Beneficiary Advisory Committee, and other invited guests to inform the Commission's deliberations. To ensure broad engagement, the RHAC will invite comments during these public sessions from rural residents, providers, and individuals with experience navigating rural care gaps. This format allows the State to elevate rural consumer voices while avoiding duplication of existing structures.

DHHS will maintain a shared data dashboard and reporting calendar to track milestones, expenditures, and outcomes accessible to RHAC members and other agency partners. Each year, the RHAC will conduct an annual public review of RHTP progress to assess outcomes, document lessons learned and recommend adjustments to program priorities for the following year. A summary of this review will be published in the Commission's annual report to ensure transparency and continued stakeholder input.

This approach provides Nebraska with a unified, efficient mechanism to manage funds, monitor performance, and coordinate across public health, Medicaid, and tribal partners while strengthening rural participation in policy and program implementation.

METRICS AND EVALUATION PLAN

Nebraska will implement a comprehensive performance measurement framework to measure progress toward the overarching goals of the RHTP and ensure accountability for achieving measurable, sustainable improvements in rural health outcomes. Metrics will capture both process and outcome measures related to access, quality, workforce capacity, and health

outcomes. This framework will include an evaluation of all pilot initiatives to ensure fidelity to implementation goals and consistent monitoring of outcomes.

Staff will conduct regular reviews, in coordination with the RHAC and relevant partners, to assess progress, guide improvements, and inform scaling and sustainability strategies. Each initiative will maintain feedback loops with funding recipients, where applicable, to provide actionable insights and support implementation progress. Performance and outcome data will be systematically reviewed to assess program effectiveness and demonstrate measurable impact on an ongoing basis. Experienced data analysts will be embedded within each initiative team to manage data collection, ensure data quality, and conduct regular analyses that inform program management and quality improvement.

Additionally, Nebraska will contract with an independent evaluator to design and conduct a formal evaluation. The evaluation contractor will synthesize statewide outcomes to assess cumulative program impact and document lessons learned. Evaluation results will be disseminated through publicly available reports to promote transparency and extend the reach of best practices beyond the program. Nebraska will use evaluation findings to ensure that effective innovations in chronic disease prevention and management, care delivery, workforce capacity, and technology adoption are sustained beyond the cooperative agreement period. Nebraska and its independent evaluator will coordinate with any CMS-led evaluation or monitoring.

METRICS BY INITIATIVE: The table below lists the primary outcome metrics that Nebraska will use to assess progress and impact, including the data sources, baseline data where available, timing, and level of analysis (e.g., State- vs. county-level). Additional metrics may be identified, as needed, to support a comprehensive, data-driven approach to program evaluation. All metrics will be assessed on an annual basis.

Outcome metric	Data source	Baseline	Target & timeframe	Level
Initiative 1: Make Rural Nebraska Healthy Again Through Food as Medicine				
Percentage of locally sourced protein menu items	Required menus and invoices for NSLP/SBP purchases	School Year (SY) Y2025-26 (any month prior to FSD skills training and nutrition education)	Locally sourced protein will appear on menus 5% more times in a given month by FY28	Community/ School District, State
Percentage of heat-and-serve items represented on menus for NSLP/SBP	Required menus for NSLP/SBP	SY2025-26 (any month prior to FSD skills training and nutrition education)	Heat-and-serve items will appear on menus 5% fewer times in a given month by FY28	Community/ School District, State
School meals participation rates	School meal participation data	SY2025-26 total meals served	10% increase in school meals participation by FY29	Community/ School District, State
Number of food producers that have developed contracts with schools and navigated USDA procurement rules	Data on agreements to be reported by participants	Baseline to be set in FY26	15% increase in contracted food producers, per year between FY26 and FY30	Community/ School District, State
Initiative 2: Regionalized Rural Access and Navigation				
Number of maternity desert counties with newly trained perinatal providers	Data from subaward agreements, compared to March of Dimes data	0 (2025)	Increase by 15 counties by FY30	County
Number of licensed community care providers (community paramedics)	DHHS will run annual reports from MyLicense Office (MLO), the software used for occupational licensing.	1 (2025)	Increase to 400 community paramedicine providers by FY30	State
Percentage of EMS services participating in regionalization	DHHS will require regional leads to submit quarterly reports to include a listing of each EMS service participating, if they are actively participating, and when they joined regionalization efforts	0% (2025)	50% EMS participation by FY30	Community
Number of hospitals with active LHD MOU/BAA	Data reported by participating sites	0 (2025)	1 per region by FY29	Region

Outcome metric	Data source	Baseline	Target & timeframe	Level
Number of rural hospitals connected to the VA EHR	Data collected through EHR system	0% (2025)	5% increase by FY28	Community
Services available locally for CAH converting to REH	Data reported by participating facilities	0% (2025)	Increase in number of services offered by FY29	Community
Initiative 3: Rural Workforce Acceleration				
Number of rural and primary care providers	SORH practice site logs	1,088 (2024, Health Professions Tracing Center/UNMC)	Increase by 150 providers by FY29	County, State
Rural counties receiving at least one VR deployment annually	LMS logs and deployment schedule	Baseline to be set in FY26	75% of rural counties with annual VR deployments by FY31	County
Five-year retention among participants in health care career pathways	Participant-reported retention	0 for health care-specific pathways (2024)	65% retention in FY 2031	County, State
Number of unique uBEATS and Health Care Heroes student participants per year (Grades 3–12)	UNMC uBEATS data and NHA Health Care Heroes data	1,090 users and participants (SY 2024–25)	≥8,500 student users annually (FY26 – FY31)	State, Community
Percentage of available housing retained post-grant	Participant-reported data on housing availability	0 (2025)	100% housing availability remains community-owned by FY31	County
Initiative 4: eHealth and Mobile				
Percentage of rural birthing hospitals with annual OB readiness training	Data from subaward agreements	0 (2025)	95% or more trained by FY30	Facility, County
Number of individuals who receive NTF dental services	Quarterly reports from LHD agreements	27,436 (2025)	5% increase annually (25% increase by FY31)	State
Number of patients interactions using the technology-enhanced pharmacy services program	Data reported by participating pharmacies	Baseline to be set in FY26	Increase by 3,000 interactions per year through FY30	Facility
Number of hospital-to-home patients using RPM for outpatient monitoring	Data reported by participating providers	15 (2025)	Increase by 300 patients annually, beginning in FY26	Facility, State
Initiative 5: Rural Emergency Behavioral Health				
Number of rural integrated clinics	NMA data	16 clinics (2025)	Increase to 25 clinics by FY30	County, State

Outcome metric	Data source	Baseline	Target & timeframe	Level
Number of contacts with a behavioral health provider at rural integrated clinics	NMA data	24,160 (2025)	15% increase in contacts with BH providers by FY31	County, State
Number of law enforcement officers that are using the telehealth platform for crisis response in rural and frontier counties	Data reported by participating law enforcement agencies	Baseline to be set in FY26	20 new officers that are using the app/mobile crisis solution by FY29	County, State
Reduce placement times from appropriate BH needs individuals in hospitals to nursing homes	Data reported by participating nursing homes and hospitals	Baseline to be set in FY26	15% decrease in placement times FY31	County, State
Initiative 6: ALF Special Needs Population Incentive Model				
Number of memory care beds in ALFs for Medicaid recipients	Nebraska Medicaid data	2,656 (29% of all ALF beds for Medicaid, 2025)	10% increase by FY31	County, State
Number of ALF beds for Medicaid population	Nebraska Medicaid data	9,229 (66% of all ALF licensed beds, 2025)	10% increase by FY31	County, State
Number of ALFs with Memory Care Units participating in Medicaid 1915(c) AD Waiver	Nebraska Medicaid data	Baseline data to be set in FY26	10% increase by FY31	State
Number of ALFs outfitted for complex care statewide	Data reported by participating sites	Baseline data to be set in FY26	10% increase by FY31	State
Initiative 7: NETECH				
Fund design and legal framework developed	Data tracked and reported by fund lead	0 (2025)	Completed by FY27	State
Technology pipeline established and vetted solutions identified	Data tracked and reported by fund lead	Baseline data to be set in FY26	At least 10 technologies by FY28	State
Investor engagement and matching commitments secured	Data tracked and reported by fund lead	Baseline data to be set in FY26	Minimum of 4:1 in private co-investment	State
Initial deployments in pilot rural communities	Data tracked and reported by fund lead	0 (2025)	2–3 cohorts by FY29	County, Facility

SUSTAINABILITY PLAN

Nebraska is committed to ensuring that the transformative initiatives implemented under the RHTP will continue to benefit rural residents and providers well beyond the five-year cooperative agreement period. Each initiative includes a detailed plan for transitioning RHTP-

funded activities to existing State or federal programs, private payer or Medicaid reimbursement mechanisms, private local investments, or durable local and regional partnerships.

Across all initiatives, Nebraska's sustainability framework is designed to ensure that investments made through the RHTP build permanent capacity within the State's rural health system. Maintaining active oversight through DHHS divisions and advisory bodies, Nebraska will achieve durable, self-sustaining transformation well beyond FY31.

INITIATIVE 1 – MAKE RURAL NEBRASKA HEALTHY AGAIN THROUGH FOOD AS MEDICINE: This initiative will be sustained through partnerships and enhanced training models that embed expertise in the community. For healthy menu design, a train-the-trainer model will be used and will equip UNL Extension professionals, food service directors, and culinary experts to provide ongoing support and mentoring. Trainers certified under the program will mentor new cohorts each year ensuring statewide continuity.

The regional food hubs will transition to self-sustaining business models and will assist farmers and ranchers to sell their products locally. These avenues to purchase healthy and nutritious local options will continue after the funding period ends. Nebraska's Department of Agriculture and Economic Development will continue to provide TA. The infrastructure and technical-assistance model developed through RHTP for the farm-to-school procurement and policy TA will be embedded within State and regional agencies ensuring that nonprofit and educational partners can sustain and increase services beyond the initial grant period.

INITIATIVE 2 – REGIONALIZED RURAL ACCESS AND NAVIGATION: To ensure sustainability of the statewide, regionalized access and navigation system that links EMS, perinatal care, CP, CHWs, and long-term care models, Nebraska will transition operational components into established reimbursement and policy frameworks. CHW positions will be

sustained through a SPA for Medicaid reimbursement of defined CHW services following the submission planned for early CY2029. Regional EMS and CP systems will align with private payers and Medicaid coverage for treat-in-place and alternate-destination protocols supported through future State rulemaking. Facility conversions will continue through billable service lines (chronic care management and telehealth) and local cost-sharing agreements. The Perinatal Regionalization and Community Health Home models will be institutionalized through the NPQIC, the EMS Board, and DPH's ongoing quality improvement infrastructure. Post-grant, governance will be led by DPH and the RHAC, with ongoing quality improvement reporting incorporated into the State's rural health dashboards.

INITIATIVE 3 – RURAL WORKFORCE ACCELERATION: Nebraska's Rural Workforce Acceleration initiative will sustain long-term workforce gains by embedding recruitment, training, and retention supports within existing funding and policy structures. Recruitment and retention programs will continue through the statutory programs, leveraging State general funds, when applicable, and private partnerships. Rural Health Career Pathways and Retention supports will transition to braided Workforce Innovation and Opportunity Act, Temporary Assistance for Needy Families, and SNAP E&T 50/50 funding models by FY31. The VR and Skills Acceleration Network will be maintained through health-system continuing education budgets, managed-care quality incentives, and periodic technology refreshes supported by DPH. uBEATS will remain supported through UNMC and UNO co-funding, philanthropic contributions, and integration into school district curricula. Short-term housing support will be sustained through philanthropic and community development partners.

Participants in previous workforce programs report they intend to continue to practice in a rural or underserved area for an additional 20 years following completion of their obligation.[65] This

indicates lasting and sustained access to medical professionals due to recruitment and retention efforts tied to an initial commitment period. Likewise, RHTP investments in bolstering the workforce in rural and frontier communities will lead to a sustained increase in providers in these targeted shortage areas.

INITIATIVE 4 – EHEALTH AND MOBILE: Following FY31, mobile maternal services, oral health outreach, and RPM will be integrated into existing Medicaid and public health structures. Mobile maternal services will transition to DHHS Title V Maternal and Child Health funding and partner hospital billing structures. Oral health outreach and prevention will be sustained through LHDs and university dental partnerships, supported by billing for preventive codes and community donations. RPM will continue under private payer, Medicare and Medicaid reimbursement, aligned with the Prospective Payment System (PPS) and Alternative Payment Models. Infection prevention/control TA will remain within DPH Office of Oral Health & Dentistry's ongoing programs. DHHS will conduct monitoring through REDCap software and existing data-sharing agreements with partner LHDs and providers.

INITIATIVE 5 –RURAL EMERGENCY BEHAVIORAL HEALTH: This initiative will create a sustainable behavioral health continuum by transitioning to other funding mechanisms. Integrated primary care sites will continue billing through Medicaid, Medicare, and private payers for behavioral health services provided in co-located clinics. Telehealth crisis response for law enforcement will transition to CCBHCs under existing PPS reimbursement. Modified crisis stabilization and withdrawal management facilities will sustain operations through private payer, Medicare and Medicaid reimbursement. If successful, the nursing home pilot will be considered for a Medicaid provider rate adjustment for high need behavioral health clients. DBH will continue to oversee performance monitoring, fiscal audits, and TA after the cooperative

agreement ends. DHHS may also consider a Medicaid waiver pathway to sustain payments to nursing homes.

INITIATIVE 6 – ALF SPECIAL NEEDS POPULATION INCENTIVE MODEL: This initiative creates incentive payments and capital investments for ALFs providing memory care and medically complex services. MLTC and the Divisions of Developmental Disabilities and Aging will incorporate memory care and complex medical services into waiver coverage through nonfederal share appropriations and associated Federal Financial Participation. Facility modernization projects will transition to standard Medicaid reimbursement and potentially to State General Fund support for ongoing infrastructure improvements. Partnerships established during RHTP will continue under long-term collaboration agreements with local long-term care associations and providers. The State will continue quality oversight through its licensing and survey processes and integrate policy changes into updated regulations.

INITIATIVE 7 – NETECH: NETECH will use initial RHTP funding to establish the operational structure of the fund, pilot early projects, and attract private partners with the goal of becoming a private investment model that continues well beyond the grant period. Governance will remain under DHHS, ensuring that State oversight and evaluation standards (described in the Metrics and Evaluation Plan) remain aligned with Nebraska's RHTP goals.

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