STAFF MEETING MINUTES
LANCASTER COUNTY BOARD OF COMMISSIONERS
COUNTY-CITY BUILDING, ROOM 113
THURSDAY, OCTOBER 4, 2012
8:30 A.M.

Commissioners Present:	Deb Schorr, Chair Larry Hudkins, Vice Chair Bernie Heier Brent Smoyer
Commissioners Absent:	Jane Raybould
Others Present:	Kerry Eagan, Chief Administrative Officer Gwen Thorpe, Deputy Chief Administrative Officer Dan Nolte, County Clerk Cori Beattie, Deputy County Clerk Ann Taylor, County Clerk's Office

Advance public notice of the Board of Commissioners Staff Meeting was posted on the County-City Building bulletin board and the Lancaster County, Nebraska, web site and provided to the media on October 4, 2012.

The Chair noted the location of the Open Meetings Act and opened the meeting at 8:30 a.m.

AGENDA ITEM

1 APPROVAL OF THE STAFF MEETING MINUTES OF THURSDAY, SEPTEMBER 27, 2012

MOTION: Smoyer moved and Heier seconded approval of the minutes of the September 27, 2012 Staff Meeting. Smoyer, Heier and Schorr voted aye. Hudkins and Raybould were absent from voting. Motion carried 3-0.

Hudkins arrived at the meeting at 8:32 a.m.

2 ADDITIONS TO THE AGENDA

A. Microcomputer Request from Juvenile Court (Exhibit A)
B. Southeast Community College (SCC) Annual Report (Exhibit B)
C. Habitat for Humanity

MOTION: Heier moved and Hudkins seconded approval of the additions to the agenda. Hudkins, Smoyer, Heier and Schorr voted aye. Raybould was absent from voting. Motion carried 4-0.

ACTION ITEMS

A. Microcomputer Request No. 867094, $592.97 from the Microcomputer Fund for a PC for County Commissioners Office

MOTION: Heier moved and Hudkins seconded approval. Smoyer, Heier, Hudkins and Schorr voted aye. Raybould was absent from voting. Motion carried 4-0.

ADDITIONS TO THE AGENDA

A. Microcomputer Request from Juvenile Court (Exhibit A)

MOTION: Hudkins moved and Smoyer seconded approval of the request with funding through the Microcomputer Fund. Heier, Smoyer, Hudkins and Schorr voted aye. Raybould was absent from voting. Motion carried 4-0.

3 NEW COUNTY COURT COURTROOM DESIGN - Greg Newport and Heather Keele, The Clark Enersen Partners; Don Killeen, County Property Manager; Mike Lee, Facilities Manager

Greg Newport, The Clark Enersen Partners, presented the design for a new County Court courtroom and judge's chambers that will be located on the second floor of the Justice and Law Enforcement Center (Exhibit C). He said approximately 5,000 square feet of space will be renovated and estimated the cost at $640,000 ($125 per square foot). Much of the finishes will be identical in appearance to the other courtrooms but more durable materials will be used. Newport said the new courtroom will be one of the larger courtrooms and will meet the new Americans with Disabilities Act of 1990 (ADA) requirements and the sound requirements for courtrooms that were adopted by the Nebraska Court System. Don Killeen, County Property Manager, said this will fill out the second floor. The next courtrooms will be located in the building that currently houses the jail.

In response to a question from Heier, Newport said the plans have been discussed with County Court Judges Fox and Yardley. Heier suggested they also share the plans with the County Attorney and Public Defender and seek their input.

Heier then asked why the judges have private restrooms. Newport said it is a security issue, adding the building is not configured for a central restroom in the judges' suite area.

Hudkins inquired about the size of the monitors that are shown in the plans. Newport said they plan to have 70" adjustable monitors to provide visibility from the jury box, counsel benches and gallery. Heier suggested that consideration be given to suspending monitors from the ceiling.

Schorr asked when construction will begin. Killeen said Juvenile Probation will be moved out of the space in November and construction can begin after that. Construction is estimated to take five months.

Becky Bruckner, Judicial Administrator for County Court, appeared and noted that Courtroom 10, which is located in the building that houses the jail, is still in use.

4 COMMUNITY MENTAL HEALTH CENTER (CMHC) INVITATION TO NEGOTIATE (ITN) DRAFT - Ron Sorensen, CMHC Executive Director; C.J. Johnson, Region V Systems Administrator

NOTE: Sorensen and Johnson are also members of the Invitation to Negotiate (ITN) Committee.

Ron Sorensen, CMHC Executive Director, presented the draft of the ITN document and a draft timeline for the CMHC transition (Exhibits D and E). He noted there will still be revisions to the ITN document to provide additional information such as service descriptions and rates. In terms of the timeline, Sorensen said there will be focus groups (providers, staff, consumers and stakeholders) over the next few months. C.J. Johnson, Region V Systems Administrator, said feedback from the focus groups may identify the need for an additional step, such as a Request for Qualifications (RFQ). He said the ITN Committee is scheduled to meet again on December 5, 2012 and could have meetings through January, 2013 to finalize the document. **NOTE:** The timeline shows release of the ITN document to potential providers on January 31, 2013. Johnson said he believes negotiations could be completed and contracts in place by June 30, 2013.

Schorr asked how the $1,454,805 figure shown in the third paragraph on Page 1 for the Crisis Center was determined. Sorensen said that figure was taken from the budget. Johnson said the amounts are not necessary the same in the different budgets and will need to be clarified. He said the upcoming Presidential election and subsequent decision by the State may also influence funding. Johnson said the County Board will also need to make a decision regarding a funding commitment.

Schorr noted Comment (AT4) on Page 3 which questions the role the Lancaster County Board will play in negotiations. She said she assumed the County would have a representative on the negotiating team. Johnson said the comment was related to the shift of authority and who would be responsible for ensuring the transition took place. He said Lancaster County can stay involved as part of the oversight component.

Johnson noted concerns have been expressed that CMHC may be "piecemealed" into the community, causing consumers to have to go to multiple places for services. He said if there is collaboration between different kinds of providers, services could be made available in one place. Johnson noted there are a significant amount of consumers that only go to CMHC for medical management. With integration, those individuals could go to a single location, such as the Peoples Health Center (PHC), and get primary care at the same site.

Schorr suggested deletion of Number 5 on Page 6 as it is vague and repetitive of points made in other areas (person-centered and self-determination). Johnson said one of the issues of ongoing discussion at the ITN Committee meetings was how to include language that promotes consumer involvement without becoming redundant. He added that Federally Qualified Health Centers (FQHC's) are required to shift their practices over the next two years to a person-centered approach.

Schorr noted a statement on Page 8 that the new provider(s) will have the option of remaining at the existing location of 2201 S. 17th Street for a minimum two-year period and asked when that two-year period will begin. Johnson said that is a question for the Board to decide.

Schorr noted the reference to General Assistance (GA) on Page 8 and asked whether the intent is to transfer 100% of the GA funding to the new provider(s). Eagan said no. Johnson pointed out that health care reform may eliminate the need for GA for behavioral health and primary care.

Schorr referred to the second sentence on Page 17 which states: *The ultimate goal is to reduce the stress of transition and retain as many consumers and staff as possible*. She felt that was an important goal, but not the ultimate goal, and suggested the sentence be reworded. Johnson cautioned that stress on this population could impact other systems (Crisis Center, Hospitals, Jail, etc.).

Schorr said she does not have a clear understanding of how evaluation methodology differs from negotiation methodology (see first paragraph on Page 21). She also pointed out that Section 2.4 does not contain information about the negotiation meetings as stated in the last paragraph on that page. Johnson said they will look at revising that language.

Heier noted a question is posed in the Outpatient Psychotherapy section of Attachment A on whether community-based sex offender management should be a separate category. He said he believes it should. Sorensen said funding will be an issue because the contract to serve sex offenders coming out of the Lincoln Regional Center (LRC) ended in September. Brittany Behrens, Deputy County Attorney, appeared and said she received a contract yesterday that will extend the funding from September 30, 2012 through June 30, 2013. The amount of the contract is $210,000. Johnson said he understands legislation will be introduced to promote more community-based support in relation to identified sex offenders.

The Board requested another update after the focus group sessions.

The following members of the ITN Committee were in attendance: Lori Seibel, Community Health Endowment (CHE); Brent Smoyer, County Commissioner; Gail Anderson, CMHC Advisory Committee; J Rock Johnson, consumer advocate; Kerry Eagan, County Chief Administrative Officer (Ex-Officio); and Vince Mejer, Purchasing Agent (Ex-Officio).

5 A) COMMUNITY CORRECTIONS BOOKING PROCESS DISCUSSION; AND B) COMMUNITY CORRECTIONS CASE MANAGEMENT SOFTWARE - Kim Etherton, Community Corrections Director; Mike Thurber, Corrections Director; Brittany Behrens, Deputy County Attorney

A) Community Corrections Booking Process Discussion

Discussion took place with Kim Etherton, Community Corrections Director, and Mike Thurber, Corrections Director, regarding the possibility of having Community Corrections book or screen certain types of offenders and release or move them to supervision by Community Corrections, rather than having them transported to the new Lancaster County Adult Detention Facility (LCADF). Thurber noted that LCADF is under Nebraska Jail Standards and said there are certain requirements for booking and release. He pointed out that local law enforcement cites and releases almost 20,000 offenders a year. It was also noted that 75% of offenders booked into the jail are released within 8 hours. Heier said LCADF is a 24-hour facility and asked whether Community Corrections has staff available that could provide the service on a 24-hour basis. Etherton said her staff is only available until 9:00 p.m. That could be expanded with an additional screener position. She also pointed out that Community Corrections does not have direct access to the National Crime Information Center (NCIC) database to check for outstanding warrants.

Board consensus was to continue to explore moving in this direction.

B) Community Corrections Case Management Software

Etherton discussed a proposed contract with New Dawn Technologies, Inc. for case management software (cost is $95,572).

Behrens said the software company has made requested changes to the contract with two exceptions: 1) Removal of limitation of liability (liability will be limited to $500,000); and 2) Dispute resolution provision (all other legal remedies would be available in the event an agreement could not be reached through binding arbitration/mediation).

In response to a question from Schorr, Etherton said she did not include the expense in her budget. Gwen Thorpe, Deputy Chief Administrative Officer, said it may have been included in the Information Services (IS) development budget. The Chair suggested that Etherton discuss the funding issue with Dennis Meyer, Budget and Fiscal Officer.

The Board scheduled the contract on the October 9, 2012 County Board of Commissioners Meeting agenda for action.

Smoyer exited the meeting at 10:00 a.m.

6 EQUINE SCIENCE FACILITY - Alan Wood, Erickson & Sederstrom, P.C.; Alan Moeller, Assistant Vice Chancellor, University of Nebraska-Lincoln (UNL); Steve Waller, Dean of the College of Agricultural Sciences and Natural Resources (CASNR), UNL; Ron Snover, Managing Director, Lancaster Event Center; Julie Burton, Assistant Managing Director, Lancaster Event Center

Alan Wood, Erickson & Sederstrom, P.C., said the University of Nebraska-Lincoln (UNL) approached the Lancaster County Agricultural Society several months ago regarding the possibility of locating an equine science facility on the County Fairgrounds. He said UNL and the Ag Society Board have entered into a letter of intent to explore the possibility of doing so.

Alan Moeller, Assistant Vice Chancellor, UNL, explained that UNL has the need for a facility for programs related to the UNL Rodeo, the Animal Science Equine Program, and Equestrian Program. He said they need indoor facilities, a barn and an indoor arena. The indoor facility would include a classroom, multi-purpose room, offices, storage, locker room and showers. The indoor arena would have 80 horse stalls and related facilities (feed and equipment storage, wash stalls, and tack rooms). Moeller estimated that approximately 45,000 square feet will be needed for the stand-alone facility.

Steve Waller, Dean of the College of Agricultural Sciences and Natural Resources (CASNR), UNL, said rodeo facilities on campus are limited and must be relocated. He said the Equine Science Program has also grown and needs additional space. Waller said the new facility would also include an equine examination room, which will tie into the Veterinarian Medicine Program, and classroom space for 4-H Clubs to meet. He added that the facility would be made available to the Event Center during the Lancaster County Fair.

In response to a question from Hudkins, Waller said enrollment in CASNR continues to grow and is currently at an all-time high.

Smoyer returned to the meeting at 10:12 a.m.

Hudkins said his only reservation is that the best location for the facility appears to be where the Event Center's campgrounds are currently located. He felt the campgrounds should be kept out of the floodplain if relocated. Wood said they are working on the floodplain/floodway issue. Heier suggested that Ron Snover, Managing Director, Lancaster Event Center, contact the Planning Department to see what can be done with the floodplain and asked that he keep the County Board updated. Julie Burton, Assistant Managing Director, Lancaster Event Center, reported that usage of the campgrounds has increased significantly since the State Fair Park campground closed.

Heier asked how the facility fits in with plans for proposed expansion of the Event Center (Phase Three). Wood said there will be economies of scale if they are constructed at the same time. He said this facility would be financed through the Lancaster County Agricultural Society Joint Public Agency (JPA), with a long-term lease, and said the lease payments would service the debt on the bonds that would be issued for the construction. Wood estimated the cost of construction at $6,000,000 to $7,000,000. He added that plans for Phase Three are being refined.

Heier asked whether it would be advantageous to attach the facility to an existing building. Wood said that might not work with the driveways and parking lot.

Heier asked whether UNL would be willing to trade land it owns north of Havelock Avenue in exchange for construction of the facility. Moeller explained that the land is being used for crop research.

Hudkins exited the meeting at 10:24 a.m.

7 PENDING LITIGATION - Mike Thew, Chief Deputy County Attorney

MOTION: Smoyer moved and Heier seconded to enter Executive Session at 10:25 a.m. for the purpose of protecting the public interest with regards to pending litigation and a security matter.

The Chair restated the motion for the record.

ROLL CALL: Heier, Smoyer and Schorr voted aye. Hudkins and Raybould were absent from voting. Motion carried 3-0.

Hudkins returned to the meeting at 10:28 a.m.

MOTION: Smoyer moved and Heier seconded to exit Executive Session at 10:47 a.m. Hudkins, Heier, Smoyer and Schorr voted aye. Raybould was absent from voting. Motion carried 4-0.

8 EXECUTIVE SESSION (SECURITY MATTER) - Andy Stebbing, County Treasurer

See Item 7.

9 ACTION ITEMS

A. Microcomputer Request No. 867094, $592.97 from the Microcomputer Fund for a PC for County Commissioners Office

Item was moved forward on the agenda.

10 CONSENT ITEMS

There were no consent items.

11 ADMINISTRATIVE OFFICER REPORT

A. Nebraska Association of County Officials (NACO) Legislative Conference (October 11, 2012 in Kearney, Nebraska)

It was noted counties have been asked to bring ideas to the legislative conference on how to make up revenue they currently collect or identify what mandated services they could eliminate to replace revenue from the inheritance tax, should it be eliminated. Board members suggested the following: 1) Eliminate responsibility of counties to pay

Nebraska Health and Human Services (HHS) rent; 2) Give counties a share of sales tax; 3) Transfer funding of the court system to the State; 3) Increase funding for sex offender treatment and tracking; 4) Funding for court security; and 5) Jail reimbursement. Board members were asked to give any additional suggestions to Commissioner Heier who will be attending the legislative conference.

B. Prudential Client Conference Report

Eagan said he received information on different types of funds, including institutional sub-advised funds, and fiduciary best practices. He also reported that Prudential is exploring the possibility of offering Voluntary Employees' Beneficiary Association (VEBA) accounts for medical costs, using the existing investment array.

C. Letter to Governor Heineman Regarding Inheritance Tax

Several minor revisions were suggested.

The Board scheduled action on the item on the October 9, 2012 County Board of Commissioners Meeting agenda.

D. Notice of City Surplus Property Near 20th and N Streets

Informational only.

E. Legal Opinion Request Regarding Assignment of Non IV-D Cases (Cases Where Child Support is Established and Maintained Privately) to Child Support Referee

MOTION: Smoyer moved and Hudkins seconded to proceed with the legal opinion request. Heier, Smoyer, Hudkins and Schorr voted aye. Raybould was absent from voting. Motion carried 4-0.

ADDITIONS TO THE AGENDA

B. Southeast Community College (SCC) Annual Report (Exhibit B)

Staff was asked to schedule the report on a County Board of Commissioners Meeting agenda.

C. Habitat for Humanity

There was Board consensus to volunteer to assist on October 25th in the construction of a Habitat for Humanity house.

12 PENDING

There were no pending items.

13 DISCUSSION OF BOARD MEMBER MEETINGS

A. Planning Meeting - Schorr, Hudkins

Schorr and Hudkins reported that discussion included the Equine Science Facility and an issue involving rural water hook-up fees.

B. Lincoln Metropolitan Planning Organization (MPO) Officials Committee - Schorr, Hudkins

Schorr said they approved the Transportation Improvement Plan. She said they also discussed delays on the South 56th Street project and where the South Beltway is on the Nebraska Department of Roads' (NDOR's) tiered list of projects.

C. Chamber Coffee - Raybould, Smoyer

Smoyer said he and Raybould reported on the jail, the Community Mental Health Center (CMHC) Invitation to Negotiate (ITN) process, and inheritance tax. He said Raybould also discussed the potential for savings from consolidating government functions, such as the County Sheriff's Office and Lincoln Police Department (LPD) and County Engineering and City Public Works & Utilities. Smoyer said there are issues, such as differences in pension plans, that would have to be addressed. **NOTE:** LPD has a defined benefits plan and the Sheriff's Office has a defined contribution plan. He said he believes it would make more sense to have the County Attorney's Office take over the City Attorney's Criminal Division or merge the County Clerk and City Clerk's Offices. Hudkins noted there are also differences in pay scales that could make merging departments cost prohibitive. He felt the Board should look at making the County Engineer an appointed position when Don Thomas, County Engineer, retires. Eagan said it would require a legislative change. Schorr suggested the Lincoln Chamber of Commerce and Lincoln Independent Business Association (LIBA) may want to study the issue further, with input from the County and City. Appointment, rather than election, of the row offices was suggested as a topic for the Tri-County Meeting with Douglas and Sarpy Counties.

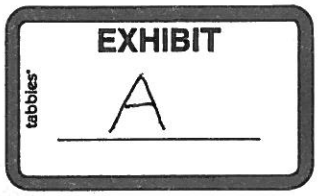
14 EMERGENCY ITEMS AND OTHER BUSINESS

There were no emergency items or other business.

15 ADJOURNMENT

MOTION: Heier moved and Hudkins seconded to adjourn the meeting at 11:17 a.m. Smoyer, Hudkins, Heier and Schorr voted aye. Raybould was absent from voting. Motion carried 4-0.

Dan Nolte
Lancaster County Clerk



From: Theresa L. Emmert
To: Craig A. Gifford; PCRequest
Cc: Reggie L. Ryder; Roger J. Heideman
Subject: FW: Internet Explorer 9.0
Date: Thursday, September 27, 2012 10:15:30 AM

Craig,
We would like to put in a second request for a new computer along with my original request. Judge Roger Heideman also uses the PSCMIS system for our Drug Court and his older computer will have the same compatibility issues as mine if we tried to upgrade his operating system to handle the PSCMIS system. We would like to order a quad core computer exactly like the one I have requested and we plan to repurpose his older computer within our office to replace an even older unit. No additional monitor will be necessary.

Please let me know if you need any additional information from me. Thanks.

Theresa Emmert
Court Administrator
Lancaster County Juvenile Court
575 S. 10th Street
Lincoln NE 68508
Ph: (402) 441-5646
Fax: (402) 441-6930

From: Theresa L. Emmert
Sent: Wednesday, September 26, 2012 3:27 PM
To: Craig A. Gifford
Cc: Reggie L. Ryder
Subject: FW: Internet Explorer 9.0

Craig,
I was able to talk with the judges today and we decided that the smartest option is to go with a new computer for me to avoid the upgrade compatibility issues that you and I discussed yesterday. We will keep my old computer and use it within our office to replace an even older unit. Please order a quad core unit and a 19" monitor for Juvenile Court and let me know if you need any additional information.

Also, we requested and were approved for 3 memory upgrades through the microcomputer fund and we would like to have you order those modules. I will identify those 3 computers for your IS folks when the modules arrive.

Theresa Emmert
Court Administrator
Lancaster County Juvenile Court

575 S. 10th Street
Lincoln NE 68508
Ph: (402) 441-5646
Fax: (402) 441-6930

From: Craig A. Gifford
Sent: Tuesday, September 25, 2012 9:59 AM
To: Theresa L. Emmert
Subject: IE 9.0 Browser

Hi Theresa, I have a meeting at 10, and you were not available when I just tried you, so I will visit with you today if possible, but in the mean time I wanted to share with you that a requirement for IE 9.0 (Internet Explorer 9.0) requires that you have Windows 7 for the operating system. The Work Order for your requirement for IE 9.0 states that you have a Windows XP machine with IE 8.0. The best solution would be to handle this with a new PC with Windows 7. Installing Windows 7 on an old machine is not high on my list of recommendations, but we will work with you to handle this need. I wanted to give you some food for thought. Thanks – Craig

---

From: Theresa L. Emmert
Sent: Monday, August 27, 2012 10:12 AM
To: Sandy K. Ries
Subject: FW: Internet Explorer 9.0

Sandy,
See the following email I received from IS folks at State of NE Probation. I use the PSCMIS system for Family Drug Court and it appears I will need to upgrade to Internet Explorer 9 in order to keep using it. I currently have IE8 and Windows XP. What problems will this cause for me?

Theresa Emmert
Court Administrator
Lancaster County Juvenile Court
575 S. 10th Street
Lincoln NE 68508
Ph: (402) 441-5646
Fax: (402) 441-6930

From: Bunch, Kimberly [mailto:kimberly.bunch@nebraska.gov]
Sent: Friday, August 24, 2012 3:37 PM
To: Jared D Gavin; pyakel@dc4dc.com; Connie Hultine (connieh@hallcountyne.gov); Theresa L. Emmert
Cc: Carlson, Scott
Subject: Internet Explorer 9.0

Folks:

We are going to be doing some enhancements to NPACS, PSCMIS and Service Provider System this fall. With that in mind, please have your Internet Explorer

upgraded to version 9.0 if you have not already done so. If you have any questions or concerns, please let me know.

Thanks!

Kim

Kimberly J. Bunch, MS
Nebraska Supreme Court/Probation Administration
P.O. Box 98910
Lincoln, NE 68509
402.471.3155 (Direct)
402.471.4488 (HelpDesk)
402.471.4136 (Fax)
402.326.4946 (Cell)
http://supremecourt.ne.gov/probation/

Microcomputer Estimate

10/03/2012

Juvenile Court	
Control #	87155

Funding Source		
Acronym:	JJC	Juvenile Court
Special Funding Source:		

Hardware	PART #	Purchase Price	Qty	Disposal Fee	Total
HP 6005 Pro AMD Phenom II X4 B95 (3.0/HT3.0/2ML2/8Mtotal), 4Gb, 160Gb, DVD+/-RW LSDL, Win 7, MT	AT493AV	$672.01	1	$10.00	$682.01
	Total Hardware Cost	$672.01			$682.01

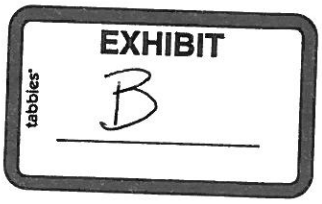
Software	PART #	Purchase Cost	Qty	
Microsoft Server 2008 Device CAL	R18-02830	$18.97	1	$18.97
Symantec Enpoint Protection v.12.1 license w/ 1yr Basic Maint 1 user Level A(5-249)	0E7IOZF0-BI1GA	$34.14	1	$34.14
	Total Software Cost:	$53.11		$53.11

Total Hardware/Software Cost	$735.12
Estimated Installation Costs:	$0.00
Total System Cost:	$735.12

K:\IS\PCSupport\PC Requests\Estimates\2012 Estimates\[1blank.XLS]A

Southeast community college
www.southeast.edu

AREA OFFICE: 301 SOUTH 68TH ST. PLACE, LINCOLN, NE 68510-2449, 402•323•3400
BEATRICE CAMPUS: 4771 W. SCOTT RD., BEATRICE, NE 68310-7042, 402•228•3468
LINCOLN CAMPUS: 8800 O ST., LINCOLN, NE 68520-1299, 402•471•3333
MILFORD CAMPUS: 600 STATE ST., MILFORD, NE 68405-8498, 402•761•2131



RECEIVED
OCT 09 2012
LANCASTER COUNTY
BOARD

October 2, 2012

Lancaster County Board of Commissioners
c/o Lancaster County Clerk
555 South Tenth Street
Lincoln, NE 68508

Dear Lancaster County Commissioners:

As we have previously shared with you, we are always pleased to visit with you about Southeast Community College.

We appreciate your financial and community support and wish to make arrangements that best meet your needs. We will be happy to visit with you at a regularly scheduled Commissioner meeting, or to attend a meeting scheduled at another time. If you would prefer to simply receive information in writing, we will be happy to mail our Annual Report information to your group.

We have enclosed a reply card to enable you to express your preference to us. If you will please return the card with your reply, we will plan our interaction with you accordingly. Please be assured of our sincere desire to maintain communication with your group. I hope you will feel free to contact me anytime I can be of service to you.

Thank you for your continuing support of Southeast Community College. We appreciate being able to serve you and the citizens of southeast Nebraska and are anxious to share our continuing successes with you.

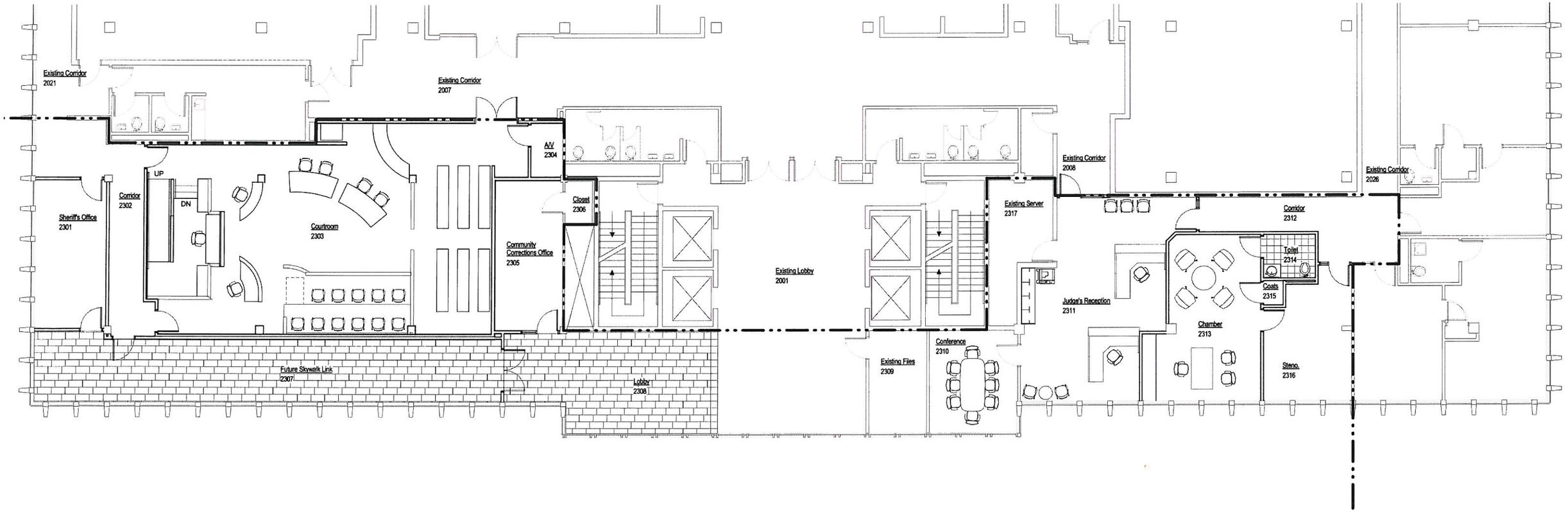
Sincerely,

Jack J. Huck
President

Enc.: Return Reply Card

BOARD OF GOVERNORS
Robert J. Feit, Chair, Pickrell; James J. Garver, Vice Chair, Lincoln; Lynn Schluckebier, Secretary, Seward; Kathy Boellstorff, Treasurer, Johnson; Helen E. Griffin, Lincoln; Ed C. Heiden, Sterling; Carl R. Humphrey, Waverly; Ruth M. Johnson, Lincoln; Dale Kruse, Beatrice; Terrence L. Kubicek, Lincoln; Nancy A. Seim, Lincoln; Steve Ottmann, Faculty Representative, Lincoln.

EXHIBIT
tabbies
C

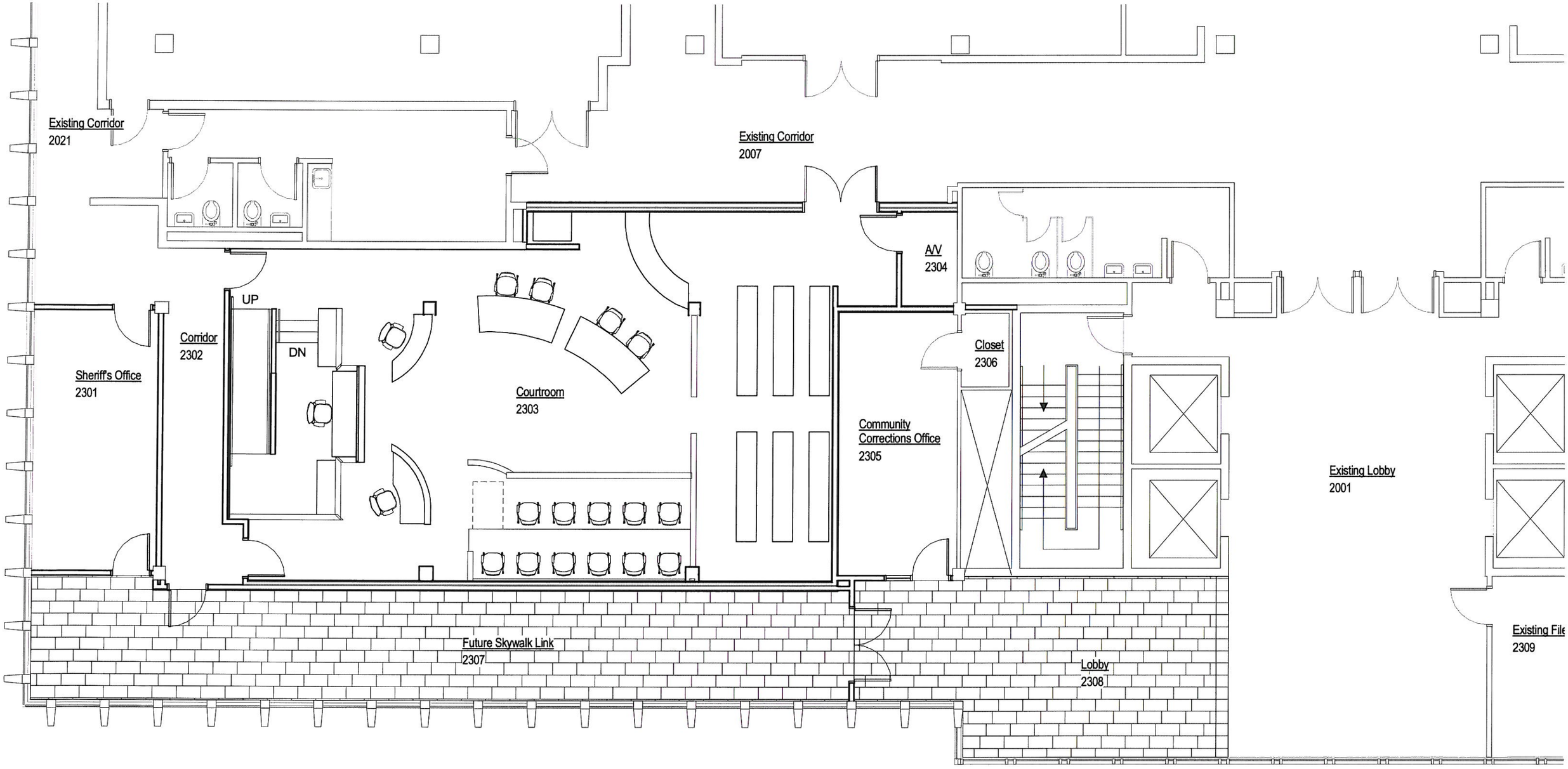


The Clark Enersen Partners

Lancaster County Court

Justice and Law Enforcement Center

Second Floor Remodel

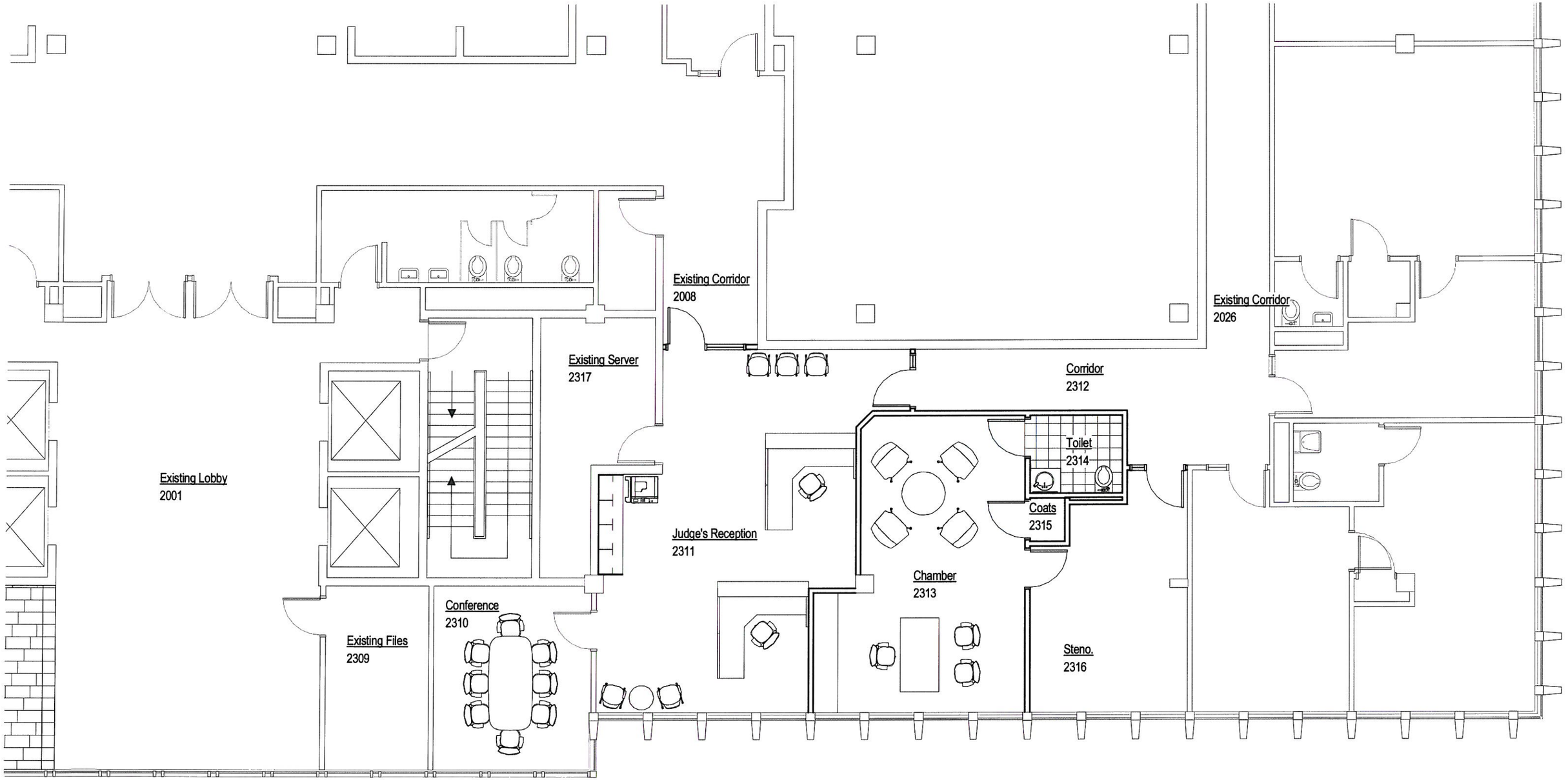


The Clark Enersen Partners

Lancaster County Court

Justice and Law Enforcement Center

Second Floor Remodel



The Clark Enersen Partners

Lancaster County Court

Justice and Law Enforcement Center

Second Floor Remodel

The Clark Enersen Partners

Lancaster County Court

Justice and Law Enforcement Center

Second Floor Remodel

The Clark Enersen Partners

Lancaster County Court

Justice and Law Enforcement Center

Second Floor Remodel

The Clark Enersen Partners

Lancaster County Court

Justice and Law Enforcement Center

Second Floor Remodel

EXHIBIT
tabbies
D

DRAFT #3—September 25, 2012
Lancaster County & Region V Systems
Invitation to Negotiate (ITN) Response Package

Contents

SECTION 1: INTRODUCTION AND PURPOSE

1.1 Introduction

Lancaster County Community Mental Health Center:
Lancaster County Community Mental Health Center (CMHC) was established by Lancaster County in 1976 through a federal grant under the Comprehensive Community Mental Health Centers Act for the purpose of treating persons with severe and persistent mental illness in the community rather than in state institutions. To date, CMHC continues to provide mental health treatment, rehabilitation, recovery supports and crisis services to approximately XXXX individuals in Lancaster County each year.

The current array of services offered by CMHC and the number of persons served within each of these services is summarized in Attachment A. CMHC's operating budget in FYXXXX was $10,148,301. CMHC revenues for FYXXXX are reflected in Attachment B. Revenue sources include Region V Systems, Medicaid, Medicare, Lancaster County and client fees.

Comment [AT1]: budgeted vs funded? Ron to follow up on FY and ensure accuracy of $ presented/time period in paragraph and attachments include GA figures since not a line item in CMHC budget; what would GA pay out for intake, meds etc.?

Region V Systems:
Region V, a political subdivision of the state of Nebraska, has the statutory responsibility under Neb. Rev. Stat. 71-802-71-820 for organizing and supervising comprehensive mental health and substance abuse services in the Region V area, which includes 16 counties in southeast Nebraska. Region V, one of six regional behavioral health authorities in Nebraska, along with the state's three Regional Centers, make up the state's public mental health and substance abuse system, also known as the Nebraska Behavioral Health System. Region V currently contracts with CMHC for publicly funded behavioral health services in the amount of $3,201,565, approximately one third of the revenues for CMHC. $1,454,805 of those funds are allocated to the provision of services at the Lancaster County Crisis Center which will continue to be operated by Lancaster County; this portion of funds will remain with Lancaster County.

Region V is governed by a board of county commissioners, who are elected officials, one from each of the counties represented in the Regional geographic area. The Regional Governing Board (RGB) is under contract with the Nebraska Department of Health and Human Services, the designated authority for administration of mental health and substance abuse programs for the state.

Each RGB appoints a regional administrator (RA) to be the chief executive officer responsible to the RGB. The RGB also appoints an advisory committee for the purpose of advising the RGB regarding the provision of coordinated and comprehensive behavioral health services within the Region to best meet the needs of the general public. In Region V, the Behavioral Health Advisory Committee is comprised of 15-20 members including consumers, concerned citizens, and representatives from other community systems in the Region.

Region V's purpose is to provide coordination, program planning, financial and contractual management, and evaluation of all mental health and substance abuse services funded through a network of providers. Region V is responsible for the development and management of a provider network that services the behavioral health needs of southeast Nebraska. Currently, Region V has 13 providers in its network that have met the minimum standards required to be a

member of the network; each provider has a contract with Region V to deliver a variety of behavioral health services.

Region V, as payer of last resort, primarily serves financially eligible adults and youth with or at risk of serious mental illness, substance abuse, and/or substance dependence. Region V's geographical area includes Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, and York counties in southeast Nebraska.

1.2 Statement of Need

In June 2011 the Lancaster County Board of Commissioners established the Community Mental Health Center (CMHC) Planning Committee with the responsibility of advising the Board on the best model for providing services in the future and the proper role of the County in funding and providing these services. The goal of the Committee was to provide the County Board with an effective, sustainable long-term plan regarding how community-based mental health services should be provided in Lancaster County.

The CMHC Planning Committee submitted its final report to the Lancaster County Board in February 2012, recommending the creation of a new recovery-based service model, which integrates primary care and behavioral health services with extensive consumer involvement and emphasis on peer-supported programming. The Planning Committee further recommended the County Board work with Region V Systems to prepare specifications for the new service model to be used in soliciting collaborative and innovative proposals through an Invitation to Negotiate (ITN) process. The County Board accepted these recommendations, and the CMHC ITN Committee was established to assist the Board in defining the essential components of the new service model. This panel is charged with developing the process to transition CMHC from County governance to the private sector.

Recommendations relevant to this process and providing guidelines for development of the new service system are summarized in three different reports:

A. CMHC Planning Committee Report: The Lancaster County Board of Commissioners established the CMHC Planning Committee in June of 2011 for the purpose of reviewing how the County is providing behavioral health services at the CMHC; determining the best model for providing services in the future; and advising the Lancaster County Board as to the proper role of the County in funding and providing these services. The Report and Recommendations of the CMHC Planning Committee is provided in Attachment C.

B. Health Management Associates Report: Delivery and coordination of mental health services in the County was also addressed in a report prepared by the Health Management Associates (HMA) for the Community Health Endowment. The HMA report specifically addresses CMHC and provided the County Board with a recommendation on how to provide services in the future. A copy of the HMA report can be found at: http://www.chelincoln.org/images/pdfs/HMA_CHE_Report_1_30_2012.pdf.

C. The Recovery Project Report: Consumers of Lancaster County have a vested interest in the CMHC transition process and have provided input into this ITN in a set of standards and recommendations relating to recovery-based integrated services which can be found in Attachment D. The report is based on extensive research on recovery-based models of

behavioral healthcare. Vital information regarding standards and recommendations from over 40 white papers and federal publications help to operationalize a recovery-based model of care.

1.3 Statement of Purpose

Pursuant to the findings and recommendations of the Planning Committee and Lancaster County Board, Lancaster County (County) and Region V Systems (Region V) are seeking to identify prospective contractor(s) through an Invitation to Negotiate (ITN) process. Qualified candidates will be community-based organizations with demonstrated experience in behavioral health services that are interested in assuming a role in the provision of behavioral health services that will replace the current CMHC service system. The contracted service provider(s) will assume the responsibility of administering, managing and providing behavioral health services in Lancaster County to residents of counties within Region V's geographical service area.

Comment [AT2]: behavioral health or mental health, be consistent throughout document

Comment [AT3]: role of County? Parameters under these funds?

It is the intent of Region V Systems to contract for the administration, management and provision of Region funded behavioral health services and supports in Lancaster County. The primary goal of the service delivery system is to improve the mental health and lives of the residents of Lancaster County by making mental health crisis, treatment, rehabilitation, and recovery support services available through a comprehensive, integrated community-based system of care and to engage and encourage persons with mental illness to live, work, learn and participate fully in their community.

A formal Transition Plan for assuming responsibility for the administration, management, and provision of services will be mutually negotiated and developed with Region V and the Lancaster County Board.

Comment [AT4]: will Lancaster County Board play a role in negotiations?

1.4 Target Population

Subject to the availability of funds, the provider(s) will deliver a comprehensive array of behavioral health services to eligible individuals within the target population as defined below:

A. Persons over 19 years of age and over who reside within ~~Lancaster County and~~ the Region V geographic service area;
B. Adults with a risk of experiencing disruption in functioning or impairments due to
C. behavioral health issues, a majority of whom may have severe and persistent mental illness (SPMI);
D. Adults who meet financial guidelines (see Attachment E) and do not have coverage for services through other payer sources or who qualify for Medicaid; and,
E. Persons meeting the mental health community service priorities as defined by the Division of Behavioral Health and Region V including :
    1) Persons being treated in a Regional Center who are ready for discharge;
    2) Persons being treated in a community inpatient setting or crisis center and who are awaiting discharge;
    3) Persons committed to outpatient care by a Mental Health Board

Comment [AT5]: Lancaster County residents? What is the county's continued role, investment and how does it impact this? Will they have additional or conflicting requirements for their $?

1.5 Scope of Service

As can be seen in Attachment A., CMHC offers a wide variety of crisis, treatment, recovery support and rehabilitation services. At this time the Region is not prescribing services to be provided as part of the transition process and development of the new service system although it

does reserve the right to identify core services that must remain as part of the service system. Providers submitting a response to the ITN may apply for one or all services as described in Attachment A and currently comprising the CMHC service system. Providers may also submit a proposal separate from the services outlined because as indicated this is not intended to be prescriptive and alternative approaches are encouraged. The ITN process promotes innovative, collaborative proposals that provide for a recovery-based, evidence-based service model that integrates behavioral health and primary care.

Comment [AT6]: at what point are these core services defined? do we specify the amount of capacity that needs to be maintained in certain services and $ available for that purpose at release of ITN?

Over the past few years, the Nebraska Behavioral Health Division (NBHD) developed new service definitions designed to meet the needs of the population while promoting service delivery efficiency and effectiveness. NBHD service definitions can be found at: *http://dhhs.ne.gov/behavioral_health/Pages/beh_bhsvcdef.aspx*.

Behavioral health services shall include but are not limited to the services described on the Nebraska Behavioral Health Division's website. It is expected that the new recovery-based service delivery system will give consideration to all available service options in incorporating a full range of crisis, treatment, rehabilitation services and recovery supports in a variety of settings. A comprehensive menu of services and supports will best meet the needs of the target population. ITN respondents must identify the core behavioral health services they intend to offer and planned service locations. Locations must be convenient and accessible to persons served Preference will be given to service locations located on city bus routes.

Comment [AT7]: preference or requirement?

1.6 Definitions (needs work)

Behavioral Health Services: mental health services and substance abuse prevention and treatment services which are provided using state and Federal funds.

Community-based:

Consumer: User of behavioral health services.

Co-occurring Disorder: Most often defined as at least one mental illness disorder and one substance abuse disorder, where the mental disorder and substance abuse disorder can be diagnosed independently of each other.

Cultural and Linguistic Competence

Evidence Based Practices: for the purposes of the ITN, an evidence-based practice is one that is based on accepted practices in the behavioral health profession and is supported by research, field recognition, or published practice guidelines.

Individuals Served
Invitation to Negotiate (ITN)

Outcome: A measure of the quantified result, impact, or benefit of program tasks on the individuals served or user of the services.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. (SAMHSA)

Proposal

Quality Improvement

Stakeholders

System of Care

1.7 Minimum Standards of Eligibility for Respondents

A. Minimum Standard Requirements: Eligible respondents may be a state, county, or community-based public; private not-for-profit; private for profit; or faith-based organization. Respondents must be a legal entity already established and functioning with paid personnel and demonstrable experience in working with the target population as evidenced by the following:

1. Region V Provider Network member or, if a new applicant, demonstrate how it meets all the minimum standard requirements including demonstration and primary source verification of facility licensure, fire inspections, professional licensure, and insurance to be enrolled as a member of Region V Systems' Provider Network.
2. Demonstration of fiscal viability; in operation and in good standing (based on a current independent audit) for at least 24 months;
3. Enrolled as a Nebraska Medicaid provider for identified behavioral health services or willingness/ability to obtain Nebraska Medicaid provider status;
4. Hold national accreditation in the provision of behavioral health services by a nationally recognized accreditation organization, i.e. CARF, COA, TJC, or have an accreditation development plan that outlines the agency's timeline (minimum 2 years) of achieving national accreditation;
5. Current applicable Nebraska behavioral health licensed clinicians and physicians on staff (including contracted personnel);
6. Have current license as a "Nebraska Mental Health Center" by the State of Nebraska or plan to obtain such license;
7. Ability to build the organizational capacity to serve the population within the chosen service category(s);
8. Ability to provide services within Region V's geographic area;
9. Able to initiate services effective XXX.
10. Willingness to accept Region V contract terms and conditions reflected in standard contract template (Attachment F-F.1)
11. Willingness to accept contracted rates for services as identified in Attachment G
12. Ability to serve the identified target population as defined in Section 1.4
13. Demonstrated competencies in provision of services and supports that are evidence-based and adhere to best practices in working with persons with serious mental illness
14. Demonstrated recovery competencies or a plan to develop recovery competencies

B. Minimum Programmatic Requirements: Provider(s) will be responsible for the development and management of a recovery-based service system. Behavioral health services will need to be coordinated and developed into an integrated network of recovery-based services accessible and directed to individuals in need of behavioral health services and community stakeholders. To accomplish this, providers will

implement evidence based and recovery based practices through participatory program development and design, training, and quality improvement activities. Recovery-based system of care development and management will include the following elements:

1. Demonstration of a collaborative approach to service delivery with diverse community stakeholders ensuring a community driven and supported system of care;
2. Implementation of a comprehensive, continuous integrated system of care model that provides behavioral health services and recovery supports for individuals to address their needs;
3. Recovery-based integration of behavioral health and primary care services;
4. Implementation of a system of care that supports the individual and the family and is recovery-based, person-centered, strengths-based and self determined, and builds empowering relationships and resiliency in the community;
5. Demonstrated commitment to maximize positive, meaningful program involvement by persons served and their family members in all phases of design, development, implementation, evaluation, operation and delivery of programming.
6. Provision of evidence-based practices in service delivery designed to meet the unique cultural and linguistic needs of the persons to be served.

Three key elements are required to be addressed in the development of the system of care including:

1. **Recovery-based Behavioral Health Integration with Primary Care:** A major component of the funded service system includes integrated behavioral/primary health care. This component must be based upon a recognized behavioral health/primary health care model. Various models of integrated behavioral/ primary healthcare exist and, based on the needs of the individual, different models are appropriate. A background document on integrated behavioral/primary healthcare, "Evolving Models of Behavioral Health into Primary Care," authored by the Millbank Foundation (2010), can be found at: http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf. Additionally SAMHSA and The Center for Medicaid Services (CMS) have developed a Guidance Document for states that provides key questions organized according to Health Home Service components (Attachment H). The document is intended to be useful, however not prescriptive, for providers responding to this ITN. Further information regarding health homes can be found on the SAMHSA website. http://www.samhsa.gov/healthreform/healthhomes/

   Although, integrated behavioral/primary healthcare is an essential component of the envisioned service system, it is anticipated that some behavioral health providers may not be offering primary care as a part of their service package, and some primary care providers may not be offering a complete package of behavioral health services (crisis, treatment, rehabilitation). However, in both scenarios, providers must address how they will ensure the behavioral and primary healthcare needs of those they serve.

   Partnerships and formal collaborations are highly recommended in the development and implementation of integrated services. Collaborative

relationships with local organizations inside and outside of the provider network that can enrich the lives of those served is expected.

2. **Adherence to Recovery-Based Principles**: In 2011, as part of its Recovery Support Strategic Initiative, SAMHSA announced a working definition of recovery from mental health and substance abuse disorders. The definition of recovery as defined by SAMHSA is, "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." SAMHSA also delineated four major dimensions that support a life in recovery:

- **Health**: overcoming or managing one's disease(s) as well as living in a physically and emotionally health way;
- **Home**: a stable and safe place to live;
- **Purpose**: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- **Community**: relationships and social networks that provide support, friendship, love and hope.

Provider(s) shall, at a minimum, identify how their proposed system of care design will support recovery in persons served and help persons served in achieving their potential in regards to health, home, purpose and community. To ensure that services are being delivered in a way that supports the recovery of behavioral health consumers, providers will:

A. Promote dignity and respect for all individuals served and their families, staff and all others;
B. Incorporate a broad array of recovery-based services and recovery supports to provide a continuum of care that supports many pathways to recovery;
C. Ensure recovery-based services are person-centered and that the individual's needs and strengths are elicited through informed choice and self-determination methods;
D. Ensure that services are provided throughout the community in the most integrated and least restrictive setting;
E. Ensure that services are available to persons regardless of ability to pay, accessible via different transportation means, and available at times convenient to persons served;
F. Ensure that services are coordinated across the recovery-based service system;
G. Ensure that intervention and treatment services focus on the whole person and promote improved health and wellness;
H. Ensure assessment and treatment is from a holistic approach which promotes the treatment of co-occurring physical health, substance abuse and mental health needs
I. Provide a recovery-based system of care that is participatory and provides services that are based on a partnership between consumer and provider where the provider serves in a consultant role focusing on collaboration and less on hierarchy; ensuring informed choice and self determination

J. Ensure that services approaches are strengths-based with emphasis on individual strengths, assets, and resilience;

K. Ensure that service will be person-centered focusing on increasing the individual's resiliency and self-determination skills and increasing their ability to successfully cope with life challenges;

L. Ensure that cultural and linguistic competence is provided throughout the system of care.

M. Ensure trauma informed competencies throughout the system of care.

N. Demonstrate commitment to foster meaningful consumer and family involvement in the program design, development and implementation, evaluation, operation, governance, training, evaluation and delivery of services and supports.

For further detailed information about the working recovery definition or the guiding principles of recovery visit: http://www.samhsa.gov/recovery/. The Recovery Project (Attachment D) also helps in providing an understanding of the principles of recovery-based systems.

3. **Relationship with Lancaster County**: Although Lancaster County–under this process will discontinue its status as a provider of community-based behavioral health services through CMHC, the County still has a vested interest in how effectively these services are delivered by the new provider(s). The new provider(s) will need to demonstrate the existence of a strong working relationship with the County or a plan to establish and maintain this type of relationship with the County. Areas of mutual interest include:

- Location of CMHC facility: To aid in a smooth transition, the new provider(s) will have the option of remaining at the existing location of 2201 S. 17th Street for a minimum two (2) years period. The County will consider proposals for the continued use of this property for this or other behavioral health services.
- Midtown Center: Lancaster County owns the Midtown Center at 2966 O Street, which houses CMHC programs for psychiatric rehabilitation and other related services. The County will consider proposals for the continued use of this property for this or other behavioral health services.
- CMHC Staff: All efforts should be made to retain as many of the current CMHC employees as possible. CMHC employees are highly trained and have years of experience providing specialized care, to consumers with severe and persistent mental illness. Retaining existing employees will also provide a continuity of care, which is essential to consumers.
- Crisis Center: The County will continue to operate the Crisis Center. For the immediate future, the Crisis Center will remain on the 2nd floor of the CMHC building. The new provider(s) will need to demonstrate the ability to work closely with the Crisis Center.
- General Assistance: Behavioral health services are provided by CMHC to consumers receiving County General Assistance. With the integration of behavioral health and primary health care, the new provider(s) will need to demonstrate how they will deliver both behavioral health and primary health care to consumers receiving General Assistance

Comment [AT8]: •(ITN Committee suggested additional information—do we need to include an attachment with a table showing costs, persons served etc?)

SECTION 2: INVITATION TO NEGOTIATE PROCESS

This Invitation to Negotiate (ITN) is issued by Region V Systems for the purpose of soliciting collaborative and innovative proposals for the transition of the Lancaster County Mental Health Center (CMHC) service array to a behavioral health service model that is 1) recovery-based, 2) inclusive of peer supported programming which may include, but is not limited to, the operation of peer run programs and provision of peer recovery supports 3) inclusive of consumers in program design at all levels of development and implementation, 4) evidence-based, 5) trauma informed and 6) integrates behavioral health with primary health.

The ITN is intended to function as an open process for groups and organizations interested in submitting responses and is less rigid than a formal Request for Proposals (RFP). It provides an opportunity for interested parties to learn about Lancaster County and Region V's expectations and specifications and provide written documentation in response. Ideally, the ITN process will lead to further negotiations with qualified parties and subsequent contract awards with selected provider(s). The provider(s) selected through the ITN process will contract with Region V for the delivery of services.

The current array of services provided by CMHC includes an array of recovery supports and crisis, treatment, and rehabilitation services and does not include integration with primary care. Region V reserves the right to negotiate with more than one entity in order to develop a service system inclusive of recovery supports and crisis, treatment, rehabilitation, and primary care services that best fits the needs of the community and persons served. Collaboration among providers in the design of a mix of services (recovery support, crisis, treatment, rehabilitation and primary care) is strongly encouraged.

2.1 Posting

All notices, decisions, and intended decisions and other matters relating to the ITN process will be electronically posted on Region V System's website: www.region5systems.net.

Region V reserves the right to amend, modify, supplement or clarify this ITN at any time at its sole discretion. The electronic posting on www.region5systems.net is the official posting. It is the exclusive responsibility of the interested parties to check the website for the following:

A. Changes to the solicitation;
B. Other documents referenced by the solicitation (Attachments);
C. Written official responses to written inquiries;
D. Notice of Intent to Negotiate;
E. Notice of Intent to Award

2.2 Contact Person

The contact person for all communication regarding this ITN is:

Procurement Manager Name
Region V Systems
1645 N Street
Lincoln, NE 68508
(402) 441-4343
Email Address

2.3 Limits on Communications

Questions to the identified contact person regarding this ITN may be made either by fax, email, or written correspondence using the "*Request for Information*" form available electronically at www.region5systems.net. Written responses to questions will be made by Region V personnel within three business days and posted accordingly on the Region V website.

Under the parameters of the ITN process, with the exception of clarifying questions, prospective respondents are prohibited from contacting personnel of Region V Systems, the Department of Health and Human Services, Lancaster County and the Community Mental Health Center; members of Region V's Behavioral Health Advisory Committee (BHAC) or Regional Governing Board (RGB); Lancaster County Board members or members of the ITN Committee regarding this ITN solicitation during the period following the release of this ITN, after the release of available funding amounts, during the proposal evaluation period, and until a determination is made and announced regarding an invitation to submit further information. Violation of these provisions may be grounds for rejecting a reply to this ITN.

2.4 Schedule of Events and Deadlines

The County and Region V expect to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change. In addition, the County and Region V reserve the right to issue a Request for Proposals if enough information is not gathered through the ITN responses received.

Activity		Date/Time
1.	ITN Process Announcement	1/31/13
2.	Notice of Intent to Submit a Proposal to be received by Region V (Submission is not mandatory)	2/15/13
3.	Pre-submission Conference	2/28/13
4.	Closing Date for Receipt of Proposals	3/31/13
5.	Evaluation of Replies	4/1/13
6.	BHAC	5/1/13
7.	Regional Governing Board	5/13/13
8.	Posting of Proposal Scores and Notice of Intent to Negotiate	5/14/13
9.	Negotiation Meetings	????
10.	Posting of Notice of Intent to Award	
11.	Anticipated Effective Date of Contract(s)	

Comment [AT9]: will evaluated proposals go to BHAC/RGB prior to negotiations for approval?

2.5 Notice of Intent to Submit a Proposal

Prospective providers wishing to submit a *Notice of Intent to Submit a Proposal* may do so by sending the notice to the contact person specified in **Section 2.2**. This is not required, but preferred, prior to attendance at the Pre-submission Conference. The format for the *Notice of Intent to Submit a Proposal* will be electronically posted along with this solicitation documents at: *www.region5systems.net*. Submission of a *Notice of Intent to Submit a Proposal* does not bind the organization to submit a proposal.

2.6 Pre-submission Conference

All interested parties are required to attend the pre-submission conference to be held at the time and location as specified in **Section 2.4.** The purpose of the pre-submission conference is to review the contents of the ITN, to explore potential service model designs, and to identify interested providers that may wish to collaborate with other interested providers in developing and providing the services to be purchased. Interested parties will have the opportunity to present oral questions regarding this ITN. However, oral responses from Region V staff to questions asked at the pre-submission conference shall not be considered binding. Attendance at the pre-submission conference is a prerequisite for acceptance of proposals from interested parties/prospective providers or groups of providers.

2.7 Withdrawal of Proposals

The applicant may withdraw its proposal, with written notification, at any time in the process. In such instance, a letter of withdrawal with an original signature by an authorized officer/executive must be submitted to the Contact Person identified in **Section 2.2**, either by hand delivery or by certified mail.

2.8 Acceptance of Proposals

A. **Proposal Deadline:** No requests for extensions of the due date will be approved. All proposals must be received by the Contact Person identified in **Section 2.2** at the date, time and address specified in **Section 2.4** of this document. Changes, modifications or additions to submitted proposals will be not be accepted after the identified deadline for submission of proposals.

B. **Receipt Statement** Replies not received by the Contact Person at the specified place and by the specified date and time will be rejected as non-responsive and returned unopened to the provider by Region V. Region V will retain one (1) unopened original proposal for use in the event of a dispute. Region V/County accepts no responsibility for mislabeled/mis-sent mail.

2.9 Posting of Proposal Scores

The results of the proposal scoring shall be posted electronically in accordance with the Schedule of Events described in **Section 2.4** at: www.region5systems.net

2.10 Posting of Intent to Award

The results of the negotiation activities including posting of intended award shall be posted electronically in accordance with the Schedule of Events and Deadlines described in **Section 2.4** at: www.region5systems.net

SECTION 3: FINANCIAL SPECIFICATIONS

3.1 Funding Source

A. STATE GENERAL FUNDING. The contract amount includes funds contracted to the Region by the Nebraska Department of Health and Human Services. Funds are passed through the RBHA and subsequently passed from the RBHA to the Network Providers.

B. FEDERAL BLOCK GRANT FUNDING. The contract amount includes funds contracted to the Nebraska Department of Health and Human Services by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Mental Health Services (CMHS). Funds are passed through to the RBHA and subsequently passed through from the RBHA to the Network Providers.

C. COUNTY FUNDING including General Assistance Funding

Comment [AT10]: ADD fund amounts available, funding source (role of County, any $ from the County (GA $) that may be separate from Region funds), contract terms

Comment [AT11]: To be determined?

3.2 Funding Amount

A. TOTAL FUNDS AVAILABLE. The estimated Regional funding available for this ITN for behavioral health services is $1,746,760. The contract amount is subject to the availability of funds. At this point, the Region cannot determine the specific amounts available. The complete anticipated funding amounts will be finalized during the negotiation process.

Comment [AT12]: County contribution to be determined.

3.3 Reimbursement Methods

NON FEE FOR SERVICE (NFFS): Services are reimbursed based on actual monthly expenditures up to the designated amount specified in the contract; or

FEE FOR SERVICE (FFS): Services are reimbursed based on a unit of service up to the designated capacity specified in the contract.

The funding amounts are annualized based upon 12 months of service or upon units of service delivered during the fiscal year.

The cost proposal for the programs/services in this RFP should be based on a maximum one-year contract term. Region V Systems' fiscal year operates from July 1 to June 30.

Comment [AT13]: Any start up costs?

3.4. Use of Funds

The use of funds provided under Region V Systems' Network Provider Contract is limited to the employment of personnel, technical assistance, operation of programs, leasing, renting, maintenance of facilities, minor improvements, and for the initiation and continuation of programs and services. An agency may be reimbursed on a Non-Fee for Service status during the period of start up and move to a Fee for Service status later in the fiscal year. It will be Region V Systems' decision to reimburse the agency on a NFFS or FFS basis and will be finalized during the contract negotiation period.

Region V will not fund:

A. Financial contributions to individuals.

B. Fund-raising events.
C. Lobbying.
D. Abortion.
E. Laboratory or clinical research.
F. Projects which do not serve the Region V geographical area.
G. Purchase or improvement of land, purchase or permanent improvement for any building or other facility, or purchase major medical equipment.
H. Cash payments to intended recipients of health service.

3.5 Non-Transfer of Funding Award

Any contract awarded to a successful applicant may not be transferred or assigned by the applicant/contractor to any other organization or individual.

3.6 Use of Subcontractors

The chosen provider may be permitted to subcontract for the performance of certain required administrative or programmatic functions. Anticipated use of subcontractors must be clearly explained in the ITN Narrative identifying the proposed subcontractors and their proposed role. Use of treatment subcontractors and the terms and conditions of the subcontract must be approved by Region V in advance of execution of any subcontract. The successful applicant is fully responsible for all work performed by subcontractors. No subcontract into which the successful applicant enters with respect to performance under the contract will, in any way, relieve the successful applicant of any responsibility for performance of its duties.

SECTION 4: GENERAL INSTRUCTIONS ON SUBMISSION OF PROPOSALS TO THE ITN

4.1 Method of Delivery and Receipt of Proposals

Any proposal must be received by the Region according to the deadline set forth in the Schedule of Events and Deadlines, **Section 2.4**, of this document. The provider(s) may choose and is responsible for the method of delivery to the Region except that **facsimiles will not be accepted at any time; electronic transmission is required but does not replace the need to submit hard copies of the proposal.** An untimely reply will be rejected and returned. The Region will keep one copy for its records. **The Region is not responsible for any lost or misdirected submittal.**

All proposals received by the date and time specified in the, **Schedule of Events and Deadlines, Section 2.4,** become the property of Region V Systems. The Region shall have the right to use all ideas, or adaptation of ideas, contained in any reply received in response to this ITN. Selection or rejection of the proposal shall not affect this right.

All instructions, conditions, and requirements included in this document are considered mandatory unless otherwise stated. ITN responses that do not conform to the items provided in this document will not be considered. All applicants must adhere to the following guidelines.

Any costs incurred in the submission of proposals are the responsibility of the provider.

4.2 Submission Instructions

A. Respondents must submit one (1) original and fifty (50) copies of the ITN Response to the Contact Person specified in **Section 2.2** by the date, time and place specified in **Section 2.4**.

B. The provider must submit an electronic version of the proposal at the same time as the hard copies are received by the Region.

C. ITN responses must be clearly referenced as **ITN Response** on the outside of the envelope or package.

D. Responses must be typed in 10-point font or larger, submitted on standard 8 ½" by 11" paper, numbered consecutively on the bottom right-hand corner of each page, starting with the Cover Page through the last document, including required attachments.

E. Staple or clip the original and each copy of the response at the upper left-hand corner. Do not use covers or add unsolicited attachments to your proposal.

F. FAX copies will not be accepted.

G. Two-side copying is allowed but not required.

H. Designated information must be provided on Region V forms provided in the attachments of this document. Electronic versions are available on the Region V website.

4.3 ITN Proposal Format:

ITN Response Proposals must be organized in the following sections in the following order:

A. Cover Page

Complete the entire Cover Page (Attachment X) and obtain the signature of the chief executive officer, board chairperson, or other individual with the authority to commit the applicant to a contract for the proposed program/services.

B. Executive Summary

Complete the entire Executive Summary (Attachment X). The Executive Summary must summarize the three components of the Capacity Development Plan including Program Narrative, Development/Implementation Time Line Plan, and Budget Justification Narrative.

C. Capacity Development Plan:

A Capacity Development Plan for Behavioral Health Services following the format specified must be used in submission of ITN Response Proposals. Specific forms referenced are available at www.region5systems.net.

I. Program Narrative

The **Program Narrative** is a written plan that describes, in detail, the program to be funded. The applicant should provide the following information in as thorough and complete detail as possible.

A. **Name and address of the provider agency or agencies, if applicable,** with an explanation of why the provider(s) is capable of providing this program. Identify the specific amount of time (up to a maximum of 12 months) needed to develop the service and the dates of the service development period requested.

B. Describe the **purpose** of the program. Explain the reason for developing the program in terms of the result expected to meet the needs of consumers.

C. Thoroughly describe the **need** for the program using current, valid data to justify why this program should be developed at the agency applying, in this geographic area, and for the purpose detailed above. Report the source and time period for the data. Include an explanation of why this need would logically lead to the development of the program being proposed.

D. Describe the **target population** to be served and provide specific details about gender, ages, ethnicity, geographic location, school grades (if appropriate), mental illness(es) and/or substance abuse needs, and other relevant information about the persons to be served in this program.

E. Provide a general overview of **how the services will be organized**. Include information about how the provider's resources (facility space, personnel-current/new, equipment, other) and administrative structure are coordinated and directed to meet the needs of the consumers through the proposed program. Include information regarding network experience, capacity to work with Medicaid and other health insurance companies, health information technology including electronic medical records, health information exchange, etc., and financial management. Describe any partnerships and collaborations that will be employed in developing this service model. Describe the organization's relationship with Lancaster County; discuss plan to establish and/or maintain a strong working relationship with Lancaster County particularly in relation to the Crisis Center and the General Assistance. Describe the proposed model addressing how the organization(s) will integrate behavioral health and primary care.

F. List and explain the **goals of the program** which describe specific, measurable desired outcomes from a consumer's point of view. What will a consumer want to gain from this program? The goals should have a direct relation to the program purpose and should deal specifically with issues related to the services to be delivered in the program. The goals should address expected short and long term benefits for the target population. Program goals do not include organization management or program development goals. These goals are different than those identified on the **BH-5**.

G. Thoroughly describe **admission criteria** and procedures for consumers to access the program or how the Behavioral Health clinical criteria will be used in this program.

H. Describe the **assessment process** and procedures which will be used in the program. Include an explanation of what information will be gathered for each consumer and how consumers in this program will be screened for other problems (i.e., substance abuse problems. if developing a mental health program or mental illness, if developing a substance abuse

program). If more detailed procedures need to be developed, include this in the Program Development/ Implementation Schedule.

I. List and include complete explanations of the **specific services** to be provided directly to the consumer:
   1. How individual treatment or rehabilitation planning will be done with the consumer and what is included in this individual plan.
   2. What is involved in the services to be provided within this program.
   3. How the services will be coordinated with other programs.
   4. The provisions for periodic reassessment and individual plan revision.
   5. Discharge planning procedures, criteria, and follow-up.
   6. The projected average length of stay in the program for the consumer to successfully reach the desired results as specified in the goals (see F above).

J. Describe procedures for **direct consumer involvement** in the program. Include an explanation of:
   1. How potential consumers will be informed about the program and consumer rights.
   2. How meaningful participation of consumers will be incorporated into the development, evaluation, and ongoing modification of the program.
   3. Describe consumer and family members involvement in conceptualization of service model design, planning including identification of needs, goals and objectives; and budget development
   4. How the program adheres to recovery based principles and demonstrates recovery-based competencies
   5. Discuss any involvement of consumers and family members in staff training and development include description of any employment positions specific to consumers or family members i.e peer support positions
   6. Describe consumer and family member involvement in program administration, governance, policy determination and program evaluation.

K. Discuss the **capacity** anticipated for the program. Program capacity means the total number of individual consumers considered "active" in the program at any given time. Daily census means the number of individual consumers who can be served on a single business day. Estimate the total number of consumers who can be served during the capacity development period, and also, in a normal 12 month period (if the capacity development period is less than one year).

L. Discuss the **program staffing** proposed. Include an explanation of the qualifications and supervision of the positions which will provide any services (direct and indirect) in the program. (Job descriptions are optional but could be included here.)

The transition from the current CMHC system to a new service delivery system will be stressful for consumers receiving services from CMHC and CMHC employees. The ultimate goal is to reduce the stress of transition and retain as many consumers and staff as possible. To accomplish this goal, careful transition planning must be employed to ensure a smooth transition for both groups. In addition, a communication plan developed to assure transparency and to assist consumers, families, and employees with the transition is expected. Describe the employee retention, transition and communication plan that will be implemented to achieve this goal.

M. Describe the quality assurance plan which be used for this program and directed at desired outcomes for the consumer. Explain how information and data will be gathered to evaluate the program, anticipated outcomes and evaluation measures, how data will be used, and who will be involved in making this happen. Include the details of the quality improvement functions including data collection, analysis, and reporting the agency plans to use. Describe how meaningful involvement of individuals served will be achieved in the quality improvement and evaluation activities of the program. The quality assurance plan should address the following elements:

- Quality improvement goals and objectives including use of evidence-based practices;
- Reliable and valid performance measures;
- Measurement of performance in relation to performance outcomes established at the local, State and Federal level, as applicable;
- Plan for continuous and progressive improvements, and measuring the impacts of these improvements;
- Plan for reviewing the results of quality assurance reviews, critical incident reports, and the numbers and kinds of grievances and appeals and using this information to initiate system improvements;
- Plan for identifying service problems and improvement opportunities;
- Plan for measuring individuals served satisfaction and recovery measures and reviewing for improvement opportunities;
- Quantitative and qualitative indicators, outcomes and outputs that can be used by the payers and persons served and other community stakeholders to objectively measure a provider's performance and used to improve services.

N. Identify the specific facility needs of the program and explain how this program will meet those needs. Specify proposed service locations for services. Include an explanation of the relationship of this program within the operation of the provider agency or agencies, if applicable.

II. Development and Implementation Timeline Plan

1) **BH - 5** Goals and Objectives One form is completed for each goal.

The **Development/ Implementation Timeline Plan** will be developed on **Form BH-5.** The development plan includes an implementation schedule. The information will explain in detail the development process and show a clear step-by-step plan of how the program will be developed over a given period of time. The Program Development Plan will conclude with consumers receiving services and a formal evaluation of the program plan, the process, and the services provided.

The Development/Implementation Timeline Plan will have several **BH-5** forms that will identify the goals and objectives needed to develop and implement a service capacity. Use a separate form for each goal. Capacity development goals should include, at a minimum, the following:

1. Develop administrative structures and personnel for service.
2. Develop facility for providing service, if needed.
3. Develop program plan, program operating policies and procedures, operation plan, authorization/referral system for service.
4. Develop reporting, financing, and quality assurance systems.
5. Develop a plan to begin to serve people.
6. State certification development plan/time line and an infectious disease policy and disaster plan.

Instructions for completing **Form BH-5**.
Identify specific **goals** to address development issues (different from program goals for consumers as stated above).

Column A. Each goal should include several time-limited, measurable **objectives** (including specific measurement indicators) which will all work together to successfully attain the goal.

Column B. Each objective will need to have several specific **activities** that have to be accomplished in order to fulfill the objective.

Column C. Each activity must include the name of the **staff** person or the title of the position which will be primarily responsible for completing that activity.

Column D. Each activity must have a specific **beginning and ending time** identified. This time period must be within the proposed service development time period. Please be as specific as possible.

Column E. Each activity must identify the **expected outcome** that demonstrates that development activity has been accomplished. This will measure if the program is progressing toward full administrative, financial, and programmatic development through successful completion of each activity.

III. Budget and Narrative Budget Justification
   1) **BH - 20a through BH - 20g** for annual ongoing budget
   2) **BH - 20a through BH - 20g** for one-time budget (all expenses and revenues expected)

The budget section should include the following two sections:

a) Itemized Annual Operating Budget
b) One Time Development/Start-up Budget

Use **Forms BH-20a through BH-20g** to develop the detailed budget for the service. Also included is a list of the specific items that would be in that budget section.

BH-20a Revenue Summary [Ensure revenues expected for the service are reported from ALL other funding sources (i.e., Medicaid)]
BH-20b Expense Summary [Ensure that indirect administration is not more than 10% of total.}
BH-20c Personal Services Expenses [Ensure that all staff to be employed to provide the service are reported on this form.]
BH-20d Operations Expenses
BH-20e Travel Expenses
BH-20f Capital Expenses
BH-20g Other Expenses

Use **Forms BH-20a through BH-20g** to develop the one time start up budget for the service. These forms have a list on the back of the page that includes specific items for that budget section.

BH-20a Revenue Summary
BH-20b Expense Summary
BH-20c Personal Services Expenses
BH-20d Operations Expenses
BH-20e Travel Expenses
BH-20f Capital Expenses
BH-20g Other Expenses

Budget Justification Narrative: This narrative will explain in detail why the costs listed on the budget itemization forms for BOTH #1 and #2 above are necessary and how those costs were calculated. The applicant should review the Regulations for allowable and unallowable costs. Please address the following items separately in the narrative:

1. *Annual Operating Budget*. Explain and justify all items included in the annual operating budget including
   - Staffing needs by position, number of full-time equivalents (FTEs), and their respective salary and fringe costs separately.
   - How ongoing operational, travel, capital outlay, personnel, professional fees, and consultant needs and costs were determined.
   - Describe the project's facility and space requirements and explain why the amount is needed.
   - Identify amounts and sources of any other revenues to be used or received with this project, in addition to the state and/or federal funds being requested with this proposal.

2. One Time Development/Start Up Budget. Explain and justify all items included in the start-up (one-time) cost budget.
   - Staffing needs by position, number of full-time equivalents (FTEs), and their respective salary and fringe costs separately.
   - How long it will take to develop the service and why.
   - How ongoing operational, travel, capital outlay, personnel, professional fees, and consultant needs and costs were determined.
   - Describe the how the agency will procure the project's facility and space requirements, and explain why the amount is needed.
   - Identify amounts and sources of any other revenues to be used or received with this project, in addition to the state and/or federal funds being requested with this proposal.

3) Budget Narrative Justification that (1) explains the one-time expenses and why they are needed, and (2) explains the ongoing annual expenses and why they are needed.

IV. Minimum Standards Primary Source Documentation: The following supporting documents are required to be submitted with your ITN proposal:
   a) Financial Audit Summary
   b) Current Facility Licensure, Fire Inspections and Food Permits, as applicable
   c) Accreditation Certificate
   d) Most Recent Accreditation Report, and
   e) Number of Staff by Licensure including source documentation of licensure
   f) Insurance documents to include workers' compensation; motor vehicle liability, professional liability, directors/officer's liability, and general liability coverage

SECTION 5: CAPACITY DEVELOPMENT PROGRESS REPORTS

Capacity Development reports will be required for any service approved for capacity development. Depending on the individual situation, the report may be required monthly, bi-monthly or quarterly to communicate the details of the progress made toward completion of the goals, the progress in developing and providing the service, and the progress made toward moving the payment method from Non-Fee for Service (NFFS) funding to Fee for Service (FFS) funding.

Format for Progress Report: A BH-5 should be used to report progress and should include details and data on specific progress completed toward successfully meeting each goal, objective, and activity identified on the **BH-5**.

Due Dates for Progress Report: Due dates for progress reports will be identified in the contract.

SECTION 6: ITN EVALUATION METHODOLOGY

The Region shall identify at least XXX evaluators with a combination of appropriate financial, data, and programmatic expertise to evaluate the proposals. The team will be comprised of a minimum of X evaluators with financial expertise and a minimum of X evaluators with behavioral health expertise.

The maximum points available is 100. The evaluation will be performed using XXX evaluation tools (to be developed?). Evaluators will be instructed to provide ratings in X point increments on criterion items. Evaluators with financial expertise will score criterion items XXXX. Evaluators with behavioral health expertise will score criterion items XXXX. The average of all evaluators' scores for each criterion rated will be tabulated. The vendor's final score will be the sum of all average criterion scores.

The Region intends to extend an invitation to enter into negotiations with up to X highest ranked providers. The Region reserves the right to negotiate with a fewer number or greater number of provider in the best interest of the community. An invitation to a provider to enter into the negotiation phase of the schedule shall not be construed as a contract award.

The posting of Proposal Scores and the Notice of Intent to Negotiate will be posted in accordance with Section 2.

SECTION 7: REGION RIGHTS AND RESPONSIBILITIES

7.1 **Right to Reject Any and All Proposals:** The Region reserves the right to reject any and all proposals.

7.2 **Right to Withdraw the ITN:** The Region reserves the right to withdraw the ITN at any time, including after and award is made and by doing so assumes no liability to any provider.

7.3 **Negotiation Methodology:** The Region may negotiate with one or more providers simultaneously. The Region intends to extend an invitation to enter negotiations up to the three highest ranked providers based on the rating methodology outlined in Section 6. The Region reserves the right to negotiate with fewer or greater providers based on the best interest of the community. An invitation to a provider to enter the negotiation phase of the schedule shall not be construed as a contract award.

Comment [AT14]: The County purchasing act prevents county from negotiating with two entities at the same time. No bearing on Region V?

Providers selected to enter negotiations should be prepared to discuss and address any issue in the ITN or the provider's proposal to the ITN.

Each party to the negotiations will designate a lead negotiator. The lead negotiators will establish a communication protocol allowing for contact between parties as provided in Section 2.X. While there may be ad hoc workgroups assigned during the negotiations, all final decisions and agreements between the parties will be made at the negotiation meetings and agreed to by the lead negotiators. Negotiation meetings are scheduled as listed in Section 2.4. The Region will designate the Region's negotiation team. The Region's negotiation team will recommend a provider(s) for further negotiations or contract award based on consensus agreement.

Attachment A

Table 1 provides a description of the services relevant to this ITN currently provided by CHMC and the number of persons served in these services. **Please note that this is an overview of the current CMHC service system only. Providers submitting a response to the ITN may apply for one or all services as described. Providers may also submit a proposal separate from the services outlined as this is not intended to be prescriptive; alternative approaches are encouraged. The ITN process promotes innovative, collaborative proposals that provide for a recovery-based, evidence-based service model.

Table 1. CMHC Programs/Services and Number Served

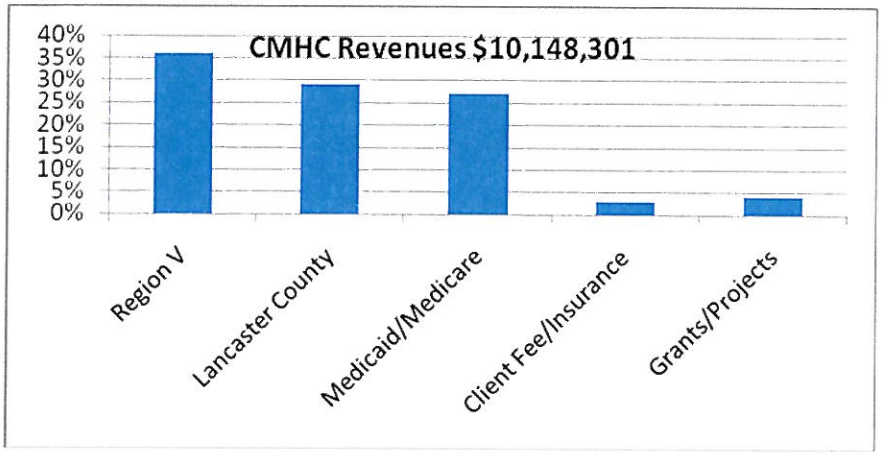
CMHC Services	Persons Served by CMHC-20?? (Duplicates Included)
Community Support Mental Health: Case management and rehabilitation services to adults and vulnerable elderly through the Harvest Project, and residential support services at The Heather, Independent Living Project, and Transitional Living for adults with severe and persistent mental illness.	1,238
Medication Management: Outpatient psychiatric services including assessment, therapy, medication education and management, and inpatient psychiatric care.	1,909
~~Inpatient Psychiatric Care:~~	~~347~~
Outpatient Psychotherapy: Individual and group therapy focused on symptom alleviation, stabilization, and recovery. Community-based sex offender management. Should this be separate category?	883
Day Treatment: Short term, intensive treatment provided through group formats, 6.5 hours daily, Monday-Friday. May serve as an alternative to inpatient treatment or as a step down for individuals making the transition from a hospital setting to the community.	227
Day Rehabilitation: The Midtown Center, open Monday-Saturday, is a clinical rehabilitation program engaging consumers in life skills, recovery and vocational activities.	195
~~Supported Employment: Employment and benefits counseling, job placement, and vocational support.~~	~~44~~
Homeless/Special Needs Outreach: Outreach and case management for adults who have a mental illness and are homeless, near homeless, or in contact with the criminal justice system.	253
Psychiatric Residential Rehabilitation: The Heather is a structured residential facility operated by CMHC and OUR Homes as a residential transition from the Lincoln Regional Center back into the community.	28

CMHC Services	Persons Served by CMHC-20?? (Duplicates Included)
Assertive Community Treatment: A collaboration designed to serve individuals who have not responded well to traditional outpatient care. Services are provided to the consumer in their home and the community.	79
24 Hour Crisis Line: Crisis assessment, intervention, and information available 24 hours by phone.	4,897
Crisis Response: Mobile services available to law enforcement or agencies requesting consultation/intervention after regular business hours.	

Nebraska Behavioral Health Division (NBHD) and Medicaid behavioral health service definitions, which provide detailed service definitions can be found at: http://dhhs.ne.gov/behavioral_health/Pages/beh_bhsvcdef.aspx

Total Revenue for CMHC in 20?? was $10,148,301. Revenue sources by percentage of the total revenue are displayed in Table 2 ~~Figure 1~~. CMHC expenditures included 74% for personnel; 6% for Region V; and 20% for operating.

Table 2 ~~Figure 1~~. CMHC Revenue Sources



REPORT AND RECOMMENDATIONS
COMMUNITY MENTAL HEALTH CENTER PLANNING COMMITTEE
February 3, 2012

INTRODUCTION

The Lancaster County Board of Commissioners established the Community Mental Health Center (CMHC) Planning Committee in June of 2011 for the purpose of reviewing how the County is providing mental health services at the CMHC, determining the best model for providing services in the future, and advising the Board as to the proper role of the County in funding and providing these services. The stated goal of the Committee is to provide the County Board with an effective, sustainable long-term plan regarding how community-based mental services should be provided in Lancaster County.

Committee Membership

In establishing the Committee the Board appointed a broad range of community providers, funders, and consumers who have an interest in the provision of mental health services in Lancaster County. Committee members include:

- Lori Seibel, Community Health Endowment
- Pat Talbott, Mental Health Association
- CJ Johnson, Region V Systems
- Dean Settle, Community Mental Health Center of Lancaster County
- Deb Shoemaker, People's Health Center

Committee appointees also included Joan Anderson, Lancaster County Medical Society, and Travis Parker, Deputy CMHC Director. However, Joan resigned for professional reasons, and Travis left the Committee to pursue other employment opportunities.

Facilitators and Ex-officio Members:

- Kerry P. Eagan, Chief Administrative Officer to the Lancaster County Board
- Kit Boesch, Lincoln-Lancaster County Human Services Director

Support Staff

- Ann Taylor, Lancaster County Clerk's Office

The Committee also wishes to recognize the numerous consumers, providers, advocates and others who attended the meetings, with special recognition of Gail Anderson, a member of the

CMHC Advisory Committee, and J. Rock Johnson, a consumer advocate, who regularly attended meetings and contributed valuable information to the discussions.

Committee Process

All meetings of the CMHC Planning Committee were conducted in compliance with the Nebraska Open Meetings Act. The Committee met eleven (11) times, from July 2, 2011 through February 3, 2012. Agendas and minutes for all Committee meetings are available on the Lancaster County Clerk's web site. The County Clerk is also maintaining a copy of all documents presented to the Committee which can be reviewed by the public upon request. A list of the documents can be found in Appendix A attached to this report. The Committee toured mental health facilities operated by Lancaster County and spoke directly with staff members about the programs and services offered at the CMHC. Tours were conducted of the main CMHC facility, the Crisis Center, the Mid-Town Center, and the Heather Program.

An important component of the Committee process was the solicitation of community input through listening tours, focus groups, a public comment line, a computer survey, and a town hall meeting. A series of core questions was developed to obtain information from consumers, providers, family members, advocacy groups, and other interested parties. Valuable information was received from the community for consideration by the Committee in formulating its recommendations to the Lancaster County Board.

COMMITTEE DISCUSSIONS

The first order of business for the Committee was a review of the history and purpose of the CMHC, including a review of services provided, budget information, and funding sources. The CMHC was established in 1976 through a federal grant under the Comprehensive Community Mental Health Centers Act for the purpose of treating individuals with severe mental illness in the community rather than in state institutions. Moving mental health treatment to the community was driven in part by Lancaster County's desire to save money. State law requires counties to pay a portion of the cost for housing their residents with the Nebraska Department of Public Institutions, and the County believed that community-based mental health treatment is not only more effective but also less expensive than institutional care. To accomplish this goal the CMHC developed a staff with the expertise to provide quality care to the severely and persistently mentally ill.

Original funding under the grant was 80% federal with a 20% match of state and local funds. The grant mandated a list of services including: inpatient care, outpatient care, medical services and administration, day treatment, partial hospitalization, consultation and education, children's services, and program evaluation.

The CMHC has added a number of additional programs including:

- Service coordination
- The Heather, a transitional living program for patients moving from the Lincoln Regional Center (LRC) to the community
- The Sexual Trauma Offense Prevention Program (STOP)
- The Outsider Arts Program
- The Harvest Program, a collaboration with CenterPointe and Aging Partners providing services to mentally ill elderly persons with substance abuse issues
- Assertive Community Treatment (ACT), a collaboration with CenterPointe and Lutheran Family Services providing specialized services in the community and at home to clients who have not responded well to traditional outpatient care
- Mid-Town Center, which provides psychiatric rehabilitation and other related services
- Homeless/Special Needs Outreach Program
- Emergency services, including a 24-hour crisis line, mobile crisis service, walk-in services, and with availability of services and phone contact after regular business hours

See Exhibit B for a complete list of CMHC programs and services.

Until recently the CMHC also operated the Behavioral Health Jail Diversion Program. However, this program was transferred to the Lancaster County Community Corrections Department at the beginning of the County's 2011-2012 budget year.

In 1988 the CMHC opened the Crisis Center. Originally consisting of ten (10) beds located at the Lincoln Regional Center, the Crisis Center was established pursuant to an interlocal agreement with Region V to meet the emergency protective custody (EPC) needs of the sixteen (16) counties served by Region V. The Crisis Center is now located on the second floor of the CMHC and consists of fifteen (15) beds. It is important to note the County is statutorily mandated to pay the cost of providing emergency protective custody for its residents. See Neb.Rev.Stat. §71-919 (Reissue 2009).

The CMHC's approved budget for fiscal year (FY) 2011-12 is $9,490,537. The primary funding sources are Medicaid, state funding through Region V, and Lancaster County property tax. The property tax request for this fiscal year's budget is approximately $2.2 million, down $500,000 from the previous fiscal year due to program and staffing cuts. Not counting the Crisis Center, CMHC operations will require approximately $800,000 of property tax this fiscal year.

The Committee also examined the role of Region V in providing behavioral health services in Lancaster County. Pursuant to the Behavioral Health Services Act, Neb. Rev. Stat. §§71-801 through 830 (Reissue 2009), the State of Nebraska is divided into six (6) behavioral health regions which are responsible for the development and coordination of behavioral health

services. Lancaster County is included in Region V, which serves sixteen (16) counties in southeast Nebraska. Each county within a region is required to contribute funding for the operation of the regional authority and for the provision of services.

The Nebraska Department of Health and Human Services, Division of Behavioral Health Services contracts with Region V to ensure the availability of behavioral health services to residents in southeast Nebraska who do not have insurance or funds to pay for services. In turn, Region V contracts with a network of service providers within the sixteen (16) counties it serves to provide an array of behavioral health services to adults and children.

The CMHC is a member of the Region V Systems service provider network. For FY 2011-12 the CMHC is budgeted to receive approximately $3.3 million from Region V Services for a wide array of services and programs.

Although the CMHC has effectively provided community-based mental health services since 1976, the Committee recognized the traditional way of providing services will need to evolve to meet future challenges. The number of Medicaid recipients needing services is expected to increase sharply in the next few years. Providers will need to become more efficient, and collaboration will become more important. New models are being developed for providing services to the persons medically under served which integrate primary health care and behavioral health care, and emphasize peer operated programs. The Committee looked at several different integration models, including the formation of a partnership between the CMHC and a primary health care provider.

Pursuing this analysis, the Committee reviewed extensive information on the People's Health Center (PHC), a federally qualified health center (FQHC) providing primary health care to the medically under served in Lincoln. As an FQHC, the People's Health Center receives an enhanced federal reimbursement rate for Medicaid patients receiving medical care. The enhanced rate of reimbursement does not apply to behavioral health services. Recognizing the behavioral health needs of its patients, the PHC has established the Behavioral Health Integration Project (BHI Project). The BHI Project is funded by Region V and the Community Health Endowment, and is seeking to establish partnerships with a number of behavioral health providers in the community, including the CMHC.

Another area where Lancaster County might gain from a partnership with the PHC is General Assistance. The County budgeted approximately $1.6 million to cover the projected costs of medical care under General Assistance for FY 2011-12. Providing this medical care through the People's Health Center could save money for the County and provide needed funding and continuity of care for the PHC and its patients.

As the County considers future challenges in providing community-based mental health services, as well as the development of new service models to meet those challenges, the information and recommendations contained in the final report from Health Management

Associates (HMA) should be carefully considered by the County Board. At the same time this Committee was formed by the County Board to examine community mental health services, the Community Health Endowment commissioned a study by HMA to provide recommendations on how to better provide for the medically under served in our community. The Lancaster County Board contributed $5,000 toward this study to include an analysis and recommendations regarding the CMHC. The guidance provided by HMA will be extremely helpful in crafting the best solution to address the primary care and behavioral health needs of the medically under served.

In this regard, HMA has already identified a grant opportunity being offered by the Centers for Medicare and Medicaid Services could have a profound effect on how primary care and behavioral health services are provided not only our community, but for the entire area of southeast Nebraska served by Region V. This grant opportunity is being pursued by a consortium of stakeholders, including Region V, the Community Health Endowment, the Lincoln Medical Education Partnership, the People's Health Center, and other key entities. From the County's perspective, an important part of the grant proposal will seek funding to create a collaborative primary care/behavioral health system of care. From a consumer perspective, the grant could help create more peer support, and more consumer operated and consumer run programs. The ultimate objective is a system with better care, better health, and lower costs.

The final essential piece of the puzzle analyzed by the Committee is the extensive comments received from more than 500 consumers, family members, advocates and providers. This invaluable information was gathered as part of the community input process conducted on behalf of the Committee by the Community Health Endowment and Leadership Lincoln. Funding to conduct the process was graciously provided by the Consumer/Family Coalition of Region V. Some of the key lessons which can be garnered from the comments include the following points:

- The current location of CMHC was generally noted as convenient and in close proximity to BryanLGH West, a grocery store, pharmacy, and other neighborhood amenities. Of highest importance was accessibility by consumers to bus routes
- Case management services were consistently viewed as vital to consumers and their family members
- The "one-stop" shop services of CMHC were considered valuable, as well as the "fluidity" that consumers experience when moving from one level of care to another within the same agency. Parceling CMHC programs among multiple agencies was cited as a concern
- The addition of CMHC satellite clinics was frequently recommended, especially in north Lincoln
- There was little evidence that there is an integration of primary care and behavioral health services among CMHC consumers. This was often noted as a specific area of service improvement and a "best practice" opportunity

- An increased use of peer services was highly encouraged
- Public safety, law enforcement involvement, and homelessness were often raised as areas of concern, especially if the level of public mental health services was decreased
- Affordable public mental health services were often noted as filling an important need for the poor and working poor.

See Exhibit C for a more complete summary of the comments received during the public input process.

Consumer involvement is a priority in all aspects of behavioral health service planning and delivery, and the information received during the community input process was weighed heavily by the Committee in formulating its recommendation to the Lancaster County Board.

ISSUES AND CONCERNS

Based on the information presented and the analysis summarized above, the following issues and concerns have been identified by the Committee:

Potential Cost to the County if Effective Community Mental Health Services Are Not Provided

Although Lancaster County is not statutorily mandated to provide behavioral health services, maintaining a strong and effective community behavioral health system is in the best interests of the County. By providing an array of services to patients with severe and persistent mental illness, the CMHC is reducing the amount of admissions to the Crisis Center, law enforcement contacts, jail admissions, and involvement with the criminal justice system. Since all these functions are the responsibility of the County in whole or part, the question which must be addressed is whether the County is saving money in the long run by operating an adequately funded mental health center. The analysis of this question should include a review of which programs offered at the CMHC are most effective in reducing the number of EPC's and amount of involvement with the criminal justice system. Also, are the services being provided in the most efficient manner with the present ownership and business structure, or should the County pursue a new model for providing services? When making this decision it is critical for the County Board to have accurate information on the true cost to the County of owning and operating the CMHC.

General Assistance

Lancaster County is statutorily responsible for providing medical care, including behavioral health care, to individuals who meet the income and resource standards set forth in the Lancaster County General Assistance Guidelines. The cost of providing mental health services to General Assistance clients at the CMHC is approximately $420,600 per year, and is

absorbed in the CMHC budget. If medication costs are included then the estimated cost exceeds $600,000 per year. If the County discontinues operation of the CMHC other service providers will need to found for General Assistance clients.

Indirect Costs

For the budget year ending June 30, 2010, the cost of services provided to the CMHC by other County departments was $394,000. See Appendix A, Exhibit 9. The value of these services must be taken into account as the County Board considers other service models.

Community Treatment of Sex Offenders

A disproportionate number of sex offenders live in Lancaster County. The CMHC is actively involved in treating this population. Concerns have been raised whether adequate funding is being provided by the State for this purpose, and whether treatment programs at the CMHC could be provided by non-governmental organizations.

Funding Concerns

The committee raised a number of concerns regarding funding for the CMHC. During the 2011 legislative session the CMHC suffered a 2.5% reduction in Medicaid funding. For 2012 Governor Heineman is proposing to eliminate the inheritance tax, which could result in a loss of over $6 million to Lancaster County. Loss of the inheritance tax would cripple the County's ability to adequately fund community mental health services. Other concerns include the fairness of existing funding formulas for the behavioral health regions. Since the Lincoln Regional Center and the State prison are located in Lancaster County, the County experiences an influx of patients from other counties. Also, residents from other counties relocate to Lincoln because of the availability of services. Do the funding formulas adequately account for this added burden on Lancaster County? Another concern is whether the CMHC is able to maximize funding from other sources which may be available for behavioral health treatment.

Cost of Divesting the CMHC

Although the County is presently contributing $2.2 million of property tax to the CMHC, $1.4 million of this cost is for operation of the Crisis Center, leaving $800,000 of funding for CMHC programs. After accounting for the cost of General Assistance, approximately $600,000, the actual savings the county could be as low as $200,000 per year. Moreover, at the time of divestiture the County will be required to pay sick leave and vacation balances to separated employees. As of the end of 2011 this figure amounted to $994,420. The County will realize some indirect cost savings.

CMHC Location

Based on numerous comments received during the public comment process, the availability of an array of services at one location is critical to the population served by the CMHC. Moreover, the present location of the CMHC is also extremely important to consumers and

family members. As the County goes forward with the planning process, careful consideration must be given to the actual location of facilities and services.

RECOMMENDATIONS

The Committee strongly believes the CMHC is an indispensable component of the provider network and service array established to meet the behavioral health needs of the residents of Lancaster County. However, financial challenges are making it increasingly difficult for the County to adequately fund the critical programs and services offered by the CMHC. At the same time, opportunities exist to establish a new service model based on the integration of primary health care and behavioral health services, peer support, and more consumer operated and consumer run programs. Therefore, the following recommendations are tendered to the Lancaster County Board of Commissioners:

1. **Discussions should begin immediately with Region V Systems for the purpose of transferring management of the CMHC to Region V Systems no later than July 1, 2012, with CMHC staff continuing to be employees of Lancaster County. Simultaneously, Region V and the County should begin preparing specifications for a new service model, and proposals should be solicited through an Invitation to Negotiate process:**
   a. **The new service model should be a recovery-based system which integrates primary care and behavioral health services, with consumer involvement and emphasis on peer supported programming;**
   b. **A communication/community outreach plan should be developed to assure transparency and to assist consumers, families, and employees with the transition; and**
   c. **A plan should be developed to assure meaningful and significant participation by consumers and advocates in the design, development and implementation of the new system.**

2. **The CMHC should be maintained in the current location during the transition period to allow for an orderly transition for consumers and family members for up to twenty-four (24) months;**

3. **Lancaster County should maintain its present level of financial support for the CMHC for up to twenty-four (24) months; and**

4. **The County should participate in the establishment of a new system of care for the medically under served based on the integration of primary health care and behavioral health services, including the use of General Assistance funding for medical and behavioral health services to support the new system.**

Respectfully submitted by the CMHC Planning Committee this 7th day of February, 2012.

Pat Talbott

Lori Selbel

CJ Johnson

Deb Shoemaker

Dean Settle

F:\files\COMMISS\COMMITTEES\CMHC Committee\Report and Recommendations Community Mental Health Center Planning Committee 1.18.2012 .wpd

APPENDIX A

List of Documents Reviewed

1. CMHC Background Information and History
2. Additional Background Information on CMHC; Lancaster County Agencies providing Support; CMHC Collaborations, Contracts, and Vendors
3. CMHC Proposed Fiscal Year (FY) 2011-12 Budget
4. Summary of Lancaster County Property Tax Applied to Various CMHC Programs
5. "What Will Become of the Mental Health Safety Net", article by Dennis Freeman, Ph.D., from the Field Mental Health Weekly, May 31, 2011
6. Summary of General Assistance Services Provided through the CMHC
7. CMHC Programs and Services
8. Lancaster County Central Services Cost Allocation Plan for FY 2009-10
9. PowerPoint Presentation on People's Health Center
10. Four Quadrants of Clinical Integration Based on Patient Needs
11. Estimate of Annual Cost General Assistance Services Provided through CMHC
12. Region V Systems Provider Network and Service Array
13. Region V Systems Behavioral Health Services by Level of Care
14. PowerPoint Presentation on Region V Systems Provider Network
15. CMHC Planning Committee Discussion Summary (September 8, 2011 Meeting)
16. Health Management Associates (HMA) Meeting Schedule
17. Lincoln Journal Star Letter to the Editor from Pat Talbott, September 4, 2011
18. Nebraska Statutes Regarding Consumer Involvement in Behavioral Health Service Planning and Delivery
19. Statistics Regarding Number of CMHC Patients Served Who Were Found to Be Not Guilty by Reason of Insanity (NGRI) or Not Responsible by Reason of Insanity (NRRI)
20. Missouri Integration Process: Comprehensive Person-Centered System of Care
21. Focus Groups: Response Summary
22. Summary of Persons Interviewed by HMA
23. CMHC Survey Results
24. Focus Group Combination Report (October 5, 2011 - October 21, 2011)
25. Strategies for Increasing and Supporting Consumer Involvement in Mental Health Policy/Planning, Management, and Services Delivery
26. "For Mentally Ill, Home Is Where the Health Home Pilot Is", California Healthline, December 5, 2011
27. Correspondence from Premier Psychiatric Group, LLC, dated December 15, 2011
28. Correspondence from Mental Health Association of Nebraska, dated January 3, 2012
29. "Shared Decision-Making in Mental Health Care", Published by U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2011)
30. "Juggling the Lineup - Seeking Better Financial Results, Providers Change Services; Experts Worry about Access", Modern Healthcare, January 16, 2012

31. A Comprehensive Plan to Address Appropriate, Effective and Sustainable Health Care Services for the Uninsured and Medicaid Populations in Lincoln, Nebraska, Prepared for the Community Health Endowment of Lincoln by Health Management Associates, January 2012
32. Correspondence from Mental Health Association of Nebraska, dated February 3, 2012
33. Final Combination Report for Focus Groups and Public Feedback, October 5, 2011 - November 21, 2011
34. Community Input Major Summary Points

F:\files\COMMISS\COMMITTEES\CMHC Committee\Appendix A.wpd

APPENDIX B

Community Mental Health Center Programs and Services

CELEBRATING
35 years
OF SERVICE

COMMUNITY MENTAL HEALTH CENTER

Annual Report 2010-2011

2201 S. 17th Street
Lincoln, NE 68502
Tel: 402-441-7940
Fax: 402-441-8625
www.lancaster.ne.gov/cnty/mental

Mission Statement:

The Community Mental Health Center of Lancaster County is dedicated to providing quality mental health care and rehabilitation services for adults who experience acute psychological distress or serious mental illness.

Programs & Services

- **Community Support** - Case management and services to adults and vulnerable elderly through the Harvest Project, and residential support services at The Heather, Independent Living Project, and Transitional Living for adults with severe and persistent mental illness.
- **Medical Services** - Outpatient psychiatric services for CMHC consumers including assessment, therapy, medication education and management, and inpatient psychiatric care.
- **Outpatient Therapy** - Individual and group therapy sessions focused on symptom alleviation, stabilization, and recovery. Community-based sex offender management.
- **Day Treatment / Partial Hospitalization Program** - Short term, intensive treatment provided through group formats, 6 ½ hours daily, Monday - Friday. May serve as an alternative to inpatient treatment or as a step down for individuals making the transition from a hospital setting to the community.
- **Day Rehabilitation** - The Midtown Center, open Monday - Saturday, is a clinical rehabilitation program engaging consumers in life skills, recovery and vocational activities. Employment and benefits counseling, job placement and training for consumers of CMHC services are also available through the AWARE program.
- **Homeless / Special Needs Outreach** - Outreach and case management for adults who have a mental illness and are homeless, near homeless or in contact with the criminal justice system.
- **Psychiatric Residential Rehabilitation** - The Heather is a structured residential facility operated by CMHC, and OUR Homes as a residential transition from the Lincoln Regional Center back into the community.
- **Crisis Center** - An assessment and crisis stabilization facility for adults placed on emergency protective custody by law enforcement in the 16 Counties of Region V.
- **Peer, Volunteer & Student Placement** - Students, volunteers, and peer recovery specialists augment the work of CMHC staff members in social and recreational activities, treatment and rehabilitation services.
- **Behavioral Health Jail Diversion Program** - This Program seeks to identify and divert individuals from jail with a mental illness or co-occurring substance use disorder who have committed a non-violent offense. The Program then links these persons to an array of community-based services with intensive case management.
- **Open Studio/Writers Wordshop** - A collaborative effort by CMHC, Centerpointe, and Parks and Recreation for adult artists and writers we serve. Open-studio sessions, workshops, readings, and many exhibitions each year are provided to those using the arts as a means of expression and maintenance of wellness.
- **PIER** - A collaboration designed to serve individuals who have not responded well to traditional outpatient care. Services are provided to the client in their home and the community. Office is at 2000 P Street. Phone number - 435-4044.
- **24 hour Crisis Line/ Mobile Crisis Service** - Crisis assessment, intervention, and information available 24 hours by phone. Mobile services available to law enforcement or agencies requesting consultation / intervention, after regular business hours **(441-7940)**.

Lancaster County Board of Commissioners

Bernie Heier
Larry Hudkins
Jane Raybould
Deb Schorr
Brent Smoyer

Strengths-Based

Quality Care

Recovery

Hope

Wellness

Access

Choice

Evidence Based Programs

Services accredited by:

CARF

CMHC is funded by Region V Systems, State of Nebraska, Federal Grants, the City of Lincoln and Lancaster County

Persons Served

Duplicates included

Program	Number
Community Support	1,085
Medical Services	1,909
Inpatient Psychiatric Services	347
Outpatient Therapy	883
Day Treatment / Partial Hospitalization	227
24 Hour Crisis Services	4,897
Day Rehabilitation Services	195
Homeless / Special Needs	253
Psychiatric Residential Rehabilitation	28
Crisis Center	615
Vocational Support	44
Harvest Project *	153
Mental Health Jail Diversion	48
PIER **	79
Open Studio / Wordshop ***	342
Total number served	**11,105**

Demographics

Unduplicated

N = 4,911

48%	**52%**
Women	**Men**

Age

18 - 34	**31%**
35 - 49	**39%**
50+	**30%**

Caucasian	**85%**
Black	**5%**
Hispanic	**5%**
Other	**2%**
Native American	**2%**
Asian	**1%**

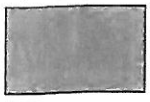
$10,149,301

EXPENSE — TOTAL 100%

Personnel **74%**

Region V **6%**

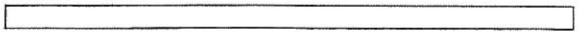
Operating **20%**



REVENUE — TOTAL 100%

County **29%**

Region V **36%**



City of Lincoln / CenterPointe **1%**

Medicaid / Medicare **27%**

Client Fee/Insurance **3%**

Special Grants & Projects **4%**

*Collaborative Project with Aging Partners and CenterPointe, Inc.
**A collaborative project with CenterPointe and Lutheran Family Service
***A collaborative project with CenterPointe and Lincoln Parks and Recreation

APPENDIX C

Mental Health Center Planning Committee
Focus Groups and Public Feedback
10/5/11 – 11/21/11
Combination Report

1. **What is the MOST important thing about the way you CURRENTLY receive mental health services?**
   - **(MIDTOWN)** Consumers at Midtown were most likely to state that their case managers were the most important thing about the way they receive mental health services. They were also highly favorable about the life skills classes and socialization opportunities at Midtown. Other important issues included the assistance they receive in insurance matters and in establishing eligibility for other services, including transportation and medication.
   - **(CMHC CONSUMERS)** CMHC consumers most commonly stated that case managers are very important, creating a system that is more of a "one-stop shop." They see CMHC as the place they can go to receive psychiatric services, case management, medications, support groups, and therapy. Other important things included the location, transportation, lack of stigma, long tenure of CMHC staff, availability of employment for clients at CMHC, proximity to BryanLGH.
   - **(FAMILY MEMBERS)** Family members were most likely to state that case managers are most important. They also noted that the "in-house" relationship between case managers and psychiatrists was essential to consumer stability. Family members often stated that CMHC was a "home away from home" where consumers find trust, self-esteem, stability, constancy, familiarity, and lack of stigma. There was strong sentiment that family members, especially those who live outside of Lincoln, feel ill-equipped to handle a consumer's situation without help from CMHC. Family members frequently noted the skill and longevity of CMHC staff.
   - **(CMHC STAFF)** CMHC staff stressed the importance of timely access that mental health consumers have to CMHC staff/programs. They see this as a hallmark of their agency. Another key issue was the "one stop shop" of services provided by CMHC, in combination with the "fluidity" that consumers experience when moving from one level of care to another. Staff described their services as "one of a kind," "community-based," "client-centered," and "pro-active." The longevity of staff was also noted as important in providing continuity for the consumers with one staff member stating "nothing can substitute for experience when you are dealing with the mentally ill." Another key issue raised was the importance of case management and outreach. Staff stated that their relationships throughout the community "cut through red tape," "ease navigation through the system," and "cannot be replicated." Other key issues raised were cultural competency, the 24-hour crisis line, a well-known location served by a bus line, and excellent employee benefits.
   - **(SERVICE PROVIDERS/ADVOCACY GROUPS)** Service providers strongly endorsed the ease of access provided by CMHC. They specifically noted walk-in services, crisis services, and sliding scale fees as key accessibility features. Service providers and advocacy groups also noted the importance of CHMC in transitioning consumers from

jail into community living. The longevity, continuity, and expertise of CMHC staff were also noted as a key feature of the current public health system.

2. **Relying on your personal experiences, what is the ONE THING YOU WOULD CHANGE about the way you receive mental health services?**
   - **(MIDTOWN)** Midtown consumers noted that they would like more assistance/opportunity in finding and securing meaningful employment. Midtown consumers also stated that the lack of available transportation and lack of physical activity/exercise is a concern to them. Other things that Midtown consumers would change include governmental policies that don't favor mentally ill clients, more structured activities, return of Wednesday evening activities, the limited timeframe for medicine disbursement at CMHC, more access to computers, lack of "face time" with psychiatrists, and inconvenient bus routes.
   - **(CMHC CONSUMERS)** The consumers generally did not feel that they would change anything about the mental health services they receive. The majority believe their needs have been met. Some specific areas of change offered by consumers included:
     - Increasing weekend and evening services, transportation, access to psychiatrists, and number of case managers;
     - Assuring that mental health services are not "politicized;"
     - Decreasing lengthy wait lists;
     - Addressing medication concerns, including cost, lack of regulation, and frequent changes in types and dosages; and
     - Allowing for decreased reliance on psychiatrists and an increased use of mid-level providers (APRN, PA) as a way to expand access to medication management services.
   - **(FAMILY MEMBERS)** Many family members stated that they would change nothing about the way their family member receives mental health services. Others stated that CMHC should actively maintain services for service-resistant clients, reduce the wait list for caseworker assignment, and assist in consumer employment, transportation, and housing.
   - **(CMHC STAFF)** CMHC suggested a number of things to change about the current delivery system, including less paperwork, increased office support, improved technology, increased funding, and increased therapy/counseling services. Several staff members indicated that greater emphasis should be placed on "front end" case management for increased consumer stability. Several staff members noted the need to eliminate barriers to getting treatment authorization/payment and the need to create "seamless funding." Two staff members asked for increased on-site security for CMHC staff at intake. Other issues raised included the need to integrate mental health and substance abuse services, utilize intake workers to provide interim services for clients on the wait list, eliminate duplicate assessments, and provide a smoother transition from child to adult services.
   - **(SERVICE PROVIDERS/ADVOCACY GROUPS)** Service providers/advocacy groups noted that they would change the amount of paperwork that is necessary to assist a client and move them between levels of care. Others recommended a walk-in clinic, greater focus

on preventive services, increased medication management services, and increased counseling services in lieu of medicating. Attention was focused on the need to decrease reliance on law enforcement as consumers move between levels of care. One service provider stressed the need to provide public mental health services in all quadrants of the city.

3. **What do you want and need to stay well?**
   - **(MIDTOWN)** Midtown consumers were most likely to respond that they need/want medication, the structure offered by the Midtown Center, and employment. They also reported needing/wanting life skill classes, physical exercise and good nutrition, education, and consistent housing.
   - **(CMHC CONSUMERS)** CMHC consumers were most likely to state that affordable medication and case management services were what they wanted and needed to stay well. Consumers also wanted/needed consistency, walk-in services, a stable service delivery system, and a sense of "community" or "safe haven" among individuals with mental illness. Several consumers noted the importance of the partial hospitalization program and easy accessibility to services.
   - **(FAMILY MEMBERS)** Family members stated that education, skill-building, and employment were key factors to staying well among consumers. Others stated that medications, socialization, and case managers were important. Some concern was raised that consumer's stability has been impacted by the ongoing questions raised about the future of CMHC and urged for quick resolution.
   - **(CMHC STAFF)** Staff was most likely to state that mental health consumers need case management, easy access to services, consistency, someone to trust, familiarity, and quality services. Low staff turnover was recognized as important in providing quality services to consumers. Staff also recognized that the friendships built among mental health consumers were important to recovery.
   - **(SERVICE PROVIDERS/ADVOCACY GROUPS)** Service providers/advocacy groups agreed that mental health consumers need access to services to stay well. These needed services ranged from case management, counseling, eligibility assistance, and crisis intervention. They also stated that consumers want honesty and to be given choices in their care. Advocacy groups stated that consumers want to feel valued in the community. According to one advocate/consumer, "I am not a mental illness, I am a person."

4. **Do you have a primary medical doctor? If no, why not? If yes, does your primary care doctor communicate about your needs with your mental health provider?**
   - **(MIDTOWN)** Midtown consumers were most likely to report that they did have a primary care physician. About one-half responded that they believe that their primary doctor communicates with their mental health provider.
   - **(CMHC CONSUMERS)** CMHC consumers were most likely to report that they do have a primary care physician. The consumers were generally confident that their primary medical provider and mental health provider communicate about their specific needs.

- **(FAMILY MEMBERS)** Most family members concurred that, while the consumer may have a primary care provider, there is little communication between the primary care provider and the mental health provider. They also stated that consumers who have highly engaged family members were more likely to have coordinated care. Family members felt that there is little integration of services and that there is little understanding of mental illness among primary care providers or the general community
- **(CMHC STAFF)** With the exception of General Assistance clients, the majority of staff reported that few consumers have a primary medical doctor. It was noted that many consumers lose their insurance and are referred to CMHC by primary care providers for continued treatment. When asked why consumers do not have a primary care provider, numerous responses were given, including paranoia, apathy, inability to communicate in that setting, cost, easy access to emergency department services, lack of information regarding options, lack of physicians who will accept Medicaid, and lack of transportation. Among those staff who reported that consumers do have a primary care doctor, they noted that staff must often accompany consumers to medical appointments because many primary care providers are "uncomfortable" or "ill-equipped" to deal with mental health patients.
- **(SERVICE PROVIDERS/ADVOCACY GROUPS)** Representatives from corrections, substance abuse organizations, mental health organizations, independent living, hospitals, law enforcement, and vocational rehabilitation agreed that very few consumers have a personal primary care provider. They stated that consumers do not prioritize physical health as important and, even if they did, the cost of medical services is prohibitive to most.

5. **How important to you is the location of the Community Mental Health Center?**
   - **(MIDTOWN)** Most Midtown consumers believe that the location of CMHC is important, noting its location on the bus route, and proximity to BryanLGH and/or their place of residence. Several stated that CMHC should consider satellite locations, especially in north Lincoln.
   - **(CMHC CONSUMERS)** Consumers stressed that the current location is easy to access by bus or on foot. They noted that recent changes in cab transportation (and voucher services) have created difficulty for consumers without a car. Many consumers noted that they live within walking distance of CMHC, including consumers using the Keya House for respite services. Some consumers offered that multiple locations throughout the city would be beneficial. The proximity of CMHC to BryanLGH West in the case of crisis situations was also noted. Consumers also noted that CMHC is currently located in a "neighborhood" with access to groceries, pharmacy, and other amenities.
   - **(FAMILY MEMBERS)** Family members frequently mentioned that the current location was within walking/biking distance or on a bus line for their family member. This central location was seen as highly important to family members. They also mentioned the proximity of CMHC to BryanLGH as an important factor.

- **(CMHC STAFF)** Staff stressed that the current location is on a bus line, near client homes, centrally located, and in close proximity to BryanLGH West. Some staff noted that the current location is near the General Assistance office and a pharmacy.
- **(SERVICE PROVIDERS/ADVOCACY GROUPS)** Service providers/advocacy groups noted that a central location with access to a bus line is critical. They also noted the proximity of BryanLGH, as well as neighborhood services like a grocery store and pharmacy, as valuable. Several individuals advocated for satellite mental health clinics throughout the city, and especially in north Lincoln.

6. **How do you pay for your mental health services?**
   - **(MIDTOWN)** The most common sources of payment by Midtown consumers are Medicaid, Medicare, Supplemental Security Income (SSI), Veteran's Administration, and/or disability.
   - **(CMHC CONSUMERS)** Most CMHC consumers stated that payment for their mental health services is provided by Medicaid, Medicare, and/or General Assistance. Fewer reported having private insurance, often with high co-pays.
   - **(FAMILY MEMBERS)** Family members more frequently stated that mental health services for their family member are paid for by Medicare, Medicaid, SSI, and/or Disability. Fewer family members reported payment by the Veteran's Administration or private insurance.
   - **(CMHC STAFF)** Staff stated that it is difficult to get payment from clients, even on a sliding scale, because of their low-income. Sources of payment mentioned include Medicaid, Medicare, General Assistance, Disability, and/or SSI. Staff stressed the value of the Medication Assistance Program. Staff also encouraged policymakers to consider impending federal health care reform and the potential for increased funding for public mental health services.
   - **(SERVICE PROVIDERS/ADVOCACY GROUPS)** Law enforcement and corrections noted that their services are provided by taxpayers. Other payment sources noted were Supplemental Security Income (SSI), Medicaid, Medicare, private insurance, and sliding fees.

7. **How important do you believe the Community Mental Health Center is to the overall quality of life in Lancaster County?**
   - **(MIDTOWN)** Midtown consumers generally stated that CMHC is very important to the overall quality of life in Lancaster County because it prevents individuals from being hospitalized, jailed, and/or admitted to the Crisis Center. Several consumers stated that they would be homeless without the services of CMHC.
   - **(CMHC CONSUMERS)** Consumers believe that CMHC is very important to the overall quality of life in Lancaster County. Several noted that, without public mental health services, jail would be the only alternative. Others stated that the lack of mental health services would result in increased homelessness, abuse, crime, and suicide. There was overwhelming sentiment among consumers that the array of CMHC services be retained in its current form without moving toward privatization or "dividing" the agency.

- **(FAMILY MEMBERS)** Family members stated that CMHC provides stability to a population that would otherwise use a community's emergency services (police, ambulance, mission, jail, emergency department). They also noted that CMHC has a role to educate the general community about mental illness and to reduce stigma. Some felt that CMHC provides a "supportive family" for mental health consumers that cannot be replicated in the general community and, as a result, the entire community benefits. Others stated that assuring medication compliance among the mentally ill is a "game-changer" for the general community.
- **(CMHC STAFF)** Staff considered CMHC to be highly important to the overall quality of life in Lincoln, stressing that CMHC prevents homelessness, unemployment, incarceration, inappropriate use of emergency services, abuse, and crime. The focus on medication management was cited as especially critical to consumers and the community's quality of life. They stressed that mental health consumers bring value to the community, as employees, volunteers, artists, musicians, and more. Staff provided specific niche areas of importance for CMHC, including the provision of services to sex offenders and persons declared not guilty by reason of insanity.
- **(SERVICE PROVIDERS/ADVOCACY GROUPS)** Service providers/advocacy groups noted that, without the services of CMHC, there would be added pressure on existing, already over-stressed providers. Many of these providers, including law enforcement, corrections, treatment centers, and hospitals do not have the same level of expertise in public mental health service delivery. One service provider noted that "jails can already be considered the largest psych hospitals in the U.S." with "one out of every five inmates on psychotropic medications." The provider noted that the corrections system cannot bear additional strain. Other service providers/advocacy groups noted that Lincoln "rose to the challenge" when Regional Centers were closed, but the additional elimination of services would be a heavy blow to the community.

8. **Based on your personal experiences, are you aware of any BEST PRACTICES in the delivery of public mental health services that should be considered in Lancaster County?**

- **(MIDTOWN)** Midtown consumers stated that Midtown Center services <u>are</u> a "best practice." They specifically noted the life skills classes and use of case managers. Potential options include providing more services in the client's home, more communication between mental and physical health providers, recovery conferences, improved privacy in visitation areas, walk-in services at the VA, and allowing pets as part of the recovery process.
- **(CMHC CONSUMERS)** Consumers generally believe that CMHC represents a "best practice" delivery of mental health services. Consumers did offer some best practice options, including the availability of more peer-to peer services, services that fall between inpatient and outpatient care (like the Keya House), integration of primary care and mental health services, and good housing and employment options to supplement recovery. One consumer advocated for a voluntary crisis center.

- **(FAMILY MEMBERS)** Several family members suggested the need for more transitional homes. One family member suggested the addition of church-organized "handyman" services for the mentally ill. Other ideas included continued and enhanced training regarding mental illness for the Lincoln Police Department and Adult Protective Services, sheltered work programs, more ACT Teams, and the use of "consumer advocates." One family member urged a mandatory curriculum in public schools regarding mental illness.
- **(CMHC STAFF)** Staff stated that there should be a stronger emphasis placed on accessible and affordable housing. They also suggested more of a "recovery focus," alumni groups, day rehabilitation, smaller caseloads, and more peer-based programs. They challenged if current Medicaid policies gave CMHC the ability to pursue best practice models.
- **(SERVICE PROVIDERS/ADVOCACY GROUPS)** Service providers and advocacy groups offered "tele-counseling" as a possible option. Peer services were strongly endorsed, including the Keya House. Some suggested more accountability and impact studies to determine that the current system is working. One provider stated that CHMC is a "training ground" for mental health students and professionals. Other providers stated that more work should be done to build mental health infrastructure outside of Lincoln so that consumers can access services closer to home.

9. Is there anything else that you would like us to know?

- **(MIDTOWN)** Midtown consumers reiterated their support for Midtown Center services, noting its importance in client stability, socialization, and life skills education. Several consumers noted that they were without family support and have relied on the Midtown Center in this way. Specific issues included the lack of dental and vision clinics who accept Medicare and the need for access to legal assistance.
- **(CMHC CONSUMERS)** Consumers endorsed the personalized nature of CMHC services, referencing it as their "lifeline," "family," and "identity." They believe that Lincoln should "take care of their own" and that the costs associated with reducing/eliminating mental health services would only be shifted to hospitals and jails. Consumers reiterated the importance of the seamless delivery system at CMHC. At the same time, several consumers recognized the need for increased service efficiency. Satellite locations for CMHC were mentioned as a possible systems improvement. Consumers were concerned that their continuity of care could be disrupted if the current system is reorganized.
- **(FAMILY MEMBERS)** Family members stressed that Nebraska's citizens and government seem to be growing more indifferent to the needs of vulnerable individuals, including those with developmental disabilities, the elderly, children, and the mentally ill. They cautioned about the long-term impact of such indifference.
- **(CMHC STAFF)** Staff recognized that there is a community perception that they are overpaid government workers. They stressed that they are working with very complicated patients and a high level of expertise and commitment is necessary. They asserted that it is impossible to determine what the impact would be of "re-inventing"

public mental health services, and that the risk of doing so could be costly for vulnerable patients. The staff provided several examples how "systems change" has negatively impacted vulnerable individuals, i.e. Beatrice State Development Center and statewide child welfare reform. They also described staff members who left CMHC for the private sector, only to return because of the higher quality of care provided by CMHC. Several CMHC staff members pointed to the recent economic downtown and how it has caused increasing caseloads, stressing that now is not the time to reduce or fragment services. In summary, they challenged policymakers to consider that "lives are at stake."

- **(SERVICE PROVIDERS/ADVOCACY GROUPS)** Service providers/advocacy groups stressed that the "one-stop shop" services provided at CMHC are important to continuity and quality of care. One provider stated that having CMHC staff on-site in the jail is critical to creating effective transition plans.

PUBLIC COMMENT

Two town hall forums were held. They were open to the public. The audience consisted of consumers, family members, providers, and other interested Lincoln residents. Although individuals making comment were not asked to respond to specific questions, they were provided with the same set of questions used during the focus groups as a guide.

In addition, a telephone comment line and on-line comment form were available. Respondents using these formats indicated that they were providers, educators, interested individuals, corrections staff, consumers, landlords, and family members. All feedback was considered anonymous unless a respondent voluntarily provided their name and contact information.

The major points of public feedback are summarized below:

- The current location of CMHC was generally noted as convenient. Of greater importance to respondents was accessibility to bus routes.
- Specific CMHC services, including medication management, support groups, case management, and caregivers education /support, were often noted as significant services.
- Public safety, law enforcement involvement, and homelessness were often raised as areas of concern, especially if the level of public mental health services was decreased.
- Affordable public mental health services were often noted as filling an important need for the poor and working poor.
- It was noted that the number of CMHC services "under one roof" was beneficial to clients.
- Service integration within CMHC was noted as an area where service delivery could be improved. In addition, some noted strong support for integration between mental health, physical health, substance abuse, and developmental disabilities.
- Some respondents were critical of the "cumbersome" intake process at CMHC.

- Respondents noted that some CMHC services could likely be provided in a more cost efficient manner by private providers. However, there was strong support that crisis services remain a function of local government.
- Waiting lists at CMHC were noted as an area of concern.
- An increase in peer services at CMHC received some support, as well as the addition of satellite clinics.
- Respondents advocated for increased opportunities for consumer housing and employment.
- Respondents frequently raised concern about the growing reliance on law enforcement/corrections to address the unique needs of the mentally ill.
- The longevity of CMHC staff was noted as important because of the consistency and time needed to build trust between a consumer and provider.
- Navigating the mental health system and a "separate" physical health system were viewed as problematic. More integration was highly urged.
- According to information provided, consumers appear to utilize free, volunteer-based primary care clinics with some frequency. This was noted as helpful with episodic needs, but not as a "medical home" for chronic conditions.
- Out-of-town respondents generally noted that their family member(s) or dependent(s) were residing in Lincoln due to the availability and/or quality of services not found elsewhere.
- Some concern was raised about a possible increase in the need for public mental health services for returning members of the military. Given the projected growth in the elderly population, concern was also raised regarding the specific mental health needs/services for this population.
- Concern was raised regarding the possible privatization of county mental health services, specifically related to availability, competency, and cost.

APPENDIX A

List of Documents Reviewed

1. CMHC Background Information and History
2. Additional Background Information on CMHC; Lancaster County Agencies providing Support; CMHC Collaborations, Contracts, and Vendors
3. CMHC Proposed Fiscal Year (FY) 2011-12 Budget
4. Summary of Lancaster County Property Tax Applied to Various CMHC Programs
5. "What Will Become of the Mental Health Safety Net", article by Dennis Freeman, Ph.D., from the Field Mental Health Weekly, May 31, 2011
6. Summary of General Assistance Services Provided through the CMHC
7. CMHC Programs and Services
8. Lancaster County Central Services Cost Allocation Plan for FY 2009-10
9. PowerPoint Presentation on People's Health Center
10. Four Quadrants of Clinical Integration Based on Patient Needs
11. Estimate of Annual Cost General Assistance Services Provided through CMHC
12. Region V Systems Provider Network and Service Array
13. Region V Systems Behavioral Health Services by Level of Care
14. PowerPoint Presentation on Region V Systems Provider Network
15. CMHC Planning Committee Discussion Summary (September 8, 2011 Meeting)
16. Health Management Associates (HMA) Meeting Schedule
17. Lincoln Journal Star Letter to the Editor from Pat Talbott, September 4, 2011
18. Nebraska Statutes Regarding Consumer Involvement in Behavioral Health Service Planning and Delivery
19. Statistics Regarding Number of CMHC Patients Served Who Were Found to Be Not Guilty by Reason of Insanity (NGRI) or Not Responsible by Reason of Insanity (NRRI)
20. Missouri Integration Process: Comprehensive Person-Centered System of Care
21. Focus Groups: Response Summary
22. Summary of Persons Interviewed by HMA
23. CMHC Survey Results
24. Focus Group Combination Report (October 5, 2011 - October 21, 2011)
25. Strategies for Increasing and Supporting Consumer Involvement in Mental Health Policy/Planning, Management, and Services Delivery
26. "For Mentally Ill, Home Is Where the Health Home Pilot Is", California Healthline, December 5, 2011
27. Correspondence from Premier Psychiatric Group, LLC, dated December 15, 2011
28. Correspondence from Mental Health Association of Nebraska, dated January 3, 2012
29. "Shared Decision-Making in Mental Health Care", Published by U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2011)
30. "Juggling the Lineup - Seeking Better Financial Results, Providers Change Services; Experts Worry about Access", Modern Healthcare, January 16, 2012

31. A Comprehensive Plan to Address Appropriate, Effective and Sustainable Health Care Services for the Uninsured and Medicaid Populations in Lincoln, Nebraska, Prepared for the Community Health Endowment of Lincoln by Health Management Associates, January 2012
32. Correspondence from Mental Health Association of Nebraska, dated February 3, 2012
33. Final Combination Report for Focus Groups and Public Feedback, October 5, 2011 - November 21, 2011
34. Community Input Major Summary Points
35. Correspondence from Topher Hansen, Executive Director of CenterPointe, Inc., dated August 16, 2011
36. "Evolving Models of Behavioral Health Integration in Primary Care", by Chris Collins, Denise Lewis Hewsen, Richard Munger, and Torlen Wade

Attachment D

The Recovery Project
of Lancaster Co, NE
Empowering & Amplifying Our Recovery Voice!

August 8, 2012

TO: ITN Committee Chair, ITN Committee Members

As consumers of Lancaster County with a vested interest in the CMHC transition process, the members of *The Recovery Project of Lancaster Co, NE* ask the ITN Committee to review and consider the attached set of standards and recommendations relating to the new recovery-based integrated service model being developed for our county.

We amassed these recommendations after extensive Internet research over a three month period on the recovery-based models of behavioral healthcare nationwide. We've analyzed and extrapolated vital information regarding standards and recommendations from over 40+ white papers and federal publications to date. Our research continues with the goal of refining our educational and operational understanding of a recovery-based model of care. These recommendations serve as a guide and are a mere snapshot of the vast amounts of information available and are, therefore, not all inclusive.

Realizing that the creation of a new integrated recovery-based service model is a massive undertaking, we have focused our recommendations on the following key areas for your review and consideration in developing the new service model:

1. Authority Sources
2. Principles of Recovery
3. Essential Services in Recovery-Based Models
4. Characteristics of a Recovery-Based Model
5. Continuity of Care
6. Measurable Outcomes
7. Integration Steps
8. Consumer Involvement Strategies
9. Peer-Operated / Peer-Run Programs
10. Recovery Support Services

By the provision of these recognized sets of criteria / standards we hope to 1) inform, 2) educate, and 3) guide all the players in this process including, the Lancaster County Board of Commissioners, Region V Systems administrators, the ITN Committee membership, any/all new service providers, all related stakeholders, and the consumers of Lancaster County, NE themselves.

If you require further clarification or questions arise regarding any of this material compiled by Kathy Ashley, you may contact her at 402-326-7638 (cell). We look forward to offering further assistance relative to these recommendations and their implementation within Lancaster County's new recovery-based integrated service model. Thank you for giving our voice due consideration!

The Recovery Project of Lancaster Co, NE Membership

The Recovery Project
of Lancaster Co NE
Empowering & Amplifying Our Recovery Voice!

ITN Committee Recommendations:
Standards and Recommendations for a Recovery-Based Integrated Service Model

Below you will find an outline of present standards and recommendations we found in practice throughout the nation. We found these particularly helpful in defining the national goals, the principles of recovery, the related recovery-based elements specific to a recovery-based service model, the specifics of recovery support services and engaging active consumer involvement. We hope this outlined material will be helpful and assist your model development.

1. Authority Sources

a. Federal changes – New Freedom Commission on Mental Health: *Achieving the Promise: Transforming Mental Health Care in America* – Final Report – Executive Summary. DHHS Pub No. SMA-03-3832. Rockville, MD: 2003

1. Six Goals to Transform Mental Healthcare In America (pg 24-25 – Citation 1)

1. Understand that mental health is essential to overall health
   a. Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention
   b. Address mental health with the same urgency as physical health

2. Mental health care is consumer and family driven
   a. Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
   b. Involve consumers and families fully in orienting the mental health system toward recovery.
   c. Align relevant Federal programs to improve access and accountability for mental health services
   d. Create a Comprehensive State Mental Health Plan.
   e. Protect and enhance the rights of people with mental illnesses.

3. Disparities in mental health services are eliminated
   a. Improve access to quality care that is culturally competent.
   b. Improve access to quality care in rural and geographically remote areas.

4. Early mental health screening, assessment, and referral to services become a common practice
   a. Promote the mental health of young children.
   b. Improve and expand school mental health programs.
   c. Screen for co-occurring mental substance use disorders and link with integrated treatment strategies.
   d. Screen for mental disorders in primary healthcare, across the life span, and connect to treatment and supports.

5. Excellent mental healthcare is delivered and research is accelerated.
   a. Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

b. Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
c. Improve and expand the workforce providing evidence-based mental health services and supports.
d. Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

6. Technology is used to access mental healthcare and information.
   a. Use health technology and telehealth to improve access and coordination of mental healthcare, especially for Americans in remote areas or in underserved populations.
   b. Develop and implement integrated electronic health record and personal health information systems

b. Quality Assurance Standards Applying to Primary and Behavioral Healthcare – National Committee for Quality Assurance (pg 7 – Citation 2)

1. Patient tracking and registry functions
2. Use of non-physician staff for case management
3. Adoption of evidence-based guidelines
4. Patient self-management supports and tests (screenings)
5. Referral tracking

2. Principles of Recovery

a. Ten Rules for Recovery-Based Services (pg 2 – Citation 3)
1. Must be informed choice
2. Must be recovery focused
3. Must be person-centered
4. Do no harm
5. Must be free access to records
6. Must be system based upon trust
7. Must have focus on cultural values
8. Must be knowledge-based
9. Must be based on a partnership between consumer and provider
10. Must have access to services regardless of ability to pay

b. Principles of Recovery (pg 5 – Citation 4) (pg 1-2 – Citation 5)
1. Many pathways to recovery
2. Self-directed and empowering
3. Involves personal recognition of the need for change and transformation
4. Is holistic, involving body, mind, relationships, and spirit
5. Has cultural dimensions
6. Exists on a continuum of improved health and wellness
7. Emerges from hope and gratitude
8. Is a process of healing and self-redefinition
9. Involves addressing discrimination and transcending shame and stigma

c. Principles of Recovery (pg 7 – Citation 4)
1. Person-centered
2. Family & wellness supporter involvement
3. Individualized and comprehensive services across lifespan
4. Systems anchored within the community
5. Continuity of care (pretreatment, treatment, continuing care, and recovery support)
6. Partnership – consultant relationship focusing on collaboration and less on hierarchy
7. Strengths-based (emphasis on individual strengths, assets, and resilience)

8. Culturally responsive
9. Responsive to personal belief systems
10. Commitment to peer recovery support services role
11. Inclusion of the voices of recovering individuals and their families
12. Integrated healthcare services (primary and behavioral)
13. System-wide education and training
14. Ongoing monitoring and outreach efforts
15. Outcomes driven
16. Based upon research
17. Adequately and flexibly financed

3. Essential Services in Recovery-Based Models

a. Recovery-based model includes (pg 7 – Citation 5)
   1. Principles
   2. Values
   3. Service strategies
   4. Essential services

b. Essential services defined (pg 161– Citation 6) (pg 11 – Citation 5)
   1. Treatment
   2. Crisis intervention
   3. Case management
   4. Rehabilitation
   5. Enrichment
   6. Rights protection
   7. Basic support
   8. Self-help
   9. Wellness / prevention

c. Care Guidelines (pg 34 – Citation 7)
   1. Care is consumer and family-driven
   2. Care is timely and responsive
   3. Care is person-centered
   4. Care is effective, equitable and efficient
   5. Care is safe and trustworthy
   6. Care maximizes use of natural supports and settings

4. Characteristics of a Recovery-Based Model

a. Characteristics defined (pg 164-165 – Citation 6) (pg 11 – Citation 5)
   1. Design
   2. Evaluation
   3. Leadership
   4. Management
   5. Integration
   6. Comprehensiveness
   7. Consumer involvement
   8. Cultural relevance
   9. Advocacy
   10. Training
   11. Funding
   12. Access

5. Continuity of Care

a. Continuity of care defined (pg 25 – Citation 5)
   1. Pretreatment
   2. Treatment
   3. Continuing Care
   4. Rehabilitation
   5. Recovery support
   6. Offer a continuum of care
   7. Contributes to improved treatment outcomes

6. Measurable Outcomes

a. Benchmarks of quality-of-life changes (pg 32 – Citation 5)
   1. Average time of first request by patient for service to first client treatment session
   2. Number of no-show patients not keeping appointments
   3. Admissions – number of unduplicated client admissions by provider
   4. Continuation – number of clients who stay engaged in treatment

b. Measurable outcomes (pg 161 – Citation 6)
   1. Symptom relief
   2. Personal safety assured
   3. Services accessed
   4. Role functioning
   5. Self-development
   6. Equal opportunities
   7. Personal survival assured
   8. Empowerment
   9. Health status improved

DLA-20

7. Integration Steps

a. CT Steps to Integrate Primary & Behavioral Healthcare (pg 34 – Citation 5) (pg 11 – Citation 4)
   1. Develop core values and principles based on input of consumers, providers, and stakeholders
   2. Establish a conceptual framework based on this vision of recovery
   3. Building workforce competencies and skills through training, education, and consultation
   4. Changing programs and services structures
   5. Aligning fiscal and administrative policies in support of recovery
   6. Monitoring, evaluation and adjusting efforts

8. Consumer Involvement Strategies

a. Strategies for including Consumer involvement (pg 5 – Citation 8)
   1. Include consumers in mental health policies / planning activities
   2. Include consumers in mental health management / governance activities
   3. Include consumers in mental health service delivery activities
   4. Include consumers in mental health training program development and activities
   5. Actively promote consumer-operated programs and services

b. Other consumer involvement strategies gleaned from all research materials to date:

   1. Identify roles for consumers / families

1. Identify ways that consumers and families can play an active role in the determination of mental health policies and issue a policy recognizing and supporting the importance of active consumer involvement in all aspects of mental health service planning and delivery

2. Engage consumers and families in all planning and policy making bodies at state, regional, and local levels. Involve them in evaluation activities, new program development, grant writing, etc.

2. Peer Program Development and Operations
    1. Assist with engaging consumers in planning and developing Peer-Operated / Peer-Run programs

    2. Provision of consumer guidance in initially operating Peer-Operated / Peer-Run programs

3. Peer Staffing Supports
    1. Engage and assist consumers in coordinating and developing Peer Support Specialists, Peer Mentoring / Peer Coaching, BH Peer Navigators and any related credentialing requirements

    2. Employ consumers, provide training and supports to provide emergency and social support programs, case management, and office support staff

4. Oversight / Governance Panels
    1. Create a Consumer Oversight Panel / Committee to monitor, evaluate, resolve consumer complaints with the new service providers

    2. Create an Office of Consumer Affairs – to serve as a watchdog agency and an in-house advocacy capacity for consumers; with a clear grievance process

5. Advisory Panels / Board Service / Taskforces/ Evaluation Committees
    1. Create and develop Consumer Advisory Panels to actively engage with new service providers and regional / state behavioral health authorities

    2. Create a Consumer Council with direct contact to system leadership for input on policies and practices; engage state attention to services, training and support needs

    3. Consumers and family members can serve on boards, taskforces, study groups, evaluation committees, advocacy / advisory committees, and consumer preference studies

6. Advocacy / Ombudsman
    1. Develop a Consumer Ombudsman / Advocate to assist with development of:
        a. Ethical codes / standards for peer programs, peer specialists, peer coaches, and other recovery support services
        b. Advocacy for all consumers

    2. Uniform complaint system developed

    3. Rights protection for consumers

7. Administrative Services
    1. Consumers can provide administrative services i.e.:
        a. Handouts
        b. Mailing announcements
        c. Copying

d. Reminder phone calls
e. Stuffing conference packets
f. Staffing registration tables
g. Distributing evaluation forms,
h. Conducting survey's and analysis

8. Support Services
    1. Consumers can create alternatives via preference surveys, focus groups, public hearings, written surveys for:
        a. Safe house
        b. Drop-in centers
        c. Hotlines; warm lines
        d. Peer support groups
        e. Housing referrals
        f. Case management functions
        g. Other peer programs

9. Peer Recovery Support Services
    1. Develop Peer-to-Peer Support Services either as a committee, or as strategic partnerships with mental health agencies / new service providers

    2. Consumers can offer free-standing support groups

c. Helping consumers to actively participate
    1. Arrange for transport assistance, rides to/from meetings when consumers have difficulty with transport issues

    2. Arrange some type of financial compensation (per diems, expense reimbursements, wages, etc) for consumer's time; they frequently live on very tight budget restrictions and want to be involved but the cost of participating prevents them from doing so

    3. Arrange for some type of non-financial compensation legally allowed

    4. Extensive public communication plan to notify all consumers of the opportunities to get involved at various levels (i.e. consumer open houses, Consumer/Family Coalition meetings, Recovery Project meetings, print ads, radio ads, flyers/handouts, distribution of flyers to local business frequented by consumers, etc.)

    5. Establishing regular meetings or lunch meetings with consumers and family members to identify current issues and concerns and conduct follow-up inquiries

9. Peer-Operated / Peer-Run Programs

a. Strategies for peer-operated/peer-run programs (pg 5 – Citation 8)
    1. Safe houses
    2. Drop-in centers
    3. Hotlines
    4. Warm lines
    5. Peer support groups
    6. Housing referral services
    7. Advocacy programs (state, regional, or local)
    8. Recovery support services programs

b. Peer Mentoring / Peer Coaching - Critical Training Criteria (pg 83 – Citation 9)
    1. Role expectations
    2. Mentoring examples
    3. Relationship building

4. Self-care
5. Barriers
6. Confidentiality
7. Avoidance of personal relationships
8. Identification of community resources
9. Successful networking strategies

10. Recovery Support Services

a. Recovery Support Services defined (pg 7 – Citation 4)
   1. Person-centered
   2. Family & wellness supporter involvement
   3. Individualized and comprehensive services across lifespan
   4. Systems anchored within the community
   5. Continuity of care (pretreatment, treatment, continuing care, and recovery support)
   6. Partnership – consultant relationship focusing on collaboration and less on hierarchy
   7. Strengths-based (emphasis on individual strengths, assets, and resilience)
   8. Culturally responsive
   9. Responsive to personal belief systems
   10. Commitment to peer recovery support services role
   11. Inclusion of the voices of recovering individuals and their families
   12. Integrated healthcare services (primary and behavioral)
   13. System-wide education and training
   14. Ongoing monitoring and outreach efforts
   15. Outcomes driven
   16. Based upon research
   17. Adequately and flexibly financed

b. Individualized Recovery Planning (pg 12 – Citation 4)
   1. Service is individualized
   2. Multidisciplinary recovery plan developed with the person receiving the services they identify as needing
   3. The recovery plan includes:
      1. The person's hopes, assets, strengths, interest, and goals
      2. It reflects a holistic understanding of behavioral health concerns, medical concerns, and a desire to build a meaningful life in the community

c. Recovery Support Services Programs – SAMHSA Service Definitions
   1. Self-Directed Care – Service Definition (Citation 10)
   2. Behavioral Health Peer Navigator – Service Definition (Citation 11)
   3. Peer-Operated Recovery Community Centers – Service Definition (Citation 12)
   4. Peer Recovery Support Coaching – Service Definition (Citation 13)
   5. Relapse Prevention / Wellness Recovery Support – Service Definition (Citation 14)

d. Four Types of Recovery Support Services (pg 9 – Citation 4)
   1. Emotional – empathy, caring, concern
   2. Informational – education, skills, wellness information, voting rights or other citizenship restoration, etc.
   3. Instrumental – assistance with task accomplishment (i.e. connections to referral agencies, food banks, vocational rehabilitation, childcare, transportation, driver's license, etc.)

4. Affiliation – assistance with connecting with social organizations or social settings

e. Common Quality Indicators in Peer Recovery Support Services (pg 18 – Citation 4)

1. Clearly defined recovery support services that differentiate them both from professional and sponsorship treatment services
2. Programs / services that are authentically peer in design and operation
3. Well-delineated processes for engaging and retaining a pool of peer leaders
4. Intentional focus on leadership development for peer leaders
5. Operates within an ethical framework that reflects peer and recovery values
6. Incorporates principles of self-care and a well-considered process for handling relapse of peer leaders
7. Services that are non-stigmatizing, inclusive, and strengths-based
8. Honors the cultural practices and incorporates cultural strengths into the recovery process
9. Connects peers with other community resources
10. Well-established, mutually supportive relationships with key stakeholders
11. Has a plan to sustain itself
12. Well-documented governance, fiscal, and risk management practices to support its efforts

f. Recovery support service elements (pg 8 – Citation 4)

1. Employment services and job training
2. Case management and individual service coordination (i.e. referrals)
3. Outreach
4. Relapse prevention
5. Housing assistance and services
6. Childcare
7. Transportation to/from treatment, recovery support activities, employment, etc.
8. Peer-to-peer services, mentoring, and coaching
9. Self-help and support groups
10. Life skills
11. Substance abuse education
12. Education
13. Parent education and child development support services
14. Spiritual and faith-based support
15. Family / marriage education

Reference Citations

Citation #

1 New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* – Final Report – Executive Summary. DHHS Pub No. SMA-03-3831. Rockville, MD: 2003 http://govinfo/library.unt.edu/mentalhealthcommison/reports/FinalReport/downloads/FinalReport.pdf

2 Milbank Memorial Fund: *Evolving Models of Behavioral Health Integration in Primary Care – 2010.* Collins, Hewson, Munger, and Wade

3 *Infusing Recovery-Based Principles into Mental Health Services* – A White Paper by People who are NY State Consumers, Survivors, and Patients & Ex-Patients – Sept 2004 www.recoveryxchange.org/downloads/whitepaper.pdf

4 *The Role of Recovery Support Services in Recovery-Oriented Systems of Care* – Kaplan, L. - DHHS Pub No SMA-08-4315. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (SAMHSA), 2008 www.facesandvoicesofrecovery.org.pdf/SAMHSARecoveryWhitePaper.pdf

5 *Guiding Principles & Elements of Recovery-Oriented Systems of Care: What do we know from the research* – August 2009 – USDHHS – SAMHSA http://partnersforrecovery.samhsa.gov/docs/guiding_principles_whitepaper.pdf

6 *A Recovery-Oriented Service System: Setting some System Level Standards* – Fall 2000. Wm A. Anthony, Exec Director – Center for Psychiatric Rehabilitation at Boston University www.bu.edu.cpr/repository/articles/pdf/anthony2000.pdf

7 *Practice Guidelines for Recovery-Oriented Care for Mental Health & Substance Use Conditions – 2008* – CT Dept of health & Addiction Services – Second Edition – 12/2008 www.ct.gov/dmhas/publications

8 *Strategies for Increasing & Supporting Consumer Involvement in Mental Health Policy / Planning, Management & Services Delivery* – NASMHPD Position Paper 12/89

9 *Shared Decision-Making in Mental Healthcare; Practice, Research, & Future Directions.* HHS Pub No. SMA-09-4371. Rockville, MD: Center for Mental Health Services, Substance Abuses & Mental Health Administration – 2010 www.samhsa.gov/shin

10 *Self-Directed Care Service Definition* – Recovery Support Services 5/9/11– SAMHSA Center for Financing Excellence www.samhsa.gov/grants/blockgrant/Self_Directed_Care_Service_Definition_05-09-11.pdf

11 *Behavioral Health Peer Navigator Service Definition* – Recovery Support Services 5/6/11 – SAMHSA Center for Financing Excellence www.samhsa.gov/grants/blockgrant/BH_Peer_Navigator_05-06-11.pdf

12 *Peer-Operated Recovery Community Center Service Definition* – Recovery Support Services 5/6/11 – SAMHSA Center for Financing Excellence
www.samhsa.gov/grants/blockgrant/Peer_Operated_Recovery_Center_Services_05-06-11.pdf

13 *Peer Recovery Support Coaching Service Definition* – Recovery Support Services 5/12/11 – SAMHSA Center for Financing Excellence
www.samhsa.gov/grants/blockgrant/Peer_Recovery_Support_Coaching_Definition_05-12-11.pdf

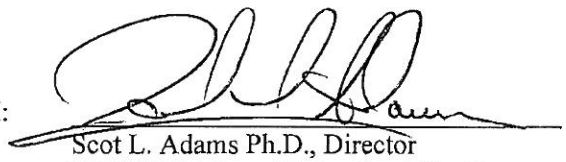
14 *Relapse Prevention / Wellness Recovery Support Service Definition* – Recovery Support Services 5/12/11 – SAMHSA Center for Financing Excellence
www.samhsa.gov/grants/blockgrant/Relapse_Prevention_Wellness_Recovery_Support_Definition_05-12-11.pdf

Department of Health and Human Services (DHHS)
Division of Behavioral Health (DBH)

POLICIES AND PROCEDURES

Effective Date: 3/1/98

Revision Date: 6/1/01, 4/1/02, 1/30/03, 11/13/07, 7/18/12

Approved: 
Scot L. Adams Ph.D., Director
DHHS Division of Behavioral Health

Subject: Financial Eligibility

Purpose: The Department of Health & Human Services Division of Behavioral Health has established Financial Eligibility Standards for consumers of behavioral health services. The Division of Behavioral Health will reimburse service providers for mental health and substance abuse services for consumers who meet clinical eligibility criteria and who meet the following financial eligibility criteria.

Rationale: Pursuant to Nebraska Revised Statutes §71-806; §71-804 and §71-838 as amended; to ensure compliance with same.

Policy:

I. Payer of Last Resort

A. The Division of Behavioral Health is the Payer of Last Resort for behavioral health services for consumers who meet:

1. The clinical eligibility criteria as specified in Behavioral Health Service Definitions;

2. Financial eligibility criteria as specified in this policy and attached Fee Schedule;

3. Citizenship/lawful presence as defined by Neb. Rev. Stat. §4-108 to 4-114 and living in the state voluntarily with the intent of making Nebraska his/her home; and,

4. For Individuals regardless of citizenship/lawful presence status receiving emergency services or inpatient or outpatient treatment mandated by Mental Health Board or for individuals mandated into the care of DHHS by a court order.

B. The Division of Behavioral Health will not reimburse:

1. For Medicaid eligible services provided to Medicaid consumers. If the consumer has accrued personal needs allowance and creates savings that disqualify him/her from a

benefit such as Medicaid, the full cost of the service must be assessed to the consumer until he/she qualifies for the Medicaid benefit.

2. For any portion of services required to be paid by a Medicaid recipient to meet a share of cost obligation.

3. For mental health, substance abuse or gambling addiction services that are eligible for or covered under other health insurance benefits, that were denied by an insurance company due to provider error or insufficient documentation, that were not submitted to the insurance company as outlined in Section II. B or that was not submitted to the insurance company by request of the consumer.

4. For any service in which the consumer is deemed eligible to pay the cost of the service.

II. Services Paid by the Division of Behavioral Health

A. For persons who meet the Division's clinical eligibility and financial eligibility criteria, the provider will be:

1. Paid the rate set by the Division of Behavioral Health for services provided which are pre-authorized with the Administrative Services Organization (ASO) or registered services that have a statewide rate established;

2. Paid a Region-determined rate for services provided which are registered with the Administrative Services Organization (ASO); or

3. Paid or reimbursed for allowable uncompensated expenses (expense reimbursement) for services provided which are registered with the ASO or otherwise documented as required by the Division of Behavioral Health, not to exceed the actual cost of the service less any copayment and third party payment received for the service.

B. The provider may bill the Region for services performed for consumers eligible for DHHS funded services after the denial of insurance benefit has been received as long as the denial is not due to provider error or for failure to submit required information. The provider may also, at the risk of violating any third party or insurance company agreement, bill allowable costs incurred in the performance of services that may be covered by the Division prior to billing any third party or insurance company. In doing this, the provider assumes all risk and penalties associated with any act that may be deemed a violation of a third party agreement or insurance company agreement, and may not bill any penalty or subsequent loss of revenue for services to individuals ineligible for DBH services to the Division. The Division reserves the right to seek reimbursement for any payment for which it would have been eligible for if the third party agreement or insurance company agreement had not been violated.

1. Except when it may pose a danger to the consumer (see II.B.7), before any cost incurred in the performance of services that may be covered by a consumer's insurance can be billed to the Division, all services performed must be submitted to the insurance company within 30 working days after the date of service and the date of submission documented for subsequent review and tracking.

2. After the service is billed to the Division, if the service is subsequently deemed to be covered by insurance and payment is remitted to the provider for the provision of the service, all funds received from the Division for the date of service being reimbursed must be reimbursed back to the Division on the next payment request to the Region.

3. If the service is deemed to be not covered by insurance or payment is denied due to the consumer's deductible not being met, a copy of the Explanation of Benefits must be placed in the consumer's file;

4. Once a consumer deductible has been met and the insurance company submits payment for services to the provider, no additional costs beyond this payment may be billed to the Division.

5. A provider may bill for services rendered to a consumer that has exhausted all insurance benefits if the person continues to meet financial eligibility criteria and it is deemed clinically eligible for treatment.

6. In the event a provider receives insurance payments after the end of the fiscal year for services paid by the Division in the previous year, the provider must reimburse the Division these funds on the next payment request to the Region.

a. In the event an agency is ceasing operation or will no longer be under contract with a Region prior to all insurance claims for DBH eligible consumers being processed, prior to the end of the contract, the Region must review all documentation to determine an estimated amount of funds that may be due to the Division and this amount be subtracted from the final bill submitted by the provider to the Region for payment by the Division. The Division also reserves the right to conduct this review and determine the amount to be reimbursed for any service provided by the Region or if a Region fails to conduct the review.

7. A provider may waive the filing of insurance forms if doing so will pose a danger to the consumer. Situations where this can happen include instances when domestic violence or child abuse is happening in the home.

III. Terms

A. For the purposes of financial eligibility:

1. **Taxable Income** is defined as alimony, wages, tips, or other money received for a good or service. This information can be obtained by review of, paycheck records, SSI/SSDI eligibility, Medicaid eligibility, and/or a signed statement from the client. For purposes of the Eligibility Worksheet, the taxable income of the consumer and other adult dependents should be used to determine Taxable Monthly Income.

2. **Liability** is defined as money owed to another person or agency to secure items such as housing or transportation, and is limited to liabilities included on the Eligibility Worksheet. The information can be obtained by review of previous monthly statements or a signed statement from the consumer.

3. **Client Fees** is defined as any Co-pay, Room and Board Fee that is required to be paid by consumer to receive the service.

b. **Co-pay:** Also known as copayment; fixed amount required to be paid for each appointment or unit of service. The co-pay amount may not exceed the amount designated by the DBH or the Region for the service. The DHHS Division of Children & Family Services may remit the copayment on behalf of the consumer.

c. **Room and board fee:** Fixed per day amount required to be paid by the consumer for meals and the use of a bed in residential facilities. The room and board fee may not be in excess of actual costs incurred for these services by the provider.

4. **Dependent**: Any person married or cohabitating with the consumer or any child under the age of 19 who depends on the consumer's income for food, shelter and care. Dependents may include parents, grandparents or adult children if the individual(s) are living with the consumer and they are dependent on the consumer's income for their food, shelter, or care.

5. **Daycare**: Refers to the funds paid to a place, program, organization or other third party for the care and well-being of one or more children under the age of 19 while parent(s) or other primary caregiver is working, in school, or in treatment.

6. **Rate** is defined as a) the rate set by the Division of Behavioral Health for services provided which are pre-authorized with the Administrative Services Organization or registered services that have a statewide rate established; b) a Region-determined rate for services provided which are registered with the Administrative Services Organization (ASO) or otherwise documented as required by the Division or Region.

7. **Cost** refers to the specific expenses incurred by an agency for providing a unit of service or the average costs of serving all customers within a given service when a Division or Region rate has not been determined for reimbursement purposes. This includes personnel, occupancy, supplies, administrative expenses, and similar types of expenditures. In determining the specific costs, a provider may include a substantiated allowance for uncollectible client fees but may not include funds in excess of actual cost (i.e., profit) per state regulations.

IV. Consumer Eligibility:

A. Prior to billing the Region and/or Department, the provider must determine if the consumer is financially eligible for the Division of Behavioral Health to pay for services. The Division of Behavioral Health and/or the Network Manager may request verification of consumers' financial eligibility from any provider.

B. To determine if a consumer meets financial eligibility criteria, on the HHS/Division of Behavioral Health Financial Eligibility & Fee Schedule:

1. Complete the Eligibility Worksheet for the consumer to determine the Adjusted Monthly Income amount.

2. Locate the adjusted monthly income amount on the schedule.

3. Locate the total number of family members dependent on the taxable income.

a) Consumers who by Adjusted Monthly Income and number of family members dependent on the taxable income fall within the shaded areas on the chart are eligible for services funded by Division of Behavioral Health. Costs (as defined in Section II) associated with performance of services to eligible consumers may be billed to the Division.

b) Consumers who by Adjusted Monthly Income and number of family members dependent on the taxable income fall within the un-shaded area of the HHS/Division of Behavioral Health Financial Eligibility Schedule are not financially eligible for payment by the State. No costs associated with performance of these services may be billed to the Division.

V. Copayment Amount:

A. To determine the maximum copayment to be requested from a consumer, on the DHHS/Division of Behavioral Health Financial Eligibility Schedule:

1. Locate the Adjusted Monthly Income amount on the appropriate schedule:

a) **Hardship Fee Schedule:** For individuals who have met one or more of the hardship criteria;

b) **Emergency Access Services Fee Schedule**: For individuals receiving assistance from Crisis Response Team, Emergency Community Support, Housing Related Assistance or 24-hour hotlines;

c) **Financial Eligibility Fee Schedule:** For all individuals eligible to receive DBH funded services but who are not eligible for other approved fee schedules.

2. Locate the total number of family members dependent on the taxable income.

3. The box in which the column and row intersect is the maximum amount of fee to be charged to the consumer for each appointment or unit of service.

B. The RBHA shall adopt a policy for use in determining the financial eligibility of all consumers and shall adopt a uniform schedule of fees and copays, based on the policy and schedule developed by the Division, to be assessed against consumers utilizing community based behavioral health services in the region. Each RBHA shall assure that its policy and schedule of fees and copays are applied uniformly by the providers in the region.

C. The assessment of a consumer's financial eligibility is an ongoing process. The consumer's financial eligibility status must be re-assessed annually or when known changes occur

such as changes in taxable income or number of dependents. The re-assessment may increase or decrease the co-pay obligations of the consumer.

D. Consumers who refuse to provide financial information shall be charged full cost of services. The provider may not bill the Division of Behavioral Health for any service for which the consumer is responsible due to failure to provide financial information or signed statement.

E. Any fees or copayments for Substance Abuse Education and Diversion programs are determined by the Region or other provider and are not subject to provisions of this policy.

F. Residential levels of care will receive payment based on the Division's established rates. In addition to room and board fees, a copayment may also be assessed. The room and board fee may not be in excess of actual costs (as defined in Section III.4) incurred for these services by the provider. All copayments charged must be in compliance with the DHHS Division of Behavioral Health Financial Eligibility and Fee Schedule.

G. For persons on whom payment of such fees would impose extreme hardship, an alternative fee schedule developed by the Division may be used following the same method as describe in Sections IV and V. Criteria for "hardship" will include:

1. Severe and persistent mental illness

2. Serious emotional disorder in youth 19 or under

3. Medical bills or medical debt in excess of 10% of the taxable annual income (as determined by taking (Taxable Monthly Income x 12) x 10%). A hardship may not be granted for non-medical related debt. If required, documentation of the debt may be obtained from statements or invoices from hospitals, doctors, labs, pharmacy, or similar medical related entities. Debt that is not medical in nature may not be used to determine eligibility for hardship.

Eligibility for the alternative hardship fee must be clearly documented on the Eligibility Worksheet.

Financial Eligibility Fee Schedule
Effective July, 2012

Annual Income Limits				Monthly Income Limits			Single	Family -2	Family - 3	Family - 4	Family - 5	Family - 6	Family - 7	Family - 8	Family - 9	Family - 10
Lower	Upper	hrly rate	hrly rate	Lower	Upper											
$0	$ 10,890	$ -	$ 5.24	$0	$ 908	0-30% of rate or cost	$ 10,890									
$ 10,891	$ 14,710	$ 5.24	$ 7.07	$ 908	$ 1,226			$ 14,710								
$ 14,711	$ 18,530	$ 7.07	$ 8.91	$ 1,226	$ 1,544	0-40% of rate or cost	$ 18,530		$ 18,530							
$ 18,531	$ 22,350	$ 8.91	$ 10.75	$ 1,544	$ 1,863			$ 22,350		$ 22,350						
$ 22,351	$ 26,170	$ 10.75	$ 12.58	$ 1,863	$ 2,181	10%-75% of rate or cost			$ 26,170		$ 26,170					
$ 26,171	$ 29,990	$ 12.58	$ 14.42	$ 2,181	$ 2,499		$ 29,990			$ 29,990		$ 29,990				
$ 29,991	$ 33,810	$ 14.42	$ 16.25	$ 2,499	$ 2,818			$ 33,810			$ 33,810		$ 33,810			
$ 33,811	$ 37,630	$ 16.26	$ 18.09	$ 2,818	$ 3,136	15%-90% of rate or cost	$ 37,630		$ 37,630			$ 37,630		$ 37,630		
$ 37,631	$ 41,451	$ 18.09	$ 19.93	$ 3,136	$ 3,454			$ 41,451		$ 41,451			$ 41,451		$ 41,451	
$ 41,452	$ 45,272	$ 19.93	$ 21.77	$ 3,454	$ 3,773				$ 45,272		$ 45,272			$ 45,272		$ 45,272
$ 45,274	$ 49,094	$ 21.77	$ 23.60	$ 3,773	$ 4,091					$ 49,094		$ 49,094			$ 49,094	
$ 49,095	$ 52,915	$ 23.60	$ 25.44	$ 4,091	$ 4,410						$ 52,915		$ 52,915			$ 52,915
$ 52,916	$ 56,736	$ 25.44	$ 27.28	$ 4,410	$ 4,728							$ 56,736		$ 56,736		
$ 56,737	$ 60,557	$ 27.28	$ 29.11	$ 4,728	$ 5,046								$ 60,557		$ 60,557	
$ 60,558	$ 64,378	$ 29.11	$ 30.95	$ 5,047	$ 5,365									$ 64,378		$ 64,378
$ 64,380	$ 68,200	$ 30.95	$ 32.79	$ 5,365	$ 5,683										$ 68,200	
$ 68,201	$ 72,021	$ 32.79	$ 34.63	$ 5,683	$ 6,002											$ 72,021
$ 72,022	$ 75,842	$ 34.63	$ 36.46	$ 6,002	$ 6,320											
$ 75,843	$ 79,663	$ 36.46	$ 38.30	$ 6,320	$ 6,639											
$ 79,664	$ 83,484	$ 38.30	$ 40.14	$ 6,639	$ 6,957											
$ 83,486	$ 87,306	$ 40.14	$ 41.97	$ 6,957	$ 7,275											
$ 87,307	$ 91,127	$ 41.97	$ 43.81	$ 7,276	$ 7,594											
$ 91,128	$ 94,948	$ 43.81	$ 45.65	$ 7,594	$ 7,912											
$ 94,949	$ 98,769	$ 45.65	$ 47.49	$ 7,912	$ 8,231											
$ 98,770	$ 102,590	$ 47.49	$ 49.32	$ 8,231	$ 8,549											
$ 102,592	$ 106,412	$ 49.32	$ 51.16	$ 8,549	$ 8,868											
$ 106,413	$ 110,233	$ 51.16	$ 53.00	$ 8,868	$ 9,186											
$ 110,234	$ 114,054	$ 53.00	$ 54.83	$ 9,186	$ 9,505											
$ 114,055	$ 117,875	$ 54.83	$ 56.67	$ 9,505	$ 9,823											
$ 117,876	$ 121,696	$ 56.67	$ 58.51	$ 9,823	$ 10,141											
$ 121,698	$ 125,518	$ 58.51	$ 60.35	$ 10,141	$ 10,460											

Rate is defined as a) the rate set by the Division of Behavioral Health for services provided which are pre-authorized with the Administrative Services Organization or registered services that have a statewide rate established; b) a Region-determined rate for services provided which are registered with the Administrative Services Organization (ASO) or otherwise documented as required by the Division or Region.

Cost refers to the specific expenses incurred by an agency for providing a unit of service or the average costs of serving all customers within a given service ***when a Division or Region rate has not been determined for reimbursement purposes***. This includes personnel, occupancy, supplies, administrative expenses, and similar types of expenditures. In determining the specific costs, a provider may include a substantiated allowance for uncollectible client fees but may not include funds in excess of actual cost (i.e., profit) per state regulations.

Financial Eligibility Fee Schedule
Effective July, 2012

Updated

The 2011 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

http://www.aspe.hhs.gov/poverty/10fedreg.shtml

http://www.aspe.hhs.gov/poverty/index.shtml#latest

Effective 1/20/2011

1	$ 10,890	$908	$908
2	$ 14,710	$1,226	$1,226
3	$ 18,530	$1,544	$1,544
4	$ 22,350	$1,863	$1,863
5	$ 26,170	$2,181	$2,181
6	$ 29,990	$2,499	$2,499
7	$ 33,810	$2,818	$2,818
8	$ 37,630	$3,136	$3,136
Average increase	$ 3,820	$318	$318

Secondary data source Comsumer Price Index Bureau of Labor Statistics
http://data.bls.gov

Nebraska Department of Health and Human Services

Financial Eligibility Emergency Access Services
Housing Fee Schedule
Effective July 18, 2012

Division of Behavioral Health

Applicable to: 24 hour Crisis Lines, Crisis Response Teams, Emergency Community Support & Housing Related Assistance only

Annual Income Limits				Monthly Income Limits	
Lower	Upper	hrly rate	hrly rate	Lower	Upper
$0	$ 10,890	$ -	$ 5.24	$0	$ 908
$ 10,891	$ 14,710	$ 5.24	$ 7.07	$ 908	$ 1,226
$ 14,711	$ 18,530	$ 7.07	$ 8.91	$ 1,226	$ 1,544
$ 18,531	$ 22,350	$ 8.91	$ 10.75	$ 1,544	$ 1,863
$ 22,351	$ 26,170	$ 10.75	$ 12.58	$ 1,863	$ 2,181
$ 26,171	$ 29,990	$ 12.58	$ 14.42	$ 2,181	$ 2,499
$ 29,991	$ 33,810	$ 14.42	$ 16.25	$ 2,499	$ 2,818
$ 33,811	$ 37,630	$ 16.26	$ 18.09	$ 2,818	$ 3,136
$ 37,631	$ 41,451	$ 18.09	$ 19.93	$ 3,136	$ 3,454
$ 41,452	$ 45,272	$ 19.93	$ 21.77	$ 3,454	$ 3,773
$ 45,274	$ 49,094	$ 21.77	$ 23.60	$ 3,773	$ 4,091
$ 49,095	$ 52,915	$ 23.60	$ 25.44	$ 4,091	$ 4,410
$ 52,916	$ 56,736	$ 25.44	$ 27.28	$ 4,410	$ 4,728
$ 56,737	$ 60,557	$ 27.28	$ 29.11	$ 4,728	$ 5,046
$ 60,558	$ 64,378	$ 29.11	$ 30.95	$ 5,047	$ 5,365
$ 64,380	$ 68,200	$ 30.95	$ 32.79	$ 5,365	$ 5,683
$ 68,201	$ 72,021	$ 32.79	$ 34.63	$ 5,683	$ 6,002
$ 72,022	$ 75,842	$ 34.63	$ 36.46	$ 6,002	$ 6,320
$ 75,843	$ 79,663	$ 36.46	$ 38.30	$ 6,320	$ 6,639
$ 79,664	$ 83,484	$ 38.30	$ 40.14	$ 6,639	$ 6,957
$ 83,486	$ 87,306	$ 40.14	$ 41.97	$ 6,957	$ 7,275
$ 87,307	$ 91,127	$ 41.97	$ 43.81	$ 7,276	$ 7,594
$ 91,128	$ 94,948	$ 43.81	$ 45.65	$ 7,594	$ 7,912
$ 94,949	$ 98,769	$ 45.65	$ 47.49	$ 7,912	$ 8,231
$ 98,770	$ 102,590	$ 47.49	$ 49.32	$ 8,231	$ 8,549
$ 102,592	$ 106,412	$ 49.32	$ 51.16	$ 8,549	$ 8,868
$ 106,413	$ 110,233	$ 51.16	$ 53.00	$ 8,868	$ 9,186
$ 110,234	$ 114,054	$ 53.00	$ 54.83	$ 9,186	$ 9,505
$ 114,055	$ 117,875	$ 54.83	$ 56.67	$ 9,505	$ 9,823
$ 117,876	$ 121,696	$ 56.67	$ 58.51	$ 9,823	$ 10,141
$ 121,698	$ 125,518	$ 58.51	$ 60.35	$ 10,141	$ 10,460

	Single	Family -2	Family - 3	Family - 4	Family - 5	Family - 6	Family - 7	Family - 8	Family - 9	Family - 10
No copyment may be charged to consumer	$ 10,890									
No copyment may be charged to consumer	$ 18,530	$ 14,710	$ 18,530							
No copyment may be charged to consumer	$ 29,990	$ 22,350	$ 26,170	$ 22,350	$ 26,170	$ 29,990				
No copyment may be charged to consumer	$ 37,630	$ 33,810	$ 37,630	$ 41,451	$ 45,272	$ 49,094	$ 52,915	$ 56,736	$ 60,557	$ 64,378
		$ 41,451	$ 45,272	$ 49,094	$ 52,915	$ 56,736	$ 60,557	$ 64,378	$ 68,200	$ 72,021

Financial Eligibility Emergency Access Services
Housing Fee Schedule
Effective July 18, 2012

Updated

The 2011 Poverty Guidelines for the 48 Contiguous States and the District of Columbia
http://www.aspe.hhs.gov/poverty/10fedreg.shtml http://www.aspe.hhs.gov/poverty/index.shtml#latest
Effective 1/20/2011

1	$ 10,890	$908	$908
2	$ 14,710	$1,226	$1,226
3	$ 18,530	$1,544	$1,544
4	$ 22,350	$1,863	$1,863
5	$ 26,170	$2,181	$2,181
6	$ 29,990	$2,499	$2,499
7	$ 33,810	$2,818	$2,818
8	$ 37,630	$3,136	$3,136
Average increase	$ 3,820	$318	$318

Secondary data source Comsumer Price Index Bureau of Labor Statistics
http://data.bls.gov

Financial Eligibility Hardship Fee Schedule
Effective July 18, 2012

Annual Income Limits				Monthly Income Limits			Single	Family -2	Family - 3	Family - 4	Family - 5	Family - 6	Family - 7	Family - 8	Family - 9	Family - 10
Lower	Upper	hrly rate	hrly rate	Lower	Upper											
$0	$ 10,890	$ -	$ 5.24	$0	$ 908	No copyment may be charged to consumer	$ 10,890									
$ 10,891	$ 14,710	$ 5.24	$ 7.07	$ 908	$ 1,226			$ 14,710								
$ 14,711	$ 18,530	$ 7.07	$ 8.91	$ 1,226	$ 1,544	No copyment may be charged to consumer	$ 18,530		$ 18,530							
$ 18,531	$ 22,350	$ 8.91	$ 10.75	$ 1,544	$ 1,863			$ 22,350		$ 22,350						
$ 22,351	$ 26,170	$ 10.75	$ 12.58	$ 1,863	$ 2,181	0%-20% of rate or cost [not to exceed $20 per unit]*			$ 26,170		$ 26,170					
$ 26,171	$ 29,990	$ 12.58	$ 14.42	$ 2,181	$ 2,499		$ 29,990			$ 29,990		$ 29,990				
$ 29,991	$ 33,810	$ 14.42	$ 16.25	$ 2,499	$ 2,818	0%-30% of rate or cost [not to exceed $30 per unit]*		$ 33,810			$ 33,810		$ 33,810			
$ 33,811	$ 37,630	$ 16.26	$ 18.09	$ 2,818	$ 3,136		$ 37,630		$ 37,630			$ 37,630		$ 37,630		
$ 37,631	$ 41,451	$ 18.09	$ 19.93	$ 3,136	$ 3,454			$ 41,451		$ 41,451			$ 41,451		$ 41,451	
$ 41,452	$ 45,272	$ 19.93	$ 21.77	$ 3,454	$ 3,773				$ 45,272		$ 45,272			$ 45,272		$ 45,272
$ 45,274	$ 49,094	$ 21.77	$ 23.60	$ 3,773	$ 4,091					$ 49,094		$ 49,094			$ 49,094	
$ 49,095	$ 52,915	$ 23.60	$ 25.44	$ 4,091	$ 4,410						$ 52,915		$ 52,915			$ 52,915
$ 52,916	$ 56,736	$ 25.44	$ 27.28	$ 4,410	$ 4,728							$ 56,736		$ 56,736		
$ 56,737	$ 60,557	$ 27.28	$ 29.11	$ 4,728	$ 5,046								$ 60,557		$ 60,557	
$ 60,558	$ 64,378	$ 29.11	$ 30.95	$ 5,047	$ 5,365									$ 64,378		$ 64,378
$ 64,380	$ 68,200	$ 30.95	$ 32.79	$ 5,365	$ 5,683										$ 68,200	
$ 68,201	$ 72,021	$ 32.79	$ 34.63	$ 5,683	$ 6,002											$ 72,021
$ 72,022	$ 75,842	$ 34.63	$ 36.46	$ 6,002	$ 6,320											
$ 75,843	$ 79,663	$ 36.46	$ 38.30	$ 6,320	$ 6,639											
$ 79,664	$ 83,484	$ 38.30	$ 40.14	$ 6,639	$ 6,957											
$ 83,486	$ 87,306	$ 40.14	$ 41.97	$ 6,957	$ 7,275											
$ 87,307	$ 91,127	$ 41.97	$ 43.81	$ 7,276	$ 7,594											
$ 91,128	$ 94,948	$ 43.81	$ 45.65	$ 7,594	$ 7,912											
$ 94,949	$ 98,769	$ 45.65	$ 47.49	$ 7,912	$ 8,231											
$ 98,770	$ 102,590	$ 47.49	$ 49.32	$ 8,231	$ 8,549											
$ 102,592	$ 106,412	$ 49.32	$ 51.16	$ 8,549	$ 8,868											
$ 106,413	$ 110,233	$ 51.16	$ 53.00	$ 8,868	$ 9,186											
$ 110,234	$ 114,054	$ 53.00	$ 54.83	$ 9,186	$ 9,505											
$ 114,055	$ 117,875	$ 54.83	$ 56.67	$ 9,505	$ 9,823											
$ 117,876	$ 121,696	$ 56.67	$ 58.51	$ 9,823	$ 10,141											
$ 121,698	$ 125,518	$ 58.51	$ 60.35	$ 10,141	$ 10,460											

* Total copayment charged per month may not exceed 20% of the Adjusted Monthly Income used to determine eligibility for NBHS funded services.

Rate is defined as a) the rate set by the Division of Behavioral Health for services provided which are pre-authorized with the Administrative Services Organization or registered services that have a statewide rate established; b) a Region-determined rate for services provided which are registered with the Administrative Services Organization (ASO) or otherwise documented as required by the Division or Region.

Cost refers to the specific expenses incurred by an agency for providing a unit of service or the average costs of serving all customers within a given service ***when a Division or Region rate has not been determined for reimbursement purposes***. This includes personnel, occupancy, supplies, administrative expenses, and similar types of expenditures. In determining the specific costs, a provider may include a substantiated allowance for uncollectible client fees but may not include funds in excess of actual cost (i.e., profit) per state regulations.

Financial Eligibility Hardship Fee Schedule
Effective July 18, 2012

Financial Eligibility Hardship Fee Schedule
Effective July 18, 2012

Updated

The 2011 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

http://www.aspe.hhs.gov/poverty/10fedreg.shtml

http://www.aspe.hhs.gov/poverty/index.shtml#latest

Effective 1/20/2011

1	$ 10,890	$908	$908
2	$ 14,710	$1,226	$1,226
3	$ 18,530	$1,544	$1,544
4	$ 22,350	$1,863	$1,863
5	$ 26,170	$2,181	$2,181
6	$ 29,990	$2,499	$2,499
7	$ 33,810	$2,818	$2,818
8	$ 37,630	$3,136	$3,136
Average increase	$ 3,820	$318	$318

Secondary data source Comsumer Price Index Bureau of Labor Statistics

http://data.bls.gov

Nebraska Department of Health & Human Services
Division of Behavorial Health

Eligibility Worksheet for NBHS Funded Services

The initial Eligibility Worksheet should be completed at admission or as soon as possible after admission and must be completed annually thereafter. You may not bill the Region or DHHS for any services for this consumer until Financial Eligility has been established. The worksheet does not need to be completed for the following services: 24 Hour Crisis Line, Crisis Response Team, Emergency Community Support or Housing Related Assistance.

Consumer Name: _____

Is the consumer covered by insurance? (must check one) Yes _____ No _____

Will filing the insurance pose a risk to the consumer? (Domestic Violence, child abuse or other danger occurring) Yes____ No ____

Taxable Monthly Income _____

Annual Income _____ (Can be computed by dividing annual income by 12)

Less Monthly Total Allowable Liabiilities:

Housing : Monthly rent/lease/ mortgage amount, not to exceed $459 per month (Limited to the home or apartment the consumer currently occupies) _____

Utilities: For the house/apartment reflected above, if the utilities are not included in rent/lease amount: Monthly utilities, not to exeed $405 per month _____

OR

For the house/apartment reflected above, if only a portion of utilities are included in rent/lease amount: Monthly utilities, not to exeed $197 per month _____

(Utilities refers to heating & cooking fuel, air conditioning, septic tank, water, sewage, trash & basic telephone only)

Transportation: Car payment and average gasoline cost or cost of public transportation, not to exceed $250 per month _____

Daycare: (if paying a 3rd Party)
$200 for each child age one or younger (Number of children ____ x $200) _____
$175 for each child age two or older (Number of children ____ x $175) _____

Total Allowable Liabilities: $ -

Adjusted Monthly Income to be used to determine Eligibility for NBHS funded services: **$ -**
(Taxable Monthly Income less Monthly Total Allowable Liabilities)

Total Number of family members dependent on taxable income: _____
(consumer + spouse (if applicable) + # children (if applicable))

By signing this form, I am verifying the above amounts are correct to the best of my knowledge.

_____
Consumer signature Date

_____
Staff Person Date

For Agency Use Only:
Consumer is eligible for Hardship Fee Schedule due to:
_____ SPMI
_____ SED
_____ Medical Bills or Medical Debt in excess of 10% of the taxable annual income
(Taxable Monthly Income x 12 x 10%)

20% of Adjusted Monthly Income = $ -
(20% is reference for maximum monthly Hardship Copay Only)

Attachment 9

Attachment 3
FY11-12 BH RATES
Community Mental Health and Substance Abuse Services

Revised 5-3-11

FY12 PROPOSED RATES Subject to change

LEVEL OF CARE	SERVICES	MH or SA	UM (Auth or Reg)	Unit	1.5% Rate Increase FY-10	.5% Rate Increase FY-11	no Change FY-12	Medicaid
Non-Residential Services (Adults)	*LEVEL 1*							
	Day Treatment	MH	Auth	Day	$195.72	$196.70	$196.70	
	Partial Care	SA	Auth	Day	$72.63	$72.99	$72.99	SAW
	LEVEL 2							
	Intensive Outpatient	SA	Auth	Hour	$27.08	$27.22	$27.22	SAW
	LEVEL 3							
	Day Rehabilitation	MH	Auth (for day only; will pay for 1/2 day)	Day/5 hrs	$54.16	$54.43	$54.43	MRO
				1/2 Day/3 hrs	$27.08	$27.22	$27.22	
	LEVEL 4							
	Assessment	MH, SA	Reg					
	Outpatient Therapy (Ind/Fm/Grp)	MH, SA	Reg					
Intensive Case Mgmt/Intensive Community Srvcs		MH, SA	Reg					
	Medication Management	MH	Reg	1/4 hr	$38.91	$39.10	$39.10	
Medication Maintenance - Methadone		SA	Reg					
	Psychological Testing	MH	Reg					
	LEVEL 5							
	Day Support	MH	Reg					
	Recovery Support	MH, SA	Reg					
Residential Services (Adults)	*Transitional*							
	Psych Residential Rehab	MH	Auth	Day	$110.78	$111.34	$111.34	MRO
	Dual Disorder Residential	SA	Auth	Day	$211.72	$212.78	$212.78	SAW
	Short Term Residential	SA	Auth	Day	$184.64	$185.56	$185.56	SAW
	Therapeutic Community	SA	Auth	Day	$136.64	$137.32	$137.32	SAW
	Halfway House	SA	Auth	Day	$62.78	$63.10	$63.10	SAW
	Intermediate							
	Intermediate Residential	SA	Auth	Day	$152.64	$153.40	$153.40	SAW
Secure Residential (incl Room & Bd)		MH	Auth	Day	$366.36	$368.20	$368.20	
	Secure Resid Room & Board Only (for Medicaid eligible only)	MH		Day			$35.00	
Inpatient (A)	Acute Inpatient	MH	Auth	Day	$687.03	$690.47	$690.47	
	Subacute Inpatient	MH	Auth	Day	$515.27	$517.85	$517.85	
Emergency Services (Adults)	24 hr. Crisis Phone	MH, SA	NA					
	Crisis Assessment	MH	Reg					
	Crisis Assessment (LADC)	SA	Reg					
	Crisis Response Teams	MH	Reg					
	Mental Health Respite	MH	Reg					
	Emerg Community Support	MH, SA	Reg					
	Social Detox	SA	Reg					SAW
	EPC Srvcs (INVOL)	MH, SA	Reg					

^ Non Fee for Service (NFFS): State pays for all Lv 4 & 5 srvcs but two on a NFFS basis to the Reg to purchase capacity. Reg purchases units / rates OR

^Non Fee for Service (NFFS): State pays for emergency services on a NFFS basis to the Region to purchase capacity. Regions purchase units/determine rates OR purchase capacity from providers.

Attachment A
FY11-12 BH RATES
Community Mental Health and Substance Abuse Services

Revised 5-3-11

FY12 PROPOSED RATES Subject to change

LEVEL OF CARE	SERVICES	MH or SA	UM (Auth or Reg)	Unit	1.5% Rate Increase FY-10	.5% Rate Increase FY-11	no Change FY-12	Medicaid
	Civil Protective Custody (INVOL)	SA	Reg					
Community Support Services (Adults)	Assertive Community Treatment (ACT)	MH	Auth	Day	$44.31	$44.53	$44.53	MRO
	Assertive Community Treatment APRN(ACT)	MH	Auth	Day	$41.16	$41.37	$41.37	MRO
	Community Support	MH	Auth	Month	$280.65	$282.06	$282.06	MRO
	Community Support	SA	Auth	Month	$230.19	$231.34	$231.34	SAW
Prevention Services (Child/Youth & Adults)	Information Dissemination	SA	NA					
	Education	SA	NA					
	Alternative Activities	SA	NA					
	Problem Solving/Referral	SA	NA					
	Community Based Process	SA	NA					
	Environmental	SA	NA					
	Training	SA	NA					
Children / Youth Services	*Middle Intensity*							
	Crisis Inpatient - Youth	MH	Reg					
	Professional Partner	MH	Reg	Month	$800.11	$804.11	$804.11	
	Day Treatment	MH	Reg					
	Home-Based	MH	Reg					
	Respite Care	MH	Reg					
	Therapeutic Consultation	MH	Reg					
	Therapeutic Community	SA	Reg					
	Halfway House	SA	Reg					
	Lower Intensity							
	Outpatient Therapy Ind/Fm/Grp	MH/SA	Reg					
	Medication Management	MH	Reg					
	Intensive Outpatient	MH, SA	Reg					
	Youth Assessment	MH, SA	Reg					
	Community Support	MH, SA	Reg					

^Non Fee for Service (NFFS): State pays for prevention services on a NFFS basis to the Region to purchase capacity.

^ Non Fee for Services (NFFS): Services for children/youth are paid through the Region to purchase capacity. Regions purchase units/determine rates OR capacity from providers.

^ Non Fee for Services (NFFS): Services for children/youth are paid through the Region to purchase capacity. Regions purchase units/determine rates OR purchase capacity from providers.

FFS = Fee for Service; paid a rate for a unit of services; services/clients must be "authorized" (exception: Medication Management) for payment through the State's managed care contractor.

NFFS = Non Fee for Service; services paid for based on actual expenses billed only; services/clients must be "registered" through the State's managed care contractor.

^NOTE: Non Fee for Service services are paid with State and/or Federal funds through contract with the State; Regions may add county tax funds.

Medicaid: MRO Services as of Jan 1, 1998

SA Waiver services as of July 1, 2005

REGIONAL BEHAVIORAL HEALTH AUTHORITY

FY 2012-2013

(July 1, 2012 - June 30, 2013)

NETWORK PROVIDER CONTRACT FOR BEHAVIORAL HEALTH SERVICES

THIS AGREEMENT, hereinafter called the "Contract," made and entered into, by and between the REGIONAL BEHAVIORAL HEALTH AUTHORITY, a Nebraska Interlocal Agreement Agency, hereinafter called "Region V," and , hereinafter called the "Network Provider," as a member of Region V's Behavioral Health Provider Network, hereinafter called the "Network."

WITNESSETH:

WHEREAS, Region V is authorized and required to provide comprehensive behavioral health services within Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, and York Counties, hereinafter called "Region V," under the provisions of the Nebraska Behavioral Health Services Act, LB 1083, adopted by the 98th Legislature, second session 2004, hereinafter called the "Act";

WHEREAS, the Division of Behavioral Health of the Nebraska Department of Health and Human Services (hereinafter referred to as DHHS), is authorized to carry out certain responsibilities for the administration of the Act;

WHEREAS, the Act authorizes Region V to contract with public and private agencies and organizations in order to provide for the comprehensive system of services required;

WHEREAS, the Nebraska Legislature and the County Boards of Region V have authorized funds, under terms of the Act, to Region V for the purpose of providing and securing the required services;

WHEREAS, Region V desires to obtain the services of the Network Provider for the performance of behavioral health program responsibilities mandated under the Act and is contracting with the Network Provider for the purpose of obtaining such services;

WHEREAS, the Network Provider is desirous of receiving from Region V such funding as is appropriate and necessary to perform certain behavioral health responsibilities of Region V and hereby accepts such responsibilities on behalf of Region V;

WHEREAS, Region V and the Network Provider mutually recognize, accept, and agree that the purpose for which the Contract is entered into as being the provision of comprehensive behavioral health services by the Network Provider within Region V;

WHEREAS, in an effort to ensure the provision of services, Region V has established a Behavioral Health Provider Network, which is coordinated by Region V Network Management, hereinafter called "Network Management;"

WHEREAS, the Network Provider has submitted a Request for Approval to Network Management to provide behavioral health services and accordingly has been approved for provision and reimbursement of services;

NOW, THEREFORE, in consideration of the above preamble, which is hereby made an integral part of the Contract, the parties hereto mutually agree to the following provisions:

I. CONTRACT TERM AND TERMINATION

A. TERM. This contract is in effect for a twelve month period, from July 1, 2012, through June 30, 2013.

B. TERMINATION. This contract may be terminated at any time upon mutual written consent or by either party for any reason upon submission of written notice to the other party at least ninety (90) days prior to the effective date of termination. Region V may also terminate this contract in accord with the provisions designated in Section XIII A-E. In the event either party terminates this contract, the Network Provider shall provide to DHHS all work in progress, work completed, and materials provided by Region V in connection with this contract immediately.

II. DOCUMENTS INCORPORATED BY REFERENCE

All references in this contract to laws, rules, regulations, guidelines, directives, attachments, state and federal requirements, Behavioral Health and Medicaid Service Definitions, and DHHS Requirements, which set forth standards and procedures to be followed by the Network Provider in discharging its obligations under this contract shall be deemed incorporated by reference and made a part of this contract with the same force and effect as if set forth in full text, herein.

III. TERMS DEFINED

A. Behavioral Health (BH) Services: services that include mental health, substance abuse, and prevention services. For the purposes of this Contract, "MH" shall mean mental health and "SA" shall mean substance abuse.

B. DHHS: is the Nebraska Department of Health and Human Services, Division of Behavioral Health Community Based Services.

C. Nebraska Behavioral Health System (NBHS): the combined structure of the state Division of Behavioral Health, the six Regional Behavioral Health Authorities, Regional Behavioral Health providers, and the three State-operated Regional Centers into an organized structure that manages and provides behavioral health services for residents of Nebraska who are indigent and not eligible for Medicaid funding in the State of Nebraska.

D. Network Management: the group of persons who work together to reach agreements for the operation of the Network of Providers in Region V. Persons included in Network Management are representatives from Region V.

E. Network Provider: an entity that has met the minimum standards set by the Nebraska Department of Health and Human Services and Region V and is enrolled in Region V's Behavioral Health Provider Network and receiving Federal and/or State funds through a contract with the Region. The entity as a recipient of these funds is responsible for ensuring compliance with all state and federal statutes, regulations, rules, conditions and limitations associated with these funds.

F. Regional Behavioral Health Authority (RBHA): means the regional administrative entity responsible for the development and coordination of publicly funded behavioral health services for each Behavioral Health Region, and receives State and Federal funds from DHHS. The RBHA responsible for ensuring compliance with all state and federal statutes, regulations, rules, conditions and limitations associated with these funds. For the purposes of this contract, the Regional Behavioral Health Authority shall be referred to as "Region V".

G. System Management Agent: Magellan Health Services

IV. BEHAVIORAL HEALTH SERVICE ALLOCATION

A. TOTAL CONTRACT AMOUNT. Region V shall pay the Network Provider a total amount not to exceed $ for the services specified herein. Network Provider shall be eligible to provide and receive reimbursement for service(s) as outlined in Attachment A.

B. FEDERAL BLOCK GRANT FUNDING. The contract amount includes funds contracted to the Nebraska Department of Health and Human Services by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS). Funds are passed through to the RBHA and subsequently passed through from the RBHA to the Network Providers. Funds included in the Network Provider's allocation include Substance Abuse Prevention & Treatment Block Grant (SAPTBG) funds and Block Grant Funds for Community Mental Health Services (MHBG) as specified below.

1. $ of MHBG (CFDA 93.958)
2. $ of SAPTBG (CFDA 93.959)

C. SERVICE PROVISION EXEMPTION. The Network Provider would be exempt from providing services throughout the Contract period under the following condition: only if the service being provided is Fee for Service (FFS), and contracted capacity for that service was met during the Contract year.

If exempt due to the above provision, the Network Provider:

1. Would not be eligible for unexpended revenue funds if registrations or authorizations for the service are not maintained through the Contract period.
2. Would have ten (10) business days to notify Region V, in writing, that it has fulfilled its contractual obligation, specifying the date this occurred.
3. Would be subject to all other terms and conditions of the Contract

V. REGION V NETWORK MANAGEMENT DUTIES AND RESPONSIBILITIES

Region V is designated as the provider of network management services for the NBHS in the Region V's geographic area of responsibility and as such agrees to provide the services in accordance with described goals, objectives, and budgets as specified in the approved Regional Budget Plan and all State statutes, standards, regulations, and federal requirements as specified in all attachments hereto in order to meet the behavioral health needs of persons who meet the DHHS Clinical and Financial eligibility criteria.

A. A Regional Budget Plan for behavioral health and network management services for each fiscal year shall be submitted to DHHS annually by the deadline set forth by DHHS.

B. Region V shall participate in DHHS / Network Management Team meetings to provide oversight to the state process to implement the NBHS. Network Management shall maintain the following regional administrative functions, at a minimum.

1. Regional Administrator
2. Fiscal Management
3. Network Development and Contract Management
4. Quality Assurance
5. Utilization Management
6. Governing Board, BH Advisory Committee, Provider Meetings, and other forms of Public Responsiveness
7. Communication with Elected Officials, the State, and the Public
8. Maintain Regional Office
9. Consumer Involvement and Advocacy

C. Region V agrees to provide Regional system coordination for the provider network by ensuring that an individual is appointed to serve as Regional Coordinator in Region V's geographic area of responsibility for the following major service systems:

1. Regional Youth BH Services System
2. Regional BH Emergency Services System
3. Regional BH Prevention Services System
4. Regional BH Consumer Services System
5. Regional Housing Coordination Services System

    a. The regional system coordinator will provide system leadership, support and technical assistance to providers in planning new services which are consistent with Region V's plans and serve as a liaison to DHHS.

D. Region V is responsible for developing a balanced behavioral health service system capacity as specified in the approved Regional Budget Plan by organizing and maintaining an integrated network of service providers. Network development and maintenance will include:

1. Annually developing and / or upgrading a regional plan for behavioral health services.
2. Identifying, recruiting, enrolling, retaining, monitoring, and ongoing evaluating of providers enrolled in the Network according to State and Federal standards, regulations, and laws. If problems arise with a provider, Network Management will assist the Network Provider in maintaining a satisfactory enrollment status by providing direct technical assistance to the provider in the development and implementation of corrective action plans to correct any financial, billing, or programmatic problem using performance and outcome data to determine if the provider shall be retained in the Network.
3. Ensuring that the Network Providers enrolled in the Network comply with the provider responsibilities and selection criteria and in accordance with the Region V and DHHS provider enrollment minimum standards.
4. Ensuring that the Network has the capacity to provide behavioral health services sufficient to provide a minimum balanced behavioral health system for the Levels of Care as defined by DHHS. In order to provide a balanced system, the network may include providers from other geographic areas of the state if the network does not have the service capacity needed within the Region. The provider network shall also include the state-operated Regional Center.
5. Ensuring that Network / regional procedures are implemented to monitor Network Providers' compliance with all terms and requirements of this Contract.
6. Ensuring that the Network has the capacity to provide the federally mandated substance abuse services, substance abuse services for priority populations, including pregnant injecting drug users, other pregnant substance users, other injecting drug users, and women with dependent children.
7. For those programs receiving Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds, Network Management shall monitor compliance of Network Providers in meeting the Block Grant Requirements.

E. Region V shall continually monitor, review, and perform programmatic, administrative, and fiscal accountability and oversight functions on a regular basis with all Network Providers.

1. Region V shall develop written policies and procedures to ensure a systematic approach to monitoring, reviewing, and providing oversight functions of the provider network. Such policies and procedures will include at a minimum:

    a. Procedures for review of Network Provider Independent Financial Audit by a Certified Public Accountant (CPA), completing Services Purchased Verifications, and Program Fidelity Reviews with NBHS service definitions and other routine monitoring activities according to agreed upon standards,

b. Format for reporting the results of the audits, and
c. Procedures for distributing the results of the audits.

F. Region V shall participate in all reporting and record keeping systems including the web-based information system to the technical level available to Network Management, and information requests required from DHHS, and its System Management agent, for all behavioral health services funded under this Contract. Network Management agrees that the accuracy of the data in the NBHS data information system is dependent on the data input by Network Providers.

1. Network Management shall monitor that Providers enrolled in the network:

   a. Comply with the authorization and registration processes and timelines.
   b. Enter data accurately into the State's information management system managed by DHHS' System Management agent.
   c. Actively participate in the training provided by DHHS System Management Agent.
   d. Comply with the terms and requirements of this Contract related to data and System Management.

2. Network Management agrees to provide technical assistance to Network Providers to correct any discrepancies in data input and follow-up with Network Providers to ensure that corrections are completed.

3. Network Management, along with DHHS and the System Management agent, will review the utilization data to determine appropriate use of Region V's funds in each level of care and review and conduct routine verification of claims submitted by Network Providers for payment of services provided to persons authorized and registered by the DHHS' System Management agent.

G. Region V will develop an annual financial Regional Budget Plan, as specified by DHHS. Network Management will provide financial oversight of (1) all FFS and NFFS funds received from DHHS, (2) Network Management funds, (3) funds for any service the Region directly provides, as well as (4) ensure that all federal maintenance of efforts are met, and (5) local tax match is allocated.

1. Network Management shall monitor and manage the utilization of contract funds with Network Providers for services specified in this Contract as determined by actual consumer utilization to ensure expenditures do not exceed funds approved for the service under this Contract.

H. Region V shall develop and implement strategies to ensure that service provision, system design, and services are culturally competent and represent the ethnic and gender needs of the community.

I. Region V shall develop and implement strategies to ensure that all behavioral health providers are informed about the effects of psychological trauma, consistently screen for trauma symptoms and history of traumatic events, provide ongoing assessment of trauma symptoms and problems related to that trauma, offer services that are recovery-oriented and trauma-sensitive and understand that re-traumatization may occur if safe, effective, responsive services are not available.

VI. NETWORK PROVIDER DUTIES AND RESPONSIBILITIES

The Network Provider must meet and agree to the following criteria to be an approved behavioral health provider, to be eligible for funds flowing through the Region from DHHS, and to be included in the NBHS.

A. Provider Enrollment and Retention

1. The Network Provider must be enrolled in the Regional Network and must demonstrate the capacity to provide behavioral health services. This shall be verified through documentation

of (a) facility licenses, fire inspections, food permits, and any other licensing required for the specific service; (b) professional licenses; (c) insurance (requirements for workers' compensation, motor vehicle liability, professional/ director's/officer's liability, and general liability coverage); (d) fiscal viability through an independent CPA audited financial statement; and (e) program plans for each service certified (admission and discharge criteria, assessment procedures, consumer input, staffing, quality improvement). The provider shall participate in any modification or revisions of this system as it is revised by the State and Region.

2. The Network Provider must meet and maintain all requirements of the Minimum Standards to become enrolled as and remain a member in good standing of Region V's Behavioral Health Provider Network.

3. The Network Provider shall maintain State licensure, as applicable.

4. The Network Provider shall provide the services as specified in the agency's Request for Approval, and the approved Regional Budget Plan, as defined by state standards and regulations, and federal requirements.

5. Region V and DHHS reserve the right to be Payer of Last Resort for consumers who meet the clinical criteria for an identified level of care and who are without the financial resources to pay for care. The Network Provider agrees to submit claims to Region V for individuals who meet the Clinical Criteria for an identified level of care and the Financial Eligibility Criteria set by DHHS.

6. The Network Provider agrees to comply with the State standards for behavioral health listed below. A provider that does not comply will not be eligible for continued funding under this contract or continued enrollment in the network.

    a. State approved levels of care and service definitions,
    b. State approved clinical eligibility criteria (levels of care entry and exit criteria),
    c. State approved financial eligibility criteria and fee schedule,
    d. State approved service rates as identified in Attachment A of this Contract.

B. Drug-Related Workplace Policies and Requirements

1. Network Provider agrees, in accordance with 41 USC §701 et al., to maintain a drug-free workplace by: (1) publishing a drug-free workplace statement; (2) establishing a drug-free awareness program; (3) taking actions concerning employees who are convicted of violating drug statutes in the workplace; and (4) in accordance with 2 CFR §180.230, identify all workplaces under its federal agreements.

2. The Network Provider agrees, in accordance with Public Law 103-227, also known as the Pro-Children Act of 1994 (act), that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local government, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers who sole source of applicable Federal funds is Medicare of Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 for each violation and / or the imposition of an administration compliance order on the responsible entity. By signing this agreement, the Network Provider certifies that the organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

C. Liability and Insurance Requirements

The Network Provider agrees to purchase and maintain adequate insurance coverage to cover their exposure to all liabilities. A current copy of the coverage certificate must be on file with Network Management at all times. Subsequent renewal certificates must be on file with Network Management within seven (7) business days after expiration for the following kinds of coverage:

1. Workers' Compensation;
2. Motor vehicle liability insurance in accordance with the minimums set by state law and agrees that Network Management and the state of Nebraska will not provide any insurance coverage for vehicles operated by the Network Provider;
3. Professional liability coverage, of not less than $1,000,000, including participation in the Excess Liability Fund under the Nebraska Hospital Medical Liability Act, if the Network Provider qualifies;
4. Director's and Officer's Liability Insurance or an Official's Bond or a Fidelity Bond for all members of boards and commissions; and
5. General liability insurance in an amount not less than $1,000,000.

D. Reporting Requirements

The Network Provider shall participate in all reporting and record keeping systems, including the web-based information system, to the technical level available to the Network Provider, and information requests required by Region V, DHHS, or its System Management agent for all behavioral health services funded under this Contract. The Network Provider agrees that the accuracy of the data in the NBHS data information system is dependent on the data input by Network Providers.

1. The Network Provider shall agree to maintain and submit all data, clinical, fiscal, and programmatic records and reports as specified by Region V and/or DHHS.
2. The Network Provider shall annually submit a non-audited report of ACTUAL revenues and expenditures for mental health and substance abuse-services (actuals) reimbursed under this Contract, to Network Management by August 15 after the end date of this Contract.
3. The Network Provider shall submit a Mid-Year Financial Income and Expenditure Report to Network Management by February 15, 2013.
4. As directed by Network Management, Network Provider agrees to submit data and/or information to promote the continuous quality improvement process within the Nebraska Behavioral Health System, both at a state and Regional level.
5. The Network Provider shall submit a Request for Approval/Budget Plan for behavioral health services to Region V annually by the deadline set by the Region.
6. The Network Provider shall provide all records necessary, for purposes of monitoring compliance with the provisions of this Contract, to meet the minimum standards, including a current listing of its agency board members' names and addresses with officers designated. This list shall be submitted to Network Management on or before October 1, 2012. (Change to November 1 in 2013) The Network Provider shall report to Network Management any changes within twenty (20) days of their occurrence.
7. The Network Provider shall participate and work with Network Management and DHHS, as requested, in the development, implementation, and use of a capacity/waiting list management system which meets Federal Block Grant requirements for pregnant women, IV drug users, and tuberculosis services. In doing so, the Network Provider shall adhere to the following capacity/wait list reporting requirements:
   a. Substance abuse and emergency programs: Submit, by fax or e-mail each Monday, the appropriate capacity and waiting list documentation.
   b. Mental health programs: Submit, by fax or e-mail by the second Monday of each month, the preceding month's capacity waiting list documentation.

8. The Network Provider shall comply with all reporting requirements for persons placed in its services pursuant to the Mental Health Commitment Act.

9. The Network Provider agrees to submit all subcontracts including Letters of Agreement and Memorandums of Understanding, as approved by DHHS and Network Management, entered into in order to carry out the contracted services within this Contract to Region V within 60 days of signature of said subcontracts agreements.

10. The Network Provider shall be fiscally accountable to Region V for all sources and expenditures of funds. The Network Provider agrees to maintain all clinical, fiscal, and programmatic records and reports for the time period specified in the applicable regulations. Such records shall be available for inspection by authorized representatives of Region V, DHHS, and/or the federal government, with the express understanding that any inspection will comply with federal and state laws and regulations regarding confidentiality.

11. The Network Provider shall agree to routine audits and verifications by Network Management and/or DHHS of the services purchased, program fidelity, and federal block grant requirements as set forth in the *Regional Site Visit Policy and Procedures*.

    a. Additionally, the Network Provider agrees to secure at its own expense an independent annual financial audit by a certified public accountant (CPA). The Network Provider shall follow the applicable cost principles set forth in OMB Circular A-87 for State, Local and Indian Tribe Governments or A-122 for Non-Profit Organizations.

        1) Audit requirements are dependent on the total amount of federal funds received by the Network Provider, as set forth in the table below and Attachment B, Audit Requirement Certification. Audits must be prepared and issued by an independent certified public accountant licensed to practice.

Amount of annual federal payments	**Audit Type**
Less than $500,000	*Audit that meets Generally Accepted Auditing Standards*
$500,000 or more in federal payments	*A-133 audit*

12. The Network Provider agrees to notify the Region of any incident that results in death or serious injury to any client, community member, or staff member that occurs during the course of service delivery by the Network Provider.

13. Given technical assistance from the Region and Division, the Network Provider agrees to conduct the Compass EZ assessment and submit results to the Region no later than November 30, 2012.

14. The Network Provider agrees to report to the Region whether or not they have a plan specifically designated to reduce suicide and self harm by persons served no later than November 30, 2012.

E. Administrative Meeting Requirements

1. The Network Provider shall assist Network Management through its Behavioral Health Advisory Committee (BHAC) in planning and coordinating behavioral health services within Region V.

2. The Network Provider shall participate in at least 80 percent of all applicable Network Provider meetings and 80 percent of all BHAC meetings.

3. The Network Provider shall participate in administrative and planning meetings called by Network Management for purposes of program development and regional coordination of services.

F. Admissions and Waiting List Management

1. The Network Provider shall keep other affiliates aware of all resources and services that are offered.

2. Network Providers, including inpatient and emergency services providers, must have the capacity to provide a complete mental health or substance abuse specific assessment/evaluation, in accordance with the State regulations and service definitions, to determine the needs and placement of any consumer for whom authorization and payment from the State for an NBHS service(s) is requested. Capacity is defined as direct staff or formal agreement with an appropriate Nebraska licensed or certified professional.

   a. A substance-abuse specific assessment/evaluation including the results of a valid, reliable substance abuse psychometric tool such as the Addictions Severity Index (ASI) must be completed PRIOR to admission to any NBHS non-emergency substance-abuse service. Providers of emergency and crisis center services receiving substance abuse emergency services funding for a Crisis Assessment must have documentation of a substance abuse - specific assessment/ evaluation, completed by a Licensed Alcohol and Drug Abuse Counselor (LADAC) or completed by a professional within their scope of practice who has specific training in substance abuse-disorders.
   b. The results of the assessment/evaluation MUST be communicated to State's System Management Agent at the time *authorization* to any NBHS mental health or substance abuse-service is requested.
   c. The results from the substance abuse assessment/evaluation, including appropriate service placement recommendations based upon the assessment/ evaluation, MUST be communicated to the Mental Health Board if a hearing for involuntary commitment is held.

3. Network Providers receiving Federal Block Grant funds agree to comply with the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) requirements as outlined in Attachment C including the waitlist management process/system as set by Network Management and DHHS.

4. Network Providers shall give priority status for admission to services to Region V residents for Region V contracted capacity. Network Providers agree to obtain prior approval from Network Management before admitting out-of-Region residents to Region V contracted service capacity.

5. The Network Provider shall give priority status for admission to emergency, inpatient, residential, and non-residential behavioral health services reimbursed under this Contract to persons in the following order:

   a. Mental Health community service priorities:

      1) Persons being treated in a Regional Center who are ready for discharge;
      2) Persons being treated in a community inpatient setting or crisis center and who are awaiting discharge;
      3) Persons committed to outpatient care by a Mental Health Board
      4) All others.

   b. Substance abuse community services priorities (including federal block grant requirements) are below:

      1) Pregnant and current intravenous drug using women
      2) Other pregnant substance abusing women
      3) Current intravenous drug users
      4) Women with dependent children, including those trying to regain custody of their children
      5) Mental Health Board commitments ready for discharge
      6) All others

6. The Network Provider shall not make admission into a behavioral health program contingent upon a consumer receiving any other service offered by the Network Provider.

7. The Network Provider agrees there shall be a "no refusal" approach to admitting persons determined eligible by DHHS' System Management agent for community-based BH services in the Region's network.

   a. The Network Provider must agree to comply with the Division's policy and procedures for the referral of any persons for Regional Center admissions whether involuntary or voluntary. A Network Provider who does not comply (1) will not be eligible for funding under this Contract; or (2) will have funds withheld pending compliance with the Contract requirements.
   b. The Network Provider shall work with the Regional Center and Network Management to facilitate effective and timely discharges for persons transitioning from the Regional Center to community-based services. Providers agree to promptly review referrals for admission made by the Lincoln Regional Center or the Lancaster Community Mental Health Center – Crisis Center. Providers agree to provide prompt notice, including reason/rationale for denial of services, to the Region in accordance with policy and procedures set forth by the Region.

8. Network Providers must agree to use their best efforts to ensure continuity of care to link the consumer to other community behavioral health services and providers so behavioral health care is not interrupted. This shall include coordinating consumer care through other providers, Network Management, the Regional Centers, and System Management.

9. The Network Provider agrees that no person shall be denied access to mental health or substance abuse treatment solely on the basis of participation in Medication Assisted Treatment for a substance use disorder. Medication Assisted Treatment refers to a range of pharmacotherapy available to detoxify, maintain or otherwise medically manage clients to treat addiction. Providers agree to serve consumers utilizing medications as prescribed by a physician.

G. Financial Eligibility Requirements

The Network Provider agrees to charge persons receiving services fees in accordance with the Division's sliding fee scale, and Region V's *Sliding Fee Schedule Policy*, but not in excess of actual cost.

1. The Network Provider shall make reasonable efforts to collect appropriate reimbursement for its services.

2. The Network Provider shall not deny service to any client solely on the ability or inability of a client to pay for such services.

3. The Network Provider shall have on file with Network Management a current copy of its sliding fee schedule policies and shall submit amended versions of its sliding fee schedule, and policies, within sixty (60) days of its revisions.

H. Medicaid Requirements for MRO and SA Waiver Services

1. If services provided by the Network Provider, with the exception of providers of Halfway House and Clinically Managed Residential Detoxification (aka Social Detox), are eligible for Medicaid funding, the Network Provider must be enrolled as a Medicaid provider and must bill Medicaid directly for all persons eligible for Medicaid. The Provider may annually request a waiver of this provision for any service by submitted a written request for approval to the Region.

2. The Network Provider of MH Medicaid Rehab Option and SA Waiver services agrees to offer services to persons eligible for Medicaid and those persons not eligible for Medicaid reimbursement. This applies to the following services:

a. MH Medicaid Rehab Option Services
   1) Community Support-MH
   2) Day Rehabilitation
   3) Psych Residential Rehabilitation, and
   4) Assertive Community Treatment (ACT)

b. SA Waiver Services
   1) Community Support—SA
   2) Intensive Outpatient—SA
   3) Intermediate Residential
   4) Short Term Residential
   5) Therapeutic Community
   6) Halfway House
   7) Dual Disorder Residential
   8) Social Detoxification

I. Client Data Requirements in System Management

1. The Network Provider must agree to serve all clinically and financially appropriate referrals authorized by System Management consistent with capacity. The System Management appeals process shall be available on all authorizations and referrals or authorization denials.
2. The Network Provider must agree to comply with information reporting to DHHS and to DHHS' System Management Agent which is required to maximize all federal funding.
3. The Network Provider agrees to the following client data requirements in System Management as follows:

   a. Authorized Services: Network Providers must receive Prior Authorization from the State's System Management agent for consumers to receive any FFS service in order to be eligible for payment with funds under this Contract. Medication Management services are excluded from the prior authorization requirement. Prior authorization applies to the following services:

      1) Adult Services
         a) Community Support
            - Community Support
            - Assertive Community Treatment (ACT)
         b) Emergency Services
            - Post-Commitment Days
         c) Residential
            - Intermediate Residential (Intermediate)
            - Short-Term Residential (Transitional)
            - Therapeutic Community (Transitional)
            - Dual Disorder Residential (Transitional)
            - Halfway House (Transitional)
            - Psychiatric Residential Rehabilitation (Transitional)
         d) Non-Residential
            - Day Treatment (Level 1)
            - Intensive Outpatient (Level 2)
            - Day Rehabilitation (Level 3)

   b. Registered Services: Network Providers must Register required consumer information in the State's System Management data system for consumers receiving NFFS services in order to be eligible for expense reimbursement payment with funds under this Contract. NFFS services do not require prior authorization. Network Providers must annually re-register consumer data in the data system for those individuals they will continue to serve in order to be eligible for reimbursement. Registration requirements apply to the following services:

1) Adult Services

a) Community Support
- Bi-Lingual / Bi-Cultural Service Coordination
- Intensive Care Management
- Supportive Living
- Recovery Support

b) Non-Residential
- Medication Management (Level 5)
- Assessment/Evaluation (Level 4)
- Outpatient Therapy (Level 4)
- Supported Employment

c) *Emergency Services
- Emergency Protective Custody
- Crisis Assessment
- Social Detox
- Civil Protective Custody
- Emergency Community Support
- Short-Term Respite
- Hospital Diversion

*Register Nebraska and non-Nebraska residents

2) Children's Services
- Outpatient Therapy
- Intensive Outpatient
- Therapeutic Community
- Therapeutic Consultation
- Youth Assessment
- Professional Partner

c. No Registration or Authorization: The following services require no on-line registration or authorization:
1) Emergency Services
- 24-hour Crisis Phone/Clinician
- Crisis Response Team
- Emergency Support Program

2) Prevention Services
3) Pilot Projects

d. Special Data Input Timelines: Network Provider shall ensure the following special timelines for data input are adhered to:

1) Procedure for Consumers in the Commitment Process. Data input for *Registrations* for consumers served in EPC/Crisis Centers must be completed by the end of the first 48 hours after admission to the EPC/Crisis Center service.
2) Procedure for Adult and Children in NFFS Services. Registration of consumer demographic, non-clinical information for all non-emergency NFFS services for adult and children's services shall be entered into the online data system within seven days of admission to the services, except as outlined in #3 below.
3) Procedure for Adult and Children in NFFS Outpatient Therapy Services. Any Non-Residential Level 4, Outpatient Therapy services, which specifically require a psychiatric diagnosis, shall have up to 21 working days from the service admission date to submit registration information.
4) Procedure for Admission of a Committed Person to an Inpatient or Outpatient Service (Residential or Non-Residential) Service at a Community Provider or a State Regional Center.

a) BH Acute and Subacute Inpatient commitments shall be committed to DHHS. Network Management shall determine the placement location of an inpatient commitment at a regionally contracted community hospital provider or at a State Regional Center. No person shall be admitted to a state-operated Regional Center from any emergency service provider without prior arrangement through the DHHS System Management agent.

b) BH outpatient commitments shall be to the Residential or Non-Residential community service provider subcontracted with the Region to provide the service.

c) *Registration* of consumer demographic, non-clinical information, including change of legal status and commitment date, must be updated in the DHHS web-based information system no later than 48 hours following the commitment.

d) *Authorized* consumer clinical information supporting the need for a commitment shall be provided to the DHHS System Management agent in the following two situations: (1) after a commitment hearing is scheduled, but prior to the actual hearing, or (2) after the emergency service clinician and/or treatment team at the emergency provider has made a decision to recommend committed placement in an NBHS service (Regional Center or community provider), but prior to the actual hearing. In either case above, such communication with System Management must occur at least 24 hours prior to the actual Mental Health Board commitment hearing to ensure the Board has knowledge of the provider location where the consumer will receive services.

e. Data input for persons discharged from services must be completed as follows:
   1) Registered outpatient services: Within 90 days of last documented activity (no activity has occurred) with the exception of Medication Management.
   2) Authorized services: Within 10 days of discharge.

J. Trauma Informed Requirements

The Network Provider shall ensure that all staff providing behavioral health services are informed about the effects of psychological trauma, consistently screen for trauma symptoms and history of traumatic events, provide ongoing assessment of trauma symptoms and problems related to trauma, offer services that are recovery-oriented and trauma-sensitive and understand that re-traumatization may occur if safe, effective, responsive services are not available. The Network Provider agrees to provide information about trauma-informed activities as requested.

K. Federal Block Grant Requirements

Network Providers who receive Federal Block Grant funding for set-aside services (SA prevention and services for pregnant women and women with children and/or mental health MH children's services and services for persons disabled by serious mental illness) must have the demonstrated ability to provide these services in accordance with Federal Block Grant requirements as set forth in this contract in Attachment C.

L. Continuous Quality Improvement

The Network Provider shall establish a program of continuing evaluation of the effectiveness of each of its behavioral health programs and services and for a review of the quality of the services provided by the Network Provider. As directed by Network Management, the Network Provider shall be expected to submit to Network Management a copy of the plan for evaluation of the effectiveness of its program of services. The plan must contain the minimum information and time-lines as requested by Network Management.

M. Management of Consumer's Funds

The Network provider must have a written policy on whether the provider will be involved in the management of consumer funds. If the provider elects to be involved in the management of

consumer funds, there must be written policies and procedures approved by the governing body which identify the system to be used when the provider exercises control over the funds of a consumer to ensure that the provider maintains proper accountability for those funds.

1. The consumer's file must document when and how it was determined that the provider would exercise control over a consumer's funds, including:

   a. The circumstances leading to this action;
   b. The rationale for this action;
   c. The protocol followed in taking this action; and
   d. The plan for revoking this action, including methods and timeframes for implementation.

   Unless the consumer has a payee, conservator, or guardian, the consumer must agree in writing with the provider's involvement in the management of these funds.

2. Each consumer must have an individual financial record that includes:

   a. Documentation of all cash funds, savings and/or checking accounts, deposits and withdrawals;
   b. An individual ledger which provides a record of all funds received and disbursed and the current balance; and
   c. Documentation that the individual has access to and opportunities to handle his/her money.

3. If the provider has the responsibility for the management of consumers' funds,

   a. A separate accounting is maintained for each consumer;
   b. Account balances and records of transactions are provided to the consumer or the consumer's fiscal representative as requested, but at least quarterly;
   c. The consumer, as well as the parents, guardian, advocate, and /or fiscal representative, are advised as required by law or agreed to by the conservator:
      1) Prior to depletion of funds;
      2) When large balances are accrued; and / or
      3) When entitlement program eligibility can be affected.

4. The provider must have policies and procedures to prohibit the borrowing of personal funds from the consumer by staff and/or other consumers.

5. The provider must have policies and procedures approved by the governing body regarding the repair of damaged property or the replacement of destroyed property (either private or public), using a consumer's personal funds.

6. The provider must not withdraw any consumer's funds without the written approval of the consumer, the consumer's legal representative, or by an order of a judge or a court.

7. The provider must have written policies and procedures on how financial errors, overdrafts, and missing money will be handled.

N. National Voter Registration

Notwithstanding any other Federal or State law, in addition to any other method of voter registration provided for under State law, Network Providers must comply with the Title 42 Public Health and Welfare Chapter 20 Elective Franchise Subchapter I-H National Voter Registration establishing procedures to register to vote in elections for Federal Office:

1. By application made simultaneously with an application for a motor vehicle driver's license pursuant to section 1973gg-3 of this title;

2. By mail application pursuant to section 1973gg-4 of this title; and

3. By application in person

a. At the appropriate registration site designated with respect to the residence of the applicant in accordance with State law; and
b. At a Federal, State, or nongovernmental office designated under section 1973gg-5 of this title.

VII. FUNDING ASSURANCES

A. The Network Provider agrees to provide an accounting to Region V, for all sources and expenditures of funds for any service(s) reimbursed by the Region V and DHHS, as outlined in this Contract (Attachment A), for the duration stated herein.

1. Such accountability shall include separate accounting for MH and SA services, and any reports, audits, program reviews, documents, or papers of a financial nature which DHHS or the Region requires or may request.

2. The Network Provider shall maintain separate accounting of fund sources used to pay for MH services and the fund sources used to pay for SA services. Records shall be available for inspection by authorized representatives of Region V, DHHS, or the federal government, upon request with the express understanding that any inspection will comply with federal and state laws and regulations regarding confidentiality.

B. The Network Provider agrees that income received by the Network Provider from charges for services provided under this Contract shall remain in the account of the Network Provider and shall be used for the provision of services.

C. The Network Provider agrees that the funds under this Contract are intended for the provision of behavioral health services and related administrative services as specified in the contract; therefore, funds received under the terms of this Contract shall not be used to litigate legal actions against Network Management, DHHS, or the state.

D. Reimbursement from all sources shall not exceed the cost of services.

E. The Network Provider shall not bill for services when a signed copy of a subcontract has not been provided to Network Management by October 1, 2012.

F. The Network Provider shall ensure that all Federal funds paid to the Provider are clearly identified as such, including the specific source and amount. These funds must be clearly identified in providers' accounting records as being Federal funds by source and audited appropriately.

G. The Network Provider shall ensure that funds are not used to supplant current funding of existing activities. Supplant means to replace funding of a recipient's existing program with funds from a Federal grant.

VIII. BILLING AND PAYMENT

A. Allowable and Unallowable Costs: The Network Provider shall ensure that all costs incurred, either direct or indirect, pertaining to the contract must be included in the financial records of the Network Provider. Allowable and unallowable costs must be tracked and recorded in accordance with the provisions specified in the contract. Unless approved in writing in the contract, all costs incurred prior to the effective date of the contract are unallowable. If any pre-award costs are allowed, the contract must specify which costs are allowable. Allowable costs include costs for the infrastructure necessary to develop, maintain, and evaluate a community-based continuum of care for behavioral health services.

1. Unallowable Costs: Any costs not properly related to carrying out the purpose of the program under contract are unallowable. Costs determined to be unallowable and not eligible for support by funds administered by the Division include but are not limited to:

a. Costs for services which occurred in a prior or subsequent fiscal year; all reimbursement must be for the cost of services rendered during the contract period;
b. Contributions to a restricted fund or any similar provision for unforeseen events;
c. Any personal costs unrelated to the provision of approved services and/or costs of personal gifts;
d. Costs of amusements, social activities, and related expenses for employees and governing body members, except when part of an authorized consumer treatment/rehabilitation/ recovery program;
e. Costs of luncheons or dinners held to award employees;
f. Costs of a personal nature unrelated to the provision of approved program;
g. Costs of alcoholic beverages;
h. Costs resulting from violations of, or failure to comply with federal, state, and local laws and regulations;
i. Costs relating to lobbying or attempts to influence/promote legislative action by local, state or federal government; and
j. Costs of lawsuits or other legal or court proceedings against the Department, its employees, or State of Nebraska.

2. Allowable Costs: Use of state and/or federal funds administered by the Department are limited to the cost of providing approved Department services including employment of personnel, technical assistance, consultation, operation of programs, leasing, renting, and maintenance of facilities, and for the initiation and continuance of programs and services.

a. Travel costs related to the programs funded in whole or in part by the Department are allowable, and cannot exceed the amounts specified in applicable Internal Revenue Service guidelines.
b. The use of state funds for alteration, renovation, or minor remodeling of real property is allowable under the following conditions:
1) Alteration or renovation is needed to accomplish the objectives of the mental health program and is approved by the Department;
2) The space involved will actually be occupied by the ~~Region /~~ Network Provider;
3) The costs of alternations or remodeling are the result of a competitive bidding process;
4) There is documentation by a suitably qualified individual that the building has a useable life consistent with program purposes and is structurally suitable for conversion;
5) There is, prior to alternation or renovation of rented space, a lease approved by the Department;
6) The costs related to purchase of adequate insurance coverage to cover the ~~Region /~~ Network Provider's exposure. The ~~Region /~~ Network Provider shall annually file a certificate of coverage showing the kinds of coverage with the contract authority.

B. Payments under this contract shall be made by Region V as approved in the Regional Budget Plan subject to receipt and approval of any reports required to be submitted and any supporting documentation required.

1. NFFS services shall be paid on a rate through reimbursement for actual expenses that have not been reimbursed through other payment sources, or through another reimbursement method, based on the approved Regional Plan and Budget. The amount paid to the Network Provider shall not exceed the total amount allocated in this Contract for each service as specified in Attachment A.

2. FFS for all services paid on a fee basis for a unit of service shall be paid based upon the capacity approved in the Regional Budget Plan at the service rates set by Region V and DHHS. The amount paid to the Network Provider shall not exceed the total amount allocated in this Contract for each category as specified in Attachment A.

3. Reimbursement to a Network Provider above the amount in Attachment A must be approved by the Regional Governing Board at a duly constituted meeting of the Board.

C. The Network Provider shall submit current claims for reimbursement on the 7th of each month to Network Management. When the 7th falls on a weekend or holiday, the reimbursement claim must be received by Network Management on the Friday before the weekend or the last working day before the holiday.

D. The Network Provider agrees that if the billing does not make the submission deadline set above, the bill may not be paid until the following month to ensure sufficient time for processing.

E. The Network Provider shall use the reimbursement forms specified by the Region, including but not limited to Summary Billing/Coding Form, Forms BH-1, BH-2, TADs (Turn Around Documents for FFS), BH-2T, BH-3, BH-3T, BH-4a, TADs (Turn Around Documents for NFFS), and the Errors and Omissions Report. Region V shall process claims and send payment to the Network Provider.

F. Requests for payments submitted by the Network Provider shall contain sufficient detail to support payment. Any terms and conditions included in the Network Provider's request shall be deemed to be solely for the convenience of the parties.

G. When Consumer Flexible Funds are requested in the reimbursement request, the Network Provider must submit a Region V BH-4b (Monthly Total Flex Fund Expense Report) and Region V BH-4c (Individual Consumer Flexible Funds Expense Report) to support the amount of funds requested for Consumer Flexible Funds. The Network Provider shall develop a system to monitor the amount of flexible funds used during the contract period.

1. Consumer Flexible Funds may be used in accordance with the NBHS Consumer Flex Funds Policy. Consumer Flexible Funds shall be used only to pay for transportation, lodging, food, lab work, medication, and initial clothing needs that are an emergency need for the consumer. State funds shall not pay for abortions. Funds allocated under this Contract for flexible funding shall be used only for the direct benefit of consumers to expedite a discharge from or prevent admission to a higher level of care.

2. If consumer flex funds are requested in the Network Provider billing, Network Management shall have a process to monitor consumer flex fund expenditures from Network Providers and how each is tied to a specific Service Plan Goal. Network Management and Network Providers shall each have a procedure for monitoring Consumer Flexible Fund expenditures and revenues throughout the Contract period:

   a. Individually, for each consumer, and
   b. In the aggregate, for all consumers served in Community Support

The process shall maintain funding levels for managing service delivery to stay within the overall contract funds.

H. Expenses incurred during the contract period may be processed and paid after June 30. Such expenses are declared payable as expenditures against and for the funds available pursuant to this Contract for the fiscal year ending June 30.

IX. PAYMENT DELAY, REDUCTION, OR DENIAL

A. Providers agree to reduction in payments based upon any failure to comply with the Contract conditions herein, as determined by audits, reviews conducted under this Contract, and/or any reviews conducted by Network Management and/or the DHHS under federal and/or state rules and regulations. Such reviews include compliance with all data input requirements verified through the State's System Management agent.

Region V will delay, reduce, or withhold payments to the Network Provider or require repayment from the Network Provider when conditions warrant such action. Region V will notify the

Network Provider in writing concerning failure to meet requirements, at which time the Network provider will be allowed twenty (20) working days to meet the request.

X. GENERAL PROVISIONS

A. ACCESS TO RECORDS AND AUDIT RESPONSIBILITIES. The Network Provider agrees to the following terms regarding access to records and audit responsibilities:

1. All Network Provider books, records, and documents regardless of physical form, including data maintained in computer files or on magnetic, optical, or other media relating to work performed or monies received under this Contract shall be subject to audit at any reasonable time upon the provision of reasonable notice by Region V and/or DHHS. These records shall be maintained for a period of three (3) years from the date of final payment, or until all issues related to an audit, litigation, or other action are resolved to the satisfaction of Region V and DHHS, whichever is longer. Records that fall under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) shall be maintained for six (6) full years from the date of final payment.
2. In addition to the foregoing retention periods, all records shall be maintained until all issues related to an audit, litigation, or other actions are resolved to the satisfaction of Region V and DHHS.
3. All records shall be maintained in accordance with generally accepted accounting principles.
4. The Network Provider shall provide Region V any and all written communications received by the Network Provider from an auditor related to the Network Provider's internal control over financial reporting requirements and communication with those charged with governance including those in compliance with or related to Statement of Auditing Standards (SAS) 112 *"Communicating Internal Control Related Matters Identified in an Audit,"* and SAS 114, *"The Auditor's Communication with Those Charged with Governance."* The Network Provider agrees to provide Region V with a copy of all such written communications immediately upon receipt or instruct any auditor it employs to deliver copies of such written communications to Region V at the same time copies are delivered to the Network Provider, in which case the Network Provider agrees to verify that Region V has received a copy.
5. The Network Provider shall immediately commence follow-up action on findings arising from audits or other forms of review. Follow-up action includes responding to those conducting such examinations with clear, complete views concerning the accuracy and appropriateness of the findings. If the finding is accepted, corrective action, such as repaying disallowed costs, making financial adjustments, or taking other actions should proceed and be completed as rapidly as possible. If the Network Provider disagrees, it should provide an explanation and specific reason that demonstrate that the finding is not valid.
6. In addition to, and in no way in limitation of any obligation in this Contract, the Network Provider shall agree that it will be held liable for audit exceptions, and shall return to Region V all payments made under this Contract for which an exception has been taken or which has been disallowed because of such an exception.

B. ANTI-DISCRIMINATION. The Network Provider shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights and equal opportunity employment, including Title VI of the Civil Rights Act of 1964; the Rehabilitation Act of 1973; Public Law 93-112; the Americans with Disabilities Act of 1990; Public Law 101-336; and the Nebraska Fair Employment Practice Act, NEB. REV. STAT. §§ 48-1101 to 48-1125. Violation of said statutes and regulations will constitute a material breach of contract. The Network Provider further agrees to insert similar provisions in all sub-contracts for services allowed under this Contract under any program or activity.

C. ASSIGNMENT. The Network Provider agrees not to assign or transfer any interest, rights, or duties under this Contract to any person, firm, or corporation without prior written consent of Region V. In the absence of such written consent, any assignment or attempt to assign shall constitute a breach of this Contract.

D. CONFIDENTIALITY. Any and all information gathered in the performance of this contract either independently or through Region V or DHHS, shall be held in the strictest confidence and shall be released to no one other than Region V or DHHS without the prior written authorization of Region V and DHHS, provided, that contrary contract provisions set forth herein shall be deemed to be authorized exceptions to the this general confidentiality provision. This provision shall survive termination of this contract.

E. CONFLICTS OF INTEREST. In the performance of this Contract, the Network Provider agrees to avoid all conflicts of interest and all appearances of conflicts of interest; the Network Provider will immediately notify Region V of any such instances encountered in the course of his/her work so that other arrangements can be made to complete the work.

F. DATA OWNERSHIP AND COPYRIGHT. All data collected as a result of this project shall be the property of DHHS. The Network Provider shall not copyright any of the copyrightable material produced in conjunction with the performance required under this contract without written consent from Region V and DHHS. DHHS reserves a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use the copyrightable material for state government purposes. This provision shall survive termination of this contract.

G. DEBARMENT, SUSPENSION OR DECLARED INELIGIBLE. The Network Provider certifies that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

H. FEDERAL FINANCIAL ASSISTANCE. The Network Provider agrees that its performance under this Contract will comply with all applicable provisions of 45 C.F.R. §§ 87.1–87.2 (2005) et seq. The Network Provider further agrees that it shall not use direct federal financial assistance to engage in inherently religious activities, such as worship, religious instruction, and/or proselytization.

I. FORCE MAJEURE. Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under this contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of this contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. Upon such notice, all obligations of the affected party under this contract which are reasonably related to the Force Majeure Event shall be suspended, and the affected party shall do everything reasonably necessary to resume performance as soon as possible. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under this contract.

J. GOVERNING LAW. This contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against Region V, DHHS or the State of Nebraska regarding this contract shall be brought in Nebraska administrative or judicial forums as defined by Nebraska State law. The Network Provider will comply with all Nebraska statutory and regulatory law.

K. HOLD HARMLESS. Network Provider shall assume all risk of loss and hold Region V and the State of Nebraska and its employees, agents, assignees, and legal representatives harmless from all liabilities, demands, claims, suits, losses, damages, causes of action, fines or judgments and all expenses incident thereto, for injuries to persons, for civil rights liability, and for loss of, damage to, or destruction of property arising out of or in connection with this contract and proximately

caused by the negligent or intentional acts or omissions of Network Provider, its officers, employees, assignees, or agents.

Region V and the State of Nebraska shall assume all risk of loss and hold Network Provider and its employees, agents, assignees, and legal representatives harmless from all liabilities, demands, claims, suits, losses, damages, causes of action, fines or judgments and all expenses incident t hereto, for injuries to persons, for civil rights liability, and of loss of, damage to, or destruction of property arising out of or in connection with this contract and proximately caused by the negligent or intentional acts or omissions of Region V and the State of Nebraska, their officers, employees, assignees, or agents.

Region V and DHHS, if liable, are limited to the extent provided by the Nebraska Tort Claims Act, the Nebraska Agreement Claims Act and any other applicable provisions of law. Region V and DHHS do not assume liability for the action of its Network Providers.

L. INDEPENDENT ENTITY. It is the express intent of the parties that this Agreement shall not create an employer-employee relationship. Employees of Network Provider shall not be deemed to be employees of Region V and employees of Region V shall not be deemed to be employees of the Network Provider. Network Provider and Region V shall be responsible to their respective employees for all salaries and benefits. Neither Region V's employees nor the Network Provider's employees shall be entitled to any salary or wages from the other party or to any benefits made to their employees, including but not limited to, overtime, vacation, retirement benefits, workers compensation, sick leave, or injury leave. Network Provider and Region V shall be responsible for maintaining Worker's Compensation Insurance and Unemployment Insurance for its employees and for payment of all Federal, State, local, and any other payroll taxes with respect to its employees' compensation. Network Provider shall further assume full responsibility for payment of any and all expenses or related costs associated with, or arising from, any injury to Network Provider's employees that may arise in the course of performing this Agreement.

M. INTEGRATION. This written Contract represents the entire agreement between the parties, and any prior or contemporaneous representations, promises, or statements by the parties, that are not incorporated herein, shall not serve to vary or contradict the terms set forth in this Contract.

N. LOBBYING. If the Network Provider receives federal funds through Region V and DHHS, for full or partial payment under this Contract, then no State or Federal appropriated funds will be paid, by or on behalf of the Network Provider, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Contract or (a) the awarding of any Federal Agreement; (b) the making of any Federal grant; (c) the entering into of any cooperative agreement; and (d) the extension, continuation, renewal, amendment, or modification of any Federal Agreement, grant, loan, or cooperative agreement. If any funds other than State or Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Contract, the Network Provider shall complete and submit Federal Standard Form-LLL, *"Disclosure Form to Report Lobbying,"* in accordance with its instructions.

O. NEBRASKA NONRESIDENT INCOME TAX WITHHOLDING. The Network Provider acknowledges that Nebraska law requires the Network Provider to withhold Nebraska income tax if payments for personal services are made in excess of six hundred dollars ($600) to any independent contractor who is not domiciled in Nebraska or has not maintained a permanent place of business or residence in Nebraska for a period of at least six months. This provision applies to individuals, to a corporation if 80% or more of the voting stock of the corporation is held by the shareholders who are performing personal services, and to a partnership or limited liability company if 80% or more of the capital interest or profits interest of the partnership or limited liability company is held by the partners or members who are performing personal services. The parties agree, when applicable, to properly complete the Nebraska Department of Revenue Nebraska Withholding Certificate for Nonresident Individuals Form W-4NA or its successor. The form is available at:

http://wvvw.revenue.ne.govitax/current/f w-4na.pdf or
http://www.revenue.ne.govitax/current/fill-inft 4na.odf

P. NEBRASKA TECHNOLOGY ACCESS STANDARDS. The Network Provider shall review the Nebraska Technology Access Standards, found at http://www.nitc.state.ne.us/standards/accessibility/tacfinal.html, and ensure that products and/or services provided under the contract comply with the applicable standards. In the event such standards change during the Network Provider's performance, the State may create an amendment to the contract to request that contract comply with the changed standard at a cost mutually acceptable to the parties.

Q. NEW EMPLOYEE WORK ELIGIBILITY STATUS. The Network Provider shall use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. § 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

R. PROMPT PAYMENT. If applicable, payment will be made in conjunction with the State of Nebraska Prompt Payment Act, Neb. Rev. Stat. §§ 81-2401 to 81-2408 (2004).

S. PUBLIC COUNSEL. In the event the Network Provider provides health and human services to individuals on behalf of Region V and DHHS under the terms of this Contract, the Network Provider shall submit to the jurisdiction of the Public Counsel under Neb. Rev. Stat. §§ 81-8,240 to 81-8,254 (2004) with respect to the provision of services under this Contract.

T. PUBLICATIONS. As required by United States Department of Health and Human Services (hereinafter "HSS") appropriations acts, all HHS recipients must acknowledge Federal and DHHS funding when issuing statements, press releases, requests for proposals, bid invitations, and other documents describing projects or programs funded in whole or in part with Federal and DHHS funds. Recipients are required to state: (1) the percentage and dollar amounts of the total program or project costs financed with Federal and DHHS funds; and (2) the percentage and dollar amount of the total costs financed by nongovernmental sources. When Federal dollars are used, the Network Provider agrees that all publications that result from work under this agreement will acknowledge that the project was supported by specifying the grant Number and the Federal Agency responsible for the grant.

U. RESEARCH. Region V reserves the right to review prior to dissemination, and require revisions to any document developed, produced, or distributed to the general public based on client or program data submitted to the Region and / or DHHS directly or through the System Management Agent.

V. SEVERABILITY. If any term or condition of this Contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if this Contract did not contain the particular provision held to be invalid.

W. SUBCONTRACTORS. The Network Provider shall not subcontract any portion of this contract without prior written consent of Region V. The Network Provider shall ensure that all subcontractors comply with all requirements of this contract and applicable federal, state, county and municipal laws, ordinances, rules and regulations.

X. TIME IS OF THE ESSENCE. Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by Region V shall not waive any rights of Region V nor constitute a waiver of the requirement of timely performance of any obligations on the part of the Network Provider remaining to be performed.

XI. CHANGES TO THE CONTRACT

A. The Network Provider may propose changes to this Contract with Network Management for the Contract period. Such proposed changes may reflect adjustments in program services, expense categories, service usage as indicated through utilization management, and/or capacity development plans but must continue to meet the requirements set by the fund source. Any adjustments will require a clear written request, supported by data and narrative to justify the request, and subsequent approval from Region V prior to implementation.

B. The Network Provider shall submit proposed changes or amendments to the Contract on or before March 8 ~~9~~, 2013. No amendments will be considered after that date unless an emergency exists and the Network Provider can demonstrate need.

C. This Contract may not be modified except by amendment made in writing and signed by both parties or their duly authorized representatives. No alteration or variation of the terms and conditions of this agreement shall be valid unless made in writing and signed by both parties.

XII. TERMINATION OF CONTRACT

A. ASSURANCE OF PERFORMANCE. If Region V in good faith has reason to believe that the Network Provider does not intend to, is unable to, or has refused to perform or continue to perform all material obligations under this contract, Region V may demand in writing that the Network Provider give a written assurance of intent to perform. Failure by the Network Provider to provide written assurance within the number of days specified in the demand may, at Region V and/or DHHS' option, be the basis for termination of this Contract.

B. FUNDING AVAILABILITY. Region V may terminate the contract, in whole or in part, in the event funding is no longer available. Should funds not be appropriated, Region V may terminate the contract with respect to those payments for the fiscal years for which such funds were not appropriated. Region V shall give the Network Provider written notice thirty (30) days prior to the effective date of any termination. The Network Provider shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Network Provider be paid for a loss of anticipated profit.

C. BREACH OF CONTRACT. Region V may immediately terminate the contract, in whole or in part, if the Network Provider fails to perform its obligations under the contract in a timely and proper manner. Region V may, by providing a written notice of default to the Network Provider, allow the Network Provider to cure a failure or breach of contract within a period of thirty (30) days or longer at Region V's discretion considering the gravity and nature of the default. Said notice shall be delivered by Certified Mail, Return Receipt Requested or in person with proof of delivery. Allowing the Network Provider time to cure a failure or breach of contract does not waive Region V's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. Region V may, at its discretion, contract for any services required to complete this contract and hold the Network Provider liable for any excess cost caused by the Network Providers' default. This provision shall not preclude the pursuit of other remedies for breach of contract as allowed by law.

D. LOSS OF LICENSURE. Region V will immediately terminate this contract with the Network Provider upon notification by DHHS that the Network Provider's licensure is denied, or revoked in any service, or in the event that the Network Provider places a consumer in imminent jeopardy of their health and safety.

E. PROVIDER CHANGES. The Network Provider shall report to Network Management within twenty (20) days of its occurrence any of the following changes, including changes regarding services offered which are different than the services agreed to in this contract:

1. Changes in ownership, legal status, control, or management of the Network Provider.

2. Changes in the capacity and/or type(s) of services offered. Network Management may immediately terminate and/or amend this Contract, or any portion thereof, based on the changes reported, within thirty (30) days of receiving the report from the Network Provider or upon notice from the Division.

XIIV. NOTICES

Notices shall be in writing and shall be effective upon receipt. Written notices, including all reports and other written communications required by this contract shall be sent to the following addresses:

For Region V:

Dennis Byars, Regional Governing Board Chair
823 North 8th Street
Beatrice, NE 68310

OR

C.J. Johnson, Regional Administrator
Region V Systems
1645 N Street
Lincoln, NE 68508

For :

Name
Executive Director
Address

XIV. EFFECTIVENESS. The Contract shall become effective upon the execution of the legal representatives or authorized representatives of both parties.

A. The Headings set forth in this Contract are for convenience only and will not control or affect the meaning or construction of the provisions of this Contract.

B. This Contract may be signed in counterpart originals, which collectively shall have the same legal effect as if all signatures had appeared on the same physical document

C. This Contract may be signed and exchanged by facsimile transmission, with the same legal effect as if the signatures had appeared in original handwriting on the same physical document.

IN WITNESS THEREOF, the parties have duly executed this agreement hereto, and each party acknowledges the receipt of a duly executed copy of this agreement with original signatures.

REGIONAL BEHAVIORAL HEALTH AUTHORITY

Chair, Board of Directors	Date	Regional Governing Board Representative ~~Chair, Regional Governing Board~~	Date
Director	Date	Regional Administrator	Date

Federal Block Grant Requirements

I. GENERAL REQUIREMENTS REGARDING ALL FEDERAL BLOCK GRANT FUNDS

A. The Federal Block Grant funds included in this Contract are contingent upon ongoing availability of Community Mental Health Services Block Grant (CFDA #93.958) and Substance Abuse Prevention and Treatment Block Grant (CFDA #93.959) funds from the federal government.

B. All block grant funds not expended under the terms of this Contract shall be retained by DHHS.

C. Influencing Federal Officials
1. The Network Provider agrees to disclose when any person or firm has been hired to influence federal officials with regard to federal funding for a specific grant, contract, or project, as set out in federal law.
2. The Network Provider agrees to hold Region V, DHHS, and the State of Nebraska harmless and further agrees that it will not use any state or federal funds to comply with the hold harmless provision.

D. Publications: When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs, the Network Provider shall clearly state that it is funded in whole, or in part through Region V Systems, with State and/or federal funds. Network Providers shall use language as specified in the applicable state regulations.

E. Upon completion or notice of termination of these grants, the Network Provider agrees to comply with the grant close out procedures set forth by the Region and DHHS.

II. REQUIREMENTS FOR MH AND SA BLOCK GRANTS

A. The Network Provider agrees that no Federal Block Grant Funding shall be used to:
1. Lobby the Nebraska Legislature or the United States Congress.
2. Supplant or replace non-federal funds.
3. Pay the salary of an individual at a rate in excess of Level I of the Executive Schedule, or $199,700 per year (5 U.S.C. §5312- updated 2011).
4. Purchase inpatient hospital services.
5. Make cash payments to intended recipients of health services.
6. Purchase or improve land, purchase, construct, or permanently improve any building or other facility or purchase major medical equipment.
7. Satisfy any requirement for the expenditure of non-federal funds as a condition of the receipt of federal funds.
8. Provide financial assistance to any entity other than a public or non-profit private entity.
9. Provide services in a penal or correctional institution of the state in an amount that exceeds SAPTGB funding that the state used for this purpose in FY 91 (SA Block Grant Only).
10. Provide for expenses that are not allowed under federal cost principles, whether they are charged on a direct or indirect cost method.

B. The Network Provider attests that:
1. Neither the entity nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded by any Federal department or agency from receiving Federal funds;
2. The provider is not delinquent on any federal loan;

3. The provider will maintain a Drug Free Workplace; and
4. No Federal funds will be used for inherently religious activities such as worship, religious instruction, or proselytization, and / or any other prohibited activity.

C. No federal funds will be awarded to any provider who has demonstrated an inability to meet any requirement associated with the funds.

III. REQUIREMENTS FOR MH BLOCK GRANTS ONLY

Network Providers receiving Community Mental Health Services Block Grant funds agree to ensure the following services are provided and requirements are met:

A. Community Mental Health Services Block Grant funds are used to establish or expand an organized community-based system for providing mental health services for adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED).

B. Appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

C. If a Community Mental Health Center is used, the Center shall meet the following criteria:
1. Services are principally provided to individuals residing in Region V's geographical area (referred to as a "service area").
2. Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility are provided.
3. 24-hour hour-a-day emergency care services are available to persons served by the Network Provider.
4. Day Treatment or other partial hospitalization services or psychosocial rehab services are available.
5. Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission are available.
6. The Community Mental Health Center services are provided within the limits of the capacities of the center, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.
7. The Community Mental Health Center services are available and accessible promptly, as appropriate, and in a manner that preserves human dignity and assures continuity and high-quality care.

IV. REQUIREMENTS FOR SA PREVENTION AND TREATMENT BLOCK GRANT ONLY

A. DHHS has established Financial Eligibility Standards for consumers of behavioral health services. DHHS reserves the right to be the Payer of Last Resort for consumers who meet the Clinical Criteria for an identified level of care and who are without the financial resources to pay for care. The Network Provider agrees to comply with the NBHS Financial Eligibility Policy (revised 11/13/07) which outlines the DHHS policy on Payer of Last Resort.

B. Network Provider agrees that all programs receiving SAPTBG funding will: Participate in Needs Assessments conducted by the State Behavioral Health Authority or Network Management.
1. Participate with Independent Peer Review to assess the quality, appropriateness, and efficacy of treatment services,

2. Offer on-going training to their workforce specific to Federal Confidentiality (42 CFR part 2), including the penalties for non-compliance, and have Federal Confidentiality procedures in place.
3. Improve the process for referrals of individuals to the treatment modality that is most appropriate for the individuals.
4. Ensure that continuing education is provided to the SAPTBG Prevention and Treatment workforce, and document such training.
5. Provide updated and accurate information in all SAPTBG reporting requirements.
6. As requested by Region V and DHHS, attend SAPTBG training provided.
7. The Network Provider will provide the Region V and DHHS with the name and contact information of the individual responsible for managing and monitoring the "Waiting List" for all Priority Populations.
8. Provide required data to monitor Priority Populations on a waiting list and receiving interim services.
9. Actively publicize within the catchment area the availability of services for pregnant women and IV drug users to include the fact that these persons receive such preference and therefore will be given admission priority.
10. Preference to treatment shall be given to the following priority populations for any program receiving SAPTBG funding, in the following order: (a) pregnant-injecting drug users, (b) other pregnant substance users, (c) other injecting drug users, and (d) women with dependent children.

C. SUBSTANCE ABUSE ASSESSMENTS

1. If an individual identified as a priority population has not received a substance abuse assessment and is requesting treatment, the individual shall be given an appointment for the assessment within 48 hours, and receive the assessment within 7 business days.

2. Upon completion of the assessment (written report), the individual should immediately receive treatment. In the event that capacity does not exist for the individual to immediately receive treatment, the individual will receive Interim Services within 48 hours (from the time the evaluation report is documented) and will receive Interim Services until treatment is available.

D. INTERIM SERVICES for PRIORITY POPULATIONS The purpose of Interim Services is to reduce the adverse effects of substance abuse, promote health, and reduce the risk of transmission of disease. Interim Substance Abuse Services are services that are provided until an individual is admitted to a treatment program. Network Providers agree to provide the delivery of Interim Services in the following manner:

1. Interim Services should be provided between the time the individual requests treatment and the time they enter treatment. Interim Services must be provided within 48 hours and until the individual can receive the appropriate treatment service, based upon the level of care identified in the substance abuse evaluation. Examples of Interim Services include but are not limited to: a lower level of care with available capacity, community support, traditional outpatient, or other like-services that assist the individual with continued contemplation and preparation for treatment.
2. Interim Services for injecting drug users must include counseling and education about human immunodeficiency virus (HIV), tuberculosis (TB), the risks of needle-sharing, the risks of transmission to sexual partners and infants, and the steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services if necessary.
3. Interim Services for injecting drug abusers must also include education on HIV transmission and the relationship between injecting drugs and communicable diseases.
4. Case management services must also be made available in order to assist client with obtaining HIV and or TB services.
5. All referrals and or follow-up information pertaining to priority populations and interim sources must be documented and this documentation must be maintained by the program and provided to Region V or DHHS upon request.

6. Interim Services for pregnant women must also include counseling on the effects of alcohol and drug use on the fetus and a referral for prenatal care, counseling and education about HIV and TB, the risks of needle sharing, the risks of transmission to sexual partners and infants, and the steps that can be taken to ensure that HIV and TB transmission does not occur. All referrals and or follow-up information must be documented and made available upon the request of the Region V and/or DHHS.

E. INTRAVENOUS SUBSTANCE USERS/SPECIAL CONSIDERATIONS

1. Individuals requesting treatment for intravenous drug use shall be admitted to a treatment program no later than 14 days after making the request for admission to such a program; or 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of the request.
2. Interim Services must be provided within 48 hours of the request for treatment. If the individual has not received a substance abuse evaluation and is requesting treatment, the individual shall be given an appointment for the evaluation within 48 hours, and complete the evaluation within 7 business days.
3. Upon completion of the substance abuse evaluation (written report), the individual should receive treatment within 14 days or be provided Interim Services until they are able to enter a treatment program.

F. CAPACITY/WAITLING LIST MANAGEMENT for PRIORITY POPULATIONS

1. The Network Provider must provide documentation to the Region within 7 days of reaching 90% of capacity to admit individuals to a treatment program.
2. The Network Provider in collaboration with Network Management will locate an alternative treatment program with the capacity to serve the individual.
3. If capacity to serve cannot be identified, the Network Provider will ensure that Interim Services are made available within 48 hours of the time the individual requested treatment services.
4. Should Interim Services not be made available to an individual within the 48 hour timeframe, the Network Provider should immediately contact Region V. Region V will notify DHHS. All parties will then collaboratively problem-solve to immediately resolve the situation.
5. Network Providers will ensure that individuals on the "Waiting List" are tracked utilizing a unique patient identifier.
6. The Network Provider will ensure that a mechanism is in place that allows for maintaining at least weekly contact with those individuals on the "Wait List" and document all communication with those on this list.
7. If an individual cannot be located or refuses treatment, the individual's name should be promptly removed from the "Waiting List", but can again be placed on the "Waiting List" should the individual request services again. Reasonable efforts should be made to encourage individuals to remain on the "Waiting List".
8. The Network Provider will ensure that individuals on the "Waiting List" are provided with the best estimated timeframe for admission to treatment.
9. The Network Provider will ensure that individuals are placed on the "Waiting List" as many times as they request treatment.
10. The Network Provider will ensure that individuals on the "Waiting List" are admitted into treatment at the earliest possible time, to the most appropriate level of care, and within a reasonable geographic area that is acceptable to the individual.
11. Should treatment capacity be available outside Region V, the Network Provider will ensure that the individual is made aware of the treatment opportunity, and will do so in consultation with Region V and the designated Field Representative from DHHS.
12. Should the individual chose to receive treatment outside Region V, the sending and receiving management entities will collaborate to ensure that treatment occurs, and will do so in consultation with Region V and the DHHS Capacity Management System.

G. SAPTBG WOMEN'S SET ASIDE PROGRAMS:

1. Providers within the Nebraska Behavioral Health System, Region V service area designated as receiving funding to provide services for women and women with dependent children (Women's Set Aside Programs) are as follows: St. Monica's, Lincoln Medical Education Partnership, and other providers that meet all criteria required by the SAPTBG.
2. The amount set aside for women's services shall be expended on individuals who have no other financial means of obtaining such services as set aside for and as provided in 45 CFR §96.124(e) and §96.137. For women with dependent children in their care and custody or for women who are attempting to regain physical custody of their children, Network Providers receiving Women's Set Aside funding will serve the family as a unit as evidenced by the provision, facilitation, or arrangement of the following:
   a. Admission of women and their children to residential services (when program serves children),
   b. Primary medical care for women, including referral for prenatal care while the woman is receiving treatment services,
   c. Childcare needs, while the women are receiving services, which facilitate engagement in treatment.
   d. Coordinate with the Division of Children and Family Services as appropriate with treatment and discharge planning.
   e. Screening (physical and mental development) for infants and children,
   f. Primary pediatric health care when appropriate, including immunizations for their children and pediatric treatment for perinatal effects of maternal substance abuse,
   g. Based on assessment information, gender-specific therapeutic interventions and or services for women which my address issues of relationships, sexual and physical abuse, and/or parenting, and child care while the women are receiving these services.
   h. Therapeutic services for children in custody of women, including developmental, abuse, and other services. Ensure that the children of drug dependent women are involved in the necessary therapeutic interventions which address developmental needs, issues of sexual and physical abuse/neglect,
   i. Provide sufficient case management and transportation to ensure that women and their children have access to services listed above.
   j. Coordinate discharge planning with family members to include DHHS/Children and Family Services representatives when applicable, and
   k. The Network Provider is responsible to provide DHHS with documentation which illustrates provision, facilitation or provision of the above listed services and ensure that any changes are reported and on file with DHHS.

4. Copies of all Letters of Agreement, Memorandums of Understanding, or any provider subcontracts that result, that demonstrate how a provider will meet the requirements to be a "qualified" provider must be received by DHHS within 30 days of the full execution of this contract.

H. TUBERCULOSIS (TB) SCREENING AND SERVICES:

1. Network Providers receiving SAPTBG funds shall:
   a. Report active cases of TB to the DHHS Division of Public Health Tuberculosis Program Manager and adhere to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6, (www.dhhs.ne.gov/reg/t173.htm)
   b. Maintain infection control procedures that are consistent with those that are established by the State's infection control office.
   c. Adhere to State and Federal confidentiality requirements when reporting such cases.
2. Network Providers receiving SAPTBG funding will routinely make TB services available to each individual receiving treatment for substance abuse and to monitor such service delivery.

3. The Network Provider shall establish procedures that ensure that the following (TB) services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:
   a. Screening of all admissions for TB,
   b. Positive screenings shall receive test for TB,
   c. Counseling related to TB,
   d. Referral for appropriate medical evaluations or TB treatment,
   e. Case management for obtaining any TB services,
   f. Documentation of screening testing, referral, and any necessary follow-up.
   g. Report any active cases of TB to state health officials, and.

4. The Network Provider is responsible to provide Region V and DHHS with documentation which illustrates facilitation or provision of the above listed services and ensure that any changes are reported and on file with Region V and DHHS.

I. STERILE NEEDLE DISBURSEMENT AND HIV/AIDS

1. Network Provider will ensure that no SAPTBG funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.
2. The Network Provider shall not carry out any testing for the etiologic agent for Acquired Immune Deficiency Syndrome unless such testing is accompanied by appropriate pre-test and post-test counseling.

J. CHARITABLE CHOICE: The Network Provider must comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54. [See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provision and Regulations.]

1. Network Providers shall include a requirement that SAPTBG funded faith-based programs cannot use SAPTBG funds for inherently religious activities such as (1) worship, (2) religious instruction, or (3) proselytization, and that the programs may engage in these activities only when they are separate in time or location from SAPTBG funded activities and participation in them is voluntary.
2. Network Providers delivering services, including outreach services programs shall not discriminate on the basis of one's religion, religious belief, refusal to hold a religious belief, or refusal to actively participate in a religious practice
3. When an otherwise eligible client objects to the religious character of a program, the Network Provider shall refer the client to an alternative provider within a reasonable period of time of the objection and in accordance with Charitable Choice provisions.
4. Network Management and Network Providers shall report all occurrences of individuals refusing services under the provision of the Charitable Choice requirements for the SAPTBG.
5. Network Providers shall use generally accepted accounting principles to account for SAPTBG funds segregate those funds from non-federal funds subject to the audits by government and apply Charitable Choice in instances where SAPTBG funds are comingled with state/local funds.

Health Homes and Individuals with Behavioral Health Issues SAMHSA's Guidance Document Affordable Care Act Health Home Provision [Sec. 2703 & Sec. 19459(e)]

From SAMHSA's consultations regarding 2703, it is clear that States are at different stages of preparing and planning their State Plan Amendments. To that end, attached is a guidance document for States as they consider taking advantage of 2703 for people with behavioral health (i.e., mental health and substance abuse, MH/SA) disorders. The document serves as a checklist of key behavioral health questions organized according to the Health Home Service components involved in Section 2703. These components are: comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, and referral to community and social services, with health information technology used to support these services. By providing states this structured background regarding the core elements of the 2703 health home, we aim to ensure that key behavioral health topics are considered as States develop health home proposals. This document serves solely as guidance for entities thinking about health homes, and is not meant to be prescriptive or regulatory. The intended audiences for this document are those involved in developing the State Plan Amendment for 2703, although SAMHSA believes this will be useful to health home providers and others interested in health homes.

GENERAL QUESTIONS

- What is/are the target chronic condition(s) of your health home proposal?
- How will individuals be identified and referred to health homes? How will individuals not connected to either the primary care or behavioral health care system be informed and referred to your health home program?
- Describe the flow (visually or by narrative) depicting how clients will move in, through, and out of your health home program.
- What measures will be used to screen and intervene for behavioral health disorders?
    - Alcohol abuse and/or dependence
    - Drug abuse/dependence
    - Tobacco use/dependence
    - Depression and suicide risk

- Do you anticipate policy and reimbursement barriers regarding the establishment of health homes for individuals with behavioral health conditions (e.g. same day billing issues)?

SERVICE COMPONENTS (N=6)

A. Comprehensive Care Management

- How will your health home providers outreach to, plan, and communicate with other primary and specialty care providers regarding a patient's care?

- How will your health home providers develop an individualized treatment plan, informed by the patient, which integrates care across varied care systems (i.e. mental health, substance use, primary care, etc.)?

- How will your health home providers clarify and communicate the patient's preferences to all involved providers while assuring timely delivery of services?

- Composition of Your Health Home Team

    - What credentials or core competencies are recommended and/or required for health home team members serving individuals with a behavioral health condition? How are health care professionals identified as team members who can treat individuals with chronic illnesses (including MH/SA)? What are the functions of these team members?

    - What are the behavioral health workforce needs of your health home providers?

    - Will individuals in recovery from MH/SA be a part of your health home team approach?

B. Care Coordination and Health Promotion

- What are the linkages established between primary and behavioral health care providers? How will you promote care coordination among your participating health home agencies and other providers within their network (e.g., respite providers)?

- How will information be shared with other agencies patients are referred to? How will records be transferred out of the system if a patient leaves the health home?

- Will your health home providers use an agreed upon shared continuity of care record or similar vehicle? Will this be part of their medical record system?

- What specific mechanisms has your health home team established with community (e.g., YMCA) and specialty care providers? Are there formal mechanisms, such as "Memoranda of Understanding" or network alliances that link those in a specific locale?

- Do you have a shared consent form among providers? How will you manage the exchange of consent information?

- How will you educate patients on their consent options and implications of information sharing?

- How do you define health promotion in the context of your health home providers' activities?

C. Comprehensive Transitional Care (including follow-up from inpatient to other settings)

- What processes will be in place so all Medicaid provider hospitals identify and refer clients to a health home provider?

- How do you propose to ensure planning between levels of care (e.g., hospital to health home)? How will information be shared and updated between levels of care (e.g., how will discharge information be transferred from hospitals or nursing facilities to your health home providers)?

- How will you know how many individuals treated by your Health Home providers have been re-hospitalized within the last thirty days? How will you know how many have seen a primary or specialty care provider within thirty days of hospital discharge?

- Will there be mechanisms to involve health home providers with discharge planning from the hospital? Do your hospitals screen for MH/SA prior to discharge for those in or moving into health homes?

- How will your health home providers communicate and educate patients and caregivers about the transition process? What tools will health home providers use to engage patients in their care planning?

D. Patient and Family Support

- How are you defining patient and family support?

- What is the role, if any, of peers and individuals in recovery in providing patient and family support?

- How will your health home providers consider a patient-directed approach in treatment planning?

E. Referral to Community and Social Services (if relevant)

- How does the State ensure that health home providers make assessments and referral for community and recovery supports (e.g., housing, recovery support services, job training, employment placement, etc)?

- How will these referrals occur (e.g., electronically)? How will you track these referrals and the results? How will the receiving provider be notified about the referral?

Data and Health Information Technology to Link Services (as feasible and appropriate)

- What outcome data do you have/need?

- What information/data currently exist across the systems?
- What common information/data can be shared across the systems?
- What information/data would constitute evidence for a successful intervention?

- Does your EHR generate a bill and can it record a payment? If not, how do you do your billing currently? How will you bill in the health home environment?
- What medical records systems are currently in use by health home providers? How will they interoperate within the health home environment?
- Are your health home provider electronic medical records systems interoperable with other agencies?

9/27/11

DEVELOP EVALUATION TOOL with designated point values and include the following/Reference as an Attachment L Proposals will be evaluated on the following points. (Base on Capacity Plan Development guidelines to be added—the following are priority areas and will be given preference in evaluation)

7.1 Service Development:

- Innovation, effectiveness, and efficiency of service delivery model
- Inclusion of evidence-based, trauma informed, recovery-oriented, and peer supported program components
- Adherence to recovery-based principles
- Ability to deliver co-occurring services
- Inclusion of prevention and wellness components
- Integrated behavioral/primary healthcare approach
- Utilization of partnerships and local organizations
- Relationship with Lancaster County

7.2 Consumer Involvement: Strength of strategies to involve on-going meaningful and significant consumer involvement in agency activities including:

- Policies/Planning
- Management/Governance
- Service Delivery
- Training Program Development

7.3 Transition/Communication Plan

- Logical approach to the development of the Transition/Communication Plan

7.4 Infrastructure

- Network experience
- Strength of administrative structure
- Experience working with Medicaid and other health insurance companies
- Strength of program evaluation
- Usage of health information technology
- Sophistication of financial management system
- Evidence of an effective quality improvement program
- Location and integration of services

7.5 Minimum Standards

- Financial Standing
- Facility Licensure
- Accreditation & Recent Report
- Depth of Current Staffing