Nebraska Cross-Systems Analysis:
Final Report



State of Nebraska
Department of Health and Human Services
Cross-Systems Analysis
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PUBLIC CONSULTING GROUP

Public Consulting Group, Inc.
148 State Street, Tenth Floor, Boston, Massachusetts 02109
Tel. (617) 426-2026
www.publicconsultinggroup.com

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EXECUTIVE SUMMARY

It is important for the Nebraska Department of Health and Human Services (DHHS) to efficiently allocate state funding, in order to maximize federal funding for services to at-risk children and juveniles. The scope of this project assessed the current prevention/intervention services to youth and identified opportunities to replace state-funded services with federal funds.

Based on the cross-system analysis that was conducted, the following seven (7) recommendations are made for Nebraska's consideration:

1. Increase Preventative Services for At-Risk Children

Nebraska lacks a comprehensive system which provides preventative services for at-risk youth across the state. Historically, Nebraska has one of the highest rates of state wards per capita in the country. In FY2010, Nebraska's rate of children in out-of-home care was 10.9 (per 1,000), while the national rate was 5.2[1]. To directly address this issue, DHHS should increase the number of available services that prevent at-risk children and juveniles from becoming state wards.

Due to this lack of preventative services, there is an excess use of Psychiatric Residential Treatment Facilities which for many children is not medically necessary and thus not covered by Medicaid, costing the State millions of dollars in general funds each year.

There are only a few Behavioral Health regional programs that currently address this issue such as the LINCS program, Prevention Professional Partner Program, Rapid Response Program and the Adolescent Therapist with the Mobile Crisis Response Team. These programs are funded with limited general funds, thus the number of children that can be served is limited.

2. Maximize Title IV-E Revenue Opportunities

Nebraska spends a significant amount of state general funds on services and expenditures that are reimbursable with Title IV-E funding. DHHS should continue its current efforts to maximize the Title IV-E funding that Nebraska receives for child welfare services.

The three (3) primary areas that Nebraska should focus on to address Title IV-E revenue opportunities are described below:

a) *Title IV-E Penetration Rate*: To improve Nebraska's eligibility rate, which is currently 30%), Nebraska should do the following:
   - Work with child specific and relative foster parents to assist in removing the barriers for licensure (when safe and possible)
   - Update the foster care licensure regulations
   - Collaborate with the Administrative Office of the Court and Judges to ensure they are making appropriate judicial determinations.

[1] Data Advocacy, Casey Family Programs. (Jurisdiction Data Report), 3/8/2012.

b) *Title IV-E Revenue (Maintenance and Administrative)*: Nebraska does not claim all of the eligible expenditures for Title IV-E maintenance and administrative reimbursement. To increase the Title IV-E reimbursement for these services, Nebraska should do the following:
   - Submit all allowable maintenance costs (Personal incidentals, school supplies, clothing, respite care, etc.)
   - Claim administrative costs for state wards who are candidates for foster care
   - Utilize the option of claiming Title IV-E reimbursement through the Guardianship Assistance program (GAP) in increasing frequency.
   - Pursue Title IV-E reimbursement for claiming services provided through the Juvenile Service Delivery Project.

c) *Considerations for Title IV-E Waiver*: Nebraska should follow through with the legislative action to submit a Title IV-E waiver demonstration. Nebraska should consider the following factors in drafting the waiver terms and conditions:
   - The waiver demonstration project must remain cost neutral to the federal government and the savings from the waiver demonstration must be reinvested into child welfare services.
   - The buy-in from Nebraska stakeholders is important to the success of the Title IV-E waiver demonstration.

3. Expand Opportunities in Children's Health Care

Nebraska should expand on opportunities for health-related services to children. These services could be used by DHHS to address the at-risk population, and specifically the medical issues of children before they become state wards. Listed below are the three (3) primary actions that Nebraska can implement:

a) *Implement Health Homes Initiatives*: Nebraska should implement health home initiatives to target children that require additional supportive services in residential placements,. This option can be utilized to serve children that would traditionally enter into foster care as a means to obtain needed services. These type of services are currently paid for with state funding, but establishing health homes would be allow for federal funding to subsidize these services, as health home services are reimbursed at 90% federal medical assistance percentage

b) *Consider Medicaid 1915(b) Waivers*: Nebraska should consider additional forms of 1915 Medicaid waivers that target child specific populations and develop a coordinated set of services. The services included in these waivers could leverage Medicaid funding (rather than state funding) and divert and/or transition youth from institutional settings into their homes and community placements.

c) *Update UPL and DSH Calculations*: Nebraska should consider implementing and/or recalculating the numbers underlying the Upper Payment Limit (UPL) and Disproportionate Share Hospital (DSH). These strategies can help

Nebraska maximize payments (and federal reimbursement) for hospitals, provide federal reimbursement for state-funded payments to the university's hospital system, and maximize federal funding for qualifying hospitals.

4. Continue to Maximize Medicaid Claiming Opportunities

Nebraska should evaluate its current monthly claiming mechanism and determine if there are other claiming methods that may be more financially advantageous. Revising the claiming methods could potentially increase the federal reimbursement for the Developmental Disabilities division, and free up additional state funds. As an additional best practice, Nebraska should also consider increasing the overall quality assurance and monitoring of Medicaid enrollment and Medicaid claiming. These measures will help the state document its efforts to fully maximize Medicaid claiming and enroll children in Medicaid programs whenever possible.

5. Increase Collaborations with Local Head Start Programs and CFS Division Programs

Nebraska should increase collaborative efforts between Head Start programs and CFS programs to serve the targeted population of at-risk children. Head Start programs include early care, education, and comprehensive services to infants and toddlers. These services could be leveraged by DHHS to proactively address the needs of children and families most likely to become wards of the state, and provide the necessary services to keep these children from being brought into the foster care system. This would allow the state to utilize current federal funding for services to at-risk children and minimize the likelihood of these children being placed in state-funded foster care.

6. Implement Increased Levels of Provider Management

DHHS, and specifically the CFS division, should implement increased levels of provider management to better utilize available funding and improve the outcome efficiency of services. To help Nebraska properly monitor the service provider network, DHHS should:

- *Develop Service Outcomes in Provider Contracts*: DHHS should develop provider contracts to include outcome measurements for services, which will allow providers to demonstrate their services actually achieve the desired outcomes of the agency.
- *Implement Monitoring Procedures for Provider Contracts*: DHHS should have a formal monitoring process of service contracts to track providers' performance in regards to the outcomes set forth in the contract.
- *Develop Accountability Measures for Providers*: The CFS division should implement a method to measure/compare providers' effectiveness, such as requiring evidence-based practices for core services or developing provider scorecards.

7. Expand the Setting/Negotiating of Provider Payment Rates

Nebraska should expand the process for setting (or negotiating) providers payment rates. This will assure DHHS that providers are reimbursed appropriately for services and funding is fully

utilized. To expand the process for setting and negotiating provider payment rates, Nebraska should:

- Establish foster care rates associated with the various levels of foster care
- Review the Title IV-E maintenance and administrative rates for Child Placing agencies.
- Conduct a peer sate review of foster care rates to those states in geographic proximity and similar cost of living to Nebraska.

INTRODUCTION

The Nebraska Department of Health and Human Services (DHHS), with direction from the Nebraska Children's Commission, contracted with Public Consulting Group (PCG) to conduct a cross-system analysis of current prevention and intervention programs and services provided by the department for the safety, health, and well-being of children. Based on Legislative Bill 821, the goals of this analysis were to:

1) Identify state General Funds being used, in order to better utilize federal funds
2) Identify resources that could be better allocated to provide more effective services to at-risk children and juveniles transitioning to home-based and school-based interventions,
3) Provide information which will allow the replacement of state General Funds for services to at-risk children and juveniles with federal funds

Each of these goals are directly related to Nebraska's plan to expand the funding base for prevention and intervention services, while maximizing the federal funding mix for these services. DHHS provides an array of services for at-risk children and juveniles through programs within its six (6) agency divisions. Each division that provides prevention/intervention services to youth, excluding the Division of Veterans' Homes, is outlined in the next section. The cross-system analysis examined the funding streams being utilized and determined key areas where there may be duplication. Additionally, we focused on identifying opportunities for Nebraska to substitute state-funded services with federal funding through grants, sub-grants, and waivers.

Over the past few years, Nebraska has been working to address the issue of the removal of children from their homes and into state custody. The number of state wards in the state reached a startling rate in 2010 where Nebraska was removing children from their homes at more than twice the national rate. (Nebraska's rate was 10.9 per 1,000 children, and the national rate was 5.2) "Child welfare experts cite several reasons for the high rate of child protective services in Nebraska. Advocates say the state has historically spent far more money on children after their removal from their homes than on prevention and family preservation." [2] Traditionally removing a child from his/her home has been the primary process to provide the child/family with needed services. In addition to the issues with removing children from their homes, Nebraska also struggled with Safe-Haven laws that were implemented in 2008, allowing parent(s) the right to voluntarily give custody of their children to DHHS. This led to many placements of children whose parent(s) were no longer willing to handle them for various reasons, such as minor delinquency, behavioral issues, mental health symptoms, etc.

Due to an increase in the number of children removed from their families, Nebraska's struggles with privatizing child welfare services, and the state's performance on federal child welfare standards, the state's legislature has taken major efforts to make the goal to reduce the number of foster care children (state wards) in Nebraska. In the January 2012 session, the state legislature promised that 2012 would be "the year of the children" and subsequently passed a series of bills

[2] O'Hanlon, Kevin. " Privatization fails: Nebraska tries again to reform child welfare." . The Center for Public Integrity, 21 2012. Web. 30 Nov 2012. <http://www.publicintegrity.org/2012/08/21/10706/privatization-fails-nebraska-tries-again-reform-child-welfare>.

to overhaul Nebraska's child welfare system.[1] These bills include a revision of child welfare spending and budgeting, plans for the state's child welfare information system, changes in foster home placements, and the provision of case management services. The package of bills, when fully implemented, are designed with the incorporation of lessoned learned from the state's past efforts to reform child welfare with a strong emphasis on the importance of keeping children in their homes and out of state custody. In addition to the legislatively mandated changes, the division itself has implemented several changes since Director Pristow was hired in March of 2012. Director Pristow created several new positions. These positions include; a deputy director of permanency and safety, regional service area administrators, policy and quality control administrators as well as a special project administrator and financial administrators. Each of these new positions have given the division clearer direction and the ability to reach set goals. In addition to the re-organization of the division, Director Pristow set a goal to safely reduce the number of children in foster care. In the past six months, CFS has implemented several initiatives to achieve this goal, including the implementation of a a new CQI system which allows staff to receive feedback on a monthly basis regarding data related to safety, permanency, and well-being of children in custody. The Director also implemented a 40 day focus which included a review of all children who had been in their homes safely over 60 days in an effort to identify any barriers to relieving the court and department of jurisdiction. This strategy resulted in a significant reduction in the number of children being served by protection and safety. So far, many of these efforts have been successful as Nebraska has lowered the total number of state wards by approximately 5% during 2012.

The National Coalition for Child Protection Reform collected evidence from various reports showing that children left in their own homes generally achieve better outcomes[1]. Children left in their own homes were shown to be far less likely to become pregnant as teenagers and less likely to enter the juvenile justice system. In a comprehensive study conducted in 2008 of 23,000 cases, researchers found that children placed in foster care, have two to three times higher arrest, conviction, and imprisonment rates than children who remained at home.[1]

The Need for a Cross-System Analysis

There is an identified need for a cross-system analysis of prevention services to at-risk children and juveniles. Nebraska DHHS is committed to providing the least disruptive services when necessary, however there is a need for a collaborative effort amongst the DHHS divisions (as well as programs outside of DHHS when appropriate) to properly serve youth in danger of being removed from their families. Each of DHHS' five divisions that provide child and youth services has its own set of funding sources for child and youth services, a significant portion from each division rely on state general funds. A cross-system analysis will help the state analyze the areas available to shift funding to services that minimally interrupt the child/family, as well as assist the state in fully leveraging existing and potentially untapped funding sources for services to needy families. Additionally, the analysis will shed light on the services in which a duplication

of services exists and provide recommendations for maximizing funding for the same or similar services.

METHODOLOGY

To provide Nebraska with a cross-system analysis of prevention services provided by DHHS to at-risk youth and juveniles, PCG worked closely with each DHHS division to understand what services are available and the current structure of funding. PCG completed the tasks described below through the following five-step process;

1) Identify current prevention/intervention services,
2) Research of state general funds used for prevention/intervention services,
3) Analyze the most effective services,
4) Research of private sector funding streams,
5) Develop final report and recommendations.

The following report will detail the PCG project team efforts to complete the following objectives:

- Identify the prevention and intervention services provided by DHHS
- Determine whether federal funds are available for services
- Isolate services funded by public and private sectors which avoid duplication and maximize public/private collaboration
- Research state general funds being used for prevention/intervention services to best utilize federal funds
- Analyze how resources can be allocated to the most effective services
- Notate private sector funding streams for prevention/intervention services
- Document all findings, recommendations and plans in a comprehensive report

Site Visits/Interviews

The PCG project team conducted individual interviews with key stakeholders to identify and discuss prevention/intervention services and available information to aid in the final recommendations. Interviewees included numerous stakeholders from each DHHS division; we specifically targeted stakeholders that were involved in the provision of services to children and families. The group of stakeholders interviewed for this analysis represented DHHS's direct service delivery to at-risk youth across the state, including social services, medical services, and other related assistance. In Table -1 below, we listed the persons included in our stakeholder interviews:

Table 1. Persons Included in Stakeholder Interview

Contact Name	Division	Department
Thomas Pristow	Children & Family Services	DHHS
Sara Goscha	Children & Family Services	DHHS
Cynthia Brammeier	Children & Family Services	DHHS
Cathy Johnson	Children & Family Services	DHHS
Shirley Pickens-White	Children & Family Services	DHHS
Terri Chasten	Children & Family Services	DHHS

Contact Name	Division	Department
Patti Reddick	Children & Family Services	DHHS
Mark Mitchell	Children & Family Services	DHHS
Allison Wilson	Children & Family Services	DHHS
Lynn Stone	Children & Family Services	DHHS
Mindi Alley	Children & Family Services	DHHS
Pam Hovis	Developmental Disabilities	DHHS
Susan Buettner	Medicaid & Long Term Disability	DHHS
Jenifer Roberts-Johnson	Public Health	DHHS
Maya Chilese	Behavioral Health	DHHS
Karen Harker	Behavioral Health	DHHS
CJ Johnson	Behavioral Health; Region 5 Systems	DHHS
Beth Baxter	Behavioral Health; Region 3	DHHS
Terri Nutzman	Children & Family Services, Office of Juvenile Services	DHHS
Willard Bouwens	Financial Services Administrator	DHHS
Deanna Brakhage	Children & Family Services	DHHS
Eleanor Kirkland	Head Start-State Collaboration Office	Department of Education
Corey Steel	Office of Probation Administration	Nebraska Supreme Court

Each interview included focused dialogue regarding the current offering of prevention/intervention services, and future developments that could improve outcomes for youth across the state. The interviewees were asked separate but related questions, including:

- **Programmatic:** Define the current service offerings to children that prevent the removal from their homes and minimize the risk of children becoming state wards. Are the least disruptive options being explored with the current services available to children/families through DHHS? What primary circumstances are affecting children in regards to service needs (Mental health needs, behavioral health factors, medical issues, etc.)?

- **Fiscal:** How does the DHHS funding structure impact the department capacity to provide prevention/intervention services? What type of funding does DHHS utilize in financing the services to children and families? What solutions would stakeholders recommend to address and move past the fiscal hurdles faced by the department?

Data Reviews

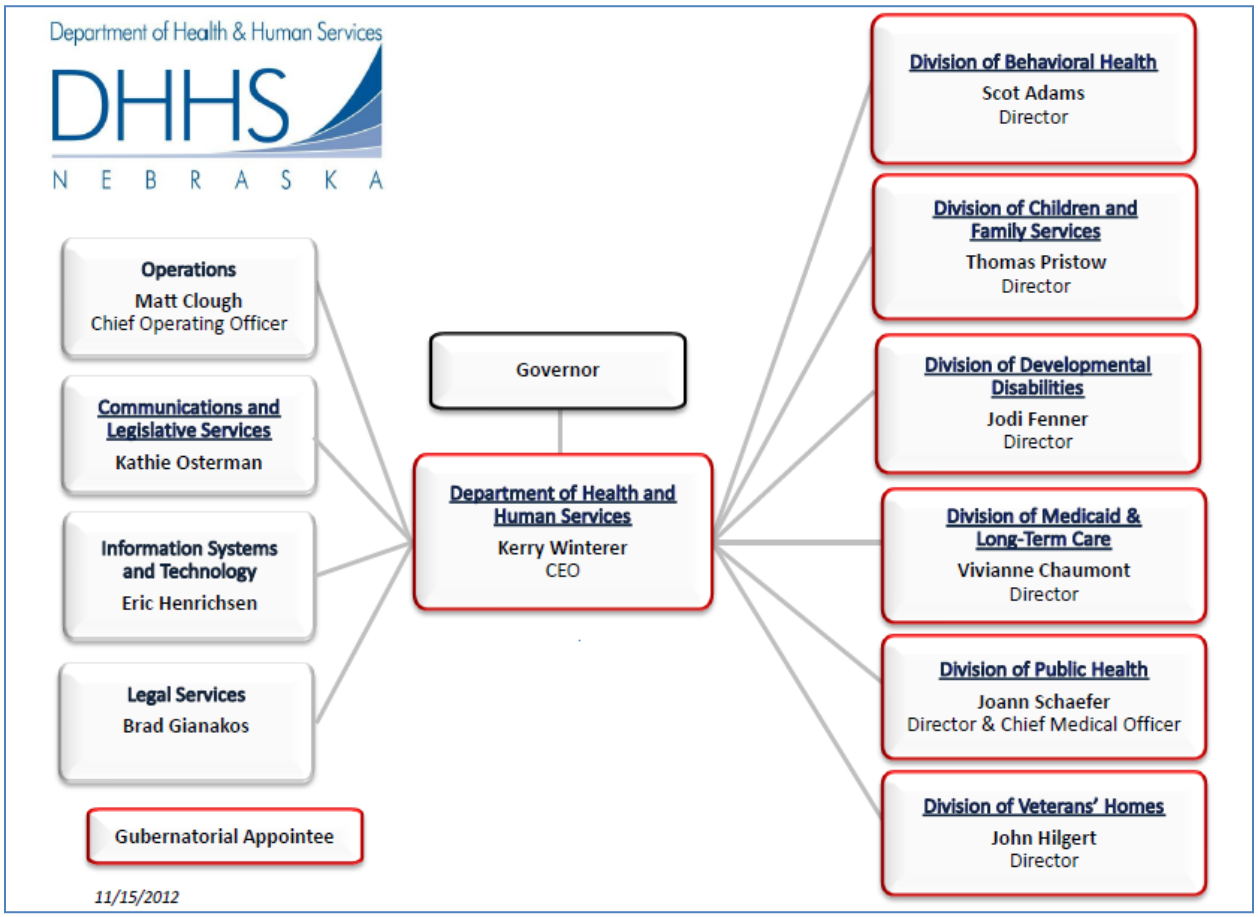
During the interviews, the PCG project team recorded feedback and utilized this information in developing the recommendations. PCG focused on conducting open and flexible interview sessions, using an adaptable questioning method to ensure that discussions were free-flowing and obtained as much interviewee feedback as possible.

In addition to the information collected during each interview, PCG also collected materials regarding program offerings, fiscal statistics, mapping of service availability, historical DHHS circumstances, legislative appropriations, and other data related to our project. This information was also utilized in developing the recommendations in this report.

DHHS DIVISIONS

The following section contains division profiles for each agency division (excluding the Division of Veteran's Affairs) under the Department of Health and Human Services. Division summaries as well as the funding streams for programs directly related to child and youth services are listed for the fiscal year most readily accessible. The division summaries and funding charts below are not meant to be an exhaustive list of programs/services, but rather the key offerings relative to Nebraska's health and human services and programs that serve at-risk youth. The following is an organizational chart of DHHS.

Figure 1. Nebraska Department of Health and Human Services Organizational Chart



The Division of Behavioral Health administers, oversees, and coordinates the state's public behavioral health system, which provides services to prevent and treat mental health issues, substance abuse and problem gambling disorders. The majority of these services are provided to adults while a small number of children and youth are served through the six (6) local Behavioral Health regions. Nebraska is divided into six regional areas, and each region is responsible for contracting with local programs to provide services. This regionally-based service model allows for each region to focus and prioritize local services to meet the needs of clients in each

community. Each community has its own set of challenges, and the regions can address these challenges through contracting the specific services needed in those communities.

The Behavioral Health regions contract with the state to receive budget appropriations for contracting for local services. The types of contracts used to procure services include fee-for-service and non-fee (expense reimbursement) for service models. The fee-for-service contracts directly reimburse providers a specific rate for each unit of service rendered, using an established service rate and unit maximum. The expense reimbursement contracts between the Behavioral Health regions and service providers require providers to submit invoices detailing expenses incurred, the contract stipulates that reimbursement will only be paid on expenditures incurred for rendered services. There is a mixture of contracting methods across providers in each Behavioral Health regions, based on service type, availability of providers, and client area of need.

The Behavioral Health region is responsible for maximizing the regional budget to procure community-based mental health and substance abuse services. As a match for the state's funding appropriation, the region provides a dollar for every $7.50 of state funding. This match requires investments from the counties within each Region, and also encourages the maximization of revenue for services. The majority of federal fund utilized by the Division are from the Community Mental Health Services Block Grant (CMHSBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), however the federal funding only covers approximately 11% of the division's total expenditures. Each Behavioral Health provider within the Region exhausts any alternative available funding/reimbursement for services, and utilizes state funding as a "last resort for service payment" using a sliding fee scale.

In addition to the Behavioral Health regions, the Division also operates three (3) Regional Centers, which serve approximately 375 people annually, most of which are adults. Hastings Regional Center (Psychiatric Residential Treatment Facility) serves youth referred from the Youth Rehabilitation and Treatment Center in Kearney, while Norfolk Regional Center exclusively provides Phase one treatment for sex offenders, and Lincoln Regional Center provides short-term inpatient and psychosocial rehabilitation mental health services to adults, as well as Phase two and three treatment for adult sex offenders. Approximately seventy nine males received substance abuse treatment in 2012 through the Hastings Regional Center. The following chart provides a breakdown of budget appropriations by state, federal, cash, and/or county for each behavioral health division's services for youth and children. A short description of the service, and the number of consumers served are also included.

Table 2. Division of Behavioral Health Funding and Number Served for Child andYouth Services

Program	Child & Youth Related Services	Number Served	Total Funding	Federal Funding	State Funding	Cash Funding	Fiscal Year Data Source
Mental Health Regional Center Operations Hastings Regional Center (HRC)	The Department of Health & Human Services (DHHS) directly operates three Regional Centers (the funding for Norfolk Sex Offender Treatment is appropriated seperately). The majority of clients served are adults. However, Hastings (HRC) provides PRTF for youth with substance abuse disorders.	79 children served through HRC	$8,324,227	$5,500,000	$2,824,227	$0	2011
Behavioral Health Community Based Service System (children only)	Mental health and substance abuse prevention and treatment service	Mental Health: 2754	$6,758,845	$850,224	$5,908,620	$0	2012
		Substance Abuse: 1427	$503,559	$148,575	$354,983	$0	2012
Nebraska Family Helpline	Provides a single point of access to children's behavioral health services through the operation of a 24-hour, year-round Helpline for the State.	15,233 (number of calls made or received)	$1,390,584	$0	$1,390,584	$0	2012
Family Navigator Program	Offers additional assistance to families needing guidance (from Family Helpline) through the mental and behavioral health systems.	1,083 (669 under Boys Town, 414 under Federation)	$866,047	$0	$866,047	$0	2010-2012

Table 3. Children and Youth Services Funding and Number Served by the Division of Behavioral Health Regions

Region	Number of Children Served	Total Funding	Federal Funding	State Funding	County Funding	Fiscal Year
Region 1	159	$697,236	$130,771	$566,465	$0	2012
Region 2	160	$500,835	$0	$460,929	$39,906	2012
Region 3	576	$1,656,493	$142,987	$1,473,600	$39,906	2012
Region 4	264	$656,584	$183,120	$473,464	$0	2012
Region 5	755	$2,225,773	$376,324	$1,849,449	$0	2012
Region 6	526	$2,730,844	$180,000	$2,550,844	$0	2012

The state's children's behavioral health system includes a continuum of children's services administered through the Behavioral Health Regions which includes the Professional Partner Program. The division of Behavioral Health administers the Helpline, and Family Navigator Services.

Table 4. Professional Partners Program Funding and Number Served by the Division of Behavioral Health Region

Region/ Program	Number Served	Total Funding	Federal Funding	State Funding	County Funding	Fiscal Year
Region 1	**81**	**$387,579**	**$114,869**	**$272,709**	**$0**	**2012**
Region 2	**99**	**$372,003**	**$0**	**$332,097**	**$39,906**	**2012**
Region 3	**201**	**$829,037**	**$47,293**	**$781,744**	**$0**	**2012**
Region 4	**128**	**$489,702**	**$160,000**	**$329,702**	**$0**	**2012**
Region 5	**160**	**$806,881**	**$130,265**	**$676,616**	**$0**	**2012**
LINCS Program Pilot	59	*$323,852*	*$0*	*$323,852*	*$0*	*2012*
Region 6	**467**	**$1,679,739**	**$188,832**	**$1,490,906**	**$0**	**2012**
Rapid Response Professional Partners Pilot	104	*$370,816*	*$0*	*$280,626*	*$90,190*	*2012*
Adolescent Therapist Addition on the Mobile Crisis Response Team	137	*$160,230*	*$0*	*$160,230*	*$0*	*2012*

The LINCS Program Pilot, Rapid Response Professional Partners Pilot, and Adolescent Therapist Additon on the Mobile Crisis Response Team are subprograms within the respective behaviorial health regions. Funding and numbers served are subsets of the total funding amount for each region's programs that serve children and youth in the state.

Division of Children and Family Services

The Division of Children and Family Services (CFS) is responsible for the administration and operation of child welfare services, juvenile services, and economic assistance to clients across the state. The CFS division houses the Office of Juvenile Services (OJS), the public and economic assistance programs, and the Protections & Safety programs. The CFS Divisions service provision includes abuse prevention, foster care for state wards, adoption services, child care services, direct assistance (includes ADC, Food Stamps, etc.), and community-based juvenile services.

The Office of Juvenile Services (OJS) is responsible to manage and administer services to juvenile offenders, including those committed to state custody and home/community-based offenders. These services include private sector providers in each region of the state, and also services through two (2) Youth Rehabilitation and Treatment Centers (YRTC). OJS services are provided to youth that have committed offenses and have been adjudicated by the state's courts as delinquent. There are not any service offerings aimed towards youth at risk of committing offenses and being determined as juvenile offenders. The only preventative program related to the OJS population is the probation pilot that is housed in the Office of Probation (separate from the DHHS Department).

The state is divided into five (5) service areas, and there are multiple local offices located in each service area that are responsible for the delivery of individual and community services. Across the state, the CFS division contracts with local agencies to provide services to children and families. The chart below outlines the service array provided by the CFS division regarding children and youth services. Note, this listing is not an exhaustive list of services provided by the CFS division:

Table 5. Division of Children and Family Services' Key Child and Youth Services

Program	Services
Child Welfare, Juvenile & Adult Protective Services	The Division of Children and Family Services works in partnership with other groups to make sure that the abused, neglected, dependent, or delinquent populations it serves are: safe from harm or maltreatment; in a permanent, healthy, nurturing, and caring environment; with a stable family; helped to heal from harmful effects on their lives; and no longer threats to their community.
Foster Care	Foster care is a safety service for children when they are unable to remain safely at home

Program	Services
Youth Rehabilitation & Treatment Centers	Two residential centers, Geneva & Kearney, help youth live better lives through effective services, giving youth the chance to become law-abiding citizens.
Adult & Child Abuse & Neglect Hotline	Hotline for persons who suspect that a child has been physically or sexually abused or neglected
Adoption	Adoption services that provide a child with the basic needs: legal status, social status, and a family of their own.
Child Support	The Child Support Enforcement Program helps a child obtain financial support from both parents, enables current public assistance recipients to end their reliance on welfare, and can help prevent single parents from entering public assistance.

The following chart provides a breakdown of budget appropriations by state, federal, cash, and/or county for each of CFS's programs and subprograms that specifically serve children and youth, as well as the numbers served.

Table 6. Division of Children and Family Services Funding and Number Served for Child and Youth Services

Program	Number Served	Total Funding	Federal Funding	State Funding	Cash Funding	Fiscal Year Data Source
Public Assistance	**59,778 (2011 duplicated count)**	**$215,745,107**	**$103,910,323**	**$108,524,784**	**$3,310,000**	**2013**
Aid to dependent children	7,268 (avg # of households)	$35,320,945	$22,277,600	$13,043,345	$0	2013
Child Care	19,649 (avg $ of recipients)	$99,174,028	$40,445,755	$58,728,273	$0	2012
CFS Administration		**$590,585**	**$0**	**$590,585**	**$0**	**2013**
Protection & Safety		**$50,002,398**	**$25,054,794**	**$24,947,604**	**$0**	**2013**
Child Welfare (Admin)		$3,765,302	$1,586,301	$2,179,001	$0	2013
Economic Assistance		**$59,003,127**	**$37,838,919**	**$21,039,208**	**$125,000**	**2013**
Food programs	77,362 (avg # of households)	$869,566	$819,566	$0	$50,000	2013
Child Abuse Prevention Fund	**21 grants awarded (2011)**	**$450,000**	**$0**	**$0**	**$450,000**	**2013**
Child Welfare		**$187,186,011**	**$30,676,983**	**$153,774,584**	**$2,734,444**	**2013**
IV-E Foster Care		$11,085,848	$6,826,513	$4,047,168	$212,167	2013
IV-E Adoption Assistance		$17,437,106	$10,752,663	$6,684,443	$0	2013
IV-E Guardianship		$26,500	$15,000	$11,500	$0	2013
Subsidized Adoption		$9,827,839	$0	$9,827,839	$0	2013
Domestic Violence Program		$2,570,383	$1,223,083	$1,347,300	$0	2013
Child Welfare		$122,673,897	$10,659,724	$109,491,896	$2,522,277	2013
Education Assistance for State Wards		$17,540,376	$0	$17,540,376	$0	2013
Adoption and Safe Families		$1,200,000	$1,200,000	$0	$0	2013
Predisposition Detention		$156,536	$0	$156,536	$0	2013
Protection and Safety		$2,639,556	$0	$2,639,556	$0	2013
Post Adoption/Guardianship/Right-Turn	746 children in 391 families	$2,444,580	$0	$2,444,580	$0	2013

Program	Number Served	Total Funding	Federal Funding	State Funding	Cash Funding	Fiscal Year Data Source
Office of Juvenile Services	***1,590 (avg. daily count)***	**$30,231,440**	**$712,823**	**$28,433,337**	**$1,085,280**	**2013**
Juvenile - Community Based		$9,562,880	$140,830	$9,422,050	$0	2013
Youth Rehabilitation and Treatment Centers (YRTC)- Geneva	81 (daily avg. 82 spots)	$7,390,980	$156,032	$7,129,358	$105,590	2012
Youth Rehabilitation and Treatment Centers (YRTC)- Kearney	160 (daily avg. 172 spots)	$11,478,824	$415,961	$10,085,370	$977,493	2012

Nebraska Juvenile Service Delivery Project (NJSDP)

The Nebraska Juvenile Service Delivery Project (NJSDP) is a collaborative effort between DHHS Office of Juvenile Services (OJS), the court system, and the Office of Probation Administration (OPA) to prevent the unnecessary commitments of youth to OJS thereby reducing the number of state wards. The pilot delivers services to juveniles placed on probation through the Probation Office and seeks to eliminate barriers to services, use the least restrictive and intrusive services possible, reduce duplication of services, and increase the use of evidence-based services. The pilot began in 2009 in Douglas County, in the city of Omaha. The initial pilot provided $7.7 million in funding from DHHS' OJS to the Douglas County Probation Office through an interagency agreement[3]. In January of 2012, the legislature passed LB 985, continuing and expanding the pilot with $8.4 million in funding appropriated, from the CFS budget, directly to the Probation Office for Judicial Districts 4 (Douglas County), 11 (North Platte) and 12 (Scottsbluff). Additionally, the bill appropriates $226,750 in General Funds for an evaluation of the pilot conducted by University of Nebraska Medical Center's College of Public Health.

NJSDP services to juveniles include drug testing, treatment services including in-home and out of home services, as well as other non-treatment services such as tutoring and transportation. All services are administered on a fee-for-services basis with NJSDP dollars serving as the payer of last resort (juveniles are screened for Medicaid, CHIP, private insurance, and any other funding sources before pulling from pilot dollars). The pilot dollars also fund administrative services including dedicated staff to ensure quality assurance which includes thorough service evaluations by probation officers before a provider payment is approved.

In alignment with OJS and the OPA's shared belief in the positive outcomes of providing services to juveniles in their natural environment (versus state care), the pilot is able to keep juveniles in their community and in their homes. Under NJSDP 83% of juveniles are able to stay in their family home during probation and receive services.[4] Furthermore, the pilot streamlines services by eliminating OJS from the criminal aspects and allowed the probation office to supervise probation services within the county. The pilot has been able to steadily reduce the number of youth committed to OJS, in 2012 alone (as of October) the pilot was able to relieve 75% of dual supervision cases (Office of Probation Administration Report 10/31/12). Despite the steady decrease, OJS has continued to serve a number of juveniles who otherwise would be served by NJSDP. In a November 2012 DHHS report, the estimated cost of providing direct service, case management, and administrative costs (for juveniles that could be served by the pilot), the rate amounts to $5,572 per day or about $2 million per year with the current total juvenile caseload from the three districts. The continued collaboration of OJS and OPA will be needed to support the increased efforts in preventing all youth under probation from penetrating the intrusive state juvenile services system.

[3] Nebraska Administrative Office of Probation, Juvenile Services Delivery Project, June 2012 Financial Report
[4] Loeks, Manuette. "Youth Probation Services Expand" Star Herald, August 2012 <http://www.starherald.com/news/local_news/youth-probation-services-expand/article_58c61f26-e753-11e1-be9b-001a4bcf887a.html>

Table 7. Nebraska Juvenile Service Delivery Project Funding and Number Served

Division	Program	Number Served	Total Funding
Nebraska Juvenile Service Delivery Project (NJSDP) 2009- June 2012	Juvenile Services Delivery	1,216	$7,725,000
Nebraska Juvenile Service Delivery Project (NJSDP) June 2012- Present		1,151	$8,408,817*

**includes cost of evaluation: $226,750*

Division of Developmental Disabilities

The Division of Developmental Disabilities (DD) is responsible for providing and contracting for specialized services to persons with developmental disabilities, integrating a statewide service plan, and administering three (3) Home and Community-Based Services 1915(c) Medicaid waivers. In addition to the provision of services and waiver programs, the DD division handles service eligibility determinations, statewide case management and funding authorizations.

The DD division provides an array of developmental disabilities services, including community-based supports that help people live/work independently as possible in their communities.

In addition to providing community-based developmental disability services, the DD division also administers the Beatrice State Developmental Center(BSDC), which consists of five licensed Intermediate Care Facilities for Intellectual and Developmental Disabilities (ICF/ID). BSDC provides 24-hour habilitative, residential, medical services to persons with developmental disabilities. The services and expenditures for this facility are primarily funded through Medicaid.

The vast majority of the DD division's community based services are funded with Medicaid dollars, available accordance to the three (3) DD Medicaid waivers operated by the DD Division. Nebraska provides state matching funds to access federal funding to purchase services. The DD division has developed a network of community-based providers of specialized services, which includes certified agencies that contract with the Department. In addition, individuals can utilize non-specialized (independent, non-agency based) services to provide needed supports.

The three (3) DD Medicaid waivers that are administered by Nebraska were established to provide services to those in need of additional support services. In addition to two DD Medicaid waivers for Adults, the HCBS waiver for Children with Developmental Disabilities and their families, is specifically designed to support families of children under the age of 22 with intellectual and developmental disabilities. The purpose of this waiver is to support these children at home with their families and reduce out of home placement. The level of care requirement for these three DD waivers is that of an Intermediate Care Facility for Intellectual and Developmental Disabilities, and includes an array of residential and day habilitation services in addition to respite services. The children's waiver directly serves the population of children that may otherwise enter into the state's custody to receive needed services. This is the only waiver program that directly serves children with developmental disabilities who are under the state's custody and do not live with their family.

The following chart provides a breakdown of budget appropriations by state, federal, and cash funds (includes fees collected for provided services and tobacco settlement funding) for each developmental disabilities division service, a short description of the service, and the number served. Please note that the funding and figures in Table 8. are comprehensive of services delivered to clients of all ages.

Table 8. Division of Developmental Disabilities Total Funding and Number Served

Program	Child & Youth Related Services	Number Served	Total Funding	Federal Funding	State Funding	Cash Funding	Fiscal Year Data Source
Developmental Disabilities Aid	The Developmental Disabilities Division is responsible for providing community based services to people with developmental disabilities in Nebraska.	4,995 (2011)	$100,964,981	$0*	$100,964,981		2012
Beatrice State Developmental Center	Serves people of all ages with intellectual and/or developmental disabilities, and related conditions (five locations).	165 (avg daily census)	$52,271,999	$0	$49,560,517	$2,711,482	2011

**Federal funding for Developmental disabilities aid is included in program number 348 Medicaid. State and cash funds for 424 are used as matched funds for the Medicaid Waiver.*

Division of Medicaid and Long-Term Care

The Division of Medicaid and Long-Term Care (MLTC) administers the states Medical Assistance program and is also the designated state Medicaid agency. MLTC is responsible for paying for (or providing) a wide array of medical care and services to eligible citizens. Included in the health and medical services provided, this division also administers the Children's Health Insurance Program (CHIP) and the Home and Community-Based Services (HCBS) waiver programs, separate from the Developmental Disabilities division.

Medicaid and LTC provide a wide variety of services, including the mandatory services required by the federal government, as well as additional services offered through waiver programs.

Nebraska's HCBS waivers (Aged and Disabled and Traumatic Brain Injury) allow the state to utilize Medicaid funding for services that are not usually considered medical and covered under Medicaid. These waivers are beneficial to the state's ability to fully serve persons in need of services that address more than the medical necessity, such as skills building, assisted living, respite, etc.

In addition to generally serving all eligible children, Nebraska utilizes the Children's Health Insurance Program (CHIP) to serve uninsured children in low-income families that would not otherwise qualify for Medicaid. In 1998, Nebraska elected to expand its existing Medicaid program to include children in families whose income falls below 200% of the Federal Poverty Level (FPL). This expands the population base of children that can access health services, and specifically targets families that are need of support for health services, but exceed the traditional Medicaid income requirements.

Federal Medicaid funds a majority of the Medicaid and Long-Term Care services. Nebraska's current federal match rate is 55.76%.

The following chart provides a breakdown of budget appropriations by state, federal, and cash for each MLTC division service that focuses on supporting children and youth and families in the state. A short description of the service, and the number served are included. Note, that this listing is not an exhaustive list of services provided by the MLTC division and only includes programs that serve children and youth.

Table 9. Division of Medicaid and Long-Term Care Funding and Number Served for Child and Youth Services

Program	Child & Youth Related Services	Number Served	Total Funding	Federal Funding	State Funding	Cash Funding	Fiscal Year Data Source
Medicaid and Long-Term Care (All population served)	Health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children and parent.	206,671 (avg. monthly eligibles)	$1,637,967,436	$1,017,281,160	$582,240,974	$38,445,302	2011
Early Development Network (EDN)	Provides service coordination for children birth through age three who are not developing typically or who have been diagnosed with a health condition that will affect their development.	3,671	$3,619,925	$1,409,680	$2,210,245	$0	2011
Medically Handicapped Children's Program	Provides specialized medical services for families with children with disabilities or ongoing health care needs. Services may include services coordination/case management, specialty medical team evaluations, access to specialty physicians, and payment of treatment services.	2,766	$2,455,955	$1,039,685	$1,416,270	$0	2012
Children's Health Insurance	Provides specialized medical services for families with children with disabilities or ongoing health care needs. Services may include services coordination/case management, specialty medical team evaluations, access to specialty physicians, and payment of treatment services.	30,872 (avg monthly eligibles)	$59,701,186	$41,983,294	$8,632,192	$9,085,700	2012
Lifespan Respite Subsidy Program	This program pays for respite services (someone to come into the home to care for a person with special needs to give the primary caregiver a temporary break). The program serves people of all ages. It is for people who are not receiving the service from another government program.	559 total open cases, 228 are for parents with eligible children	$1,215,000	$0	$150,000	$1,065,000	2011

Please note that the Medicaid funding and number served includes all populations served.

Division of Public Health

The Division of Public Health (PH) is responsible for providing health related services to Nebraska citizens, with the objective of improving the quality of public health and safety. The PH division is organized into two sections: Health Licensure/Investigations and Community Health. The Health Licensure and Investigations unit focuses on regulation of health-related professionals and healthcare facilities/services. The Community Health unit provides/contracts preventive and local health programs and services.

The PH division includes an array of services that are aimed at improving the health of persons in need, particularly children and families. The PH division is primarily funded through federal funds, particularly federal health grants (Title V Maternal and Child Health Services Block Grant, Supplemental Nutrition Program for Women, Infants, and Children). Approximately 90% of services provided through PH programs are federally funded.

The following chart provides a breakdown of budget appropriations by state, federal, and cash for each PH division service, a short description of the service, and the number served.

Table 10. Division of Public Health Funding and Number Served for Child and Youth Services

Program	Child & Youth Related Services	Number Served	Total Funding	Federal Funding	State Funding	Cash Funding	Fiscal Year Data Source
Maternal, Infant and Early Childhood Home Visiting Program	Contracted evidence-based home visiting; DHHS carries out planning, data, training, program- and systems-level functions.	26,029 screened in 2011 CY; 75 individuals for special formulas, 68 families for special foods	$3,393,572	$2,543,572	$850,000	$0	2012*
Immunization program	The program provides funding, vaccines, and training to immunization clinics and private providers throughout the state to vaccinate children from birth through 18 years of age.	351,610 doses of vaccine	$24,545,726	$2,171,472 administration $22,044,553 Vaccines from CDC	$329,701	$0	2012
Nebraska Child Death Review Team	Reviews the numbers and causes of deaths of children ages 0 to 17.	NA	$113,622	$133,622	$0	$0	2012
Pregnancy Risk Assessment Monitoring System (PRAMS):	A monthly survey of new mothers from across the state. NE PRAMS partners with the Centers for Disease Control & Prevention (CDC), to identify and monitor selected maternal behaviors and experiences before, during, and right after pregnancy.	NA	$244,319	$244,319	$0	$0	2012
New born screening	As per State statute, mandatory screening of all newborns for conditions detected through the collection and testing of blood samples; associated follow-up, foods & formula, education, and quality assurance.	26,029 screened in 2011 CY; 75 individuals for special formulas and 68 families for special foods	$945,697	$643,697	$42,000	$260,000	2012
Perinatal child & adolescent health	Multiple programs & activities including MIECHV, Abstinence, Education, Personal Responsibility Education Program (PREP), school health consultation, toll free line, and provider education. Services provided under contract and/or sub grant other than state level consultation, staff development, and quality assurance.	See MIECHV for numbers served; other programs educational	$1,229,558	$1,229,558	$0	$0	2012
Women, Infant, and Children Nutrition Program (WIC)	WIC provides health screening, nutrition education, nutrient-rich foods, breastfeeding support, referrals to other health and social services and infant and medical formulas through sub grants to local providers.	40,014 for most recent report month of Oct. 2012; includes women, infants and children	$33,580,356	$33,580,356	$0	cash rebate from formula manufacturer considered a reduction in federal costs	2012
Commodity Supplemental Food Program (CSFP)	Provides foods purchased and distributed by the USDA to: Infants up to the 12th month of age; Children from age one up to the sixth birthday; Women who are pregnant, breastfeeding and/or who have had a baby within the past year; and Seniors who are 60 years or older through sub grants to local providers.	Infants and children comprise only 17% of the total monthly caseload of 12,342	$1,316,484	$856,484 administration $460,000 food distributed to mothers/infants/ children	$0	$0	2012

**Funding sources include federal FY 2011 funds and FY 2012 funds from 2 different grants (formula and competitive)*

Please note, Maternal, Infant and Early Childhood Home Visiting, Newborn Screening Program, Perinatal, Child and Adolescent Health, and WIC, all include administrative costs as well as service delivery costs

RECOMMENDED ACTIONS

The ultimate goal of the cross-systems analysis was to identify state general funds being used for current services to better utilize federal funds, specifically for services for children at risk of becoming state wards. As such, PCG recommends that Nebraska implement the following actions to address the goal of expanding the funding base for services to at-risk children and juveniles with federal funds:

1. Increase Preventative Services for At-Risk Children
    a. Decrease the use of Psychiatric Residential Treatment Facilities
    b. Increase funding for Lincs, Rapid Response and Professional Partners Programs through the Behavioral Health Regions
    c. Support Differential Response Practice Model
2. Continue the Current Strategic Actions in regards to Title IV-E Revenue Opportunities
    a. Title IV-E Penetration Rate
        - Re-write and pass new Foster Care Licensing Regulations
        - Work with AOC, CIP(Court Improvement Project) and CFS staff to improve Title IV-E judicial determinations
    b. Title IV-E Revenue (Maintenance and Administrative)
        - Review Title IV-E Maintenance claims to ensure maximization of federal revenue
        - Administrative claiming for Candidates for Foster Care
        - Maximize Guardianship Assistance Program Title IV-E Reimbursement
        - Claim Title IV-E reimbursement for youth participating in the NJSDP Pilot
    c. Considerations for IV-E Waiver
        - Cost Neutrality and Reinvestment of Savings
        - Stakeholder Buy-In
        - Improved Outcomes for Children
3. Expand Opportunities in Children's Mental and Behavioral Health Care
    a. Implement Health Homes
    b. Consider 1915(b) and (i) Medicaid waivers
    c. Update UPL and DSH Calculations
4. Continue to Maximize Medicaid Claiming Opportunities
    a. Review and determine if there are additional Medicaid Opportunities for Children
    b. Increase quality control of Medicaid enrollment and claiming
5. Increase Collaborations with Local Head Start Programs and CFS Division Programs
6. Implement Increased Levels of Provider Management
    a. Develop Service Outcomes in Provider Contracts
    b. Implement Monitoring Procedures for Provider Contracts
    c. Develop Accountability Measures for Providers
        - Evidence Based Practices in Each Core Service
        - Provider Scorecards
7. Expand the Setting/Negotiating of Provider Payment Rates

a. Establish Foster Care Rates associated with various levels of Foster Care
b. Review Title IV-E maintenance and administrative rates for Child Placing Agencies
c. Peer State review of Foster Care Rates

1. Increase Preventative Services for At-Risk Children

PCG recommends that DHHS increases preventative services that are provided for children at risk of becoming wards of the state. Nebraska DHHS lacks a comprehensive system which provides preventative services for at-risk children across the state. Table 11 outlines how DHHS funding for children and families is spread across service types. Just over $9 million dollars is spent statewide on preventative services.

Table 11. DHHS Child and Youth Services Funding by Type of Service

Indirect Services		Preventative Services		Direct Services			
Cash Assistance & Financial Aid		Preventative Services		Wrap-around Services & Service Coordination		Direct Services	
Program	Total Funding	Program	Total Funding	Program	Total Funding	Program	Total Funding
Aid to Dependent Children	$35,320,945	Child Abuse Prevention Fund	$450,000	Behavioral Health- Helpline, Family Navigators, Right-Turn	$4,888,793	YTRCs	$18,869,804
Child Care	$99,174,028	LINCS & Prevention Professional Partners Program (BH Region 5)**	$323,852	Nebraska Professional Partner Program	$6,758,845	Mental Health Regional Center Operations	$1,762,155
Economic assistance	$59,003,127	Rapid Response Professional Partners & Adolecsent Therapist Addition (BH Region 6)	$1,490,906	Child Welfare	$187,186,011	Community based Juvenile Centers	$9,562,880
Children's Health Insurance	$59,701,186	*Probation Pilot*	*$7,725,000*	Early Development Network (EDN)	$3,619,925	Mental Health Regional Center Operation	$8,324,227
Commodity Supplemental Food Program (CSFP)*	$460,000					Developmental Disabilities Community based services	$100,964,981
						Beatrice State Developmental Center	$52,271,999
						Medically Handicapped Children's Program	$2,455,955
						Maternal, Infant and Early Childhood Home Visiting Program	$3,393,572
						Immunization program***	$22,044,554
						New born screening	$945,697
						Perinatal child & adolescent health	$1,229,557
						WIC	$33,580,356
Total	**$253,659,286**	**Total**	**$9,989,758**	**Total**	**$202,453,574**	**Total**	**$255,405,737**

**Commodity Supplemental Food Program distributed approximately $460,000 of food to mothers/infants/children in 2012. While the program administration that supports both the state and local level is valued at $856,484.*

***LINCS (Family Assessments provided by Child Guidance ($71,405 from LB 603 "state" funding), Prevention Professional Partners ($200,000 - $122,082 from LB 603 funding, $77,918 from other state funds),Evaluation, Education and Coordination with county attorneys, schools and other stakeholders ($52,447 from state funds)*

****Immunization funding included on this chart is only for vaccines from the Center for Disease Control*

Currently, Nebraska has one of the highest rates of state wards per capita in the country. While, CFS has worked over the past eight months to reduce the number of state wards, (as of December 3rd 2012 the number of state ward has decreased by about 500 since March of 2012[5]) there can still be improvements made.

PCG Recommends that community based behavioral health options be available to reduce the unnecessary use of Psychiatric Residential Treatment Facilities

One of CFS greatest general fund expenses is on court ordered placements in Psychiatric Residential Treatment Facilities (PRTF's). Often times when youth become involved with CFS, they require services that are more intensive than what can be provided by either the parents or regular foster care. Because Nebraska generally lacks preventative, or community based behavioral services for children, judges feel they have no other option but to require children be placed in these PRTF's. PRTFs placements can be covered by Medicaid but only if the service is determined to meet medical necessity criteria. If a placement in the PRTF is not determined to be medically necessary, then not only does Medicaid not pay for the cost of placement, but the child also becomes ineligible for Medicaid, thus requiring CFS to pay for all costs related to the child (this includes pharmaceuticals etc) Currently, it is estimated the children judicially ordered to PRTF who do not meet Medicaid's medical necessity, account for approximately $1 Million of general funds expended between July and October of 2012[6]. PCG believes that by shifting general funds to be used for behavioral health programs for children, they will not need to be placed in PRTF's. Many times the level of care is much too high for the needs of the children being placed there. Not only are PRTF's very expensive placements, but if children are being sent there and do not have a need for that level of care, they are exposed to situations which are not best for their well being.

PCG believes that by making a systematic shift in focus, by judicial, legislative and agency stakeholders, to focus on prevention, the number of state wards will continue to decline.

There are some very good examples of how DHHS is focusing on prevention currently. The programs below are a part of the Behavioral Health Regional services. Please note that Behavioral Health Regions 1-4 provide Professional Partners Program. Family Helpline, Family Navigator Program services, and Right Turn are also available statewide. The programs described below are additional preventative services efforts made by Regions 5 and 6 funded by LB603.

- Behavioral Health Region 5 LINCS program: LINCS offers assessment, services, and supports to families who have acknowledged a need for assistance with their children who are demonstrating difficulties in their homes, schools, and communities. The voluntary process also responds to youth with serious/complex needs who are at risk of a juvenile court filing and becoming state wards by applying the wraparound approach, including prevention, intervention, and coordination designed to address the behavioral health needs of youth and their families. The primary goal of LINCS is to reduce formal

[5] Weekly count of state wards Dec 3 2012
[6] Based off of 50% of contract costs for PRTF's listed on the individual contract report as of 10/31/2012

juvenile justice involvement while generating community support and service for the youth and their families. Of the **98 families referred** within FY12, 29% came from a county attorney's office, 80% were about youth 12-18yrs old, 39% declined services or did not engage. [7]

- Behavioral Health Region 5 Prevention Professional Partner Program: The Region's Prevention Professional Partner (PPP) program provides intensive case management designed to bring together community resources to help families in need of supports and services for their children. The PPP program is completely voluntary and of 29 families referred, **24 families** accepted and were served. Of families served, the top three reported historical problems were: **mental illness, crime and substance abuse**. The top three diagnoses of youth served were: Attention-Deficit and Disruptive Behavior, Mood Disorders and Adjustment Disorders. Over half (54%) of families served met the 2011 federal poverty guidelines, and 38% of the youth were receiving Medicaid. Both programs are demonstrating significant success, positive youth and family outcomes and system savings by connecting families to appropriate community- based services and averting restrictive environments.[8]
- Behavioral Health Region 6 Rapid Response Program: The Region 6 Rapid Response Program provides short term (90 days) services for severely emotionally disturbed (SED) youth ages 0-19 to achieve goals of stability, improve functioning, and reduce the need for involvement with the juvenile justice system. This program works in collaboration with the Douglas County Attorney, Truancy Coalition and the Juvenile Assessment Center to respond to youth experiencing behavioral health concerns that may be at risk for custody relinquishment. The program is a voluntary in-home case management service, meeting with the family weekly to coordinate services and implement both formal and informal supports into the family structure. The program promotes the use of strength-based strategies intended to build on the family's natural resources and abilities. The Rapid Response Program received 254 referrals in fiscal year 2010-2011, and 104 youth accepted and were served in the program. Not all referrals were appropriate or opted to enter the program, and were then referred to other community programs. **70% of youth did not enter the Child Welfare** system during the 12 months after program admittance.
- Behavioral Health Region 6 Adolescent Therapist addition on the Mobile Crisis Response Team: The Mobile Crisis Rapid Response Team in Region 6 provides immediate aid services for behavioral health crisis while doing so in the least restrictive environment available. The LB 603 state funds are used to expand the Nebraska Family Helpline Referral process to allow the Mobile Rapid Response team to also make referrals for youth experiencing a mental health crisis. Referrals are made mostly by law enforcement (60%) as well as the Nebraska Family Helpline (40%) with the majority of youth in the 15-19 age range, in 2012; only 12 out of 137 youth served were already state wards. Of the 137 only 16 were hospitalized while the remaining served had their crisis resolved.

[7] 2012 LB603 Annual Report
[8] Ibid

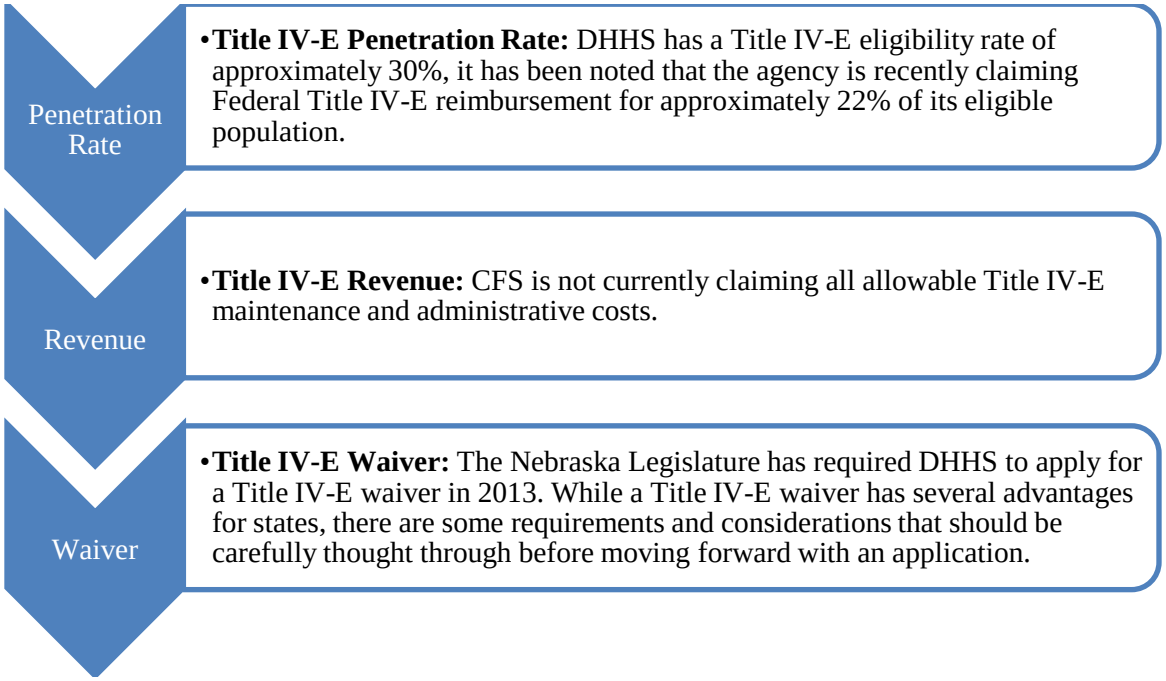
Funding for each of the above behavioral health regional pilots come from LB603 dollars. Funding is limited, thus the number of youth served is also limited. These pilots should be closely examined by both DHHS as well as the legislature to determine if the pilots can be executed statewide. All three pilots have shown to reduce the number of state wards, while numbers are not high, the population that can be served by the regions is small due to the limited funding received to support the work.

CFS is also working to implement the differential response practice model in pilot counties across the state in FY13. This practice model is a model where child welfare agencies offer both traditional investigations and assessment alternatives to families, depending on the degree of allegations.

This is a huge shift in practice for the agency and will provide great alternatives to placement for many children and families that the agency works with. It will be important however, that there are community based interventions statewide to support the model. In order for differential response to be successful there need to be alternatives to foster care, thus working with community partners to identify and secure services for struggling children and families. Additionally, it will be important for stakeholders across the state to fully commit to ensuring that appropriate funding shifts are made to support these types of preventative services for at-risk children and families.

2. Title IV-E Revenue Opportunities

PCG recommends that Nebraska continue its current strategic actions to address the Title IV-E procedures, processes, claiming, and activities to identify additional revenue opportunities. Based on PCG's review of CFS services, there are opportunities to increase Title IV-E revenue for the state. There are three primary factors that are currently decreasing Nebraska's Title IV-E revenue; recommendations for addressing each factor follows. The factors include:



Title IV-E Penetration Rate

There are several contributing factors to Nebraska's current Title IV-E penetration rate:

- *Foster Care Home Licensing:* DHHS does not require that relative and child specific foster homes be licensed. Currently, 1140 children live in approved relative and child specific foster homes. An approved home does not mean the home is licensed. In order to receive Title IV-E reimbursement, children must be placed in a licensed placement in accordance with Administration for Children and Families (ACF) regulations. The majority, approximately 52% of children in Nebraska, that are ineligible for Title IV-E reimbursement are due to the child's placement in an unlicensed home[9].
- *Title IV-E Eligibility:* Over 60% of children in out-of-home placement that are ineligible to receive Title IV-E reimbursement are due to not meeting financial need criteria outlined in Nebraska's 1996 AFDC state plan.[10] The federal regulations under which the Nebraska state plan operates include the consolidated need standards from 1996, which

[9] LB 820 Final Report
[10] ibid

establishes the household income level that qualifies families for entitlement funding. Since this requirement is based on family income levels from 1996, many families have household income above the Title IV-E requirement.

- *Documentation of appropriate judicial determinations*: Title IV-E requires that each child have judicial determinations made that document appropriate care and responsibility for the agency as well as "contrary to the welfare" and "reasonable efforts" language. If appropriate judicial orders are not made timely or the documentation is not gathered by DHHS, the child cannot be eligible for Title IV-E reimbursement.

PCG recommends that Nebraska DHHS should work with child specific and relative providers to understand barriers to licensure and assist with removing those barriers (when possible and safe). Legislation passed and enacted in July 2012 that requires that new child specific placements be licensed (child specific providers that were in place prior to July 2012 were exempt from this requirement due to DHHS having contracts in place with these placements). While some of these homes have begun the licensing process, there are still many homes that need to be licensed in order to improve the Title IV-E eligibility rate. DHHS could have the ability and authority to waive non-safety licensing standards, by utilizing these waivers, many more relative and child specific homes could be licensed. While going through the licensure process may require more DHHS staff time, it could save the State approximately ($1 million in general funds that are now supporting children who are in placements that are not reimbursable by Title IV-E.

According to ACF guidance, "special situations may arise where there are grounds for waiving a requirement for an individual relative/foster parent on behalf of a foster child. For example, a relative's dwelling may contain 10% fewer square feet than necessary to meet normal licensing standards. In these exceptional circumstances, the reason for the waiver must be documented in the licensing/approval record for the foster home and the certification of licensure/approval must indicate its applicability only to the specific relative child"[1].

Table 12. Cost of Unlicensed Relative Homes

Number of Children in Unlicensed Relative Homes	Average Daily Per Diem	Amount Per Month	Amount Per Year	Eligibility Rate (best case scenario)	Gross	FFP
1140	$13	$444,600	$5,335,200	40%	$2,134,080	$1,208,743

Not only would waiving specific non-safety requirements allow for more relative and child specific homes to be licensed, but re-writing and passing new foster care licensing regulations would allow for more relatives to be licensed. These regulations were last updated in 1999. A review of the licensing regulations and modifications would allow for less restrictive requirements allowing more relatives to have the capacity to meet the licensing standards. As the regulations stand now, many relatives don't have the capacity to meet the requirements. Once the

regulations are updated DHHS staff should complete trainings with caseworkers and relatives so that they understand the processes for licensure.

PCG recommends that DHHS works with Administrative Office of the Court to train and work closely with Judges to ensure they are making the appropriate judicial determinations within given timeframes. DHHS staff should work with judicial staff to educate them on the importance of not only making the judicial findings and determinations, but to document them within appropriate timeframes and with appropriate dates and signatures. DHHS should also work with its caseworkers, attorneys and eligibility unit staff to ensure that they are gathering appropriate documentation from the courts. Eligibility staff should be refreshed on what documentation is needed and within what timeframes required by Title IV-E regulations. Many times education of all parties can vastly improve the legal documentation process. It would be worthwhile for eligibility staff to do a "clean up" of missing or incomplete legal documents to enhance Title IV-E revenue. PCG has found that by going to courts and working with court staff to find or correct judicial documents, it can earn states millions of dollars in federal Title IV-E reimbursement.

Title IV-E Revenue

There are several contributing factors to Nebraska's current Title IV-E maintenance and administrative reimbursement:

- Nebraska DHHS is not capturing all possible maintenance costs on Title IV-E maintenance claim. DHHS staff recently learned that Title IV-E maintenance costs were not being reimbursed for all allowable costs. Policy interpretation led federal claiming staff to leave allowable costs off of the Title IV-E maintenance claim.
- Title IV-E administration costs for reasonable candidates for foster care are not being claimed by Nebraska DHHS.
- DHHS is not currently claiming any Title IV-E administrative costs for private lead agencies, due to directive from DCA and ACF.

PCG recommends that Nebraska submits all allowable maintenance costs for Title IV-E reimbursement. Federal regulation allows for the following costs to be reimbursed by Title IV-E[11]:

- Personal incidentals: items related to personal hygiene; cosmetics; over-the-counter medications and special dietary foods; infant and toddler supplies, including high chairs and diapers; fees related to activities, such as Boy/Girl Scouts; special lessons, including horseback riding; graduation fees; funeral expenses; and miscellaneous items such as stamps, envelopes, writing paper, film and the cost of film
- School Supplies
- Clothing

[11] Child Welfare Policy Manual 8.3B.1 TITLE IV-E, Foster Care Maintenance Payments Program, Payments, Allowable costs http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=46#438

- Transportation- In as a separate item of expense is only allowable for reasonable travel to the child's home for visitation and for the child to remain in the school in which the child is enrolled at the time of placement.
- Respite Care – short term care provided by a licensed foster care provider.
  CFS should look closely at what is and is not being claimed as maintenance to Title IV-E and determine how much federal reimbursement is being left on the table.

PCG recommends that Nebraska claim administrative costs for state wards who are candidates for foster care. According to the October 2012 "state wards level of care report" from DHHS 1698 children are placed with their parents. ACF allows for reimbursement of administrative costs the agency incurs for a candidate for foster care if the State is providing reasonable efforts to keep the child in its home and re-determines at least every six months that the child remains at imminent risk of removal from the home. The state must document in one of the three following ways a child's candidacy for foster care[12]:

1) A defined case plan which clearly indicates that, absent effective preventative services, foster care is the planned arrangement for the child.
2) An eligibility determination form which has been completed to establish the child's eligibility under title IV-E.
3) Evidence of court proceedings in relation to the removal of the child from the home, in the form of a petition to the court, a court order or a transcript of the court proceedings.

Many states document candidates by utilizing option one (above). States document very explicitly in their case plans that a child is at imminent risk of removal if actions outlined in the case plan are not adhered to. It is very important that these case plans and language exist for all children that are being claimed as candidates. DHHS can claim administrative costs for both pre-placement and post placement candidates for foster care. Due to Nebraska's high population of children in custody but placed with parents, it is highly recommended that CFS explore claiming candidates.

PCG recommends that Nebraska utilize the option of claiming Title IV-E revenue through the Guardianship Assistance Program (GAP) in increasing frequency. Nebraska has an approved Title IV-E state plan amendment for guardianship assistance. To date, the guardianship subsidy process has not been widely utilized. In order to be eligible for GAP subsidy a child must have been Title IV-E eligible for the six months leading up to guardianship. Because of current relative licensing guidelines most relatives are not licensed foster care providers, thus making most of the youth who would be candidates for the subsidy ineligible for Title IV-E reimbursement. As CFS works to change licensing regulations and make more children Eligible for Title IV-E reimbursement, they should utilize this option in increasing frequency.

PCG recommends that Nebraska pursue Title IV-E claiming for services provided through the Juvenile Service Delivery Project (NJSDP). Currently the NJSDP pilot is funded only with

[12] Child Welfare Policy Manual 8.1D TITLE IV-E, Administrative Functions/Costs, Candidates
http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=79#791

general funds. While not a large number of youth participating in the pilot will be eligible for IV-E, it would be advantageous for the state to maximize federal reimbursement where possible.

In addition to the anticipated increase in Title IV-E revenue going forward, It is important to note, that for all of the Title IV-E revenue maximization recommendations, CFS can claim retroactively eight quarters.

Considerations for Applying for Title IV-E Waiver in FY2013

PCG recommends that Nebraska follow through with the legislative action to submit a Title IV-E waiver demonstration and consider the following factors. Section 1130 of the Social Security Act was amended by the Child and Family Services Improvement and Innovation Act (Public Law 112-34) and signed into law on September 30, 2011. This law reauthorized the Department of Health and Human Services (HHS) to approve up to ten (10) new waiver demonstrations in each of Federal Fiscal Years 2012 through 2014. HHS has asked for the FY13 waiver applications to be submitted by January 15, 2013. Nebraska DHHS division of Children and Family Services is planning to submit an application for FY13. There are several factors that the State should consider and be aware of before agreeing to waiver terms and conditions with DHHS.

- *Cost Neutrality and reinvestment of Savings* – demonstration projects must remain cost neutral to the federal government over the life of the project. The waiver is a capped allocation based on the State's historic expenditures. In addition, states must account for all state, federal, local and private expenditures for two years prior to the waiver, and an accounting of those same expenditures over the lifetime of the waiver to ensure reinvestment of savings. This is an important aspect of the waiver, while the agency may begin to save money as out of home placements decrease, all savings must be reinvested into child welfare services. In order for the waiver to be successful, and for implementation of differential response, the agency is going to have to shift how it funds services from the back end to the front end, the Title IV-E waiver, ensures that the local and state dollars are maintained as practices shift.

- *Buy in of Stakeholders*- it is vitally important to the success of the Title IV-E waiver that there is the buy in of all pertinent stakeholders, this includes executive, legislative, judicial and local stakeholders. Implementation of differential response is going to be a major shift in practice for CFS. In order for the waiver to be successful all involved parties need to buy in to the change. The support of all stakeholders from the governor all the way down to local providers is imperative, this will be a paradigm change and shift in philosophy not only for CFS but for the entire statewide child welfare system, in the end it will provide better outcomes for children in Nebraska, and prevent so many children from being placed in out of home placements.

- *Improve outcomes for children* - One goal of the waiver and differential response is to decrease the number of state wards. By focusing on preventative services, and keeping

kids out of care in the long term will save Nebraska money and provide better outcomes for children of the state.

The Florida Department of Children and Families has been under a Title IV-E waiver since 2006. One of the three goals of their waiver was to decrease the number of children in out of home placement. From the time when the demonstration project started in 2006 through 2010 evaluation, the number of children in out of home placement decreased by 37%. While the out of home placements decreased, the agency increased its spending on preventative services by 300% over the course of the waiver. Florida managed to do all of this while remaining cost neutral. Florida's results show much promise for the work that Nebraska can do to reduce the number of children in out of home placement across the state.

3. Expand Opportunities in Children's Health Care

The provision of health services for children in Nebraska can be used by DHHS to address the at-risk population, and also address medical issues before children become state ward. To expand on this concept, PCG has identified three major trends taking place nationally that Nebraska should note:

1) The growing emphasis on customer-centric care
2) The decentralization of services and associated rise of coordinating bodies
3) The changing face of payment models in the field.

The recommendations that regarding opportunities in Children's Health Care are consistent with these national trends and believe will help Nebraska better coordinate care for the children's population. PCG recommends that the following steps be taken that can help improve children and families access to quality health care in Nebraska:

Table 13. Recommended Steps to Improve Children and Family Access to Quality Health Care

Title	Brief Description
Implement Health Homes Initiative(s)	Section 2703 of the Affordable Care Act (ACA) provides enhanced federal match for health home initiatives focusing on beneficiaries with chronic illnesses.
Consider 1915i State Plan Amendment or Medicaid 1915(b) Waiver(s)	The Federal government provides two vehicles through which to provide home and community based services – through the 1915i state plan amendment or through 1915(b) waivers. These options can be utilized to target specific community-based services to specific populations. Many states are focusing on care provided to children with serious emotional disturbances (SED).
Update UPL and DSH calculations	Upper Payment Limit (UPL) and Disproportionate Share Hospital (DSH) are reimbursement methodologies to reimburse certain provider types for unreimbursed Medicaid and free care costs. Identifying "unused" UPL or DSH room could create additional provider funding opportunities.

Implement Health Home Initiative(s)

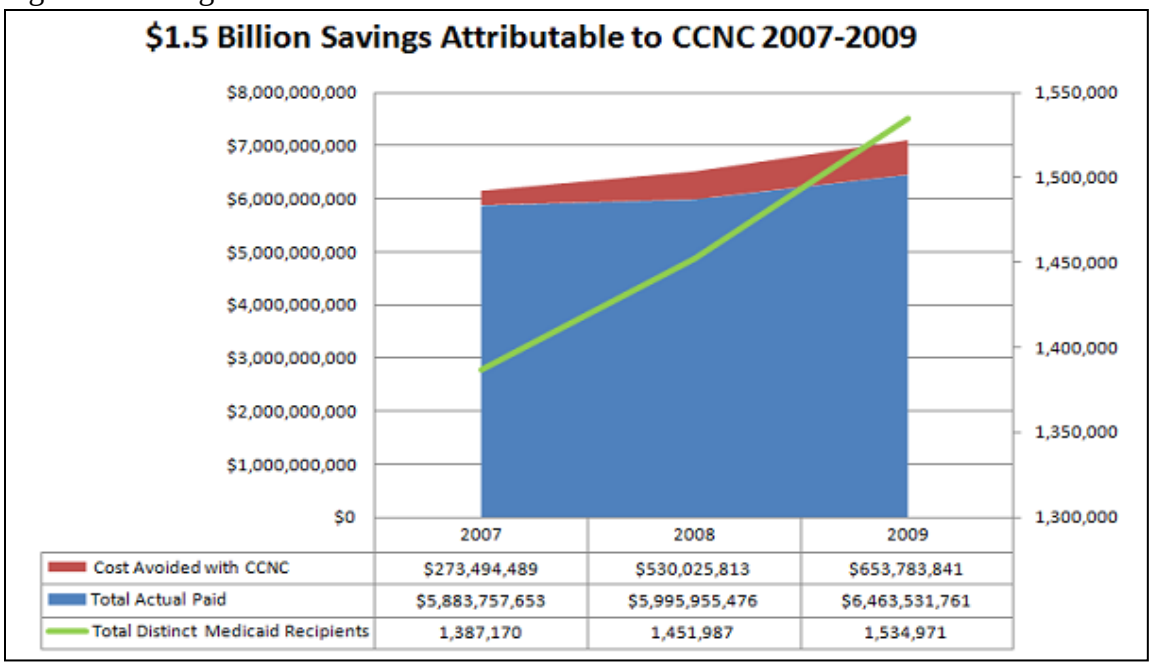
PCG recommends that Nebraska implement health home initiatives to target children that required additional supportive services in residential placements. Many of the issues found in states' health care systems revolve around the lack of coordination – between insurances, between providers, between provider and beneficiary incentives, etc. As discussed above, our evolving health care system is undergoing significant change, spurred on by the passage in 2010

of the Patient Protection and Affordable Care Act (PPACA or the ACA). The ACA brings with it wide-ranging and comprehensive changes that will have a direct and significant impact on the operations of the Nebraska's Medicaid program, as well as other DHHS divisions, individuals, and businesses. Some of these changes have already begun, while others will take effect over the next several years.

Nebraska has potentially significant programmatic and financial opportunities, especially within Section 2703 of the ACA. Section 2703 establishes a new "State Option to Provide Health Homes for Enrollees with Chronic Conditions." This option allows States to enroll Medicaid beneficiaries with chronic conditions into designated *Health Homes*. Beyond the list of Health Home services and limited guidance available from the Centers for Medicare and Medicaid Services (CMS), states have considerable flexibility to design Health Home programs to control the cost growth of the chronically ill populations. This option could be strategically leverage by Nebraska to help care for chronically ill children that reside in high-costing placements. Nationally, more than 60 percent of Medicaid costs come from 10% of the Medicaid population, demonstrating that the highest-costing patients generally account for most of the cost incurred for medical services. DHHS Coordinating care through medical homes has the potential to save millions of dollars and improve the quality of care for Medicaid beneficiaries.

The following charts illustrate the impact of health homes in North Carolina, which implemented their CCNC program – Coordinated Care of North Carolina – a statewide medical home.

Figure 2. Savings Attributable to CCNC



Medical homes are ways of coordinating the care for individuals. Generally, it is organized so that a primary care physician serves as a beneficiaries "home" for coordination of all services necessary for their efficient and effective care. Even though the concept of health homes has yet

to be proven to control costs on a large scale, the momentum of its inclusion in the ACA is pressuring States to make decisions about designing and implementing health home initiatives.

A health home is a term mainly used in Section 2703 to differentiate itself from the definitional nuances of a "medical home."[13] A health home is an attempt by the federal government to spur the states' development of medical-home like care – coordinated care – by providing significant federal monies into the state program after the submission and approval of a health home state plan amendment. The Center for Medicare and Medicaid Services (CMS) has provided guidance to States in the form of a State Medicaid Director's Letter (SMDL#10-024[14]), which provides details about the following program features:

- Health Home Populations
- Service Definitions
- Payment Methodologies
- Enhanced FMAP

Health Home Populations**:** Section 2703 amends Section 1945(a) of the Social Security Act, permitting States the option to offer health home services to "eligible individuals with chronic conditions." A chronic condition, described in section 1945(h) (2) of the Act include:

1. a mental health condition;
2. a substance use disorder;
3. asthma;
4. diabetes;
5. heart disease; and
6. Overweight (body mass index over 25).

Other chronic conditions can be considered for inclusion in the health home model. The minimum criteria consists of individuals eligible under the State plan or under a waiver who have at least two chronic conditions, one chronic condition and be at risk or another, or one serious and persistent mental health condition. States may elect to target the population to individuals with a greater number or higher severity of condition. Nebraska could target a health home program specifically on children who meet the conditions described above. PCG recommends Nebraska undertake a detailed review of its claims and eligibility data to perform the following analysis:

- Identify the chronic conditions and combination of chronic conditions (described above) that are most prevalent within the Medicaid child population.
- For these beneficiaries, identify the primary and specialty providers who deliver services.

Service Definitions: Section 1945(h) (4) of the Act defines health home services as "comprehensive and timely high quality services," and includes the following services to be provided by health home providers:

- Comprehensive care management;
- Care coordination and health promotion;

[13] Terms that are similar in nature, but may have different definitions include: medical home and patient centered medical home.
[14] http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representative;
- Referral to community and social support services, if relevant; and,
- The use of health information technology to link services, as feasible and appropriate.

As the state looks for providers to participate in the program Nebraska can utilize its list of providers who have participated in the Electronic Health Record (EHR) incentive program.

Payment Methodologies: Section 1945(c)(2)(A) permits States to structure a tiered payment methodology that accounts for the severity of each individual's chronic conditions and the capabilities of the designated provider, the team of health care professionals operating with the provider, or the health team. The Act also allows States to propose alternative models of payment that are not limited to per member per month payments. Payment reform is a major trend in health care, spurred by ACA initiatives such as health homes and Accountable Care Organizations (ACOs). Payment reform is intended to better align reimbursement methodologies with desired provider behavior. This health homes initiative encourages innovative payment methodologies.

Enhanced FMAP: The ACA provides states with increased federal revenue. Section 1945(c) (1) of the Act provides **90 percent FMAP** (Federal Medical Assistance Percentage) for health home services (described above) for the **first eight quarters** that a State Plan Amendment (SPA) is in effect. PCG recommends that Nebraska take advantage of this enhanced FMAP rate to assist in strengthening medical homes that can, at least in part, assist in delivering the health care needs of Nebraskan children. Nebraska's Health Home program can work within existing medical home initiatives, either in managed care or fee-for-service (FFS) environments. PCG has assisted states in the design and implementation of medical home programs. Using this experience, PCG recommends Nebraska following these general steps to *design* a health home program:

Table 14. Recommended Steps to Design Health Home Program

Step		Consideration
1	Readiness Assessment	Are your providers ready to be health homes? Does the state have the necessary data? How does Nebraska get to where it needs to be?
2	Data Aggregation	Evaluate comprehensive, multi-payer (Medicaid/Medicare) data warehouse needs for design, management and evaluation. Include flexibility to incorporate clinical, patient engagement measures as well as administrative.
3	Intervention Analysis	Determine what types of care management and care coordination interventions will best produce your desired outcomes.
4	Development of Provider Standards	Determine the minimum qualifications and services that you want Health Homes to provide.
5	Defining Outcome	Identify the outcomes you want to achieve with your

Step		Consideration
	Measurement and Goals	Health Home, and what data do you need to collect it to measure it.
6	Financial Modeling	90% FMAP available for Health Home services. Develop a comprehensive, multi-year budget forecast and ROI.
7	Cost Allocation Planning	CMS has been clear that you must adjust your Medicaid cost allocation plan for all of the different grants and special programs.
8	Draft State Plan Amendment	Draft and submit a State Plan Amendment that describes your Health Home(s).

Consider Implementing 1915i state plan amendment or 1915(b) and (c) Waiver(s)

PCG recommends that Nebraska considers additional forms of 1915i state plan amendments or 1915(b) and (c) Medicaid Waivers that could be used to target children and develop a coordinated set of services. The Medicaid program is comprised of a State Plan and various Medicaid Waivers. A State Plan is a document that serves as an official agreement between the federal government and the State to administer the Medicaid program (Title XIX).

Section 6086 of the Deficit Reduction Act of 2005 (DRA) added section 1915(I) to the Social Security Act. It is quite similar to options and services that are available through 1915 (c) HCBS waivers. The significant difference is that a 1915(i) does not require individual to meet an institutional level of care in order to qualify for HCBS (at risk of institutionalization is a requirement for the waivers). States can apply for this state plan option to offer services and supports before individuals need institutional care, and also provides a mechanism to provide state plan HCBS to individuals with mental health and substance abuse disorders.

An August 2010 State Medicaid Director Letter (SMDL#10-015; ACA#6) describes some changes made to the 1915(i) section made by the Affordable Care Act (ACA).

In addition to a state plan, a state can ask the federal government for opportunities to test new or existing ways to deliver and pay for health care services that require some flexibility to waive certain Title XIX requirements – these are called Medicaid Waivers. There are four primary types of waivers and demonstration projects[15]:

- **Section 1115 Research & Demonstration Projects:** States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
- **Section 1915(b) Managed Care Waivers:** States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.

[15] www.medicaid.gov

- **Section 1915(c) Home and Community-Based Services Waivers:** States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.
- **Concurrent Section 1915(b) and 1915(c) Waivers:** States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly.

The 1915(c) waivers allow the provision of long term care services in home and community based settings. CMS allows for states to "offer a variety of services under an HCBS Waiver program". Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose 'other' types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community."[16]

A number of states have implemented 1915(c) Medicaid Waivers that Nebraska can learn from. Many 1915(c) Medicaid Waivers are used to provide home and community based services for the developmentally and physically disabled populations, but there is growing use of these waivers for children with Serious Emotional Disturbances (SEDs). PCG recommends Nebraska review 1915(c) Medicaid Waivers from the following states[17]:

- Georgia's Community Based Alternatives for Youth waiver
- Kansas' SED waiver
- Louisiana's Coordinated System of Care waiver
- Michigan's Waiver for Children with SED
- New York's OMH SED waiver
- New York's Bridges to Health for Children with SED waiver
- North Carolina's Alternatives Program for Children waiver
- Washington's Children's Intensive In-Home Behavioral Supports waiver
- Wyoming's Children's Mental Health waiver

1915(c) Medicaid waivers can provide Nebraska the flexibility to design a Medicaid program that meets the specific needs of the child population.

Update UPL and DSH Calculations

PCG recommends Nebraska consider the implementation and/or re-calculation of numbers underlying the Upper Payment Limit (UPL) and Disproportionate Share Hospital (DSH) programs. An **upper payment limit** is a limit on how much the federal government will spend on fee-for-service reimbursement to Medicaid providers. It is the maximum amount that a state can pay (and the federal government will reimburse for) for a type of provider, in aggregate. A

[16] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html
[17] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html

UPL effectively serves as a cap for how much the state should spend in paying providers – hospitals, for instance. States can utilize its UPL in different ways. For instance, rates can be set so as to maximize the amount of UPL room within a type of provider. Other states utilize "the room" (i.e., the difference between the UPL and payments to the provider type) to provide supplemental payments to certain providers within the provider type.

Federal law allows for special payments to hospitals that serve a **disproportionate share** of Medicaid and low-income patients. These hospitals are often called DSH hospitals or Safety Net hospitals and often receive much of the DSH funding. DSH funds are different from other Medicaid payments because they're not associated with a specific service. Rather, DSH payments are used to cover unreimbursed Medicaid and free care costs at the hospital.
Both of these funding mechanisms provide opportunities to draw down federal revenue. As such, PCG recommends Nebraska:

1) Re-calculate its Hospital UPL – Nebraska is currently utilizing a cost-based UPL calculation methodology. PCG recommends exploring the use of more current data to calculate the UPL and/or explore alternative UPL calculation methodologies in order to maximize payments (and federal reimbursement) for hospitals
2) Consider developing a Physician UPL payment methodology – Nebraska could potentially calculate a UPL for physician services provided by a state entity, such as the Nebraska Medical Center. The UPL would allow for a supplemental payment to be made to the medical center, which can be calculated as a percentage, which shall not exceed 100% of the difference between:
    - payments to the eligible provider made pursuant to the Medicaid fee schedule, and
    - the annually calculated average private commercial rate (the average private commercial rate is derived using the ratio of commercial payments to commercial charges applied to paid Medicaid claims as reported to the MMIS).

Making a supplemental payment could provide Nebraska with Federal reimbursement to payments that the State of Nebraska may already be making to the university's hospital system.

3) Update DSH calculation – while not a certainty, PCG recommends Nebraska review its current DSH payment calculation to ensure that the DSH allotment for the state is distributed in a manner so as to maximize federal DSH funding available to qualifying hospitals.

4. Continue to Maximize Medicaid Claiming Opportunities

PCG recommends that Nebraska evaluate its current monthly claiming mechanism and determine if there are other claiming methods that may be more financially advantageous. The Developmental Disabilities (DD) program currently provides service coordination services that are claimed to Medicaid under the Targeted Case Management (TCM) option, and reimbursed through a monthly rate. Revising the claiming methods for coordination services to DD clients could possibly result in more federal reimbursement for the state, freeing up additional state funds.

Nebraska's current method of claiming TCM services is utilizing a monthly rate, which is established annually based on historical expenditures. Each month the DD division reviews the case records of clients served, and all allowable cases are submitted to the Nebraska Medicaid system for processing. The current process appropriately captures the allowable cases that are served and reviewed each month. However, other methods of claiming would use a different unit base to capture claimable services. PCG would recommend that Nebraska examines the potential revenue of using a cost settlement process, which reconciles the reimbursement paid to providers and the actual cost of provided services. If Nebraska's expenditures for TCM services (coordinators, support staff, operations, overhead, etc) were more than the total reimbursement, Medicaid would settle the difference in additional reimbursement; and vice versa, if Nebraska was reimbursed more than the costs of providing TCM services, Nebraska would owe funds back to Medicaid. This is a potential opportunity for Nebraska to ensure that the state is maximizing its federal reimbursement, especially if there is an opinion that the state's expenditures related to providing TCM services are significantly more than the current TCM reimbursement.

PCG recommends that Nebraska also increase the quality assurance and monitoring of Medicaid enrollment and Medicaid claiming. Nebraska is currently peforming well in regards to maximizing the Medicaid enrollment of children. However, we were unable to identify specific quality assurance/monitoring procedures that track these efforts. There should be measures in place to validate that the state is fully maximizing its opportunities to claim Medicaid and fully enroll Medicaid programs with as many children in need as possible.

5. Increase Collaborations with Local Head Start Programs and CFS Division Programs

PCG recommends that Nebraska increase the collaborations between Head Start programs and CFS programs to serve a targeted population of at-risk children (this should include current state wards, as well as children that are at risk of becoming state wards). The goal of many DHHS programs (and specifically the CFS division) is to proactively serve children before they become wards of the state. CFS should leverage Head Start programs and services to target children and families that are most likely to become wards of the state, based on general risk factors. This would help Nebraska address family issues as soon as possible and potentially mitigate problems before deep-end services are needed.

The Head Start program has provided high quality early education and comprehensive support services to the nation's poorest children from the age of three through school age since 1965. In 1995, Early Head Start was created to provide early care and education and comprehensive services to infants and toddlers (from birth to age 3) and pregnant women. In addition to early learning and cognitive development, Head Start's comprehensive early childhood development programs provide children and families with access to a range of services, such as parenting resources, health screenings, referrals, and follow-up support, and social services. To be eligible for Head Start, generally children must be living at or below the federal poverty line, or receiving public benefits. Under the 2007 reauthorization of the Head Start program, Grantees may choose to serve up to 35 percent of their children from families with incomes of up to 130 percent of the poverty line. Recent estimates suggest that nationally, Head Start is serving only about half of eligible preschool-age children.

Both Head Start and Early Head Start have proven their effectiveness in national studies; more importantly, both programs have proven their effectiveness by improving the lives of children and families. Head Start and Early Head Start serve a diverse array of children and families living in poverty. Seventy-seven percent of participants across all Head Start funded programs (including children participating in Head Start, Early Head Start, and American Indian/Alaskan Native, and Migrant and Seasonal programs) are in families earning below the federal poverty level; another fifteen percent qualify because they receive public assistance. A greater proportion of African-American and Latino children participate in Head Start than do White or Asian children.

Nationally, Head Start and Early Head Start families are working hard to become self-sufficient:

- 70% of all Head Start families include at least one working parent, and 13% of families include a parent in school or job training.
- 66% of Early Head Start families have at least one employed parent, and 22% have at least one parent in school or job training.

To improve the lives of all children vulnerable to the effects of poverty and other risk factors, state early childhood systems cannot just focus on any one aspect of development, but need to address the full range of child development needs. High-quality early childhood programs—

including Head Start and Early Head Start and quality child care and preschool programs—can help young children and their families access all they need to thrive.

As noted in the groundbreaking *From Neurons to Neighborhoods*: Early childhood intervention is more a concept than a specific service. Much of its diversity is related to differences in target groups—from the broad-based agendas of health promotion and disease prevention, early child care, and preschool education to the highly specialized challenges presented by developmental disabilities, economic hardship, family violence, and serious mental health problems, including child psychopathology, maternal depression, and parental substance abuse. In the present day economic recession, access to high quality early childhood services is even more essential. Early care and education programs produce significant, positive returns for at-risk children. For example, Art Rolnick of the Minneapolis Federal Reserve Bank argues that investments in early childhood programs yield significant returns on investments compared to other public spending.

It is estimated that for every dollar spent on quality early education, the public receives a return of $7 in savings from reduced grade retention, crime, and other public assistance. Nobel Prize winner James Heckman also argues that investments in young children, particularly those living in poverty, have significant cost savings compared to later interventions and have large social and economic benefits for society by leveling the playing field and closing the achievement gap early in life.

For these reasons, *PCG recommends that DHHS divisions coordinate closely with Head Start and other high-quality early childhood services*. It is important to work closely to ensure that the children that are most at –risk of being placed in state custody are placed in Head Start programs. This close coordination would ensure that vulnerable children and families share in the benefits.

To make the necessary systemic changes for young children envisioned by child development experts and economists alike, states are developing multiple strategies to improve their early childhood systems. One important choice for states is making policy changes that foster collaboration and coordination between Head Start programs at the local level and the state child care subsidy system. Particularly as the number of low-income working families who need full day, full-year child care and early education services for their young children grows, programs serving these children and families increasingly need to collaborate and partner with each other. Federal funding streams such as Head Start, Child Care and Development Fund (CCDF), and Temporary Assistance for Needy Families (TANF) are designed to help low-income working families access early childhood services. However, individually these funding streams may not provide the hours, or the quality that low-income working families need.

"Over the past several years, Head Start grantees have been encouraged to explore new and innovative ways to collaborate with child care providers to provide full-day, full-year services to Head Start and Early Head Start families who need such services." – Office of Head Start

The Head Start comprehensive model of health, parent involvement, family support and education, when linked with child care, can provide parents and children with quality

comprehensive full day/full year services. We encourage CFS to explore and support any efforts at closer coordination with early childhood programs.

6. Implement Increased Levels of Provider Management

PCG recommends that DHHS, and specifically the CFS division, implement increased levels of provider management. DHHS contracts with a wide network of provider agencies for services to children and families across the state. Various stakeholders noted that there is a significant need to better utilize available funding and improve the outcome efficiency of services, and these are especially prevalent in the CFS division. There are currently over 3,000 contracts with the CFS division for a variety of services, however these contract agreements included available services with a budget maximum amount. Many of the active contracts are sparsely used and will not be fully utilized to the full budget maximum. To ensure that this network of service providers is managed appropriately, we recommend the following best practices:

- *PCG recommends that the CFS division develop service outcomes in their provider contracts.* The current process for developing contracts with the CFS division includes a proposal of a contract agreement from the provider, which is reviewed and approved by CFS. The proposed contracts have a general format that is used for all contracts, which includes the legal requirements for CFS contractors. However, there is not a required section for outcome measured for the provided services. Many of the contracts lack the requirement for providers to demonstrate their services actually achieve a desired outcome (showing a cause/effect link between the services provided and an outcome that CFS wants to accomplish with the client). The CFS division recently began to add language to their contracts which addresses moving toward results based accountability. This added language is aimed at shifting provider contracts to include outcome measurements for services, such as family preservation and home removals. It is important that services are measured with tangible results, which improve the situations of children and families, as well as address the service needs of clients.
- *PCG recommends that DHHS implement monitoring procedures for provider contracts*. CFS contracts with service providers are not formally monitored for effectiveness. Many of the service contracts are designed to address specific family needs and improve the lives of children/families served. However, CFS does not actively track if families improve after receiving services and if the service need was fully addressed (such as self-sufficiency and minimizing risk factors). In addition to adding outcome measures to provider contracts, there needs to be a division-wide commitment to monitor these outcomes and the overall impact of services purchased by the CFS division. To fully monitor the provider contracts, CFS should implement a combination of the following steps:
    1) Determine specific outcomes to be achieved by providers
    2) Develop tools to measure these outcomes in a reliable manner (ensure tool also accounts for the impact of unintended outcomes)
    3) Utilize tools to measure progress in clients during contract periods
    4) Show the direct impact of service provision and the outcomes
- *PCG recommends that the CFS division develop accountability measures for contracted providers*: Nebraska generally contracts with a large number of providers, which provides coverage for services if needed. However, there are few measures in place to compare the effectiveness of providers. Below we recommend two methods to achieving this goal:

1) Require an Evidence Based Practice for Each Core Services Offering: The CFS division has a base of 10 – 12 services that are considered to be the core services. These services are contracted with various agencies across the five CF service areas, each core services are contracted through multiple providers. However, each provider offers services in its own prescribed manner. There is not a standard approach for service provision, which makes it difficult for the department to compare and contrast the effectiveness of services. For example, during FY2012, there were over 22 provider agencies contracted to provide Intensive Family Preservation Services (IFPS). These services are offered to specifically address family crisis situations, but throughout 22 agency contracts, the models of services are immensely varied across the state. The outcomes/results of services are extremely difficult for the CFS division to evaluate, particularly in comparing agencies that provide the same service. If providers were required to use one evidence based practice for each core service, CFS could rationally examine services across providers and increase the focus on maximizing service outcomes.
2) Develop Provider Scorecards*:* Nebraska should consider using "provider scorecards" to help measure the effectiveness of service providers. This method is cost-effective for the state and primarily based on service outcomes. Provider scorecards allow CFS to rank important factors of their providers, and can be used as a basis for selective contracting. By bringing together utilization data, provider cost data, client case information, and other metrics, CFS could develop scorecards to rate providers based on efficiency, outcomes, costs, and client satisfaction. CFS could then reward providers with efficient systems and effective programs, and also compare service providers with a standard approach.

7. Expand the Setting/Negotiating of Provider Payment Rates

PCG recommends that DHHS, and specifically the CFS division, expands the process to set (or negotiate) provider payment rates. Currently, provider rates are reviewed on an annual basis, but the process for review in prior years has been rather informal, and based on what providers indicated was needed to continue providing services to children and families. In 2012 the legislature passed LB820 which required DHHS to take a close look at how foster care reimbursement rates were set. While the agency used M.A.R.C. and USDA data to determine rates for the upcoming contract year SF2014, PCG has some additional recommendations.

PCG recommends that DHHS should establish foster care rates associated with the various levels of foster care, after a Standardized Level of Care Assessment is implemented. Other states have struggled with quantifying the additional cost associated with a higher level of need child or 'enhanced supervision'. It would be a good practice to use peer states as a benchmark to establish rates for enhanced supervision. According to the federal Child Welfare Policy Manual Question 8.3B2.2, "certain categories of children, including those with physical or emotional disabilities, may require more day-to-day supervision and attention than those without such conditions. A supplement to the basic maintenance payment for a particular child is justified when the child has greater than usual needs for the items included in the definition, as determined by the State agency".[1] Many states use clinical assessment tools to identify children with higher physical or emotional needs. Each determined level of care has an assigned per diem maintenance rate or a supplemental rate that is paid in addition to the departmental foster care per diem. Federal Title IV-E policy does not distinctly prescribe how enhanced supervision rates should be set. It simply states that a supplement in addition to the maintenance is reasonable under Title IV-E care and maintenance. The state must determine how to define "greater than usual needs".

DHHS assesses foster care rates for cost of living of the State of Nebraska but does not appear to look at regional differences across the state. If there is a regional difference in COLA across the state, Nebraska might consider regional foster care rates. In addition, DHHS should also review its congregate care rates.

PCG recommends that DHHS reviews the Title IV-E maintenance and administrative rates for Child Placing Agencies across the state. DHHS should engage in a process to establish payment rates that consider provider costs while implementing some state imposed controls on costs and measures of performance. This type of process includes the following steps:

- Regular submissions by providers detailing the costs to provide the services that Nebraska wishes to purchase. Cost reports should be required annually.
  A review of provider costs by DHHS when submitted to revise rates in accordance with standards and caps established by DHHS, including:

[1] Child Welfare Policy Manual. Question 8.3B.2.2. Accessed October 27, 2010
http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=80

  - Caps on certain types of costs, for example: executive pay, unused space, excess capacity, based on an analysis of submitted provider costs and industry standards.
  - State service standards that clarify to providers exactly what the state expects to purchase, such as caseload ratio requirements, education requirements for staff, etc.
  - Establishing a standard indirect administrative percentage across provider entities similar to federal, local or foundation grant requirements.
  - Periodic on site audits of provider cost reports to validate that costs are accurately represented.
  - Implementation of performance measures that assess whether providers are meeting goals established by the state, for example: time to permanency, number of placement changes, continuity of health and education throughout placement.
  - Consider establishing a Random Moment Sampling (RMS) methodology for private provider staff to capture all activities conducted at agency. This will allow DHHS to compliantly allocate expenditures to applicable federal funding programs such as Title IV-E and Title XIX.
- While this process does impose additional administrative activities on DHHS to review cost reports, establish caps, articulate service standards and monitor performance, and additional administrative activities on providers to report cost and undergo audits, the process has clear political and practical advantages:
  - The process for establishing payment rates becomes transparent to all parties. There is no risk that payment rates can be considered arbitrary.
  - By implementing clear service standards and performance measures, the state articulates clearly to providers exactly what the state intends to purchase, and exactly how it expects providers to perform. This helps to clarify to providers how they can meet state expectations and directs their activities towards those activities that best meet the state's articulated goals.
  - Cost caps ensure that the state is not paying for excessive executive salaries, unnecessary space, unused capacity, or other costs that are unnecessary to provide services.

PCG recommends DHHS conduct a peer state review of foster care rates to those states in geographic proximity and similar cost of living to Nebraska before implementing the calculated foster care rates stated in "LB820 Final Legislative Report." While the M.A.R.C. and the USDA Cost of Raising a Child Report are standards used nationally to establish foster care per diems, social researchers have identified many weaknesses with the study. Ball State University conducted a review of the reports for Indiana's Department of Child Services citing that both reports calculate rates based on averages and not the incremental cost associated with foster care

(Hicks, 2011[18]). The additional step of conducting a peer state review could help DHHS justify the adjusted foster care rates if the rates are questioned.

The recommendations included in this report were developed to help Nebraska examine the funding for prevention/intervention services to at-risk youth and identify the state funding being used, in order to better utilize federal funds. Based on PCG's analysis and the current activities across DHHS, Nebraska appears to be improving on replacing state-funded services with federal funds. **By working to implement these recommendations in a timely manner,** Nebraska can achieve its goal of expanding the funding base for prevention/intervention services, and reduce the overall state fund expenditures on these services.

[18] Foster Care Cost Survey of Indiana Memorandum of Findings Prepared by Center for Business and Economic Research Ball State University

Division	**Program**
Behavioral Health (BH)	The Department of Health & Human Services (DHHS) directly operates three Regional Centers (the funding for Norfolk Sex Offender Treatment is appropriated seperately). The majority of clients served are adults. However, Hastings (HRC) provides PRTF for youth with substance abuse disorders.
Behavioral Health (BH)	Behavioral Health Community Based Service System (children only)
Behavioral Health (BH)	**Region 1- PPP**
Behavioral Health (BH)	**Region 2-PPP**
Behavioral Health (BH)	**Region 3-PPP**
Behavioral Health (BH)	**Region 4-PPP**
Behavioral Health (BH)	**Region 5-PPP**
Behavioral Health (BH)	*LINCS Program Pilot*
Behavioral Health (BH)	**Region 6-PPP**
Behavioral Health (BH)	*Rapid Response Professional Partners Pilot*
Behavioral Health (BH)	*Adolescent Therapist Addition on the Mobile Crisis Response Team*
Behavioral Health (BH)	Nebraska Family Helpline

Division	Program
Behavioral Health (BH)	Family Navigator Program
Behavioral Health (BH)	Region 1 Overview of total children served
Behavioral Health (BH)	Region 2 Overview of total children served
Behavioral Health (BH)	Region 3 Overview of total children served
Behavioral Health (BH)	Region 4 Overview of total children served
Behavioral Health (BH)	Region 5 Overview of total children served
Behavioral Health (BH)	Region 6 Overview of total children served
Children & Family Services (CFS)	**Public Assistance**
Children & Family Services (CFS) (under 347)	Aid to dependent children
Children & Family Services (CFS) (under 347)	Child Care
Children & Family Services (CFS)	**CFS Administration**
Children & Family Services (CFS)	**Protection & Safety**
Children & Family Services (CFS) (under 265)	Child Welfare (Admin)
Children & Family Services (CFS)	**Economic Assistance**
Children & Family Services (CFS) (under266)	Food programs
Children & Family Services (CFS)	**Child Abuse Prevention Fund**
Children & Family Services (CFS)	**Child Welfare**
Children & Family Services (CFS) (under 354)	IV-E Foster Care
Children & Family Services (CFS) (under 354)	IV-E Adoption Assistance
Children & Family Services (CFS) (under 354)	IV-E Guardianship
Children & Family Services (CFS) (under 354)	Subsidized Adoption
Children & Family Services (CFS) (under 354)	Domestic Violence Program
Children & Family Services (CFS) (under 354)	Child Welfare
Children & Family Services (CFS) (under 354)	Education Assistance for State Wards
Children & Family Services (CFS) (under 354)	Adoption and Safe Families
Children & Family Services (CFS) (under 354)	Predisposition Detention
Children & Family Services (CFS) (under 354)	Protection and Safety
Children & Family Services (CFS) (under 354)	Post Adoption/Guardianship/Right-Turn

Division	Program
Children & Family Services (CFS)	**Office of Juvenile Services**
Children & Family Services (CFS) (under 250)	Juvenile - Community Based
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Geneva
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Kearney
Developmental Disabilities (DD)	Beatrice State Developmental Center
Developmental Disabilities (DD)	Developmental Disabilities Aid
Medicaid and Long-Term Care (MLTC)	Early Development Network (EDN)
Medicaid and Long-Term Care (MLTC)	Medically Handicapped Children's Program
Medicaid and Long-Term Care (MLTC)	Children's Health Insurance
Medicaid and Long-Term Care (MLTC)	Medicaid and LTC
Medicaid and Long-Term Care (MLTC)	Lifespan Respite Subsidy Program

Division	Program
Public Health (PH)	Maternal, Infant and Early Childhood Home Visiting Program
Public Health (PH)	Immunization program
Public Health (PH)	Nebraska Child Death Review Team
Public Health (PH)	Pregnancy Risk Assessment Monitoring System (PRAMS):
Public Health (PH)	New born screening
Public Health (PH)	Perinatal child & adolescent health
Public Health (PH)	Women, Infant, and Children Nutrition Program (WIC)
Public Health (PH)	Commodity Supplemental Food Program (CSFP)- Administration
Nebraska Juvenile Service Delivery Project (NJSDP) 2009- 2012	Nebraska Juvenile Service Delivery
Nebraska Juvenile Service Delivery Project (NJSDP) 2012- Current	Nebraska Juvenile Service Delivery

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	The Department of Health & Human Services (DHHS) directly operates three Regional Centers (the funding for Norfolk Sex Offender Treatment is appropriated seperately). The majority of clients served are adults. However, Hastings (HRC) provides PRTF for youth with substance abuse disorders.	direct
Behavioral Health (BH)	Behavioral Health Community Based Service System (children only)	direct
Behavioral Health (BH)	**Region 1- PPP**	**direct**
Behavioral Health (BH)	**Region 2-PPP**	**direct**
Behavioral Health (BH)	**Region 3-PPP**	**direct**
Behavioral Health (BH)	**Region 4-PPP**	**direct**
Behavioral Health (BH)	**Region 5-PPP**	**direct**
Behavioral Health (BH)	*LINCS Program Pilot*	*direct*
Behavioral Health (BH)	**Region 6-PPP**	**direct**
Behavioral Health (BH)	*Rapid Response Professional Partners Pilot*	*direct*
Behavioral Health (BH)	*Adolescent Therapist Addition on the Mobile Crisis Response Team*	*direct*
Behavioral Health (BH)	Nebraska Family Helpline	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	Family Navigator Program	direct
Behavioral Health (BH)	Region 1 Overview of total children served	direct
Behavioral Health (BH)	Region 2 Overview of total children served	direct
Behavioral Health (BH)	Region 3 Overview of total children served	direct
Behavioral Health (BH)	Region 4 Overview of total children served	direct
Behavioral Health (BH)	Region 5 Overview of total children served	direct
Behavioral Health (BH)	Region 6 Overview of total children served	direct
Children & Family Services (CFS)	**Public Assistance**	**direct & indirect**
Children & Family Services (CFS) (under 347)	Aid to dependent children	indirect
Children & Family Services (CFS) (under 347)	Child Care	indirect
Children & Family Services (CFS)	**CFS Administration**	**indirect**
Children & Family Services (CFS)	**Protection & Safety**	**direct & indirect**
Children & Family Services (CFS) (under 265)	Child Welfare (Admin)	indirect
Children & Family Services (CFS)	**Economic Assistance**	**direct & indirect**
Children & Family Services (CFS) (under266)	Food programs	direct & indirect
Children & Family Services (CFS)	**Child Abuse Prevention Fund**	**direct?**
Children & Family Services (CFS)	**Child Welfare**	**direct & indirect**
Children & Family Services (CFS) (under 354)	IV-E Foster Care	direct
Children & Family Services (CFS) (under 354)	IV-E Adoption Assistance	direct
Children & Family Services (CFS) (under 354)	IV-E Guardianship	direct
Children & Family Services (CFS) (under 354)	Subsidized Adoption	direct
Children & Family Services (CFS) (under 354)	Domestic Violence Program	direct
Children & Family Services (CFS) (under 354)	Child Welfare	direct
Children & Family Services (CFS) (under 354)	Education Assistance for State Wards	direct
Children & Family Services (CFS) (under 354)	Adoption and Safe Families	direct
Children & Family Services (CFS) (under 354)	Predisposition Detention	direct
Children & Family Services (CFS) (under 354)	Protection and Safety	direct
Children & Family Services (CFS) (under 354)	Post Adoption/Guardianship/Right-Turn	direct

Division	Program	Services (Direct and Indirect)
Children & Family Services (CFS)	**Office of Juvenile Services**	**direct & indirect**
Children & Family Services (CFS) (under 250)	Juvenile - Community Based	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Geneva	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Kearney	direct
Developmental Disabilities (DD)	Beatrice State Developmental Center	direct
Developmental Disabilities (DD)	Developmental Disabilities Aid	direct & indirect
Medicaid and Long-Term Care (MLTC)	Early Development Network (EDN)	direct
Medicaid and Long-Term Care (MLTC)	Medically Handicapped Children's Program	direct
Medicaid and Long-Term Care (MLTC)	Children's Health Insurance	indirect
Medicaid and Long-Term Care (MLTC)	Medicaid and LTC	indirect
Medicaid and Long-Term Care (MLTC)	Lifespan Respite Subsidy Program	indirect

Division	Program	Services (Direct and Indirect)
Public Health (PH)	Maternal, Infant and Early Childhood Home Visiting Program	direct
Public Health (PH)	Immunization program	direct & indirect
Public Health (PH)	Nebraska Child Death Review Team	indirect
Public Health (PH)	Pregnancy Risk Assessment Monitoring System (PRAMS):	direct
Public Health (PH)	New born screening	direct
Public Health (PH)	Perinatal child & adolescent health	direct & indirect
Public Health (PH)	Women, Infant, and Children Nutrition Program (WIC)	direct & indirect
Public Health (PH)	Commodity Supplemental Food Program (CSFP)- Administration	direct & indirect
Nebraska Juvenile Service Delivery Project (NJSDP) 2009- 2012	Nebraska Juvenile Service Delivery	direct
Nebraska Juvenile Service Delivery Project (NJSDP) 2012- Current	Nebraska Juvenile Service Delivery	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	The Department of Health & Human Services (DHHS) directly operates three Regional Centers (the funding for Norfolk Sex Offender Treatment is appropriated seperately). The majority of clients served are adults. However, Hastings (HRC) provides PRTF for youth with substance abuse disorders.	direct
Behavioral Health (BH)	Behavioral Health Community Based Service System (children only)	direct
Behavioral Health (BH)	**Region 1- PPP**	**direct**
Behavioral Health (BH)	**Region 2-PPP**	**direct**
Behavioral Health (BH)	**Region 3-PPP**	**direct**
Behavioral Health (BH)	**Region 4-PPP**	**direct**
Behavioral Health (BH)	**Region 5-PPP**	**direct**
Behavioral Health (BH)	*LINCS Program Pilot*	*direct*
Behavioral Health (BH)	**Region 6-PPP**	**direct**
Behavioral Health (BH)	*Rapid Response Professional Partners Pilot*	*direct*
Behavioral Health (BH)	*Adolescent Therapist Addition on the Mobile Crisis Response Team*	*direct*
Behavioral Health (BH)	Nebraska Family Helpline	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	Family Navigator Program	direct
Behavioral Health (BH)	Region 1 Overview of total children served	direct
Behavioral Health (BH)	Region 2 Overview of total children served	direct
Behavioral Health (BH)	Region 3 Overview of total children served	direct
Behavioral Health (BH)	Region 4 Overview of total children served	direct
Behavioral Health (BH)	Region 5 Overview of total children served	direct
Behavioral Health (BH)	Region 6 Overview of total children served	direct
Children & Family Services (CFS)	**Public Assistance**	**direct & indirect**
Children & Family Services (CFS) (under 347)	Aid to dependent children	indirect
Children & Family Services (CFS) (under 347)	Child Care	indirect
Children & Family Services (CFS)	**CFS Administration**	**indirect**
Children & Family Services (CFS)	**Protection & Safety**	**direct & indirect**
Children & Family Services (CFS) (under 265)	Child Welfare (Admin)	indirect
Children & Family Services (CFS)	**Economic Assistance**	**direct & indirect**
Children & Family Services (CFS) (under266)	Food programs	direct & indirect
Children & Family Services (CFS)	**Child Abuse Prevention Fund**	**direct?**
Children & Family Services (CFS)	**Child Welfare**	**direct & indirect**
Children & Family Services (CFS) (under 354)	IV-E Foster Care	direct
Children & Family Services (CFS) (under 354)	IV-E Adoption Assistance	direct
Children & Family Services (CFS) (under 354)	IV-E Guardianship	direct
Children & Family Services (CFS) (under 354)	Subsidized Adoption	direct
Children & Family Services (CFS) (under 354)	Domestic Violence Program	direct
Children & Family Services (CFS) (under 354)	Child Welfare	direct
Children & Family Services (CFS) (under 354)	Education Assistance for State Wards	direct
Children & Family Services (CFS) (under 354)	Adoption and Safe Families	direct
Children & Family Services (CFS) (under 354)	Predisposition Detention	direct
Children & Family Services (CFS) (under 354)	Protection and Safety	direct
Children & Family Services (CFS) (under 354)	Post Adoption/Guardianship/Right-Turn	direct

Division	Program	Services (Direct and Indirect)
Children & Family Services (CFS)	**Office of Juvenile Services**	**direct & indirect**
Children & Family Services (CFS) (under 250)	Juvenile - Community Based	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Geneva	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Kearney	direct
Developmental Disabilities (DD)	Beatrice State Developmental Center	direct
Developmental Disabilities (DD)	Developmental Disabilities Aid	direct & indirect
Medicaid and Long-Term Care (MLTC)	Early Development Network (EDN)	direct
Medicaid and Long-Term Care (MLTC)	Medically Handicapped Children's Program	direct
Medicaid and Long-Term Care (MLTC)	Children's Health Insurance	indirect
Medicaid and Long-Term Care (MLTC)	Medicaid and LTC	indirect
Medicaid and Long-Term Care (MLTC)	Lifespan Respite Subsidy Program	indirect

Division	Program	Services (Direct and Indirect)
Public Health (PH)	Maternal, Infant and Early Childhood Home Visiting Program	direct
Public Health (PH)	Immunization program	direct & indirect
Public Health (PH)	Nebraska Child Death Review Team	indirect
Public Health (PH)	Pregnancy Risk Assessment Monitoring System (PRAMS):	direct
Public Health (PH)	New born screening	direct
Public Health (PH)	Perinatal child & adolescent health	direct & indirect
Public Health (PH)	Women, Infant, and Children Nutrition Program (WIC)	direct & indirect
Public Health (PH)	Commodity Supplemental Food Program (CSFP)- Administration	direct & indirect
Nebraska Juvenile Service Delivery Project (NJSDP) 2009- 2012	Nebraska Juvenile Service Delivery	direct
Nebraska Juvenile Service Delivery Project (NJSDP) 2012- Current	Nebraska Juvenile Service Delivery	direct

Division	Program	Services (Direct and Indirect)
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Behavioral Health (BH)	Behavioral Health Community Based Service System (children only)	direct
Behavioral Health (BH)	**Region 1- PPP**	**direct**
Behavioral Health (BH)	**Region 2-PPP**	**direct**
Behavioral Health (BH)	**Region 3-PPP**	**direct**
Behavioral Health (BH)	**Region 4-PPP**	**direct**
Behavioral Health (BH)	**Region 5-PPP**	**direct**
Behavioral Health (BH)	*LINCS Program Pilot*	*direct*
Behavioral Health (BH)	**Region 6-PPP**	**direct**
Behavioral Health (BH)	*Rapid Response Professional Partners Pilot*	*direct*
Behavioral Health (BH)	*Adolescent Therapist Addition on the Mobile Crisis Response Team*	*direct*
Behavioral Health (BH)	Nebraska Family Helpline	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	Family Navigator Program	direct
Behavioral Health (BH)	Region 1 Overview of total children served	direct
Behavioral Health (BH)	Region 2 Overview of total children served	direct
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Behavioral Health (BH)	Region 4 Overview of total children served	direct
Behavioral Health (BH)	Region 5 Overview of total children served	direct
Behavioral Health (BH)	Region 6 Overview of total children served	direct
Children & Family Services (CFS)	**Public Assistance**	**direct & indirect**
Children & Family Services (CFS) (under 347)	Aid to dependent children	indirect
Children & Family Services (CFS) (under 347)	Child Care	indirect
Children & Family Services (CFS)	**CFS Administration**	**indirect**
Children & Family Services (CFS)	**Protection & Safety**	**direct & indirect**
Children & Family Services (CFS) (under 265)	Child Welfare (Admin)	indirect
Children & Family Services (CFS)	**Economic Assistance**	**direct & indirect**
Children & Family Services (CFS) (under266)	Food programs	direct & indirect
Children & Family Services (CFS)	**Child Abuse Prevention Fund**	**direct?**
Children & Family Services (CFS)	**Child Welfare**	**direct & indirect**
Children & Family Services (CFS) (under 354)	IV-E Foster Care	direct
Children & Family Services (CFS) (under 354)	IV-E Adoption Assistance	direct
Children & Family Services (CFS) (under 354)	IV-E Guardianship	direct
Children & Family Services (CFS) (under 354)	Subsidized Adoption	direct
Children & Family Services (CFS) (under 354)	Domestic Violence Program	direct
Children & Family Services (CFS) (under 354)	Child Welfare	direct
Children & Family Services (CFS) (under 354)	Education Assistance for State Wards	direct
Children & Family Services (CFS) (under 354)	Adoption and Safe Families	direct
Children & Family Services (CFS) (under 354)	Predisposition Detention	direct
Children & Family Services (CFS) (under 354)	Protection and Safety	direct
Children & Family Services (CFS) (under 354)	Post Adoption/Guardianship/Right-Turn	direct

Division	Program	Services (Direct and Indirect)
Children & Family Services (CFS)	**Office of Juvenile Services**	**direct & indirect**
Children & Family Services (CFS) (under 250)	Juvenile - Community Based	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Geneva	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Kearney	direct
Developmental Disabilities (DD)	Beatrice State Developmental Center	direct
Developmental Disabilities (DD)	Developmental Disabilities Aid	direct & indirect
Medicaid and Long-Term Care (MLTC)	Early Development Network (EDN)	direct
Medicaid and Long-Term Care (MLTC)	Medically Handicapped Children's Program	direct
Medicaid and Long-Term Care (MLTC)	Children's Health Insurance	indirect
Medicaid and Long-Term Care (MLTC)	Medicaid and LTC	indirect
Medicaid and Long-Term Care (MLTC)	Lifespan Respite Subsidy Program	indirect

Division	Program	Services (Direct and Indirect)
Public Health (PH)	Maternal, Infant and Early Childhood Home Visiting Program	direct
Public Health (PH)	Immunization program	direct & indirect
Public Health (PH)	Nebraska Child Death Review Team	indirect
Public Health (PH)	Pregnancy Risk Assessment Monitoring System (PRAMS):	direct
Public Health (PH)	New born screening	direct
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Nebraska Juvenile Service Delivery Project (NJSDP) 2012- Current	Nebraska Juvenile Service Delivery	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	The Department of Health & Human Services (DHHS) directly operates three Regional Centers (the funding for Norfolk Sex Offender Treatment is appropriated seperately). The majority of clients served are adults. However, Hastings (HRC) provides PRTF for youth with substance abuse disorders.	direct
Behavioral Health (BH)	Behavioral Health Community Based Service System (children only)	direct
Behavioral Health (BH)	**Region 1- PPP**	**direct**
Behavioral Health (BH)	**Region 2-PPP**	**direct**
Behavioral Health (BH)	**Region 3-PPP**	**direct**
Behavioral Health (BH)	**Region 4-PPP**	**direct**
Behavioral Health (BH)	**Region 5-PPP**	**direct**
Behavioral Health (BH)	*LINCS Program Pilot*	*direct*
Behavioral Health (BH)	**Region 6-PPP**	**direct**
Behavioral Health (BH)	*Rapid Response Professional Partners Pilot*	*direct*
Behavioral Health (BH)	*Adolescent Therapist Addition on the Mobile Crisis Response Team*	*direct*
Behavioral Health (BH)	Nebraska Family Helpline	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	Family Navigator Program	direct
Behavioral Health (BH)	Region 1 Overview of total children served	direct
Behavioral Health (BH)	Region 2 Overview of total children served	direct
Behavioral Health (BH)	Region 3 Overview of total children served	direct
Behavioral Health (BH)	Region 4 Overview of total children served	direct
Behavioral Health (BH)	Region 5 Overview of total children served	direct
Behavioral Health (BH)	Region 6 Overview of total children served	direct
Children & Family Services (CFS)	**Public Assistance**	**direct & indirect**
Children & Family Services (CFS) (under 347)	Aid to dependent children	indirect
Children & Family Services (CFS) (under 347)	Child Care	indirect
Children & Family Services (CFS)	**CFS Administration**	**indirect**
Children & Family Services (CFS)	**Protection & Safety**	**direct & indirect**
Children & Family Services (CFS) (under 265)	Child Welfare (Admin)	indirect
Children & Family Services (CFS)	**Economic Assistance**	**direct & indirect**
Children & Family Services (CFS) (under266)	Food programs	direct & indirect
Children & Family Services (CFS)	**Child Abuse Prevention Fund**	**direct?**
Children & Family Services (CFS)	**Child Welfare**	**direct & indirect**
Children & Family Services (CFS) (under 354)	IV-E Foster Care	direct
Children & Family Services (CFS) (under 354)	IV-E Adoption Assistance	direct
Children & Family Services (CFS) (under 354)	IV-E Guardianship	direct
Children & Family Services (CFS) (under 354)	Subsidized Adoption	direct
Children & Family Services (CFS) (under 354)	Domestic Violence Program	direct
Children & Family Services (CFS) (under 354)	Child Welfare	direct
Children & Family Services (CFS) (under 354)	Education Assistance for State Wards	direct
Children & Family Services (CFS) (under 354)	Adoption and Safe Families	direct
Children & Family Services (CFS) (under 354)	Predisposition Detention	direct
Children & Family Services (CFS) (under 354)	Protection and Safety	direct
Children & Family Services (CFS) (under 354)	Post Adoption/Guardianship/Right-Turn	direct

Division	Program	Services (Direct and Indirect)
Children & Family Services (CFS)	**Office of Juvenile Services**	**direct & indirect**
Children & Family Services (CFS) (under 250)	Juvenile - Community Based	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Geneva	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Kearney	direct
Developmental Disabilities (DD)	Beatrice State Developmental Center	direct
Developmental Disabilities (DD)	Developmental Disabilities Aid	direct & indirect
Medicaid and Long-Term Care (MLTC)	Early Development Network (EDN)	direct
Medicaid and Long-Term Care (MLTC)	Medically Handicapped Children's Program	direct
Medicaid and Long-Term Care (MLTC)	Children's Health Insurance	indirect
Medicaid and Long-Term Care (MLTC)	Medicaid and LTC	indirect
Medicaid and Long-Term Care (MLTC)	Lifespan Respite Subsidy Program	indirect

Division	Program	Services (Direct and Indirect)
Public Health (PH)	Maternal, Infant and Early Childhood Home Visiting Program	direct
Public Health (PH)	Immunization program	direct & indirect
Public Health (PH)	Nebraska Child Death Review Team	indirect
Public Health (PH)	Pregnancy Risk Assessment Monitoring System (PRAMS):	direct
Public Health (PH)	New born screening	direct
Public Health (PH)	Perinatal child & adolescent health	direct & indirect
Public Health (PH)	Women, Infant, and Children Nutrition Program (WIC)	direct & indirect
Public Health (PH)	Commodity Supplemental Food Program (CSFP)- Administration	direct & indirect
Nebraska Juvenile Service Delivery Project (NJSDP) 2009- 2012	Nebraska Juvenile Service Delivery	direct
Nebraska Juvenile Service Delivery Project (NJSDP) 2012- Current	Nebraska Juvenile Service Delivery	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	The Department of Health & Human Services (DHHS) directly operates three Regional Centers (the funding for Norfolk Sex Offender Treatment is appropriated seperately). The majority of clients served are adults. However, Hastings (HRC) provides PRTF for youth with substance abuse disorders.	direct
Behavioral Health (BH)	Behavioral Health Community Based Service System (children only)	direct
Behavioral Health (BH)	**Region 1- PPP**	**direct**
Behavioral Health (BH)	**Region 2-PPP**	**direct**
Behavioral Health (BH)	**Region 3-PPP**	**direct**
Behavioral Health (BH)	**Region 4-PPP**	**direct**
Behavioral Health (BH)	**Region 5-PPP**	**direct**
Behavioral Health (BH)	*LINCS Program Pilot*	*direct*
Behavioral Health (BH)	**Region 6-PPP**	**direct**
Behavioral Health (BH)	*Rapid Response Professional Partners Pilot*	*direct*
Behavioral Health (BH)	*Adolescent Therapist Addition on the Mobile Crisis Response Team*	*direct*
Behavioral Health (BH)	Nebraska Family Helpline	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	Family Navigator Program	direct
Behavioral Health (BH)	Region 1 Overview of total children served	direct
Behavioral Health (BH)	Region 2 Overview of total children served	direct
Behavioral Health (BH)	Region 3 Overview of total children served	direct
Behavioral Health (BH)	Region 4 Overview of total children served	direct
Behavioral Health (BH)	Region 5 Overview of total children served	direct
Behavioral Health (BH)	Region 6 Overview of total children served	direct
Children & Family Services (CFS)	**Public Assistance**	**direct & indirect**
Children & Family Services (CFS) (under 347)	Aid to dependent children	indirect
Children & Family Services (CFS) (under 347)	Child Care	indirect
Children & Family Services (CFS)	**CFS Administration**	**indirect**
Children & Family Services (CFS)	**Protection & Safety**	**direct & indirect**
Children & Family Services (CFS) (under 265)	Child Welfare (Admin)	indirect
Children & Family Services (CFS)	**Economic Assistance**	**direct & indirect**
Children & Family Services (CFS) (under266)	Food programs	direct & indirect
Children & Family Services (CFS)	**Child Abuse Prevention Fund**	**direct?**
Children & Family Services (CFS)	**Child Welfare**	**direct & indirect**
Children & Family Services (CFS) (under 354)	IV-E Foster Care	direct
Children & Family Services (CFS) (under 354)	IV-E Adoption Assistance	direct
Children & Family Services (CFS) (under 354)	IV-E Guardianship	direct
Children & Family Services (CFS) (under 354)	Subsidized Adoption	direct
Children & Family Services (CFS) (under 354)	Domestic Violence Program	direct
Children & Family Services (CFS) (under 354)	Child Welfare	direct
Children & Family Services (CFS) (under 354)	Education Assistance for State Wards	direct
Children & Family Services (CFS) (under 354)	Adoption and Safe Families	direct
Children & Family Services (CFS) (under 354)	Predisposition Detention	direct
Children & Family Services (CFS) (under 354)	Protection and Safety	direct
Children & Family Services (CFS) (under 354)	Post Adoption/Guardianship/Right-Turn	direct

Division	Program	Services (Direct and Indirect)
Children & Family Services (CFS)	**Office of Juvenile Services**	**direct & indirect**
Children & Family Services (CFS) (under 250)	Juvenile - Community Based	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Geneva	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Kearney	direct
Developmental Disabilities (DD)	Beatrice State Developmental Center	direct
Developmental Disabilities (DD)	Developmental Disabilities Aid	direct & indirect
Medicaid and Long-Term Care (MLTC)	Early Development Network (EDN)	direct
Medicaid and Long-Term Care (MLTC)	Medically Handicapped Children's Program	direct
Medicaid and Long-Term Care (MLTC)	Children's Health Insurance	indirect
Medicaid and Long-Term Care (MLTC)	Medicaid and LTC	indirect
Medicaid and Long-Term Care (MLTC)	Lifespan Respite Subsidy Program	indirect

Division	Program	Services (Direct and Indirect)
Public Health (PH)	Maternal, Infant and Early Childhood Home Visiting Program	direct
Public Health (PH)	Immunization program	direct & indirect
Public Health (PH)	Nebraska Child Death Review Team	indirect
Public Health (PH)	Pregnancy Risk Assessment Monitoring System (PRAMS):	direct
Public Health (PH)	New born screening	direct
Public Health (PH)	Perinatal child & adolescent health	direct & indirect
Public Health (PH)	Women, Infant, and Children Nutrition Program (WIC)	direct & indirect
Public Health (PH)	Commodity Supplemental Food Program (CSFP)- Administration	direct & indirect
Nebraska Juvenile Service Delivery Project (NJSDP) 2009- 2012	Nebraska Juvenile Service Delivery	direct
Nebraska Juvenile Service Delivery Project (NJSDP) 2012- Current	Nebraska Juvenile Service Delivery	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	The Department of Health & Human Services (DHHS) directly operates three Regional Centers (the funding for Norfolk Sex Offender Treatment is appropriated seperately). The majority of clients served are adults. However, Hastings (HRC) provides PRTF for youth with substance abuse disorders.	direct
Behavioral Health (BH)	Behavioral Health Community Based Service System (children only)	direct
Behavioral Health (BH)	**Region 1- PPP**	**direct**
Behavioral Health (BH)	**Region 2-PPP**	**direct**
Behavioral Health (BH)	**Region 3-PPP**	**direct**
Behavioral Health (BH)	**Region 4-PPP**	**direct**
Behavioral Health (BH)	**Region 5-PPP**	**direct**
Behavioral Health (BH)	*LINCS Program Pilot*	*direct*
Behavioral Health (BH)	**Region 6-PPP**	**direct**
Behavioral Health (BH)	*Rapid Response Professional Partners Pilot*	*direct*
Behavioral Health (BH)	*Adolescent Therapist Addition on the Mobile Crisis Response Team*	*direct*
Behavioral Health (BH)	Nebraska Family Helpline	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	Family Navigator Program	direct
Behavioral Health (BH)	Region 1 Overview of total children served	direct
Behavioral Health (BH)	Region 2 Overview of total children served	direct
Behavioral Health (BH)	Region 3 Overview of total children served	direct
Behavioral Health (BH)	Region 4 Overview of total children served	direct
Behavioral Health (BH)	Region 5 Overview of total children served	direct
Behavioral Health (BH)	Region 6 Overview of total children served	direct
Children & Family Services (CFS)	**Public Assistance**	**direct & indirect**
Children & Family Services (CFS) (under 347)	Aid to dependent children	indirect
Children & Family Services (CFS) (under 347)	Child Care	indirect
Children & Family Services (CFS)	**CFS Administration**	**indirect**
Children & Family Services (CFS)	**Protection & Safety**	**direct & indirect**
Children & Family Services (CFS) (under 265)	Child Welfare (Admin)	indirect
Children & Family Services (CFS)	**Economic Assistance**	**direct & indirect**
Children & Family Services (CFS) (under266)	Food programs	direct & indirect
Children & Family Services (CFS)	**Child Abuse Prevention Fund**	**direct?**
Children & Family Services (CFS)	**Child Welfare**	**direct & indirect**
Children & Family Services (CFS) (under 354)	IV-E Foster Care	direct
Children & Family Services (CFS) (under 354)	IV-E Adoption Assistance	direct
Children & Family Services (CFS) (under 354)	IV-E Guardianship	direct
Children & Family Services (CFS) (under 354)	Subsidized Adoption	direct
Children & Family Services (CFS) (under 354)	Domestic Violence Program	direct
Children & Family Services (CFS) (under 354)	Child Welfare	direct
Children & Family Services (CFS) (under 354)	Education Assistance for State Wards	direct
Children & Family Services (CFS) (under 354)	Adoption and Safe Families	direct
Children & Family Services (CFS) (under 354)	Predisposition Detention	direct
Children & Family Services (CFS) (under 354)	Protection and Safety	direct
Children & Family Services (CFS) (under 354)	Post Adoption/Guardianship/Right-Turn	direct

Division	Program	Services (Direct and Indirect)
Children & Family Services (CFS)	**Office of Juvenile Services**	**direct & indirect**
Children & Family Services (CFS) (under 250)	Juvenile - Community Based	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Geneva	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Kearney	direct
Developmental Disabilities (DD)	Beatrice State Developmental Center	direct
Developmental Disabilities (DD)	Developmental Disabilities Aid	direct & indirect
Medicaid and Long-Term Care (MLTC)	Early Development Network (EDN)	direct
Medicaid and Long-Term Care (MLTC)	Medically Handicapped Children's Program	direct
Medicaid and Long-Term Care (MLTC)	Children's Health Insurance	indirect
Medicaid and Long-Term Care (MLTC)	Medicaid and LTC	indirect
Medicaid and Long-Term Care (MLTC)	Lifespan Respite Subsidy Program	indirect

Division	Program	Services (Direct and Indirect)
Public Health (PH)	Maternal, Infant and Early Childhood Home Visiting Program	direct
Public Health (PH)	Immunization program	direct & indirect
Public Health (PH)	Nebraska Child Death Review Team	indirect
Public Health (PH)	Pregnancy Risk Assessment Monitoring System (PRAMS):	direct
Public Health (PH)	New born screening	direct
Public Health (PH)	Perinatal child & adolescent health	direct & indirect
Public Health (PH)	Women, Infant, and Children Nutrition Program (WIC)	direct & indirect
Public Health (PH)	Commodity Supplemental Food Program (CSFP)- Administration	direct & indirect
Nebraska Juvenile Service Delivery Project (NJSDP) 2009- 2012	Nebraska Juvenile Service Delivery	direct
Nebraska Juvenile Service Delivery Project (NJSDP) 2012- Current	Nebraska Juvenile Service Delivery	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	The Department of Health & Human Services (DHHS) directly operates three Regional Centers (the funding for Norfolk Sex Offender Treatment is appropriated seperately). The majority of clients served are adults. However, Hastings (HRC) provides PRTF for youth with substance abuse disorders.	direct
Behavioral Health (BH)	Behavioral Health Community Based Service System (children only)	direct
Behavioral Health (BH)	**Region 1- PPP**	**direct**
Behavioral Health (BH)	**Region 2-PPP**	**direct**
Behavioral Health (BH)	**Region 3-PPP**	**direct**
Behavioral Health (BH)	**Region 4-PPP**	**direct**
Behavioral Health (BH)	**Region 5-PPP**	**direct**
Behavioral Health (BH)	*LINCS Program Pilot*	*direct*
Behavioral Health (BH)	**Region 6-PPP**	**direct**
Behavioral Health (BH)	*Rapid Response Professional Partners Pilot*	*direct*
Behavioral Health (BH)	*Adolescent Therapist Addition on the Mobile Crisis Response Team*	*direct*
Behavioral Health (BH)	Nebraska Family Helpline	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	Family Navigator Program	direct
Behavioral Health (BH)	Region 1 Overview of total children served	direct
Behavioral Health (BH)	Region 2 Overview of total children served	direct
Behavioral Health (BH)	Region 3 Overview of total children served	direct
Behavioral Health (BH)	Region 4 Overview of total children served	direct
Behavioral Health (BH)	Region 5 Overview of total children served	direct
Behavioral Health (BH)	Region 6 Overview of total children served	direct
Children & Family Services (CFS)	**Public Assistance**	**direct & indirect**
Children & Family Services (CFS) (under 347)	Aid to dependent children	indirect
Children & Family Services (CFS) (under 347)	Child Care	indirect
Children & Family Services (CFS)	**CFS Administration**	**indirect**
Children & Family Services (CFS)	**Protection & Safety**	**direct & indirect**
Children & Family Services (CFS) (under 265)	Child Welfare (Admin)	indirect
Children & Family Services (CFS)	**Economic Assistance**	**direct & indirect**
Children & Family Services (CFS) (under266)	Food programs	direct & indirect
Children & Family Services (CFS)	**Child Abuse Prevention Fund**	**direct?**
Children & Family Services (CFS)	**Child Welfare**	**direct & indirect**
Children & Family Services (CFS) (under 354)	IV-E Foster Care	direct
Children & Family Services (CFS) (under 354)	IV-E Adoption Assistance	direct
Children & Family Services (CFS) (under 354)	IV-E Guardianship	direct
Children & Family Services (CFS) (under 354)	Subsidized Adoption	direct
Children & Family Services (CFS) (under 354)	Domestic Violence Program	direct
Children & Family Services (CFS) (under 354)	Child Welfare	direct
Children & Family Services (CFS) (under 354)	Education Assistance for State Wards	direct
Children & Family Services (CFS) (under 354)	Adoption and Safe Families	direct
Children & Family Services (CFS) (under 354)	Predisposition Detention	direct
Children & Family Services (CFS) (under 354)	Protection and Safety	direct
Children & Family Services (CFS) (under 354)	Post Adoption/Guardianship/Right-Turn	direct

Division	Program	Services (Direct and Indirect)
Children & Family Services (CFS)	**Office of Juvenile Services**	**direct & indirect**
Children & Family Services (CFS) (under 250)	Juvenile - Community Based	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Geneva	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Kearney	direct
Developmental Disabilities (DD)	Beatrice State Developmental Center	direct
Developmental Disabilities (DD)	Developmental Disabilities Aid	direct & indirect
Medicaid and Long-Term Care (MLTC)	Early Development Network (EDN)	direct
Medicaid and Long-Term Care (MLTC)	Medically Handicapped Children's Program	direct
Medicaid and Long-Term Care (MLTC)	Children's Health Insurance	indirect
Medicaid and Long-Term Care (MLTC)	Medicaid and LTC	indirect
Medicaid and Long-Term Care (MLTC)	Lifespan Respite Subsidy Program	indirect

Division	Program	Services (Direct and Indirect)
Public Health (PH)	Maternal, Infant and Early Childhood Home Visiting Program	direct
Public Health (PH)	Immunization program	direct & indirect
Public Health (PH)	Nebraska Child Death Review Team	indirect
Public Health (PH)	Pregnancy Risk Assessment Monitoring System (PRAMS):	direct
Public Health (PH)	New born screening	direct
Public Health (PH)	Perinatal child & adolescent health	direct & indirect
Public Health (PH)	Women, Infant, and Children Nutrition Program (WIC)	direct & indirect
Public Health (PH)	Commodity Supplemental Food Program (CSFP)- Administration	direct & indirect
Nebraska Juvenile Service Delivery Project (NJSDP) 2009- 2012	Nebraska Juvenile Service Delivery	direct
Nebraska Juvenile Service Delivery Project (NJSDP) 2012- Current	Nebraska Juvenile Service Delivery	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	The Department of Health & Human Services (DHHS) directly operates three Regional Centers (the funding for Norfolk Sex Offender Treatment is appropriated seperately). The majority of clients served are adults. However, Hastings (HRC) provides PRTF for youth with substance abuse disorders.	direct
Behavioral Health (BH)	Behavioral Health Community Based Service System (children only)	direct
Behavioral Health (BH)	**Region 1- PPP**	**direct**
Behavioral Health (BH)	**Region 2-PPP**	**direct**
Behavioral Health (BH)	**Region 3-PPP**	**direct**
Behavioral Health (BH)	**Region 4-PPP**	**direct**
Behavioral Health (BH)	**Region 5-PPP**	**direct**
Behavioral Health (BH)	*LINCS Program Pilot*	*direct*
Behavioral Health (BH)	**Region 6-PPP**	**direct**
Behavioral Health (BH)	*Rapid Response Professional Partners Pilot*	*direct*
Behavioral Health (BH)	*Adolescent Therapist Addition on the Mobile Crisis Response Team*	*direct*
Behavioral Health (BH)	Nebraska Family Helpline	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	Family Navigator Program	direct
Behavioral Health (BH)	Region 1 Overview of total children served	direct
Behavioral Health (BH)	Region 2 Overview of total children served	direct
Behavioral Health (BH)	Region 3 Overview of total children served	direct
Behavioral Health (BH)	Region 4 Overview of total children served	direct
Behavioral Health (BH)	Region 5 Overview of total children served	direct
Behavioral Health (BH)	Region 6 Overview of total children served	direct
Children & Family Services (CFS)	**Public Assistance**	**direct & indirect**
Children & Family Services (CFS) (under 347)	Aid to dependent children	indirect
Children & Family Services (CFS) (under 347)	Child Care	indirect
Children & Family Services (CFS)	**CFS Administration**	**indirect**
Children & Family Services (CFS)	**Protection & Safety**	**direct & indirect**
Children & Family Services (CFS) (under 265)	Child Welfare (Admin)	indirect
Children & Family Services (CFS)	**Economic Assistance**	**direct & indirect**
Children & Family Services (CFS) (under266)	Food programs	direct & indirect
Children & Family Services (CFS)	**Child Abuse Prevention Fund**	**direct?**
Children & Family Services (CFS)	**Child Welfare**	**direct & indirect**
Children & Family Services (CFS) (under 354)	IV-E Foster Care	direct
Children & Family Services (CFS) (under 354)	IV-E Adoption Assistance	direct
Children & Family Services (CFS) (under 354)	IV-E Guardianship	direct
Children & Family Services (CFS) (under 354)	Subsidized Adoption	direct
Children & Family Services (CFS) (under 354)	Domestic Violence Program	direct
Children & Family Services (CFS) (under 354)	Child Welfare	direct
Children & Family Services (CFS) (under 354)	Education Assistance for State Wards	direct
Children & Family Services (CFS) (under 354)	Adoption and Safe Families	direct
Children & Family Services (CFS) (under 354)	Predisposition Detention	direct
Children & Family Services (CFS) (under 354)	Protection and Safety	direct
Children & Family Services (CFS) (under 354)	Post Adoption/Guardianship/Right-Turn	direct

Division	Program	Services (Direct and Indirect)
Children & Family Services (CFS)	**Office of Juvenile Services**	**direct & indirect**
Children & Family Services (CFS) (under 250)	Juvenile - Community Based	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Geneva	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Kearney	direct
Developmental Disabilities (DD)	Beatrice State Developmental Center	direct
Developmental Disabilities (DD)	Developmental Disabilities Aid	direct & indirect
Medicaid and Long-Term Care (MLTC)	Early Development Network (EDN)	direct
Medicaid and Long-Term Care (MLTC)	Medically Handicapped Children's Program	direct
Medicaid and Long-Term Care (MLTC)	Children's Health Insurance	indirect
Medicaid and Long-Term Care (MLTC)	Medicaid and LTC	indirect
Medicaid and Long-Term Care (MLTC)	Lifespan Respite Subsidy Program	indirect

Division	Program	Services (Direct and Indirect)
Public Health (PH)	Maternal, Infant and Early Childhood Home Visiting Program	direct
Public Health (PH)	Immunization program	direct & indirect
Public Health (PH)	Nebraska Child Death Review Team	indirect
Public Health (PH)	Pregnancy Risk Assessment Monitoring System (PRAMS):	direct
Public Health (PH)	New born screening	direct
Public Health (PH)	Perinatal child & adolescent health	direct & indirect
Public Health (PH)	Women, Infant, and Children Nutrition Program (WIC)	direct & indirect
Public Health (PH)	Commodity Supplemental Food Program (CSFP)- Administration	direct & indirect
Nebraska Juvenile Service Delivery Project (NJSDP) 2009- 2012	Nebraska Juvenile Service Delivery	direct
Nebraska Juvenile Service Delivery Project (NJSDP) 2012- Current	Nebraska Juvenile Service Delivery	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	The Department of Health & Human Services (DHHS) directly operates three Regional Centers (the funding for Norfolk Sex Offender Treatment is appropriated seperately). The majority of clients served are adults. However, Hastings (HRC) provides PRTF for youth with substance abuse disorders.	direct
Behavioral Health (BH)	Behavioral Health Community Based Service System (children only)	direct
Behavioral Health (BH)	**Region 1- PPP**	**direct**
Behavioral Health (BH)	**Region 2-PPP**	**direct**
Behavioral Health (BH)	**Region 3-PPP**	**direct**
Behavioral Health (BH)	**Region 4-PPP**	**direct**
Behavioral Health (BH)	**Region 5-PPP**	**direct**
Behavioral Health (BH)	*LINCS Program Pilot*	*direct*
Behavioral Health (BH)	**Region 6-PPP**	**direct**
Behavioral Health (BH)	*Rapid Response Professional Partners Pilot*	*direct*
Behavioral Health (BH)	*Adolescent Therapist Addition on the Mobile Crisis Response Team*	*direct*
Behavioral Health (BH)	Nebraska Family Helpline	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	Family Navigator Program	direct
Behavioral Health (BH)	Region 1 Overview of total children served	direct
Behavioral Health (BH)	Region 2 Overview of total children served	direct
Behavioral Health (BH)	Region 3 Overview of total children served	direct
Behavioral Health (BH)	Region 4 Overview of total children served	direct
Behavioral Health (BH)	Region 5 Overview of total children served	direct
Behavioral Health (BH)	Region 6 Overview of total children served	direct
Children & Family Services (CFS)	**Public Assistance**	**direct & indirect**
Children & Family Services (CFS) (under 347)	Aid to dependent children	indirect
Children & Family Services (CFS) (under 347)	Child Care	indirect
Children & Family Services (CFS)	**CFS Administration**	**indirect**
Children & Family Services (CFS)	**Protection & Safety**	**direct & indirect**
Children & Family Services (CFS) (under 265)	Child Welfare (Admin)	indirect
Children & Family Services (CFS)	**Economic Assistance**	**direct & indirect**
Children & Family Services (CFS) (under266)	Food programs	direct & indirect
Children & Family Services (CFS)	**Child Abuse Prevention Fund**	**direct?**
Children & Family Services (CFS)	**Child Welfare**	**direct & indirect**
Children & Family Services (CFS) (under 354)	IV-E Foster Care	direct
Children & Family Services (CFS) (under 354)	IV-E Adoption Assistance	direct
Children & Family Services (CFS) (under 354)	IV-E Guardianship	direct
Children & Family Services (CFS) (under 354)	Subsidized Adoption	direct
Children & Family Services (CFS) (under 354)	Domestic Violence Program	direct
Children & Family Services (CFS) (under 354)	Child Welfare	direct
Children & Family Services (CFS) (under 354)	Education Assistance for State Wards	direct
Children & Family Services (CFS) (under 354)	Adoption and Safe Families	direct
Children & Family Services (CFS) (under 354)	Predisposition Detention	direct
Children & Family Services (CFS) (under 354)	Protection and Safety	direct
Children & Family Services (CFS) (under 354)	Post Adoption/Guardianship/Right-Turn	direct

Division	Program	Services (Direct and Indirect)
Children & Family Services (CFS)	**Office of Juvenile Services**	**direct & indirect**
Children & Family Services (CFS) (under 250)	Juvenile - Community Based	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Geneva	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Kearney	direct
Developmental Disabilities (DD)	Beatrice State Developmental Center	direct
Developmental Disabilities (DD)	Developmental Disabilities Aid	direct & indirect
Medicaid and Long-Term Care (MLTC)	Early Development Network (EDN)	direct
Medicaid and Long-Term Care (MLTC)	Medically Handicapped Children's Program	direct
Medicaid and Long-Term Care (MLTC)	Children's Health Insurance	indirect
Medicaid and Long-Term Care (MLTC)	Medicaid and LTC	indirect
Medicaid and Long-Term Care (MLTC)	Lifespan Respite Subsidy Program	indirect

Division	Program	Services (Direct and Indirect)
Public Health (PH)	Maternal, Infant and Early Childhood Home Visiting Program	direct
Public Health (PH)	Immunization program	direct & indirect
Public Health (PH)	Nebraska Child Death Review Team	indirect
Public Health (PH)	Pregnancy Risk Assessment Monitoring System (PRAMS):	direct
Public Health (PH)	New born screening	direct
Public Health (PH)	Perinatal child & adolescent health	direct & indirect
Public Health (PH)	Women, Infant, and Children Nutrition Program (WIC)	direct & indirect
Public Health (PH)	Commodity Supplemental Food Program (CSFP)- Administration	direct & indirect
Nebraska Juvenile Service Delivery Project (NJSDP) 2009- 2012	Nebraska Juvenile Service Delivery	direct
Nebraska Juvenile Service Delivery Project (NJSDP) 2012- Current	Nebraska Juvenile Service Delivery	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	The Department of Health & Human Services (DHHS) directly operates three Regional Centers (the funding for Norfolk Sex Offender Treatment is appropriated seperately). The majority of clients served are adults. However, Hastings (HRC) provides PRTF for youth with substance abuse disorders.	direct
Behavioral Health (BH)	Behavioral Health Community Based Service System (children only)	direct
Behavioral Health (BH)	**Region 1- PPP**	**direct**
Behavioral Health (BH)	**Region 2-PPP**	**direct**
Behavioral Health (BH)	**Region 3-PPP**	**direct**
Behavioral Health (BH)	**Region 4-PPP**	**direct**
Behavioral Health (BH)	**Region 5-PPP**	**direct**
Behavioral Health (BH)	*LINCS Program Pilot*	*direct*
Behavioral Health (BH)	**Region 6-PPP**	**direct**
Behavioral Health (BH)	*Rapid Response Professional Partners Pilot*	*direct*
Behavioral Health (BH)	*Adolescent Therapist Addition on the Mobile Crisis Response Team*	*direct*
Behavioral Health (BH)	Nebraska Family Helpline	direct

Division	Program	Services (Direct and Indirect)
Behavioral Health (BH)	Family Navigator Program	direct
Behavioral Health (BH)	Region 1 Overview of total children served	direct
Behavioral Health (BH)	Region 2 Overview of total children served	direct
Behavioral Health (BH)	Region 3 Overview of total children served	direct
Behavioral Health (BH)	Region 4 Overview of total children served	direct
Behavioral Health (BH)	Region 5 Overview of total children served	direct
Behavioral Health (BH)	Region 6 Overview of total children served	direct
Children & Family Services (CFS)	**Public Assistance**	**direct & indirect**
Children & Family Services (CFS) (under 347)	Aid to dependent children	indirect
Children & Family Services (CFS) (under 347)	Child Care	indirect
Children & Family Services (CFS)	**CFS Administration**	**indirect**
Children & Family Services (CFS)	**Protection & Safety**	**direct & indirect**
Children & Family Services (CFS) (under 265)	Child Welfare (Admin)	indirect
Children & Family Services (CFS)	**Economic Assistance**	**direct & indirect**
Children & Family Services (CFS) (under266)	Food programs	direct & indirect
Children & Family Services (CFS)	**Child Abuse Prevention Fund**	**direct?**
Children & Family Services (CFS)	**Child Welfare**	**direct & indirect**
Children & Family Services (CFS) (under 354)	IV-E Foster Care	direct
Children & Family Services (CFS) (under 354)	IV-E Adoption Assistance	direct
Children & Family Services (CFS) (under 354)	IV-E Guardianship	direct
Children & Family Services (CFS) (under 354)	Subsidized Adoption	direct
Children & Family Services (CFS) (under 354)	Domestic Violence Program	direct
Children & Family Services (CFS) (under 354)	Child Welfare	direct
Children & Family Services (CFS) (under 354)	Education Assistance for State Wards	direct
Children & Family Services (CFS) (under 354)	Adoption and Safe Families	direct
Children & Family Services (CFS) (under 354)	Predisposition Detention	direct
Children & Family Services (CFS) (under 354)	Protection and Safety	direct
Children & Family Services (CFS) (under 354)	Post Adoption/Guardianship/Right-Turn	direct

Division	Program	Services (Direct and Indirect)
Children & Family Services (CFS)	**Office of Juvenile Services**	**direct & indirect**
Children & Family Services (CFS) (under 250)	Juvenile - Community Based	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Geneva	direct
Children & Family Services (CFS) (under 250)	Youth Rehabilitation and Treatment Centers (YRTC)- Kearney	direct
Developmental Disabilities (DD)	Beatrice State Developmental Center	direct
Developmental Disabilities (DD)	Developmental Disabilities Aid	direct & indirect
Medicaid and Long-Term Care (MLTC)	Early Development Network (EDN)	direct
Medicaid and Long-Term Care (MLTC)	Medically Handicapped Children's Program	direct
Medicaid and Long-Term Care (MLTC)	Children's Health Insurance	indirect
Medicaid and Long-Term Care (MLTC)	Medicaid and LTC	indirect
Medicaid and Long-Term Care (MLTC)	Lifespan Respite Subsidy Program	indirect

Division	Program	Services (Direct and Indirect)
Public Health (PH)	Maternal, Infant and Early Childhood Home Visiting Program	direct
Public Health (PH)	Immunization program	direct & indirect
Public Health (PH)	Nebraska Child Death Review Team	indirect
Public Health (PH)	Pregnancy Risk Assessment Monitoring System (PRAMS):	direct
Public Health (PH)	New born screening	direct
Public Health (PH)	Perinatal child & adolescent health	direct & indirect
Public Health (PH)	Women, Infant, and Children Nutrition Program (WIC)	direct & indirect
Public Health (PH)	Commodity Supplemental Food Program (CSFP)- Administration	direct & indirect
Nebraska Juvenile Service Delivery Project (NJSDP) 2009- 2012	Nebraska Juvenile Service Delivery	direct
Nebraska Juvenile Service Delivery Project (NJSDP) 2012- Current	Nebraska Juvenile Service Delivery	direct