

**TITLE 471
SERVICES**

NEBRASKA MEDICAL ASSISTANCE PROGRAM

CHAPTER 35

REHABILITATIVE PSYCHIATRIC SERVICES

001. SCOPE AND AUTHORITY. These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901-68-9,101.

001.01 INTRODUCTION. Nebraska Medicaid covers rehabilitative psychiatric services to rehabilitate beneficiaries experiencing severe and persistent mental illnesses in the community and thereby avoid more restrictive levels of care. Rehabilitative psychiatric services for children age 20 and younger are covered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) treatment plans, as described in this title. Rehabilitative psychiatric services for adults age 21 and older are covered under the rules and regulations of this chapter. The services must be medically necessary and the most appropriate level of treatment for the beneficiary. This does not include treatment for a primary substance use disorder diagnosis.

002. DEFINITIONS. The following definitions apply:

002.01 COLLATERAL CONTACT. Contacts which occur outside the provider organization without the beneficiary present and are related to the beneficiary's individual treatment, rehabilitation, and recovery plan.

002.02 DIRECT BENEFICIARY CONTACT. Face-to-face or telehealth services between the community support worker and the beneficiary.

002.03 FAMILY THERAPY. A therapeutic service between the beneficiary and their family and a qualified licensed practitioner who provides intervention as identified by the family-focused goals of the individual treatment, rehabilitation, and recovery plan. Consent from the beneficiary must be documented prior to the involvement of the family and delivery of the service.

002.04 GROUP PSYCHOTHERAPY. Group psychotherapy service provided by a licensed clinician who is practicing within their scope of practice and provides a psychotherapy service in groups of no fewer than three and no more than twelve beneficiaries.

002.05 INDIVIDUAL PSYCHOTHERAPY. An individual treatment and rehabilitation service between an identified beneficiary and a qualified licensed practitioner who focuses upon the identified goals of the individual treatment, rehabilitation, and recovery plan.

002.06 MEDICAL NECESSITY. Nebraska Medicaid incorporates the definition of medical necessity from these regulations. Services and supplies that do not meet the definition of medical necessity in these regulations are not covered. Services may be subject to specific limitations or prior authorization requirements listed in this chapter.

002.06(A) REHABILITATIVE PSYCHIATRIC MEDICAL NECESSITY. Rehabilitative psychiatric services are medically necessary when those services can reasonably be expected to increase or maintain the level of functioning in the community of beneficiaries with severe and persistent mental illness.

002.06(A)(i) PHYSICIAN SERVICES. The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean that it is covered by Nebraska Medicaid. Services and supplies, which do not meet the definition of medical necessity set out in this chapter are not covered.

002.07 PSYCHIATRIC RESIDENTIAL REHABILITATION. A facility-based, non-hospital or non-nursing facility program for beneficiaries disabled by severe and persistent mental illness, who are unable to reside in a less restrictive residential setting.

002.08 SECURE PSYCHIATRIC RESIDENTIAL REHABILITATION. A secure facility-based, non-hospital or non-nursing facility program for beneficiaries disabled by severe and persistent mental illness, who are unable to reside in a less restrictive setting.

002.09 SEVERE AND PERSISTENT MENTAL ILLNESS. Beneficiaries with severe and persistent mental illness must meet the following criteria:

- (A)The beneficiary is age 21 and over;
- (B)The beneficiary has a primary diagnosis of schizophrenia, major affective disorder, or other major mental illness . Developmental disorders, or psychoactive substance use disorders can be included if they co-occur with the primary mental illnesses listed above;
- (C)The beneficiary has a persistent mental illness as demonstrated by the presence of the disorder for the last 12 months or, which is expected to last 12 months or longer and will result in a degree of limitation that seriously interferes with the beneficiary's ability to function independently in an appropriate and effective manner in two of the three following functional areas: vocation and education, social skills, and activities of daily living;
 - (i)Functional limitations in the area of vocation and education abilities are defined as:

- (1) An inability to be consistently employed or an ability to be employed only with extensive supports, except that a person who can work but is recurrently unemployed because of acute episodes of mental illness is considered vocationally impaired;
 - (2) Deterioration or decompensation resulting in an inability to establish or pursue educational goals within a normal time frame or without extensive supports; and
 - (3) An inability to consistently and independently carry out home management tasks, including household meal preparation, washing clothes, budgeting, and childcare tasks and responsibilities;
- (ii) Functional limitations in the area of social skills and abilities are defined as:
- (1) Repeated inappropriate or inadequate social behavior or an inability to behave appropriately or adequately without extensive or consistent support or coaching or outside of special contexts or situations; or
 - (2) An inability to consistently participate in adult activities without extensive support or coaching or outside of limited special activities established for persons with mental illness or interpersonal impairments; or
 - (3) A history of dangerousness to self or others;
- (iii) Functional limitations in the area of activities of daily living are defined as an inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community. A beneficiary may be considered to have functional limitations in this area if they are unable to perform tasks from at least three of the following five domains :
- (1) Grooming, hygiene, washing of clothes, and meeting nutritional needs;
 - (2) Care of personal business affairs;
 - (3) Transportation and care of residence;
 - (4) Procurement of medical, legal, and housing services; or
 - (5) Recognition and avoidance of common dangers or hazards to self and possessions;
- (D) The beneficiary has a significant risk of continuing to either live in a severely impaired manner or requiring institutionalization without provision of mental health services, and whose risk has persisted for one year or longer

and is likely to continue for one year or longer; and

- (E) The beneficiary does not have a primary diagnosis of substance use disorder or developmental disability.

002.10 SUBSTANCE USE DISORDER COMMUNITY SUPPORT. A rehabilitative and supportive service for beneficiaries with primary Axis I diagnosis of substance use disorder.

002.11 SUPERVISING PROVIDER. The supervising provider must be:

- (A) Currently licensed and eligible to practice independently under Nebraska state law;
- (B) Currently enrolled with Nebraska Medicaid and eligible to provide Medicaid services;
- (C) Eligible to provide supervision to the supervisee under Nebraska state law; and
- (D) Within their scope of practice to prescribe and oversee the service being provided.

003. PROVIDER PARTICIPATION. Providers of rehabilitative psychiatric services must comply with all applicable provider participation requirements.

004. SERVICES PROVIDED TO BENEFICIARIES ENROLLED IN NEBRASKA MEDICAL ASSISTANCE PROGRAM MANAGED CARE.

004.01 COVERED SERVICES. The following rehabilitative services are covered by Nebraska Medicaid:

- (A) Community support;
- (B) Day rehabilitation; and
- (C) Psychiatric residential rehabilitation.

005. COMMUNITY SUPPORT. The following community support service requirements apply.

005.01 COMMUNITY SUPPORT. The community support program is designed to:

- (A) Provide and develop the necessary skills, services, and supports to enable beneficiaries to reside and participate in the community;
- (B) Improve the skills of daily living and quality of life;

(C)Facilitate communication and coordination between rehabilitative mental health providers that serve the same beneficiary; and

(D)Decrease the frequency and duration of hospitalization.

005.02 SERVICES PROVIDED IN COMMUNITY SUPPORT. Community support providers must provide beneficiary advocacy, ensure continuity of care, support beneficiaries in time of crisis, provide or procure skill training, ensure the acquisition of necessary resources, to assist beneficiaries with spend downs and other financial insurance coverage programs, and assist the beneficiary in achieving community and social integration. The community support program must provide a clear focus of accountability for meeting the beneficiary's needs within the resources available in the community. The role or roles of the community support provider may vary based on beneficiary's needs. Community support is a service in which the beneficiary's contact occurs outside of program offices in community locations, frequently in the beneficiary's private residence, consistent with the needs and desires of each beneficiary. 90-day treatment, rehabilitation, and recovery team meetings are not considered to be a community support service. The frequency of contact between the community support provider and the beneficiary is individualized and adjusted in accordance with the needs of the beneficiary.

005.03 INITIAL DIAGNOSTIC INTERVIEW. Prior to admission to a community support program, an initial diagnostic interview must be completed by an independently licensed practitioner, a psychiatrist, psychologist, or a licensed independent mental health practitioner (LIMHP). The purpose of this assessment is to determine or verify the presence of a severe and persistent mental illness which requires psychiatric rehabilitation services. The document must include the need of the specific rehabilitation services necessary to meet the treatment and recovery goals of the beneficiary.

005.04 SEPARATE AND DISTINCT SERVICE. Community support is a separate and distinct service, and will not be provided as a component of other rehabilitative psychiatric services or mental health outpatient services. Agencies that provide more than one level of rehabilitative psychiatric or mental health outpatient service must have staff dedicated to the community support program. These community support staff must not provide any other rehabilitative psychiatric or treatment service to the beneficiary.

005.04(A) PROGRAM COMPONENTS. The community support program must:

(i)Facilitate communication and coordination among the rehabilitative mental health providers serving the beneficiary;

(ii)Ensure that the beneficiary has a diagnosis of severe and persistent mental illness, as exhibited by the completion of an initial diagnostic interview, no more than 12 months prior

to admission to a community support program. The initial diagnostic interview must identify the need for community support and outline the needed services and resources for the beneficiary;

- (iii) Ensure completion of a strength-based needs assessment which can include skills inventories, interviews, and other tools to develop treatment and rehabilitation plans, which must be completed within 30 days of admission by the rehabilitation team or team members;
- (iv) Ensure the completion of an individual treatment, rehabilitation, and recovery plan for each beneficiary served. The individual treatment, rehabilitation, and recovery plan must be completed within 30 days following the admission of the beneficiary and reviewed and updated every 90 days or as often as clinically necessary thereafter while receiving services. The individual treatment, rehabilitation, and recovery plan must be based on the results of comprehensive assessments and is developed with the beneficiary's involvement and through an interdisciplinary team process. The individual treatment, rehabilitation, and recovery plan must include methods and interventions to address: activities of daily living, community living skills, budgeting, education, independent living skills, social skills, interpersonal skills, psychiatric emergency or relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, physical health care, vocational and educational resource acquisition, and other related areas as necessary for successful living in the community;
- (v) Ensure the individual treatment, rehabilitation, and recovery plan encompasses the supportive and rehabilitative interventions that will be directly provided by the community support program;
- (vi) Identify the provision of services and interventions identified in the individual treatment, rehabilitation, and recovery plan as the responsibility of other rehabilitative service providers;
- (vii) Develop and implement strategies to assist the beneficiary in becoming engaged and remaining engaged in medically necessary mental health treatment and psychiatric rehabilitation services;
- (viii) Provide service coordination and case management activities, including coordination or assistance in accessing medical, social, education, housing, transportation or other appropriate support services as well as linkage to other community services identified in the individual treatment, rehabilitation, and recovery plan;
- (ix) Facilitate communication between the treatment and rehabilitation providers and with the primary care physician, psychiatrist, or advanced practice registered nurse (APRN) serving the beneficiary;

- (x) Monitor beneficiary progress of the services being received and participate in the revision of the individual treatment, rehabilitation, and recovery plan as needed or at the request of the beneficiary;
- (xi) Provide contact as needed with other service provider, beneficiary family member, and other significant people in the beneficiary's life to facilitate communication necessary to support the beneficiary in maintaining community living;
- (xii) Assist the beneficiary in the developing, evaluating, and updating a crisis and relapse prevention plan. This plan must be coordinated with any other rehabilitative service and include the beneficiary's natural supports;
- (xiii) Provide therapeutic support and intervention to the client in time of crisis. If hospitalization is necessary, facilitate, in cooperation with the inpatient treatment provider, the beneficiary's transition back into the community upon discharge;
- (xiv) Participate with and report to the treatment and rehabilitation team on the progress of the beneficiary in areas of medication compliance, relapse prevention, social skill acquisition, application, education, substance use disorder, and ability to sustain community living;
- (xv) Monitor medication compliance; and
- (xvi) Assist the beneficiary with all health insurance issues including share of cost eligibility issues. Ensure the beneficiary's understanding of financial benefits and procedures to use those benefits .

005.04(B) ADMISSION CRITERIA. Community support services require a prior authorization by Nebraska Medicaid or its designee. To be eligible for community support services, the beneficiary must meet all of the criteria described in this chapter. .

() 005.04(C) STAFFING REQUIREMENTS. Staff of rehabilitative programs that deliver rehabilitative services must either be licensed practitioners operating within their scope of practice or be skilled direct care staff that meet the following minimum standards:

- (i) Have demonstrated skills and competencies in working with people experiencing severe and persistent mental illness;
- (ii) Have completed a staff training curriculum for initial orientation and complete a continuing education curriculum at intervals as defined and prepared by the providing agency. This curriculum and periodic updates must be included in the program description submitted to Nebraska Medicaid; and

(iii) Be trained in the principles of recovery.

00.0 005.04(D) CLINICAL STAFF. The community support program must have available a:

- (i) LICENSED CLINICAL SUPERVISOR. The clinical supervisor must qualify as a licensed practitioner and must participate in the individual treatment, rehabilitation, and recovery plan development and provide clinical supervision, consultation, and support. The licensed clinical supervisor will review the community support beneficiary's clinical needs and progress toward their goals with the community support worker every 30 days. The review can be accomplished by the supervisor consulting with the community support worker on their assigned beneficiaries and providing clinical guidance or recommendations to better serve the beneficiary.
- (ii) OTHER CONSULTANTS. Consultation by licensed professionals for general medical, psychopharmacology, and psychological issues, as well as overall program design as necessary. These consultations must themselves meet the standards laid out in the appropriate sections of these regulations.

005.04(E) DIRECT CARE STAFF. The community support program must have community support staff who meet the following requirements:

- (i) Direct care staff must have a minimum level of experience or training that is satisfied by one of the following:
 - (1) A bachelor's degree or higher in psychology, sociology, or a related human services field;
 - (2) Two years of coursework in a human service field; or
 - (3) Two years of experience or training in a human service field, and two years of lived recovery experience, with demonstrated skills in the treatment of individuals with a behavioral health diagnosis; and
- (ii) Community support staff must receive monthly supervision by the community support clinical supervisor.

005.05 PROGRAM AVAILABILITY. The community support program must establish hours of service delivery that ensure program staff are accessible and responsive to the needs of the beneficiary. Scheduled services must include evening and weekend hours. The community support program must directly provide or otherwise demonstrate that each beneficiary has on-call access to a licensed mental health practitioner (LMHP) 24 hours per day . Access to a licensed mental health practitioner (LMHP) must be documented

in the beneficiary's individual treatment, rehabilitation, and recovery plan.

005.06 CONTACTS. The frequency of contact between the beneficiary and the community support worker must be individualized and adjusted in accordance with the needs of the beneficiary. Community support providers must ensure that the amount of direct contact is sufficient to meet the beneficiary's needs as identified in the individual treatment, rehabilitation, and recovery plan. Contacts may either be direct beneficiary contact or collateral contact.

- (A) DIRECT BENEFICIARY CONTACT. Direct beneficiary contacts are contacts with the beneficiary that focus on the development of skills, or the management of other activities or goals identified on the individual treatment, rehabilitation, and recovery plan. Contacts must occur in community settings and be medically necessary for the beneficiary's recovery. Face-to-face contact must be individualized to the beneficiary's recovery needs and must be identified in the beneficiary's individual treatment, rehabilitation, and recovery plan. Contacts must be timed in units, with each unit being equivalent to a 15-minute period, with contacts being limited in duration with a maximum of 144 units per 180-day period. In situations of beneficiary absence or unavailability for a scheduled contact, providers must document the circumstances in which the scheduled contact did not occur and the program's response to the lack of beneficiary's availability to participate in the community support intervention.
- (B) COLLATERAL CONTACT. Collateral contacts must be documented in the beneficiary's clinical record and are considered an essential supportive component to the beneficiary's treatment, recovery, and rehabilitation plan but may not be billed as a separate service to Nebraska Medicaid.

005.07 CLINICAL DOCUMENTATION. Rehabilitative psychiatric service providers must maintain a clinical record that is confidential, complete, accurate, and contains up-to-date information relevant to the beneficiary's care and services. The record must sufficiently document assessments; individual treatment, rehabilitation, and recovery plans and plan reviews; and important provider discussion. The clinical record must document beneficiary contacts describing the nature and extent of the services provided, such that a clinician unfamiliar with the service can identify the beneficiary's service needs and services received. The documentation must reflect the rehabilitative services provided, be consistent with the goals in the treatment and recovery plan, and be based upon the comprehensive assessment. The absence of appropriate, legible, and complete records can result in the recoupment of previous payments for services. Providers must provide the clinical record in the English language, however, providers must accommodate beneficiaries of other cultures and language in order that the beneficiary can completely participate in and understand their treatment and recovery rehabilitation program. Each entry must identify the date, beginning and end time of the service, and the location of service. The individuals in attendance must be identified by name and relationship to the

identified beneficiary and the name and title of the staff person providing the intervention and entering the information.

005.07(A) CLINICAL RECORDS. Clinical records must be maintained at the provider's headquarters. Records must be kept in a locked file when not in use. For purposes of confidentiality, disclosure of treatment information is subject to all the provisions of applicable state and federal laws. The beneficiary's clinical record must be available for review by the beneficiary, and their guardian with appropriate consent, unless there is a specific medically indicated reason to preclude this availability. The specific reason must be documented in the clinical record and reviewed periodically.

005.07(B) CLINICAL RECORD REQUIREMENTS. The clinical record must include, at a minimum:

- (i) Beneficiary identifying data, including demographic information and the beneficiary's legal status;
- (ii) Assessment and evaluations;
 - (1) initial diagnostic interview completed prior to admission;
 - (2) Strength-based needs assessment; and
 - (3) Other appropriate assessments;
- (iii) Treatment and recovery plan and updates to plans;
- (iv) Documentation of review of client rights with the beneficiary;
- (v) A chronological record of all services provided to the beneficiary. Each entry must include the staff member who performed the service received. Each entry includes the date the service was performed, the duration of the service, including the beginning and end time, the place of the service, and the staff member's name and title and legible signature ;
- (vi) Documentation of the involvement of family and significant others;
- (vii) Documentation of treatment and recovery services and discharge planning;
- (viii) A chronological listing of the medications prescribed for the beneficiary, including dosages and schedule, and the beneficiary's response to the medication;
- (ix) Documentation of coordination with other services and treatment providers;
- (x) Discharge summaries from previous levels of care;
- (xi) Discharge summary when appropriate; and

(xii)Any clinical documentation requirements identified in the specific service._

005.08 PROVIDER PARTICIPATION. Providers must comply with all applicable provider participation requirements . The provider must sign an agreement at the time of enrollment that states the provider will submit initial and annual cost information to Nebraska Medicaid as a part of the enrollment. The cost information must be updated upon request.

005.08(A) LICENSURE REQUIREMENTS. Community support providers must be appropriately licensed when licensure is required to provide the service and the program must have acquired national accreditation in The Joint Commission , the Commission on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA) as a condition for enrollment as a participating provider. Accreditation must be maintained throughout the Nebraska Medicaid participation period.

005.09 BENEFICIARY RIGHTS POLICY. Individual staff and the treatment and recovery team must provide all services in a manner to support and maintain the beneficiary's rights with a continuous focus on empowerment and movement toward recovery. Providers must have a written beneficiary rights and responsibilities policy and staff must review beneficiary rights, responsibilities, and grievance procedures with each new beneficiary at admission, at treatment and recovery plan review, and at the request of the beneficiary. This review must be documented in the clinical record. Substance use disorder and mental health treatment providers must comply with all state and federal beneficiary rights requirements.

005.09(A) BENEFICIARIES' RIGHTS. Beneficiaries' rights must be observed when providing mental health and substance use disorder services through Nebraska Medicaid. The beneficiary has the right to:

- (i)Be treated with respect and dignity regardless of state of mind or condition;
- (ii)Have privacy and confidentiality related to all aspects of care;
- (iii)Be protected from neglect; physical, emotional or verbal abuse; and exploitation of any kind;
- (vi)Be part of developing an individual treatment and recovery plan and decision-making regarding their treatment and rehabilitative services;
- (v)Refuse treatment or therapy unless ordered by a mental health board or court;
- (vi)Be free of any sexual exploitation or harassment;
- (vii)Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed; and

- (viii)Receive such forms, instructions, and assistance as needed to file a complaint or request a state fair hearing.

005.10 BILLING FOR COMMUNITY SUPPORT SERVICES. Community support services must be billed in 15-minute increments for a maximum of 144 units per 180 days.

006. DAY REHABILITATION. The following day rehabilitation service requirements apply.

006.01 DAY REHABILITATION. The day rehabilitation program is designed to:

- (A)Enhance and maintain the 's beneficiary's ability to function in community settings; and
- (B)Decrease the frequency and duration of hospitalization. Beneficiaries served in this program receive rehabilitation and support services to develop and maintain the skills needed to successfully live in the community. Day rehabilitation is a facility-based program. The program must provide:
 - (i) Prevocational services including services designed to rehabilitate and develop the general skills and behaviors needed to prepare the beneficiary to be employed or engage in other related substantial gainful activity. The program does not provide training for a specific job or assistance in obtaining permanent competitive employment positions for beneficiaries;
 - (ii) Community living skills and daily living skills development;
 - (iii) Beneficiary skills development for self-administration of medication, as well as recognition of signs of relapse and control of symptoms;
 - (iv)Planned socialization and skills training and recreation activities focused on identified rehabilitative needs;
 - (v)Skill building in the usage of public transportation or assistance in accessing suitable local transportation to and from the day rehabilitation program;
 - (vi)A scheduled program of services to beneficiaries for a minimum of five hours per day, five days per week. Specific services for each beneficiary will be individualized, based on beneficiary needs; and
 - (vii)Directly provide or otherwise demonstrate that each beneficiary has on-call access to a mental health provider 24 hours per day .

006.02 SUPPORTIVE SERVICES. The program provides the following supportive services for all active beneficiaries: referrals, problem

identification and solution, and coordination of the day rehabilitative program with other services.

007. PSYCHIATRIC RESIDENTIAL REHABILITATION. The following psychiatric residential rehabilitation service requirements apply.

007.01 PSYCHIATRIC RESIDENTIAL REHABILITATION. The psychiatric residential rehabilitation program is designed to:

- (A) Increase the beneficiary's functioning so that they can eventually live successfully in the residential setting of their choice, based on their capabilities and resources; and
- (B) Decrease the frequency and duration of hospitalization.

007.02 PURPOSE. The psychiatric residential rehabilitation program provides skill building in community living skills, daily living skills, medication management, and other related psychiatric rehabilitation services as needed to meet individual beneficiary needs. These facilities are integrated into the community, and every effort is made for these residences to approximate other homes in their neighborhoods.

007.03 PROGRAM COMPONENTS. The program provides:

- (A) **COMMUNITY SKILLS.** Community living skills and daily living skills development;
- (B) **MEDICATION.** Beneficiary skills development for self-administration of medication, as well as recognition of signs of relapse and control of symptoms; and
- (C) **TRANSPORTATION.** Skill building in the usage of public transportation or assistance in accessing suitable local transportation to and from the psychiatric residential rehabilitation program.

007.04 LICENSURE REQUIREMENTS. The program must be licensed as a residential care facility, domiciliary, or mental health center by the Department .

007.05 STAFFING REQUIREMENTS. The program must have the appropriate staff coverage to provide services for beneficiaries needing to remain in the residence during the day.

007.06 BED LIMITATION. The maximum capacity for this facility must not exceed 16 beds.

007.07 SUPPORTIVE SERVICES. The program provides the following supportive services for all active beneficiaries: referrals, problem identification and solution, and coordination of the residential rehabilitation program with other services the beneficiary may be receiving.

007.08 REFERRALS FOR REHABILITATIVE PSYCHIATRIC SERVICES. Referrals for rehabilitative psychiatric services will be directed to Nebraska Medicaid or

its designee. The referral must include documentation that establishes:

(A)The beneficiary's eligibility for Nebraska Medicaid; and

(B)How the beneficiary meets the definition of serious and persistent mental illness specified in this chapter.

007.09 ELIGIBILITY FOR REHABILITATIVE PSYCHIATRIC SERVICES.To be eligible for rehabilitative psychiatric services, the beneficiary must be eligible for Nebraska Medicaid, meet the definition of severe and persistent mental illness, and be authorized by Nebraska Medicaid or its designee for specific services.

007.10 SERVICE NEEDS ASSESSMENT AND REHABILITATIVE PSYCHIATRIC SERVICE RECOMMENDATIONS. All beneficiaries determined eligible for rehabilitative psychiatric services must be assessed and have rehabilitative psychiatric service recommendations developed by a referring provider according to specified protocols.

008. APPEALS AND FAIR HEARINGS. Appeal and fair hearing procedures are governed by this title and federal regulations.

009. ASSERTIVE COMMUNITY TREATMENT (ACT). The assertive community treatment (ACT) team provides high intensity services and must be available to provide treatment, rehabilitation, and support activities seven days per week, 24 hours per day, 365 days per year. The team must have the capacity to provide multiple contacts each day as dictated by beneficiary need. The team must provide ongoing continuous care for an extended period of time, and beneficiaries admitted to the service who demonstrate any continued need for treatment, rehabilitation, or support must not be discharged except by mutual agreement between the beneficiary and the team. Services provided must focus on treatment and rehabilitation of the effects of serious mental illness, as well as support and assistance in meeting such basic human needs as housing, transportation, education, and employment.

009.01 CLINICAL TEAM. assertive community treatment (ACT) must be provided by a self-contained clinical team which:

(A)Assumes overall responsibility and clinical accountability for beneficiaries disabled by severe and persistent mental illness by directly providing treatment, rehabilitation, and support services and by coordinating care with other providers;

(B)Does not refer beneficiaries to outside service providers when services are identified as a responsibility of the assertive community treatment

(ACT) program as outlined in this chapter. ;

(C)Provides services on a long-term basis with continuity of caregivers over time;

(D)Delivers most of the services outside program offices;

(E)Emphasizes outreach, relationship building, and individualization of services;

F)Provides psychiatric treatment and rehabilitation that is culturally sensitive and competent; and

(G)Shares team roles expecting each staff member to know all the beneficiaries and assist in assessment, treatment planning, and care delivery as needed.

009.02 ADMISSION AND DISCHARGE CRITERIA.

009.02(A) ADMISSION CRITERIA. Nebraska Medicaid covers assertive community treatment (ACT) services for those persons disabled by severe and persistent mental illness who are unable to remain stable in community living without high intensity services. Assertive community treatment (ACT) services must be prior authorized by Nebraska Medicaid or its designee. To be eligible for assertive community treatment (ACT) services, beneficiaries must meet all of the criteria described in this chapter , and demonstrate indicators of high need and utilization.

009.02(B) DISCHARGE CRITERIA. The assertive community treatment (ACT) program is intended to provide services over a long period of time. Beneficiaries admitted to the service who demonstrate continued need for treatment, rehabilitation, or support must not be discharged except by mutual agreement between the beneficiary and the assertive community treatment (ACT) team. Discharge from the assertive community treatment (ACT) team occurs when the beneficiary and program staff mutually agree to termination of services. Specific documentation must be included in the beneficiary's clinical chart when a discharge occurs. Discharge may occur in the following situations:

- (i) GEOGRAPHIC RELOCATION. The beneficiary moves outside the team's geographic area of responsibility. In such cases, the assertive community treatment (ACT) team must arrange for transfer of mental health service responsibility to a provider wherever the beneficiary is moving. To meet this responsibility, the assertive community treatment (ACT) team must maintain contact with the beneficiary until this service transfer is arranged;
- (ii) SIGNIFICANTLY IMPROVED FUNCTIONING. The beneficiary demonstrates by functional assessment measurement the ability to function with minimal assistance in the following functional areas:

vocation and education, social skills, and activities of daily living;

- (iii) BENEFICIARY REQUESTED DISCHARGE. Requested discharge despite the team's best efforts to develop an individual treatment, rehabilitation, and recovery plan acceptable to the beneficiary. Efforts to develop an acceptable individual treatment, rehabilitation, and recovery plan must be documented in the beneficiary's clinical record; and
- (iv) HOSPITALIZATION OF THE BENEFICIARY IN AN INSTITUTION FOR MENTAL DISEASE (IMD). Nebraska Medicaid is not able to reimburse for services provided to beneficiaries over age 20 and under age 64 who are being treated in an institution for mental disease (IMD).

009.03 STAFF REQUIREMENTS. Each assertive community treatment (ACT) team must provide a comprehensively staffed team, including a psychiatrist, team leader, a peer support person, and program assistants. The assertive community treatment (ACT) team must have among its staff individuals who are qualified to provide the required services. Each assertive community treatment (ACT) team must employ, at a minimum, the following number of clinical staff persons, peer support, and psychiatrists to provide the treatment, rehabilitative, and supportive services. Providers are responsible for verifying that staff are appropriately licensed or certified.

009.03(A) STAFF QUALIFICATIONS. All clinical staff must be appropriately licensed or credentialed as required by the Department of Health and Human Services, Division of Public Health. All clinical staff must have at least two years of experience working with persons with serious and persistent mental illness. All clinical staff must maintain sufficient hours of continuing education to maintain certification or licensure.

009.03(B) BACKGROUND CHECKS. The employer of the assertive community treatment (ACT) team members is responsible and accountable for the activities and interventions of the assertive community treatment (ACT) team staff. The employer must consider which type of criminal background and Abuse and Neglect Central Registry checks are appropriate for their staff and how the results impact hiring decisions. The use of criminal background and Abuse and Neglect Central Registry checks must be described in the employer's policy and procedure manual and be available for review.

009.03(C) STAFF CONFIGURATION. The configuration of an assertive community treatment (ACT) team depends on the number of beneficiaries to be served. The assertive community treatment (ACT) team must maintain a 1:10 staff to beneficiary ratio. The team psychiatrist or mental health advanced practice registered nurse (APRN), if used, and program assistant are not included in the ratio:

- (i) MINIMUM STAFF CONFIGURATION. The following minimum staffing configuration must be met in each assertive community treatment (ACT) team regardless of the number of beneficiaries served. This

configuration may serve up to 50 beneficiaries. The team must have at least one member who demonstrates competency in drug and alcohol use and dependence or is a licensed alcohol and drug counselor (LADC). The assertive community treatment (ACT) team must include:

- (1) TEAM PSYCHIATRIST. One team psychiatrist, who must be a board certified or board eligible psychiatrist. The team psychiatrist must provide coverage at a minimum of 16 hours per week. This psychiatry time must be spent exclusively on assertive community treatment (ACT) team activities. The team psychiatrist provides clinical services including psychiatric assessment, individual treatment, rehabilitation, and recovery plan development and approval, psychopharmacologic and medical treatment, and crisis intervention to all assertive community treatment (ACT) team beneficiaries. The team psychiatrist must be available 24 hours per day and seven days per week for crisis management. The team psychiatrist works with the team leader to monitor each beneficiary's clinical status and response to treatment, provides staff clinical supervision, and participates in the development of all individual treatment, rehabilitation, and recovery plans;
- (2) TEAM LEADER. The team leader must be a psychiatrist, physician, physician assistant (PA), or advanced practice registered nurse (APRN), or have at least a master's degree in nursing, social work, psychiatric rehabilitation, psychology, or counseling. The team leader must have demonstrated clinical and administrative experience;
- (3) MENTAL HEALTH PROFESSIONAL. One full time mental health professional who is a licensed psychologist, provisionally licensed psychologist, licensed independent mental health practitioner (LIMHP), licensed mental health practitioner (LMHP), or provisionally licensed mental health practitioner (LMHP);
- (4) NURSING STAFF. One full time registered nurse (RN);
- (5) MENTAL HEALTH WORKER. One full time mental health worker who meets one of the following qualifications:
 - (a) Is a licensed alcohol and drug counselor (LADC);
 - (b) Has a bachelor's degree in psychology, sociology, or a behavioral health field; or
 - (c) Has a bachelors' degree in a field other than behavioral sciences or has a high school degree, and has work experience with adults with severe and persistent mental illness or with individuals with similar human services needs;

(6) SUBSTANCE USE SPECIALIST. One full time substance use specialist who meets one of the following qualifications:

- (a) Is a licensed alcohol and drug counselor (LADC) or a provisionally licensed alcohol and drug counselor (LADC);
- (b) Has at least one year of training or experience in substance use disorder treatment and is a licensed independent mental health practitioner (LIMHP), licensed mental health practitioner (LMHP), or provisionally licensed mental health practitioner (LMHP);

(7) VOCATIONAL SPECIALIST. One full time vocational specialist with at least one year of training or experience in vocational rehabilitation and support;

(8) ADDITIONAL STAFF. One additional full time staff person who meets the qualifications of the mental health professional or mental health worker;

(9) PEER SUPPORT. A half time coverage of peer support. This team member position must be a self-identified consumer of mental health services. The peer support staff must have training, experience, and ability to work with the team in carrying out appropriate aspects of the individual treatment, rehabilitation, and recovery plan. The peer support staff must hold a certification through the Department of Health and Human Services, Division of Behavioral Health as a certified peer support provider;

(10) SUPPORT STAFF. At least one full-time support staff person. Support staff is defined as a non-clinician responsible for working under the direction of the team leader to support all non-clinical operations of the assertive community treatment (ACT) team. This is a full time position and not considered in the staff to beneficiary ratio;

(ii) ADVANCED PRACTICE REGISTERED NURSE (APRN) OPTIONAL CONFIGURATION. When a psychiatrist is not providing coverage, an advanced practice registered nurse (APRN) may substitute for coverage. The advanced practice registered nurse (APRN) may provide coverage for existing psychiatry time while not replacing the team psychiatrist responsibility in the above services. The advanced practice registered nurse (APRN) must work collaboratively with the psychiatrist. An advanced practice registered nurse (APRN) can provide services within their scope of practice, except for the mandatory services which must be delivered by the team psychiatrist as described in this chapter. The team psychiatrist must be available for consultation and direction of the treatment activities provided by the advanced practice registered nurse (APRN). There must be a documented agreement

between the team psychiatrist and the advanced practice registered nurse (APRN) for 24 hours per day, seven days per week psychiatric coverage. A copy of the agreement must be sent to Nebraska Medicaid at the time of enrollment, prior to the initiation of services, and at any time the agreement is modified or terminated;

(iii) EXPANDED STAFF CONFIGURATION. If an assertive community treatment (ACT) team will serve more than 50 beneficiaries, the following staff must be added:

- (1) REGISTERED NURSE (RN). At least one additional registered nurse (RN) to meet the nursing needs of the expanded population;
- (2) PEER SUPPORT. At least one full time peer support specialist;
- (3) TEAM PSYCHIATRIST. Additional psychiatric coverage of 2.6 hours for every eight beneficiaries;
- (4) MENTAL HEALTH PROFESSIONAL. At least two mental health professionals; and
- 5) ADDITIONAL STAFF. Additional staff to maintain a minimum 1:10 staff to beneficiary ratio. This ratio excludes the team psychiatrist, and advanced practice registered nurse (APRN) if used, and the program assistant. The configuration of the assertive community treatment (ACT) team must reflect the needs of the beneficiary population.

009.03(D) STAFF FUNCTIONS. The assertive community treatment (ACT) team must perform the following functions:

(i) CLINICAL SUPERVISION. All members of the assertive community treatment (ACT) team who are not licensed to practice independently must have clinical supervision. A member of the assertive community treatment (ACT) team who is a psychiatrist, advance practice registered nurse (APRN), or a licensed independent mental health practitioner (LIMHP), must be designated as the clinical supervisor. The clinical supervisor must have regular contact with the client and with members of the assertive community treatment (ACT) team who are not independently licensed to practice. Clinical supervision must include:

- (1) Review of the beneficiary's clinical status;
- (2) Ensuring appropriate treatment services are provided to the beneficiary;
- (3) Review and improvement of the assertive community treatment (ACT) team member's service provision;

- (4) Provision of clinical supervision during daily team meetings, individual treatment, rehabilitation, and recovery plan meetings, side-by-side and face-to-face supervision sessions, and through a review of the beneficiary's clinical record; and
- (5) Appropriate documentation of clinical supervision activities;
- (ii) CRISIS INTERVENTION AND RESPONSE. In addition to the beneficiary specific crisis intervention plans, the assertive community treatment (ACT) team must have a procedure to respond to emergencies and crises;
- (iii) ASSESSMENT. Initial and updated assessments of the beneficiary must be provided as described in this chapter. Appropriate staff must be assigned to this function based on individualized beneficiary need. The beneficiary and their family, as allowed by beneficiary permission, must be involved in all assessments;
- (iv) TREATMENT PLANNING. Initial and updated individual treatment, rehabilitation, and recovery plans must be developed as described in this chapter. In addition to the team leader and team psychiatrist, appropriate staff must be assigned to this function based on individualized beneficiary need. One specific staff person must be designated to document the individual treatment, rehabilitation, and recovery plan for the clinical record. The beneficiary and their family, as allowed by beneficiary permission, must be involved in development, review, and revision of all individual treatment, rehabilitation, and recovery plans;
- (v) INDIVIDUAL TREATMENT, REHABILITATION, AND RECOVERY PLAN COORDINATION. Individual treatment, rehabilitation, and recovery plan coordination is an organized process of coordination among the multi-disciplinary team in order to provide a full range of appropriate treatment, rehabilitation, and support services to a beneficiary in a planned, coordinated, efficient, and effective manner, as outlined in the individual treatment, rehabilitation, and recovery plan; and
- (vi) INTERVENTIONS. Based on individualized beneficiary need and preference and assertive community treatment (ACT) team qualifications, experience, and training, assertive community treatment (ACT) team members must be assigned to provide the active treatment, rehabilitative, and supportive services described in this chapter.

009.04 ACT PROGRAM ORGANIZATION.

009.04(A) HOURS OF OPERATION, COVERAGE, AND AVAILABILITY OF SERVICES. The assertive community treatment (ACT) team must meet the following requirements related to availability and scheduling:

(i) HOURS OF OPERATION AND AVAILABILITY OF SERVICES. The assertive community treatment (ACT) team must be available to provide treatment, rehabilitation, and support interventions 24 hours per day, seven days per week, 365 days a year. The assertive community treatment (ACT) team must be able to:

- (1) Meet the beneficiaries needs at all hours of the day including evenings, weekends, and holidays;
- (2) Provide services at the time that is most appropriate and natural for the beneficiary as described in the beneficiary's individual treatment, rehabilitation, and recovery plan; and
- (3) Operate a minimum of 12 hours per day and eight hours each weekend day and every holiday; and

(ii) PSYCHIATRIC COVERAGE. Psychiatric coverage must be available at all times. If availability of the team psychiatrist during all hours is not feasible, alternative psychiatric backup must be arranged. The covering psychiatrist or advanced practice registered nurse (APRN) must have an orientation to the assertive community treatment (ACT) team concept and be supportive of its services. The covering psychiatrist or advanced practice registered nurse (APRN) must be able to get beneficiary specific information from an assertive community treatment (ACT) team member.

009.04(B) SERVICE INTENSITY. The assertive community treatment (ACT) team services must be able to provide the level of service intensity as dictated by beneficiary need. Beneficiary need is determined through the severity of symptoms and limitations in daily living and is documented in the beneficiary's individual treatment, rehabilitation, and recovery plan. No other psychiatric service or psychiatric rehabilitation service may be reimbursed, except for acute and subacute inpatient hospitalization for assessment and stabilization, when prior authorized by Nebraska Medicaid or its designee.

009.04(C) PLACE OF SERVICE. The assertive community treatment (ACT) team must provide most of the interventions and service contacts in the community, in non-office-based settings.

009.04(D) SHARED RESPONSIBILITY. The responsibility of the total beneficiary caseload is shared by the entire assertive community treatment (ACT) team, even though team members can serve as a primary contact for certain beneficiaries.

009.04(E) STAFF COMMUNICATION AND PLANNING. The assertive community treatment (ACT) team must use systems and methods for continuous daily communication and planning. These must include:

- (i) DAILY ORGANIZATIONAL STAFF MEETING. A daily organizational staff meeting must be held to review the status of all program beneficiaries, update the team on contacts provided in the past 24 hours and to communicate essential information on current events and activities as they relate to the interventions provided by the assertive community treatment (ACT) team;
- (ii) DAILY TEAM ASSIGNMENT SCHEDULE. The daily team assignment schedule must list all of the interventions that need to be provided on that day and the assertive community treatment (ACT) team member assigned to complete the intervention;
- (iii) DAILY LOG. A daily log must be used to document that a beneficiary review has occurred;
- (iv) CLIENT WEEKLY CONTACT SCHEDULE. The client weekly contact schedule must be a written schedule of all treatment, rehabilitation, and support interventions which staff must carry out to fulfill the goals and objectives in the beneficiary's individual treatment, rehabilitation, and recovery plan; and
- (v) INDIVIDUAL TREATMENT, REHABILITATION, AND RECOVERY PLAN MEETINGS. treatment, rehabilitation, and recovery plan meetings must be regularly scheduled meetings to identify and assess individual beneficiary needs and problems; to establish measurable long- and short-term treatment and service goals; to plan treatment and service interventions; and to assign staff persons responsible for providing the services. If the beneficiary and their family are not able to participate, the meeting must include their input. Appropriate support must be provided to maximize the participation of the beneficiary and their family. If necessary, the individual treatment, rehabilitation, and recovery plan should address any barriers to participation. The assertive community treatment (ACT) team must conduct individual treatment, rehabilitation, and recovery plan meetings, under the supervision of the team leader and team psychiatrist.

009.05 PROGRAM COMPONENTS AND INTERVENTIONS. Operating as a continuous treatment and rehabilitative service, the assertive community treatment (ACT) team must have the capability to provide assessment, comprehensive treatment, rehabilitation, and support services as a self-contained clinical service unit. Services must be available 24 hours a day, seven days a week, 365 days per year. Services must be provided by the most appropriate assertive community treatment (ACT) team members operating within their scope of practice. Services must include:

009.05(A) ASSESSMENT AND EVALUATION.

: 009.05(A)(i) INITIAL ADMISSION ASSESSMENT. Prior to accepting the beneficiary for admission, the assertive community treatment (ACT) team must assess and determine the appropriateness of the

beneficiary for admission to the assertive community treatment (ACT) team program. The assessment must include a review of clinical information and beneficiary interview and may include additional assessment activities.

009.05(A)(ii) COMPREHENSIVE ASSESSMENT. The comprehensive assessment is unique to the assertive community treatment (ACT) program in its scope and completeness. A comprehensive assessment is the process used to evaluate a beneficiary's past history and current condition in order to identify strengths and problems, outline goals, and create a comprehensive individual treatment, rehabilitation, and recovery plan. The comprehensive assessment reviews information from all available resources including past medical records, beneficiary self-report, interviews with family or significant others if approved by the beneficiary, and other appropriate resources, as well as current assessment by team clinicians from all disciplines. A comprehensive assessment must be initiated and completed within 30 days after the beneficiary's admission to the assertive community treatment (ACT) program, according to the following requirements:

- (1) Each assessment area must be completed by staff with skill and knowledge in the area being assessed and must be based upon all available information and resources, including beneficiary self-reports, reports of family members and other significant parties, written summaries from other agencies, including police, courts, and outpatient and inpatient facilities, interviews with the beneficiary, and standardized assessment materials;
- (2) The comprehensive assessment must include a thorough medical and psychiatric evaluation and must identify beneficiary strengths as well as problems. The assessment must gather sufficient information to develop an individual treatment, rehabilitation, and recovery plan; and
- (3) The comprehensive assessment may be added to, revised, or clarified during a beneficiary's tenure in the assertive community treatment (ACT) program.

009.05(B) INDIVIDUAL TREATMENT, REHABILITATION, AND RECOVERY PLAN DEVELOPMENT AND COORDINATION. Individual treatment, rehabilitation, and recovery plan development and coordination is a continuing process involving each beneficiary, the beneficiary's family, guardian, and support system as appropriate, and the team, which individualizes service activity and intensity to meet beneficiary-specific treatment, rehabilitation, and support needs. The written individual treatment, rehabilitation, and recovery plan documents the beneficiary's goals and the services the beneficiary will receive in order to achieve them. The plan also delineates the roles and responsibilities of the team members who will carry out the services. An initial individual treatment, rehabilitation, and recovery plan must be developed upon the beneficiary's admission to the assertive community treatment (ACT) team. The comprehensive individual treatment, rehabilitation, and

recovery plan must be developed for each beneficiary within 21 days of the completion of the comprehensive assessment. This individual treatment, rehabilitation, and recovery plan will be developed and revised according to this section.

009.05(B)(i) COMPREHENSIVE INDIVIDUAL TREATMENT, REHABILITATION, AND RECOVERY PLAN DEVELOPMENT.

A comprehensive individual treatment, rehabilitation, and recovery plan is developed through an organized process of coordination among the multi-disciplinary team in order to provide a full range of appropriate treatment, rehabilitation, and support services to the beneficiary in a planned, coordinated, efficient, and effective manner. The comprehensive individual treatment, rehabilitation, and recovery plan provides a systematic approach for meeting a beneficiary's needs, treatment rehabilitation, and support needs, and documenting progress on treatment, rehabilitation, and service goals.

009.05(B)(i)(1) KEY AREAS. The following key areas must be addressed in the individual treatment, rehabilitation, and recovery plan based upon the individual needs of the beneficiary: symptom stability, symptom management and education, housing, activities of daily living, employment and daily structure, family and social relationships, and crisis support. The individual treatment, rehabilitation, and recovery plan must be developed in collaboration with the beneficiary or guardian, if any, and, when appropriate, the beneficiary's family. The beneficiary's participation and consent in the development of the individual treatment, rehabilitation, and recovery plan must be documented. The plan must be signed by the beneficiary and the team psychiatrist.

This plan must:

- (a) Identify the beneficiary's needs and problems;
- (b) List specific long- and short-term goals with specific measurable objectives for these needs and problems;
- (c) List the specific treatment and rehabilitative interventions and activities necessary for the beneficiary to meet these objectives and to improve their capacity to function in the community; and
- (d) Identify the assertive community treatment (ACT) team members who will be providing the intervention.

009.05(B)(ii) INDIVIDUAL TREATMENT, REHABILITATION, AND RECOVERY PLAN REVIEWS. The assertive community treatment (ACT) team must review and revise the beneficiary's individual treatment,

rehabilitation, and recovery plan every six months, whenever there is a major decision point in the beneficiary's course of treatment, or more often if necessary. The team psychiatrist, team leader, and appropriate staff from the assertive community treatment (ACT) team must participate in each individual treatment, rehabilitation, and recovery plan review. The assertive community treatment (ACT) team must include the beneficiary in the review. Guardians and family members should be encouraged to participate, as allowed by the beneficiary.

009.05(B)(ii)(1) DOCUMENTATION. The individual treatment, rehabilitation, and recovery plan review must be documented in the beneficiary's clinical record. This documentation must include a description of the beneficiary's progress and functioning since the last individual treatment, rehabilitation, and recovery plan review, the beneficiary's current functional strengths and limitations, a list of attendees, the discussion related to the individual treatment, rehabilitation, and recovery plan, and any changes to the plan. The plan and review will be signed by the beneficiary and the team psychiatrist, which indicates this is the most appropriate level of care for the beneficiary and that the treatment, rehabilitative, and service interventions are medically necessary.

009.05(B)(iii) BENEFICIARY AND FAMILY PARTICIPATION. The assertive community treatment (ACT) team is responsible for engaging the beneficiary in active involvement in the development of the treatment and service goals. With the permission of the beneficiary, assertive community treatment (ACT) team staff must involve pertinent agencies and members of the beneficiary's family and social network in the formulation of individual treatment, rehabilitation, and recovery plans.

009.05(C) TREATMENT, REHABILITATIVE, AND SUPPORTIVE INTERVENTIONS. The assertive community treatment (ACT) team must be able to provide treatment, rehabilitative, and supportive interventions to beneficiaries assigned to the assertive community treatment (ACT) team. The interventions are categorized into three areas and the specific application of each type of intervention must be based on the beneficiary's specific goals and objectives. The interventions must address the needs identified in the comprehensive assessment. While there are no requirements that the beneficiary receive a minimum number of a specific categories of intervention, the beneficiary must receive the interventions that are appropriate for their needs.

009.05(C)(i) TREATMENT INTERVENTIONS. All interventions must be performed by professionals acting within the appropriate scope of practice.

009.05(C)(i)(1) MEDICAL ASSESSMENT, MANAGEMENT, AND INTERVENTION. The assertive community treatment (ACT) team must provide the interventions necessary to treat the beneficiary's psychiatric and physical conditions.

009.05(C)(i)(2) INDIVIDUAL, FAMILY, AND GROUP THERAPY OR COUNSELING. The assertive community treatment (ACT) team must provide individual, family, and group therapy or counseling to assist the beneficiary to gain skills in interpersonal relationships, identify and resolve conflicts, and systematically work on identified individual goals. These interventions must focus on lessening distress and symptomology, improving psychological defenses and role functioning, and increasing and reinforcing the beneficiary's understanding of and participation in treatment, rehabilitative services, and activities of daily living.

009.05(C)(i)(3) MEDICATION. The assertive community treatment (ACT) team must provide the prescription, preparation, delivery, administration, and monitoring of medications.

009.05(C)(i)(4) CRISIS INTERVENTION. The assertive community treatment (ACT) team must provide crisis intervention services by assessing beneficiary needs that require immediate attention and initiate a resolution to the need.

009.05(C)(i)(5) SUBSTANCE USE DISORDER SERVICES. The assertive community treatment (ACT) team must provide Substance use disorder services to assist the beneficiary in achieving periods of abstinence and stability. The interventions must include assessment, individual and group counseling, education, and skill development. The interventions should help the beneficiary:

- (a) Learn to identify substance use, effects, and patterns;
- (b) Recognize the relationship between substance use, mental illness, and psychotropic medications; and
- (c) Develop motivation to eliminate or decrease substance use and coping skills or alternatives to minimize substance use.

009.05(C)(ii) REHABILITATIVE INTERVENTIONS.

009.05(C)(ii)(1) SYMPTOM MANAGEMENT SKILL DEVELOPMENT. The assertive community treatment (ACT) team must provide symptom management skill development to help the beneficiary cope with and gain mastery over symptoms and functional impairments in the context of adult role functioning.

009.05(C)(ii)(2) VOCATIONAL SKILL DEVELOPMENT. The assertive community treatment (ACT) team must provide vocational skill development that includes individualized assessment and planning for employment based upon functional assessment and the beneficiary's needs, desires, interests, and abilities.

009.05(C)(ii)(3) ACTIVITIES OF DAILY LIVING AND COMMUNITY LIVING SKILL DEVELOPMENT. The assertive community treatment

(ACT) team must provide services to help the beneficiary rehabilitate their functional impairments and limitations related to activities of daily living and living in a community setting. The services will help beneficiaries carry out personal hygiene and grooming tasks, perform household activities, find housing that is safe and affordable, develop or improve money management skills, use available transportation, and have and effectively use a personal physician and dentist.

009.05(C)(ii)(4) SOCIAL AND INTERPERSONAL SKILL DEVELOPMENT. The assertive community treatment (ACT) team must provide interventions to help the beneficiary rehabilitate their social functioning.

009.05(C)(ii)(5) LEISURE TIME SKILL DEVELOPMENT. The assertive community treatment (ACT) team must provide interventions to rehabilitate the beneficiary's ability to use leisure time appropriately.

009.05(C)(iii) SUPPORTIVE INTERVENTIONS.

009.05(C)(iii)(1) ASSISTANCE. The assertive community treatment (ACT) team must provide support services, direct assistance, and coordination to ensure that the beneficiary obtains the basic necessities of daily life.

009.05(C)(iii)(2) SUPPORT. The assertive community treatment (ACT) team must provide support to beneficiaries, on a planned and as needed basis, to help them accomplish their personal goals, gain a sense of personal mastery and empowerment, and to cope with the stresses of day-to-day living. This includes interaction that focuses on decreasing distress, improving understanding and reinforcing the beneficiary's participation in services.

009.05(C)(iii)(3) FAMILY INVOLVEMENT. The assertive community treatment (ACT) team will provide education, support, and consultation to beneficiaries' families and other major supports, with beneficiary agreement and consent. The assertive community treatment (ACT) team must encourage family members and other major sources of support to be involved in the services received by the beneficiary unless prohibited by the beneficiary, through legal action, or because of confidentiality laws. This includes education about the beneficiary's illness and condition and the role of the family in the therapeutic process, intervention to resolve conflict, and ongoing communication and collaboration between the assertive community treatment (ACT) team and the beneficiary's family.

009.05(C)(iii)(4) POSITIVE PEER ROLE MODELING. The assertive community treatment (ACT) team will offer opportunities for positive peer role modeling and peer support including practical

problem-solving approaches to daily challenges, peer perspective on steps to recovery and support, mentoring toward greater independence, empowerment, and ability to manage severe symptomology.

009.06 NATIONAL ACCREDITATION AND CERTIFICATION. Providers must be nationally accredited under specific assertive community treatment (ACT) team standards , or must be actively pursuing accreditation in order to be enrolled. Providers that are actively pursuing accreditation with a national body must submit their accreditation plan for consideration. Providers actively pursuing accreditation will be enrolled on a provisional status.

009.07 CLINICAL DOCUMENTATION REQUIREMENTS. Records must be kept in accordance with the national accreditation body surveying the provider. The clinical records for assertive community treatment (ACT) team services must include the following information:

- (A)Team psychiatrist's orders;
- (B)Treatment, rehabilitation, and service planning;
- (C)Progress and contact notes must be recorded by all assertive community treatment (ACT) team members providing services to the beneficiary;
- (D)Reports of consultations, laboratory results, and other relevant clinical and medical information; and
- (E)Documentation of transition and discharge planning.

009.08 PERFORMANCE IMPROVEMENT AND PROGRAM EVALUATION. The assertive community treatment (ACT) team must have a performance improvement and program evaluation plan that meets the criteria for accreditation in the approved national accreditation organization. In addition, the program will participate in all aspects of statewide assertive community treatment (ACT) evaluation projects.

009.09 PROVIDER ENROLLMENT. An assertive community treatment (ACT) team must complete the appropriate Nebraska Medicaid approved provider agreement form, and submit the completed agreement and a program overview that addresses the requirements in these regulations to Nebraska Medicaid for approval. The assertive community treatment (ACT) team must maintain written policies and procedures that document compliance with all of the standards and requirements in this chapter . Annual updates of enrollment may be required. The provider must submit updates of the identity and expertise of assertive community treatment (ACT) team members as new staff are added to the program.

009.10 PRIOR AUTHORIZATION. Reimbursement for services from the assertive community treatment (ACT) team must be prior authorized by

Nebraska Medicaid or its designee.

009.11 TELEHEALTH. Assertive community treatment (ACT) team interventions can be provided via telehealth when provided according to this title .

009.12 REIMBURSEMENT AND BILLING INFORMATION. Nebraska Medicaid pays for assertive community treatment services at established rates. Providers must follow these billing requirements:

- (A) Claims for services provided by the assertive community treatment (ACT) team must be billed on the appropriate completed Nebraska Medicaid approved health care claim form ;
- (B) Claims for assertive community treatment (ACT) team services must use the procedure codes determined by Nebraska Medicaid ; and
- (C) The unit of service for assertive community treatment (ACT) team reimbursement is one day.

009.13 LIMITATIONS ON THE REIMBURSEMENT FOR ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM SERVICES. Nebraska Medicaid eligibility for beneficiaries age 21 to 64 who are admitted to an institution for mental disease (IMD) for longer than ten days will end .

010. SECURE PSYCHIATRIC RESIDENTIAL REHABILITATION. secure psychiatric residential rehabilitation facilities are integrated into the community and provide programming in an organized, structured setting, including treatment and rehabilitation services and offer support to beneficiaries with a severe and persistent mental illness or co-occurring substance use disorders, or both. These beneficiaries demonstrate a moderate to high risk for harm to self or others and are in need of recovery, treatment, and rehabilitation services. The beneficiaries who are in need of this level of care have long standing limitations with limited ability to live independently over an extended period of time. These beneficiaries have needed a high level of psychiatric intervention and have limitations in all three functional areas, vocational and educational, social skills, and activities of daily living as defined in this chapter. The secure psychiatric residential rehabilitation program provides skill building and other related recovery oriented psychiatric rehabilitation services as needed to meet individual beneficiary needs.

010.01 PURPOSE. The secure psychiatric residential rehabilitation program is designed to:

- (A) Increase the beneficiary's functioning while improving psychiatric stability so that they can eventually live successfully and safely in a less restrictive residential setting of their choice and capabilities;
- (B) Decrease the frequency and duration of hospitalization;

- (C) Decrease or eliminate all high risk, unsafe behavior to self or others; and
- (D) Improve the ability to function independently by improving ability to function.

010.02 PROGRAM COMPONENTS. A secure psychiatric residential rehabilitation program provides a variety of on-site psychosocial rehabilitation and skill acquisition activities and treatment each day. The program must facilitate beneficiary driven skills training and activities as appropriate. A secure psychiatric residential rehabilitation program must provide services identified on the beneficiary specific individual treatment, rehabilitation, and recovery plan, providing culturally-sensitive and trauma-informed care. The activities must include :

- (A) Ongoing assessment;
- (B) Arrangement for general medical care including laboratory services, psychopharmacological services, or psychological services, as necessary;
- (C) Provision of a minimum of 42 hours per week of on-site staff led psychosocial rehabilitation activities and skill acquisition;
- (D) Programming focused on relapse prevention, recovery, nutrition, daily living skills, social skill building, community living, substance use disorders, education, medication education and self-administration, symptom management, and focus on improving the level of functioning to get to a less restrictive level of care;
- (E) Educational and vocational focus as appropriate; and
- (F) Access to community-based rehabilitation and social services to assist in transition to community as symptoms are managed and behaviors are stabilized.

010.03 ASSESSMENTS. The following assessments must be completed:

- (A) A comprehensive mental health and substance use disorder assessment by an independently licensed mental health practitioner (LMHP) must occur prior to admission. As appropriate, a substance use disorder addendum must be developed to clarify or update the treatment needs and recommendations and gather information that covers the time frame where a beneficiary was not receiving treatment;
- (B) Following admission and within 24 hours of stay, an assessment by the program's psychiatrist must be completed;
- (C) A history and physical must be completed by a physician, physician assistant (PA), or advanced practice registered nurse (APRN) within 24 hours of admission and be available in the clinical record;

(D)A nursing assessment must be completed by a registered nurse (RN) within 24 hours of admission; and

(E)A functional assessment must be completed initially upon admission and annually with continued stay at this level of service.

010.04 INDIVIDUAL TREATMENT, REHABILITATION, AND RECOVERY PLANNING. An initial individual treatment, rehabilitation, and recovery plan must be completed within 24 hours of admission. secure psychiatric residential rehabilitation service providers must develop an individual treatment, rehabilitation, and recovery plan with the beneficiary within 30 days following admission to the program. The plan must include treatment protocols for substance use disorder issues. With the beneficiary's consent, the beneficiary's family or guardian must be included in all assessment and treatment, rehabilitation, and recovery planning. The provider must make every effort to be available and responsive to the beneficiary's family or guardian to assist their involvement in the beneficiary's recovery. The plan must be reviewed and revised with the beneficiary, discussing and documenting the discharge plan a minimum of every 30 days according to the following requirements.

010.04(A) INDIVIDUAL TREATMENT, REHABILITATION, AND RECOVERY PLAN. The individual treatment, rehabilitation, and recovery plan must be based upon a comprehensive assessment and completed within 30 days of admission. This plan must:

- (i)Be oriented to the principles of recovery and meaningful beneficiary participation;
- (ii)Apply the principles of recovery to include meaningful beneficiary participation, and a life in the community of the beneficiary's choosing;
- (iii)Incorporate and be consistent with best practices;
- (iv)Include the beneficiary's individualized goals and expected outcomes;
- (v)Contain prioritized objectives that are measurable and time-limited;
- (vi)Describe therapeutic interventions to be used in achieving the goals and objectives that are recovery-oriented, trauma-informed, and strength-based;
- (vii)Identify staff responsible for implementing the therapeutic interventions;
- (viii)Specify the planned frequency and duration of each therapeutic method;
- (ix)Delineate the specific behavioral criteria to be met for discharge or transition to a lower level of care and reviewed

weekly;

- (x) Include a plan developed with the beneficiary that includes strategies to avoid crisis or admission to a higher level of care using principles of recovery and wellness;
- (xi) Include the signature of the beneficiary, parent, or guardian;
- (xii) Include the health care proxy and trauma safety forms when available and with beneficiary's consent;
- (xiii) Include documentation that the initial individual treatment, rehabilitation, and recovery plan has been completed within the timeframe specified in the program's policies and procedures;
- (xiv) Document that the plan has been reviewed, updated every 30 days, and revised according to client needs and progress; and
- (xv) Document that the plan was reviewed by the program's treatment practitioners a minimum of every 30 days and that written revisions were approved, signed, and dated each 30 days by the program psychiatrist.

010.04(B) TREATMENT SERVICES. The program must offer structured, planned treatment and rehabilitation services as prescribed by the individualized treatment, rehabilitation, and recovery plan. The following services must be available and offered to the beneficiary:

- (i) Individual psychotherapy;
- (ii) Group psychotherapy;
- (iii) Family therapy; and
- (iv) Psychoeducational services.

010.04(C) SUPPORTIVE SERVICES. The program must provide the following supportive services for all active beneficiaries: referrals as necessary, problem identification and solution, and coordination of the secure psychiatric residential rehabilitation program treatment and activities with other services the beneficiary may be receiving.

010.05 STAFFING. The secure psychiatric residential rehabilitation provider must contract with or employ a licensed psychiatrist for the program. The psychiatrist's hours must be at a sufficient level to provide weekly direct contact with the beneficiary; to provide assessment; to review the individual treatment, rehabilitation, and recovery plan; to evaluate beneficiary's level of progress; to assist in eliminating barriers to recovery; and to provide psychiatric consultation as necessary 24 hours per day, and seven days per week. Programs must have staff available in skill and numbers to meet the acuity of the beneficiaries being served. Programs must have ability to call staff back when necessary.

010.05(A) STAFFING STANDARDS. Secure psychiatric residential rehabilitation providers must meet the following minimum staffing requirements. The program must employ a:

- (i) Program director;
- (ii) Licensed mental health practitioner (LMHP), or licensed alcohol and drug counselor (LADC), or both. ;
- (iii) Registered nurse (RN); and
- (iv) Direct care staff.

010.05(A)(1) PROGRAM DIRECTOR REQUIREMENTS. The program director must:

- (a) Be fully licensed as a mental health practitioner, which could be a psychiatrist, advanced practice registered nurse (APRN), a registered nurse (RN), a licensed mental health practitioner (LMHP), a licensed independent mental health practitioner (LIMHP) or psychologist; and
- (b) Possess leadership, supervisory, and management skills.

010.05(A)(2) RESPONSIBILITIES OF THE SECURE PSYCHIATRIC RESIDENTIAL REHABILITATION PROGRAM DIRECTOR. The program director must:

- (a) Complete and sign a comprehensive biopsychosocial assessment for each beneficiary within 14 days of admission or delegate responsibility for the assessment to the program's licensed practitioner who functions as the therapist for the program;
- (b) Develop, approve, and sign an initial individual treatment, rehabilitation, and recovery plan within the first 24 hours of admission;
- (c) Supervise and participate in the development of a comprehensive individual treatment, rehabilitation, and recovery plan with the beneficiary and the program staff within 30 days of admission. The program director must approve and sign the plan prior to implementation;
- (d) Supervise the professional staff and direct care staff by onsite presence during programming;
- (e) Assure adequate staff training through initial and ongoing training sessions and provide supervision of staff competency checks;
- (f) Supervise and provide direction regarding all documentation requirements, including organization and completeness of clinical records; and

- (g) Supervise and direct the development and implementation of the discharge plan.

010.05(A)(3) RESPONSIBILITIES OF THE REGISTERED NURSE (RN).
The registered nurse (RN) must:

- (a) Complete a nursing assessment within 24 hours of admission;
- (b) Participate in the development of the individual treatment, rehabilitation, and recovery plan and the plan updates;
- (c) Oversee and monitor daily medication administration;
- (d) Provide medication education as necessary;
- (e) Communicate with the psychiatrist and physician consultants as necessary; and
- (f) Monitor, supervise, and oversee the program's daily activities in conjunction with and in the absence of the program director.

010.05(A)(4) RESPONSIBILITIES OF THE MENTAL HEALTH PRACTITIONER. The mental health practitioner must:

- (a) Complete a comprehensive assessment within 14 days of admission when this responsibility is delegated by the program director;
- (b) Participate in the development of the individual treatment, rehabilitation, and recovery plan and the updates;
- (c) Provide individual, group, and family psychotherapy according to the beneficiary's individual treatment, rehabilitation, and recovery plan;
- (d) Communicate with the program director and psychiatrist regarding the clinical needs of the beneficiary as necessary;
- (e) Monitor, supervise, and oversee the program's daily treatment and activities in the absence of the program director as assigned by the program director;
- (f) Assist with aggressive discharge planning; and
- (g) Maintain a maximum staffing ratio of one practitioner to eight beneficiaries.

010.05(A)(5) DIRECT CARE STAFF. Direct care staff to beneficiary ratios must be sufficient to meet beneficiary needs, and ratios must be enhanced to meet beneficiary needs as necessary. The secure psychiatric residential rehabilitation program must employ direct care staff who:

- (a) Are on site and available to the beneficiaries at a ratio of one staff per four beneficiaries during awake hours and a minimum of one awake direct care per staff per six beneficiaries during overnight hours; and
- (b) Have a bachelor's degree in psychology, sociology, or related human services field, except that two years of course work in the human services field and two years of experience and training or two years of lived recovery experience is an acceptable substitute. Each staff must have demonstrated skills and competency in treatment with individuals with mental health diagnosis.

010.06 DISCHARGE PLANNING. Discharge and transition planning must begin upon admission. The beneficiary's family or guardian must be included in discharge planning as authorized by the beneficiary. The plan must be recovery-oriented, trauma-informed, and strength-based. Providers must meet the following standards regarding recovery and discharge planning:

- (A) Discharge planning must be consistent with the goals and objectives identified in the individual treatment, rehabilitation, and recovery plan and clearly documented in the clinical record;
- (B) Discharge planning must address the beneficiary's needs for ongoing services to maintain the gains and to continue as normal functioning as possible following discharge. A crisis, relapse, and safety plan must be in place;
- (C) Providers must make or facilitate referrals and applications to the next level of care or community support services, or both ;
- (D) Providers must arrange for the prompt transfer of clinical records and information to ensure continuity of care; and
- (E) A written discharge summary must be provided as part of the clinical record. It must identify the readiness for discharge and contain the signature of a fully licensed clinician and date of signature and must identify a summary of the services provided.

010.07 CLINICAL DOCUMENTATION. Clinical records must be maintained at the beneficiary's primary rehabilitation site.

010.08 CLINICAL RECORD REQUIREMENTS. The clinical record must include information required in this chapter and, at a minimum:

- (A) Assessment and evaluations:
 - (i) Psychiatric assessment, including the name of the clinician and the date of the assessment;
 - (ii) Comprehensive assessment; and

(iii) Other assessments completed related to the beneficiary's behavioral health diagnosis;

(B) The beneficiary's diagnostic formulation, including all five axes; and

(C) The individual treatment, rehabilitation, and recovery plan and updates to plans.

010.09 PROVIDER PARTICIPATION. Providers are required to provide annual updates of program information and cost information to determine ongoing compliance with Nebraska Medicaid regulations. Providers must maintain documentation of policies and procedures that meet the standards and regulations described in this chapter.

010.10 BED LIMITATION. The maximum capacity for the provider of secure psychiatric residential rehabilitation services must not exceed 16 beds.

010.11 TREATMENT PRIOR AUTHORIZATION. All secure psychiatric residential rehabilitation services must be prior authorized by Nebraska Medicaid or its designee, including initial admissions and continued stay requests.

010.12 INSPECTIONS OF CARE (IOC). Nebraska Medicaid or its designee can periodically inspect the care which includes the treatment, rehabilitative, and recovery services provided to beneficiaries in each type of service.

011. SUBSTANCE USE DISORDER COMMUNITY SUPPORT. Substance use disorder community support interventions provide direct rehabilitation and support services to beneficiaries in the community to assist the beneficiary in maintaining abstinence, stabilizing community living, and preventing exacerbation of symptoms and admissions to more restrictive levels of care. Services are based upon medical necessity as identified in the beneficiary's treatment and recovery plan and must be provided in 15-minute increments.

011.01 PROGRAM COMPONENTS. The substance use disorder community support program must:

(A) Facilitate communication and coordination among all health care professionals providing services to the beneficiary;

- (B) Ensure completion of a strength-based needs assessment completed within 30 days of admission by the rehabilitation team or team member;
- (C) Develop and implement strategies to encourage the beneficiary to become engaged and remain engaged in necessary substance use and mental health treatment services as recommended and included in the treatment and recovery plan;
- (D) Have access to the comprehensive substance use disorder assessment conducted prior to admission by an independently licensed practitioner practicing within their scope of practice, which must be reviewed and updated within 30 days of admission into the program. As appropriate, a substance use disorder addendum must be developed to clarify or update the treatment needs and recommendations and gather information that covers any time frame where a beneficiary was not receiving treatment;
- (E) Participate with and report to the treatment and recovery team on the beneficiary's progress and response to community support intervention in areas of relapse prevention of substance use and application of education and skills in the recovery environment;
- (F) Review and update the treatment and recovery plan and discharge plan with the beneficiary and other approved family supports every 90 days or more often as clinically necessary;
- (G) Coordinate with the providers of mental health services beneficiary has a co-occurring diagnosis and receiving mental health services by a licensed practitioner either located in the agency or in a separate program;
- (H) Assist in facilitating the transfer to and the transition to other levels of treatment service;
- (I) Assist in the development, evaluation, and update in a crisis and relapse plan with the beneficiary;
- (J) Provide contact as needed with other providers, beneficiary family members, and other significant individuals in the beneficiary's life to facilitate communication necessary to support the beneficiary in maintaining community living;
- (K) When prescribed, monitor medication compliance, and report compliance issues as necessary;
- (L) Assist the beneficiary with all health insurance issues; and
- (M) Assist in the discharge plan for the beneficiary and support development of community-based resources.

011.02 PROGRAM AVAILABILITY. The substance use disorder Community Support program must establish hours of service delivery that ensure program staff availability and accessibility to the treatment, rehabilitation, and recovery needs of the beneficiary. The

frequency of face-to-face contacts with the beneficiary is based upon clinical need.

011.03 STAFFING REQUIREMENTS. Substance use disorder Community Support programs must employ a licensed practitioner to provide supervision of the substance use disorder Community Support program. The licensed practitioner must supervise any individualized treatment and recovery service interactions provided by a community support worker. The licensed clinical supervisor will review community support beneficiary's clinical needs and progress toward their goals with the community support worker every 30 days. The support worker must have a minimum of:

- (i) Bachelor's degree in psychology, sociology, or related human service field, or
- (ii) Two years coursework in a human services field and two years of training or training, or
- (iii) Two years of lived recovery experience with demonstrated skills and competencies in the provision of substance use disorder services and demonstrated skill in competency in working with chronic substance dependence.

011.03(A) CLINICAL DOCUMENTATION. Direct care staff employed by the agency before the effective date of these regulations will be considered to meet staffing requirements when the provider submits documentation identifying the name, address and provider number of the provider, service provided, names of direct care staff employed before the effective date of these regulations, and their date of hire. Documentation must be submitted 30 days following the effective date of these regulations.

011.04 ASSESSMENT AND TREATMENT PLANNING. Outpatient substance use disorder treatment must be delivered following the completion of the comprehensive substance use disorder assessment. Prior to delivery of services, an individual treatment and recovery plan must be developed by the provider with the beneficiary. The plan must be individualized, reviewed, and approved by the beneficiary and therapist, and adjusted as clinically necessary. As appropriate, a substance use disorder addendum must be developed to clarify or update the treatment needs and recommendations and gather information that covers any time frame where a beneficiary was not receiving treatment.

011.05 DOCUMENTATION. Outpatient substance use disorder treatment providers must document in a summary the treatment service delivered in an individualized progress note. The progress note must describe the treatment intervention provided, the beneficiary's response to the intervention, and must be placed in the beneficiary's clinical record. Documentation must clearly reflect the implementation of the treatment and recovery plan. Discharge planning must be an essential part of the treatment and recovery plan and the documentation of the progress toward discharge must be documented in the clinical record.

.011.06 PROVIDER ENROLLMENT. Outpatient adult substance use disorder providers must comply with all applicable provider participation requirements. Providers of outpatient services must provide annual cost information as a requirement by Nebraska Medicaid at the time of enrollment and maintain any licensure requirements in order to continue participation with Nebraska Medicaid.

011.07 PRIOR AUTHORIZATION. Outpatient substance use disorder treatment services must be prior authorized by Nebraska Medicaid or its designee before treatment service delivery.

011.08 PAYMENT FOR COMMUNITY SUPPORT ABUSE TREATMENT SERVICES. Providers must bill community support services in 15-minute increments for a maximum of 144 units for 180 days.

