NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

June 18, 2026

Mr. Brandon Metzler
Clerk of the Legislature
P.O. Box 94604
Lincoln, NE 68509

Subject: Rural Health Transformation Program Grant Application

Dear Mr. Metzler:

Pursuant to Neb. Rev. Stat. § 81-3147(2), attached is a copy of the Rural Health Transformation Program (RHTP) application submitted by the Department of Health and Human Services on behalf of the State of Nebraska to the Centers for Medicare and Medicaid Services. The RHTP application was authorized by the One Big Beautiful Bill Act, Section 71401 of Public Law 119-21.

Sincerely,

Ashley L Newmyer

Ashley Newmyer
Director, Division of Public Health

Attachment

OMB Number: 4040-0004
Expiration Date: 11/30/2025

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier: Centers for Medicare & Medicai

5b. Federal Award Identifier: CMS-RHT-26-001

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Health & Human Services, Nebraska Department of

* b. Employer/Taxpayer Identification Number (EIN/TIN): 47-0491233

* c. UEI: HKQDEXRXGKL1

d. Address:

* Street1: 301 Centennial Mall South
Street2:
* City: Lincoln
County/Parish:
* State: NE: Nebraska
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 68509-2529

e. Organizational Unit:

Department Name: Health & Human Services

Division Name: Division of Public Health

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:
* First Name: Sara
Middle Name:
* Last Name: Morgan
Suffix:

Title: Deputy Director,Health Promotion & Prevention

Organizational Affiliation:

* Telephone Number: 402-450-6683
Fax Number:

* Email: sara.morgan@nebraska.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Centers for Medicare & Medicaid Services

11. Assistance Listing Number:

93.798

Assistance Listing Title:

Rural Health Transformation Program

*** 12. Funding Opportunity Number:**

CMS-RHT-26-001

* Title:

Rural Health Transformation Program

13. Competition Identification Number:

CMS-RHT-26-001-117822

Title:

Rural Health Transformation Program

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

RHTP – Make Nebraska Healthy Again - Nebraska Department of Health and Human Services (DHHS) will build a prevention-first, tech-enabled sustainable rural health care system.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: 1

* b. Program/Project: 1,2,3

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 12/31/2025

* b. End Date: 09/30/2030

18. Estimated Funding ($):

* a. Federal	1,000,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:

* First Name: Sara

Middle Name:

* Last Name: Morgan

Suffix:

* Title: Deputy Director,Health Promotion & Prevention

* Telephone Number: 402-450-6683

Fax Number:

* Email: sara.morgan@nebraska.gov

* Signature of Authorized Representative: Completed by Grants.gov upon submission.

* Date Signed: Completed by Grants.gov upon submission.

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 06/30/2028

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Assistance Listing Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Rural Health Transformation Program CMS-RHT-26-001	93.798	$	$	$ 200,000,000.00	$	$ 200,000,000.00
2.						
3.						
4.						
5. Totals		$	$	$ 200,000,000.00	$	$ 200,000,000.00

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Prescribed by OMB (Circular A -102) Page 1

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
	Rural Health Transformation Program CMS-RHT-26-001	N/A	N/A	N/A	
a. Personnel	$ 1,529,374.00	$ 1,890,307.00	$ 1,906,374.00	$ 1,953,107.00	$ 7,279,162.00
b. Fringe Benefits	535,281.00	661,607.00	667,231.00	683,588.00	2,547,707.00
c. Travel	105,456.00	104,288.00	104,288.00	104,288.00	418,320.00
d. Equipment	0.00	0.00	0.00	0.00	0.00
e. Supplies	500,000.00	500,000.00	500,000.00	500,000.00	2,000,000.00
f. Contractual	180,262,705.00	176,370,368.00	176,345,423.00	176,272,870.00	709,251,366.00
g. Construction					
h. Other	16,666,667.00	20,000,000.00	20,000,000.00	20,000,000.00	76,666,667.00
i. Total Direct Charges (sum of 6a-6h)	199,599,483.00	199,526,570.00	199,523,316.00	199,513,853.00	$ 798,163,222.00
j. Indirect Charges	400,517.00	473,430.00	476,684.00	486,147.00	$ 1,836,778.00
k. TOTALS (sum of 6i and 6j)	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 800,000,000.00
7. Program Income	$	$	$	$	$

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Rural Health Transformation Program CMS-RHT-26-001	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 200,000,000.00	$	$ 30,000,000.00	$ 85,000,000.00	$ 85,000,000.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 200,000,000.00	$	$ 30,000,000.00	$ 85,000,000.00	$ 85,000,000.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Rural Health Transformation Program CMS-RHT-26-001	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: Other includes Category B, excluded from direct.

22. Indirect Charges: State of Nebraska will charge the de minimis, 15%.

23. Remarks: The State of Nebraska appreciates CMS' recognition that at the time of application submission, we do not have all of the details solidified. Once details are solidified on contractual items, updates can be made as needed to the 424 & Cash Needs.

OMB Number: 4040-0019
Expiration Date: 06/30/2028

Project Abstract Summary

This Project Abstract Summary form must be submitted or the application will be considered incomplete. Ensure the Project Abstract field succinctly describes the project in plain language that the public can understand and use without the full proposal. Use 4,000 characters or less. Do not include personally identifiable, sensitive or proprietary information. Refer to Agency instructions for any additional Project Abstract field requirements. If the application is funded, your project abstract information (as submitted) will be made available to public websites and/or databases including USAspending.gov.

Funding Opportunity Number

CMS-RHT-26-001

Assistance Listing Number(s):

93.798

Applicant Name

Health & Human Services, Nebraska Department of

Descriptive Title of Applicant's Project

RHTP – Make Nebraska Healthy Again - Nebraska Department of Health and Human Services (DHHS) will build a prevention-first, tech-enabled sustainable rural health care system.

Project Abstract

The Rural Health Transformation Program (RHTP) is a once-in-a-generation opportunity to Make Rural Nebraska Healthy Again. Nearly 95% of counties in Nebraska are rural or frontier. Over one-third of Nebraskans live in areas where critical workforce shortages in primary care, obstetrics, and behavioral health persist. Despite Nebraska's agricultural strength, 48 of 93 counties qualify as food deserts and children lack access to healthy foods. Nebraska will leverage RHTP funds to address unique challenges, including obesity amid food deserts, lack of maternal care in a State committed to family values, and an aging rural population. With a proposed annual budget of $200 million, the Nebraska Department of Health and Human Services (DHHS) will build a prevention-first, tech-enabled sustainable rural health care system. The project will prevent chronic disease, regionalize care, and advance Make America Healthy Again priorities. To achieve this vision, DHHS will implement seven integrated initiatives to strengthen the State's rural health infrastructure, address workforce gaps, and ensure access to care through consumer-facing technology. DHHS will partner with health care providers, agriculture and community partners through requests for application (RFA).

1. Make Rural Nebraska Healthy Again through Food as Medicine: Establish statewide infrastructure to improve access to whole foods and lower obesity risk by transforming rural school kitchens, developing regional food hubs to include farmers and ranchers, and introducing nutrition education and fitness programs. Subrecipients include Nebraska Department of Education and University of Nebraska Kearney.
2. Regionalized Rural Access and Navigation: Develop hub and spoke regional networks to ensure rural residents can access care for emergency response, maternal care, post-acute follow-up, preventive care, and other local services. Subrecipients include Local Health Departments (LHD), Tribal Organizations (TO), Nebraska Association of Local Health Departments, Nebraska County Extension Offices, and rural hospitals and clinics.
3. Rural Workforce Acceleration: Address care gaps by recruiting, training, and retaining a resilient workforce that advances whole-person health through the State's "grow local" strategy. Subrecipients include Nebraska Hospital Association (NHA), community colleges, private colleges, University of Nebraska system, and Creighton University as teaching partners ensuring the funding goes to rural Nebraska workforce.
4. eHealth and Mobile: Implement remote care through mobile clinical units, oral health teams, technology-enhanced pharmacy services, and consumer-facing remote patient monitoring. Subrecipients include Nebraska Perinatal Quality Improvement Collaborative, LHD, TO, Creighton University and UNMC School of Dentistry, and Nebraska Enhanced Services Pharmacies.
5. Rural Emergency Behavioral Health: Address behavioral health needs by creating a continuum of care for early intervention and emergency behavioral health and substance use services. Subrecipients include Nebraska Medical Association.
6. Assisted Living Facility (ALF) Special Needs Population Incentive Model: Better serve residents with complex medical, physical, intellectual, and other high-acuity needs through provider add-ons and modernization grants for ALFs.
7. Nebraska Rural Health Technology Catalyst Fund and Partnership Initiative: Improve access, enhance disease management, and strengthen the financial sustainability and workforce capacity of rural providers by investing in high-tech innovations to support critical healthcare gaps in rural communities.

Nebraska's proposal combines evidence-based innovation with deep community partnerships to transform how care is delivered across the state. Through the RHTP, Nebraska will not only improve health outcomes but also revitalize rural economies, empower local providers, and build healthier, more connected communities for generations.

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** Project Narrative.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

Project Narrative

RURAL HEALTH NEEDS AND TARGET POPULATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RURAL HEALTH TRANSFORMATION PLAN: GOALS AND STRATEGIES

STRATEGIC GOALS ALIGNMENT AND PROGRAM KEY PERFORMANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OTHER REQUIRED INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

KEY STAKEHOLDERS:

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

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

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

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

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

PROPOSED INITIATIVE 2: REGIONALIZED RURAL ACCESS AND NAVIGATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

KEY STAKEHOLDERS:

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

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

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

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

PROPOSED INITIATIVE 3: RURAL WORKFORCE ACCELERATION

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

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

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

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

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

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

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

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

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

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

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

KEY STAKEHOLDERS:

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

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

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

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

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

PROPOSED INITIATIVE 4: EHEALTH AND MOBILE ACCESS

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

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

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

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

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

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

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

4.2 Oral Health (Nebraska Teeth Forever (NTF) and Emergency Department Diversion):

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

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

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

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

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

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

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

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

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

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

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

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

KEY STAKEHOLDERS:

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

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

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

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

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

PROPOSED INITIATIVE 5: RURAL EMERGENCY BEHAVIORAL HEALTH

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

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

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

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

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

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

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

KEY STAKEHOLDERS:

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

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

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

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

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

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

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

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

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

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

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

KEY STAKEHOLDERS:

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

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

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

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

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

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

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

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

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

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

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

KEY STAKEHOLDERS:

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

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

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

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

IMPLEMENTATION PLAN AND TIMELINE

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

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

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

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

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

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

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

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

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

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

STAKEHOLDER ENGAGEMENT

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

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

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

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

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

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

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

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

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

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

METRICS AND EVALUATION PLAN

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

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

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

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

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

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

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

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

SUSTAINABILITY PLAN

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

END NOTES

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[59] Project-level funding estimates exclude monitoring and initiative costs, so they may not sum to the total. Please see the Budget Narrative for more detail.
[60] Project-level funding estimates exclude monitoring and initiative costs, so they may not sum to the total. Please see the Budget Narrative for more detail.
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Budget Narrative File(s)

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Budget Narrative

The Nebraska Program Director, Carisa Schweitzer Masek, will dedicate time and effort to managing the Rural Health Transformation Program (RHTP) for the Nebraska Department of Health and Human Services (DHHS). All staff will adhere to 2 CFR Part 200 and 2 CFR Part 300 (effective October 2, 2024), the HHS Grants Policy Statement, federal statutes, and antidiscrimination laws, with these requirements extending to subrecipients and contractors and their subcontractors. In response to the Notice of Funding Opportunity (NOFO), a detailed budget for each cost category, outlining estimated annual expenditures for Budget Periods (BP) 1 – 5, FY 26 – FY 30, is included. Nebraska lowered the administrative cost limit from 10% to 7.5%. Not-To-Exceed calculations are included in Section H. for compliance with unallowable costs.

INITIATIVE COST SUMMARY

Initiative Title	BP 1	BP 2	BP 3	BP 4	BP 5
1. Make Rural Nebraska Healthy Again Through Food as Medicine	$22,000,000	$22,000,000	$22,000,000	$22,000,000	$22,000,000
2. Regionalized Rural Access and Navigation	$58,463,100	$58,431,723	$58,209,892	$58,220,885	$57,932,463
3. Rural Workforce Acceleration	$26,253,702	$26,306,496	$26,242,575	$26,244,468	$26,246,418
4. eHealth and Mobile	$42,668,107	$38,877,592	$39,123,211	$39,049,221	$39,272,711
5. Rural Emergency Behavioral Health	$12,050,000	$12,403,000	$12,400,000	$12,400,000	$12,400,000
6. ALF Special Needs Population Incentive Model	$16,000,000	$19,000,000	$19,000,000	$19,000,000	$19,000,000
7. Nebraska Rural Health Technology Catalyst Fund and Partnership Initiative	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000
Initiatives Total	$197,434,909	$197,018,811	$196,975,678	$196,914,574	$196,851,592
Other State Expenses (unallocated to a specific initiative)	$2,565,091	$2,981,189	$3,024,322	$3,085,426	$3,148,408
Grand Total	$200,000,000	$200,000,000	$200,000,000	$200,000,000	$200,000,000

COST CATEGORY SUMMARY

Category	BP 1	BP 2	BP 3	BP 4	BP 5
Personnel	$1,529,374	$1,890,307	$1,906,374	$1,953,107	$2,001,325
Fringe Benefits	$535,281	$661,607	$667,231	$683,588	$700,464
Travel	$105,456	$104,288	$104,288	$104,288	$104,288
Equipment	$0	$0	$0	$0	$0
Supplies	$500,000	$500,000	$500,000	$500,000	$500,000
Contractual	$180,262,705	$176,370,368	$176,345,423	$176,272,870	$176,198,012
Other	$16,666,667	$20,000,000	$20,000,000	$20,000,000	$20,000,000
Indirect	$400,517	$473,430	$476,684	$486,147	$495,911
Total	$200,000,000	$200,000,000	$200,000,000	$200,000,000	$200,000,000

A. PERSONNEL

Personnel Total							$1,529,374
Grant							$1,529,374
Recipient Share							$0
Initiative	**Position Title**	**Justification**	**Quantity**	**Time**	**Months**	**Annual Salary**	**BP 1 Requested Amount**
All	Principal Investigator/Program Director	Leads all aspects of RHTP – managing operations, coordinating with agencies, overseeing staff and contractors, directing data collection and reporting to CMS, and ensuring the program meets objectives.	1	100%	10	$150,000	$125,000
All	Administrator 2	Supervises day-to-day project execution, milestone tracking, and internal coordination across initiatives.	3	100%	10	$82,755	$206,888
All	Federal Aid Administrator III	Conducts desk reviews and monitoring of subawards; ensures program integrity and compliance; provides technical assistance to subrecipients; supports fiscal and performance oversight.	4	100%	10	$78,000	$260,000
All	Contract Specialists	Drafts and manages procurement documents (Requests for Applications [RFAs], Request for Qualifications [RFQs], Requests for Proposals [RFPs], and contracts); ensures compliance with state and federal procurement rules.	4	100%	10	$63,779	$212,597
All	Implementation Lead	Coordinates implementation across 12 staff; manages timelines, milestones, and communication between project teams and management.	2	100%	10	$71,612	$119,353
2	Health Program Manager I	Oversees contractual efforts; is responsible for the implementation of perinatal regionalization efforts including coordination with agencies, hospitals, clinics, and local health departments; is responsible for evaluating the progress.	1	100%	10	$49,167	$40,973

2	Community Health Worker (CHW) Program Manager I	Oversees the implementation of subawards with each local health department (LHD) and tribal organization (TO) to staff CHWs at each LHD/TO and Nebraska Association of Local Health Directors (NALHD) for Community of Practice and will evaluate the progress of the initiative for internal and CMS reporting.	1	100%	10	$57,033	$47,528
2	EMS Sustainability Coordinator	Oversees regionalization efforts; assists in the coordination of EMS Services, hospitals, clinics, contractors, local officials, and other stakeholders; monitors overall progress and report progress to the Nebraska Office of Emergency Health Systems (OEHS) Program Director.	1	100%	10	$37,920	$31,600
3	DHHS Program Coordinator	Manages rural workforce incentive processes; tracks awards, participants, and service commitments.	2	100%	10	$59,490	$99,150
3	DHHS Program Specialist	Provides administrative, analytical, and reporting support for rural workforce acceleration.	1	100%	10	$49,462	$41,219
3	Program Manager	Coordinates statewide training and skills network; ensures compliance with training and reporting requirements.	1	100%	10	$100,000	$83,333
4	Epidemiologist I	Analyzes rural health data, monitors outcomes, and supports evaluation and reporting. Develops metrics, tracks progress and prepares data visualizations for dashboards.	1	100%	10	$56,118	$46,765
4	Health Program Manager I	Oversee contractual and program activities focused on strengthening the State's oral health infrastructure, coordinating with LHD, universities, tribal organizations, and free clinics.	1	100%	10	$57,228	$47,690
4	Program Coordinator	Identifies community partners, creates subawards, monitors budget and project progress, supports implementation and operations, and provides quality assurance/compliance.	2	100%	10	$50,368	$83,947

5	Program Manager	Supports implementation and operations for behavioral health initiative activities, including scheduling, vendor management, stakeholder communications, and tracking deliverables; assists with grant documentation.	1	100%	10	$100,000	$83,333
Justification: The Program Director will lead Nebraska RHTP, dedicating sufficient time to manage and oversee planning, implementation, monitoring, and contract activities, with all personnel employed by State of Nebraska and responsibilities outlined in the table directly supporting RHTP, capped at a maximum salary of $225,700 with a 3% year-over-year increase reflected in the SF-424. There are no funds to supplant any current staff who will serve RHTP. The interim Program Director, Ms. Masek, will have none of her salary charged to the program, whereas the new Program Director will have their full salary charged.							

B. FRINGE BENEFITS

Fringe Total			**$535,281**
Grant			**$535,281**
Recipient Share			**$0**
Fringe Benefit	**Average NE Rate**	**BP 1 Salary Requested**	**BP 1 Fringe Amount Requested**
Mandatory and Voluntary Benefits	35%	$1,529,374	$535,281

C. TRAVEL

Travel Total					**$105,456**
Grant					**$105,456**
Recipient Share					**0**
Initiative	**Purpose of Travel**	**Location**	**Item**	**Rate**	**BP 1**
1, 2, 3, 4, 5, 6	Initiative Implementation Site Visits	Rural Nebraska	Mileage	$0.70 x 4000 miles x 4 visits per year x 6 Initiatives	$67,200
1, 2, 3, 4, 5, 6	Initiative Implementation Site Visits	Rural Nebraska	Hotel	$110/night x 2 Staff x 5 nights x 4 trips per year x 6 Initiatives	$26,400
1, 2, 3, 4, 5, 6	Initiative Implementation Site Visits	Rural Nebraska	Per Diem	$68/day x 2 Staff x 5 days x 4 trips per year x 6 Initiatives	$8,160
All	CMS RHTP Conference	DC	Airfare	$381/flight x 2 (Roundtrip) x 2 persons	$1,524

All	CMS RHTP Conference	DC	Hotel	$276/night x 2 persons x 3 nights	$1,656
All	CMS RHTP Conference	DC	Per Diem	$70/day x 2 persons x 3 nights	$420
All	CMS RHTP Conference	DC	Ground Transport	$25 x 2 persons x 2 trips	$96

Justification: State staff travel will be essential for effective initiative implementation, standardizing care, sharing best practices, and fostering collaboration with regional partners. Travel costs are limited to State staff, with contractor travel included under the contract category. Travel cost details will be finalized post-award, before incurring costs or drawing funds for subawardees or contractors. The Nebraska State mileage rate is $0.70 per mile, equal to the 2025 General Services Administration (GSA) rate; hotel and per diem are estimated using the GSA rates.

D. EQUIPMENT

Equipment Total			**$ -**
Grant			**$ -**
Recipient Share			**$ -**
Initiative	**Item**	**Rate**	**BP 1**
	No State Equipment		

Justification: The State will prioritize use of grant funds for local and rural partners to purchase equipment, as defined under 2 CFR § 200. No grant funds will be used for State-owned equipment. The State will cover personnel-related equipment, such as printers to support project management. Contractor budgets, including costs for equipment, such as virtual reality (VR) equipment, are not yet separated but will be clarified post-award, before incurring costs or drawing funds. All IT equipment and systems will be tagged, recorded in an equipment/technology database, and categorized based on nature, cost, and useful life. The State will ensure accountability through regular financial reporting and audits to verify funds are used appropriately and align with program goals.

E. SUPPLIES

Supplies Total			**$500,000**
Grant			**$500,000**
Recipient Share			**0**
Initiative	**Item**	**Rate**	**BP 1**
2	Regional rural supplies for Initiative 2	$500,000	$500,000

Justification: The State will prioritize use of grant funds for local and rural partners to purchase supplies, as defined under 2 CFR § 200. The State will cover personnel-related supplies, such as personal computers for program staff, to support project management. Contractor budgets, including costs for supplies, like medical supplies, are not yet separated but will be clarified post-award, before incurring costs or drawing funds. All IT equipment and systems will be tagged, recorded in an equipment/technology database, and categorized based on nature, cost, and useful life. The State will ensure accountability through regular financial reporting and audits to verify funds are used appropriately and align with program goals.

F. CONSULTANT/SUBRECIPIENT/CONTRACTUAL COSTS

Contracts Summary

Initiative	Itemized Budget Contract	BP 1	BP 2	BP 3	BP 4	BP 5
1	1.1 School Kitchen Modernization Grants	$2,500,000	$2,500,000	$2,500,000	$2,500,000	$2,500,000
1	1.2 Regional Food Pantry Development	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000
1	1.3 Farm-to-School Procurement and Policy Technical Assistance	$8,500,000	$8,500,000	$8,500,000	$8,500,000	$8,500,000
1	1.4 Healthy Menu Design & Culinary Workforce Training	$500,000	$500,000	$500,000	$500,000	$500,000
1	1.5 Nebraska Kids Fitness and Nutrition Day Expansion	$500,000	$500,000	$500,000	$500,000	$500,000
2	2.1 EMS and Perinatal Regionalization	$4,000,000	$4,000,000	$4,000,000	$4,000,000	$4,000,000
2	2.2a Community Paramedicine Regionalization	$11,000,000	$11,000,000	$11,000,000	$11,000,000	$11,000,000
2	2.2b ImageTrend Expansion for Paramedicine	$103,000	$93,280	$98,877	$104,809	$111,098
2	2.3a Rural Health Hubs and Community Health Worker (CHW) Network	$16,320,000	$16,320,000	$16,320,000	$16,320,000	$16,320,000
2	2.3b Rural Health Hubs – Regional Coordination	$13,000,000	$13,000,000	$13,000,000	$13,000,000	$13,000,000
2	2.4 Veteran Electronic Health Report (EHR) Coordination	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
2	2.5 Critical Access Hospital (CAH) to Rural Emergency Hospital (REH) Conversion	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000
2	Implementation, Evaluation, Continuous Improvement, and ROI	$530,000	$530,000	$530,000	$530,000	$530,000
2	Regionalization Services	$890,000	$840,000	$590,000	$590,000	$290,000
3	3.1 Rural Provider Recruitment and Retention Incentive Program & 2.3 Rural Health Hubs and Statewide CHW Network	$17,680,000	$17,680,000	$17,680,000	$17,680,000	$17,680,000
3	3.2 Rural Virtual Training & Skills Acceleration Network	$4,800,000	$4,800,000	$4,800,000	$4,800,000	$4,800,000
3	3.3 Rural Health Care Workforce Incentive and Sustainability Model	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
3	3.4 School-Age Health Care Pipeline	$500,000	$500,000	$500,000	$500,000	$500,000
3	3.5 Short-Term Subsidized Housing	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
3	Oversight and Monitoring Consultant	$50,000	$50,000	$50,000	$50,000	$50,000
4	4.1a Mobile Maternal Care and Training	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
4	4.1b OB Readiness and Training	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
4	4.2a Oral Health - Mobile Expansion	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
4	4.2b Oral Health - Workforce Expansion	$2,500,000	$2,500,000	$2,500,000	$2,500,000	$2,500,000
4	4.2c Oral Health - Evaluation	$85,833	$107,500	$107,500	$107,500	$107,500
4	4.3 Technology Enhanced Pharmacy Services	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000

4	4.4 Chronic Disease Management / Remote Patient Monitoring	$26,903,872	$23,049,588	$23,269,046	$23,190,561	$23,409,414
5	5.1 Integrated Primary Care Sites	$1,500,000	$1,500,000	$1,500,000	$1,500,000	$1,500,000
5	5.2 Telehealth Crisis Responders for Law Enforcement Law Enforcement Crisis Response Network	$4,000,000	$4,000,000	$4,000,000	$4,000,000	$4,000,000
5	5.3 Modification of Existing Clinical Facilities for Mental Health Crisis Stabilization Centers	$4,500,000	$4,500,000	$4,500,000	$4,500,000	$4,500,000
5	5.4a Behavioral Health Nursing Homes Grants	$250,000	$250,000	$250,000	$250,000	$250,000
5	Crisis Stabilization Implementation, Evaluation, and Continuous Improvement	$50,000	$50,000	$50,000	$50,000	$50,000
6	6.2 Facility Modernization Grants	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
7	Nebraska Rural Health Technology Catalyst Fund and Partnership Initiative	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000
1, 4, 6	Strategic Oversight: Implementation, Evaluation, and Continuous Improvement	$600,000	$600,000	$600,000	$600,000	$600,000
Total		$180,262,705	$176,370,368	$176,345,423	$176,272,870	$176,198,012

Justification: The State has established a streamlined framework to deploy grant funds to rural communities through consultants, subrecipients/subawardees, and contracts. This approach will maximize impact, incentivize cost-effectiveness, and scale initiatives based on final awards if approved. Contract terms will outline the selection process, criteria, locations, timelines, outcomes, deliverables, services, purchases, evaluations, sustainability goals, and recoupment or withholding clauses for non-compliance, ensuring alignment with State milestones and federal regulations including 2 CFR Parts 200 and 300. Compliance will be monitored through site visits, data collection, scheduled financial and outcome reporting, by the Contract Oversight Team (COT). The COT, comprising financial, implementation, and contract specialists, will monitor performance and require quarterly, semiannual, annual, or ad-hoc check-ins to ensure alignment and progress towards State outcomes and goals. Monitoring frequency for awards varies based on amount, with the highest awards receiving quarterly reviews determined by risk stratification. Accountability will include annual reporting integrated for the State annual report, including budget, milestones, and outcomes. Period of performance for contractors will start between January 2026 – September 2026. Performance will extend through the duration of the grant. Each awardee's budget will be itemized by cost category. All IT equipment and systems will be recorded in an equipment/technology database. Budget and cost details will be finalized with CMS post-award, before incurring costs or drawing funds for subawardees or contractors. Direct and Indirect cost requirements and compliance will be monitored for each subawardee.
*Due to space limitations, please find additional detail on the Scopes of Work in the Budget Narrative Appendix in the Other Supporting Documentation section.

Consultant Hiring

Initiative and Item	Nature of Services	Relevance of Service to the Project	Days, Compensation Rate, & Justification	Method of Accountability

Initiative 3: Oversight and Monitoring Consultant	Consultant will oversee the strategic development, implementation, monitoring, and sustainability transition of all activities in this initiative. Rural workforce is the critical foundation to our long-term successful transformation.	In order to spur innovation and sustainability, a consultant will bring a strategic perspective to the interworking of the layered implementation of local partnerships, resulting in growing the supply side of our rural health care and technology workforce (E).	• Number of days: 1,825 • Rate: $200.00 • Consultant rates in our market range between $100 - $150	Consultant's work will be a deliverables based contract requiring reports directly tied to milestones, outcomes, sustainability.

Subrecipients/Subawardees

Subrecipient (if known)	Scope of Work & Use of Funds Category	Method of Accountability	Justification
Initiative 1.1 School Kitchen Modernization Grants			
Subrecipient Selection through RFA	DHHS will oversee the RFA and partner with the Nebraska Department of Education, with centralized oversight of schools. Funding will provide Rural Schools, School Districts, or Educational Services Units funding to purchase new equipment necessary to support the expansion or scale of healthy lunch options (A). Each subwardee may receive up to $100,000 annually for equipment, such as scratch-cook equipment, blast chillers, salad bars, refrigeration, and green house equipment to increase access and use of fresh foods and healthy options. No funding will be used for modifications or the replacement of equipment.	Contractual monitoring and evaluation of equipment or supplies purchased will be reviewed to monitor for market-competitive pricing and the use of equipment to provide healthy food and reduce use of processed foods.	87% of Nebraska's school districts are rural. This is open to all rural schools. Each rural qualifying school will be capped at $100,000 annually, estimated based on equipment costs. This initiative is scalable. Impacted cost categories will include equipment and supplies only.
Initiative 1.3 Farm-to-School Procurement & Policy Technical Assistance			
Subrecipient Selection through RFA	An organization, such as a cooperative with infrastructure and knowledge, will work in rural and frontier counties or food deserts to provide funding and technical assistance to local farmers, ranchers, producers, cooperatives, and food suppliers to purchase equipment to develop kitchen-ready local foods, to enhance supply chains for rural school and health care facilities, and to promote healthy eating and chronic disease management (A, D). Subawardee(s) will work collaboratively to form a Statewide School Food Learning Lab (SSFLL) to provide technical assistance to rural school districts on bids, contracts and menu cycles for local sourcing food, including working with USDA requirements. Outcomes include the formation of the SSFLL, number of technical assistance workshops for producers, use of funds to enhance producer	Contractual monitoring and evaluation of reporting on outcomes will be conducted semiannually by the COT to ensure progress and scale. COT will evaluate locations served, local purchasing rates, nutritional quality of menus, and student participation trends in its implementation of the SSFLL.	This initiative is scalable. We estimate over 40 local partners per year at $150,000. Impacted cost categories will include personnel, fringe, travel, equipment, supplies, and contractual, and indirect.

	abilities, digital marketplace, number of rural schools utilizing local producers, and evaluation of missing suppliers and targets for inclusion for the utilization of local food solutions.		
Initiative 1.4 Healthy Menu Design & Culinary Workforce Training			
Nebraska Department of Education (NDE)	NDE, with centralized oversight of schools and the ability to target rural and frontier areas, will work with the University of Nebraska-Lincoln Extension, the Metropolitan Community College Institute for Culinary Arts, and the Great Plains Culinary Institute to develop and scale trainings for rural cafeteria and hospital staff and clinic dietitians to receive certification in healthy, scratch-cooking techniques and chronic disease prevention menu design (A). Outcomes include number staff trained and certified.	Contractual monitoring and evaluation of reporting on the training design, locations, certifications, and a continuous learning feedback loop over the life of the program to measure progress and scale.	This initiative is scalable. Impacted cost categories will include personnel, fringe, travel, supplies, and indirect.
Initiative 1.5 Nebraska Kids Fitness and Nutrition Day			
University of Nebraska Kearney (UNK)	With their current evidence-based program, UNK will design, scale, and deliver fitness and nutrition education focusing on health literacy and healthy behaviors for children in rural schools. Funding will pay for interactive educational events that teach children about nutrition, physical activity, and wellness through hands-on activities, fitness demonstrations, and nutrition sessions. Developed programs will be self-sustainable (A). Outcomes include number of rural students and school districts engaged annually as well as survey results to measure need and impact.	Contractual monitoring and evaluation of reporting on the evidence-based prevention initiative will be conducted by the COT to ensure progress and scale.	This initiative is scalable. Impacted cost categories will include personnel, fringe, travel, supplies, and indirect.
Initiative 2.2a Community Paramedicine Regionalization*			
Subrecipients through an RFA	Regional lead agencies will be selected to develop a rural Community Paramedicine Regionalization model through collaborative needs and supply assessments, asset reallocation, affiliation agreements, technical assistance for patient retention, billing support, workforce development, VR training, standardized care protocols, regional supply management, and technology integration, supported by shared purchasing and governance with physician medical directors and legal/regulatory experts (C, D, F, G, K).	Each award will include a regional lead agency to coordinate model development, reporting, and annual progress reports. COT will monitor and review progress with regional leads through quarterly reporting. EMS Sustainability Coordinator will conduct check-ins for progress, potential for shared best practices, and other fail fast or quality reviews which can improve performance wholistically.	Parts of this initiative are scalable. We have designed this with a full statewide implementation with local governance and control. We plan for up to 22 lead agencies to receive approximately $500,000. We expect to have at least 100 more Community Paramedics trained by 2030. Impacted cost categories will include personnel, fringe, travel, equipment, contract, supplies, other, and indirect.

Initiative 2.3a Rural Health Hubs and Community Health Worker (CHW) Network			
LHDs, Tribal Organizations, NALHD, Ag Extension Offices, Rural Hospitals and Clinics	LHDs, tribal organizations, NALHD, UNL Extension offices, rural hospitals and clinics, selected as subawardees for their collaborative leadership and rural presence, will receive funding based on need and lack of access to deploy CHWs for chronic disease prevention, care coordination, oral health, and maternal/child health (A, C, D, E, F, G, H, I, K); recruiting and training CHWs; supporting remote patient monitoring (RPM) technology; and making minimal modifications to embed CHWs, such as piloting a market-ready tech-enabled care station for ambulatory visits within a tribal community. Subawardees will provide technical assistance to optimize payer mechanisms, establish a statewide CHW Community of Practice for quarterly collaboration and specialized training.	Contractual monitoring and evaluation of each subawardee will include semi-annual financial reporting for expenses and reporting on outcomes from CHWs within their system of care. COT will evaluate the number of hospitals with active MOU/BAA agreements with subawardees.	This initiative is scalable. We plan for at least 230 CHWs, each $50,000. We have designed this with a full statewide implementation with local control by organizations which will employ the CHWs. Other costs include the On-Med pilot and payer readiness for sustainability. Impacted cost categories will include personnel, fringe, travel, equipment, supplies, contract, other, and indirect.
Initiative 2.3b Rural Health Hubs – Regional Collaboration			
Subrecipients through an RFA	A non-lobbying nonprofit, representing diverse health care associations, will create regional governance structures to build a patient referral hub across the care continuum; analyze data for operational efficiencies; identify group purchasing opportunities – including a shared mobile imaging unit; and strengthen cybersecurity capabilities (D, F, K). Outcomes include collaboration across provider types, regional coordination of care, and systematic evolution from IT advancements.	Contractual monitoring and evaluation of each subawardee will include semi-annual financial reporting for expenses and reporting on outcomes from the RCG.	This initiative is scalable. We expect $1.5M for governance, $4.5M for care analytics, $4M for a mobile imaging PET/CT, and $3 million for cybersecurity. Impacted cost categories will include personnel, fringe, travel, equipment, supplies, contract, other, and indirect.
Initiative 2.4 Veteran EHR Coordination			
Subrecipients through an RFA	Rural CAHs, Rural Health Clinics (RHCs), and other providers in rural and frontier counties (verified rural health facilities without EPS) will be awarded funds to integrate the External Provider Scheduling (EPS) system with their EHR, enabling seamless scheduling and improved care coordination for Veterans (F). This initiative will reduce appointment wait times, enhance continuity of care, increase VA reimbursements for rural providers, and ensure Veterans in rural and frontier counties access high-quality, timely care comparable to urban centers.	COT will monitor and track progress with each facility awarded funds to implement, train, and track usage of EPS by VA patients. COT will engage with the VA as needed to ensure successful integration.	This initiative is scalable based on funding. Assumptions are for up to 72 facilities in rural and frontier counties identified as needing EPS. With fewer funds, we will have to add additional criteria for subawardee selection like proximity to health care or geographic isolation. Impacted cost categories will include equipment, supplies, contract, and other categories.
Initiative 2.5 Critical Access Hospital (CAH) to Rural Emergency Hospital (REH) Conversion			

Subrecipients through an RFA	Up to ten at-risk CAHs will receive funding to convert to REHs through planning, technical assistance on billing, subleasing, and virtual care, and facility modifications for telehealth clinics, behavioral health crisis units, RPM stations, or skilled nursing spaces (D, F, H, J), collaborating with the Nebraska Hospital Association, Nebraska Rural Hospital Association, and payers to ensure compliance, reimbursement readiness, and long-term financial viability, while preserving essential emergency, outpatient, and preventive services to prevent closures and rural care deserts.	Contractual monitoring and evaluation of each subawardee will include semi-annual financial reporting for expenses and reporting on milestones planned for the transition from CAH to REH. Annual reports from subawardees will include information and updates on solvency, pre and post conversion.	This initiative is scalable based on funding. Assumptions are for up to 10 CAHs to convert to REHs. Fewer conversions could be funded with the risk of closures for those facing insolvency. Additional criteria to limit the use of funds could reduce awards. Impacted cost categories include personnel, fringe, equipment, supplies, contract, other, and indirect categories. Included in Capital Cap.
Initiative 3.3 Rural Health Care Workforce Incentive and Sustainability Model			
Subrecipients through an RFA	Non-profit, community college, and employer subawardees will be provided start-up grants to become new SNAP employment and Training Third Party Partners who will provide career guidance case management, training opportunities, apprenticeships and other career services for health care careers in Nebraska's high-need rural areas (E). Subawardees will use a braided funding model (Workforce Innovation and Opportunity Act, TANF, and SNAP E&T 50/50) to provide supportive services.	COT will meet quarterly with subawardee(s) for quality and financial monitoring. Targets will be developed participants served, employment gained, participants entering the health care workforce, participants retaining employment in health care career pathway programming, and ways to monitor geographic reach.	This initiative is scalable based on funding. Each subawardee will partner with other organizations to stretch dollars and scale for sustainability. Cost categories will include personnel, fringe, equipment, supplies, contract, and other. Included in Capital Cap.
Initiative 3.4 School-Age Health Care Pipeline			
University of Nebraska Medical Center (UNMC), University of Nebraska at Omaha (UNO), and Health Care Heros League	Subawardees have been selected based upon the platform they have already created. The award will require them to expand and scale their platform with a focus on rural health workforce development (E, F, G). Outcomes will include an expansion of modules and free trainings for teachers, facilities, and communities seeking to expand their health care workforce.	COT will meet annually with subawardees to discuss their annual reporting on RHTP outcomes as well as conduct financial and quality monitoring of performance.	This initiative is scalable based on funding. Impacted cost categories will include personnel, fringe, equipment, other, and indirect categories.
Initiative 3.5 Short-Term Subsidized Housing			
Subrecipient through an RFA	A non-lobbying nonprofit will have programmatic oversight of funds that can be distributed for short-term housing in rural areas where provider recruitment requires housing assistance (E, G, J, K). Subawardee will establish programmatic criteria for health systems seeking to use funds, including requiring a	COT will meet annually with subawardee to discuss their annual reporting on RHTP outcomes as well as conduct financial and quality monitoring of performance.	We plan for awards to fund short-term housing. This initiative is scalable based on funding. Impacted cost categories will include

	minimum service commitment in a designated rural facility and local hospital/clinic sponsorship. Long-term maintenance is sustained by local philanthropic partners post-agreement.		personnel, fringe, equipment, other, and indirect categories. Included in Capital Cap.
Initiative 4.1a Mobile Maternal Care and Training*			
Subrecipient through an RFA	A subawardee, selected for leadership in local and statewide maternal care transformation, will deploy three mobile clinics, expanding to six, to provide prenatal/postpartum care, pregnancy confirmation, fetal monitoring, ultrasound, STI screening, immunizations, health education, and referrals in Nebraska's maternity care deserts (D, F, G, J, K).	Subrecipient will be monitored on a quarterly basis so the COT can assist with financial and quality monitoring. Subject Matter Experts will be included to ensure reach and impact are achieved.	We estimate each mobile unit is $1.5M plus ongoing staff training and some operations costs. This initiative is scalable based on funding. Impacted cost categories will include personnel, fringe, equipment, supplies, contract, other, and indirect categories. Included in Capital Cap.
Initiative 4.1b OB Readiness and Training*			
Nebraska Perinatal Quality Improvement Collaborative	The subawardee, selected as Nebraska's statewide perinatal quality improvement experts with birthing facility members and proven success in reducing maternal and infant morbidity/mortality, will deliver assessments, training, support plans, and a multi-modal strategy to strengthen maternal care deserts (A, D, G).	Subawardee will be monitored on an annual basis so the COT can monitor financial, quality, outcomes, and coordination with other contractors.	This initiative is not scalable. Impacted cost categories will include personnel, fringe, other, and indirect categories.
Initiative 4.2a Oral Health Nebraska Teeth Forever (NTF) and Emergency Department Diversion – Mobile Expansion*			
LHDs and Tribal Organizations	Selected rural LHDs and tribal organizations will receive subawards based on oral health needs, rurality, and local priorities to expand oral health prevention teams, access point expansion, including a mobile dental unit, dental education/rotation programs, and other programs, aligning with State outcomes (A, D, E, F, G, J, K).	Subrecipient will be monitored on a quarterly basis so the COT can assist with financial and quality monitoring. Subject Matter Experts will be included to ensure reach and impact are achieved.	We estimate 17 LHDs and TOs will receive up to $170,000 each and the mobile unit is $1.2M. Dental carts are $40,000 each. This initiative is scalable based on funding. Impacted cost categories will include personnel, fringe, equipment, supplies, contract, other, and indirect categories. Included in Capital Cap.
Initiative 4.2b Oral Health NTF and Emergency Department Diversion – Workforce Expansion*			

Creighton University School of Dentistry, UNMC	The subawardees will expand Nebraska's rural dental workforce by integrating student rotations into LHD teams to deliver preventive services (exams, cleanings, sealants, x-rays, and urgent procedures like extractions) in underserved areas, collaborating with tribal organizations for co-designed prevention services and facility upgrades, while partnering with clinics on infection prevention, antimicrobial stewardship, and tracking outcomes for student rotations and clinical services (E).	Subawardees will be monitored on an annual basis so the COT can assist with financial and quality monitoring. Monitoring will also include progress to outcomes and coordination subrecipients on the larger rural Oral Health initiative.	This initiative is scalable based on funding. If funding reduced, subrecipients may be reduced as well as the services and trainings for rural communities. Impacted cost categories will include personnel, fringe, equipment, supplies, other, and indirect categories.
Initiative 4.3 Technology Enhanced Pharmacy Services*			
Nebraska Enhanced Services Pharmacies (NESP)	As a subawardee, the Nebraska Enhanced Services Pharmacies (NESP) network will strengthen rural pharmacy services by developing a mobile app for monthly medication reviews, patient adherence, and AI-driven risk assessments, connecting patients to RPM technologies like blood pressure monitors and glucose tracker (A, C, D, I, K).	COT will meet annually with NESP to monitor financial and deliverable progress, including the number of pharmacies and patients. Collaboration with other stakeholders will be monitored to ensure the data is being used to inform programmatic decisions.	This initiative is scalable. We plan for 30 pharmacies per year, including training and technical assistance as well as $1.5M for 36,000 patient contacts per year. Impacted cost categories will include travel, equipment, contract, and other categories.
Initiative 4.4 Chronic Disease Management / Remote Patient Monitoring*			
Subrecipient through an RFA	A contractor or non-profit entity will design and execute a comprehensive strategy to support independent providers, rural clinics, rural hospitals, and regionalized health partners design consumer-facing technology strategies across rural providers, including hospital systems, independent providers, FQHCs, and CCBHCs (C, D, F, I, K). Evaluation criteria will include ensuring seamless data sharing, enhancing rural health care through standardized protocols, staff training, RPM kits, telehealth hubs, AI-assisted wearables, consumer-oriented health technology, health information exchange (HIE) interoperability, CHW-supported chronic disease management, with outcomes tracked for reduced readmissions and increased HIE usage, and partnership with innovations from the Rural Health Catalyst Fund. RFAs will be accepted that deploy implementation ready solutions. This emersion across the community, from hospital to home, will transform what rural health care looks like in a meaningful and innovative way. For patients seen in an FQHC or CCBHC, care management will include technology-supported risk stratified reporting tools to identify which patients are at highest risk for negative health outcomes. This innovative care model will deliver seamless	COT, with subject matter experts, will monitor financial and work progress toward outcomes and deliverables through quarterly activities reports. Upon award, a timeline and deliverables schedule will inform work and scale of work into rural areas. Monitoring will include site, expansion, and scale to reach rural Nebraska. Various stakeholders, like the statewide HIE, will be brought in for continuous monitoring for maximum results.	We estimate Chronic Disease Management at $4 million, consumer-facing solutions and platform connectivity at $14 million, and hospital adoption of technology solutions, like robotics, is $8 million. This initiative is scalable. However, it seeks to be a cohesive approach to immerse rural communities in consumer-facing tech solutions, train patients and staff, and integrate technology. Impacted cost categories will include personnel, fringe, equipment, supplies, contract, other, and indirect.

	interoperability, increased HIE utilization, targeted IT training, education for clinicians and patients, deployment and adoption of RPM, streamlined referrals to CBOs, and comprehensive patient management tracking.		
Initiative 5.1 Integrated Primary Care Sites*			
Nebraska Medical Association (NMA)	NMA, as a subawardee, will incentivize rural, independent primary care clinics to integrate behavioral health services, like screenings and therapists, (E, G, H, J, K) by providing startup funds, systems redesign, minor renovations, clinician recruitment/retention, virtual/e-health solutions, billing technical assistance, and sustainability planning, with outcomes tracked through clinic recruitment, resource deployment, progress monitoring, and State reporting to enhance access to co-located behavioral health and primary care in rural areas.	COT will meet semi-annually with NMA to monitor financial and outcomes progress. This will include a dashboard for annual tracking including number of clinics recruited and established and utilization of integrated experts from DHHS will provide technical assistance and oversight as needed.	We plan for up to $100,000 per clinic per year. This initiative is scalable. Impacted cost categories will include travel, equipment, contract, and other. Start-up or seed funding will be used for systems, integration, staff, and changes needed to support co-location of behavioral health services. Included in Capital Cap.

Contracts

Contractor (if known) & Selection Method	Scope of Work & Use of Funds	Method of Accountability	Justification
Initiative 1.2 Regional Food Pantry Development			
Selection Method: RFA	We expect to fund over 120 partners, including non-profit organizations and co-ops with direct equipment expenses to enhance infrastructures to support food pantries and promote healthy foods options in rural areas. Where necessary "last-mile" logistics systems will be used to strengthen healthy, local food solutions (A). Minor modifications will be considered (J). Outcomes include healthy food stored & distributed, households served, volunteer coordination, staffing coordination, training, safety of the location for clients and staff, food safety, and nutrition education and training. No food will be purchased.	Contractual monitoring and evaluation of financial reporting on expenses and reporting on outcomes will be conducted by the COT to ensure progress and scale. COT will evaluate expenses for compliance as well as access sites to healthy food solutions.	We expect over 120 partners to participate annually, up to $80,000. This initiative is scalable. Impacted cost categories will include personnel, fringe, travel, equipment, supplies, and contractual, and indirect. Included in Capital Cap.
Initiative 2.1 EMS and Perinatal Regionalization			
Selection Method: RFA	The RFA will fund a regionalized maternal and neonatal care network by standardizing levels of care, formalizing referral pathways, and piloting a Maternal-Fetal Medicine (MFM)–Rural Provider Pairing Program to enable rural providers to co-manage high-risk pregnancies via secure teleconsultation. The initiative includes updating EMS	COT, with SMEs, will monitor financial reporting and progress toward outcomes through semi-annual reporting and monitoring activities including data	We estimate start-up costs for OB transport will be $3 million. Other costs include recruitment for rural midwives and APPs.

Contractor (if known) & Selection Method	Scope of Work & Use of Funds	Method of Accountability	Justification
	training with obstetric and neonatal content, advanced obstetric and neonatal training in person and virtual, piloting a high-risk transport system along I-80 with dedicated equipment and an on-call MFM consult line, and recruiting Certified Nurse Midwives and advanced practice clinicians to expand services in maternity-desert counties (A, D, E, F, G, K). Deliverables and outcomes will measure newly trained staff and availability of specialized trained staff across the State.	aggregation, analysis, quality improvement and best practice evaluations, learning collaboratives, and pilot evaluation.	This initiative is not scalable. The design supports the regionalized rural access model with a focus on EMS and Perinatal care. Cost categories will include personnel, fringe, travel, equipment, supplies, contract, other, and indirect. Included in Capital Cap.
Initiative 2.2b ImageTrend Expansion for Paramedicine			
Contractor: ImageTrend, LLC Selection Method: Contract Amendment	New service ability will be added to the current contract with ImageTrend, LLC. The amendment will add the ability to document critical care paramedic patient care reports and community paramedicine patient encounters (F). Enhancements will allow the collection of data for the Community Paramedicine Regionalization to support program evaluation, patient outcomes, and program effectiveness (F).	COT and the current contract management team will monitor financial compliance and implementation tracking reports from ImageTrend on a semi-annual basis.	This initiative is not scalable. Impacted cost categories will include equipment, supplies, contract, other, and indirect.
Initiative 2 Regionalization Services			
Selection Method: RFA	The contractor will bid on delivering targeted technical assistance by mapping regionalization best practices, plans, pitfalls, and quality reviews to support EMS regions in implementing collaborative efforts and achieving streamlined administration (G). Contractor will provide ongoing resources for establishing and executing regionalization, while hosting five-day intensive leadership training for existing and new EMS leaders to address issues and boost program outcomes. Deliverables will include assessments, reviews, hosting and planning learning collaborative events, and leadership development to strengthen local and regional EMS strategic partnerships.	Contractual monitoring and evaluation of financial reporting for expenses and reporting on deliverables will be conducted by the COT annually. COT will evaluate expenses for compliance, activity reports for engagement with regionalization lead agencies, and deliverables as specified in the contract.	This initiative is not scalable. Impacted cost categories will include personnel, fringe, travel, equipment, supplies, and contractual, and indirect.
Initiative 2 Implementation, Evaluation, Continuous Improvement, and ROI			
Contract through Inter-Agency Agreement with UNMC	DHHS will contract for consulting, evaluation services, and economic impact for Regionalization Initiatives (G). Timeline will include mid-grant evaluations and recommendations for progress and improvement toward State goals. Deliverables will include implementation guides,	COT, with subject matter experts, will monitor progress toward deliverables through annual reporting and monitoring	This initiative is not scalable. Impacted cost categories will include personnel, fringe, other, and indirect.

Contractor (if known) & Selection Method	Scope of Work & Use of Funds	Method of Accountability	Justification
	health impact, economic impact, return on investment, and rural economic impact.	activities reports based on findings each year.	
Initiative 3.1 Rural Provider Recruitment and Retention Incentive Program & 2.3b Rural Health Hubs and Statewide CHW Network*			
Selection Method: RFA	Awards will be issued to individuals for incentives, retention bonus funding, apprenticeships, and training to support health care careers in rural and remote areas of Nebraska with the highest need for access (E). Funding will be distributed over the 5 years, to facilitate employment and location checks, and will be tied to a requirement for 5-year service commitments and recoupments subject to fulfillment.	COT will meet semiannual with the team reviewing and awarding funds for quality and financial monitoring. Targets will be developed for incentives and ways to monitor physical location of workforce in rural and remote areas.	We will disperse up to $75,000 per individual per year, estimating 235 individuals awarded per year. This initiative is scalable based on funding. Impacted cost categories will include other.
Initiative 3.2 Rural Virtual Training & Skills Acceleration Network			
Inter-Agency Agreement or RFA	Contractor(s) will be institution(s) of higher education with the capacity to outfit and to operate rural VR training for OB and EMS including through virtual reality exercises (D, K). Minor modifications will be considered (J). The contract will require competency-based training as well as exam pass rates and skills readiness for serving in rural areas.	COT will meet quarterly for outcome and financial monitoring. Specifically, deployment into rural areas will be tracked as well as the number of trainings and those that show competency and readiness for based on trainings.	This initiative is scalable based on funding. Assumptions include an enterprise VR network, trainings held, and certifications. Impacted cost categories will include personnel, fringe, travel, equipment, supplies, contract, other, and indirect categories. Included in Capital Cap.
Initiative 4.2c Oral Health NTF and Emergency Department Diversion – Evaluation*			
Inter-Agency Agreement: UNMC	The College of Public Health at UNMC will leverage academic expertise to assist with evaluation of initiative activities. These include monitoring health care workforce distribution, specialties, and retention in rural Nebraska, integrating data with the statewide HIE, and delivering evaluation reports, a workforce tracking database, and policy briefs to address service gaps, enhance health equity, and guide sustainable workforce planning (A, D, E).	COT will meet annually with UNMC to monitor financial and deliverable progress. Collaboration with other stakeholders will be monitored to ensure the data is being used to inform programmatic decisions.	This initiative is not scalable. Impacted cost categories will include personnel, fringe, other, and indirect categories.
Initiative 5.2 Telehealth Crisis Responders for Law Enforcement*			
Selection Method: RFP	Through an RFP, the awardee will develop a telehealth-based crisis response platform (D, E, F, H, K) integrating with the 988 lifeline,	COT will monitor financial and outcomes progress through	Technology is not scalable to Rural Nebraska Law

	connecting rural Nebraska law enforcement with 24/7 mobile crisis providers via a mobile app, alongside Crisis Intervention Team training, to enhance de-escalation, divert individuals from jails/ERs, and deliver a functional app, training modules, implementation guides, and evaluation reports on utilization and diversion outcomes.	quarterly reporting and coordination with SMEs, law enforcement, and CCBHC stakeholders to ensure equitable access and sustainable mental health crisis response in rural and frontier areas.	Enforcement. To prepare for the RFP, we used current vendor pricing to estimate total costs for developing, launching, training, and expanding services of the shared mobile diagnostic imaging unit. Trainings are scalable. Impacted cost categories will include personnel, fringe, travel, equipment, supplies, contract, other, and indirect.
Initiative 5.3 Modification of Existing Clinical Facilities for Mental Health Crisis Stabilization Centers			
Selection Method: RFA	Through an RFA, DHHS will award funds based on need and goals to improve access to crisis stabilization. The awardee(s) will identify spaces that could be renovated for use as crisis stabilization centers (G, H, J). Working with a consultant, applications will be reviewed to determine how to maximize funds in creating access. Staffing plans, care coordination, and sustainability will be included in the review. Outcomes include the creation of additional stabilization centers in rural communities to divert patients from hospitals to lower acute stay behavioral health costs. The initiative will create integrated, trauma-informed crisis units that provide rapid stabilization, coordinated referrals, and follow-up care through the State's CCBHC network.	COT, with subject matter experts, will monitor financial and work progress toward outcomes and deliverables through quarterly activities reports. A timeline and deliverables schedule will confirm milestones and goals toward outcomes. Monitoring will include site modifications, expansion, and utilization of services. Annual monitoring will track the number of sites.	This initiative is scalable and not all applications may be fully funded. We plan for up to 4 spaces per year, up to $1.25 million. Impacted cost categories will include equipment, supplies, contract, and other. Included in Capital Cap.
Initiative 5.4a Behavioral Health Nursing Homes Pilot			
Selection Method: RFA	The RFA will award up to 25 Nursing Facilities (NFs) in HRSA-designated rural, frontier, and tribal areas to fund one-time equipment and modifications to serve patients with behavioral health needs (J). Deliverables include implementation timelines, impact reports detailing improved resident outcomes and cost efficiencies, and a sustainability plan to support ongoing access for aging populations and individuals with complex medical needs.	COT will monitor financial and outcomes progress through annual reporting with each awardee. Coordination with Medicaid will be key to track outcome measures and link incentives and access for Medicaid beneficiaries.	This initiative is scalable but could impact providers ability to serve BH patients. Impacted cost categories will include equipment, supplies, contract, and other. Included in Capital Cap.
Initiative 5 Crisis Stabilization Implementation, Evaluation, and Continuous Improvement			
Sole Source	Reviewing criteria for expertise in crisis stabilization in rural areas, a consultant will evaluate Crisis Stabilization Centers (H) for site	COT will monitor financial and outcomes progress through	This initiative is not scalable as it seeks to bring

	suitability, renovation timelines, cost appropriateness, property valuation impact, and progress toward achieving sustainable outcomes.	annual reporting and coordination with SMEs.	implementation expertise. Impacted cost categories will include personnel, fringe, travel, supplies, contracts, other, and indirect.
Initiative 6.2 Facility Modernization Grants*			
Selection Method: RFA	Through an RFA, up to $500,000 per site will be awarded to Assisted Living Facilities in HRSA-designated rural, frontier, and tribal areas to fund equipment and safety modifications (e.g., ventilators, dementia-safe doors, Hoyer lifts) and foster partnerships with CAHs, RHCs, and EMS (G, J, K), aiming to increase Medicaid AD Waiver participation, memory care slots, and complex care capacity, with deliverables including implementation timelines, impact reports on resident outcomes and cost efficiencies, and a sustainability plan.	COT will monitor financial and outcomes progress through annual reporting with each awardee. Coordination with Medicaid will be key to track outcome measures and link incentives and access for Medicaid beneficiaries.	We plan for up to $500,000 per ALF in a rural area. This initiative is scalable but could impact providers' ability to participate in the Medicaid add-on if they are not equipped. Impacted cost categories will include equipment, supplies, contract, and other. Included in Capital Cap.
Initiative 7 Nebraska Rural Health Technology Catalyst Fund and Partnership Initiative			
Selection Method: RFP	Through an RFP, a contractor will establish a rural health-focused incubator to solicit, vet, and support early-stage health tech startups, forming a steering committee with DHHS and rural provider representation, providing mentorship and resources for innovators enhancing chronic disease prevention, care quality, affordability, and access for rural, Medicaid, and low-income communities (A, C, D, F, I, K), with deliverables including startup selection reports, evaluation frameworks, mentorship plans, investment outcome and impact assessments, and a sustainability plan, compliant with NOFO, 2 CFR Parts 200 and 300, without fund management fees.	The COT, along with a non-equity advisor from DHHS, will monitor progress through quarterly reporting of financial and outcomes reporting. The non-equity advisor from DHHS will provide personal accountability to the program to maintain focus and strategy toward rural health care innovations. The annual report will be used to report milestones and achievements toward State outcomes including deliverables, overall funding invested, and reporting on products launched in rural Nebraska.	No more than $3M of non-dilutive funding to any one company. This initiative is scalable. Impacted cost categories will include contract and other.
Initiatives 1, 4, 6: Strategic Oversight: Implementation, Evaluation, and Continuous Improvement*			
Contractor: PCG	DHHS has an existing consulting contract, with an experienced consulting firm, which will be amended for expediency, to expand the scope to include strategic oversight and monitoring for the	COT, with subject matter experts, will monitor progress toward deliverables through	This initiative is scalable. Impacted cost categories will include personnel,

Selection Method: Contract Amendment	implementation, evaluation, continuous improvement, and sustainability planning for Making Rural Nebraska Healthy Again, eHealth for Remote Care and Special Needs Population Incentive Model (A, G).	annual reporting and monitoring activities reports based on findings each year.	fringe, travel, other, and indirect.

G. CONSTRUCTION

Not applicable.

H. OTHER

Other Total			**$16,666,667**
Grant			**$16,666,667**
Recipient Share			**$0**
Initiative	**Item**	**Rate**	**BP 1**
5	**5.4b Nursing Home Add-On for Behavioral Health:** DHHS will develop an add-on rate to pay for services not currently billable or reimbursed. The add-on is based on programs in other states and is for services not paid by insurers and supports the funding of comprehensive behavioral health services in nursing homes (B, H). This, in combination with integrating services from a CCBHC, will allow nursing homes a better framework to take nursing facility appropriate patients with high behavioral health needs from hospitals that have held these individuals for an extended period due to lack of placement. Services will include stabilization and treatment for residents with aggressive or violent behaviors in a safe, therapeutic environment.	The add-on amount is estimated to $20 - $30 PPD and adjusted for severity.	$1,666,667
6	**6.1 Incentive Payments for Memory Care and Complex Care:** DHHS will develop an add-on rate to pay for services not currently billable or reimbursed. The add-on will pay for enhanced services required for memory care patients who need specialized service related to Alzheimer's and other dementias (B).	The add-on amount is estimated to be $87 per diem.	$15,000,000
Justification: Expenses not covered elsewhere will be included in Other. Specifically, Category B: Provider Payments are consolidated here and evaluated for long-term sustainability, distinct from contracts. These payments, modeled after other states' programs, cover services not reimbursed by insurers. BP 1 is estimated with only 10 months. Maintenance or rental fees for equipment, such as forklifts for installations, will be included with appropriate justification from subs.			

I. TOTAL DIRECT COSTS

Total Direct Costs	**$199,599,483**	**$199,526,570**	**$199,523,316**	**$199,513,853**	**$199,504,089**
Category	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**

Personnel	$1,529,374	$1,890,307	$1,906,374	$1,953,107	$2,001,325
Fringe Benefits	$535,281	$661,607	$667,231	$683,588	$700,464
Travel	$105,456	$104,288	$104,288	$104,288	$104,288
Equipment	$0	$0	$0	$0	$0
Supplies	$500,000	$500,000	$500,000	$500,000	$500,000
Contractual	$180,262,705	$176,370,368	$176,345,423	$176,272,870	$176,198,012
Other	$16,666,667	$20,000,000	$20,000,000	$20,000,000	$20,000,000

J. INDIRECT COSTS

Category	BP 1	BP 2	BP 3	BP 4	BP 5
Personnel	$1,529,374	$1,890,307	$1,906,374	$1,953,107	$2,001,325
Fringe Benefits	$535,281	$661,607	$667,231	$683,588	$700,464
Travel	$105,456	$104,288	$104,288	$104,288	$104,288
Supplies	$500,000	$500,000	$500,000	$500,000	$500,000
Total Indirect Costs	$400,517	$473,430	$476,684	$486,147	$495,911

Justification: For this comprehensive program, the State of Nebraska doesn't have an agreement and will therefore charge the de minimis rate of 15% on modified total direct costs noted in the table. The Modified Total Direct Costs (MTDC) will be updated to include up to the first $50,000 of each subaward, excluding capital costs, other non-allowable costs, and Category B Provider Payments.

H. CAPS TABLE

Limited Funds Category	Annual Estimate	% of Hypothetical Budget
Administration (Nebraska adopted 7.5%)	$14,315,295	7.2%
Provider Payments (15%)	$19,333,333	9.7%
Capital (20%)	$28,990,000	14.5%
EMR Replacement (5%)	$0	0.0%
Tech Catalyst (10% or $20 million)	$20,000,000	10.0%

Justification: Each contract has been assigned an administrative percentage (7.5% to 100%) and then aggregated with Personnel, Fringe, Travel, Supplies, and Indirect categories for the overall administrative cost cap, following CMS Office Hours guidance. Provider payments (B) are classified under Other, Capital (J) is assigned to contracts involving modifications, Tech Catalyst is under contractual, and there are no EMR Replacement costs. These are current estimates that will be reconciled to actuals for compliance.

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

OMB Number: 4040-0013
Expiration Date: 06/30/2028

1. * Type of Federal Action:

- [ ] a. contract
- [ ] b. grant
- [x] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:

- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:

- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

** Name:* Health & Human Services, Nebraska Department of

** Street 1:* 301 Centennial Mall South *Street 2:*

** City:* Lincoln *State:* NE: Nebraska *Zip:* 68509

Congressional District, if known:

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

Centers for Medicare & Medicaid Services

7. * Federal Program Name/Description:

Rural Health Transformation Program

Assistance Listing Number, *if applicable:* 93.798

8. Federal Action Number, *if known:*

CMS-RHT-26-001

9. Award Amount, *if known:*

$ 200,000,000.00

10. a. Name and Address of Lobbying Registrant:

Prefix: ** First Name:* N/A *Middle Name:*

** Last Name:* N/A *Suffix:*

** Street 1:* N/A *Street 2:*

** City:* N/A *State:* *Zip:*

b. Individual Performing Services (including address if different from No. 10a)

Prefix: ** First Name:* N/A *Middle Name:*

** Last Name:* N/A *Suffix:*

** Street 1:* N/A *Street 2:*

** City:* N/A *State:* *Zip:*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** *Prefix:* ** First Name:* Sara *Middle Name:*

** Last Name:* Morgan *Suffix:*

Title: Deputy Director, Division of Public Health **Telephone No.:** 402-450-6683 **Date:** Completed on submission to Grants.gov

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Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Health & Human Services, Nebraska Department of

UEI:

* Street1: 301 Centennial Mall South

Street2:

* City: Lincoln County:

* State: NE: Nebraska

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 68509-2529 * Project/ Performance Site Congressional District: NE-001

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

UEI:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

Other Attachment File(s)

*** Mandatory Other Attachment Filename:** Program Duplication Assessment.pdf

Add Mandatory Other Attachment | Delete Mandatory Other Attachment | View Mandatory Other Attachment

To add more "Other Attachment" attachments, please use the attachment buttons below.

Add Optional Other Attachment | Delete Optional Other Attachment | View Optional Other Attachment

PROGRAM DUPLICATION ASSESSMENT

Nebraska Department of Health and Human Services (DHHS) understands its obligation to avoid program duplication in its use of the Rural Health Transformation Program (RHTP) funds. To ensure that Nebraska's RHTP application avoids program duplication, DHHS reviewed existing budgets and evaluated proposed new activities. A comprehensive review of the proposed budgets was conducted to ensure that any RHTP funds were applied to new, distinct activities not already funded by existing state or federal funds.

Nebraska DHHS functions as a "superagency" with divisions working in close coordination and communication with each other, reducing the risk of divisions providing the same services to individuals. Additionally, as described in more detail below, DHHS staff who will administer the proposed new activities will be embedded in the relevant Divisions to ensure visibility into current state programs. DHHS is adept at administering multiple federal funding sources to ensure allowability, allocability, and reasonableness and to avoid supplantation and duplication of services. In addition, DHHS's accounting system tracks all funding sources separately, ensuring transparency and accountability. DHHS also has multiple existing policies governing procurement practices, subrecipient monitoring, and federal grant management and reporting, as well as proven experience in understanding and following the Code of Federal Regulations. Standard templates for contractual and subaward agreements ensure that these requirements flow down to participating vendors and subrecipients. Standard operating procedures support consistent monitoring and reporting to verify that each funding stream supports distinct and allowable activities, reducing the risk of duplication. Business units (identified by numbers) are set up in Enterprise One (JD Edwards State Accounting System) to separately identify costs based on funding sources, grants, grant years, and other criteria used for reporting purposes. The

appropriate business units are then listed on each grant, contract, and subaward to obligate funds and allow for budget and expenditure tracking.

There are no services outlined in Nebraska's RHTP application that are current Medicaid or Medicare covered benefits. The focus of the RHTP investment is to invest in new and innovative projects, developing sustainable health care infrastructure, rather than providing ongoing coverage for services. RHTP funding for new initiatives may build upon current State and Federal programs but does not duplicate them.

Initiative 1: DHHS Office of Economic Assistance (OEA) will utilize experience with food benefit programs, specifically experience gained by administering the Local Food Assistance Program from 2022 to 2025, as well as experience working with food banks through administration of The Emergency Food Assistance Program (TEFAP). OEA also works closely with the Nebraska Department of Education to administer the Summer Electronic Benefits Transfer (EBT) program, serving approximately 200,000 individuals per year over the last two years. This experience, along with relationships with Nebraska's network of producers and service providers, will ensure the State can implement proposed new activities that promote nutritious eating and healthy living in innovative ways while avoiding program duplication. Proposed activities such as the School Food Learning Lab and the Nebraska School Nutrition Training Institute are examples of how the current system will be expanded and sustained with this new funding. Additionally, the Department of Public Health (DPH) outreach and communication platforms, currently maintained for the Healthy Eating Active Living campaign, can be leveraged to share information and raise awareness about new RHTP efforts.

Initiative 2: Existing teams within DHHS bring expertise and will leverage existing partnerships and systems to transform rural health care through the proposed activities in Initiative 2. The

DHHS DPH Office of Emergency Health Systems (OEHS) maintains the licensure, training, and stakeholder feedback structure that supports Nebraska's emergency medical services (EMS). Similarly, the DPH Maternal Child Health (MCH) programs include the Title V MCH Block Grant and the Child and Maternal Death Review teams, which bring expertise and required relationships with MCH health care providers and will help ensure RHTP funding does not supplant or duplicate block grant funding. DHHS is also responsible for the laws and regulations governing the licensure of critical access hospitals (CAHs) and nursing homes, as well as electronic health record (EHR) systems. This responsibility enables the department to provide technical assistance (TA), distribute funds, and conduct effective oversight. Proposed activities, such as EMS/MCH regionalization, the Rural Health Hub, and CAH conversion, are examples of new work that will transform the rural healthc are system in Nebraska.

Initiative 3: Both the DHHS DPH Office of Rural Health (ORH) and the OEA have existing workforce development programs. Loan repayment programs administered by ORH offer incentives to health care professionals in exchange for service in a rural setting. OEA has implemented a successful SNAP Next Step and Employment & Training (E&T) program, which assists motivated individuals in improving their skills and helping them achieve the ultimate goal of self-sufficient employment tailored to each individual's needs. RHTP funds will build upon these efforts by developing new programs that will engage a higher number of providers, establish rural health career pathways, and offer additional incentives for recruitment, such as short-term subsidized housing.

Initiative 4: Despite the workforce development efforts already in place, many rural Nebraskans still face long travel times to access health care services. Bringing services to them—particularly preventive care such as screening—or enhancing pathways for patients to monitor their health in

partnership with their provider is critical. Additionally, offering supplemental training to emergency responders or CAH staff to prepare for low-frequency events is a critical part of health care when long distances exist. Existing MCH, Chronic Disease Prevention and Control, and Oral Health programs have all worked to enhance access in clinic settings and have agreements in place with provider offices across the state. RHTP funds will support mobile care and training, remote patient monitoring, and an expansion of oral health care services to the Nebraska rural health care system.

Initiative 5: The Enhancing Rural Behavioral Health Access initiative aims to bring new behavioral health services to rural areas. In Nebraska, most behavioral health services are rendered in community mental health centers, often located in urban areas. The initiatives proposed for RHTP funding will build needed touchpoints that are currently absent in rural communities by way of bringing integrated behavioral health care clinicians into local primary care clinics, bringing immediately available mobile crisis services to law enforcement, and creating needed access pathways for hospitals and nursing homes to collaborate to lower costs and duration of hospital stays for behavioral health patients. As part of the Behavioral Health Nursing Home Pilot, behavioral health clinicians will coordinate with nursing facilities for the care of residents and bill independently to Medicaid and other applicable payers for covered services. RHTP funding will supplement but not supplant Medicaid per diem payments and will cover minor facility upgrades, clinical enhancements that enable high-quality care, and non-Medicaid covered coordination and support. Based on the success of this pilot, Medicaid would then pursue a waiver to incorporate that coverage into Medicaid for long term sustainability.

Initiative 6: Ensuring that older adults can age within their communities is vital to rural living, even more so when additional or specialized care is necessary. Not only does an assisted living

facility help to combat social isolation and offer support for the aging population, but it is also an economic driver for the community. Funds from the RHTP award will provide for facility modifications and enhanced rates that will position the facility for long-term sustainability – an entirely new line of effort for DHHS and the rural health care system in Nebraska.

Initiative 7: This initiative will deploy cutting-edge health technologies in rural Nebraska by creating a mechanism to blend public RHTP funding with private equity and investment. NETECH will serve as an investment platform and convener of government, investors, and health systems, with the goal of identifying and funding new technology solutions that address rural health challenges. The initiative's focus on new startups and solutions will ensure that it avoids program duplication.

CMS Business Assessment of Applicant Organization

Applicants review and answer the business assessment questions outlined below. There are eleven (11) topic areas labeled A-K, with a varying number of questions within each topic area. **Applicants MUST provide a brief substantive answer to each question (and supporting documentation, as applicable. Singular web links are not acceptable).** If the answer to any question is not- applicable, please provide an explanation. Please note: If CMS cannot complete its review without contacting the applicant for additional clarification, the applicant risks selection for award.

A. General Information

1. Provide organization:
    a. Legal name: **Nebraska Department of Health & Human Services (DHHS)**
    b. EIN (include PMS prefix and suffix, if applicable): **47-0491233**
    c. Organizational Type: **State Government**
2. What percentage of your organization's capital is from Federal funding? (percentage = total Federal funding received in previous fiscal year / organization's total gross revenue in previous fiscal year). **DHHS is included under the State of Nebraska Financial Statements. Federal funds represent 35% of capital for the State of Nebraska. Fiscal year 2026 was approximately $6.6B federal funds out of $18.9B total funds.**
3. Does/did your organization receive additional oversight (examples include: Correction Action Plan, Responsibility and Qualification (R/Q) findings, reimbursement payments for enforcement actions) from a federal agency within the past 3 years due to past performance or other programmatic or financial concerns with the organization)? **No.**
    a. If yes, please provide the following information: Name of the Federal agency and the reason for the additional oversight as explained by the Federal agency.
    b. If resolved, please indicate how the issue was resolved with the Federal agency.
4. Does your organization currently manage grants with other U.S. Department of Health and Human Services components or other Federal agencies? **Yes.**
5. Explain your organization's process to ensure annual renewal in SAM.gov including R/Q and Reps and Certs. **DHHS has a project structure in place in which we monitor System for Award Management (SAM). DHHS monitors SAM for any information requests, including R/Q and Reps and Certs.**
6. Explain your organization's process to comply with (a) 2 CFR 200.113 "Mandatory Disclosures" and (b) your organization's process to comply with FFATA requirements. **DHHS has a team dedicated to reviewing all subawards and ensuring reporting is completed to comply with this requirement. This team is within the Department's Office of Procurement and Grants, specifically within the Grants section that completes FFATA reporting.**
7. Do you have conflict of interest policies? **Yes.**

Does your organization or any of its employees have any personal or organizational conflicts of interest related to the possible receipt of these CMS award funds? If yes, please explain and provide a mitigation plan. **No, DHHS nor its employees have conflicts of interest related to the possible receipt of these CMS award funds.**

8. Does your organization currently, or in the past, had delinquent Federal debt in the last 3 years? If yes, please explain. **No, DHHS has not had delinquent Federal debt in the last three years.**
9. Have you filed bankruptcy or entered into proceedings for bankruptcy, whether voluntarily or involuntarily? **No.**
10. Has your organization obtained fidelity bond insurance coverage for responsible officials and employees of the organization in amounts required by statute or organization policy? What is that amount? **Yes, the State of Nebraska has fidelity bond insurance coverage. The coverage amount is $11,000,000.**
11. Do you have (and briefly describe) policies and procedures in place to meet the requirements below? If not, explain your plan and estimated timeline for establishing these policies and procedures if selected for award. **Yes, DHHS has policies and procedures to meet the requirements as described below.**
    a. Determinations between subrecipients versus contracts in accordance with 2 CFR 200.331? **Yes, DHHS has procedures in place to make determinations between recipients and contracts. This is done in the form of a checklist that is available upon request.**
    b. Compliance with 2 CFR 200.332 “Requirements for pass-through entities”? **Yes, DHHS has procedures in place to notify entities at the time of award and agreement, primarily through the use of DocuSign.**
    c. Manage, assess risk, review audits, and monitor the subrecipients as necessary to ensure that subawards are used for authorized purposes in compliance with laws, regulations, and terms and conditions of the award and that established subaward performance goals are achieved (2 CFR 200.331-200.333)? **Yes, DHHS has procedures in place to manage, assess risk, review audits, and monitor subrecipients. Audit reviews and responses are coordinated within Financial Services. Monitoring is done at the program level and specific procedures exist for each different program, depending on the requirements of the applicable federal award.**

B. Accounting System

1. Does your organization have updated (last two years) written accounting policies and procedures to manage Federal awards in accordance with 2 CFR 200? **Yes.**
    a. If no, please provide a brief explanation of why not.
    b. Describe the management of Federal funds and how funds are separated (not co-mingling) from other organizational funds. **Business units (identifying numbers)**

are set up in Enterprise One (JD Edwards State Accounting System) to separately identify costs based on funding sources, grants, grant year, and other criteria used for reporting purposes.

2. Briefly describe budgetary controls in effect to preclude incurring obligations in excess of:
    a. Total funds available for an award. **Business units (identifying numbers) are set up in Enterprise One (JD Edwards State Accounting System) to separately identify costs based on funding sources, grants, grant year, and other criteria used for reporting purposes.**
    b. Total funds available for a budget cost category. **Business units (identifying numbers) are set up in Enterprise One (JD Edwards State Accounting System) to separately identify costs based on funding sources, grants, grant year, and other criteria used for reporting purposes.**
3. Has any government agency rendered an official written opinion within the last 3 years concerning the adequacy of the organization's accounting system for the collection, identification, and allocation of costs under Federal awards? **Our accounting system is reviewed annually by our Nebraska Auditor of Public Accounts during ACFR (Annual Comprehensive Financial Report) testing and Statewide Single Audit testing.**
    a. If yes, please provide the name and address of the agency that performed the review.
    NE Auditor of Public Accounts
    State Capitol, Room 2303
    Lincoln, NE 68509
    b. Provide a summary of the opinion. **No issues were identified with the State's Accounting system.**
    c. How did your organization resolve any concerns? **DHHS is continuously making improvements to all recommendations by the auditors. Our accounting system has been found adequate and there have been no findings directly related to Enterprise One.**
4. How does the accounting system provide for recording the non-Federal share and in- kind contributions (if applicable) **Business units (identifying numbers) are set up in Enterprise One (JD Edwards State Accounting System) to separately identify costs based on funding sources, grants, grant year, and other criteria used for reporting purposes of non-Federal share. In-kind contributions would be recorded and monitored at the program level by the applicable program staff.**
5. Does the organization's accounting system provide identification for award funding by Federal agency, pass-through entity, Assistance Listing (CFDA), award number and period of funding? **Yes**.

a. If yes, how does your organization identify awards? **Yes, our accounting system allows all of this information to be identified and is based on all information provided on the Notice of Award received by the federal government.**
b. If not, please explain why not.

C. Budgetary Controls

1. What are your organization's controls used to ensure that the Authorized Organizational Representative (AOR), as identified on the SF-424, approves all budget changes for the Federal award? **The Department's AOR authorizes any changes to the project budget after recommendation from the project's governance structure.**
2. Describe your organization's procedures for minimizing the time between transfer of funds from the U.S. Treasury (e.g. Payment Management System) and disbursement for grant activities (See 2 CFR 200.305, "Federal Payment."). **Expenditures are paid prior to funds being drawn down from PMS (Payment Management System). The State's Department of Administrative Services (contains the State's central accounting unit) manages all PMS draws for the State of Nebraska.**

D. Personnel

1. Does your organization have a current organizational chart or similar document establishing clear lines of responsibility and authority? **Yes.**
    a. If yes, please provide a copy. **Refer to the Organizational Chart in the Other Supporting Materials section of this application.**
    b. If no, how are lines of responsibility and authority determined?
2. Does your organization have updated (last two years) written Personnel and/or Human Resource policies and procedures? If no, provide a brief explanation. **Yes.**
3. Does your organization pay compensation to Board Members? **No, DHHS is a State governmental entity and does not have board members.**
4. Are staff responsible for fiscal and administrative oversight of HHS awards (Grants Manager, CEO, Financial Officer) familiar with Federal rules and regulations applicable to grants and cooperative agreements (e.g. 2 CFR 200)? **Yes.**
5. Please describe how the payroll distribution system accounts for, tracks, and verifies the total effort (100%) to determine employee compensation. **The State of Nebraska uses a timecard system, Kronos, for identification and tracking all employee time. The employee's time entered is required to be reviewed and signed off by the supervisor. This record then goes to the payroll team (in Finance as a section of the accounting unit) for final review prior to paychecks being completed by the State Department of Administrative Services.**

E. Payroll

In preparation of payroll is there a segregation of duties for the staff who prepare the payroll and those that sign the checks, have custody of cash funds and maintain accounting records? Please describe. **No, cash or paper checks are handled for payroll. The payroll team consists of five individuals and one supervisor who review payroll at DHHS. After time is reviewed and submitted, it is paid out to employees as direct deposits by the State Department of Administrative Services. All accounting records are maintained in both Kronos (timecards) and Enterprise One (paychecks).**

F. Consultants

1. Are there written policies or consistently followed procedures regarding the use of consultants which detail the following (include an explanation for each question below): **Yes.**
    a. Briefly describe your organization's method or policy for ensuring consultant costs and fees are allowable, allocable, necessary and reasonable. **Contract performance is monitored through monthly reviews by the DHHS program/project owners that the individual project consultant resources are engaged to support. The DHHS program/project owners are working on the project with that consultant resource and, therefore, can determine that the appropriate amount of time and effort is billed. Consultant account managers and DHHS leadership meet monthly (more frequently if needed) to address resource needs, evaluate performance, and plan for the proactive roll-off of resources who have fulfilled the needs of the specific project.**
    b. Briefly describe your organization's method or policy to ensure prospective consultants prohibited from receiving Federal funds are not selected. **The State of Nebraska follows national procurement standards and requires prospective consultants to bid for the services being offered. As part of this bid process, the State includes language allowing the State the right to reject bids, withdraw an intent to award or award, or terminate a contract if the bidder commits or has committed ethical violations, including being considered for, presently being, or being debarred, suspended, ineligible, or excluded from contracting with any state or federal entity.**

G. Property Management

1. Briefly describe the system for property management (tangible or intangible) utilized for maintaining property records consistent with 2 CFR 200.313. Refer to (2 CFR 200) for definitions of property to include personal property, equipment, and supplies. **DHHS has a Central Operations team responsible for managing property, equipment, and supplies. Applicable items are recorded in the State's accounting system, Enterprise One. DHHS adheres to the requirements of the State Accounting Manual, State**

Asset Management Manual, and DAS Materiel Administrator for definitions and treatment of personal property, equipment, and supplies.

2. Does your organization have adequate insurance to protect the Federal interest in equipment and real property (see 2 CFR 200.310 "Insurance coverage.")? How does the organization calculate the amount of insurance? **Yes – Insurance coverage is managed by the Nebraska Department of Administrative Services.**

H. Property Standards

Describe the organization's property standards in accordance 2 CFR 200.310-327 "Procurement Standards")? If there are no procurement procedures, briefly describe how your organization handles purchasing activities. **DHHS has a procurement team that works in collaboration with the Nebraska Department of Administrative Services and the State's Chief Procurement Officer. The State of Nebraska follows the State's procurement manual. DHHS has its own separate procurement manual that would follow everything in the State's procurement manual but also adds various rules and requirements that go beyond the minimum requirements in the State's procurement manual that are specific to DHHS.**

a. Include individuals responsible and their roles. **DHHS has a procurement team that works in collaboration with the Nebraska Department of Administrative Services and the State's Chief Procurement Officer. The DHHS procurement office oversees all contracts, subawards, competitive procurements, and commodity purchases to ensure the state procurement policies are followed.**

b. Describe the competitive bid process for procurement purchases of equipment, rentals, or service agreements that are over certain dollar amounts. **DHHS has a segment of the procurement staff that is specifically responsible for competitive procurements. This would include drafting and navigating the actual RFP and scoring process. This team also manages renewals or amendments necessary for agreements that originated as a competitive solicitation.**

I. Transportation Costs

1. Describe your organization's written travel policy. Ensure, at minimum, that:
    a. Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates (see 2 CFR 200.474, "Transportation costs."). **State of Nebraska policy generally calls for travel costs such as airfare (as applicable), lodging, and event fees (in cases such as conferences) to be billed directly to the State. Travel costs incurred by State of Nebraska employees that are not pre-paid are reimbursed according to a per diem scale equivalent to 70% of the General Services Administration (GSA) travel rates.**

Every reimbursement is reviewed and approved by two accounting team members to ensure compliance with federal and state regulations.

b. Receipts for lodging and meals are required when reimbursement is based on actual cost incurred. **As noted above, lodging costs are generally pre-paid by the State prior to employee travel. Receipts are not required when meals are reimbursed according to the per diem scale for employees in approved travel status. Receipts are required when reimbursement is based on actual cost.**
c. Subsistence and lodging rates are equal to or less than current Federal per diem and mileage rates. **Yes, lodging rates are paid at the applicable government rate, and the State's per diem rate for meals is 70% of the GSA rate for the location of employee travel.**
d. Commercial transportation costs incurred at coach fares unless adequately justified. Lodging costs do not exceed GSA rate unless adequately justified (e.g. conference hotel). **Yes, state policy requires that coach fare be purchased with limited exceptions when coach fare is unavailable.**
e. Travel expense reports show purpose and date of trip. **Yes. To be reimbursed, the expense must be a necessary expense, incurred in the line of duty, reason/purpose of the expense must be clearly stated, all start/stop dates and times must be recorded, and the amount of the expense must be substantiated.**
f. Travel costs are approved by organizational official(s) and funding agency prior to travel. **Yes, employee travel must be authorized in advance of departure. All costs associated with travel are pre-paid except for per diem for meals and few other exceptions (like transfers from airport).**

J. Internal Controls

1. Provide a brief description of your organization's internal controls that will provide reasonable assurance that the organization will manage award funds properly. (see 2 CFR 200.303, "Internal controls.") **The State of Nebraska ensures proper management of award funds through a comprehensive internal control framework aligned with the 2 CFR 200 and the detailed State Accounting Manual. Each agency is required to implement a DAS-approved internal control plan that includes formal risk assessment procedures, segregation of duties, documented policies, reliable financial reporting systems, and routine monitoring and testing. These controls are built around the COSO framework and provide reasonable assurance that funds are used appropriately, risks are identified and mitigated, financial activities are properly authorized and recorded, and any issues are addressed through ongoing oversight and corrective actions.**
2. What is your organization's policy on separation of duties as well as responsibility for receipt, payment, and recording of cash transactions? **The State of Nebraska follows a**

strict separation of duties policy as outlined in the State Accounting Manual to ensure accountability and reduce risk of errors or fraud in handling public funds. Responsibilities for receiving, authorizing, recording, and reconciling cash transactions are deliberately divided among different individuals and departments. No single employee has control over all aspects of a financial transaction. For example, one staff member may be responsible for receiving and depositing funds, another for approving or initiating payments, and a separate individual for recording transactions in the accounting system. This layered approach to financial management helps maintain accurate records, supports proper oversight, and aligns with internal control standards.

3. Does your organization have internal audit or legal staff? If not, how do you ensure compliance with the award? Please describe. **DHHS has both an internal audit unit and full legal department to ensure compliance within the agency.**
4. If your organization has a petty cash fund how is it monitored? **DHHS only has petty cash funds at the DHHS 24-hour facilities. Each facility has cash handling procedures to ensure compliance with the State accounting manual and monitor petty cash.**
5. Who in the organization reconciles bank accounts? Is this person familiar with the organization's financial activities? Does your organization authorize this person to sign checks or handle cash? **DHHS only has separate bank accounts for petty cash funds at the DHHS 24-hour facilities. All other funds are handled through the Nebraska State Treasury. Each facility has finance staff that are responsible for these accounts and that report to Central Finance for oversight. The account signer could be a facility staff or a member of Central Finance, depending on the facility.**
6. Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty? **No.**

K. Audit

1. What is your organization's fiscal year? **July 1st through June 30th.**
2. Did your organization expend $1,000,000 or more in Federal awards from **all** sources during its most recent fiscal year? **Yes.**
3. Has your organization submitted;

   (a) an audit report to the Federal Audit Clearing House (FAC) in accordance with the Single Audit Act in the last 3 years? (see 2 CFR 200.501, "Audit requirements" and 2 CFR 300.218 "Special Provisions for Awards to for-profit organization as recipients.") **Yes, the State of Nebraska has submitted an audit report to the Federal Audit Clearing House (FAC) in the last three years. The most recent audit report is for the State of Nebraska – Statewide Single Audit for the fiscal year ended June 30, 2024. The audit was for the entire State of Nebraska, of which DHHS is a part.**

or

(b) an independent, external audit? If no, briefly explain.

If yes, address the following:

a. The date of the most recently submitted audit report. **The audit report is dated March 25, 2025, covering the audit period of July 1, 2023 – June 30, 2024.**
b. The auditor's opinion on the financial statement. **Unmodified Opinion.**
c. If applicable, indicate if your organization has findings in the following areas:
   - internal controls **Yes, identified finding.**
   - questioned or unallowable costs **Yes, identified finding.**
   - procurement/suspension and debarment **N/A.**
   - cash management of award funds, and **N/A.**
   - subrecipient monitoring. **Yes, identified finding.**

d. Include (if applicable):

   • a description of each finding classified as Material Weakness. **Internal controls over subrecipient monitoring, specifically citing inadequate procedures to ensure timely submission of required reports to the State of Nebraska. The finding was more a process issue than related to inappropriate activity or spending.**

   • a description of each finding classified as Significant Deficiency. **A significant deficiency was notated related to cash management controls, where some federal draws were not properly aligned with immediate disbursement needs.**

4. Has your organization had corrective actions in the past 2 years for the findings identified above (3(iii))? **Yes.**

If yes, describe the status (closed or open) and progress made on those corrective actions. **DHHS has various findings with federal partners, including the Centers for Medicare & Medicaid Services, the Administration for Children and Families, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Food and Nutrition Service. Findings are at various stages of the corrective action process (some open, some closed). A full report of all outstanding audit findings and the applicable corrective action plans is available upon request.**

The following documents were referenced in the assessment and are available upon request:

- State of Nebraska Accounting Manual - https://das.nebraska.gov/accounting/manual.html
- State of Nebraska Bond Insurance Coverage Policy - https://das.nebraska.gov/risk/docs/NE_DAS_Risk_Mgmt-Insurance_Certificate_of_Self_Insurance_Instructions_to_Agencies.pdf
- State of Nebraska Procurement Manual - https://das.nebraska.gov/materiel/docs/NE_DAS_Materiel_SPB_Procurement%20Manual2024.pdf
- State of Nebraska Asset Management Manual - https://das.nebraska.gov/materiel/docs/NE_DAS_Materiel_Asset_Management-Asset_Management_Manual.pdf
- DHHS Subaward and Contract Checklist
- DHHS Organizational Chart
- DHHS Personnel and Human Resource Policy and Procedures
- DHHS Internal Control Policy
- DHHS Travel Policy
- State of Nebraska State-wide Single Audit report

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 06/30/2028

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Assistance Listing Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Rural Health Transformation Program CMS-RHT-26-001	93.798	$	$	$ 200,000,000.00	$	$ 200,000,000.00
2.						
3.						
4.						
5. Totals		$	$	$ 200,000,000.00	$	$ 200,000,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
	Rural Health Transformation Program CMS-RHT-26-001				
a. Personnel	$ 2,001,325.00	$	$	$	$ 2,001,325.00
b. Fringe Benefits	700,464.00				700,464.00
c. Travel	104,288.00				104,288.00
d. Equipment	0.00				0.00
e. Supplies	500,000.00				500,000.00
f. Contractual	176,198,012.00				176,198,012.00
g. Construction					
h. Other	20,000,000.00				20,000,000.00
i. Total Direct Charges (sum of 6a-6h)	199,504,089.00				$ 199,504,089.00
j. Indirect Charges	495,911.00				$ 495,911.00
k. TOTALS (sum of 6i and 6j)	$ 200,000,000.00	$	$	$	$ 200,000,000.00
7. Program Income	$	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Rural Health Transformation Program CMS-RHT-26-001	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 200,000,000.00	$	$ 30,000,000.00	$ 85,000,000.00	$ 85,000,000.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 200,000,000.00	$	$ 30,000,000.00	$ 85,000,000.00	$ 85,000,000.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Rural Health Transformation Program CMS-RHT-26-001	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: Other includes Category B, excluded from direct.

22. Indirect Charges: State of Nebraska will charge the de minimis, 15%.

23. Remarks: The State of Nebraska appreciates CMS' recognition that at the time of application submission, we do not have all of the details solidified. Once details are solidified on contractual items, updates can be made as needed to the 424 & Cash Needs.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

November 4, 2025

The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz,

The recent passage and President Trump's signing of the historic One Big Beautiful Bill Act provide an unparalleled opportunity for the State of Nebraska to transform rural health care access through investments that create sustainability and improve health outcomes for rural communities.

As one of the most rural states in America, this bears enormous potential for Nebraska. This issue matters to the people of my state – and is deeply personal to me.

I was raised outside of a small town on a farm, which is work I continue to this day. As the only sitting Governor who has made a career out of farming, I know very well the challenges our producers and rural families face when trying to access life-improving and often life-saving health care.

Nebraska is uniquely positioned to benefit from the Rural Health Transformation Program (RHTP) which, when implemented, will also strengthen our nation. Ours is one of the most rural states in America: 37% of Nebraskans live in rural areas, compared to just 14% nationally. Many counties have fewer than 10,000 residents, and some fewer than 3,000.

Our rural communities are strategically important to the country. Nearly 90% of our land is dedicated to farms and ranches that feed the nation and the world. Nebraska is nationally ranked:

- #1 in beef processing and beef exports
- #2 in ethanol production
- #3 in corn production
- #4 in soybean production, essential for feed and biofuels
- Top 5 in total agricultural receipts and farm income nationwide

Nebraska feeds the world and is unleashing homegrown American energy with our biofuels production. Food and energy security equates to national security, all of which depends on healthy rural communities.

Yet, our rural health system is failing:

- 62 of 93 hospitals are critical access hospitals

- Rural facilities include one (1) rural emergency hospital and 130 rural health clinics
- 14 counties have no primary care physician
- 48 counties are maternity care deserts
- 24 counties have no behavioral health provider
- EMS relies heavily on volunteers, stretching response times and costs. Out of 428 licensed EMS services, only 70 have a paid workforce

And these failures are impacting our rural communities:

- The average rural Nebraskan lives about 130 miles from a Level 1 Trauma Center.
- The average woman of reproductive age in rural Nebraska lives about 99 miles from a perinatology specialist.
- Residents in our Sandhills region face drives exceeding 60 miles for basic medical care and well over 100 miles for specialized or maternity services.
- Statewide, 36% of Nebraskans are obese. 72.5% of those living in rural areas are reported to be overweight or obese. These numbers are difficult to comprehend, but another glaring example of a failed healthcare system.

Nebraskans work together and are always ready to help each other when the need arises. It's the 'Nebraska Way' of doing things. That is why, in partnership with the Nebraska Department of Health and Human Services (DHHS) and community leaders, my office has submitted a comprehensive, research-driven RHTP proposal.

I have appointed Nebraska DHHS, a significant cabinet agency comprised of the divisions of Public Health, Behavioral Health, Medicaid and Long-Term Care, Children and Family Services and the Office of Economic Assistance, to be the lead agency of RHTP. To best collect data and input for this proposal, Nebraska DHHS and my office engaged with stakeholders, State office of rural health, and tribal liaisons from across the state to deeply understand the unique challenges we face in rural Nebraska. While many other states posted online submission forms, requests for proposals, and RFI's, in Nebraska, we coordinated meetings with a vast number of stakeholder groups.

With the support made possible by President Trump's Administration, Nebraska will use these funds to build sustainable rural health infrastructure that will serve our communities – and our country – for decades to come.

Our strategic goals include:

1. Make Rural Nebraska Healthy Again Through Food as Medicine

- Modernize rural school kitchens, develop food hubs, and expand nutrition education and fitness programs.
- Lower obesity risk and improve access to healthy foods.
- Reduce access to processed foods.

2. Regionalized Rural Access and Navigation

- Building coordinated regional networks to ensure rural residents can access the care they need.

3. Rural Workforce Acceleration

- Attract and train a skilled workforce with education, virtual reality (VR) training, and competency programs.
- Focus on developing a workforce that originates from and is committed to serving rural communities long-term.

4. eHealth and Mobile Access

- Expand remote-care capacity through mobile clinics, preventative oral health teams, enhanced technology pharmacy services, and remote patient monitoring.

5. Rural Emergency Behavioral Health

- Enhance the state's behavioral health systems by creating a continuum of care that is capable of responding to and managing emergency behavioral health needs.

6. Assisted Living Facility (ALF) Special Needs Population Incentive Model

- Provide modernization grants and add-on payments for ALFs to better serve residents with complex medical, intellectual, and other high acuity needs.

7. Nebraska Rural Health Technology Catalyst Fund and Partnership Initiative

- Establish and manage the Nebraska Rural Health Technology Catalyst Fund and Partnership Initiative, which aims to facilitate the strategic deployment of cutting-edge health technology in rural Nebraska while bringing additional private funding to the state.
- Support innovations that would be sustainable and would tie funding to outcomes.

My administration will maintain executive-level accountability through direct reporting from DHHS to the Governor's Office. I have instructed Nebraska DHHS to prioritize timely communication, responsiveness, and data accuracy in all interactions with CMS. Specifically, Nebraska's implementation will follow rigorous oversight standards:

- Establishment of a Governor's Rural Health Transformation Steering Committee comprised of state agency leadership to monitor progress and guide decision-making.
- Nebraska will establish a grant management team, implementing a structured coordination framework to ensure alignment across the divisions and multi-sector partners.
- Nebraska's Rural Health Advisory Committee will provide oversight and stakeholder engagement throughout program implementation, including reviewing program milestones, overseeing fund deployment, monitoring outcome metrics and obtaining stakeholder comments via quarterly meetings.
- Submission of performance and financial reports meeting all CMS requirements.
- Participation in all CMS-sponsored evaluation, learning and technical assistance activities
- Continuous tracking on measurable outcomes.

My administration is committed to encouraging healthy choices and we have been a leader in the MAHA movement. Nebraska was the first in the nation to receive a SNAP Food Restriction Waiver restricting the purchase of soda and energy drinks -- approved on May 19, 2025. Nebraska will also reestablish the Presidential Fitness Test by December 31, 2028.

Additionally, my administration is committed to presenting legislation to Nebraska's state senators that aligns with the priorities outlined in the RHT NOFO:

- Requiring maternal/neonatal level of care designations.
- Enabling Medicaid reimbursement for community paramedicine through a Medicaid State Plan Amendment (SPA) and regulation change.
- Obtaining legislative authority for state CHW certification.
- Establishing state recognition of VR-based competencies for continuing education credit.
- Establishing Medicaid coverage of technological interventions such as remote patient monitoring through state regulatory changes.

I also certify that the state will not spend any award funds on activities prohibited under 42 U.S.C. 1397ee(h)(2)(A)(ii).

It is the honor of my life to represent Nebraska, the beating heart of American agriculture. As I often say, the greatest part of my state is its people – those who feed the world and save the planet. I am committed to ensuring that the Cornhusker State's approach delivers lasting value to rural Nebraskans when the federal funding concludes.

I understand what it means when a family must drive hours for care or when a rural hospital struggles to keep its doors open. We owe those families better. With CMS as our partner in this cooperative agreement, Nebraska will lead the way in building a rural health system that is innovative, efficient, accountable, and built to last.

I am deeply grateful to the Trump Administration for making this opportunity possible.
Together, we can create long-term, life-changing support for Nebraska's rural families and, in turn, strengthen the core of our great country.

Sincerely,

Jim Pillen
Governor

Other Supporting Documentation

Contents

USE OF FUNDS AND TECHNICAL SCORE FACTORS BY INITIATIVE

Initiative	Use of Funds	Technical Score Factors
Initiative 1: Make Rural Nebraska Healthy Again through Food as Medicine 1.1 School Kitchen Modernization Grants 1.2 Regional Food Pantry Development 1.3 Farm-to-School Procurement and Policy Technical Assistance 1.4 Healthy Menu Design and Culinary Workforce Training 1.5 Nebraska Kids Fitness and Nutrition Day	**A, D, F, J**	**B.2, F.2**
Initiative 2: Regionalized Rural Access and Navigation 2.1 EMS and Perinatal Regionalization 2.2 Community Paramedicine Regionalization 2.3 Rural Health Hubs and Statewide CHW Network 2.4 Veteran EHR Coordination 2.5 CAH to REH Conversion	**A, C, D, E, F, G, H, I, J, K**	**B.1, B.2, C.1, C.2, D.1, F.1, F.2, F.3**
Initiative 3: Rural Workforce Acceleration 3.1 Rural Provider Recruitment and Retention Incentive Program 3.2 Rural Virtual Reality and Skills Acceleration Network 3.3 Rural Health Care Workforce Incentive and Sustainability Model 3.4 School-Age Health Care Pipeline 3.5 Subsidized Short-Term Provider Housing	**D, E, F, G, J, K**	**C.1, C.2, D.1, F.1**
Initiative 4: eHealth and Mobile Access 4.1 Mobile Maternal Care and Training 4.2 Oral Health (Nebraska Teeth Forever and Emergency Department Diversion) 4.3 Technology Enhanced Pharmacy Services 4.4 Chronic Disease Management/Remote Patient Monitoring	**A, C, D, E, F, G, I, J, K**	**B.1, B.2, C.1, D.1, E.1, E.2, F.1, F.2, F.3**
Initiative 5: Rural Emergency Behavioral Health 5.1 Integrated Primary Care Sites 5.2 Telehealth Crisis Responders for Law Enforcement 5.3 Modification of Existing Clinical Facilities for Mental Health Crisis Stabilization Centers 5.4 Behavioral Health Nursing Home Pilot	**D, E, F, G, H, J, K**	**B.1, C.1, E.1, E.2, E.2, F.1**
Initiative 6: Assisted Living Facility Special Needs Population Incentive Model 6.1 Incentive Payments for Memory Care and Complex Care 6.2 Facility Modernization Grants	**B, G, J, K**	**B.1, C.1, C.2, E.1, E.2**
Initiative 7: Nebraska Rural Health Technology Catalyst Fund and Partnership Initiative	**A, C, D, F, I, K**	**C.1, F.1, F.2, F.3**

RHTP MAKE NEBRASKA HEALTHY AGAIN PATIENT SCENARIOS

The impact of RHTP will be felt directly by citizens of Nebraska. Today there are kids, families, and grandparents with complex health care needs that are committed to staying in their rural communities. The initiatives will build sustainable health care infrastructure to ensure the heart of Nebraska, its people, can stay in rural Nebraska.

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

Jenny is a 6-year-old from a single-parent home. She lives in a rural town with no grocery store. Jenny's main source of nutrition is what she receives in school. The initiative will ensure her school cafeteria staff receive training in building menus with whole fresh foods produced by local farmers and ranchers.

INITIATIVE 2: REGIONALIZED RURAL ACCESS AND NAVIGATION

This initiative will help Frank, the 67-year-old farmer who goes into the ag extension office to pick up his fertilizer license. In speaking with a CHW who is co-located in the ag extension office she learns Frank has had difficulty breathing for a few months. The CHW immediately connects Frank with a doctor for a clinic appointment. The local ag extension office has become a gateway to better health.

INITIATIVE 3: RURAL WORKFORCE ACCELERATION

Sara was raised in a small town and attended training to receive her radiology technologist degree. Sara thought her only opportunity for a career was in a metropolitan area. The local clinic in the rural town where her grandparents live contacts Sara to let her know they are hiring radiology technologists and have a program to provide short-term housing. This initiative

provides Sara with the opportunity to move back to a rural community, and the ability to live near her grandparents continuing her family's commitment to the town. The 5-year commitment Sara gives to the clinic in return for the support ensures the community has a sustainable workforce and access to necessary diagnostic services provided locally.

INITIATIVE 4: EHEALTH AND MOBILE ACCESS

Bob is a 42-year-old with type 2 diabetes and cardiovascular disease. Bob starts to have a dry mouth, dizziness, and his vision becomes blurred. Bob is home alone and calls 911 for help. The Community Paramedics arrive at his home and determine Bob is experiencing a hyperglycemic event. Bob can follow his doctor's orders and administers his own insulin. Due to this initiative the Community Paramedic has been trained to utilize remote patient monitoring by placing a sensor on Bob's chest that tracks his vitals. The local hospital can monitor Bob's vitals while he stays at home overnight and then Bob follows up with an office visit to his local doctor the next morning.

INITIATIVE 5: RURAL EMERGENCY BEHAVIORAL HEALTH

James is a 28-year-old with a history of substance use. He has been sober for 5 years although he recently lost his job. To deal with the stress James started using meth again. Under the influence of meth, he vandalizes a neighbor's car. Law enforcement is called, and they are familiar with James and his situation. They know he has been a law-abiding citizen for the last 5 years and is usually very respectful to law enforcement. When they arrive on the scene they witness his erratic behavior. Because of this initiative, officers are able to immediately connect with a mental health practitioner who recommends James be admitted for detox. There is now a crisis stabilization unit in his town where James can be admitted for treatment instead of law enforcement placing him under arrest which gives him a criminal record and delays treatment.

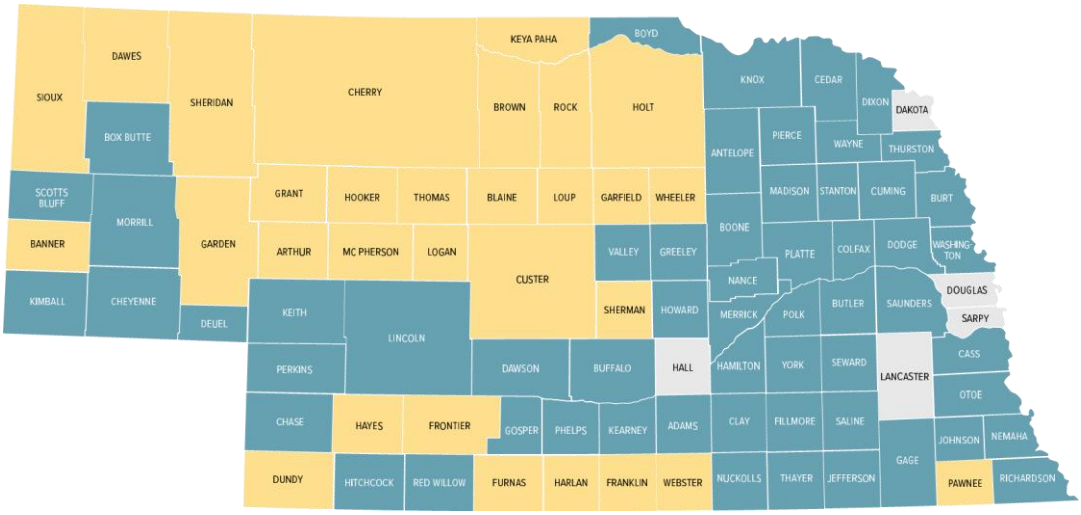
INITIATIVE 6: ASSISTED LIVING FACILITY (ALF) SPECIAL NEEDS POPULATION INCENTIVE MODEL

Wendy is a 38-year-old paraplegic who has been living in her home and now due to muscle wasting needs additional support. Wendy is able to move into an assisted living facility where the staff have been trained with RHTP funds to provide care for those with disabilities that need extra support, and the assisted living facility has modifications to support her needs. This provides community living for Wendy and other young adults where the only other alternative would have been a nursing home or a facility far away from her family.

GRAPHICS AND MAPS

RURAL AND FRONTIER COUNTIES

Figure 1: Nebraska Rural and Frontier Counties

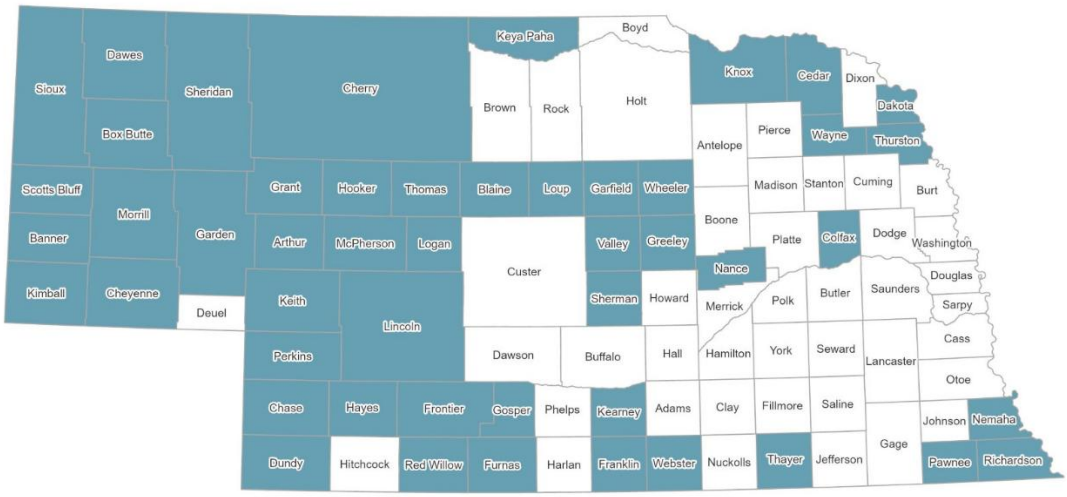


Rural counties

Frontier counties

HEALTH PROFESSIONAL SHORTAGE AREAS (HSPAS) AND CARE DESERT MAPS

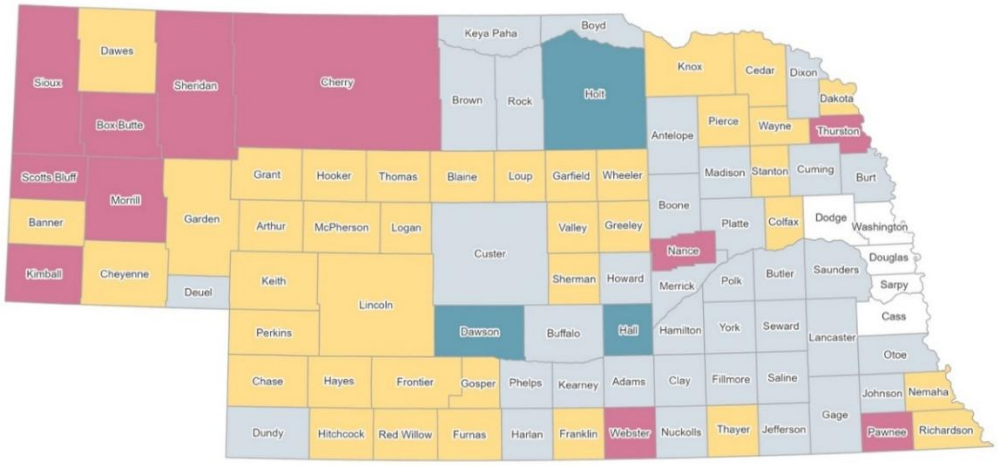
Figure 2: Primary Care HPSAs



Shortage Area

Not a Shortage Area

Figure 3: Obstetrics (OB), Family Medicine, Dental, and Behavioral Health HPSAs



Shortage Designated County: Dental and Behavioral Health

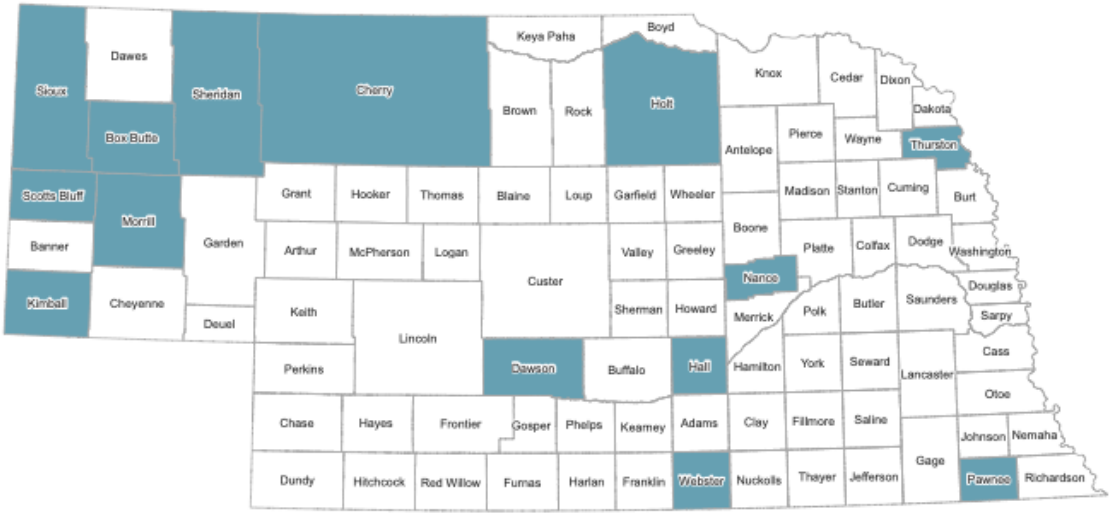
Shortage Designated County: Behavioral Health

Shortage Designated County: OB, Family Medicine, Dental, and Behavioral Health

Shortage Designated County: OB, Family Medicine, and Behavioral Health

No Designation

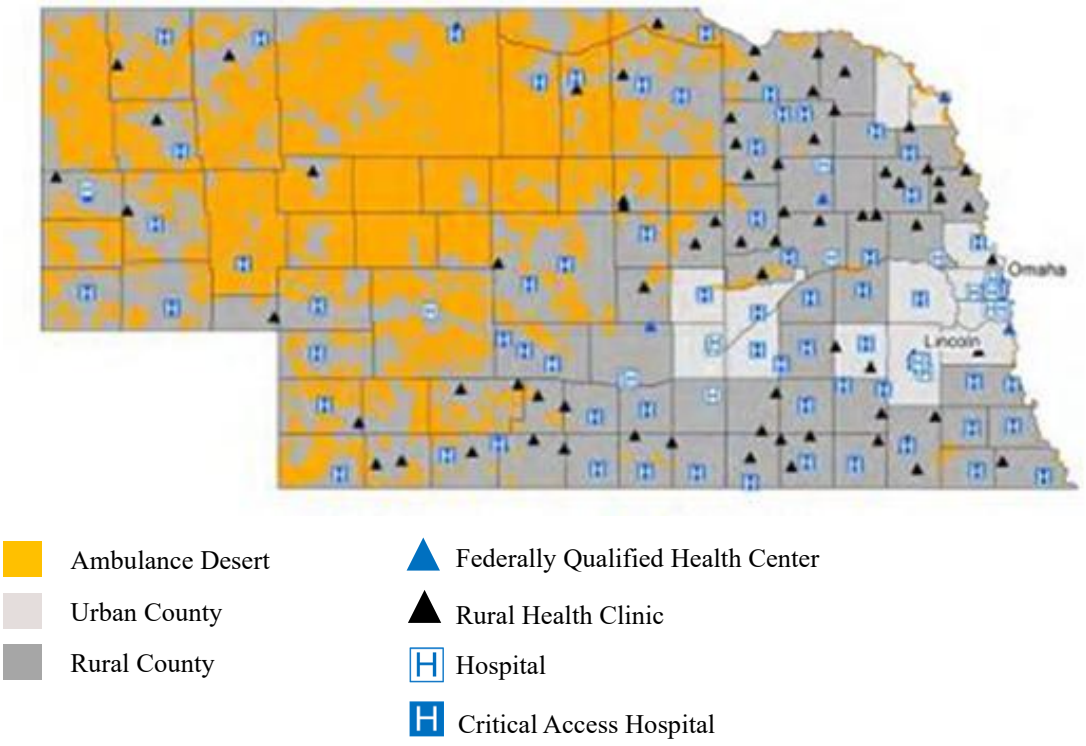
Figure 4: Dental Health Professional Shortage Areas (HPSAs)



Dental Shortage Area

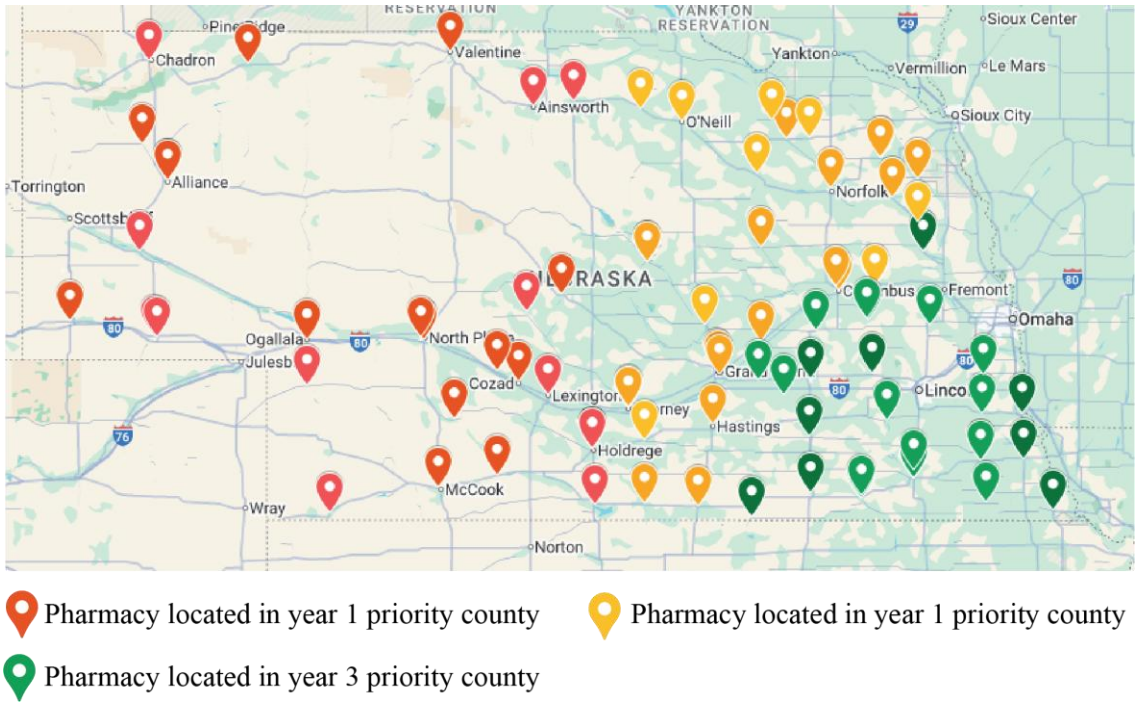
Not a Dental Shortage Area

Figure 5: Health Care Facilities and Ambulance Deserts



MAP OF NEBRASKA PHARMACIES

Figure 6: All Independent Pharmacies



NEBRASKA POPULATION AGE PYRAMIDS

The following age pyramids are built using 2020 Census data, showing the disproportionately older population in rural Nebraska. The rural map shows the population age demographics of HRSA-designated rural counties, as compared to the statewide age demographics. The darker banding represents the Prime Age labor force, the population responsible for supporting the youth and older age portions of the pyramid.

Figure 7: Statewide Age Pyramid

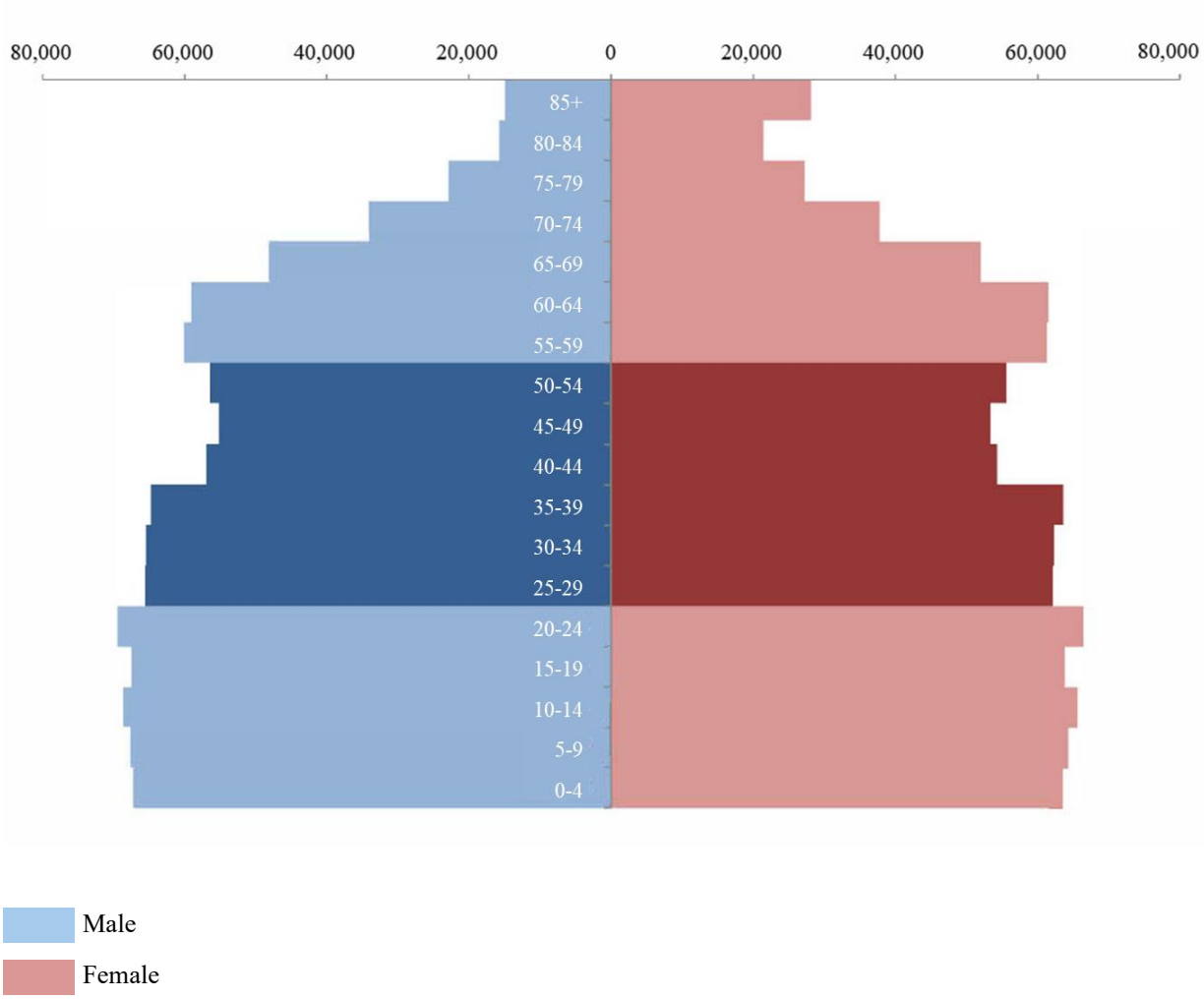
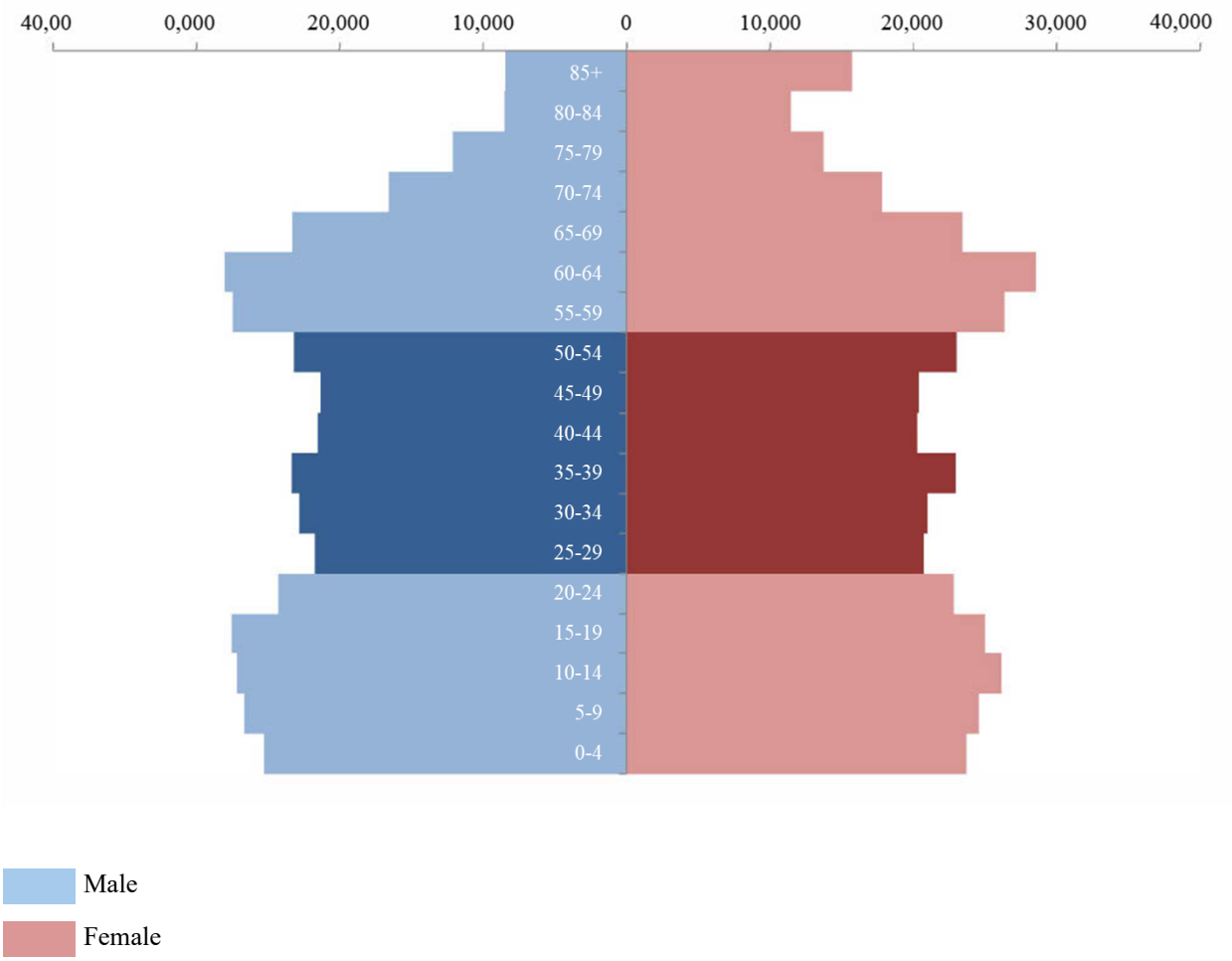


Figure 8: Age Pyramid for HRSA-Designated Rural Counties



TRAVEL TIME MAPS

Figures 9-13 present a hypothetical patient who lives in Mullen, Nebraska, the heart of the Nebraska Sandhills. These maps illustrate the vast travel times for residents of shortage areas and care deserts in greater Nebraska, including maternity care, mental health services, dental services, and long-term care. These maps use estimates of standard travel time under ideal road conditions.

Figure 9: Nebraska Birthing Hospital Travel Time

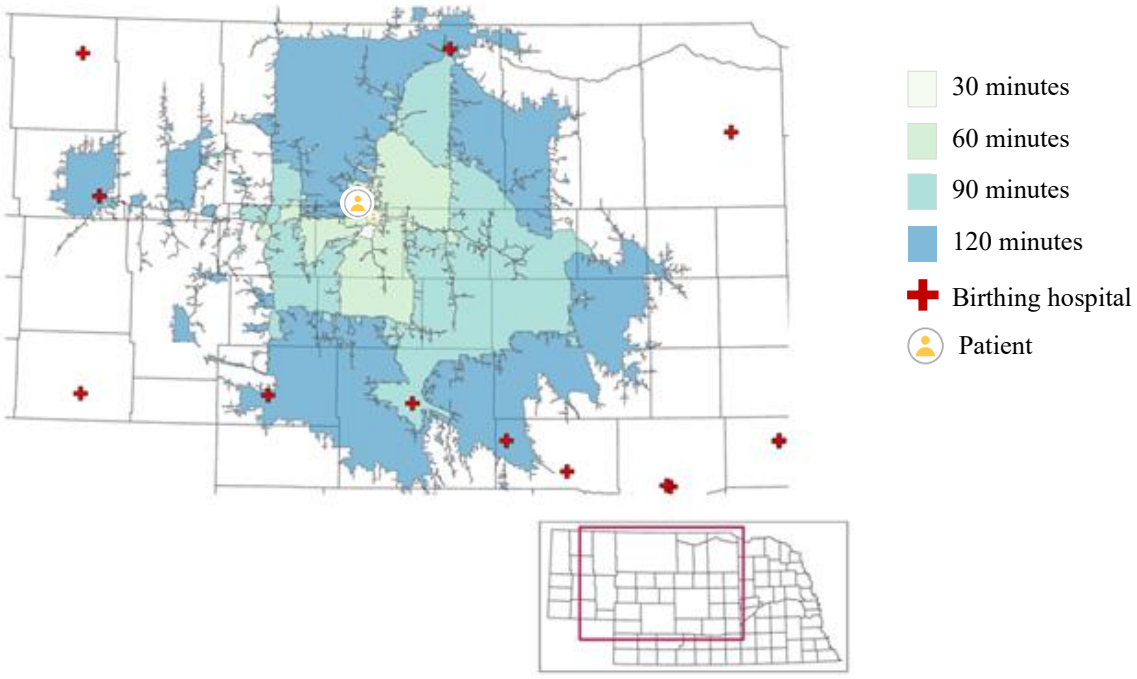


Figure 10: Long-Term Care (LTC) Facility Travel Time Map

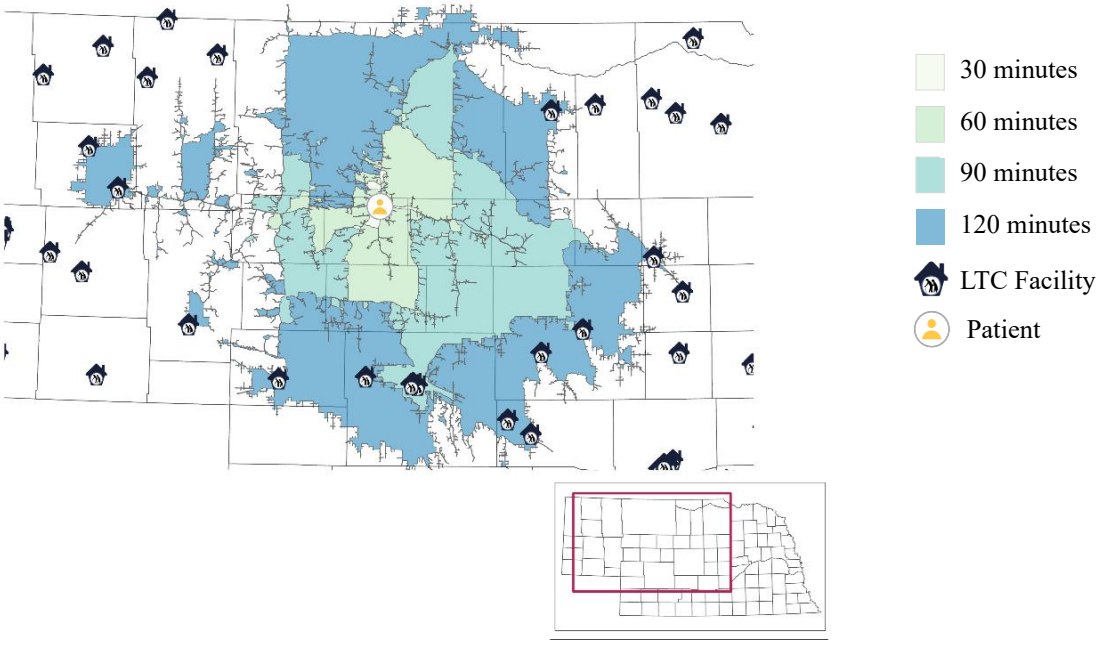


Figure 11: Licensed Independent Mental Health Practitioner (LIMHP) and Licensed Mental Health Practitioner (LMHP) Travel Time Map

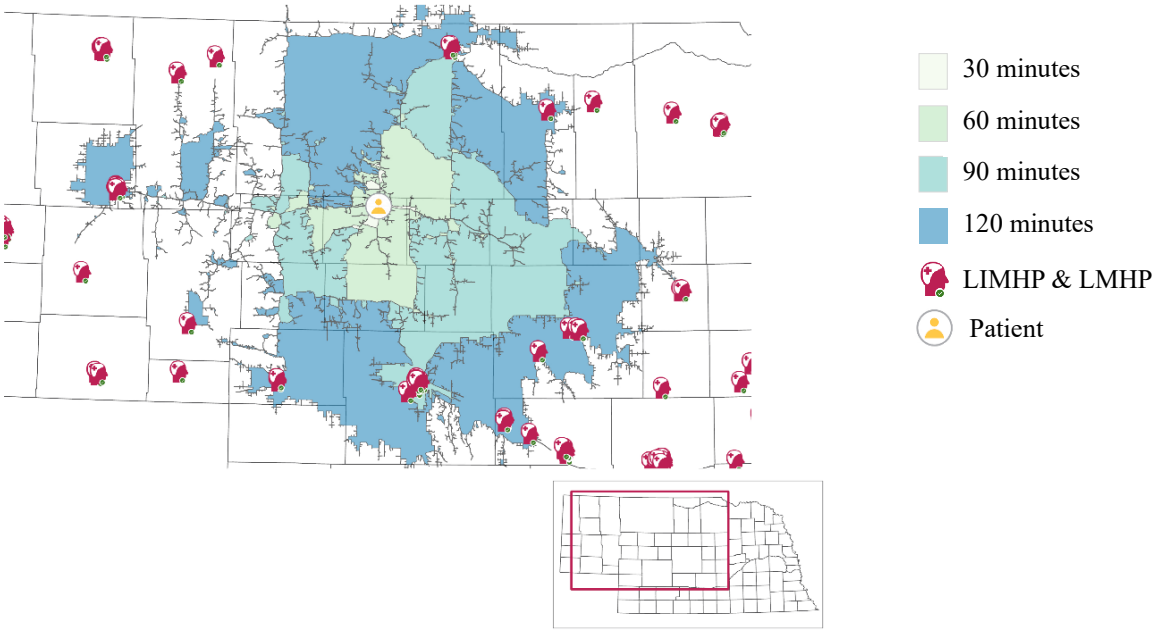


Figure 12: Clinical Psychologist Travel Time Map

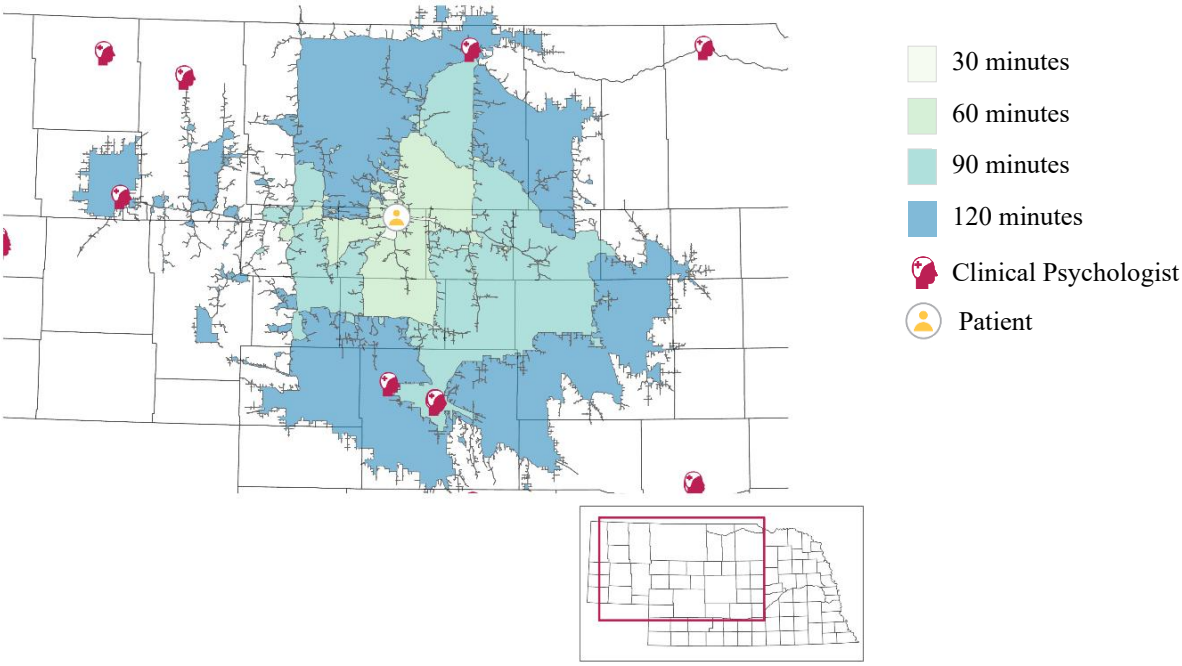
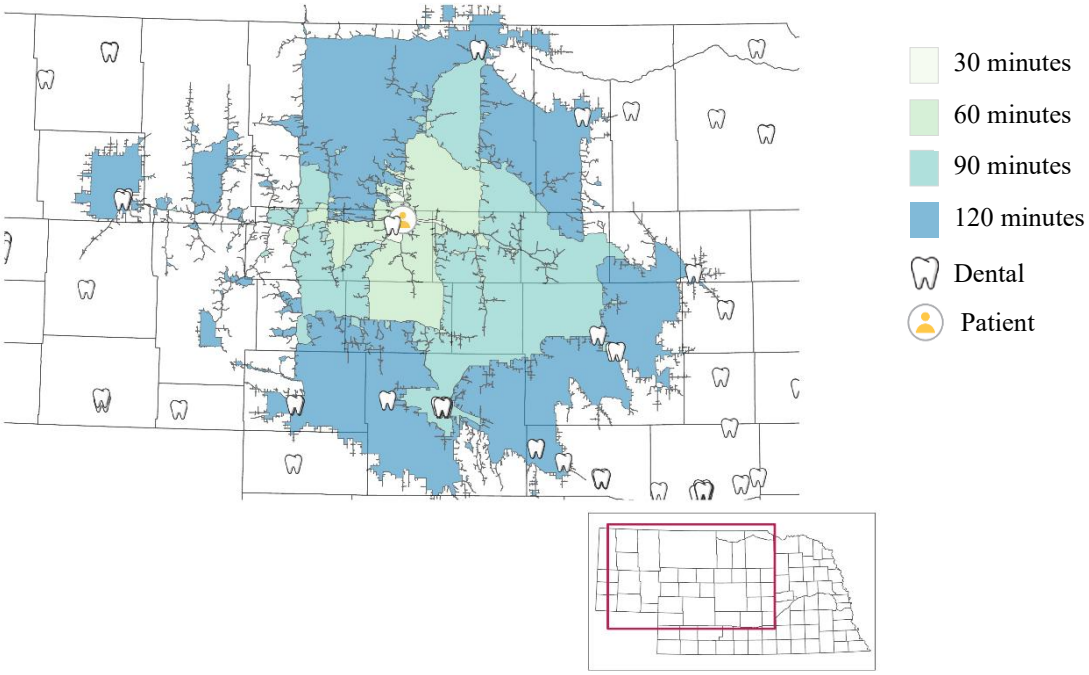


Figure 13: Dental Travel Time Map



NEBRASKA COUNTIES AND FIPS CODES

The following table lists all 93 counties in Nebraska with their corresponding Federal Information Processing Series (FIPS) codes. There are 88 Health Resources & Services Administration (HRSA)-designated rural counties, 30 of which are frontier counties, which are indicated below.

County	FIPS		County	FIPS		County	FIPS
Adams (R)	001		Frontier (F)	063		Nance (R)	125
Antelope (R)	003		Furnas (F)	065		Nemaha (R)	127
Arthur (F)	005		Gage (R)	067		Nuckolls (R)	129
Banner (F)	007		Garden (F)	069		Otoe (R)	131
Blaine (F)	009		Garfield (F)	071		Pawnee (F)	133
Boone (R)	011		Gosper (R)	073		Perkins (R)	135
Box Butte (R)	013		Grant (F)	075		Phelps (R)	137
Boyd (R)	015		Greeley (R)	077		Pierce (R)	139
Brown (F)	017		Hall	079		Platte (R)	141
Buffalo (R)	019		Hamilton (R)	081		Polk (R)	143

County	FIPS		County	FIPS		County	FIPS
Burt (R)	021		Harlan (F)	083		Red Willow (R)	145
Butler (R)	023		Hayes (F)	085		Richardson (R)	147
Cass (R)	025		Hitchcock (R)	087		Rock (F)	149
Cedar (R)	027		Holt (F)	089		Saline (R)	151
Chase (R)	029		Hooker (F)	091		Sarpy	153
Cherry (F)	031		Howard (R)	093		Saunders (R)	155
Cheyenne (R)	033		Jefferson (R)	095		Scotts Bluff (R)	157
Clay (R)	035		Johnson (R)	097		Seward (R)	159
Colfax (R)	037		Kearney (R)	099		Sheridan (F)	161
Cuming (R)	039		Keith (R)	101		Sherman (F)	163
Custer (F)	041		Keya Paha (F)	103		Sioux (F)	165
Dakota	043		Kimball (R)	105		Stanton (R)	167
Dawes (F)	045		Knox (R)	107		Thayer (R)	169
Dawson (R)	047		Lancaster	109		Thomas (F)	171
Deuel (R)	049		Lincoln (R)	111		Thurston (R)	173
Dixon (R)	051		Logan (F)	113		Valley (R)	175
Dodge (R)	053		Loup (F)	115		Washington (R)	177
Douglas	055		McPherson (F)	117		Wayne (R)	179
Dundy (F)	057		Madison (R)	119		Webster (F)	181
Fillmore (R)	059		Merrick (R)	121		Wheeler (F)	183
Franklin (F)	061		Morrill (R)	123		York (R)	185

(R) – rural counties; (F) – frontier counties

LIST OF CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS (CCBHC)

The table below lists the Certified Community Behavioral Health Clinics (CCBHCs), including all active sites of care along and the site addresses.

Active Site of Care Name	Street Address	City	State	ZIP Code	Corresponding CCBHC Entity/Institution Name	Demonstration	State-certified	SAMHSA	HRSA Rurality (Y/N)
Centerpointe	1201 Arbor Drive	South Sioux City	NE	68776	Centerpointe		Y	Y	N
Centerpointe - Auxillary Site	2633 P Street	Lincoln	NE	68503	Centerpointe		Y	Y	N
Community Alliance	7150 Arbor Street	Omaha	NE	68106	Community Alliance		Y	Y	N
Heartland Counseling Services, Inc	1201 Arbor Drive	South Sioux City	NE	68776	Heartland Counseling Services, Inc		Y		N
Heartland Family Services	2101 South 42nd Street	Omaha	NE	68105	Heartland Family Services		Y	Y	N
Heartland Family Services - Benson Auxiliary Site	3300 North 60th Street, Building C	Omaha	NE	68104	Heartland Family Services		Y	Y	N
Heartland Family Services Sarpy Office - Auxiliary Site	302 American Parkway	Papillion	NE	68046	Heartland Family Services		Y	Y	N
Heartland Family Services Nebraska Family Works - Auxiliary Site	4847 Sahler Street	Omaha	NE	68104	Heartland Family Services		Y	Y	N
Lutheran Family Services	1420 East Military Avenue	Fremont	NE	68025	Lutheran Family Services		Y	Y	Y
Lutheran Family Services	2301 O Street, Suite 1	Lincoln	NE	68510	Lutheran Family Services		Y	Y	N
Lutheran Family Services Kountze - MH	2661 Douglas Street	Omaha	NE	68131	Lutheran Family Services		Y	Y	N
Lutheran Family Services Mourning Hope - MH	1311 South Folsom Street	Lincoln	NE	68522	Lutheran Family Services		Y	Y	N
Lutheran Family Services Project Harmony MH	11011 Q Street Suite 104C	Omaha	NE	68137	Lutheran Family Services		Y	Y	N
Lutheran Family Services Urban League MH	3040 Lake Street	Omaha	NE	68111	Lutheran Family Services		Y	Y	N
Lutheran Family Services Crisis Support Service (TFC)	2661 Douglas Street	Omaha	NE	68131	Lutheran Family Services		Y	Y	N
Lutheran Family Services Dana - MH	750 Angels Share Drive	Blair	NE	68008	Lutheran Family Services		Y	Y	Y
Lutheran Family Services Marco - MH	7929 West Center Road	Omaha	NE	68124	Lutheran Family Services		Y	Y	N

Active Site of Care Name	Street Address	City	State	ZIP Code	Corresponding CCBHC Entity/Institution Name	Demonstration	State-certified	SAMHSA	HRSA Rurality (Y/N)
Lutheran Family Services Thanksgiving Lutheran Church	11513 S 37th Street	Bellevue	NE	68123	Lutheran Family Services		Y	Y	N
South Central Behavioral Services	616 West 5th Street	Hastings	NE	68901	South Central Behavioral Services		Y	Y	Y
South Central Behavioral Services - Auxiliary Site	724 South Burlington Avenue	Hastings	NE	68901	South Central Behavioral Services		Y	Y	Y
South Central Behavioral Services - Auxiliary Site	835 South Burlington Avenue, Suite #107	Hastings	NE	68901	South Central Behavioral Services		Y	Y	Y
South Central Behavioral Services - ACT Auxiliary Site	835 South Burlington Avenue, Suite #108	Hastings	NE	68901	South Central Behavioral Services		Y	Y	Y
South Central Behavioral Services - Auxiliary Site	835 South Burlington Avenue, Suite #105	Hastings	NE	68901	South Central Behavioral Services		Y	Y	Y
The Well	1203 South 8th Street	Norfolk	NE	68701	The Well		Y		Y
The Well - Auxiliary Site	2718 13th Street	Columbus	NE	68601	The Well		Y		Y
The Well - Auxiliary Site	1800 West Pasewalk Avenue	Norfolk	NE	68701	The Well		Y		Y
The Well - Auxiliary Site	130 East Walnut Street	West Point	NE	68788	The Well		Y		Y

DETAILED WORK PLAN AND TIMELINE CHARTS

The following table includes tasks and timelines for accomplishing the key milestones listed in the Implementation Plan and Timeline section of this application.

Task by Initiative (Stages)	Start	End
1. MAKE RURAL NEBRASKA HEALTHY THROUGH FOOD AS MEDICINE		
1.1 School Kitchen Modernization Grants		
Finalize program design and application, and make first round of awards (Stages 0-1)	Q2 FY26	Q1 FY27
Monitor round 1 awards, maintain annual award cycles, and provide ongoing monitoring (Stages 2-4)	Q2 FY27	Q4 FY30
Publish outcomes and complete sustainability handoff (Stage 5)	Q4 FY29	Q4 FY31
1.2 Regional Food Pantry Development		
Release request for applications application, and establish agreements with participating entities (Stages 0-1)	Q2 FY26	Q3 FY27
Provide ongoing monitoring and oversight of subrecipients' implementation of infrastructure development (stages 2-4)	Q4 FY27	Q4 FY31
Publish outcomes and complete transition of budget quality funds (Stage 5)	Q1 FY31	Q4 FY31
1.3 Farm-to-School Procurement and Policy TA		
Finalize participation criteria and engage eligible school sites; procure vendor to design and build digital marketplace (Stages 0-1)	Q2 FY26	Q3 FY27
Launch and maintain digital marketplace (Stage 2)	Q4 FY27	Q2 FY28
Provide ongoing TA to participating sites (Stages 2-5)	Q4 FY27	Q4 FY31
1.4 Healthy Menu Design & Culinary Workforce Training		
Conduct a readiness assessment of interested school sites, and design regional training program (Stage 0)	Q2 FY26	Q4 FY26
Launch and expand regional food service and culinary trainings (Stages 1-5)	Q1 FY27	Q4 FY30
1.5 Nebraska Kids Fitness and Nutrition Day		
Nebraska will reestablish the Presidential Fitness Test, aligned with any announced federal guidance associated with Executive Order 14327 (Stage 0-1)	Q2 FY26	Q1 FY29
Finalize program design and launch pilot in partnership with Department of Education (Stages 0-1)	Q2 FY26	Q1 FY27
Expand to central, eastern, and western regions of the State annually (Stages 2-4)	Q2 FY27	Q4 FY29
Maintain statewide implementation and publish outcomes (Stage 5)	Q1 FY30	Q4 FY31
2. REGIONALIZED RURAL ACCESS AND NAVIGATION		
2.1 EMS & Perinatal Regionalization		
Define maternal/neonatal levels of care designations, and design OB transport and maternal-fetal medicine (MFM) pairing pilots (Stage 0)	Q2 FY26	Q4 FY26
Require maternal/neonatal level of care designations (Stage 1)	Q1 FY27	Q4 FY27
Verify level of care designations for first cohort; stand up MFM–rural pairing pilot; purchase perinatal equipment; train pilot EMS (Stages 1-4)	Q1 FY27	Q4 FY30
Publish statewide outcomes and transition governance to sustainability partners (Stage 5)	Q1 FY31	Q4 FY31
2.2 Community Paramedicine (CP) Regionalization		

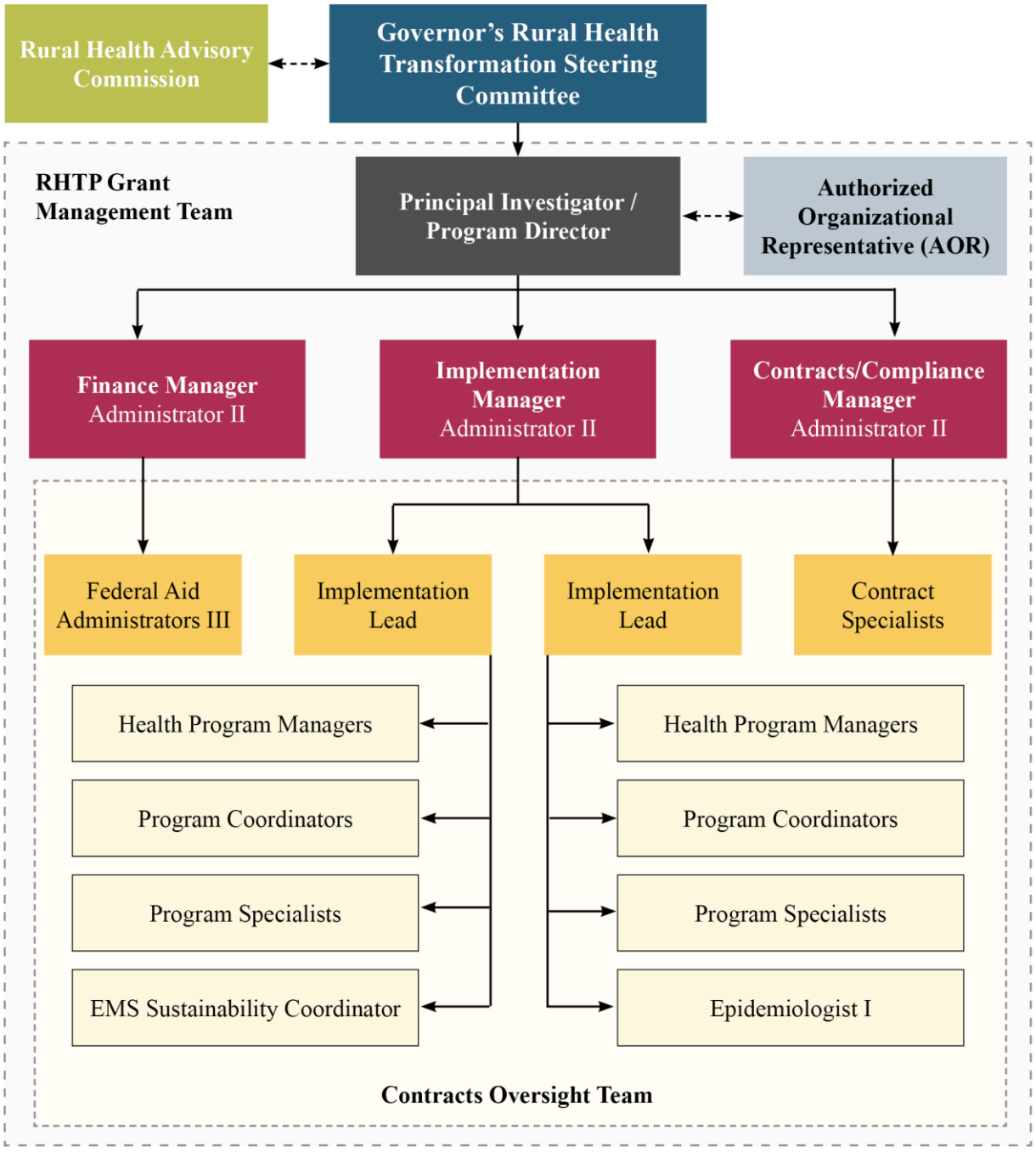
Task by Initiative (Stages)	Start	End
Complete statewide EMS & CP assessment; design regional hub-and-spoke governance, and complete PulsePoint feasibility assessment (Stages 0-1)	Q2 FY26	Q1 FY27
Implement State regulatory change and submit a Medicaid State Plan Amendment (SPA) for CP coverage (Stages 1-2)	Q3 FY26	Q1 FY28
Implement PulsePoint feasibility recommendations and establish regional hubs (Stages 2-3)	Q2 FY27	Q4 FY28
Maintain regional hubs and initiate reimbursement for CPs; provide ongoing monitoring and oversight (Stages 3-5)	Q2 FY28	Q4 FY31
2.3 Rural Health Hubs and Statewide Community Health Worker (CHW) Network		
Draft partner agreements and procure Community of Practice (COP) vendor (Stage 0)	Q2 FY26	Q1 FY27
Introduce and aim to pass legislation for CHW certification (Stages 0-1)	Q2 FY26	Q1 FY28
Draft and submit SPA for CHW coverage (Stage 2)	Q2 FY27	Q1 FY28
Begin CHW reimbursement; monitor and report outcomes reporting sustain via Medicaid reimbursement and local braiding (Stages 3-5)	Q2 FY28	Q3 FY31
2.4 Veteran Electronic Health Record (EHR) Coordination		
Develop site-specific project plans for wave 1 sites; engage hospitals, rural clinics, and EHR vendors (Stages 0-1)	Q2 FY26	Q4 FY26
Implement wave 1 and track milestones (Stages 1-2)	Q4 FY26	Q4 FY28
Implement waves 2 and 3, and provide ongoing monitoring (Stages 2-5)	Q1 FY28	Q4 FY31
2.5 CAH to REH Conversion		
Identify priority communities/facilities for wave 1 and execute contract with contractors and health care supply vendors (Stages 0-1)	Q2 FY26	Q4 FY26
Implement wave 1 and refine model/plan for wave 2 (Stage 2)	Q4 FY26	Q4 FY28
Complete wave 1 and 2 implementation and sustain via diversified, billable services and local co investment (Stages 3-5)	Q1 FY29	Q4 FY31
INITIATIVE 3: RURAL WORKFORCE ACCELERATION		
3.1 Rural Provider Recruitment and Retention Incentive Program		
Open application and make first round of awards; design verification protocols (Stages 0-1)	Q2 FY26	Q1 FY27
Execute initial 1–2 community awards and finalize financing agreements and site selection for short-term housing subsidies (Stage 1-2)	Q1 FY 27	Q2 FY27
Expand program to support up to 5 new communities annually; continuously improve program operations (Stages 3-4)	Q2 FY27	Q4 FY30
Maintain annual awards, implement quarterly verifications, evaluation post-obligation retention (Stages 2-5)	Q2 FY27	Q4 FY31
3.2 Rural VR Simulation & Skills Acceleration Network		
Issue content/vendor RFPs, procure device pool, and design roadshow and training curriculum (Stage 0)	Q2 FY26	Q4 FY26
Establish statewide recognition of VR-based competencies for CE credit (Stage 1)	Q1 FY27	Q4 FY27
Pilot roadshows (5–8 sites/quarter); recruit trainers and implement train-the-trainer cohorts (Stages 1-2)	Q1 FY27	Q4 FY27
Scale and maintain statewide operations and sustained local trainer network (Stages 3-5)	Q1 FY28	Q4 FY31
3.3 Rural Health Care Workforce Incentive and Sustainability Model		
Develop competitive bid for partner capacity-building mini-grants, and build and launch application for participant incentives (Stages 0-1)	Q2 FY26	Q1 FY28

Task by Initiative (Stages)	Start	End
Initiate and maintain participant incentives; facilitate ongoing recruitment and supports/bonuses (Stages 2-3)	Q1 FY27	Q1 FY28
Expand partner network to additional organizations; conduct evaluation of retention (Stages 3-4)	Q2 FY28	Q4 FY29
Continue supports and braided wage subsidies; transition to employer/partner-funded model (Stage 5)	Q1 FY30	Q4 FY31
3.4 School-Age Health Care Pipeline		
Design program expansion of existing program and launch new modules (Stages 0-1)	Q2 FY26	Q4 FY26
Expand partnerships and network building to increase classroom integration (Stages 2-4)	Q1 FY27	Q4 FY30
Develop and implement middle-school elective (Stages 2-5)	Q1 FY27	Q4 FY31
3.5. Subsidized Short-Term Provider Housing		
Establish eligibility criteria, matching fund requirements, and selection process (Stage 0)	Q2 FY26	Q4 FY26
Execute initial 1–2 community awards; finalize financing agreements and site selection (Stages 1-2)	Q1 FY 27	Q2 FY27
Expand program to support up to 5 new communities annually; continuously improve program operations (Stages 3-4)	Q2 FY27	Q4 FY30
Publish outcomes, and transition ongoing housing supports to full local or philanthropic management (Stage 5)	Q1 FY30	Q3 FY31
4. EHEALTH AND MOBILE ACCESS		
4.1 Mobile Maternal Care and Training (Mobile OB)		
Conduct regional assessment (Stage 0)	Q2 FY26	Q1 FY27
Launch and evaluate pilot of 3 mobile clinics; launch toolkit, carts, and virtual CME library (Stages 1-2)	Q1 FY27	Q4 FY28
Evaluate pilot; add 1 unit/year; expand transport training	Q1 FY28	Q4 FY29
Complete sustainability transition in partnership with other Divisions and program partners (Stage 5)	Q1 FY30	Q4 FY31
4.2 Oral Health (Nebraska Teeth Forever [NTF] and Emergency Department Diversion)		
Establish agreements with partner sites and launch NTF operations (Stages 0-1)	Q2 FY26	Q4 FY27
Expand ER-diversion clinic capacity and launch dental outreach program (Stages 2-3)	Q3 FY26	Q4 FY27
Annual scale-up and ongoing monitoring and evaluation (Stages 4-5)	Q1 FY28	Q4 FY31
4.3 Technology Enhanced Pharmacy Services		
Execute agreement for platform use and conduct outreach to rural pharmacies (Stage 0)	Q2 FY26	Q4 FY26
Select pharmacies for Year 1 pilot; implement and evaluate pilot (Stages 1-2)	Q4 FY26	Q4 FY27
Select pharmacies for Years 2 and 3 pharmacies: monitoring ongoing implementation (Stages 3-4)	Q4 FY27	Q4 FY29
Transition to sustainability through shared savings model (Stage 5)	Q1 FY28	Q4 FY31
4.4 Chronic Disease Management/RPM		
Complete internal planning and site recruitment framework, and complete multi-award vendor selection (Stages 0-1)	Q2 FY26	Q4 FY26
Implement State regulatory change and submit SPA for coverage of RPM, remote therapeutic monitoring, chronic care management, and maternal transport (Stages 1-2)	Q2 FY26	Q1 FY28

Task by Initiative (Stages)	Start	End
Complete platform integration and implement pilot launch at 2–3 sites (Stages 1-2)	Q1 FY27	Q2 FY27
Complete year 1 pilot complete and scale to additional cohorts (Stages 2-4)	Q3 FY27	Q4 FY30
Continue coverage, pending pilot evaluation findings and aligning with Prospective Payment System (PPS) and Alternative Payment Models (Stage 5)	Q4 FY30	Q4 FY31
5. RURAL EMERGENCY BEHAVIORAL HEALTH		
5.1 Integrated Primary Care Sites		
Finalize project plan, outreach to primary care clinics and behavioral health providers to assess interest, and launch implementation (Stages 0-1)	Q2 FY26	Q1 FY27
Expand implementation to additional sites, provide ongoing monitoring and quality improvement support (Stages 2-5)	Q1 FY27	Q4 FY30
5.2 Telehealth Crisis Responders for Law Enforcement		
Procure technology platforms for telehealth crisis response (Stages 0-1)	Q2 FY26	Q4 FY27
Launch and expand platform for use by law enforcement officers, and provide ongoing training (Stages 2-4)	Q4 FY27	Q4 FY30
Supporting continuous quality improvement and transition to sustainable practices (Stage 5)	Q2 FY28	Q4 FY31
5.3 Modification of Existing Clinical Facilities for Mental Health Crisis Stabilization Centers		
Release application and select clinical sites for participation; execute agreements (Stages 0-1)	Q2 FY26	Q1 FY27
Implement facility upgrades based on approved plans; select additional awards; and monitor progress outcomes (Stages 2-4)	Q1 FY27	Q4 FY30
Achieve statewide operationalization of crisis stabilization centers and publish outcomes (Stage 5)	Q4 FY30	Q4 FY31
5.4 Behavioral Health Nursing Homes Pilot		
Draft preliminary funding model for non-duplicative add-on rate (Stage 0)	Q2 FY26	Q4 FY26
Implement the pilot in selected nursing homes, providing ongoing support and monitor early performance indicators (Stages 1-4)	Q1 FY27	Q4 FY29
Evaluate and publish findings for pilot; finalize sustainability and payment recommendations based on pilot results (Stage 5)	Q1 FY30	Q4 FY31
6. ALF SPECIAL NEEDS POPULATION INCENTIVE MODEL		
6.1 Incentive Payments for Memory Care and Complex Care		
Draft and submit amendment for the 1915(c) AD Waiver (Stages 0-2)	Q2 FY26	Q2 FY28
Implement incentive payments and monitor outcomes (Stages 3-5)	Q3 FY28	Q4 FY31
6.2 Facility Modernization Grants		
Design and launch application for ALF mini-grants; make awards (Stages 0-1)	Q2 FY26	Q2 FY27
Monitor implementation of first round awards; award mini-grants to additional sites annually (Stages 2-3)	Q2 FY27	Q4 FY30
Continue to provide ongoing oversight and publish outcomes (Stage 5)	Q4 FY30	Q4 FY31
7. NETECH		
Finalize the legal structure and governance model for the fund; secure foundational seed capital from key anchor investors (Stage 0-1)	Q2 FY26	Q4 FY27
Complete the first investment cycle; launch full-scale products and services from cohort 1 (Stages 2)	Q4 FY27	Q4 FY28
Award funding to additional cohorts annually (Stages 3-4)	Q1 FY29	Q4 FY30
Assist funded projects with transition planning (Stage 5)	Q1 FY31	Q4 FY31

ORGANIZATIONAL CHART

The following is the Organizational Chart for Nebraska's RHTP. RHTP team members are embedded within DHHS Divisions.



COMMUNITY PERSPECTIVES ON NEBRASKA'S HEALTH CARE LANDSCAPE

Nebraska's rural health system builds on the strengths of its community partnerships, including collaborations between local health departments (LHDs), universities, tribal organizations, community-based organizations (CBOs), health care providers and associations, and many others. These partners are committed to achieving a robust, high-quality, inter-connected rural health system. Through stakeholder engagement sessions for the RHTP, stakeholders across the State identified key challenges and opportunities that would best serve their local communities, while emphasizing the resilience of Nebraskans and strong partnerships already driving progress.

Theme	Stakeholder Quotes
Distance and Workforce Shortages	• "Sometimes it is easier to get care from another State based on your location in Nebraska." • "In regard to the 4 Nebraska tribes … lack of all services such as medical, dental, & behavioral health services. Recruiting medical staff is definitely a hardship." • A story about a "2-hour car ride to a doctor with zero stop light; the kid out of school for all that time."
Gaps in Behavioral and Specialty Care	• There are "health deserts, food deserts, legal deserts, and mental health deserts." • "Provider shortage, with specialty-service shortage areas. A high transfer percentage" … "related to lack of specialists."
Uneven Infrastructure and Access	• "1 in 7 neighbors in Nebraska experience food insecurity, including 1 in 5 children." • There are "limits in access to care for Medicaid and uninsured patients."
Community Resilience and Collaboration	• "Leverage partnerships and collaborations already in place to enhance services to improve NE rural health care" • "Despite the shortages, we will have a high quality of life for most people. With additional investment into rural areas, we can ensure all people have access to the quality of life that they want and deserve." • "…we can pull together and collaborate and have the people and partnerships to pull this off."

Through the RHTP, Nebraska will lift up the work of these communities and ensure that every resident can access the care they need close to their home.

BUDGET NARRATIVE APPENDIX

As an appendix to the Budget Narrative, please find a full description of the Scope of Work and Use of Funds for subrecipients/subawards and contracts by sub-initiative.

SUBRECIPIENTS/SUBAWARDS

Subawardee/Subrecipient or Selection Method	Scope of Work and Use of Funds
2.2a Community Paramedicine (CP) Regionalization	
Subrecipients through a Request for Application (RFA)	Regional lead agencies, based on the number of regions and boundaries, will be selected based on their ability to develop a rural CP Regionalization model through collaboration and launch trainings. Development will include needs assessments, supply assessments, asset reallocation, affiliation development assistance, participation agreements, technical assistance to retain patients in rural communities through volume, revenue, and efficiency, training for billing support, education, training and testing, workforce coordination and development, VR trainings, standardized care protocols, technology integration feasibility study, integration, and care coordination for statewide coordination and tracking from the ImageTrend paramedicine modules through State HIE, and shared purchasing agreements for infrastructure (G, K). Governance structures will include physician medical directors to ensure appropriate standards for clinical and triage protocols and experts with technical assistance on legal, regulatory, and technological issues for remote care services. Programmatic decisions will include training agencies to develop curriculum for service lines and Emergency Medical Dispatching. Service lines for regionalization include EMS, community paramedicine, rural stockpile resources, and telemedicine and technology assisted care where appropriate (C, D, F). Outcomes include a regional excellence models, increased Critical Care and Community Paramedicine providers, improved financial stability of rural EMS providers, integrated data between EMS services and hospitals, health clinics, and primary care providers, and improved access to community paramedicine services and digital therapeutics in rural areas.
2.3 Rural Health Hubs and Statewide CHW Network	
Local Health Departments (LHDs), Tribal Organizations, Nebraska Association of Local Health Directors (NALHD), Ag Extension Offices, Rural Hospitals and Clinics.	LHDs, tribal organizations, and NALHD will be subawardees based on their leadership and experience of working together. Subawardees will receive funding based on need for Community Health Workers (CHWs) and programmatic priorities aligned with local needs and priorities (such as chronic disease prevention and control, care coordination and navigation, oral health support and education, and maternal or child health) identified for regionalized rural access and navigation (A, C, D, E, F, G, H, I, K). Each awardee will recruit and retain CHWs or create workforce development and other pathway incentives and trainings to increase supply in rural area communities. Funds will also support RPM technology and minimal modifications to existing facilities to embed CHWs in the community, such as piloting a market-ready tech-enabled care station for ambulatory visits, like On-Med, within a tribal organization. Awardees will deploy CHWs to CCBHCs, FQHCs, rural hospitals, tribal organizations, and prisons where needed and CHWs will: 1) Educate individuals and communities about how to use health and social service systems; 2) build individual capacity with information to understand, prevent, and manage health conditions, including chronic disease; 3) motivate and encourage people to obtain care and other services; 4) provide health promotion and disease prevention education tailored to linguistic and cultural needs; 5) connect families to existing services through

Subawardee/Subrecipient or Selection Method	Scope of Work and Use of Funds
	AccessNebraska, facilitate referrals, and provide follow-up support; 6) identify and address barriers to care; 7) develop community-based programs to promote health literacy and healthy behaviors within a population; 8) promote community engagement and awareness of programs; and 9) work in innovative sites of care (like schools, through home visits, and via mobile clinics) to provide education, assessment, and social support. Each awardee will provide technical assistance to clinicians, medical coders, and staff to optimize the use of existing payer mechanisms for sustainable care coordination services. They will also support a statewide Community of Practice (COP) for CHWs in rural areas, fostering collaboration, reinforcing CHW core competencies, and offering specialized training for roles such as home visitors, breastfeeding champions, cancer screening navigators, and parent resource coordinators. The COP will facilitate quarterly meetings to enhance service awareness, reduce duplication, and promote resource sharing, with progress tracked through regular reporting to demonstrate impact over time. Hubs will fund technological solutions for bi-directional, seamless interoperability to share data and enhance care coordination. For sustainable regionalization, subawardees will engage technical assistance for understanding and deploying necessary agreements with local hospitals, clinics, and payers to facilitate data sharing toward formal integration of CHWs into care teams.
2.5 CAH to REH Conversion	
Subrecipients through an RFA	Up to ten CAHs at risk of closure and insolvency will be able to convert to REHs. Scope of work will include planning, technical assistance regarding the transition and impact on billing, subleasing, and virtual care options, renovating limited-care areas to expand services like telehealth clinics, behavioral health crisis units, RPM monitoring stations, or skilled-nursing spaces (D, F, H, J). The initiative will fund facility renovations, clinical equipment, technology integration, and technological solutions to ensure compliance and operational efficiency under the REH model, while collaborating with the Nebraska Hospital Association, Nebraska Rural Hospital Association, and payers to secure billing and reimbursement readiness. Progress will be monitored through regular reporting on long-term financial viability, preservation of essential emergency and outpatient services, preventive health services in vulnerable rural communities, and financial solvency. Flexibility will be provided to the subawardee for award design, but it will be approved by the state in coordination with CMS to ensure compliance. The goal is avoid closures and expansion of rural care deserts.
4.1a Mobile Maternal Care and Training (Mobile OB) – Maternal Care and Training	
Subrecipients through an RFA	A subawardee will be selected based on their ability to lead both local and statewide maternal care transformation. Mom & Baby Mobile Clinic initiative will deploy three mobile units, expanding to six, to deliver prenatal/postpartum care, pregnancy confirmation, fetal monitoring, ultrasound, STI screening, immunizations, health education, and referrals in Nebraska's maternity care deserts, addressing OB access gaps (D, F, G, J, K). The program will establish a statewide OB Readiness and Simulation Training program for birthing/non-birthing hospitals and EMS, including toolkits, mini-grants for OB readiness carts and minor renovations, and a CE library with evidence-based resources. By standardizing EMS transport protocols, expanding tele-OB consultation, and conducting regional gap assessments, the initiative will enhance maternal emergency response, integrate with Nebraska's Rural VR Training Network, and improve care quality and outcomes for mothers and infants in rural communities. Sustainability planning and training will be required includes payer, billing, and administration readiness. These clinic deliverables align with state outcomes.
4.1b Mobile Maternal Care and Training (Mobile OB) – OB Readiness and Training	

Subawardee/Subrecipient or Selection Method	Scope of Work and Use of Funds
Nebraska Perinatal Quality Improvement Collaborative	Subawardee is selected based on its established statewide experts in perinatal quality improvement, with birthing facilities as members and evidence-based initiatives reducing maternal and infant morbidity/mortality. They will access birthing and non-birthing facilities across rural Nebraska and work with subrecipient of the Mobile Maternal Care and Perinatal Regionalization programs. Deliverables include assessments, training and support plans, and create and implement a multi-modality plan to strengthen the maternal are deserts (A, D, G).
4.2a Oral Health Nebraska Teeth Forever (NTF) and Emergency Department Diversion – Mobile Expansion	
LHDs and Tribal Organizations	Subawards will go to selected rural LHDs and tribal organizations based on oral health needs and programmatic priorities aligned with local needs and priorities (such as chronic disease prevention and control, care coordination and navigation, & oral health support and education) identified for regionalized rural access and navigation (A, D, E, G). Awardee will receive funds based on need, rurality, and local initiatives to advance oral health care and achieve state outcomes. Funds will assist LHDs, FQHCs, tribal organizations, and community-based clinics with oral health prevention teams, expansion of oral health access points, rural dental education and rotation programs, and tribal partnerships. Examples of supports to achieve outcomes includes oral kits, software integration, minor renovations for dental expansions, navigation support, virtual visits, and education (D, F, G, J, K). Sustainability planning and training will be required includes payer, billing, and administration readiness. Their specific goals will be to expand and scale of NTF.
4.2b Oral Health NTF and Emergency Department Diversion – Workforce Expansion	
University of Nebraska Medical Center (UNMC) College of Dentistry and Creighton University School of Dentistry	Subawardees are both institutions that have dental education programs that can effectively integrate student rotations into rural areas, providing hands-on training in public health dentistry while addressing service gaps in rural and underserved areas. The UNMC College of Dentistry and Creighton University School of Dentistry will expand and scale rural Nebraska's dental workforce pipeline by implementing student rotations to assist LHD teams in delivering preventive dental services, such as exams, cleanings, sealants, and silver diamine fluoride, while gaining hands-on experience in community and public health dentistry (E). The colleges of dentistry will develop outreach programs to provide portable dental services, including x-rays and limited urgent procedures like extractions, to frontier communities lacking access, in collaboration with tribal organizations who will co-design prevention services and support modest facility upgrades for tribal health facilities. The colleges of dentistry will partner with clinics and facilities on infection prevention and control and antimicrobial stewardship. Outcomes will be tracked to measure student rotations and clinical services provided in rural areas.
4.3 Technology Enhanced Pharmacy Services	
Nebraska Enhanced Services Pharmacies (NESP)	With its established role as a statewide clinically integrated network (CIN) of community pharmacies and deep expertise in enhancing patient-centered services, NESP, as a subawardee, will enhance pharmacy services in rural Nebraska by developing and implementing a mobile application that enables monthly medication reviews, promotes patient adherence, and integrates AI-driven risk assessment screening for patients to connect them to Remote Patient Monitoring (RPM) technology solutions, like blood pressure monitors or glucose trackers. The app will feature user-friendly tools, including automated reminders, adherence tracking, and secure EHR data integration (A, C, D, K). NESP will expand and scale to an anticipated 30 pharmacies per year, providing staff training, and ensure HIPAA and state privacy compliance. Deliverables include the fully functional mobile app, implementation guides, evaluation reports on adherence improvements and risk reduction, and a sustainability plan for statewide rollout.
4.4 Chronic Disease Management / RPM	

Subawardee/Subrecipient or Selection Method	Scope of Work and Use of Funds
Subrecipient through an RFA	DHHS will contract with an entity to plan, implement, enhance, and launch a sustainable systems integration initiative for health care infrastructure across rural Nebraska (C, D, F, K). The contractor will design and execute a comprehensive strategy to integrate health information systems across rural providers, including hospital systems, independent providers, FQHCs, and CCBHCs, ensuring seamless data sharing through the statewide Health Information Exchange (HIE). The initiative will include developing standardized protocols, providing technical assistance for system interoperability, and training staff to optimize integration with existing electronic health record (EHR) platforms. The organization will also establish metrics for continuous improvement and sustainability, with progress monitored through regular reporting and stakeholder coordination to ensure long-term operational success and improved health outcomes. Technology advances may include hospital to home RPM systems, integrating EHR data to connect patients with chronic conditions like diabetes, hypertension, congestive heart failure, and chronic obstructive pulmonary disease to clinicians and CHWs through secure, data-driven tools. Consumer-facing solutions for launch will include RPM kits (including blood pressure cuffs, glucose monitors, pulse oximeters, and scales) with cellular connectivity options for broadband-limited areas, supported by nurses and CHWs who provide device setup, multilingual/low-literacy education, and home/telephonic check-ins, with CHWs. The program will implement virtual visits through telehealth hubs at LHDs and clinics, alongside continuous multi-parameter wearable sensors with AI-assisted analytics for high-risk patients, particularly older adults, to enable timely interventions. To incentivize non-acute care providers, not more than $8 million will be allocated to projects that only engage acute care systems. Systems integration will leverage vendor-neutral technology partners to enhance disease control, reduce readmissions and emergency department visits, and empower rural and tribal communities. Start-ups funded through the Rural Health Catalyst Fund will coordinate on this initiative to spur innovative solutions. Outcomes and deliverables will include innovative care models, interoperability, increased HIE utilization, targeted tech trainings, education and trainings for health care professionals and patients, provision and use of RPMs, streamlined referrals to community-based organizations (CBOs) and comprehensive patient management tracking.
5.1 Integrated Primary Care Sites	
Nebraska Medical Association (NMA)	As a longstanding, trusted partner for physicians across the state and deep connections to rural practices, DHHS will establish a subaward with NMA to incentivize primary care clinics to integrate behavioral health into practices where integrated services do not exist (E, G, H, J, K). NMA will establish criteria for selection focusing on the location, ownership - with a focus on independent practices, and the goals of the RHTP. NMA will provide overarching support and resources for clinic wishing to integrate services. Uses of funds examples include initial start-up allowances, systems redesign, minor renovations, behavioral health provider recruitment and retention, virtual and e-health solutions, technical assistance for billing, and business sustainability planning. NMA will identify clear goals to create clinics with co-located behavioral health and primary care services to increase appropriate access to behavioral health services in rural areas. Outcomes for achievement include recruiting clinics to integrate, deploying resources to help them integrate, monitoring progress, planning for sustainability, and reporting outcomes for state reporting and achievement of goals.

CONTRACTS

Selection Method	Contract
1. Make Rural Nebraska Healthy Through Food as Medicine, 4. eHealth and Mobile Access, & 6. ALF Special Needs Population Incentive Model	
• Contractor: Public Consulting Group • Selection Method: Contract Amendment	Strategic Oversight: Implementation, Evaluation, and Continuous Improvement: DHHS has an existing consulting contract, with an experienced consulting firm, which will be amended for expediency, to expand the scope to include strategic oversight and monitoring for the implementation, evaluation, continuous improvement, and sustainability planning for Making Rural Nebraska Healthy Again, eHealth for Remote Care and Special Needs Population Incentive Model (A, G). The firm will develop and manage a strategic plan to ensure effective execution of activities, conduct mid-grant evaluations to assess progress toward state health goals, and deliver actionable recommendations for ongoing improvement. Deliverables include implementation guides, impact assessments, return-on-investment analyses, an online data platform for real-time monitoring, and a sustainability plan emphasizing rural workforce development. The consultant will collaborate with the state, contractors and subrecipients, and stakeholders.
3.1 Rural Provider Recruitment and Retention Incentive Program & 2.3 Rural Health Hubs and Statewide CHW Network	
RFA	Awards will be made individuals as incentives, retention bonus funding, and trainings to support healthcare careers in rural and remote areas of Nebraska with the highest need for access (E). Funding will be tied to a requirement for 5-year service commitments and recoupments subject to fulfillment of service in a rural or frontier area of Nebraska. The Rural Health Advisory Commission will establish the criteria for prioritization of funds and licenses based on need and shortages. Deliverables and outcomes are aligned to the increase in workforce supply, establishment of training programs in rural areas, and the number of rural health workforce members receiving incentives to move and/or to stay.
4.2c Oral Health NTF and Emergency Department Diversion – Evaluation	
Inter-Agency Agreement: UNMC	The University will conduct a Health Professions Tracking and Public Health Evaluation initiative to assess and strengthen Nebraska's healthcare workforce and public health outcomes, focusing on rural and underserved areas. The scope includes developing a comprehensive tracking system to monitor health professions' distribution, specialties, and retention, particularly in rural clinics, hospitals, and Local Health Departments (LHDs), using data integrated with the statewide Health Information Exchange (HIE). The University will perform public health evaluations to identify gaps in service delivery, measure program impacts, and provide evidence-based recommendations for workforce development and health equity improvements (A, D, E). Deliverables include a workforce tracking database, evaluation reports with health and economic impact analyses, and policy briefs to guide sustainable workforce planning.
5.2 Telehealth Crisis Responders for Law Enforcement	
Request for Proposal (RFP)	Through an RFP focused on improving the intersection of behavioral health and law enforcement in rural Nebraska, an awardee will develop and implement a telehealth-based crisis response platform to provide rural and frontier law enforcement agencies in western Nebraska with 24/7 access to mobile crisis providers, enabling de-escalation and diversion from jail or emergency room care (H). The contractor will collaborate with local crisis response agencies, telehealth vendors, and CCBHCs to create a mobile application that connects law enforcement officers instantly to crisis professionals for real-time support, integrating the platform with the 988 crisis lifeline for immediate face-to-face contact. The initiative includes training rural officers in Crisis Intervention Team (CIT) protocols to enhance de-escalation skills and ensure effective use of the platform. Deliverables include the fully functional crisis response app, training modules, implementation guides, evaluation reports assessing officer utilization of the platform in rural and frontier counties and jail and emergency room diversions for mental health and SUD.

6.1 Facility Modernization Grants	
RFA	Through an RFA, up to $500,000 per site will be awarded to Assisted Living Facilities in HRSA-designated rural, frontier, and tribal areas to fund equipment and safety modifications (e.g., ventilators, dementia-safe doors, Hoyer lifts) and foster partnerships with CAHs, RHCs, and EMS (G, J, K), aiming to increase Medicaid 1915(c) AD Waiver participation, memory care slots, and complex care capacity, with deliverables including implementation timelines, impact reports on resident outcomes and cost efficiencies, and a sustainability plan.
7. NETECH	
RFP	Through and RFP process, a strategically aligned contractor will solicit and vet competitive proposals from companies to develop technological solutions that meet the in rural Nebraska. Incubator groups will be evaluated based on their rural health care focus, resources, track record, success metrics, network quality, and location. Once selected they will establish a steering committee specific to Nebraska's fund and include a non-equity seat for a DHHS employee and a rural provider without financial conflicts to serve as subject matter experts. Operationally, they will foster innovation in Nebraska's rural health care ecosystem by identifying, evaluating, and supporting early-stage health tech startups. The incubator will provide strategic oversight, mentorship, and resources with a preference to companies that deliver or enable care. Funds will be restricted to innovations that serve rural communities, benefit Medicaid, low-income, and vulnerable rural consumers, focus on prevention and management of chronic disease, are significantly different from or fulfill and unmet need, increase quality, affordability and access to care (A, C, D, F, I, K). Other company and funding restrictions will apply in compliance with the NOFO and 2 CFR Part 200, with some modifications included in 2 CFR Part 300. The incubator will not be allowed to pay for fund management activities nor charge any fees to the State. Deliverables include a startup selection and onboarding report, evaluation and legal framework, mentorship and training program plan, investment outcome reports, investment impact assessments with health and economic metrics, and a sustainability plan for companies and products.

LETTERS OF SUPPORT

Please see the remaining pages for Nebraska's four letters of support.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

October 31, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Dear Administrator Oz,

We, the undersigned organizations, write in strong support of the Nebraska Department of Health and Human Services (DHHS) and its Rural Health Transformation Program (RHTP) proposal.

Our organizations represent the largest health care associations in Nebraska comprised of physicians and hospitals across Nebraska. The shared mission of advocating for the health of all Nebraskans by advocating for policies that improve access to care, enhancing public health outcomes, and enhancing the delivery of quality patient care and services to Nebraska communities aligns with the strategic goals of the RHTP.

In partnership with our organizations, DHHS has developed a sustainable rural health plan guided by data. The RHTP supports the Make America Healthy Again (MAHA) framework, driving transformative strategies that strengthen statewide care delivery, workforce capacity, and technology integration.

We, the undersigned organizations below, respectfully request that you consider this proposal, which offers an opportunity to provide long-term, life-changing support for Nebraska's rural families.

Sincerely,

Amy Reynoldson
Executive Vice President
Nebraska Medical Association

Jeremy Nordquist, MPA
President & CEO
Nebraska Hospital Association

Jed R. Hansen, PhD, APRN, FNP-C
Executive Director
Nebraska Rural Health Association

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

October 31, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Dear Administrator Oz,

We, the undersigned organizations, write in strong support of the Nebraska Department of Health and Human Services (DHHS) and its Rural Health Transformation Program (RHTP) proposal.

Collectively, our organizations represent a broad coalition of community partners, nonprofit service providers, and regional stakeholders who share a commitment to improving the health and well-being of our rural and frontier communities.

DHHS's proposed plan aligns closely with our shared priorities and we believe it will provide a once-in-a-lifetime opportunity for the State of Nebraska to transform rural health care access through investments that create sustainability and improve health outcomes.

In partnership with our organizations, DHHS has developed a comprehensive, data-driven proposal designed to build sustainable rural health infrastructure that will serve Nebraskans for decades to come. The RHTP aligns closely with the Make America Healthy Again (MAHA) framework, advancing transformative strategies that strengthen care delivery, workforce capacity, and technology integration statewide.

We, the undersigned organizations below, respectfully request your strong consideration for this proposal. Together, we can create long-term, life-changing support for Nebraska's rural families.

Sincerely,

Rebecca Schroeder, PhD
Vice Chairperson, Rural Health Advisory Commission

Amy R. Behnke
CEO, Health Center Association of Nebraska

Susan Bockrath
Executive Director, Nebraska Association of Local Health Directors (NALHD)

Nicki Behmer Popp
Executive Director, Nebraska Association of Behavioral Health Organizations

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

October 23, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Dear Administrator Oz,

We, the undersigned organizations, write in strong support of the Nebraska Department of Health and Human Services (DHHS) and its Rural Health Transformation Program (RHTP) proposal.

Collectively, our organizations represent a broad coalition of State agencies, community partners, nonprofit organizations, and regional stakeholders who share a commitment to improving the health and economic well-being of our rural and frontier communities.

DHHS's proposed plan aligns closely with our shared priorities and will provide a once-in-a-lifetime opportunity for the State of Nebraska to transform rural communities through investments that improve health. A healthy rural Nebraska is vital for a strong workforce pipeline and long-term economic sustainability.

In partnership with our organizations, DHHS has developed a comprehensive, data-driven proposal designed to build sustainable infrastructure that will serve Nebraskans for decades to come. The RHTP aligns closely with the Make America Healthy Again (MAHA) framework, advancing transformative strategies that strengthen care delivery, deliver healthy foods, build workforce capacity, advance education, and technology integration statewide.

We, the undersigned organizations below, respectfully request your strong consideration for this proposal. Together, we can all create long-term, life-changing support for Nebraska's rural families.

Sincerely,

Brian L. Maher, Ed.D.
Commissioner of Education

Maureen Larsen
Interim Director
Nebraska Department of Economic Development

NEBRASKA
Good Life. Great Roots.
DEPARTMENT OF AGRICULTURE

Jim Pillen, Governor

October 24, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Dear Administrator Oz,

We, the undersigned organizations, write in strong support of the Nebraska Department of Health and Human Services (DHHS) and its Rural Health Transformation Program (RHTP) proposal.

Collectively, our organizations represent a broad coalition of State agencies, community partners, nonprofit organizations, and regional stakeholders who share a commitment to improving the health and economic well-being of our rural and frontier communities.

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In partnership with our organizations, DHHS has developed a comprehensive, data-driven proposal designed to build sustainable infrastructure that will serve Nebraskans for decades to come. RHTP aligns closely with the Make America Healthy Again (MAHA) framework, advancing transformative strategies that strengthen care delivery, deliver healthy foods, build workforce capacity, advance education, and technology integration statewide.

We, the undersigned organizations below, respectfully request your strong consideration for this proposal. Together, we can create long-term, life-changing support for Nebraska's rural families.

Sincerely,

Sherry Vinton
Director, Nebraska Department of Agriculture Assn.

Kris Bousquet
Executive Director, Nebraska State Dairy

Royce Schaneman
Executive Director, Nebraska Wheat Board Commission

Chris Kelley
Chairman, Nebraska Dry Bean