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DEPT. OF HEALTH AND HUMAN SERVICES

Draft

Substance Use Disorder Section 1115 Demonstration Amendment

July 18, 2025

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EXECUTIVE SUMMARY

The Nebraska Department of Health and Human Services (DHHS) Division of Medicaid & Long-Term Care (MLTC) seeks to amend its current Section 1115 Substance Use Disorder (SUD) Demonstration Waiver in support of the Department's goals of increasing availability of cost-effective services and lowering overall costs for the program.

Specifically, Nebraska is requesting expenditure authority for: (1) short-term medically necessary residential and inpatient stays primarily for mental health treatment within settings that meet the regulatory classification of institutions for mental diseases (IMDs); and (2) a targeted medical respite care service provided to adult individuals who are homeless or at-risk of homelessness and are recovering from acute or acute-on-chronic physical health conditions post-discharge from an eligible setting to reduce the need for preventable hospitalizations.

Coverage of short-term IMD stays for otherwise eligible youths and adults who have Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) is an important component in DHHS's strategy to build a robust behavioral health continuum of care that knits Medicaid coverage together with programs administered by DHHS sister divisions, initiatives of other state agencies and community-based programs. Increasing mental health treatment availability at every level of need throughout the state's behavioral health continuum of care for youth and adults with SMI or SED would allow MLTC to better address acute mental health needs and improve health outcomes for covered populations, thereby reducing out-of-state treatment placements and avoiding treatment in less appropriate and costlier settings such as emergency departments. The State remains committed to maintaining a robust continuum of community-based outpatient services and supports and will continue expanding on current efforts to promote a coordinated and integrated system of care to improve outcomes and prevent unnecessary residential admissions.

The medical respite care service would provide individuals being discharged from eligible settings with a stable environment for safe recuperation and prevent avoidable hospitalizations. Nebraska faces significant challenges in addressing the healthcare needs of homeless individuals discharged from settings in which they had been receiving care for a physical acute or acute-on-chronic illness or injury. Medicaid coverage of the medical respite care service aims to avoid preventable costs to the healthcare system by providing temporary care in medical respite care facilities to address physical and behavioral healthcare and social needs for homeless individuals and provide support between eligible discharges and recovery. The goal of this service is to reduce unnecessary hospital readmissions by addressing ongoing care needs in the most appropriate environment and supporting the long-term health and well-being of this vulnerable population.

The State seeks approval of this amendment effective January 1, 2026. The state intends to implement the coverage of SMI/SED stays in an IMD effective January 1, 2026, and coverage of medical respite care services effective April 1, 2026.

1 NEBRASKA SYSTEM OF CARE

1.1 OVERVIEW: SERIOUS MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCE IN NEBRASKA

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 359,000 Nebraskans were diagnosed with a mental health condition on average in 2022 and 2023.[1] In State Fiscal Year 2022, approximately 52,000 Medicaid-enrolled adults and more than 28,500 Medicaid-enrolled youth received behavioral health services, accounting for approximately 20% of enrolled members.[2]

1.1.1 SMI/SED TREATMENT SYSTEM

The State of Nebraska seeks to address these needs through a continuum of care financed through various sources. Nebraska MLTC works closely with Nebraska Division of Behavioral Health (DBH) and Nebraska Division of Children and Family Services (CFS) to ensure a broad range of services are available throughout the state that include both inpatient and community-based options.

DHHS operates one 85 bed psychiatric hospital serving adults, Lincoln Regional Center (LRC), as well as LRC Whitehall Psychiatric Residential Treatment Facility (PRTF), a 24 bed PRTF that services youth. Both of these facilities fit the regulatory definition of an IMD. Currently, DBH covers stays at LRC for adults with SMI, while Medicaid is able to cover stays for youth at Whitehall under the Inpatient Psychiatric Services for Individuals Under Age 21 Exception.[3]

The State has expenditure authority through its Section 1115 SUD Demonstration Waiver to cover services during short-term substance use disorder (SUD) treatment stays in facilities that meet the regulatory definition for IMDs. The IMD authority has been critical to ensuring adequate treatment availability for individuals requiring clinically appropriate services in residential settings. Since July 1, 2019, the SUD Demonstration has allowed Nebraska Medicaid to cover services during 3,558 short-term IMD stays that would not have been reimbursable absent the Demonstration waiver. These stays represent over 63% of the SUD short-term stays covered by Medicaid for adults ages 21-64.[4]

Provider testimonial on the benefits of the 1115 SUD Demonstration:

> *"Even the engagement that you see is different once people are not worried how much this [SUD treatment] is going to cost them or if it's possible. We've had people come into services simply because they did get Medicaid and it [SUD treatment] was something that was now a possibility for them."*

As part of the SUD Demonstration Waiver implementation plan, MLTC also expanded access to medication assisted treatment (MAT) by adding coverage of an opioid treatment program in 2021. The State also expanded its SUD treatment continuum by adding Medicaid coverage for medically monitored inpatient withdrawal management (MMIW). MLTC implemented several additional SUD treatment delivery system enhancements as outlined in the 1115 SUD Demonstration Interim Report.[5]

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[1] Substance Abuse and Mental Health Services Administration. (2022). *National Surveys on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia) 2022 and 2023*. https://www.samhsa.gov/data/sites/default/files/reports/rpt56186/2023-nsduh-sae-totals-tables/2023-nsduh-sae-totals-tables.pdf

[2] Claim and managed care encounter data from July 1, 2021 through June 30, 2022, queried from state Medicaid enterprise data warehouse (HIA – HealthInteractive).

[3] It is allowable for Medicaid to reimburse Whitehall for code H2013 for PRTF services with associated modifiers on account of PRTFs being carved out of the IMD Exclusion.

[4] Stay information from July 1, 2019 through September 30, 2023, received directly from contracted managed care health plans.

[5] Nebraska Substance Use Disorder Section 1115 Demonstration: CMS Approved Interim Evaluation Report, nb-cms-aprvd-intrm-evltn-rprt.pdf

1.1.1.1 CURRENT NON-MEDICAID SMI/SED SERVICES

Nebraska provides access to a wide array of community-based focused interventions for individuals experiencing acute and long-term behavioral health conditions. These interventions are part of a continuum of care to prevent the need for or to decrease the duration of residential care for both pre- and post-admission to an IMD. As detailed in the Program Description section below, Nebraska Medicaid beneficiaries have access to a range of behavioral health services that address multiple levels of care, including crisis services, comprehensive community-based services, and other outpatient therapy and support. Together these benefits aim to ensure individuals are engaged in care immediately, and over the long-term, to promote residential diversion and support step down and transitions if residential care is needed.

Through grant and state funding, Nebraska DBH and CFS expand access to treatment options and add the availability of unique alternatives that include crisis and inpatient diversion services.

Community Based Crisis and Inpatient Diversion Behavioral Health Services		
Service	**Description**	**Responsible Agency**
24-Hour Crisis Line	Links to a licensed behavioral health professional, law enforcement, and other emergency services, and is designed to work with the consumer toward immediate relief of their distress in pre-crisis and crisis situations, reduce the risk of escalation of a crisis, arrange for emergency onsite responses when necessary, and provide referral to appropriate services when other or additional intervention is required.	DBH
Crisis Response	Uses natural supports and resources to resolve an immediate mental health or substance use crisis in the least restrictive environment by creating a plan with the individual to resolve the crisis. The goal of the service is to develop and begin implementation of a crisis intervention plan, ensure safety, and ensure access to the necessary level of care.	DBH
Emergency Community Support	Assists individuals who can benefit from high levels of support due to an urgent behavioral health need, offering stabilization by providing case management, behavioral health referrals, assistance with	DBH

Community Based Crisis and Inpatient Diversion Behavioral Health Services		
Service	**Description**	**Responsible Agency**
	daily living skills, and coordination between the individual, the formal and informal support system, and behavioral health providers.	
Hospital Diversion	Peer-operated service that assists individuals in decreasing psychiatric distress which may lead to hospitalization. Hospital Diversion offers individuals the opportunity to take control of a crisis or potential crisis and develop new skills through a variety of traditional self-help and proactive tools designed to maintain wellness. Certified Peer Support Specialists provide contact, support, and/or referral for services, as requested, during and after the stay, as well as manning a Warm Line. Hospital Diversion settings are fully furnished for comfort.	DBH
Intensive Community Services	Promotes independent and community living skills and prevents the need for a higher level of care for individuals with SMI. Services include treatment/recovery, care coordination activities as well as linkage to community services, provision of active rehabilitation and support interventions, and other independent living skills that enable the individual to reside in the community.	DBH
Day Support	Provides social support to individuals who currently receive, or have received, treatment for SMI and are in the recovery process so they can benefit from socialization, leisure skill development, communication, and coping skill development.	DBH

Community Based Crisis and Inpatient Diversion Behavioral Health Services		
Service	**Description**	**Responsible Agency**
Mental Health Respite	Short-term program designed to provide shelter and assistance to address immediate needs for individuals with SMI transitioning between residential settings or who benefit from a break from the current home or residential setting. This service supports an individual throughout the transition or break, provides linkages to needed behavioral health services, and assists in timely transition back into the community.	DBH
Recovery Support	Promotes successful independent community living by assisting individuals in achieving behavioral health goals, supporting recovery, and connecting the individual to services aiding the goals. Recovery Support links individuals to community resources, identifies and problem solves barriers that limit independent living, and builds on strengths and interests that support wellbeing.	DBH
Therapeutic Consultation	Interdisciplinary collaborative, organized clinical consultations in the youth's natural community environments (such as school or home) and the development of recommendations for youth with SED-focused behavioral health skills development and potential treatment of critical behavioral health issues that will allow the youth to participate and function more successfully in the community.	DBH
Supported Employment	Provides recovery and rehabilitation services and supports to individuals engaged in community-based competitive employment-related activities in integrated settings. A Supported	DBH

Community Based Crisis and Inpatient Diversion Behavioral Health Services		
Service	**Description**	**Responsible Agency**
	Employment team provides assistance with all aspects of employment development as requested and needed by the individual.	
Family Centered Treatment Homes	Includes the implementation of evidence-based practice prevention services designed to empower families at-risk of entering the child welfare system. The services include in-home, skills-based training for parents; mental health care, including family therapy; and substance use services.	CFS
Parents Anonymous	Seeks to enhance family functioning and parent/caregiver resilience to prevent and treat child maltreatment by offering groups for parents/caregivers and their children/youth.	CFS

1.2 MEDICAL RESPITE CARE SERVICE

MLTC is including a request for authority for a medical respite care service in response to state Legislative Bill 905 (LB905), which was signed into law by Governor Jim Pillen on March 27, 2024. The bill requires MLTC to submit a Medicaid Section 1115 Demonstration Waiver application seeking authorization for a Medicaid-covered medical respite care service. The goal of this legislation is to reduce costs associated with acute and acute-on-chronic physical medical conditions by addressing the healthcare needs of the homeless population, specifically creating a new option for continued recovery post-discharge for unsheltered individuals who may otherwise need continued care provided in eligible settings. The bill directs MLTC to introduce the service in two medical respite facilities – one in a city of the metropolitan class and one in a city of the primary class.

According to 2022 data from the United States Department of Housing and Urban Development, approximately 2,246 individuals experience homelessness on any given night in Nebraska.[6] When recovering from an acute or acute-on-chronic condition, these individuals do not have the stable and safe setting required to make a full recovery. This, in turn, can result in an exacerbation of health care conditions and avoidable care needs and admissions, which increases costs to the Medicaid program. Insecure housing may increase the risk of infectious diseases in environments where residents are overcrowded.[7] It

[6] Stebbens, S. *How the Homelessness Problem in Nebraska Compares to Other States*, 25 Sep. 2023. The Center Square. www.thecentersquare.com/nebraska/article_622f35ca-f593-543d-b25f-c9717ea40c71.html.
[7] Ibid.

also contributes to poor access to needed healthcare services and affects mental health as well as other health-related factors.[8] The result is a need for preventable acute care and hospitalizations.

The waiver program is an opportunity to partner with facilities dedicated to supporting the homeless population and to understand and address gaps in recuperative care experienced by individuals in these areas of the state. Doing so will allow the state to reduce Medicaid expenses for high-price services such as hospital admissions and chronic illnesses.[9] Nebraska is fortunate to have an established medical respite program at Siena Francis House in Omaha and commitments from Lincoln stakeholders eager to put their partnerships and resources together to create a similar program. The state will be able to leverage an established program with mature processes for admissions, care and discharge planning, existing referral networks, and care coordination to support the success of this waiver that expands services to the target Medicaid population.

2 PROGRAM DESCRIPTION

2.1 SMI/SED STAYS IN INSTITUTIONS FOR MENTAL DISEASE

Through this Demonstration, Nebraska seeks to improve upon its behavioral health continuum of care and is requesting authority to claim federal financial participation (FFP) for reimbursement of services to Medicaid beneficiaries with SMI/SED receiving services during short-term inpatient psychiatric treatment or residential mental health stays in IMDs.

Despite the wide range of community-based behavioral health services currently offered, some individuals still require treatment that can only be managed in a secure residential setting staffed with the specialty clinicians most qualified to care for the unique needs of this population. Without the waiver, Nebraska faces a shortage of Medicaid reimbursable settings that can provide intensive treatment. This shortage places both the member and the State in less than desirable, sometimes dangerous, and inefficient circumstances when an institutional setting is necessary. Individuals may find themselves in lengthy emergency department stays where they are unlikely to receive adequate care and often must wait before space in an inpatient psychiatric facility becomes available. Similarly, they may find themselves in general hospitals not equipped to provide the proper treatment and for only a very short period of time before being discharged. Some general hospitals are also unable to provide adequate stabilization or connections to outpatient care. None of this care is cost-efficient.

Nebraska is committed to prompt and quality treatment in IMDs that will prioritize minimizing the number of days required in the institutional setting and ensuring members are discharged with the appropriate medications and resources to successfully manage their illness in their desired community living environment. This option will complement the slate of available and proposed crisis and community-based services to assist with management of long-term behavioral health conditions.

2.1.1 LENGTH OF STAY

In accordance with CMS requirements, the State will not reimburse for stays of more than 60 consecutive days and will maintain a statewide average length of stay of 30 days.

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[8] US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). *Social Determinants of Health*. Retrieved from Healthy People 2030: https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health.

[9] Chisolm, D. J., Brook, D. L., Applegate, M. S., & Kelleher, K. J. (2019). *Social determinants of health priorities of state Medicaid programs.* BMC health services research, *19*(1), 167. https://doi.org/10.1186/s12913-019-3977-5.

2.1.2 COMMUNITY-BASED SUPPORTS AND SERVICES

The facility-based services that would be authorized via this Demonstration would be part of a broader continuum of services for individuals with SMIs and SEDs. The addition of coverage for IMDs will become part of, and not supplant, existing community-based services and initiatives, including those noted in the System of Care section above. The CCBHC rollout, projected to be implemented January 1, 2026, is underway in the state and will create a new foundation for the community-based treatment continuum that this waiver will complement.

Nebraska Medicaid currently offers a range of Medicaid covered evidence-based behavioral health services, including both crisis stabilization and comprehensive services, optimized to assist during a crisis or to manage long term illnesses. This helps to ensure individuals are engaged in care immediately and seek to prevent the need for residential care. This service continuum reflects MLTC's strategy of investing in community-based services that address the diagnoses most often exhibited by the state's Medicaid population as illustrated in the table below.

Medicaid Covered Community Based Behavioral Health Services	
Service	**Description**
Assertive Community Treatment (ACT)	A community-based service provided by transdisciplinary professionals who use a team approach to meet the needs of individuals with SMI. ACT uses an assertive, recovery-focused, and individualized treatment model that values self-determination, strengths, and rehabilitation.
Crisis Outpatient Psychotherapy	An immediate, short-term treatment service provided to an individual or families. The intervention/safety plan identifies the crisis with steps for further resolution, outlines an individualized safety plan for the individual and/or family, and identifies additional formal and informal supports. The clinician assists in making appropriate referrals. This service is complimented by coverage of non-crisis individual, group and family psychotherapy.
Intensive Outpatient Services (IOP)	Non-residential, intensive, structured interventions consisting of counseling and education regarding the needs of the targeted population. Interventions include ongoing assessment, individual, group, and family psychotherapy and psycho-educational services aimed at preparing the individual to apply learned skills in "real world" environments.
Peer Support Services	Services provided by individuals who have lived experience with behavioral health or substance use disorders. These services are designed to assist individuals with initiating and maintaining the process of long-term recovery and resiliency to improve their quality of life, health, and wellness by living self-directed lives and striving to reach their full potential.
In-Home Psychiatric Nursing Services	Primary care services provided by psychiatric registered nurses and advanced practitioner registered nurses to the mental health population in the primary residence of the individual. Advanced practice registered nurses assess, diagnose, and treat individuals with psychiatric disorders or the potential for such disorders using their full scope of therapeutic skills, including the prescription of medication and administration of psychotherapy.

Medicaid Covered Community Based Behavioral Health Services	
Service	**Description**
Adult Day Treatment	A service designed to prevent hospitalization or to facilitate the movement of an acute psychiatric individual to a status in which the individual is capable of functioning within the community with less frequent contact with the psychiatric health care provider.
Day Rehabilitation	A service designed to provide individualized treatment and recovery, inclusive of psychiatric rehabilitation and support for individuals with SMI and/or co-occurring disorders who are in need of a program operating variable hours. The intent of the service is to support the individual in the recovery process so that they can be successful in a community living setting of their choice.
Community Support	Provides rehabilitative and support services for individuals with a primary mental health diagnosis. Community support workers provide direct rehabilitation and support services in the community with the intention of supporting the individual to maintain stable community living and preventing exacerbation of their mental illness and admission to higher levels of care.
Community Treatment Aide	Includes supportive interventions designed to assist the individual and parents or primary caregivers to learn and rehearse the specific strategies and techniques that can decrease the severity of, or eliminate, symptoms and behaviors associated with the individual's mental illness that create significant impairments in functioning. Services are delivered in the individual's natural environment, primarily the individual's home, but may also include a foster home, school or other appropriate community locations.
1915(i) Therapeutic Family Care Crisis Support Services	Expanded the service array for high-acuity children and youth in the foster care system experiencing a crisis. The program includes crisis service maintenance and response, and mobile crisis services.

2.1.3 COMMUNITY-BASED MAINTENANCE OF EFFORT (MOE)

As part of this amendment, Nebraska reiterates its commitment to maintaining funding for and access to outpatient community-based behavioral health services. As such, the State assures that resources will not be disproportionately drawn into increasing access to treatment in inpatient or residential settings at the expense of community-based services. Nebraska acknowledges that the Demonstration must maintain a level of state appropriations and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of this Demonstration that is no less than the amount of funding provided at the beginning of the Demonstration.

All beneficiaries will continue to have access to the array of mental health services listed above. Additionally, the state is exploring opportunities to expand access to community-based services as part of the continuum of services that will be implemented in alignment with this waiver.

2.1.3.1 SMI/SED PROGRAMS AND INITIATIVES IN DEVELOPMENT

Highlighting Nebraska's commitment to grow its behavioral health treatment array, the statewide initiatives outlined below seek to further expand access and compliment already established community-based services.

2.1.3.1.1 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC

Legislative Bill 276, authorized and enacted by the Nebraska Legislature and signed into law by Governor Jim Pillen on May 25, 2023, began the implementation of Certified Community Behavioral Health Clinics (CCBHCs). The intent of this initiative is to increase access to mental health and substance use treatment and expand capacity for comprehensive, integrated, high quality, and equitable services based in evidence-based practices. Care coordination and community partnerships with community-based entities, including law enforcement, schools, health care providers and human services organizations, will be the foundation of the CCBHC initiative.

Once implemented, the CCBHCs will serve as the cornerstone for community-based behavioral health care. Nebraska's CCBHCs will meet federal certification standards and will ensure statewide access to crisis mental health services, including through mobile crisis services. CCBHCs will also provide, at a minimum, the following additional community-based services either directly or through partnerships:

- Outpatient mental health and substance use services;
- Screening, assessment, and diagnosis, including risk assessments;
- Person-centered treatment planning;
- Outpatient clinic primary care screening and monitoring of key health indicators and health risks;
- Targeted case management;
- Psychiatric rehabilitation services;
- Peer support and counselor services and family supports; and
- Community-based mental health care for members of the armed forces and veterans consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration.

Design of a Medicaid State Plan Amendment for CCBHCs is underway with implementation planned for January 1, 2026.

2.1.3.1.2 CARE COORDINATION AND TRANSITIONAL SUPPORTS FOR INDIVIDUALS WITH SMI

In an effort to ensure particularly vulnerable populations with SMI are connected with the supportive services they need to allow them to remain in or transition to community-based settings, MLTC, DBH, and the Nebraska Division of Developmental Disabilities (DDD) are collaborating on a new 1915(i) program that will provide transitional supports, supportive housing, and supported employment to Medicaid-covered individuals that meet the program eligibility criteria. The new 1915(i) program will be accompanied by expansion of the Medicaid State Plan Targeted Case Management (TCM) service to individuals with a SMI. Nebraska is working towards an April 1, 2025 implementation date for the 1915(i) and TCM services.

2.1.3.2 FUTURE INITIATIVE UNDER CONSIDERATION: MOBILE CRISIS

The state is actively exploring the feasibility of implementing a Mobile Crisis Service for all Medicaid-enrolled members. This service would build upon the current crisis infrastructure in the state, which includes crisis hotlines, and upcoming initiatives such as CCBHCs. Should the State move forward with mobile crisis response, authority will be requested through a State Plan Amendment.

2.2 MEDICAL RESPITE CARE SERVICE

MLTC has taken a comprehensive approach to developing the direction of the medical respite care service in collaboration with providers and organizations who currently support the homeless population. These stakeholders have provided invaluable feedback on the needs of these individuals and have helped to inform how the service could be most impactful. Through reviewing data from Siena Francis House, MLTC was able to identify program details that align with the current needs of individuals living with acute medical conditions while navigating unstable housing situations. This information was coupled with standards and frameworks recommended by the National Institute of Medical Respite Care (NIMRC) to form the basis of the proposed medical respite care service.

MLTC considered many specific factors during development of the program criteria that are essential to the recovery of individuals receiving the service. Those include ensuring the medical respite provider could deliver a comprehensive level of care that includes:

- Providing safe and adequate accommodations;
- Managing timely transition to the medical respite care facility from the discharge setting;
- Arranging for post-acute clinical care;
- Assisting with medical and social care coordination; and
- Employing personnel who are trained, equipped, and licensed, if applicable, to deliver the components furnished directly by the medical respite provider.

2.2.1 SERVICE DESCRIPTION

The medical respite care service will provide short-term housing with access to supportive physical and behavioral healthcare and social services for individuals who require ongoing monitoring and regular access to medical care. To be eligible, individuals must be enrolled in a full benefit eligibility group under the State Plan, be an adult age 19 and over, and meet the risk factors noted below.

The medical respite care service will include the following core components:

- Room and board
- Case/care management of medical and social needs
- Daily wellness check
- Access to medical care and clinical services
- Medication support
- Limited non-medical transportation

Non-emergency medical transportation (NEMT), medical/clinical services needed to treat the illness or injury that prompted the medical respite care service admission, and any additional specialty or primary care will remain covered separately under the Nebraska Medicaid State Plan.

2.2.2 LENGTH OF STAY

The medical respite care service will be limited to a length of stay of no more than six months per rolling 12-month period.

2.2.3 RISK FACTORS

Medicaid beneficiaries in the applicable eligibility group must also meet clinical and social risk factors as determined by assessment to qualify for medical respite care.

Social Risk Factor	Health Risk Factor
Meet the definition of homeless as defined by 42 U.S.C. § 11302	Require ongoing recovery in order to heal from a physical illness or injury, are post-discharge/release from certain institutions, and at risk of re-hospitalization due to inadequate housing for recuperation.

2.2.4 ELIGIBLE DISCHARGE SETTINGS

Eligible Discharge Settings
Acute care hospitals (inpatient and outpatient)
Ambulatory surgical centers
Skilled nursing facilities

MLTC intends to establish a referral process to identify and communicate potential candidates for medical respite care to create a seamless transition between inpatient care to one of the medical respite care facilities, as well as a process for assessing a beneficiary's appropriateness for this service. These processes will be further outlined in the Protocol for Assessment of Beneficiary Eligibility and Needs to be submitted following approval.

2.2.5 ELIGIBLE PROVIDERS

MLTC will engage two providers, one in a city of the metropolitan class and one in a city of the primary class. These providers will be required to enroll as a Medicaid provider and to meet state licensure and/or certification requirements. MLTC will allow providers flexibility to partner with a clinical care provider, such as a federally qualified health center, to provide any recuperative or rehabilitative treatment required for the beneficiary's illness or injury for which medical respite care is being provided as well as other covered healthcare services. Such provider must also be Medicaid-enrolled to receive reimbursement of State Plan covered specialty or primary services or waiver services for which their provider type is permitted to render.

2.3 GOALS

2.3.1 SMI/SED STAYS IN INSTITUTIONS FOR MENTAL DISEASE

The goals of this aspect of the Demonstration build upon community-based efforts already utilized throughout the state, including:

1. Reducing utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings;
2. Reducing preventable readmissions to acute care hospitals and residential settings;
3. Improving availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
4. Improving access to community-based services to address the chronic mental health care needs of beneficiaries with SMI/SED, including through increased integration of primary and behavioral health care; and
5. Improving care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

2.3.2 MEDICAL RESPITE CARE SERVICE

MLTC is seeking to advance the following goals with this aspect of the Demonstration:

- Ensure individuals can be seen in the most cost effective and medically appropriate settings.
- Provide a stable, medically-supported setting for extended recuperation.
- Reduce the risk for readmission into an inpatient facility or emergency department.
- Improve future health outcomes and reduction in Medicaid costs for the homeless population.

2.4 MILESTONES FOR SMI/SED STAYS IN INSTITUTIONS FOR MENTAL DISEASE

Nebraska's coverage of short-term IMD stays for SMI and SED will be implemented through specific milestones that align with the goals of improving behavioral health options available throughout the state. Some of these milestones will be demonstrated through current initiatives and policies. Others will be developed during the Demonstration and outlined in the State's Implementation Plan. The state will also outline its process for monitoring and reporting on milestones and data in its Implementation Plan.

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

- Participating hospitals and residential settings are licensed or otherwise authorized by the state to primarily provide treatment for mental illnesses and are accredited by a nationally recognized accreditation entity including the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) prior to receiving FFP for services provided to beneficiaries;
- Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
- Use of a utilization review entity (e.g., a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
- Participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements, and the State has a process for conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, states must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
- Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and SUD and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in these treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

Milestone 2: Improving Care Coordination and Transitions to Community-Based Care

- Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help transition beneficiaries out of these settings and into appropriate community-based outpatient services - as well as requirements that community-based providers participate in these transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings and/or by hiring peer support specialists to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment);

- Implementation of a process to assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available;
- Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider the person was referred to;
- Implementation of strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers);
- Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

Milestone 3: Increasing Access to Continuum of Care Including Crisis Stabilization Services

- Annual assessments of the availability of mental health services throughout the state, particularly crisis stabilization services and updates on steps taken to increase availability;
- Commitment to a financing plan approved by CMS to be implemented by the end of the Demonstration to increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, coordinated community crisis response that involves law enforcement and other first responders, and observation/assessment centers as well as on-going community-based services, e.g., intensive outpatient services, assertive community treatment, and services in integrated care settings such as the CCBHC model described above as well as consideration of a self-direction option for beneficiaries;
- Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
- Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association, e.g., LOCUS or CASII to help determine appropriate level of care and length of stay.

Milestone 4: Earlier Identification and Engagement in Treatment Including Through Increased Integration

- Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with serious mental health conditions, in treatment sooner including through supported employment and supported education programs;
- Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of serious mental health conditions sooner and improve awareness of and linkages to specialty treatment providers; and
- Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

2.5 OTHER PROGRAM CHANGES

Except as outlined above, there are no other program features expected to be impacted by the proposed demonstration amendment.

3 DEMONSTRATION ELIGIBILITY

This Demonstration amendment will not affect any of the eligibility categories or criteria set forth in the approved Nebraska Medicaid State Plan.

3.1 SMI/SED STAYS IN INSTITUTIONS FOR MENTAL DISEASE ELIGIBILITY

All youths and adults who are approved for full Medicaid benefits under the State Plan and are eligible for short-term IMD stays allowable under this Demonstration will receive those services.

3.2 MEDICAL RESPITE CARE SERVICE ELIGIBILITY

Adults aged 19 and over eligible for full benefits under the State Plan will be eligible for Medical Respite Care Services.

3.3 EXCLUDED ELIGIBILITY GROUPS

The following eligibility groups with limited benefits will be excluded:

- Qualified Medicare Beneficiaries (QMB)
- Specified Low Income Medicare Beneficiaries (SLMB)
- Qualified Individual (QI) Program
- Qualified Disabled Working Individual (QDWI)
- Non-citizens qualifying for emergency services only benefits

3.4 PROJECTED ENROLLMENT

This Demonstration amendment will expand the availability and access to needed treatment. The State anticipates the Demonstration amendment will have no impact on annual Medicaid enrollment.

Below is the projected enrollment for the first two demonstration years

3.4.1 SMI/SED STAYS IN INSTITUTIONS FOR MENTAL DISEASE ENROLLMENT

State Fiscal Year	Enrollment by Member Months
SFY26	504
SFY27	1025

3.4.2 MEDICAL RESPITE CARE SERVICE ENROLLMENT

State Fiscal Year	Enrollment by Member Months
SFY26	150
SFY27	600

4 DEMONSTRATION BENEFITS AND COST-SHARING REQUIREMENTS

4.1 BENEFITS

4.1.1 SMI/SED STAYS IN INSTITUTIONS FOR MENTAL DISEASE BENEFITS

As described above, Nebraska's behavioral health system of care offers a wide range of Medicaid-covered behavioral health benefits. Through this waiver amendment, the State will expand the settings that are eligible for reimbursement for clinically appropriate short-term inpatient stays for individuals with acute psychiatric episodes of care in a qualifying IMD.

4.1.2 MEDICAL RESPITE CARE SERVICE BENEFITS

The medical respite care service will provide short-term housing with supportive medical and social services, including the following service components:

- Room and board
- Case/care management of medical and social needs
- Daily wellness check
- Access to medical care and clinical services
- Medication support
- Limited non-medical transportation

MLTC will institute a length of stay limitation no longer than six months per rolling 12-month period under the Demonstration.

4.2 COST SHARING

Cost-sharing requirements under the Demonstration will not differ from the approved Medicaid State Plan for either service described in this waiver.

5 DELIVERY SYSTEM AND PAYMENT RATES FOR SERVICES

5.1 DELIVERY SYSTEM

No modifications to the current Medicaid fee for service (FFS) or managed care delivery systems are proposed through this amendment. All Medicaid-enrolled individuals will continue to receive services through their current delivery system.

5.1.1 SMI/SED STAYS IN INSTITUTIONS FOR MENTAL DISEASE

Expenditure authority authorized under the SMI/SED section of this Amendment will apply to both the FFS and managed care delivery systems and be available to all eligible beneficiaries.

5.1.2 MEDICAL RESPITE CARE SERVICE

Expenditure authority authorized under the Medical Respite section of this Amendment will apply to both the FFS and managed care delivery systems and be available to all eligible beneficiaries.

5.2 PAYMENT RATES

5.2.1 SMI/SED STAYS IN INSTITUTIONS FOR MENTAL DISEASE PAYMENT RATE

Services for SMI/SED rendered in an IMD are reimbursed consistent with payment methodologies provided in the Medicaid State Plan.

5.2.2 MEDICAL RESPITE CARE SERVICE PAYMENT RATE

MLTC will establish a per diem payment methodology for medical respite care services that encompass the service array required to be delivered by medical respite care providers as outlined in the waiver and subsequent protocols. Primary, specialty, and ancillary care and any other service that is covered under the State Plan and not part of the per diem, will be billed separately by the appropriate Medicaid-enrolled provider.

6 IMPLEMENTATION OF DEMONSTRATION

MLTC requests a five-year waiver approval for this Demonstration amendment.

6.1 SMI/SED STAYS IN INSTITUTIONS FOR MENTAL DISEASE IMPLEMENTATION

The IMD/SMI portion of this amendment will be implemented statewide, with implementation starting January 1, 2026.

Nebraska will provide detailed information on its strategies, timelines and state activities for meeting the demonstration milestones in its Implementation Plan. The State will finalize and submit its Implementation Plan no later than 90-days after submission of this amendment for IMD/SMI.

6.2 MEDICAL RESPITE CARE SERVICE IMPLEMENTATION

The medical respite care service will be implemented through managed care and in collaboration with providers in each of the metropolitan areas of Omaha and Lincoln. Nebraska intends to implement the services effective April 1, 2026.

Detailed information on strategies, timelines and state activities for meeting the Demonstration's goals will be provided to CMS in the protocols for assessment of beneficiary eligibility and needs, infrastructure planning, and provider qualifications no later than 90 days after approval of this amendment. The implementation plan will be submitted in accordance with the Special Terms and Conditions.

7 EVALUATION

7.1 SMI/SED STAYS IN INSTITUTIONS FOR MENTAL DISEASE EVALUATION

The state will engage an Independent Evaluator to conduct a mixed-methods evaluation employing quasi-experimental methods to investigate the impact of the Demonstration. Both in-state and out-of-state comparisons will be used to test the evaluation hypotheses shown in the table below.

Hypothesis	Measures
The Demonstration will reduce unnecessary acute care utilization for Medicaid beneficiaries with SMI/SED	• Rate of ED visits for behavioral health (BH) diagnoses • Average length of stay (LOS) in the ED • 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
The Demonstration will increase access to the state's continuum of care for mental health services, including crisis stabilization and community-based behavioral health services	• Utilization rates: Crisis stabilization services, Intensive Outpatient Services, Partial Hospitalization Services • Utilization rates for mental health-related: Outpatient, rehabilitation and case management, home and community-based services, long term services and supports • Perceived access to appropriate treatment • Percent of Nebraska residents who report having received a mental health service in the last year
The Demonstration will improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities	• Follow-Up After Emergency Department Visit for Mental Illness (FUM) • Follow-up After Hospitalization for Mental Illness (FUH) • Medication Continuation Following Inpatient Psychiatric Discharge (AMA)

7.2 MEDICAL RESPITE CARE SERVICE EVALUATION

The Demonstration will test whether the waivers and expenditure authority granted under this amendment results in providing better health outcomes and reduces re-hospitalizations for homeless Medicaid beneficiaries recuperating from acute or acute-on-chronic physical medical conditions.

Hypothesis	Measures
The target population will receive the medical respite care service during recuperation	• Service counts
The target population will receive increased preventive and community-based care and social supports compared to a pre-Demonstration baseline	• Screening rates • Referral Rates • Service Counts
The Demonstration will improve health outcomes for the target population compared to a pre-Demonstration baseline	• Rate of inpatient hospitalization • Rate of ED visits • Rate of mortality
The Demonstration will reduce the total cost of care for the target population compared to a pre-Demonstration baseline	• Average total cost of care • Average cost of care in an inpatient or acute setting

8 DEMONSTRATION FINANCING AND BUDGET NEUTRALITY

MLTC is seeking a waiver of the 15-day monthly maximum for Serious Mental Illness (SMI) related Institute for Mental Disease (IMD) utilization as well as to provide coverage for Medical Respite services. CBIZ Optumas (Optumas) worked in conjunction with MLTC to develop the 1115 budget neutrality template for the SMI/Medical Respite component of the 5-year IMD waiver extension period outlined in Table 1.
The remainder of this document describes the assumptions used in the accompanying SMI/Medical Respite 1115 budget neutrality template called "NE SMI Med Respite 1115 Waiver BN Model - DY1-DY5."

Table 1 - Five-Year Demonstration Years

DEMONSTRATION YEARS (DY)				
DY1 (SFY2026)	DY2 (SFY2027)	DY3 (SFY2028)	DY4 (SFY2029)	DY5 (SFY2030)
7/1/2025 - 6/30/2026	7/1/2026 - 6/30/2027	7/1/2027 - 6/30/2028	7/1/2028 - 6/30/2029	7/1/2029 - 6/30/2030

Medicaid Eligibility Group (MEG)

The MEG structure is consistent with that used in the DY7-DY11 1115 SUD IMD waiver renewal. These MEGs include ABD, Dual, FAM, and EXP as shown in Table 2.

Table 2 – MEG Structure

MEDICAID ELIGIBILITY GROUP
ABD
Dual
FAM
EXP

Historical Data Assumptions

The potential SMI IMD users were identified based on existing behavioral health inpatient/residential utilization within the existing Heritage Health managed care program. To align with the intention of IMD services, the data was limited to members receiving these services that are aged 21 to 64 with a SMI/SED primary diagnosis code who used at least 10 days, but no more than 60 days, of behavioral health inpatient/residential services in a given stay.

The potential Medical Respite users were identified based on existing diagnosis code information within the Heritage Health managed care program for members with a "Z59" diagnosis code indicating that the member has "problems related to housing and economic circumstances," which is used as a proxy to identify the population that may be experiencing homelessness. This population was limited to members aged 19 to 64 within urban

counties and who incurred a hospital stay during the year, to align with the MLTC's expectations of who would be eligible to receive Medical Respite services under the waiver.

With the potential SMI and Medical Respite members and member months identified, the January 1, 2023 – December 31, 2023 (CY23) capitation payments were summarized as the baseline to be used in the Budget Neutrality modeling. This serves as the base data projection point for the SMI/Medical Respite 1115 budget neutrality template.

Trend Months

The SMI component of the demonstration proposal will be effective January 1, 2026 (six-months of DY1) and the Medical Respite component of the demonstration proposal will be effective April 1, 2026 (three-months of DY1). The trend months between the midpoint of the CY23 historical period and the midpoint of the waiver service effective period during DY1 differs for SMI and Medical Respite.
Table 3 shows the difference in trend months for the SMI and Medical respite demonstration proposals. This information can be found in the "Trend Months" tab in the SMI/Medical Respite 1115 budget neutrality template.

Table 3 – Projected IMD Member Months/Caseloads

DEMONSTRATION PROPOSAL	Historical Period Start Date	Historical Period End Date	Midpoint
SMI	1/1/2023	12/31/2023	7/2/2023
Medical Respite	1/1/2023	12/31/2023	7/2/2023

DEMONSTRATION PROPOSAL	Waiver Service Start Date	DY1 (SFY26) End Date	Midpoint
SMI	1/1/2026	6/30/2026	4/1/2026
Medical Respite	4/1/2026	6/30/2026	5/16/2026

DEMONSTRATION PROPOSAL	Trend Months
SMI	33.0
Medical Respite	34.5

Projected IMD Member Months/Caseloads

As stated above, CY23 was selected as the base point for the number of projected SMI IMD and Medical Respite service Member Months and Caseload. The potential CY23 utilizers were estimated based on the methodology outlined in the Historical Data Assumptions section above. The projected caseload growth is assumed to be 2%

annually for each MEG for SMI, which is consistent with the growth assumed in the current approved 1115 SUD IMD waiver.

For Medical Respite services, there are expected to only be 50 available slots each month, which results in an expected maximum of 600 member months annually. Once the historical population of potential utilizers of the service was identified, the overall enrollment was capped at 600 member months and distributed to each MEG based on the distribution observed in the historical data. Because of the limitation of 50 available slots, and implied maximum of 600 annual member months, caseload growth for this service is assumed to be 0% annually for each MEG.

Since SMI is effective January 1, 2026, and Medical Respite is effective April 1, 2026, DY1 reflects 6 months of SMI enrollment and 3 months of Medical Respite enrollment.
Table 4 shows the Projected waiver Member Months and Caseload by DY for each proposed waiver service. This information can be found in the "Member Months" tab in the SMI/Medical Respite 1115 budget neutrality template.

Table 4 – Projected Member Months/Caseloads

			DEMONSTRATION YEARS (DY)				
Waiver Service	MEDICAID ELIGIBILITY GROUP	Estimated CY23 Member Months	DY1 (SFY2026) - Partial Year	DY2 (SFY2027)	DY3 (SFY2028)	DY4 (SFY2029)	DY5 (SFY2030)
SMI IMD	ABD	300	159	323	329	336	343
	Dual	182	96	196	200	204	208
	FAM	39	21	42	43	44	45
	EXP	431	228	464	473	482	492
Medical Respite	ABD	136	34	136	136	136	136
	Dual	72	18	72	72	72	72
	FAM	58	15	58	58	58	58
	EXP	334	84	334	334	334	334

Historical PMPM Adjustments

While CY23 capitation rates were determined to be the most recent complete historical period, there are programmatic and fee schedule changes that are necessary to account for, before projecting to the new waiver period. The capitated rates used in the historical base data were adjusted for benefit and significant fee schedule changes implemented by DHHS. The Budget Neutrality PMPMs were not adjusted for standard annual increases in fee schedules since these are reasonably accounted for in trend. Below is a description of each item that was included in the "SMI Historical" and "Med_Respite Historical" tabs in the SMI/Medical Respite 1115 budget neutrality template. Table 5 illustrates the impact of these adjustments on the CY23 historical PMPMs, each

impacting the proportion of the historical data associated with the Heritage Health capitation rates. While the same adjustments were applied to both the SMI and Medical Respite historical PMPMs, since the underlying distribution of Heratage Health and Dental cohorts by MEG are different for SMI and Medical Respite, the impacts by MEG for these adjustments vary between the proposals.

Adjustment to CY23 PMPMs:

- Increase in pharmacy dispensing fees for independent pharmacies.
- Provider Rate Increase of 12.5% effective July 1, 2024 for dental providers along with a change in MCO contracting with dental providers.
- Increase to capitation rates related to the estimated acuity changes due to the ending of the continuous enrollment provision of the Public Health Emergency (PHE).
- Increase to capitation rates for the new Medical Respite service as part of this 1115 Waiver.

For the Medical Respite adjustment, MLTC's preliminary estimate of the daily rate of $101.15 for Medical Respite services was used to estimate the overall impact to capitation rates. The final rate may differ from the estimated $101.15 per day, however this is not expected to have a material impact on the budget neutrality calculation due to the cost of these services being spread across the entire Heritage Health population within capitation rate development.

Note: To the extent that any new directed payments or taxes are implemented into the Heritage Health capitation rates, the budget neutrality amounts would need to be adjusted accordingly.

Table 5 – Historical PMPM Adjustments

Waiver Service	MEDICAID ELIGIBILITY GROUP	CY23 Actual PMPM	CY23 Adjusted PMPM	Percent Change
SMI IMD	ABD	$ 2,071.65	$ 2,081.50	0.5%
	Dual	$ 283.87	$ 285.82	0.7%
	FAM	$ 623.60	$ 659.42	5.7%
	EXP	$ 934.69	$ 1,028.81	10.1%
Medical Respite	ABD	$ 2,053.18	$ 2,061.19	0.4%
	Dual	$ 286.56	$ 288.06	0.5%
	FAM	$ 618.98	$ 654.18	5.7%
	EXP	$ 1,014.34	$ 1,107.30	9.2%

Projected Without Waiver PMPMs

The CY23 Adjusted PMPMs were projected to DY1 through DY5 (shown in Table 6) using the President's Budget trend factors provided by CMS in May 2025 within the current approved 1115 SUD IMD waiver renewal, shown in Table 7. As described earlier in this document, there are 33 trend months between the historical CY23 period and DY1 of the 1115 waiver extension for SMI IMD and 34.5 trend months between the historical CY23 period and DY1 for Medical Respite.

Table 6 – Projected Without Waiver PMPMs

			DEMONSTRATION YEARS (DY)				
Waiver Service	MEDICAID ELIGIBILITY GROUP	CY23 Adjusted PMPM	DY1 (SFY2026) - Partial Year	DY2 (SFY2027)	DY3 (SFY2028)	DY4 (SFY2029)	DY5 (SFY2030)
SMI IMD	ABD	$2,081.50	$2,380.46	$2,499.48	$2,624.45	$2,755.67	$2,893.45
	Dual	$285.82	$326.87	$343.21	$360.37	$378.39	$397.31
	FAM	$659.42	$750.18	$786.19	$823.93	$863.48	$904.93
	EXP	$1,028.81	$1,182.76	$1,244.26	$1,308.96	$1,377.03	$1,448.64
Medical Respite	ABD	$2,061.19	$2,371.46	$2,490.03	$2,614.53	$2,745.26	$2,882.52
	Dual	$288.06	$331.42	$347.99	$365.39	$383.66	$402.84
	FAM	$654.18	$748.54	$784.47	$822.12	$861.58	$902.94
	EXP	$1,107.30	$1,280.96	$1,347.57	$1,417.64	$1,491.36	$1,568.91

Table 7 – Trend Rates

MEDICAID ELIGIBILITY GROUP	Annual Trend Rates
ABD	5.0%
Dual	5.0%
FAM	4.8%
EXP	5.2%

Budget Neutrality Summary:

The Without and With Waiver are equivalent and treated as “Hypothetical” consistent with the current approved SUD IMD 1115 Waiver demonstration. The budget neutrality expenditure estimates for SMI/Medical Respite are summarized in Table 8 below:

Table 8 – Budget Neutrality Expenditure Estimates

		DEMONSTRATION YEARS (DY)					
Waiver Service	MEDICAID ELIGIBILITY GROUP	DY1 (SFY2026) - Partial Year	DY2 (SFY2027)	DY3 (SFY2028)	DY4 (SFY2029)	DY5 (SFY2030)	Total DY1-DY5
SMI IMD	ABD	$378,493	$807,332	$863,444	$925,905	$992,453	$3,967,628
	Dual	$31,380	$67,269	$72,074	$77,192	$82,640	$330,555
	FAM	$15,754	$33,020	$35,429	$37,993	$40,722	$162,918
	EXP	$269,669	$577,337	$619,138	$663,728	$712,731	$2,842,603
	Total	**$695,296**	**$1,484,958**	**$1,590,085**	**$1,704,818**	**$1,828,547**	**$7,303,703**
Medical Respite	ABD	$80,630	$338,644	$355,576	$373,355	$392,023	$1,540,228
	Dual	$5,966	$25,055	$26,308	$27,624	$29,004	$113,957
	FAM	$11,228	$45,499	$47,683	$49,972	$52,371	$206,752
	EXP	$107,601	$450,088	$473,492	$498,114	$524,016	$2,053,311
	Total	**$205,424**	**$859,287**	**$903,059**	**$949,065**	**$997,414**	**$3,914,248**

9 LIST OF PROPOSED WAIVERS AND EXPENDITURE AUTHORITIES

9.1 SMI/SED STAYS IN INSTITUTIONS FOR MENTAL DISEASE EXPENDITURE AUTHORITY

The State requests expenditure authority for otherwise covered services (those authorized under the Medicaid State Plan and existing Medicaid waivers) furnished to otherwise eligible youths and adults who are primarily receiving treatment for SMI and SED and who are short-term residents in hospitals or residential facilities that meet the definition of an IMD.

All other initiatives and proposed program enhancements will be implemented through other State Plan and waiver authorities outside of this amendment.

9.2 MEDICAL RESPITE CARE SERVICE WAIVERS AND EXPENDITURE AUTHORITY

MLTC is requesting the following waivers and expenditure authorities necessary to implement the policies described in this Demonstration amendment:

1. Statewideness (SSA Section 1902(a)(1)). To the extent necessary to enable the state to provide medical respite care, as described herein, to qualifying beneficiaries on a geographically-limited basis.
2. Comparability; Amount Duration, and Scope of Services (SSA Section 1902(a)(10)(B)). To the extent necessary to enable the state to provide services to qualifying beneficiaries that are different than the services available to other beneficiaries, as described herein.
3. Freedom of Choice (SSA Section 1902(a)(23)(A)). To the extent necessary to enable the state to require qualifying beneficiaries to receive medical respite care through only certain providers.
4. Expenditure authority for expenditures for the medical respite care service as furnished to individuals that meet the eligibility and qualifying criteria as described in this Demonstration.

10 PUBLIC NOTICE

10.1 PUBLIC NOTICE PROCESS

MLTC conducted a thorough public engagement process in accordance with federal requirements set forth at 42 CFR 431.408. The following describes the actions taken by MLTC to ensure compliance with the federal public notice process requirements.

MLTC has provided the public with an opportunity to review and comment on this waiver amendment. MLTC posted a notice of the waiver amendment on MLTC's dedicated public notice page: https://dhhs.ne.gov/Pages/Medicaid-Public-Notices.aspx.

Public comments on the waiver amendment were accepted from July 18, 2025 to August 18, 2025.

Comprehensive information on the waiver amendment, public comment opportunities, and a copy of the full public notice were made available on the MLTC's dedicated waiver amendment webpage: https://dhhs.ne.gov/Pages/Substance-Use-Disorder-Demonstration.aspx.

Members of the public could submit written comments electronically at DHHS.Demonstrationwaivers@nebraska.gov or at the following address:

Department of Health and Human Services
Nebraska Medicaid
ATTN: Crystal Georgiana
301 Centennial Mall South
P.O. Box 95026
Lincoln, Nebraska 68509-5026

MLTC hosted two open public hearings where an overview of the waiver amendment was presented and public comments accepted. Printed copies of the waiver amendment and public notice were made available at each public hearing. Both public hearings included toll-free teleconference numbers. Details for the public hearings were posted on the dedicated waiver webpage and in the full public notice. The public hearing details (including locations, dates and times) are documented in the appendix.

The agendas for both public hearings were made available through the dedicated waiver webpage.

[To be added after hearings:

- *Number of attendees*
- *The meeting agendas]*

10.2 SUMMARY OF PUBLIC COMMENTS

[To be added after public comment period: Summary of comments received and responses]

10.3 TRIBAL CONSULTATION

On July 18, 2025, the Department sent electronic notification to representatives of the state's federally recognized tribal organizations of the opportunity to review and comment on the waiver amendment. Tribal organizations were allowed 30

calendar days to provide comments with a comment deadline of August 18, 2025. Copies of the correspondence are included in the appendix.

[*Summary of comments received and responses– to be added after tribal consultation*]

11 DEMONSTRATION ADMINISTRATION

Name and Title: Crystal Georgiana, Administrator II
Telephone Number: 402-470-1797
Email Address: Crystal.Georgiana@nebraska.gov

APPENDIX

SMI SED Provider Assessment Narrative

Narrative Description (to be completed at baseline)
1. In the space below, describe the mental health service needs (e.g. prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. [Limit responses to 500 words if possible]
In calendar year 2024, approximately 80,000 Medicaid-enrolled adults and youth had mental health related services, accounting for approximately 20% of Medicaid members. Of these, approximately 16,000 Medicaid-enrolled adults and 400 Medicaid-enrolled youth received SMI/SED related services, accounting for around 4% of enrolled members. A fairly large percentage of the population is concentrated in the urban areas of the state, along with the facilities providing mental health related services. Access and availability of SMI/SED related services remains a challenge for the state, with more than half of the state classified as a federally designated health professional shortage area (HPSA).
2. In the space below, describe the organization of the state's Medicaid behavioral health service delivery system at the beginning of the demonstration. [Limit responses to 500 words if possible]
Behavioral health services are provided through an at-risk managed care system delivery model through 1915(b) managed care authority. DHHS contracts three (3) managed care organizations (MCOs) for members to be enrolled in. Managed organizations cover the member's behavioral health, physical health, dental and pharmacy benefits.
3. In the space below, describe the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. At minimum, explain any variations across the state in the availability of the following: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. [Limit responses to 1000 words if possible]
There are known access and availability limitations for behavioral health services outside of major urban centers. SMI/SED related services remains a challenge for the state, with more than half of the state classified as a federally designated health professional shortage area (HPSA). As of January 2024, the state has around 360 beds within 16 mental health residential treatment facilities for adults and youth. The managed care organizations contractually provide mental health services, care coordination, and care transition planning that is not regionally limited.
4. In the space below, describe any gaps the state identified in the availability of mental health services or service capacity while completing the Availability Assessment. [Limit responses to 500 words if possible]
The mental health provider availability assessment reaffirms the known service limitations shown by the behavioral health shortage designations. Primarily, there are known gaps in availability of services in rural settings and to a lesser extent in limited urban settings.

5. In the space below, describe any gaps in the availability of mental health services or service capacity NOT reflected in the Availability Assessment. [Limit responses to 500 words if possible]
The assessment does not provide the opportunity to notate out of state placement agreements that expand access and availability of services. The state works with 8 out of state PRTFs that help expand the availability of services for Medicaid members. In 2024, approximately 100 Nebraska Medicaid enrolled youth received services in out of state PRTFs. These agreements help bridge the gaps in availability of services.

SME/SED Provider Assessment

Geographic Designation			Beneficiaries										
			Adult					Children			Total		
Geographic designation	Is this geographic designation primarily urban or rural?	Geographic Designation Notes	Number of adult Medicaid beneficiaries (18 - 20)	Number of adult Medicaid beneficiaries with SMI (18 - 20)	Number of adult Medicaid beneficiaries (21+)	Number of adult Medicaid beneficiaries with SMI (21+)	Percent with SMI (Adult)	Number of Medicaid beneficiaries (0 - 17)	Number of Medicaid beneficiaries with SED (0 - 17)	Percent with SED (0-17)	Number of Medicaid beneficiaries (Total)	Number of Medicaid beneficiaries with SMI or SED (Total)	Percent with SMI or SED (Total)
DBH Region 1	N/A	N/A	1269	49	10913	775	7%	9190	39	0%	21372	863	4%
Region 2	N/A	N/A	1363	37	10971	965	8%	10331	25	0%	22665	1027	5%
Region 3	N/A	N/A	3190	81	25431	1922	7%	24081	68	0%	52702	2071	4%
Region 4	N/A	N/A	2753	34	20626	1162	5%	22082	28	0%	45461	1224	3%
Region 5	N/A	N/A	5656	128	50189	4234	8%	41567	94	0%	97412	4456	5%
Region 6	N/A	N/A	11367	179	87803	6594	7%	89218	123	0%	188388	6896	4%
	N/A	N/A					-			-	0	0	-
Statewide	N/A	N/A	25598	508	205933	15652	7%	196469	377	0%	428000	16537	4%
	N/A	N/A					-			-	0	0	-
	N/A	N/A					-			-	0	0	-
	N/A	N/A					-			-	0	0	-
Total			**51196**	**1016**	**411866**	**31304**	**7%**	**392938**	**754**	**0%**	**856000**	**33074**	**4%**

Geographic Designation	Providers												
	Psychiatrists or Other Practitioners Who Are Authorized to Prescribe							Other Practitioners Certified and Licensed to Independently Treat Mental Illness					
Geographic designation	Number of Psychiatrists or Other Practitioners Who Are Authorized to Prescribe	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Accepting New Medicaid Patients	Ratio of Medicaid beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatrists or Other Prescribers	Ratio of Total Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers Accepting New Medicaid Patients	Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Category Notes	Number of Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Ratio of Other Practitioners Certified or Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Ratio of Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness Accepting New Patients
DBH Region 1		44		19.61363636	0	-			61		14.14754098	0	-
Region 2		33		31.12121212	0	-			98		10.47959184	0	-
Region 3		100		20.71	0	-			323		6.411764706	0	-
Region 4		113		10.83185841	0	-			189		6.476190476	0	-
Region 5		342		13.02923977	0	-			615		7.245528455	0	-
Region 6		686		10.05247813	0	-			1242		5.552334944	0	-
				-	-	-					-	-	-
Statewide		1169		14.14627887	0	-			2368		6.983530405	0	-
				-	-	-					-	-	-
				-	-	-					-	-	-
				-	-	-					-	-	-
Total	**0**	**2487**	**0**	**-**	**0**	**-**		**0**	**4896**	**0**	**-**	**0**	**-**

Geographic Designation	Intensive Outpatient or Partial Hospitalization Providers						
Geographic designation	Number of Intensive Outpatient/ Partial Hospitalization Providers	Number of Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	Number of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	Ratio of Total Partial Hospitalization/ Day Treatment Providers to Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	Ratio of Medicaid-Enrolled Partial Hospitalization/ Day Treatment Providers to Medicaid- Enrolled Intensive Outpatient/ Partial Hospitalization Providers Accepting New Medicaid Patients	Intensive Outpatient/ Partial Hospitalization Category Notes
DBH Region 1		3		287.6666667	0	-	
Region 2		4		256.75	0	-	
Region 3		13		159.3076923	0	-	
Region 4		12		102	0	-	
Region 5		20		222.8	0	-	
Region 6		29		237.7931034	0	-	
				-	-	-	
Statewide		75		220.4933333	0	-	
				-	-	-	
				-	-	-	
				-	-	-	
Total	**0**	**156**	**0**	**-**	**0**	**-**	

Geographic Designation	Residential Mental Health Treatment Facilities														
	Residential Mental Health Treatment Facilities (Adult)								Psychiatric Residential Treatment Facilities						
Geographic designation	Number of Residential Mental Health Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Ratio of Total Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Total Number of Residential Mental Health Treatment Facility Beds (Adult)	Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds (Adult)	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Beds	Ratio of Total Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health Treatment Beds	Number of Psychiatric Residential Treatment Facilities (PRTF)	Number of Medicaid-Enrolled PRTFs	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PTRFs	Ratio of Total PTRFs to Medicaid-Enrolled PRTFs	Total Number of PRTF Beds	Number of Medicaid-Enrolled PRTF Beds	Ratio of Total Number of PRTF Beds to Medicaid-Enrolled PRTF Beds
DBH Region 1	0	0	-	-	0	0	-	-	0	0	-	-	0	0	-
Region 2	0	0	-	-	0	0	-	-	0	0	-	-	0	0	-
Region 3	2	2	1001.5	1	21	21	95.3809524	1	0	0	-	-	0	0	-
Region 4	2	2	598	1	22	22	54.3636364	1	0	0	-	-	0	0	-
Region 5	4	3	1454	1.333333333	127	42	103.857143	3.023809524	2	2	47	1	40	40	1
Region 6	10	9	752.5555556	1.111111111	191	175	38.7028571	1.091428571	1	1	123	1	16	16	1
Statewide	18	16	1010	1.125	361	260	62.1538462	1.388461538	3	3	125.666667	1	56	56	1
Total	**36**	**32**	**-**	**1.125**	**722**	**520**	**-**	**1.388461538**	**6**	**6**	**-**	**1**	**112**	**112**	**1**

Geographic Designation	Inpatient							
	Psychiatric Hospitals				Psychiatric Beds			
Geographic designation	Number of Psychiatric Hospitals	Psychiatric Hospitals Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals Available to Medicaid Patients	Ratio of Psychiatric Hospitals to Psychiatric Hospitals Available to Medicaid Patients	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units) Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Licensed Psychiatric Hospital Beds Available to Medicaid Patients	Licensed Psychiatric Hospital Beds to Licensed Psychiatric Hospital Beds Available to Medicaid Patients
DBH Region 1			-	-			-	-
Region 2	3	2	513.5	1.5	125	40	25.675	3.125
Region 3			-	-			-	-
Region 4			-	-			-	-
Region 5			-	-			-	-
Region 6	1	1	6896	1	16	16	431	1
Statewide	4	3	5512.333333	1.333333333	141	56	295.3035714	2.517857143
Total	**8**	**6**	**-**	**1.333333333**	**282**	**112**	**-**	**2.517857143**

Geographic Designation	Institutions for Mental Diseases							
	Residential Treatment Facilities That Qualify As IMDs						Psychiatric Hospitals That Qualify As IMDs	
Geographic designation	Number of Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid- Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid- Enrolled Residential Mental Health Treatment Facilities that Qualify as IMDs	Ratio of Total Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting New Medicaid Patients	Number of Psychiatric Hospitals that Qualify as IMDs	Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals that Qualify as IMDs
DBH Region 1	0	0	-	-	-	-	0	-
Region 2	0	0	-	-	-	-	0	-
Region 3	2	2	-	1001.5	1	-	0	-
Region 4	3	3	-	398.6666667	1	-	0	-
Region 5	7	6	-	727	1.166666667	-	2	2228
Region 6	8	7	-	967.5714286	1.142857143	-	0	-
Statewide	20	18	-	897.7777778	1.111111111	-	2	8268.5
Total	**40**	**36**	**0**	**-**	**1.111111111**	**-**	**4**	**-**

NE SMI_Med Respite 1115 Waiver BN Model – DY1-DY5

Historical PMPMs: SMI IMD

Adjustments to the CY23 actual PMPMs reflects the following:

- Increase in pharmacy dispensing fees for independent pharmacies
- Provider Rate Increase of 12.5% effective July 1, 2024 for dental providers along with a change in MCO contracting with dental providers.
- Increase to capitation rates related to the estimated acuity changes due to the ending of the continuous enrollment provision of the Public Health Emergency (PHE).
- Increase to capitation rates for the new Medical Respite service as part of this 1115 Waiver.

MEDICAID ELIGIBILITY GROUP	Estimated CY23 Member Months	CY23 Actual PMPM	CY23 Adjusted PMPM	Percent Change
ABD	300	$2,071.65	$2,081.50	0.5%
Dual	182	$283.87	$285.82	0.7%
FAM	39	$623.60	$659.42	5.7%
EXP	431	$934.69	$1,028.81	10.1%

Historical PMPMs: Medical Respite

Adjustments to the CY23 actual PMPMs reflects the following:

- Increase in pharmacy dispensing fees for independent pharmacies
- Provider Rate Increase of 12.5% effective July 1, 2024 for dental providers along with a change in MCO contracting with dental providers.
- Increase to capitation rates related to the estimated acuity changes due to the ending of the continuous enrollment provision of the Public Health Emergency (PHE).
- Increase to capitation rates for the new Medical Respite service as part of this 1115 Waiver.

MEDICAID ELIGIBILITY GROUP	Estimated CY23 Member Months	CY23 Actual PMPM	CY23 Adjusted PMPM	Percent Change
ABD	136	$ 2,053.18	$2,061.19	0.4%
Dual	72	$ 286.56	$288.06	0.5%
FAM	58	$ 618.98	$654.18	5.7%
EXP	334	$ 1,014.34	$1,107.30	9.2%

Trend Month Calculation

DEMONSTRATION PROPOSAL	Historical Period Start Date	Historical Period End Date	Midpoint
SMI	1/1/2023	12/31/2023	7/2/2023
Medical Respite	1/1/2023	12/31/2023	7/2/2023

DEMONSTRATION PROPOSAL	Waiver Start Date	DY1 (SFY2026) End Date	Midpoint
SMI	1/1/2026	6/30/2026	4/1/2026
Medical Respite	4/1/2026	6/30/2026	5/16/2026

DEMONSTRATION PROPOSAL	Trend Months
SMI	33.0
Medical Respite	34.5

Projected Enrollment - DY1 (SFY2026) Adjustment

DEMONSTRATION PROPOSAL	MEDICAID ELIGIBILITY GROUP	Estimated CY23 Member Months	Trend Months	Enrollment Trend	DY1 (SFY2026)	Waiver Start Date	Proportion of DY1 (SFY2026)	DY1 (SFY2026) Member Months - Adjusted for Waiver Start Date
SMI IMD	ABD	300	33.0	2%	317	1/1/2026	50%	159
	Dual	182	33.0	2%	192	1/1/2026	50%	96
	FAM	39	33.0	2%	41	1/1/2026	50%	21
	EXP	431	33.0	2%	455	1/1/2026	50%	228
Medical Respite	ABD	136	34.5	0%	136	4/1/2026	25%	34
	Dual	72	34.5	0%	72	4/1/2026	25%	18
	FAM	58	34.5	0%	58	4/1/2026	25%	15
	EXP	334	34.5	0%	334	4/1/2026	25%	84

Projected Enrollment

DEMONSTRATION APPROVAL	MEDICAID ELIGIBILITY GROUP	Enrollment Trend	DY1 (SFY2026) - Partial Year	DY2 (SFY2027)	DY3 (SFY2028)	DY4 (SFY2029)	DY5 (SFY2030)
SMI IMD	ABD	2%	159	323	329	336	343
	Dual	2%	96	196	200	204	208
	FAM	2%	21	42	43	44	45
	EXP	2%	228	464	473	482	492
Medical Respite	ABD	0%	34	136	136	136	136
	Dual	0%	18	72	72	72	72
	FAM	0%	15	58	58	58	58
	EXP	0%	84	334	334	334	334

Demonstration Without Waiver (WOW) Budget Projection: Coverage Costs for Populations

Population Type: Hypothetical

DEMONSTRATION PROPOSAL	MEDICAID ELIGIBILITY GROUP	METRIC	PB TREND	Trend Months	LAST HISTORIC	DEMONSTRATION YEARS (DY)					TOTAL
			RATE		YEAR	DY1 (SFY2026)	DY2 (SFY2027)	DY3 (SFY2028)	DY4 (SFY2029)	DY5 (SFY2030)	WOW
SMI IMD: Federal Financial Participation (FFP) for up to 15 days for non-SUD IMD stays that exceed 15 days	ABD	Eligible Member Months	2.0%	33.0	300	159	323	329	336	343	
		PMPM Cost	5.0%	33.0	$2,082	$2,380	$2,499	$2,624	$2,756	$2,893	
		Total Expenditure				$378,493	$807,332	$863,444	$925,905	$992,453	$3,967,628
	Dual	Eligible Member Months	2.0%	33.0	182	96	196	200	204	208	
		PMPM Cost	5.0%	33.0	$286	$327	$343	$360	$378	$397	
		Total Expenditure				$31,380	$67,269	$72,074	$77,192	$82,640	$330,555
		Eligible Member Months	2.0%	33.0	39	21	42	43	44	45	

	FAM	PMPM Cost	4.8%	33.0	$659	$750	$786	$824	$863	$905	
		Total Expenditure				$15,754	$33,020	$35,429	$37,993	$40,722	$162,918
	EXP	Eligible Member Months	2.0%	33.0	431	228	464	473	482	492	
		PMPM Cost	5.2%	33.0	$1,029	$1,183	$1,244	$1,309	$1,377	$1,449	
		Total Expenditure				$269,669	$577,337	$619,138	$663,728	$712,731	$2,842,603

Population Type: Hypothetical

DEMONSTRATION PROPOSAL	MEDICAID ELIGIBILITY GROUP	METRIC	PB TREND	Trend Months	LAST HISTORIC	DEMONSTRATION YEARS (DY)					TOTAL WOW
			RATE		YEAR	DY1 (SFY2026)	DY2 (SFY2027)	DY3 (SFY2028)	DY4 (SFY2029)	DY5 (SFY2030)	
Medical Respite	ABD	Eligible Member Months	0.0%	34.5	136	34	136	136	136	136	
		PMPM Cost	5.0%	34.5	$2,061	$2,371	$2,490	$2,615	$2,745	$2,883	
		Total Expenditure				$80,630	$338,644	$355,576	$373,355	$392,023	$1,540,228
	Dual	Eligible Member Months	0.0%	34.5	72	18	72	72	72	72	
		PMPM Cost	5.0%	34.5	$288	$331	$348	$365	$384	$403	
		Total Expenditure				$5,966	$25,055	$26,308	$27,624	$29,004	$113,957
	FAM	Eligible Member Months	0.0%	34.5	58	15	58	58	58	58	
		PMPM Cost	4.8%	34.5	$654	$749	$784	$822	$862	$903	
		Total Expenditure				$11,228	$45,499	$47,683	$49,972	$52,371	$206,752
	EXP	Eligible Member Months	0.0%	34.5	334	84	334	334	334	334	
		PMPM Cost	5.2%	34.5	$1,107	$1,281	$1,348	$1,418	$1,491	$1,569	
		Total Expenditure				$107,601	$450,088	$473,492	$498,114	$524,016	$2,053,311

Demonstration With Waiver (WW) Budget Projections: Coverage Costs for Populations

Population Type: Hypothetical

DEMONSTRATION PROPOSAL	MEDICAID ELIGIBILITY GROUP	METRIC	DEMO TREND	LAST HISTORIC	DEMONSTRATION YEARS (DY)	TOTAL

			RATE	YEAR	DY1 (SFY2026)	DY2 (SFY2027)	DY3 (SFY2028)	DY4 (SFY2029)	DY5 (SFY2030)	WW
SMI IMD: Federal Financial Participation (FFP) for up to 15 days for non-SUD IMD stays that exceed 15 days	ABD	Eligible Member Months	2.0%	300	159	323	329	336	343	
		PMPM Cost	5.0%	$ 2,082	$ 2,380	$ 2,499	$ 2,624	$ 2,756	$ 2,893	
		Total Expenditure			$ 378,493	$ 807,332	$ 863,444	$ 925,905	$ 992,453	$ 3,967,628
	Dual	Eligible Member Months	2.0%	182	96	196	200	204	208	
		PMPM Cost	5.0%	$ 286	$ 327	$ 343	$ 360	$ 378	$ 397	
		Total Expenditure			$ 31,380	$ 67,269	$ 72,074	$ 77,192	$ 82,640	$ 330,555
	FAM	Eligible Member Months	2.0%	39	21	42	43	44	45	
		PMPM Cost	4.8%	$ 659	$ 750	$ 786	$ 824	$ 863	$ 905	
		Total Expenditure			$ 15,754	$ 33,020	$ 35,429	$ 37,993	$ 40,722	$ 162,918
	EXP	Eligible Member Months	2.0%	431	228	464	473	482	492	
		PMPM Cost	5.2%	$ 1,029	$ 1,183	$ 1,244	$ 1,309	$ 1,377	$ 1,449	
		Total Expenditure			$ 269,669	$ 577,337	$ 619,138	$ 663,728	$ 712,731	$ 2,842,603

Population Type: Hypothetical

DEMONSTRATION PROPOSAL	MEDICAID ELIGIBILITY GROUP	METRIC	DEMO TREND RATE	LAST HISTORIC	DEMONSTRATION YEARS (DY)					TOTAL
				YEAR	DY1 (SFY2026)	DY2 (SFY2027)	DY3 (SFY2028)	DY4 (SFY2029)	DY5 (SFY2030)	WW
	ABD	Eligible Member Months	0.0%	136	34	136	136	136	136	
		PMPM Cost	5.0%	$ 2,061	$ 2,371	$ 2,490	$ 2,615	$ 2,745	$ 2,883	
		Total Expenditure			$ 80,630	$ 338,644	$ 355,576	$ 373,355	$ 392,023	$ 1,540,228
	Dual	Eligible Member Months	0.0%	72	18	72	72	72	72	
		PMPM Cost	5.0%	$ 288	$ 331	$ 348	$ 365	$ 384	$ 403	

Medical Respite		Total Expenditure			$ 5,966	$ 25,055	$ 26,308	$ 27,624	$ 29,004	$ 113,957
	FAM	Eligible Member Months	0.0%	58	15	58	58	58	58	
		PMPM Cost	4.8%	$ 654	$ 749	$ 784	$ 822	$ 862	$ 903	
		Total Expenditure			$ 11,228	$ 45,499	$ 47,683	$ 49,972	$ 52,371	$ 206,752
	EXP	Eligible Member Months	0.0%	334	84	334	334	334	334	
		PMPM Cost	5.2%	$ 1,107	$ 1,281	$ 1,348	$ 1,418	$ 1,491	$ 1,569	
		Total Expenditure			$ 107,601	$ 450,088	$ 473,492	$ 498,114	$ 524,016	$ 2,053,311

Budget Neutrality Summary

Hypothetical Analysis

DEMONSTRATION PROPOSAL	MEDICAID ELIGIBILITY GROUP	DEMONSTRATION YEARS (DY)					
		DY1 (SFY2026)	DY2 (SFY2027)	DY3 (SFY2028)	DY4 (SFY2029)	DY5 (SFY2030)	TOTAL
SMI IMD MEGs Federal Financial Participation (FFP) for up to 15 days for non-SUD IMD stays that exceed 15 days	Without-Waiver Total Expenditures						
	ABD	$ 378,493	$ 807,332	$ 863,444	$ 925,905	$ 992,453	$ 3,967,628
	Dual	$ 31,380	$ 67,269	$ 72,074	$ 77,192	$ 82,640	$ 330,555
	FAM	$ 15,754	$ 33,020	$ 35,429	$ 37,993	$ 40,722	$ 162,918
	EXP	$ 269,669	$ 577,337	$ 619,138	$ 663,728	$ 712,731	$ 2,842,603
	Total Expenditure	$695,296	$1,484,958	$1,590,085	$1,704,818	$1,828,547	$7,303,703
	With-Waiver Total Expenditures						
	ABD	$ 378,493	$ 807,332	$ 863,444	$ 925,905	$ 992,453	$ 3,967,628
	Dual	$ 31,380	$ 67,269	$ 72,074	$ 77,192	$ 82,640	$ 330,555
	FAM	$ 15,754	$ 33,020	$ 35,429	$ 37,993	$ 40,722	$ 162,918
	EXP	$ 269,669	$ 577,337	$ 619,138	$ 663,728	$ 712,731	$ 2,842,603
	Total Expenditure	$695,296	$1,484,958	$1,590,085	$1,704,818	$1,828,547	$7,303,703
	HYPOTHETICALS VARIANCE	$-	$-	$-	$-	$-	$-

DEMONSTRATION PROPOSAL	MEDICAID ELIGIBILITY GROUP	DEMONSTRATION YEARS (DY)					
		DY1 (SFY2026)	DY2 (SFY2027)	DY3 (SFY2028)	DY4 (SFY2029)	DY5 (SFY2030)	TOTAL
Medical Respite	Without-Waiver Total Expenditures						
	ABD	$ 80,630	$ 338,644	$ 355,576	$ 373,355	$ 392,023	$ 1,540,228
	Dual	$ 5,966	$ 25,055	$ 26,308	$ 27,624	$ 29,004	$ 113,957
	FAM	$ 11,228	$ 45,499	$ 47,683	$ 49,972	$ 52,371	$ 206,752
	EXP	$ 107,601	$ 450,088	$ 473,492	$ 498,114	$ 524,016	$ 2,053,311
	Total Expenditure	$205,424	$859,287	$903,059	$949,065	$997,414	$3,914,248
	With-Waiver Total Expenditures						
	ABD	$ 80,630	$ 338,644	$ 355,576	$ 373,355	$ 392,023	$ 1,540,228
	Dual	$ 5,966	$ 25,055	$ 26,308	$ 27,624	$ 29,004	$ 113,957
	FAM	$ 11,228	$ 45,499	$ 47,683	$ 49,972	$ 52,371	$ 206,752
	EXP	$ 107,601	$ 450,088	$ 473,492	$ 498,114	$ 524,016	$ 2,053,311
	Total Expenditure	$205,424	$859,287	$903,059	$949,065	$997,414	$3,914,248
	HYPOTHETICALS VARIANCE	$-	$-	$-	$-	$-	$-

[ADD FULL PUBLIC NOTICE, TRIBAL NOTICE, AND ABBREVIATED PUBLIC NOTICE]