STAFF MEETING MINUTES
LANCASTER COUNTY BOARD OF COMMISSIONERS
COUNTY-CITY BUILDING, ROOM 113
THURSDAY, JANUARY 24, 2013
8:30 A.M.

Commissioners Present: Larry Hudkins, Chair
Brent Smoyer, Vice Chair
Deb Schorr
Jane Raybould
Roma Amundson

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 January 23, 2013

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, JANUARY 17, 2013

MOTION: Smoyer moved and Raybould seconded approval of the minutes of the January 17, 2013 Staff Meeting. Schorr, Smoyer, Amundson, Raybould and Hudkins voted aye. Motion carried 5-0.

2 ADDITIONS TO THE AGENDA

A. Scheduling of Pension Investment Review
B. Meeting with Governor (February 4, 2013)
C. Press Release in Support of Legislative Bill (LB) 577 (Change provisions relating to the medical assistance program)
D. Lancaster County Adult Drug Court Graduation
E. County Board Meeting Times

MOTION: Schorr moved and Raybould seconded approval of the additions to the agenda. Smoyer, Amundson, Raybould, Schorr and Hudkins voted aye. Motion carried 5-0.

3 LEGISLATIVE UPDATE - Gordon Kissel and Joe Kohout, Kissel/E&S Associates (Legislative Consultants)

Joe Kohout, Kissel/E&S Associates, presented a legislative update (Exhibit A), noting this week concluded bill introductions. He also presented a bills of interest report (Exhibit B), noting no bills were introduced to eliminate the inheritance tax this year. Kohout said Senator Wightman introduced LB 600 (Change inheritance tax rates) and said they will try to determine what the impact would be to Lancaster County.

Smoyer said he has shared the Board's concerns regarding LB 215 (Change provisions relating to use of the County Visitors Promotion Fund) with Senator Schilz, introducer of the bill, and Senator Schilz has expressed a willingness to work on changes.

Schorr noted the Nebraska Association of County Officials (NACO) Legislative Committee will be meeting to determine legislative priorities and asked if the Board has specific issues it would like her to relay to the Committee. Board members suggested the following: 1) Expansion of Medicaid under the Affordable Care Act (LB 577); 2) The responsibility of counties to maintain facilities for the Department of Health and Human Services (HHS) (LB 632); and 3) Proposed changes to the Political Subdivisions Tort Claims Act relating to limits on actions and amounts recoverable (LB 284).

Smoyer suggested the County advocate for LB 592 (Authorize the carrying of concealed handguns by qualified law enforcement officers and qualified retired law enforcement officers).

Kerry Eagan, Chief Administrative Officer, noted LB 123 (Change distribution of indigent defense fees) is scheduled for hearing on Friday and said Dennis Keefe, Public Defender, has inquired about the Board's position. **NOTE:** The Board opposed similar legislation last year. Smoyer said the bill is not in its final form. Gordon Kissel, Kissel/E&S Associates, suggested that Keefe be allowed to oppose the bill but indicate that he would be willing to work on compromise language.

Bill Jarrett, Chief Deputy County Treasurer, appeared and expressed concerns regarding LB 97 (Adopt the Nebraska Municipal Land Bank Act and authorize land banks to acquire tax-delinquent properties). Kohout said the scope of the bill is limited and doesn't apply to Lancaster County.

Sheli Schindler, Youth Services Center (YSC) Director, appeared and said a number of bills were introduced that relate to juvenile justice and suggested the need to determine the fiscal impact if these changes go through.

ADMINISTRATIVE OFFICER REPORT

A. Microcomputer Request No. 90876, $29,672.66 from County Assessor Special Fund

Norm Agena, County Assessor/Register of Deeds, appeared and said the Register of Deeds Office will collect additional fees for five years beginning January, 2013, as a result of LB 14 which was passed last year (see June 14, 2012 Staff Meeting minutes). The fees will be split between the Register of Deeds Technology Fund and the General Fund. It was noted over $1,000,000 will be collected in each fund after five years. The Technology Fund can only be used for software, attending users conferences, training, equipment, maintenance and contract services. Agena said he is asking to use a portion of these funds to purchase new computer equipment for his office, which will allow the office to become 95% paperless.

Dennis Meyer, Budget and Fiscal Officer, appeared and said it is anticipated that $125,000 per fund will be collected this fiscal year (January-June, 2013).

MOTION: Smoyer moved and Raybould seconded approval of the request. Amundson, Raybould, Schorr, Smoyer and Hudkins voted aye. Motion carried 5-0.

B. City-County Common Meeting Agenda (February 4, 2013)

The following agenda items were noted: 1) Authority of the City-County Common to act; 2) Nominations to the City/County Consolidation Task Force Focus Group; and 3) Annual Weed Control Update.

4 COMMUNITY MENTAL HEALTH CENTER (CMHC) REQUEST FOR QUALIFICATIONS (RFQ) - C. J. Johnson, Region V Systems Administrator; Ron Sorensen, Community Mental Health Center (CMHC) Executive Director

C. J. Johnson, Region V Systems Administrator, gave an overview of the Request for Qualifications (RFQ) for Community Behavioral Health Services (Exhibit C).

With regard to the process, Johnson noted the RFQ will be released on February 1st and will seek qualified agencies with an interest in the CMHC transition. Applications will then be scored. Beginning February 28th, a series of meetings will be held with the selected agencies to "negotiate" and to answer questions. Johnson noted that he may

be coming to the County Board on a weekly basis for assistance in answering questions related to such things as buildings, furniture/fixtures and computers. During this time, a determination will also need to be made with regard to CMHC subcontracts. If more than one entity wants to provide core services, they will go through the competitive bid process or Request for Proposal (RFP), otherwise, a Request for Approval (RFA) will be required. On March 21st, the RFP or RFA process would begin and last approximately two months. Johnson hoped to have the County's final approval by June 13, 2013.

Johnson said three specific recommendations from the last Invitation to Negotiate (ITN) Committee meeting have been incorporated into the document: transportation, culturally/linguistically appropriate services and consumer employment.

In response to Schorr's inquiry, Johnson said the Crisis Center is not included in the RFQ.

MOTION: Schorr moved and Smoyer seconded to obtain professional appraisals on the Community Mental Health Center (2201 S. 17th Street) and Midtown Center (2966 "O" Street) buildings. Smoyer, Schorr, Raybould, Amundson and Hudkins voted aye. Motion carried 5-0.

Eagan said he would consult Don Killeen, County Property Manager, with regard to appraisal options and potential cost.

Johnson said it would also be helpful if, prior to the negotiation process, the County would provide a complete inventory of all furniture/fixtures, computers, vehicles, etc., belonging to the CMHC. Thorpe said she will also run a report of all current CMHC contracts and their expiration dates.

Raybould noted the County's transition funding over the course of the next two years will be very critical. She added there is some skepticism among providers and consumers with regard to this funding, as well as communication about the transition process and time line. She questioned whether it might be appropriate to schedule another television program. Thorpe said she would arrange for the program to be taped in late February and to include Commissioners Raybould and/or Smoyer and CMHC and Region V representatives.

Johnson indicated that the finalized RFQ will be posted on Region V's website on February 1st.

NOTE: *Authorization for Region V Systems to issue a Request for Qualifications (RFQ) from providers for Lancaster County Community Mental Health Center services was scheduled for the January 29, 2013 County Board meeting.*

5 NEBRASKA DEPARTMENT OF AGRICULTURE ANNUAL NOXIOUS WEEDS REPORT - Brent Meyer, Noxious Weed Control Superintendent

Brent Meyer, Noxious Weed Control Superintendent, gave an overview of the following documents: 1) Noxious Weed Control Plan for 2013; 2) Budget Report; 3) Activity Report for 2013; 4) Noxious Weed Infestation Report for 2012; and 5) Weed Control Authority Board Roster (see agenda packet). Maps depicting noxious weed infestations in the County were also disseminated (Exhibit D). He noted that he anticipates that Sericea Lespedeza will be designated a noxious weed in the near future.

MOTION: Smoyer moved and Raybould seconded to adopt the report and authorize signature by the Chair. Raybould, Amundson, Smoyer, Schorr and Hudkins voted aye. Motion carried 5-0.

6 OPEN MEETINGS LAW PRESENTATION - Doug Cyr, Chief Administrative Deputy County Attorney; Brittany Behrens, Deputy County Attorney

Doug Cyr, Chief Administrative Deputy County Attorney, and Brittany Behrens, Deputy County Attorney, gave a presentation on the Open Meetings Law (Nebraska Revised Statute §84-1407 to §84-1414), noting the following (Exhibit E):

- Basic Provisions
- Public Bodies Which Are Covered
- Meeting Definition
- Notice Requirements
- Emergency Meetings
- Closed Sessions of a Public Body
- Circumvention of the Open Meetings Act
- Actions for Enforcement
- Criminal Sanctions

Cyr noted that County Board subcommittees and committees that provide recommendations to the Board are also subject to the Open Meetings Law.

Adding items to the agenda was discussed. Cyr said the items should only be emergency in nature.

Behrens cautioned the Board to avoid continuing discussion of Board matters once the meeting is closed.

7 REVISIONS TO GENERAL ASSISTANCE (GA) GUIDELINES - Gary Chalupa, Veterans Service Officer/General Assistance Director

Gary Chalupa, Veterans Service Officer/General Assistance Director, outlined proposed changes to the General Assistance (GA) Guidelines (Exhibit F).

Eagan referred to the work search requirement (see Page 10) and said he believes there may be a statutory provision that prohibits requiring an applicant to search for work if the applicant is working a certain number of hours per week.
Chalupa said one of the changes involves cremation services (see Pages 29-33). He said the GA Advisory Committee felt the County is providing more services than it needs to and has recommended services be limited to a basic cremation (no newspaper notice, viewing/visitation or chapel services). The fee for cremation services (transport of the body from the place of death to the funeral home and cremation) will be $800 and will be renegotiated every three years beginning in 2015. The funeral homes will be asked to sign new contracts that reflect these terms.

NOTE: The proposed changes will be scheduled for a public hearing at a regular County Board of Commissioners Meeting.

8 A) UNCLASSIFIED SALARY, CLINICAL DIRECTOR; AND B) LABOR NEGOTIATIONS - Doug McDaniel, Personnel Director; Nicole Gross and Amy Sadler, Compensation Technicians

Labor Negotiations

MOTION: Smoyer moved and Raybould seconded to enter Executive Session at 10:34 a.m. for the purpose of protecting the public interest with regards to labor negotiations.

The Chair restated the motion for the record.

ROLL CALL: Schorr, Smoyer, Amundson, Raybould and Hudkins voted aye. Motion carried 5-0.

Raybould exited the meeting.

MOTION: Smoyer moved and Amundson seconded to exit Executive Session at 11:22 a.m. Amundson, Smoyer, Schorr and Hudkins voted aye. Raybould was absent from voting. Motion carried 4-0.

Unclassified Salary, Clinical Director

Doug McDaniel, Personnel Director, presented market data for the position of Clinical Director (psychiatrist) at the Community Mental Health Center (CMHC) (Exhibit G). **NOTE:** Comparisons were made with the following: Douglas County; Sedgwick County, Kansas (includes Wichita); Nebraska Hospital Association (compensation

survey data); Towers Watson (private compensation firm); State of Nebraska; and Local Physician Network. The average of market range data is as follows: $176,565.80 (minimum), $194,469.58 (midpoint) and $216,188.20 (maximum). Dr. Roy, Clinical Director at CMHC, receives a salary of $213,183.00. McDaniel said a 1% increase would equal $2,100 and a 2% increase would equal $4,263.

Raybould returned to the meeting at 11:24 a.m.

Board consensus was to hold the item for one week and have the Chair and Commissioner Raybould, who serves on the CMHC Advisory Committee, discuss the matter further with Ron Sorensen, CMHC Executive Director.

Board consensus was to schedule action on the other unclassified salaries (Appointed Directors, Assistant Directors, Bailiffs, District Court Referee, District Court Law Clerks and Sheriff Captains) on the January 29, 2013 County Board Meeting agenda.

9 REQUEST FOR RECORDS SYSTEMS SPECIALIST IN THE SHERIFF'S OFFICE - Terry Wagner, Lancaster County Sheriff; Jeff Bliemeister, Chief Deputy Sheriff

Terry Wagner, Lancaster County Sheriff, outlined his request for an additional Records Systems Specialist, citing the following (Exhibit H):

- Dramatic increase in handgun purchase permit applications
- Increase in Sex Offender Registry verifications, status changes and update
- Increase in overtime hours for Records System Specialists
- 50% turnover in Records System Specialists, causing an extremely heavy workload for remaining staff

A five-year summary of handgun applications was also disseminated (Exhibit I).

Wagner estimated the cost of the additional position at $56,000 (salary and benefits), compared to $25,000 to $30,000 currently being spent on overtime.

Hudkins asked Wagner whether he has funds in his budget to cover the cost. Wagner said the Sheriff's Office has approximately $180,000 in salary savings this year from vacancies, but will still have a budget deficit at mid-year because of the cost-of-living increases the deputies received.

MOTION: Amundson moved and Smoyer seconded approval of the request.

Raybould stated she would prefer that the request be brought forward at mid-year.

ROLL CALL: Raybould, Amundson, Smoyer, Schorr and Hudkins voted aye. Motion carried 5-0.

10 ACTION ITEMS

There were no action items.

11 CONSENT ITEMS

There were no consent items.

12 ADMINISTRATIVE OFFICER REPORT

A. Microcomputer Request No. 90876, $29,672.66 from County Assessor Special Fund
B. City-County Common Meeting Agenda (February 4, 2013)

Items A and B were moved forward on the agenda.

C. Round 37 Keno Prevention Fund Recommendations

This item was held.

13 PENDING

There were no pending items.

14 DISCUSSION OF BOARD MEMBER MEETINGS

A. Planning Meeting with Marvin Krout, Planning Director, and Sara Hartzell, Planner - Hudkins, Smoyer

Hudkins said they discussed an application for a Change of Zone from Agricultural (AG) to Agricultural Residential (AGR) for property near Malcolm (probable acreage development). He also reported that an issue involving rural water hook-up fees has been resolved.

B. Community Mental Health Center (CMHC) Advisory Committee - Raybould

See Item 4.

ADDITIONS TO THE AGENDA

A. Scheduling of Pension Investment Review

The Board scheduled the item on the March 21, 2013 Staff Meeting agenda.

B. Meeting with Governor (February 4, 2013)

Commissioner Schorr agreed to attend in place of the Chair, who has a scheduling conflict.

C. Press Release in Support of Legislative Bill (LB) 577 (Change provisions relating to the medical assistance program)

Item was not discussed.

D. Lancaster County Adult Drug Court Graduation

Raybould said the event will be held on January 28th at 6:00 p.m. in the Law School Auditorium on the University of Nebraska-Lincoln (UNL) East Campus.

E. County Board Meeting Times

Item was not discussed.

15 EMERGENCY ITEMS AND OTHER BUSINESS

There were no emergency items or other business.

16 ADJOURNMENT

MOTION: Schorr moved and Smoyer seconded to adjourn the meeting at 11:53 a.m. Raybould, Amundson, Schorr, Smoyer and Hudkins voted aye. Motion carried 5-0.

Dan Nolte
Lancaster County Clerk

EXHIBIT
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KISSEL/E&S
ASSOCIATES

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MEMORANDUM

TO: Lancaster County Board of Commissioners

FROM: Gordon Kissel
Joseph D. Kohout

DATE: January 24, 2013

RE: Weekly Update on the 2013 Legislature

Please accept this as the second of your weekly reports for the 2013 Legislative Session.

Significantly, this week saw the conclusion of bill introductions and we are providing information regarding legislation that has been introduced at Lancaster County's permission below.

LANCASTER COUNTY PRIORITIES:

1. **Oppose Elimination of the inheritance tax.** We are extremely pleased to report that no bills have been introduced to eliminate the inheritance tax. Only one bill, Senator Wightman's LB600 that would lower rates of taxation. We have attached for your review.
2. **Support Expansion of Medicaid under the Affordable Care Act.** LB577 was introduced by Senator Kathy Campbell on Wednesday.
3. **Eliminate Responsibility of Counties to Pay HHS Rent.** Senator Kate Bolz introduced LB632 yesterday. We appreciate the efforts of Mr. Eagan, Ms. Thorpe and Mr. Chalupa to address questions that Senator Bolz had. She did have some additional questions but decided to introduce the bill to spur a conversation.
4. **Modify Right to Court Appointed Attorney in Juvenile Court.** Senator Colby Coash introduced LB342 last Friday.
5. **Definition and Oversight for Staff Secure Juvenile Detention Facilities.** Senator Amanda McGill introduced this legislation and it is LB86.

OTHER LEGISLATION:

1. **LB284 (Conrad) Change provisions of the Political Subdivisions Tort Claims Act relating to actions and amounts recoverable.** *OPPOSE.* The hearing on this bill has not yet been scheduled.
2. **LB215 (Schilz) Change provisions relating to use of the County Visitors Promotion Fund.** *NO POSITION.* We agree with the synopsis provided by Commissioner Smoyer last week – it would require the fund to be spent down to zero each year. We would like to direction to speak with Senator Schilz about our concerns.
3. **LB241 (Sullivan) Authorize voters to change election of county offices from partisan to nonpartisan.** *NO POSITION.* This bill applies to all counties across the state, not just those smaller than 10,000. Commissioner Raybould asked about it during the meeting last week.

Please do not hesitate to contact us with any questions you might have.

LEGISLATURE OF NEBRASKA

ONE HUNDRED THIRD LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 600

Introduced by Wightman, 36.

Read first time January 23, 2013

Committee:

A BILL

FOR AN ACT relating to revenue and taxation; to amend sections 77-2005, 77-2006, and 77-2040, Reissue Revised Statutes of Nebraska; to change inheritance tax rates; to provide for applicability; and to repeal the original sections.

Be it enacted by the people of the State of Nebraska,

Section 1. Section 77-2005, Reissue Revised Statutes of Nebraska, is amended to read:

77-2005 In the case of an uncle, aunt, niece, or nephew related to the deceased by blood or legal adoption, or other lineal descendant of the same, or the spouse or surviving spouse of any of such persons, the rate of tax shall be ~~thirteen~~ nine percent of the clear market value of the property received by each person in excess of fifteen thousand dollars. If the clear market value of the beneficial interest is fifteen thousand dollars or less, it shall not be subject to tax.

Sec. 2. Section 77-2006, Reissue Revised Statutes of Nebraska, is amended to read:

77-2006 In all other cases the rate of tax shall be ~~eighteen~~ thirteen percent on the clear market value of the beneficial interests in excess of ten thousand dollars. Such rates of tax shall be applied to the clear market value of the beneficial interests in excess of ten thousand dollars received by each person. If the clear market value of the beneficial interest is ten thousand dollars or less, it shall not be subject to any tax.

Sec. 3. Section 77-2040, Reissue Revised Statutes of Nebraska, is amended to read:

77-2040 Sections 77-2002 to 77-2004 and 77-2102 shall become operative on December 31, 1982, and shall apply to all property which passes from a decedent dying after such date. Sections 77-2001, 77-2032, and 77-2106 shall become operative on July 17,

1982. The changes made in sections 77-2004 to 77-2006 by Laws 2007, LB 502, apply to all property which passes from a decedent dying on or after January 1, 2008. The changes made to section 77-2010 by Laws 2007, LB 502, apply to decedents dying on or after January 1, 2008. The changes made to sections 77-2005 and 77-2006 by this legislative bill apply to decedents dying on or after January 1, 2014.

Sec. 4. Original sections 77-2005, 77-2006, and 77-2040, Reissue Revised Statutes of Nebraska, are repealed.

Kissel/ES Associates
Bills of Interest Report
Client: LC

LB/LR	Sponsor	Priority	One-Liner	Committee	Hearing Date	Status	LC	*LC Position*
LB8	Krist		Provide for coverage of children's day services under medicaid and social services	Health and Human Services			x	
LB11	Krist		Change provisions relating to surcharges for 911 service	Transportation and Telecommunications			x	
LB28	Hadley		Change a late filing penalty relating to personal property tax	Revenue	1.25.13		x	
LB29	Hadley		Provide a duty for county treasurers relating to recording tax assessments and collections	Revenue	1.25.13		x	
LB30	Hadley		Change distribution of motor vehicle certificate of title fees	Transportation and Telecommunications	1.22.13	General File	x	
LB34	Hadley		Change provisions of the Nebraska Advantage Act	Revenue	1.23.13		x	
LB36	Wightman		Change an exemption to the documentary stamp tax	Revenue	1.25.13		x	
LB41	Cook		Provide for permanent early voting request list and return of early voting ballots to polling places	Government, Military and Veterans Affairs	1.23.13		x	

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LB43	Cook		Change provisions relating to a property tax exemption	Revenue			x	
LB55	Wightman		Change provisions relating to reassumption of assessment function by counties	Revenue			x	
LB56	Larson		Provide for automatic nomination of certain county officers	Government, Military and Veterans Affairs	1.23.13		x	
LB62	Schilz		Change levy provisions for rural and suburban fire protection districts	Revenue			x	
LB63	Schilz		Change distribution of certain sales and use tax revenue	Revenue			x	
LB65	Schilz		Authorize counties to set sheriff's fees and commissions	Government, Military and Veterans Affairs	1.30.13		x	
LB76	Nordquist		Adopt the Health Care Transparency Act	Health and Human Services			x	
LB82	Schumacher		Adopt the Taxpayer Investment Program	Revenue			x	
LB86	McGill		Authorize inspection and regulation of staff secure juvenile facilities	Judiciary			x	
LB101	Watermeier		Change valuation of agricultural land and horticultural land	Revenue			x	

LB108	Karpisek			Prohibit counties, cities, and villages from imposing credentialing requirements	Government, Military and Veterans Affairs	1.30.13		x
LB110	McGill			Change the eligibility determination for homestead exemptions	Revenue			x
LB115	Lautenbaugh			Change provisions relating to homicide	Judiciary			x
LB119	Cook			State intent relating to appropriations for Public Health Aid	Appropriations			x
LB123	Lautenbaugh			Change distribution of indigent defense fees	Judiciary	1.25.13		x
LB127	McGill			Provide for preregistration to vote for 16 and 17 year olds	Government, Military and Veterans Affairs			x
LB134	Avery			Provide for inheritance by issue conceived after death	Judiciary	1.30.13		x
LB149	Pirsch			Provide for biennial reviews of state agency programs and services	Executive Board	1.28.13		x
LB157	Cook			State intent relating to the appropriation of funds in support of dental services	Appropriations			x

LB168	Larson		Authorize series limited liability companies	Transportation and Telecommunications			x	
LB171	Bloomfield		Provide for an expedited concealed handgun permit process for applicants who are victims of domestic violence	Government, Military and Veterans Affairs			x	
LB182	Avery		Change paternity provisions for a child conceived as a result of sexual assault	Judiciary	2.6.13		x	
LB183	Karpisek		Provide for county board appointment of election commissioners	Judiciary	1.31.13		x	
LB188	Karpisek		Require legislative approval of gubernatorially appointed election commissioners	Judiciary	1.31.13		x	
LB194	Speaker Adams		Provide for deficit appropriations	Government, Military and Veterans Affairs			x	
LB195	Speaker Adams		Appropriate funds for state government expenses	Government, Military and Veterans Affairs			x	
LB196	Speaker Adams		Appropriate funds for salaries of members of the Legislature	Appropriations			x	

LB197	Speaker Adams		Appropriate funds for salaries of constitutional officers	Appropriations			x	
LB198	Speaker Adams		Appropriate funds for capital construction and property acquisition	Appropriations			x	
LB199	Speaker Adams		Provide fund transfers, create funds, and authorize the sale of land	Appropriations			x	
LB200	Speaker Adams		Provide for transfers from the Cash Reserve Fund	Appropriations			x	
LB202	Coash		Change provisions relating to DNA collection	Judiciary			x	
LB206	Schumacher		Require secret-ballot envelopes for mailed ballots	Government, Military and Veterans Affairs			x	
LB207	McCoy		Change motor vehicle registration provisions	Transportation and Telecommunications	1.28.13		x	
LB209	Harr		Change provisions relating to publication of trade names	Banking, Commerce and Insurance	1.29.13		x	
LB215	Schilz		Change provisions relating to use of the County Visitors Promotion Fund	Government, Military and Veterans Affairs			x	

LB218	Avery		Require insurance coverage for certain food formulas as prescribed	Banking, Commerce and Insurance			x	
LB224	Janssen		Provide veterans preference for public contracts as prescribed	Government, Military and Veterans Affairs	2.1.13		x	
LB226	Smith		Regulate dealers in the business of purchasing and reselling precious items	Judiciary	1.31.13		x	
LB235	Howard		Change precinct size requirements and procedures for drawing political subdivision boundaries and changing polling places and provide for election advisory committees	Government, Military and Veterans Affairs			x	
LB237	Karpisek		Change provisions relating to a property tax exemption	Revenue			x	
LB241	Sullivan		Authorize voters to change election of county offices from partisan to nonpartisan	Government, Military and Veterans Affairs			x	

LB246	Larson		Provide for a health care copayment for jail and prison inmates	Judicary			x	
LB247	Larson		Change Nebraska Juvenile Code provisions relating to reimbursement by parents for costs of care and treatment	Judiciary			x	
LB260	Gloor		Change requirements for a data and information system under the Nebraska Behavioral Health Services Act	Judiciary			x	
LB266	Chambers		Eliminate provisions relating to increases in local option sales tax rates	Government, Military and Veterans Affairs			x	
LB267	Chambers		Prohibit persons on parole, probation, or work release from acting as undercover agents or employees of law enforcement and prohibit admissibility of certain evidence	Health and Human Services			x	
LB271	Lautenbaugh		Change provisions relating to early voting	Revenue			x	

LB284	Conrad		Change provisions of the Political Subdivisions Tort Claims Act relating to limits on actions and amounts recoverable	Judiciary			x	
LB286	Conrad		Provide for Cash Reserve Fund transfers for affordable housing, homeless shelter assistance, and legal aid	Appropriations			x	
LB292	Karpisek		Change population restrictions for conducting elections by mail	Government, Military and Veterans Affairs			x	
LB293	Kintner			Judiciary			x	
LB294	Seiler		Change provisions relating to use of public resources by public officials and public employees	Government, Military and Veterans Affairs			x	
LB297	Bolz		Change mental injuries and mental illness compensation under the Nebraska Workers' Compensation Act	Business and Labor	1.28.13		x	
LB299	Seiler		Change political subdivision election provisions	Government, Military and Veterans Affairs			x	

LB311	Scheer		Change filing requirements for official bonds and oaths	Government, Military and Veterans Affairs	1.30.13		x	
LB317	Price		Change a duty of county assessors relating to real property valuation	Revenue			x	
LB318	McGill		Change duties of law enforcement officers and agencies relating to the taking and distribution of fingerprints	Judiciary			x	
LB324	Lautenbaugh		Change provisions of the Nebraska Workers' Compensation Act	Business and Labor			x	
LB326	Howard		Change provisions of Pharmacy Practice Act and Automated Medication Systems Act	Health and Human Services	2.1.13		x	
LB341	Wightman		Change tax sale procedures	Revenue			x	
LB342	Coash		Change right to counsel provisions under the Nebraska Juvenile Code	Judiciary			x	
LB345	Wightman		Change transfer on death deed requirements and filings	Judiciary			x	

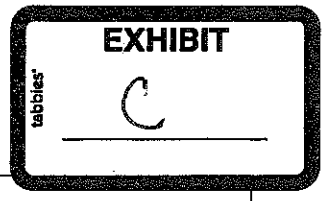
LB350	Murante		Add members to the Nebraska Police Standards Advisory Council	Judiciary			x	
LB351	Harms		Require cognitive tests for persons eighty years of age or older obtaining motor vehicle operator's licenses	Transportation and Telecommunications			x	
LB355	Larson		Change the age of majority and certain age requirements	Judiciary			x	
LB360	Karpisek		Change court fees, sheriff's fees, identification inspection fees, and handgun certificate fees	Judiciary			x	
LB363	Avery		Change provisions relating to access to public records	Government, Military and Veterans Affairs			x	
LB364	Avery		Permit government bodies to set limits on certain contracts	Government, Military and Veterans Affairs			x	
LB370	Lathrop		Create the County Property Tax Assistance Program and the Municipal Property Tax Assistance Program	Revenue			x	

LB377	Johnson		Change provisions relating to annexation of a county road by a city or village	Urban Affairs			x	
LB378	Smith		Eliminate fees for the issuance of certain license plates	Transportation and Telecommunications			x	
LB381	Janssen		Require photographic identification to vote	Government, Military and Veterans Affairs			x	
LB386	Christensen		Require notice of road maintenance by counties as prescribed	Transportation and Telecommunications			x	
LB387	Christensen		Eliminate provisions relating to constructing drainage facilities and taking other control measures on public roads	Transportation and Telecommunications			x	
LB390	Christensen		Change provisions relating to Governor's powers regarding restrictions on firearms and ammunition under the Emergency Management Act	Judiciary			x	

LB399	Lautenbaugh		Permit members of certain organizations to use flashing amber lights on motor vehicles	Transportation and Telecommunications			x	
LB405	McCoy		Eliminate certain sales tax exemptions, corporate and individual income taxes, and the franchise tax and change other tax provisions				x	
LB406	McCoy		Change tax provisions				x	
LB417	Kolowski		Provide for guidelines for election workers				x	
LB418	Kolowski		Change powers and duties of election commissioners, chief deputy election commissioners, and county boards				x	
LB433	Price		Require a report and change administration procedures for ballots at hospitals and nursing homes				x	
LB434	Price		Provide for emergency management registries for persons with special needs				x	

LB441	Seiler		Change provisions relating to control of dead human remains				x	
LB443	Cook		Adopt the Children's Residential Facilities and Placing Licensure Act				x	
LB449	Avery		Redefine high elective office for restrictions on multiple office holding				x	
LB450	Avery		Change political party convention and caucus provisions				x	
LB462	Ashford		Change provisions relating to contracts for joint law enforcement services				x	
LB463	Ashford		Change the number of separate juvenile court judges				x	
LB464	Ashford		Change court jurisdiction over juveniles and indictment procedures				x	
LB470	Scheer		Adopt the Superintendent Pay Transparency Act				x	

LB473	Bloomfield		Authorize certain residency restrictions near parks under the Sexual Predator Residency Restriction Act				x	
LB483	Bolz		Provide for a reentry planning program in adult correctional facilities				x	
LB485	Conrad		Prohibit discrimination based upon sexual orientation as prescribed				x	



Region V Systems
Request for Qualifications
For Community Behavioral Health Services

Release Date:	Friday, February 1, 2013	**Contact:**	Amanda Tyerman-Harper
Submittal Deadline:	Friday, February 15, 2013		402-441-4354
	No later than 4:15 p.m. To:		atyerman-harper@region5systems.net
	Region V Systems		
	1645 'N' Street		
	Lincoln, NE 68508		Submission by fax, telephone, or e-mail is not permitted.

Region V Systems (RVS) and the Lancaster County Board of Commissioners (LCBC) are pleased to announce the release of a Request for Qualifications (RFQ) for entities interested in providing behavioral health services currently provided by the Lancaster County Community Mental Health Center (LCCMHC) in Lincoln, Nebraska.

Applicants should submit one (1) original and 10 copies of the application. The application must contain all information as required in Section VIII of this document. Application must be received by the submittal date and time.

RVS reserves the right to request clarification or additional information from any applicant. RVS also reserves the right to negotiate with more than one (1) entity in order to ensure a service system that meets the needs of the community and persons served. This solicitation does not obligate RVS to award contract to any applicant. RVS, at its option, reserves the right to waive as informality any irregularities in and/or reject any or all applications.

All questions regarding this RFQ should be made in writing to Amanda Tyerman-Harper with RVS at atyerman-harper@region5systems.net. Questions will be posted on RVS' website at www.region5systems.net. Questions to the identified contact person regarding this RFQ may be made either by fax, e-mail, or written correspondence using the *"Request for Information"* form available electronically at www.region5systems.net. Written responses to questions will be made by RVS personnel within three (3) business days and posted accordingly on the RVS website.

All notices, decisions, documents and other matters relating to the RFQ process will be electronically posted on RVS' website at www.region5systems.net. RVS reserves the right to amend, modify, supplement, or clarify this RFQ at any time at its sole discretion.

Under the parameters of the Intent to Negotiate (ITN) process coordinated by RVS, with the exception of clarifying questions, prospective respondents are prohibited from contacting personnel of RVS, the Department of Health and Human Services, LCBC, LCCMHC, members of RVS' Behavioral Health Advisory Committee (BHAC) or Regional Governing Board (RGB), LCBC members, or members of the ITN Committee regarding this solicitation during the period following the release of this RFQ, 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 RFQ.

Note: No applicant shall be excluded from participation in, denied the benefit of, subject to discrimination under, or denied employment in the administration of or in connection with this RFQ because of race, color, creed, marital status, familial status, religion, sex, sexual orientation, national origin, Vietnam era or disabled veteran's status, age, or disability. The applicant shall comply with all applicable federal, state, and local nondiscrimination laws, regulations, and policies.

TABLE OF CONTENTS

I. HISTORY

A. Lancaster County Community Mental Health Center

Lancaster County Community Mental Health Center (LCCMHC) 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, LCCMHC continues to provide mental health treatment, rehabilitation, recovery supports, and crisis services to approximately 5,000 individuals in Lancaster County each year (See Attachment A). LCCMHC is a funded provider in RVS' network of behavioral health providers.

B. Region V Systems

RVS, 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 RVS' geographical area, which includes Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, and York counties in southeast Nebraska. RVS, one of six (6) regional behavioral health authorities in Nebraska, along with the state's three (3) Regional Centers, make up the state's public behavioral health system, also known as the Nebraska Behavioral Health System.

RVS is governed by a board of county commissioners, who are elected officials, one (1) from each of the counties represented in the RVS' 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 RVS' geographical area to best meet the needs of the general public. In RVS, the Behavioral Health Advisory Committee (BHAC) is comprised of 15-20 members including consumers, concerned citizens, and representatives from other community systems in the Region.

RVS' 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. RVS is responsible for the development and management of a provider network that serves the behavioral health needs of southeast Nebraska. Currently, RVS has 13 providers, including LCCMHC, in its network that have met the minimum standards required to be a member of the network; each provider has a contract with RVS to deliver an array of behavioral health services.

RVS, 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. RVS currently contracts with the LCCMHC for publicly funded behavioral health services for Lancaster County residents in the amount of $3,201,565, approximately one third of the revenues for LCCMHC. Of those funds, $1,454,805 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.

C. Transition of Behavioral Health Services/Lancaster County Community Mental Health Center

In June 2011, the Lancaster County Board of Commissioners (LCBC) made a decision to transition the administration, management, and delivery of behavioral health services (except for the Crisis Center) currently provided by the Lancaster County Community Mental Health Center (LCCHMC) to the private and/or public service sector. LCCMHC began providing services to persons with severe and persistent mental illness in 1976 and to date they continue to provide mental health treatment, rehabilitation, recovery supports, and crisis services to individuals in Lancaster County.

In June 2011, the LCBC established the LCCHMC Planning Committee to guide the transition process, with the responsibility of advising the LCBC 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 LCBC 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 (see Attachment B) to the LCBC 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 LCBC accepted these recommendations, and the CMHC Intent to Negotiate (ITN) Committee was established to assist the LCBC in defining the essential components of the new service model. This panel was charged with developing the process to transition the LCCMHC from county governance to the private and/or public sector. The CMHC Planning Committee further recommended the LCBC work with RVS to prepare specifications for the new service model to be used in soliciting collaborative and innovative proposals through an ITN process. Pursuant to the findings and recommendations of the CMHC Planning Committee and the ITN Committee, RVS was selected to oversee the ITN process.

D. Input Groups

At the recommendation of the ITN Committee, an important step in the ITN process was to bring together groups of individuals that would be impacted by the transition of LCCMHC services. A series of input groups were held in October and November of 2012 for providers/stakeholders interested in providing services, LCCMHC staff, and consumers. A total of 155 individuals attended one or more sessions. Based on feedback from the group sessions, it was determined that the most logical next step would be to seek qualified applicants interested in proceeding with the ITN process (See Attachment C).

II. STATEMENT OF PURPOSE

The LCBC and RVS are seeking to identify prospective applicants for the transition and provision of services from the LCCMHC. It is the strategic intent of the ITN process to ensure that current consumers of LCCMHC continue to receive necessary recovery-based services and supports.

III. TARGET POPULATION

Applicants should be able to deliver a comprehensive array of behavioral health services to eligible individuals within the priority target population defined as follows:

1. Persons 19 years of age and over who reside within the RVS' geographic service area (priority will be given to Lancaster County residents);
2. Adults with or at risk of experiencing disruption in functioning or impairments due to mental illness; a majority of whom may have a diagnosis consistent with a serious and persistent mental illness (SPMI) i.e. a primary diagnosis of schizophrenia, major affective disorder or other major mental illness; and,
3. Adults who meet financial eligibility criteria (See Attachment D) and do not have coverage for services through other payer sources including Medicaid.

IV. SCOPE OF SERVICE

CMHC offers a wide variety of crisis, treatment, recovery support, and rehabilitation services and applicants should be able to assume the responsibility of administering, managing, and providing these behavioral health services in Lancaster County to residents residing in the counties within RVS' geographical service area. Applicants should be community-based organizations with demonstrated experience in providing behavioral health services that are 1) recovery-based, 2) inclusive of peer support 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) provides behavioral health in an integrated environment with primary health.

Applicants submitting a response to the Request for Qualifications may apply in whole or in part for services currently comprising the LCCMHC service system as identified below.

A. Service Categories

1. Fee-for Service

a. Core Services, including, Community Support, Medication Management, Outpatient, and Day Treatment.
b. Day Rehabilitation (MidTown).
c. Psychiatric Residential Rehabilitation (The Heather).

2. Non-fee-for Service

a. 24-hour Crisis Line.

Service definitions and utilization guidelines as developed by the Nebraska Behavioral Health Division (NBHD) can be found at http://dhhs.ne.gov/behavioral_health/Documents/BH-Medicaid-Svc-Def-2006.pdf.

NOTE: Revisions to the NBHD regulations, service definitions, and utilization guidelines are pending and can be found at:
http://www.sos.ne.gov/rules-and-regs/regtrack/proposals/0000000000000965.pdf.

B. Persons Served

The number of persons served in each of the services categories is summarized in Attachment E.

V. FINANCIAL SPECIFICATIONS

A. Funding Source

LCCMHC revenues for FY10 through FY12 are reflected in Attachment F. Revenue sources include RVS, Medicaid, Medicare, Lancaster County, and client fees.

This ITN process is specific to RVS funds only. RVS funds include:

STATE GENERAL FUNDING: The contract amount includes funds contracted to RVS by the Nebraska Department of Health and Human Services. Funds are passed through the Regional Behavioral Health Authority (RBHA), RVS, and subsequently passed from the RBHA to the Network Providers.

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.

B. Total Funds Available

The funding available for this ITN for behavioral health services is $1,394,214. The contract amount is subject to the availability of funds. Based on a 3-year average utilization of services at CMHC, the following funding is available as specified by service category.

Service Category	RVS Available Funds	Unit Capacity
Core Services, including, Community Support, Medication Management, Outpatient, and Day Treatment	$1,065,034	**POOL (See Attachment G)
Day Rehabilitation	$93,967	1,727
Psychiatric Residential Rehabilitation	$33,517	302
24 hr Crisis Line	$201,696	N/A

** Specific capacity will be negotiated for these Non-Residential services and identified in subsequent provider proposals.

VI. ITN PROCESS

The ITN process will be completed in three phases. Following is the timeline and explanation of the ITN process. The LCBC and RVS expect to adhere to the schedule shown below. It should be noted, however, that some dates are approximate and are subject to change.

Activity	Date/Time
Phase I - Request for Qualifications	

Activity	Date/Time
RFQ Announcement	February 1, 2013
RFQ Applications Received by RVS	February 15, 2013
RFQ Applications Reviewed and Scored	February 18-22, 2013
Identified RFQ Applicants Notified of Acceptance/Denial to Proceed with Process (via e-mail)	February 25, 2013
Phase II - Pre-Proposal Negotiations	
Series of Pre-proposal Negotiations with Identified Applicants	February 28 – March 15, 2013 Initial Meeting: February 28, 2013 @1:00 p.m. Held at Region V Systems 1645 'N' St., Lincoln, NE
Phase III - Proposal Submission	
Qualified Applicants Submit Letter of Intent to Submit Full Proposal	March 18, 2013
Meeting with Qualified Applicants to Review Proposal Process & Guidelines	March 21, 2013 (Time To Be Announced)
Applicants Submit Full Proposal	April 19, 2013
Review and Approval of Proposals Completed	April 26, 2013
RVS Updates BHAC, RGB, and LCBC on Review of Proposals & Recommendations for Contract Development	May 1, 2013 (BHAC) May 13, 2013 (RGB) May 16, 2013 (LCBC)
Begin Contract Development with Approved Providers	May 22, 2013
RVS Seeks Approval of Final Contract	May 29, 2013 (BHAC) June 10, 2013 (RGB) June 13, 2013 (LCBC)
Anticipated Effective Date of Contract(s)	7/1/2013

A. Phase I – Request for Qualifications

The RFQ is intended to function as an open process for qualified groups and organizations that are interested in providing behavioral health services in an integrated environment with primary care

services that will replace the current LCCMHC service system in Lincoln, Nebraska. Applicants should be qualified to provide services set forth by county, state, and federal requirements. Based upon the criteria set forth in this document, an RFQ committee will identify qualified applicants.

B. Phase II – Pre-proposal Negotiations

Once qualified applicants are identified, applicants will be asked to join RVS and other qualified applicants in a series of pre-proposal negotiations to identify possible collaborations, innovative ideas, and best practices for the transition and delivery of behavioral health services to replace the current CMHC service system.

Collaboration among applicants in the design of a mix of services (recovery support, crisis, treatment, rehabilitation, and primary care) is strongly encouraged. These informal meetings will determine what parties are interested in continuing forward in the next steps of the ITN process; these parties will submit a "Letter of Intent." Submitting a "Letter of Intent" does not bind the organization to submission of a proposal. Proposal guidelines will be provided only to applicants submitting a "Letter of Intent."

C. Phase III – Proposal Submission

Dependent on the outcome of the pre-proposal negotiations, RVS may proceed with either a Request for Approval (RFA) or Request for Proposals (RFP). The RFP process is a competitive process that will be initiated if multiple parties are interested in providing the same service(s); this process will be competitive. Both processes will require submission of a proposal. RVS' intent is to contract with selected provider(s) for the delivery of services to replace the existing LCCMHC.

VII. Evaluation Methodology

A. All responses to this RFQ will be evaluated. Each category will have a maximum possible point potential. RVS will conduct a fair, impartial and comprehensive evaluation of all submissions in accordance with the criteria set forth in Section VIII. Areas that will be addressed and scored during the evaluation include:

1. Executive Summary (10 pts)
2. Minimum Standards (25 pts)
3. Provider Capacities (60 pts)
4. Assurances (5 pts)

Proposals will be independently evaluated by members of the Evaluation Committee. The committee will consist of RV5 staff and volunteer members from the ITN Committee with the appropriate expertise to conduct such proposal evaluations. Names of the members of the Evaluation Committee will not become public information.

VIII. General Instructions on Submission of the "Request for Qualifications Application Form"

A. To participate in the RFQ process, applicants must submit the information as identified below in the format of the "Request for Qualifications Application Form." The "Request for Qualifications Application Form" will be posted at www.region5systems.net.

1. Executive Summary

a. **Agency Contact Information**
   1. Name of Applicant
   2. Name of Corporate Officer (authorized to execute agreements)
   3. Address of Applicant
   4. Phone number of Applicant
   5. Applicant Contact
   6. Phone number of Contact
   7. E-mail of Contact

b. **Description of Applicant Organization**
   Provide a brief description of the applicant's history, mission, ownership, and organizational structure.

c. **Provider Intent**
   As an applicant, check all service categories of provider interest as it pertains to this RFQ.

   ☐ Core Services, including community support, medication management, and outpatient
   ☐ Day Treatment
   ☐ Day Rehabilitation
   ☐ Psychiatric Residential Rehabilitation
   ☐ 24-hour Crisis Line

2. **Minimum Standards**

Eligible applicants may be a state, county, or community-based public or private nonprofit, private for profit, or faith-based organization. Applicants 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:

a. Applicant is:
   ☐ State, County, or Community-based Public Organization
   ☐ Private Nonprofit Organization
   ☐ Private for Profit Organization
   ☐ Faith-based Organization

b. Applicant 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:
   ☐ A member of the RVS Provider Network
   OR
   ☐ A new applicant
   Include the following documentation and source of:
      ☐ Verification of facility licensure
      ☐ Fire inspections
      ☐ Professional licensure
      ☐ Insurance
   ☐ A current independent audit for at least 24 months, including any correspondence or letters to management from the CPA completing the audit
   ☐ Verification of national accreditation in the provision of behavioral health services by a nationally recognized accreditation organization, i.e. CARF, COA, TJC, or an accreditation development plan that outlines the agency's timeline (minimum 2 years) of achieving national accreditation

- ☐ Verification of current applicable Nebraska behavioral health licensed clinicians and physicians on staff (including contracted personnel)

c. Verification of a Nebraska Medicaid provider for identified behavioral health services or willingness/ability to obtain Nebraska Medicaid provider status Include the following documentation and source of Medicaid provider status:
   - ☐ Medicaid Provider Agreements

3. Provider Capacities

Briefly respond to the following:

a. RVS is engaged in implementing a Cluster-Based planning (CBP) and Outcomes Management initiative. This is a service planning, quality improvement, program management and evaluation process. CBP can assist the system of care by better identifying who the consumers of services are, what types of services are needed and what we can best offer to meet their needs. Attachment I identifies the subgroups and provides a brief explanation of each. Select and identify which subgroup(s) your organization has experience in serving and briefly describe.
b. Describe the organization's experience and/or ability to build the capacity to serve the population within the chose service category(s) as selected in Section VIII.1.
c. Describe the organization's experience and capacity to provide services within Lancaster County serving individuals within RVS' geographic area.
d. Describe the organization's competencies in the provision of services and supports that are evidence-based and adhere to best practices in working with persons with serious mental illness.
e. Describe the organization's recovery philosophy and how that is reflected in organizational staffing, competencies and programming.
f. Describe the organization's experience and approach to integrating behavioral health and primary care.
g. Describe the organization's experience and approach to involving consumers in the design, evaluation or provision of services.
h. Describe the organization's experience in hiring consumers for functions that might typically be outsourced i.e. custodial, maintenance, transportation.
i. Describe the organization's approach to addressing transportation issues related to access for the target population.
j. Describe the organization's efforts in providing culturally and linguistically appropriate services.

4. Assurances

Ensure applicant signature on this portion of the application.

ASSURANCES

1. Applicant agrees to maintain a drug free work place environment.
2. Agency is not currently in violation of any federal, state, or local laws, regulations or policies.
3. Agency is not involved in any current litigation.
4. Applicant is willing to accept RVS' contract terms and conditions reflected in standard contract template (Attachment J).
5. Applicant is willing to accept contracted rates for services as identified in Attachment K.
6. Applicant is able to initiate services effective July 1, 2013.
7. Applicant will provide services in Lincoln, NE to residents of Lancaster County and the other RVS' counties.
8. Applicant will abide by the NBHD service definitions designed to meet the needs of the population while promoting service delivery efficiency and effectiveness.
9. Applicant will have, or have a plan to acquire appropriate licenses as appropriate to the service category(s) to be provided.
10. Applicant agrees to comply with all System Management Agent (Magellan) data reporting requirements and register and authorize services accordingly.
11. Applicant will be able to deliver a comprehensive array of behavioral health services to eligible individuals within the priority target population as defined in Section III.
12. Applicant will maintain positive working relationship with Lancaster County, LCBC, and RVS' staff in executing any agreements.

By signing below, Applicant agrees to all conditions above.

_____ _____

Agency Name Signature of Person Authorized to Execute Agreements

_____

Date

List of Attachments:

Attachment A – CMHC Annual Report
Attachment B – LCCMHC Planning Committee Report
Attachment C – ITN Input Group Summary
Attachment D – Financial Eligibility Policy
Attachment E – Persons Served Magellan Data
Attachment F – LCCMHC Revenues FY 10 – FY 12 (Actuals)
Attachment G – Capacity and Utilization RVS
Attachment H –
Attachment I – Cluster Based Planning
Attachment J – RVS Contract Template
Attachment K – Current Rates
Attachment L – Definitions

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

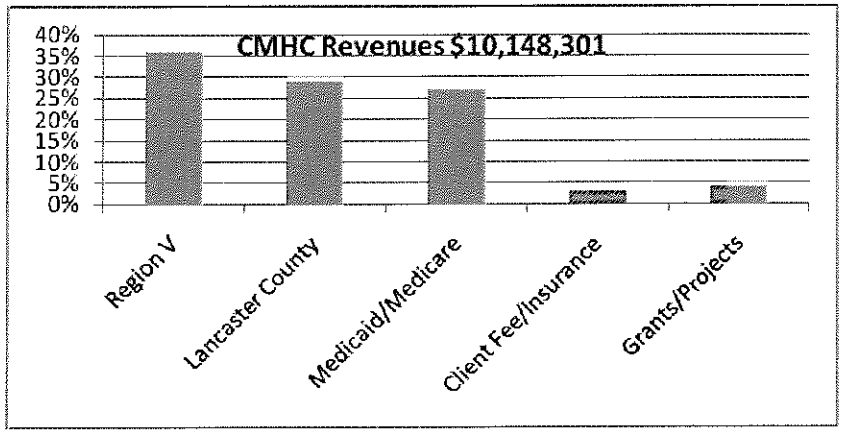
CMHC Services	Persons Served by CMHC-20?? (Duplicates Included)
Assertive Community Treatment: A collaboration designed to serve individuals who have not responded well to traditional outpatient care. Services are provided to the consumer in their home and the community.	79
24 Hour Crisis Line: Crisis 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

Attachment B

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 Seibel

CJ Johnson

Deb Shoemaker

Dean Settle

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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

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).

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%**

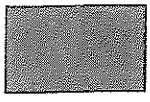
$10,149,301

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 are 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

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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

Nebraska Department of Health and Human Services

Division of Behavioral Health

Financial Eligibility Fee Schedule
Effective July, 2012

Annual Income Limits				Monthly Income Limits												
Lower	Upper	hrly rate	hrly rate	Lower	Upper		Single	Family -2	Family - 3	Family - 4	Family - 5	Family - 6	Family - 7	Family - 8	Family - 9	Family - 10
$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	15%-80% of rate or cost		$ 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											

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.

Nebraska Department of Health and Human Services **Division of Behavioral Health**

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/10/fedreg.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 Consumer 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			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	No copyment may be charged to consumer			$ 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	No copyment may be charged to consumer		$ 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											

Nebraska Department of Health and Human Services

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

Division of Behavioral Health

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
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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 Consumer Price Index Bureau of Labor Statistics
http://data.bls.gov

Nebraska Department of Health and Human Services

Division of Behavioral Health

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			$ 33,810			$ 33,810		$ 33,810			
$ 33,811	$ 37,630	$ 16.26	$ 18.09	$ 2,818	$ 3,136	0%-30% of rate or cost (not to exceed $30 per unit)*	$ 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
$ 64,390	$ 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											
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$ 110,234	$ 114,054	$ 53.00	$ 54.83	$ 9,186	$ 9,505											
$ 114,055	$ 117,876	$ 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

Nebraska Department of Health and Human Services **Division of Behavioral Health**

Financial Eligibility Hardship Fee Schedule
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8	$ 37,630	$3,136	$3,136
Average increase	$ 3,820	$318	$318

Secondary data source Consumer 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 Liabilities:

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:

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

Consumer is eligible for Hardship Fee Schedule due to:

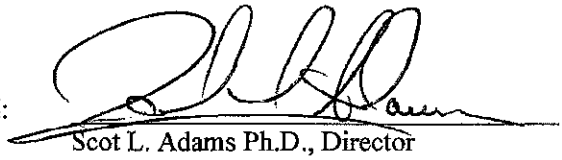
_____ SPMI
_____ SED
_____ Medical Bills or Medical Debt in excess of 10% of the taxable annual income
(Taxable Monthly Income x 12 x 10%)

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.

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.

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

Attachment 9

Attachment 8
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

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

Attachment I (NEEDS WORK)

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

2012 NOXIOUS WEEDS

EXHIBIT

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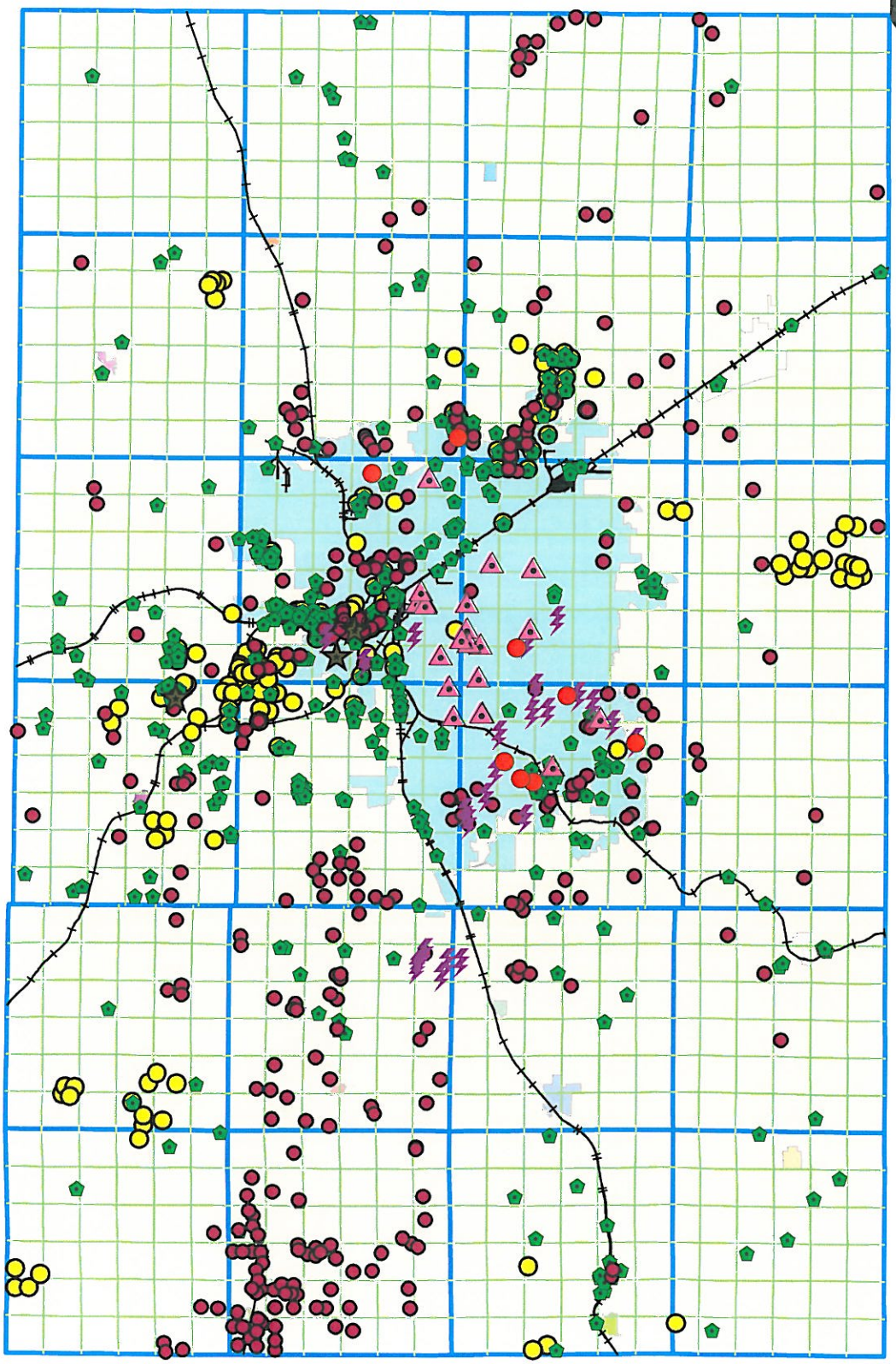

Legend

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- 2012Knotweed
- 2012CanadaThistle
- 2012PurpleLoosestrife
- 2012Phragmites
- 2012MuskThistle
- 2012LeafySpurge
- RailroadLines
- sections
- precincts

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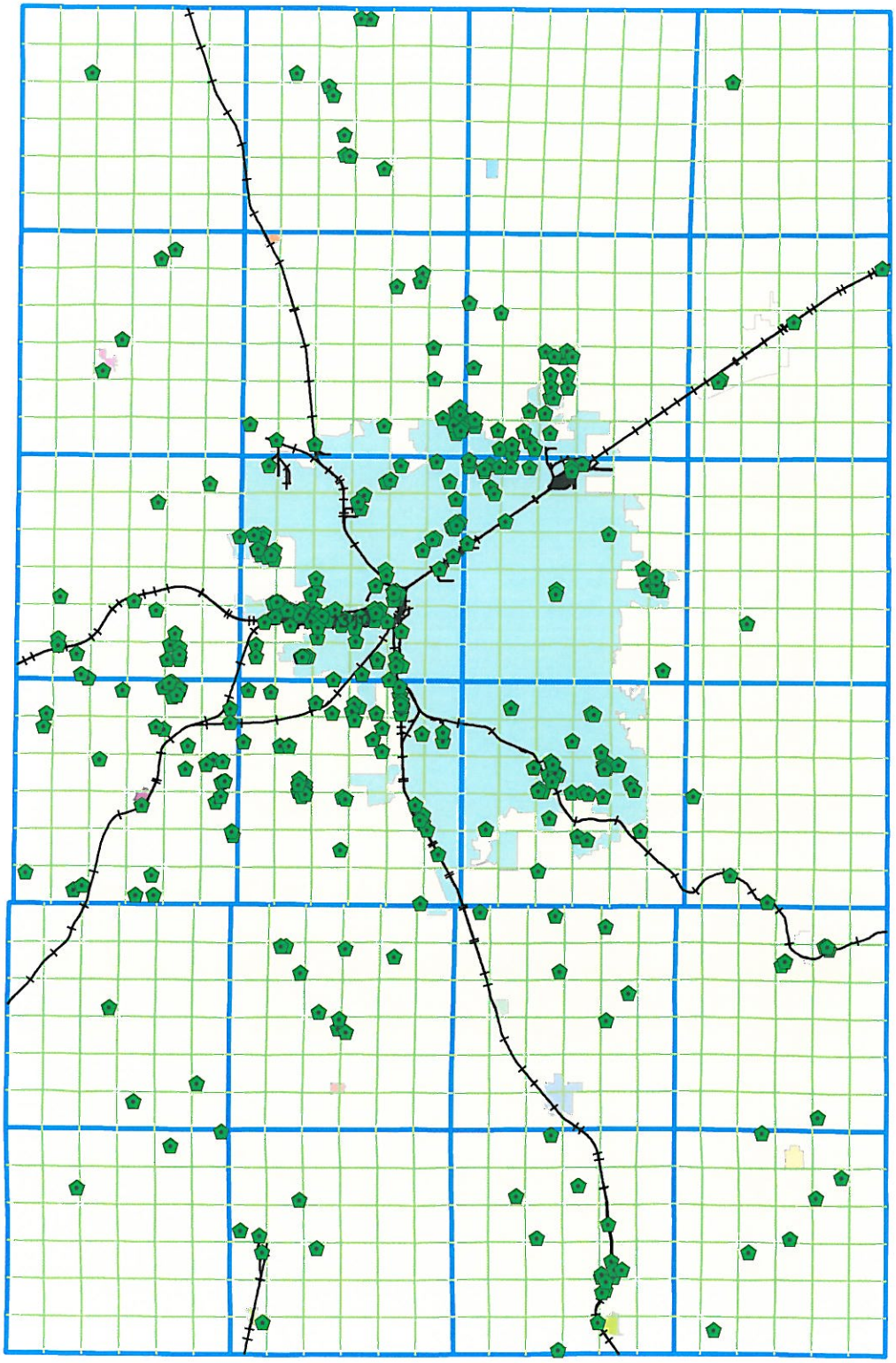
map by: Lancaster County Weed Control

2012 Musk Thistle



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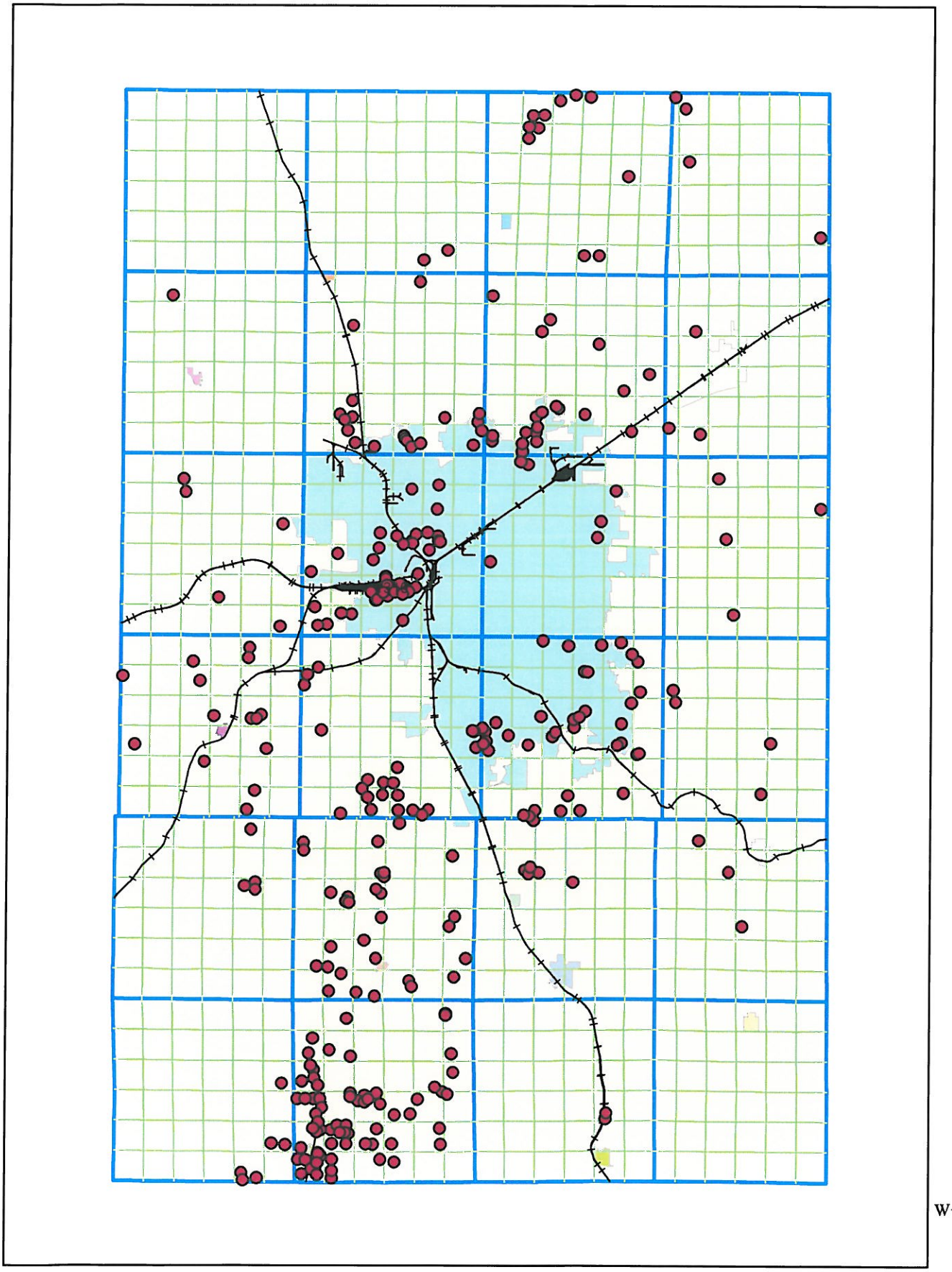

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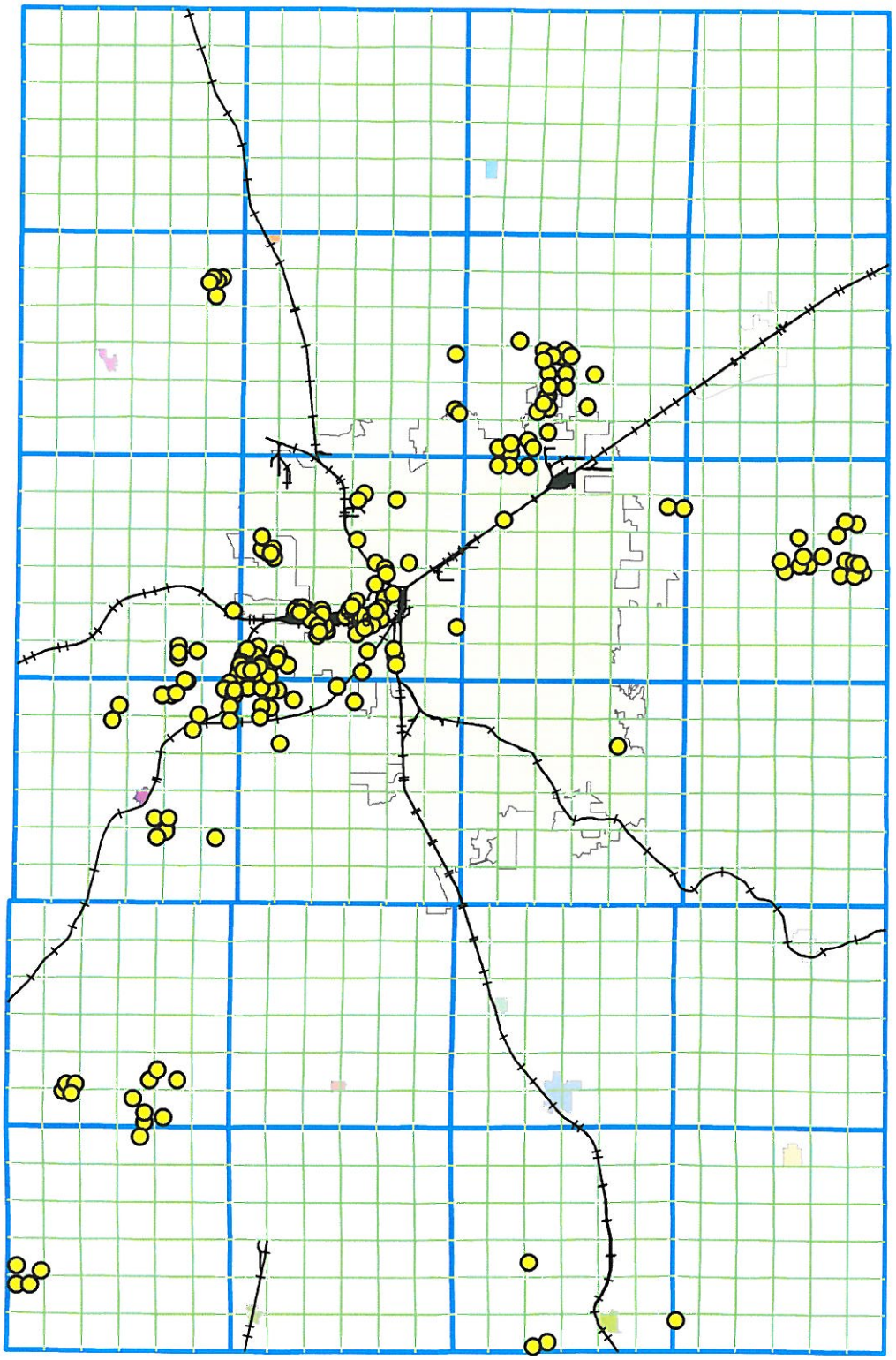

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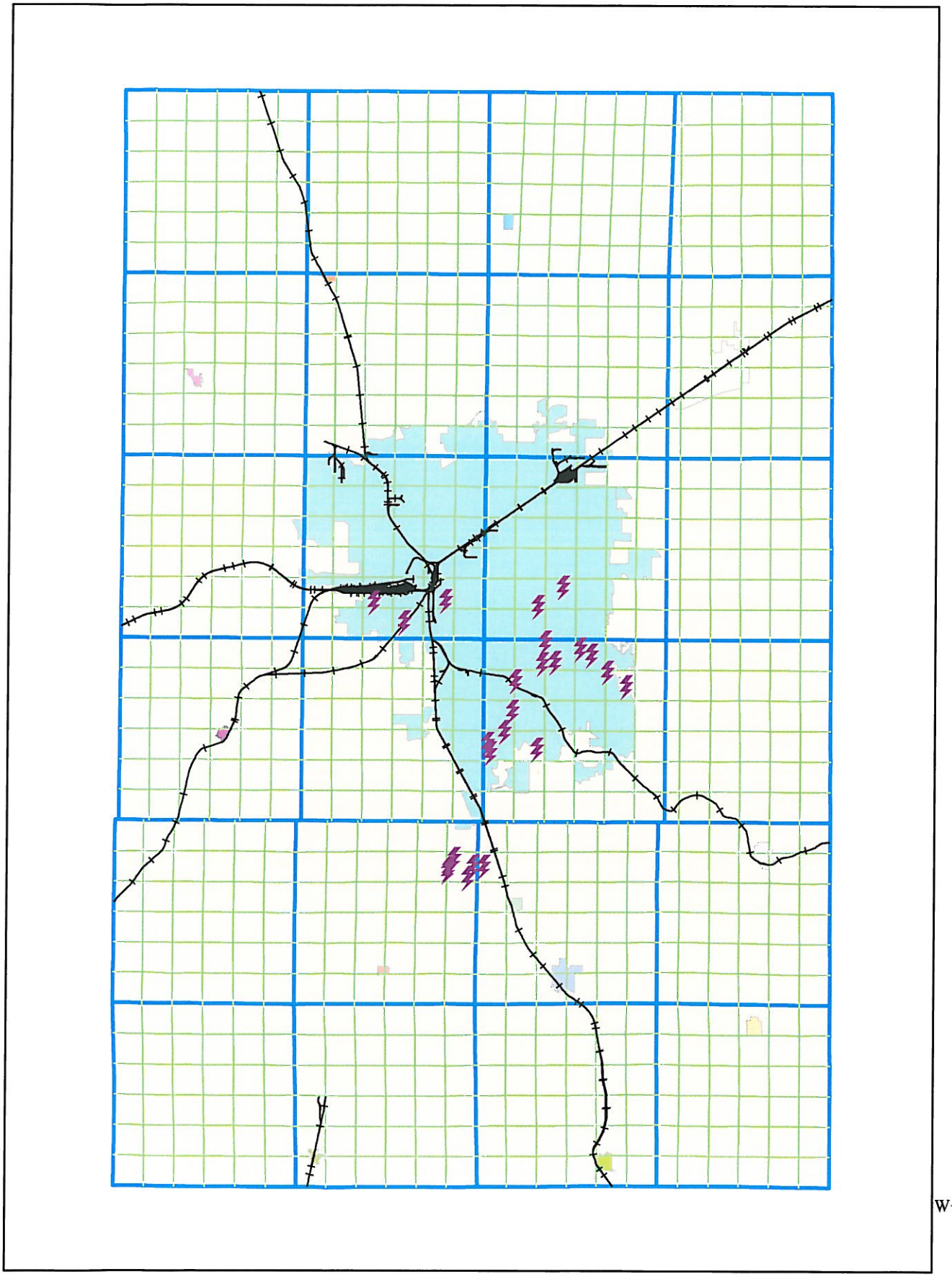
2012 Purple Loosestrife



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2012PurpleLoosestrife

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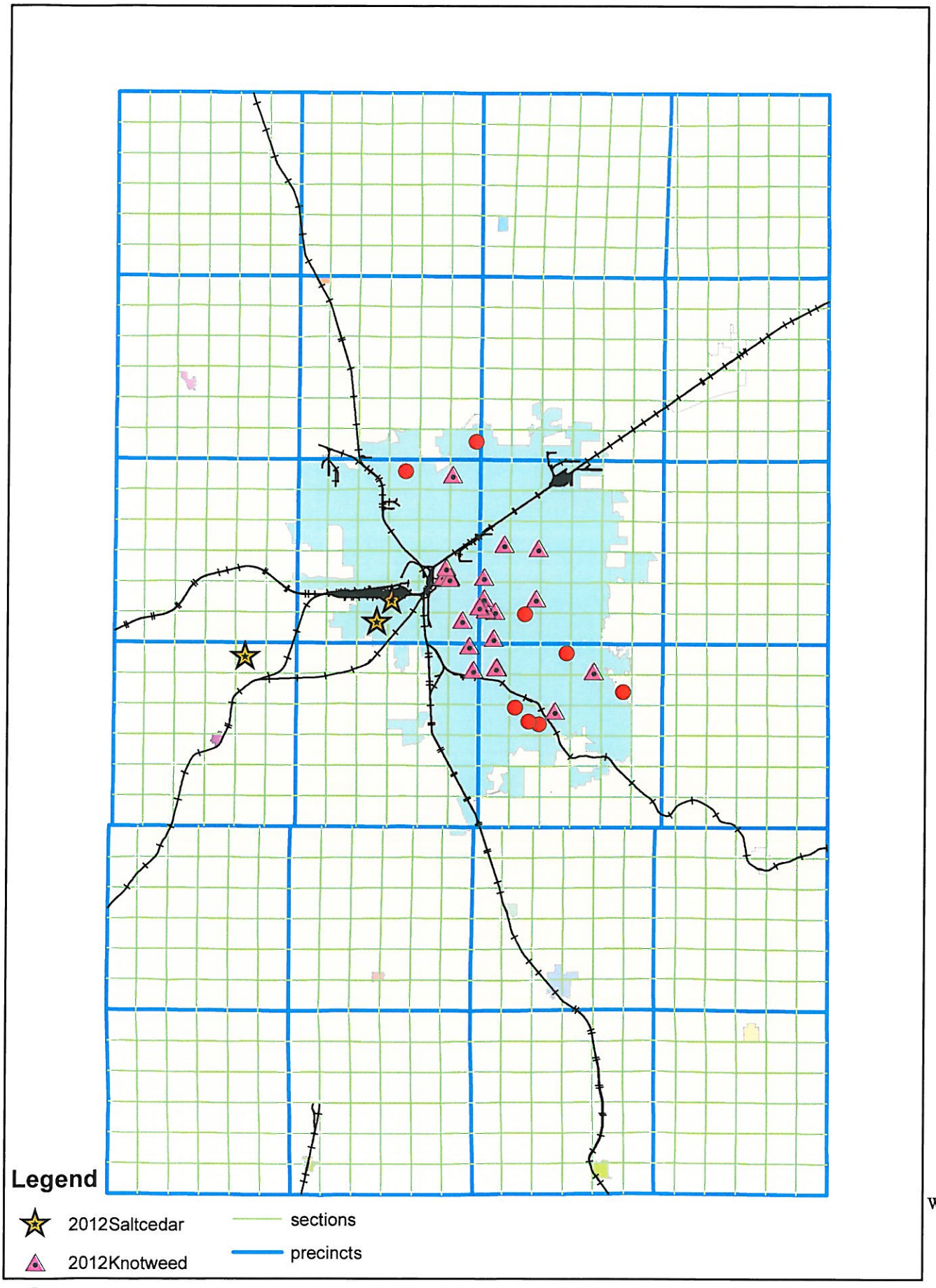
2012 Saltcedar, Knotweed, CanadaThistle



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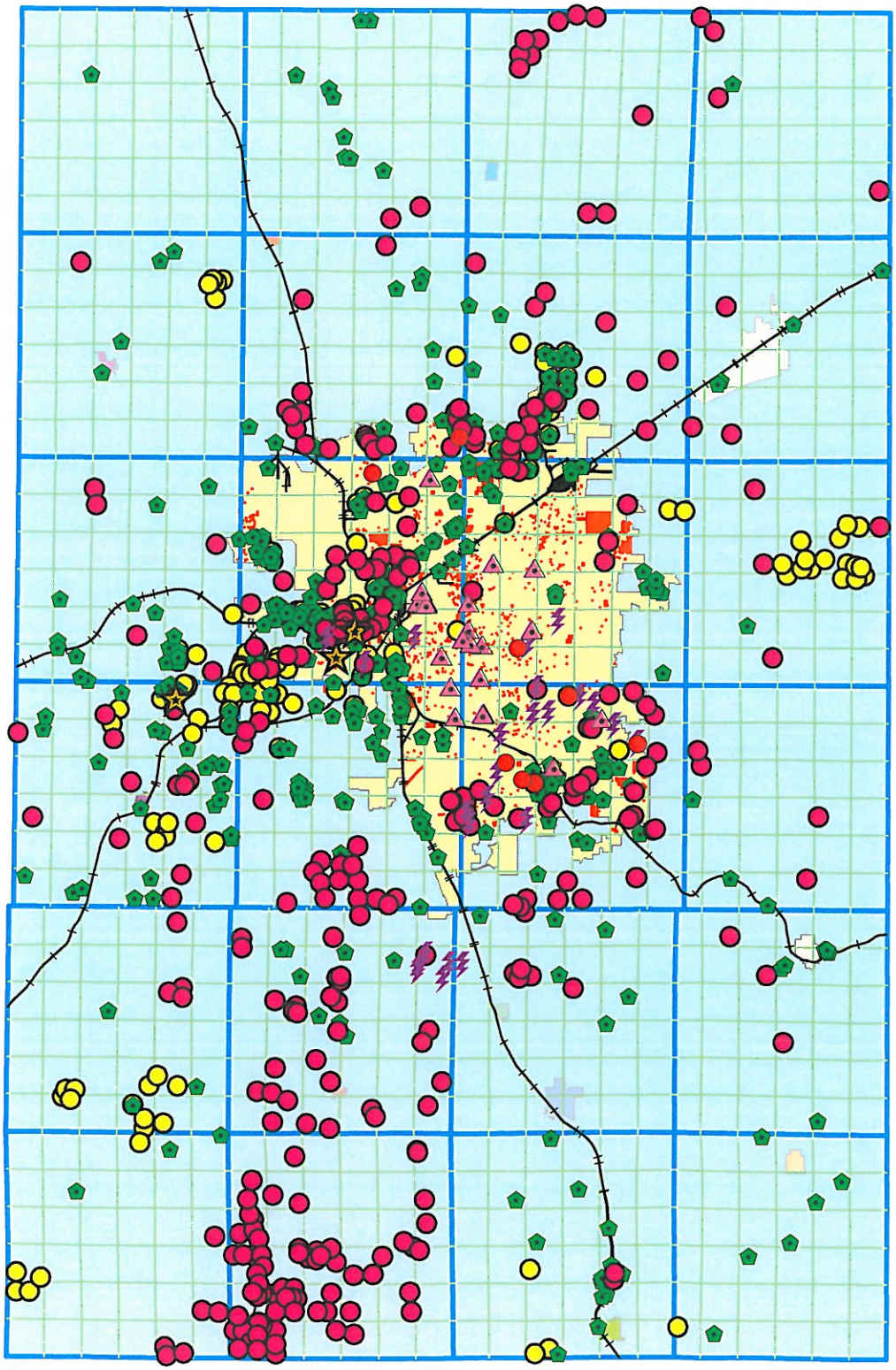
2012 All Weeds



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- 2012WeedAbatement

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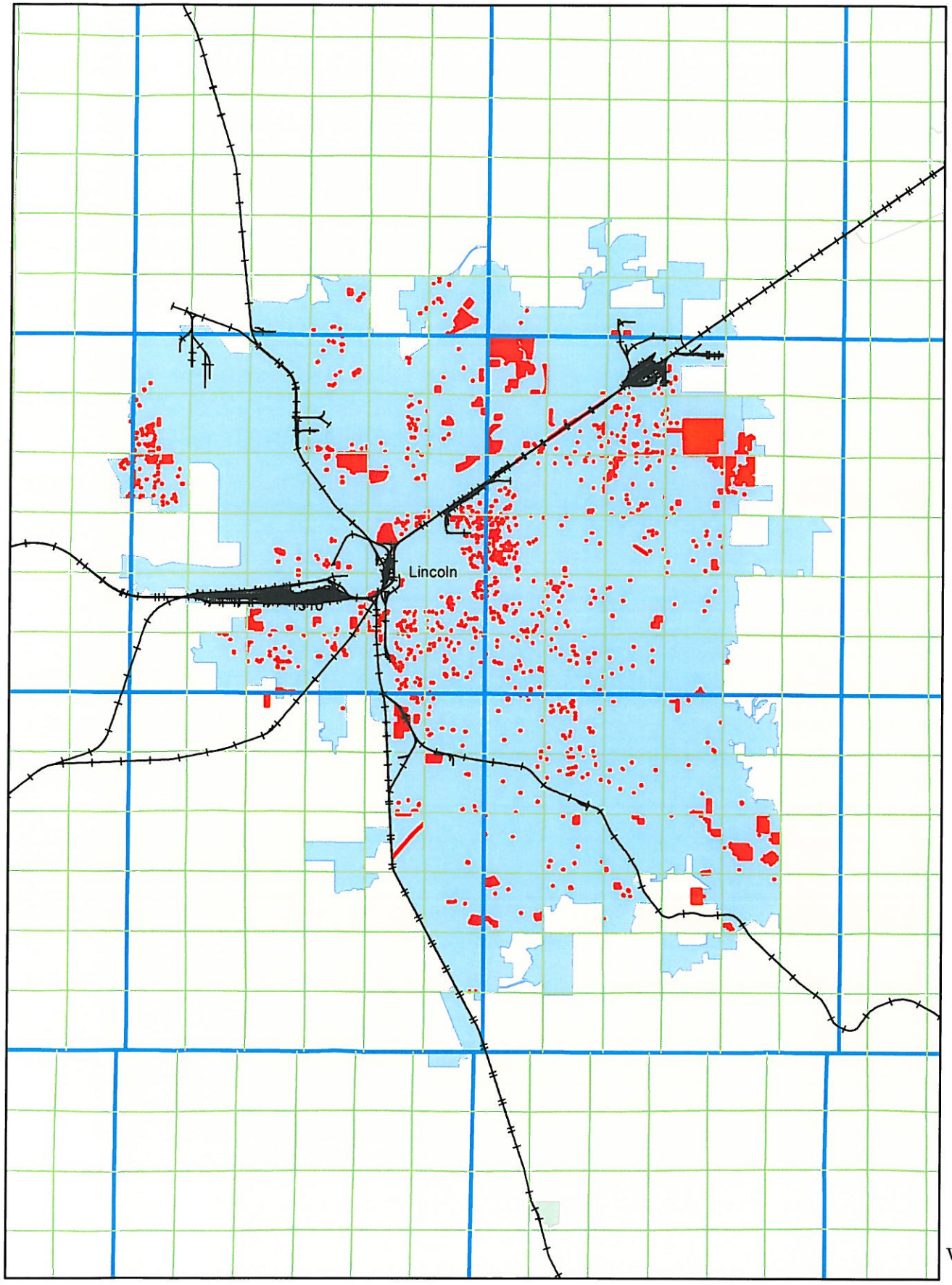
2012 Weed Abatement



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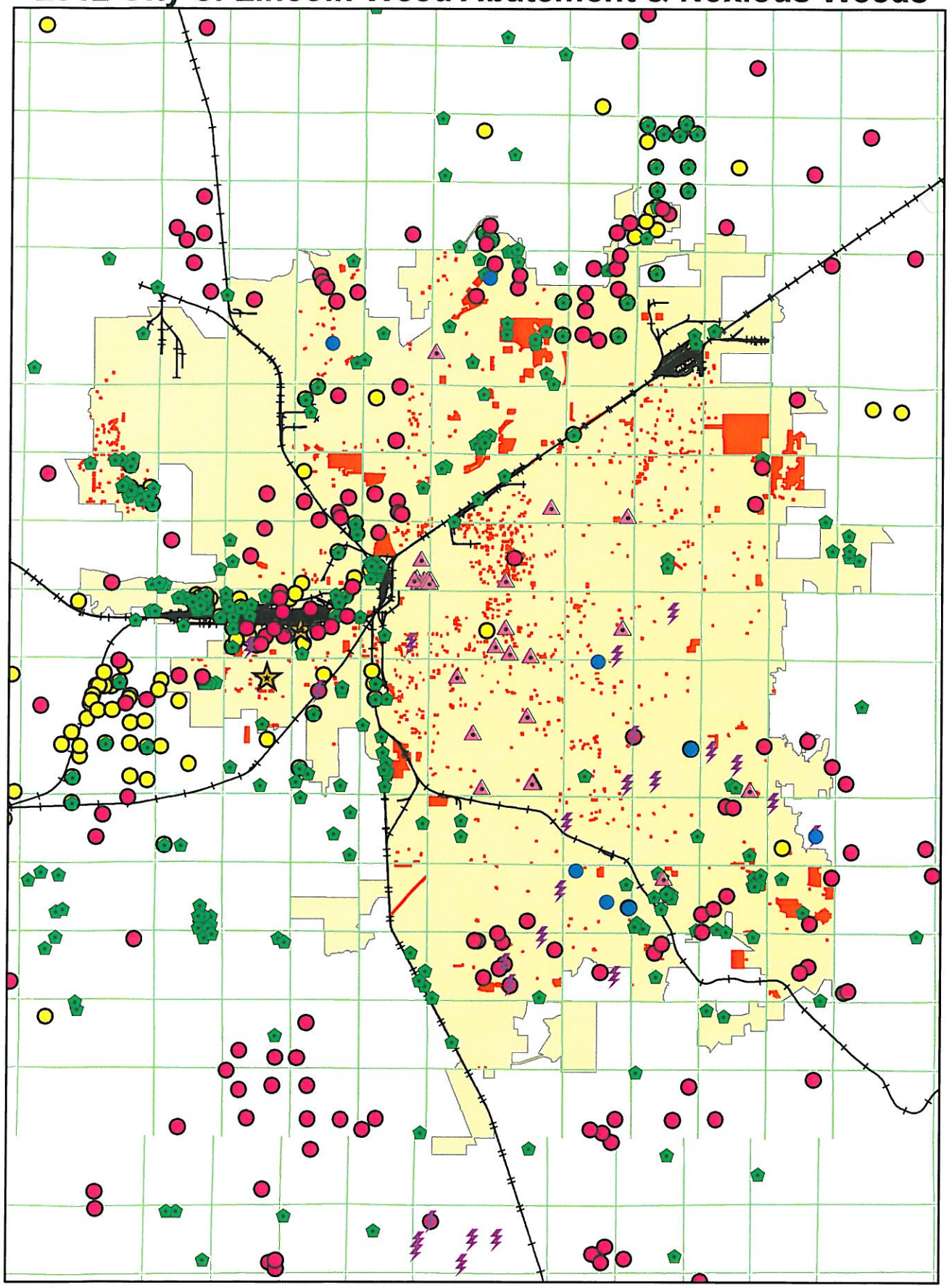
2012 City of Lincoln Weed Abatement & Noxious Weeds



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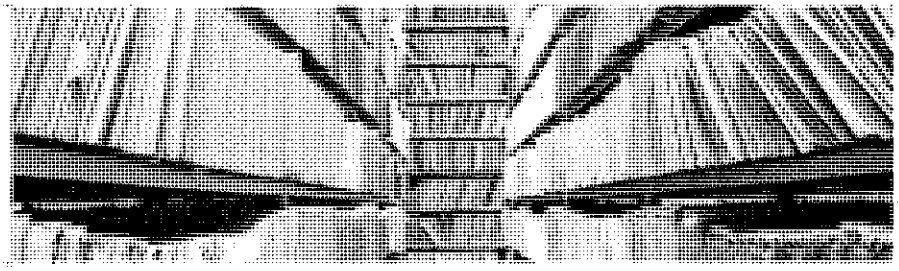

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Nebraska Open Meetings Act

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Nebraska Open Meetings Act

The Nebraska Open Meetings Act guarantees that every meeting of a public body shall be open to the public in order that citizens may exercise their democratic privilege of attending and speaking at meetings of public bodies. The information below details NEB. REV. STAT. §§ 84-1407 TO 84-1414 (2008, Supp 2009)

BASIC PROVISION

The basic statement of our state policy on public meetings is found at Neb. Rev. Stat. § 84-1408. That statute provides, "[i]t is hereby declared to be the policy of this state that the formation of public policy is public business and may not be conducted in secret. Every meeting of a public body shall be open to the public in order that citizens may exercise their democratic privilege of attending and speaking at meetings of public bodies, except as otherwise provided by the Constitution of the State of Nebraska, federal statutes, and the Open Meetings Act."

History. Section 84-1408 was passed as a part of LB 325 in 1975. That bill repealed previously existing public meetings provisions and substituted new provisions which were intended to preserve the features of the previous law and strengthen and expand their authority. Government Committee Statement on LB 325, 84th Nebraska Legislature, First Session (1975). LB 325 was passed to ensure that all meetings of public bodies would be open to the public, except when protection of the public interest clearly called for a closed session concerning specific matters. Id. 2004 Neb. Laws LB 821, § 34 formally established the name of §§ 84-1407 through 84-1414 as the "Open Meetings Act."

Purpose. The Nebraska open meetings laws are a statutory commitment to openness in government. Wasikowski v. The Nebraska Quality Jobs Board, 264 Neb. 403, 648 N.W.2d 756 (2002); Steenblock v. Elkhorn Township Board, 245 Neb. 722, 515 N.W.2d 128 (1994); Grein v. Board of Education of the School District of Fremont, 216 Neb. 158, 343 N.W.2d 718 (1984). Their purpose is to ensure that public policy is formulated at open meetings of the bodies to which the law is applicable. Dossett v. First State Bank, Loomis, NE, 261 Neb. 959, 627 N.W.2d 131 (2001); Marks v. Judicial Nominating Commission for Judge of the County Court of the 20th Judicial District, 236 Neb. 429, 461 N.W.2d 551 (1990); Pokorny v. City of Schuyler, 202 Neb. 334, 275 N.W.2d 281 (1979). In Nebraska, the formation

of public policy is public business, which may not be conducted in secret. Johnson v. Nebraska Environmental Control Council, 2 Neb. App. 263, 509 N.W.2d 21 (Neb. Ct. App. 1993).

Construction. The open meetings laws should be broadly interpreted and liberally construed to obtain their objective of openness in favor of the public. State ex rel. Upper Republican Natural Resources District v. District Judges of the District Court for Chase County, 273 Neb. 148, 728 N.W.2d 275 (2007); State ex rel. Newman v. Columbus Township Board, 15 Neb. App. 656, 735 N.W.2d 399 (Neb. Ct. App. 2007); Alderman v. County of Antelope, 11 Neb. App. 412, 653 N.W.2d 1 (Neb. Ct. App. 2002); Rauert v. School District I-R of Hall County, 251 Neb. 135, 555 N.W.2d 763 (1996); Grein, supra. The beneficiaries of the openness sought by the Open Meetings Act include citizens, members of the general public, and reporters or other representatives of the news media. State ex rel. Newman v. Columbus Township Board, 15 Neb. App. 656, 735 N.W.2d 399 (Neb. Ct. App. 2007).

Exceptions. Section 84-1408 requires open meetings except "as otherwise provided by the Constitution of the State of Nebraska, federal statutes, and the Open Meetings Act." The Attorney General has concluded that the Nebraska Legislature is not covered under the open meetings statutes because the Nebraska Constitution separately provides for public access to that body. Op. Att'y Gen. No. 120 (July 25, 1985).

Subsequent legislative limitations. The Legislature holds the power to decide the scope of citizen access to governmental meetings. As a result, the Legislature has the right to limit access to public meetings and the effect of the Open Meetings Act through later statutory provisions which provide that certain information in the possession of government should remain confidential without exception or limitation. Wasikowski v. The Nebraska Quality Jobs Board, 264 Neb. 403, 648 N.W.2d 756 (2002).

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PUBLIC BODIES WHICH ARE COVERED

Under § 84-1409(1), public bodies covered by the public meetings statutes include: (1) governing bodies of all political subdivisions of the State, (2) governing bodies of all agencies of the executive department of state government created by law, (3) all independent boards, commissions, bureaus, committees, councils, subunits, or any other bodies created pursuant to law, (4) all study or advisory committees of the executive department of the state whether of continuing or limited existence, (5) advisory committees of the governing bodies of political subdivisions, of the governing bodies of agencies of the executive branch of state government, or of independent boards, commissions, etc., and (6) "instrumentalities exercising essentially public functions."

1. History. The initial portion of § 84-1409(1) defining public bodies was originally part of LB 325 passed in 1975. It has been amended several times to add additional entities to the list of bodies covered, and the Certificate of Need Review Committee was removed in 1997. See 1997 Neb. Laws LB 798; 1989 Neb. Laws LB 429 and LB 311; 1983 Neb. Laws LB 43. The language concerning "instrumentalities exercising essentially public functions" was added in 1989 to reach entities such as the Nebraska Investment Finance Authority. Floor Debate on LB 311, 91st Nebraska Legislature, First Session, May 9, 1989, at 6039, 6040.

2. Cases and Opinions. A number of cases and opinions of the Attorney General deal with various aspects of the definitions of public body found in § 84-1409(1).

a. "Political subdivision" is not defined within the public meetings statutes. However, the Attorney General has indicated that generally the term denotes any subdivision of a state which has as its purpose carrying out functions of the state which are inherent necessities of government and which have always been regarded as such by the public. 1979-80 Rep. Att'y Gen. 140 (Opinion No. 98, dated April 25, 1979). Presumably, this term includes cities, counties, villages, etc., and their governing boards are covered by the open meetings law. In Nixon v. Madison County Agricultural Society, 217 Neb. 37, 348 N.W.2d 119 (1984), the Court held that a county agricultural society, organized under the Nebraska statutes, was subject to the provisions of the open meetings law. The Court noted that, although the society at issue resembled a private corporation in some respects, the fact that it had the right to receive support from the public revenue gave it a public character. The agricultural society appareutly was an "independent board . . . created by constitution, statute, or otherwise pursuant to law." Based upon the Nixon case, the Attorney General concluded that county extension services which have the right to receive support from public revenues are subject to the open meetings law. Op. Att'y Gen. No. 219 (July 24, 1984). Also based upon the Nixon case, the Attorney General has indicated that county agricultural societies are subject to the open meetings statutes. Op. Att'y Gen. No. 91007 (January 28, 1991). In addition, Neb. Rev. Stat. § 2-238 requires that result.

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c. In Marks v. Judicial Nominating Commission for Judge of the County Court of the 20th Judicial District, 236 Neb. 429, 461 N.W.2d 551 (1990), the Court held that the open meetings statutes do not apply to the activities of a jndicial nominating commission which is meeting to select nominees for judicial vacancies. Such a nomination procedure does not involve the formulation of public policy subject to the act.

d. The Nebraska Court of Appeals, in Johnson v. Nebraska Environmental Control Council, 2 Neb. App. 263, 509 N.W.2d 21 (Neb. Ct. App. 1993), held that the open meetings statutes apply to the governing bodies of all agencies of the execntive branch of government, including the Nebraska Environmental Control Council.

e. In State ex rel. Newman v. Columbus Township Board, 15 Neb. App. 656, 735 N.W.2d 399 (Neb. Ct. App. 2007), the Nebraska Court of Appeals concluded that the electors of a Nebraska township, when assembled at the township's annual meeting, constitute a governing body of the township which is subject to the Open Meetings Act and its provisions concerning notice and preparation of an agenda.

f. The Nebraska Court of Appeals indicated in Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (Neb. Ct. App. 2009) that a county board of equalization is a public body as defined in § 84-1409. The conrt also held in that case that when two boards are made np of the same members, the duties and functions of the two boards, rather than their membership, determine if they are the same or separate and distinct bodies.

g. Committees of faculty, administration and students created by the Board of Regeuts of the University of Nebraska to advise the Chancellor of the Uuiversity in his administrative/management function with respect to budget cuts were part of the management structure of the University and not public bodies subject to the open meetings statutes. Op. Att'y Gen. No. 92020 (February 12, 1992).

h. In Op. Att'y Gen. No. 11 (January 20, 1983), the Attorney General indicated that the Environmental Control Council is a public body subject to the open meetings law. On the other hand, the Department of Environmental Control is not. Section 84-1409 applies to governing bodies of state agencies, not the agencies themselves.

i. An employee grievance appeal hearing conducted by a hearing officer is not a meeting of a public body since the word "body" is commonly understood to refer to a group or number of persons, and thus does not include an individual conducting a hearing. Op. Att'y Gen. No. 210 (May 16, 1984).

j. In 1989, the Attorney General indicated that the Central Low-Level Radioactive Waste Compact Commission was not subject to the Nebraska open meetings law because it was a multi-state body which was not created by constitution or statute and which was not a governing body of a Nebraska state ageney. Op. Att'y Gen. No. 89008 (February 14, 1989). However, Neb. Rev. Stat. § 71-3521 (the Waste Compact agreement itself) provided that meetings of the Compact Commission must be open to the public with reasonable advance publicized notice, and that the Compact Commission mnst adopt by-laws consistent in scope and principle with the open meetings law of the host state. Section 71-3521 was repealed by 1999 Neb. Laws LB 530, § 2, and Nebraska withdrew from the Central Low-Level Radioactive Waste Compact.

k. A county welfare board is subject to the open meetings law as an independent board created by statute. 1979-80 Rep. Att'y Gen. 351 (Opinion No. 244, dated March 4, 1980).

l. In Op. Att'y Gen. No. 95014 (February 22, 1995), the Attorney General indicated that the Mayor's Citizen Review Board, appointed by the Mayor of Omaha to advise the Mayor with respect to alleged misconduct of police officers, was not subject to the open meetings statutes because it did not fall under the definition found in § 84-1409(1), and because the board was essentially an administrative body which was part of the management structure of tbe City.

m. In Op. Att'y Gen. No. 93065 (July 27, 1993), the Attorney General concluded that parole reviews under Neb. Rev. Stat. § 83-1,111 may be closed, and are not subject to open meetings requirements.

n. The Excellence in Education Council created to make recommendations to the Governor regarding selection of projects for Education Innovation grants is a public body which is subject to the open meetings statutes, and its decisions concerning specific recommendations must be done in open session. Op. Att'y Gen. No. 94092 (November 22, 1994).

o. The Division of Rehabilitation Services of the State Department of Education is a public body, and its business must be conducted in compliance with the provisions of the open meetings statutes. Op. Att'y Gen. No. 93091 (October 22, 1993).

p. The Quality Jobs Board created under the Quality Jobs Act, Neb. Rev. Stat. §§ 77-4901 throngh 77-4935 is a public body snbject to the Open Meetings Act. Op. Att'y Gen. No. 96071 (October 28, 1996).

q. A County Hospital Authority formed under the Hospital Authorities Act, Neb. Rev. Stat. §§ 23-3579 through 23-35,120 is a puhlic body which is subject to the Open Meetings Act. Op. Att'y Gen. No. 97012 (February 14, 1997).

r. The Nebraska State Board of Agriculture (the State Fair Board) is not a public body which is subject to the Open Meetings Act, primarily because it has no statutory right to public revenue and also because of case law which indicates that it is a private corporation. Op. Att'y Gen. No. 01038 (November 27, 2001).

s. A county clerk, county attorney and county treasurer acting as a group under § 32-567 (3) to make an appointment to fill a vacancy on a county board constitute a public body which is subject to the Open Meetings Act. Op. Att'y Gen. No. 97050 (September 18, 1997).

t. The Attorney General has indicated informally that the Nebraska Board of Pardons and the Board of Inquiry and Review created under Neb. Rev. Stat. §§ 80-317 through 80-319 to receive and act upon applications submitted for membership in Nebraska Veterans Homes are subject to the state's open meetings statutes.

3. Other Statutes. Neb. Rev. Stat. § 2-238 requires county agricultural societies and county fair hoards to comply with the open meetings statutes. Under Neb. Rev. Stat. § 85-1502 all coordination activities conducted by the association of community college area boards are subject to the open meetings statutes.

4. Exceptions. The latter portion of § 84-1409(1) provides that two entities are not public bodies for purposes of the Open Meetings Act:

a. Subcommittees. Subcommittees of the various bodies described earlier in § 84-1409 are not public bodies under the Open Meetings Act unless a quorum of the public body attends a subcommittee meeting, or unless those subcommittees are holding hearings, making policy or taking formal action on behalf of the parent body. For example, in Meyer v. Board of Regents of the University of Nebraska, 1 Neb. App. 893, 510 N.W.2d 450 (Neb. Ct. App. 1993), the court indicated that meetings of an executive subcommittee of the University of Nebraska Board of Regents with the University President to discuss his tenure were not subject to the open meetings laws because of that portion of the statute.

i. In City of Elkhorn v. City of Omaha, 272 Neb. 867, 880- 881, 725 N.W.2d 792, 805-806 (2007), the court indicated that, while "subcommittee" is not defined in the Open Meetings Act, a subcommittee is generally a "group within a committee to which the committee may refer business." In addition, "making policy," which subjects a subcommittee to the Open Meetings Act under § 84-1409, apparently includes "receiving background information about a policy issne to be decided." Id. In contrast, "nonquorum gatherings" of members of a puhlic body "intended to obtain information or voice opinions" do not seem to involve violations of the Act. Id.

ii. The language applying the open meetings statutes to certaiu subcommittee meetings when there is a quorum of the public body present was added to § 84-1409(1) as a result of LB 1019 passed by the Legislature during the 1992 regular session.

b. Entities Conducting Judicial Proceedings. Entities conducting judicial proceedings are uot public bodies under the Opeo Meetings Act unless the court or other judicial body is exercising rule making authority, deliberating, or deciding upon the issuance of administrative orders. LB 325, the original open meetings statute of 1975, was directed strictly at policy making bodies which were legislative or quasi-legislative. Floor Debate on LB 325, 84th Nebraska Legislature, First Session, May 14, 1975, at 4618.

i. In McQuinn v. Douglas County School District No. 66, 259 Neb. 720, 612 N.W.2d 198 (2000), the Nebraska Supreme Court held that a hearing before a school board on the question of the nonrenewal of a probationary certificated teacher's contract where the matters before the board pertained solely to disputed adjudicative facts involved a judicial funetion, and on that basis, the hearing was not subject to the open meetings statutes. Iu that context, a school board exercises a judicial function if it decides a dispute of adjudicative fact or if a statute requires it to act in a judicial manner. Adjudicative facts are those ascertained from proof adduced at an evidentiary hearing which relate to a specific party. The McQuinn case is discussed further in Bligh v. Douglas County School District No. 0017, 2008 WL 2231063, 2008 Neb. App. LEXIS 106 (Neb. Ct. App. 2008)(Not approved for publication).

ii. The Attorney General has determined that hearings before various agencies are judicial and not subject to the open meetings law: 1975-76 Rep. Att'y Gen. 127 (Opinion No. 105, dated July 14, 1975)

(hearing before a Conuty Board of Mental Health); Op. Att'y Gen. No. 184 (January 31, 1984) (hearing before the Nebraska Equal Opportunity Commission); Op. Att'y Gen. No. 210 (May 16, 1984) (hearing before a hearing officer appointed by the State Personnel Board); Op. Att'y Gen. No. 02016 (May 21, 2002)(contested case hearing before the Power Review Board on application of electricity suppliers for construction or acquisition of generation facilities); Op. Att'y Gen. No. 05014 (October 19, 2005) (appeal hearing regarding the Nebraska Veterans' Aid Fund before the Nebraska Veterans' Advisory Commission). But, the Attorney General has concluded that a hearing before the Certificate of Need Review Committee is covered by the open meetings statutes. Op. Att'y Gen. No. 87019 (February 13, 1987).

iii. Parole hearings conducted by the Board of Parole are judicial in nature and not subject to the open meetings statutes. However, other statutes specifically pertaining to operation of the Board of Parole require that such parole hearings be coudncted with elements of notice and in a manuer open to the public. Op. Att'y Gen. No. 93065 (July 27, 1993).

iv. When the State Board of Education holds hearings in contested cases under the state Administrative Procedure Act, such hearings are not subject to the Open Meetings Act. The Board is not required to give notice of such hearings to the public under those statutes, and it may conduct its deliberations and decision-making process for such hearings by a telephone conference call. Op. Att'y Gen. No. 99046 (November 15, 1999).

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MEETING DEFINED

Under § 84-1409(2), meetings, for purposes of the open meetings statutes, are defined as "all regular, special, or called meetings, formal or informal, of any public body for the purposes of briefing, discussion of public business, formation of tentative policy, or the taking of any action of the public body." Section 84-1410(5) also provides that the open meetings statutes shall not apply to "chance meetings or to attendauce at or travel to conventions or workshops of members of a public body at which there is no meeting of the body then intentionally convened, if there is no vote or other action taken regarding any matter over which the pnblic body has supervision, control, jurisdiction, or advisory power."

1. The legislative history of LB 325, from 1975, indicates that meetings of a public body do not include social meetings or meetings which were not called by the body. Government Committee Hearing on LB 325, 84th Nebraska Legislature, First Session (1975) at 3.

2. However, § 84-1409 was amended hy LB 43 in 1983 to include "formal or informal" meetings. The legislative history of that bill indicates that a meeting hetween a state senator and the members of a local school board to discuss legislation would constitute an "informal called meeting." Government, Military and Veterans' Affairs Committee Hearing on LB 43, 88th Nebraska Legislature, First Session (1983) 5-8.

3. The provision of § 84-1410(5) pertaining to "chance" meetings, etc., was added by LB 43 in 1983.

4. The legislative history of LB 43 from 1983 indicates that a "meeting" does not occur absent a quorum. Government Military and Veterans' Affairs Committee Hearing ou LB 43, 88th Nebraska Legislature, First Session (1983) at 19. In addition, the Attorney General has concinded that the presence of a majority of the members of a public body is necessary for a meeting to occur. 1975-76 Rep. Att'y Gen. 150 (Opinion No. 116, dated August 29, 1975). In Johnson v. Nebraska Environmental Control Council, 2 Neb. App. 263, 509 N.W.2d 21 (Neb. Ct. App. 1993), the Nebraska Court of Appeals indicated that "private quorum conferences" are an evasion of the law. The Nebraska Supreme Court also indicated that subgroups of the Omaha City Council constituting less than a quorum of that body were not public bodies on that ground. City of Elkhorn v. City of Omaha, 272 Neb. 867, 725 N.W.2d 792 (2007).

5. In Johnson v. Nebraska Environmental Control Council, 2 Neb. App. 263, 509 N.W.2d 21 (Neb. Ct. App. 1993), the Court of Appeals held that informational sessions where the Council heard reports from staff of the Department of Euvironmental Control were briefings which were subject to the requirements of the open meetings statutes. The Court stated that listening and exposing itself to facts, arguments and statements constitutes a crucial part of a governmental body's decision making. As a result, receiving information triggers the requirements of the statutes, and the open meetings law applies to meetings at which briefing or the formation of tentative policy takes place, as well as to meetings where action is contemplated or taken.

6. Rauert v. School District I-R of Hall County, 251 Neb. 135, 555 N.W.2d 763 (1996), involved allegations by the plaintiff that a quorum of the defendant school board met in the office of the

superintendent of schools on a regular basis for "clandestine" meetings before the beginning of most scheduled board meetings where business was discussed and decided and checks were signed to pay claims which had not been approved in public session. The board then allegedly moved and voted on business at its public meeting with little or no discussion in order to deprive the public of the right to be fully informed. The Supreme Court held that the District Court properly failed to find a violation of the Open Meetings Act with respect to those allegations in the absence of any evidence as to the specific dates and details of the alleged "clandestine" meetings.

7. The Attorney General has indicated that an "emergency meeting" may be conducted by electronic and telecommunications equipment including radio and telephone conferences. 1975-76 Rep. Att'y Gen. 150 (Opinion No. 116, dated August 29, 1975). On the other hand, the open meetings statutes do not generally authorize the use of telephone conference calls for non-emergency meetings of a public body, and absent members of a public body may not be counted to achieve a quorum through the use of a conference call. Op. Att'y Gen. No. 92019 (February 11, 1992). [Section 84-1411 has been amended a number of times to allow specified public bodies including the governing body of an entity formed under the Interlocal Cooperation Act, the Joint Public Agency Act or the Municipal Cooperative Financing Act, the board of an educational service unit, or the governing body of a risk management pool or its advisnry committees organized in accordance with the Intergovernmental Risk Management Act to meet by telephone conference call in certain circumstances. See 1999 Neb. Laws LB 461; 2000 Neb. Laws LB 968; 2007 Neb. Laws LB 199; 2009 Neb. Laws LB 361.]

8. An "informational and educational" meeting of a public body governing a political subdivision where members generally discuss matters pertaining to their subdivision, hear reports from various department heads of the subdivision as to their duties and learn the workings of the subdivision is a meeting of the public body for "briefing" purposes which is subject to the open meetings statutes. Op. Att'y Gen. No. 92043 (March 17, 1992). In addition, the Attorney General has also indicated informally that a meeting of a public body "for the purpose of receiving training or doing planning (such as a retreat)" should probably be treated as subject to the Open Meetings Act.

9. In Op. Att'y Gen. No. 94035 (May 11, 1994), the Attorney General indicated that discussions and deliberations by the State Board of Education in connection with the selection of a Commissioner of Education were subject to the reqnirements of the open meetings statutes. In additinn, that opinion indicated that interviews with individual candidates for the Commissioner position were also subject to the requirements of the open meetings statutes, if a quorum of the Board was present for those interviews. However, in the latter interview situation, a brief closed session (as discussed below) might be warranted for a candid discussion by the Board and the candidate which might potentially elicit responses injurions to the reputation of an individual.

10. A workshop held by the Board of Regents of the University of Nebraska with a professional facilitator to discuss commuuicatiou practices and the roles of the Board aud the University President was not subject to the Open Meetings Act on the basis of § 84-1410 (5) which exempts chance meetings or attendance at or travel to conventions or workshops. The University also asserted that there wonld be no briefing, discussion of public business, formation of tentative policy, vote, or taking of other action at the workshop. Op. Att'y Gen. No. 04027 (October 20, 2004).

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PUBLIC MEETINGS BY VIDEOCONFERENCING AND TELEPHONE CONFERENCE CALL

Section 84-1411 allows certain public bodies to meet by videoconferencing and by telephone conference call.

1. Videoconferencing. Section 84-1411 was first amended hy LB 635 in 1993 to allow meetings of certain public bodies by means of videoconferencing. Under the current amended § 84-1411(2), public bodies which are allowed to meet by videoconferencing include: (1) varions bodies of state goverument including state agencies, boards, commissions, councils and committees, together with their advisory committees; (2) organizations created under the Interlocal Cooperation Act, the Joint Public Agency Act or the Municipal Cooperative Financing Act; (3) governing bodies of public power districts with chartered territories of more than 50 counties in this state; (4) boards of educational service units; and (5) the governing body of a risk management pool or its advisory committees organized in accordance with the Intergovernmental Risk Management Act.

a. The public bodies listed above may hold meetings by videoconferencing if the following requirements are met: (1) reasonable advance publicized notice is given, (2) reasonable arrangements are made to accommodate the public's right to attend, hear and speak at the meeting, including seating, recording by audio and visual recording devices, and an reasonable opportunity for input such as public comment or questions to at least the same extent as would be provided absent

videoconferencing, (3) at least one copy of all documents being considered is available to the public at each site of the videoconference, (4) at least one member of the public body is present at each site of the videoconference, and (5) no more than one-half of the public body's meetings in a calendar year are held by videoconferencing.

b. Under an amended § 84-1409(3), videoconferencing is defined as "conducting a meeting involving participants at two or more locations through the use of audio-video equipment which allows participants at each location to hear and see each meeting participant at each other location, including public input. Interaction between meeting participants shall be possible at all meeting locations."

c. Under § 84-1411(6) a public body may allow a member of the public or any other witness other than a member of the public body to appear before the public body by means of video or telecommunications equipment.

d. 1999 Neb. Laws LB 87, § 100 added organizations created under the Joint Public Agency Act to the list of entities permitted to conduct meetings by videoconferencing. 2009 Neb. Laws LB 361 added the boards of educational service units to the list.

2. Telephone Conference Call. Section 84-1411 was also amended by a number of legislative bills over time (1999 Neb. Laws LB 461; 2000 Neb. Laws LB 968; 2007 Neb. Laws LB 199, 2009 Neb. Laws LB 361) to allow the governing body of an entity formed under the Interlocal Cooperation Act, the Joint Public Agency Act or the Municipal Cooperative Financing Act, the board of an educational service unit, or the governing body of a risk management pool or its advisory committees organized in accordance with the Intergovernmental Risk Management Act to meet by telephone conference call if: (1) the territory represented by the educational service unit or the member public agencies of the entity or pool covers more than one county, (2) reasonable advance publicized notice is given which identifies each telephone conference location at which an educational service unit board member or member of the entity's or pool's governing body will be present, (3) all telephone conference meeting sites identified in the notice are located within public buildings used by members of the educational service unit board or of the entity or pool or at a place which will accommodate the anticipated audience, (4) reasonable arrangements are made to accommodate the public's right to attend, hear, and speak at the meeting, including seating, recordation by audio recording devices, and a reasonable opportunity for input such as public comment or questions to at least the same extent as would be provided if a telephone conference call was not used, (5) at least one copy of all documents being considered is available to the public at each site of the telephone conference call, (6) at least one member of the educational service unit board or of the governing body of the entity or pool is present at each site of the telephone conference call identified in the public notice, (7) the telephone conference call lasts no more than one hour and (8) no more than one-half of the board's, entity's or pool's meetings in a calendar year are held by telephone conference call, except that a governing body of a risk management pool that meets at least quarterly and the advisory committees of the governing body may each hold more than one-half of its meetings by telephone conference call if the governing body's quarterly meetings are not held by telephone conference call or videoconferencing. Nothing in this section dealing with telephone conference calls prevents the participation in the call by consultants, members of the press, and other nonmembers of the governing body at sites not identified in the public notice. These telephone conference calls may not be used to circumvent any of the public government purposes established in the Open Meetings Act.

a. 1999 Neb. Laws LB 47, § 2 also amended § 84-1411 (2) to provide that certain meetings of the Judicial Resources Commission may be held by telephone conference if the criteria for videoconferencing listed above are met.

3. Circumvention of Open Meetings Act. Under § 84-1411, videoconferencing, telephone conferencing or conferencing by other electronic communication may not be used to circumvent any of the public government purposes established by the Open Meetings Act. Neither may emails, faxes, or other electronic communications be used for such purposes.

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PUBLIC MEETINGS; NOTICE REQUIRED AND AGENDA

Section 84-1411 sets out several requirements for the notice which must be given for a public meeting and for the agenda which must be prepared: (1) the public body must give reasonable advance publicized notice of the time and place of each meeting by a method designated by the body and recorded in its minutes, (2) that notice must be transmitted to all members of the body and to the public, (3) the notice must contain an agenda of subjects known at the time of the publicized notice, or a statement that such an agenda, which must be kept continually current, is readily available for inspection at the principal office of the public body during normal business hours.

1. Agenda. Under § 84-1411(1), an agenda maintained at the office of a public body for public inspection must be kept continually current and may not be altered later than 24 hours before the scheduled commencement of the public meeting (or 48 hours before commencement of a meeting of a city council if that meeting is noticed outside the corporate limits of the municipality). A public body may modify an agenda to include items of an emergency nature only at such public meeting.

2. Specificity of the Agenda . LB 898 from 2006 added language to § 84-1411 (1) which states that agenda items shall be "sufficiently descriptive to give the public reasonable notice of the matters to be considered at the meeting." That statutory change arose out of a sense that lack of specificity in meeting agendas was a major issue of concern around the state. Government Military and Veterans' Affairs Committee Hearing on LB 898, 99th Nebraska Legislature, Second Session (2006) at 19. The intent of the change was to require public bodies to include sufficient detail in their agendas regarding issues to be discussed or acted upon so as to provide information and notice to the public. Floor Debate on LB 898, 99th Nebraska Legislature, Second Session, March 28, 2006 at 11701 (Statement of Senator Preister). The change was also intended to require sufficient detail in an agenda so that members of the public are not forced to look at past agendas in order to understand the issue to be discussed and/or the action to be taken. Id.

3. News Media. Section 84-1411(4) requires that the secretary or other designee of each public body shall maintain a list of news media requesting notification of meetings and shall make reasonable efforts to provide advance notification to that list of media of the time and place of each meeting and the subjects to be discussed at that meeting.

4. History. The provision of § 84-1411 which prohibits altering an agenda within 24 hours of a meeting was added in 1983 to prevent addition of last minute matters to an agenda which did not really represent emergencies. Floor Debate on LB 43, 88th Nebraska Legislature, First Session, March 22, 1983, at 1896.

5. In Rauert v. School District I-R of Hall County, 251 Neb. 135, 555 N.W.2d 763 (1996), the court stated that the Open Meetings Act requires public bodies to give reasonable advance publicized notice of the time and place of their meetings, in part so that the public may attend and speak at those meetings.

6. The Legislature has imposed only two conditions on public bodies regarding the method of notification for their meetings: 1. the public body must give reasonable advance publicized notice of the time and place of each meeting, and 2. the method of notification must be recorded in the public body's minutes. City of Elkhorn v. City of Omaha, 272 Neb. 867, 725 N.W.2d 792 (2007). There is no minimum time period for public notification of a special meeting, and an agenda for a public meeting can be created (not altered) later than 24 hours before the scheduled meeting. Id. In the City of Elkhorn case, the court held that notice of a meeting of the Omaha City Council posted and placed on the city's website at 10:15 a.m. for a meeting at 10:00 p.m. the same day was sufficient under the facts of the case where the local newspaper printed an article about the meeting in its afternoon edition and four television broadcasters were present at the meeting. The court also indicated that any defect in notice intended for the benefit of council members would not invalidate a council meeting when all of the members of the council attended without objection.

7. The purpose of the agenda requirement is to give some notice of the matters to be considered at the meeting so that persons who are interested will know which matters are under consideration. State ex rel. Newman v. Columbus Township Board, 15 Neb. App. 656, 735 N.W.2d 399 (Neb. Ct. App. 2007); Pokorny v. City of Schuyler, 202 Neb. 334, 275 N.W.2d 281 (1979). In Pokorny, the agenda at issue, considered with all the previous records of the city council involved, was sufficient to satisfy the open meetings statutes. Pokorny also indicates that posting notice at 10 p.m. on March 15 before a meeting at 10:30 a.m. on March 16 does not constitute reasonable notice. Posting notice one week ahead does.

8. In Hansmeyer v. Nebraska Public Power District, 6 Neb. App. 889, 578 N.W.2d 476 (1998), aff'd, 256 Neb. 1, 588 N.W.2d 589 (1999), the Court of Appeals considered whether an agenda item which simply stated "Work Order Reports" was sufficient to give adequate public notice of a decision to approve a work order which involved expenditure of over $47 million for the construction of a 96-mile power transmission line across privately held property to connect two power substations. The Court held that the agenda item was insufficient under the Open Meetings Act. The court also seemed to suggest, based upon the Pokorny case, that the sufficiency of an agenda item might by measured, at least to some degree, in the context of the other meetings of the public body immediately prior to the public meeting in question.

9. A member of the public should not be required to hunt up and read the documents underlying an agenda of a public body to determine what is actually on that agenda. Hansmeyer v. Nebraska Public Power District, 6 Neb. App. 889, 578 N.W.2d 476 (1998), aff'd, 256 Neb. 1, 588 N.W.2d 589 (1999).

10. If a public body uses or publishes its agenda to give the required notice for a particular meeting, then the notice contained in the agenda must comport with the law for giving notice of what is to be considered at the meeting. Hansmeyer v. Nebraska Public Power District, 6 Neb. App. 889, 578 N.W.2d 476 (1998), aff'd, 256 Neb. 1, 588 N.W.2d 589 (1999).

11. A notice of a hearing, given by a school board, which stated that a hearing would be held, and that an agenda would be available for inspection, once established, is not proper notice. An agenda must be available. Allen v. Greeley County School District No 501, 1994 WL 272223, 1994 Neb. App. LEXIS 186 (Neb. Ct. App. 1994)(Not approved for publication)

12. When governmental subdivisions which hold annual meetings, such as townships, conduct their annual meeting, electors who participate in the annual meeting must place matters which they wish to discuss on the agenda for the annual meeting. State ex rel. Newman v. Columbus Township Board, 15 Neb. App. 656, 735 N.W.2d 399 (Neb. Ct. App. 2007). Electors under those circumstances may not simply appear at the annual meeting and bring up any subject falling within the broad powers of electors if that subject is not on the agenda. Id.

13. Two separate public bodies may publish notice of their meetings on the same sheet of paper and need not use separate sheets when the notices contain only the time and place of their meetings, and when the notices direct interested citizens to the place where agendas for each body may be found. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (Neb. Ct. App. 2009). In addition, two separate public bodies may combine their agendas when the combined agendas make it clear which items are to be addressed by each body. Id. The same rule applies to combined minutes. Id. The Wolf case involved a situation where a county board met both as a county board and as a county board of equalization.

14. Placing notice of future meetings in minutes of a prior meeting does not give sufficient notice under the Open Meetings Act. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (Neb. Ct. App. 2009).

15. Notice of recessed or reconvened meetings of a public body must be given in the same fashion as notice of the original meeting. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (Neb. Ct. App. 2009).

16. The Attorney General has concluded that "advance publicized notice" means a separate, specific advance notice must be given for each meeting. 1971-72 Rep. Att'y Gen. 314 (Opinion No. 137, dated August 8, 1972).

17. The Attorney General has also determined that: (1) an agenda may not be used as the minutes of a meeting, (2) reasonable notice under the statute means notice reasonably calculated to give appropriate notice to citizens of the time and place of a meeting and notice which complies with the formal requirements of the statute. 1975-76 Rep. Att'y Gen. 150 (Opinion No. 116, dated August 29, 1975).

18. In Op. Att'y Gen. No. 96071 (October 28, 1996), the Attorney General indicated that the Quality Jobs Board should give its normal 10-day published notice of meeting rather than an "informal" notice where the Board had recessed a previous meeting on a tax credit application pending a renewed meeting call from the Governor after issuance of an opinion from the Attorney General.

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EMERGENCY MEETINGS

Section 84-1411(5) allows public bodies to hold emergency meetings without reasonable advance public notice. There are several statutory requirements with respect to such emergency meetings: (1) the nature of the emergency shall be stated in the minutes, and any formal action taken shall pertain only to the emergency, (2) the provisions of § 84-1411(4) dealing with notice to the media shall be complied with in connection with an emergency meeting, (3) complete minutes of the emergency meeting specifying the nature of the emergency and any formal action taken at the meeting shall be made available to the public no later than the end of the next regular business day.

1. Under § 84-1411(5), emergency meetings may be held by electronic or telecommunications equipment.

2. In Steenblock v. Elkhorn Township Board, 245 Neb. 722, 515 N.W.2d 128 (1994), the Court indicated, in a case involving allegations of a violation of the open meetings statutes, that an emergency is defined as "any event or occasional combination of circumstances which calls for immediate action or remedy; pressing necessity; exigency; a sudden or unexpected happening; an unforeseen occurrence or condition." In that case, the Court held that a township board meeting to consider the job status of a township employee, convened as an emergency meeting because of a

snowstorm, was not a proper emergency meeting because the employee was given two week's notice of his resultant termination, and because the reasons given for the employee's termination were based upon his past performance.

3. In Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (Neb. Ct. App. 2009) the Court of Appeals considered whether a number of items taken up at meetings of a county board without any listing on the board's agenda were "emergency" items. In making that determination in each case, the court focused upon whether there was anything in the record which indicated that a particular item required immediate action or involved pressing necessity.

3. The Attorney General has also stated that an item of an emergency nature is one that requires immediate resolution by the public body, and one which has arisen in circumstances impossible to anticipate at a time sufficient to place on the agenda of a regular, called, or special meeting of the body. 1975-76 Rep. Att'y Gen. 150 (Opinion No. 116, dated August 29, 1975).

4. In Op. Att'y Gen. No. 95063 (August 9, 1995), the Attoruey General indicated that action taken during a meeting of the Nebraska Equal Opportunity Commission by a telephone conference call which did not comply with the requirements of the open meetings statutes for emergency meetings was

void.

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PUBLIC MEETINGS; MINUTES AND VOTING PROCEDURES

Section 84-1413 contains several provisions regarding the minutes which are to be maintained by pnblic bodies and regarding voting procedures for public bodies.

1. Minutes. Every public body shall keep minntes of all meetings showing the time, place, members present and absent, and the substance of all matters discussed. The minutes of all meetings and evidence or documentation received or disclosed during open session shall be public records, open to public inspection during normal business hours. Minutes shall be written aud available for inspection within 10 working days or prior to the next convened meeting, whichever occurs earlier, except that cities of the secoud class and villages may have an additional 10 working days if the employee responsible for writing the minntes is absent due to a serious illness or emergency.

2. Voting procedures. Any action taken on any question or motion duly made and seconded shall be by roll call vote of the public body in open session, and the record shall state how each memher voted or if the member was absent or not voting. The vote to elect leadership within a public body may be by secret ballot, but the total number of votes for each candidate shall be recorded in the minutes.

a. Electronic Voting Devices. The roll call or viva voce vote requirements of the Open Meetings Act may be satisfied by a municipality, a county, a learning community, a joint entity created pursnant to the Interlocal Cooperation Act, a joint public agency created pursuant to the Joint Public Agency Act or an agency formed under the Municipal Cooperative Financing Act which uses an electronic voting device which allows the vote of each member of the governing body to be readily seen. The governing hodies permitted to use electronic voting devices was broadened by 2009 Neb. Laws. LB 361.

3. In State ex rel. Schuler v. Dnnbar, 208 Neb. 69, 302 N.W.2d 674 (1984), the Supreme Conrt held that the requirement of § 84-1413(2) that the record shall state how each member of a body voted could not be satisfied by a nunc pro tunc amendment to the body's minutes showing that the recording of the vote in the minntes was performed prior to the time the actual recording in the minutes took place. However, when the same case was before the court a second time, the court held that, as a general rule, a public body may, if no intervening rights of a third person have arisen, order the minutes of its own proceedings at a previous meeting to be corrected according to the facts to make them speak the truth. State ex rel. Schuler v. Dunbar, 214 Neb. 85, 333 N.W.2d 652 (1983).

4. Section 84-1413 is violated by a failure to make or take a vote in accordance with the statute rather than a failure to record a properly taken vote. State ex rel. Schuler v. Dunbar (1983), supra.

5. Section 84-1413(2) dealing with roll call votes does not require the record to state that the vote was by roll call but only requires that the record show if and how each member voted. Neither does that statute set a time limit for recording the resnlts of a vote. State ex rel. Schuler v. Dunbar (1983), supra.

6. The statutory requirements here dealing with voting and minutes are mandatory since the Legislature provided that action taken in violation of this statute is void. State ex rel. Schuler v. Dunbar (1981), supra.

7. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (Neb. Ct. App. 2009) seems to indicate that the Open Meetings Act does not require that minutes of meetings be "published," but only that they be written and available for inspection within 10 working days or prior to the next convened meeting of the public body.

8. The legislative history of the original open meetings statutes, LB 325 from 1975, indicates that the requirement of a roll call vote was directed at votes on questions that would bind the particular public body. Other procedural questions were not covered. Government Committee Hearing on LB 325, 84th Nebraska Legislature, First Session, (1975) at 10.

9. The Attorney General has stated that nothing in the open meetings statutes requires approval of the minutes of a public body prior to their publication. Op. Att'y Gen. No. 162 (December 28, 1981).

10. In Op. Att'y Gen. No. 98045 (November 4, 1998), the Attorney General indicated that detailed minutes of all matters discussed need not be maintained when a public body is meeting in closed or executive session, so long as the requirements of § 84-1410 pertaining specifically to the minute entries necessary for a closed session are met.

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PUBLIC MEETINGS; RIGHTS OF THE PUBLIC ATTENDING

Section 84-1412 establishes the rights of members of the public attending a meeting of a public body.

1. Members of the public have the right to attend and the right to speak at meetings of public bodies, and all or any part of a public meeting except closed sessions under § 84-1410, may be videotaped, recorded, televised, broadcast, photographed, etc. by any person.

2. Public bodies may make and enforce reasonable rules and regulations regarding the conduct of persons attending, speaking at, videotaping, or recording their meetings. A public body is not required to allow citizens to speak at each meeting, but it may not forbid public participation at all meetings.

3. Members of the public cannot be required to identify themselves as a condition for admission to a public meeting. The public body may require persons desiring to address the body to identify themselves.

4. No public body shall, to circumvent the open meetings laws, hold its meeting in a place known to be too small to accommodate the anticipated audience. However, a public body shall not he in violation of this prohibition if it meets in its traditional meeting place in this state.

5. LB 898 from 2006 added language to § 84-1412 which provides that public bodies shall make available at least one current copy of the Open Meetings Act posted in the meeting room at a location accessible to members of the public. At the beginning of any meeting, the public shall be informed abont the location of the posted information. The legislative history of LB 898 indicates that "posting" a copy of the Open Meetings Act means putting it up in some fashion, including attaching it to a bnlletin board, hanging it by a chain or fastening it to a wall. Floor Debate on LB 898, 99th Nehraska Legislature, Second Session, March 28, 2006 at 11697 (Statement of Senator Preister). "Posting" does not include placing the Act on a table as a loose document which can be removed and therefore might not be available throughout the meeting. Id. If a meeting of a public body is moved to another location to accommodate a larger andience, then the posted copy of the act should be moved and posted in the new location. Id.

6. In 2008, LB 962 amended § 84-1412 to provide that public bodies may not require that "the name of any member of the public be placed on the agenda prior to . . . [a] meeting in order to speak abont items on the agenda." That change was made so that members of the public are not required to place themselves on the agenda of a public body prior to a meeting in order to speak on agenda items during the times at that meeting set aside for public comment. Floor Debate on LB 962, 100th Nebraska Legislature, Second Session, February 28, 2008 at 2 (Statement of Senator Preister). That change in statutory language was not intended to affect the right of a public body to make reasonable rules and regulations regarding the condnct of persons attending, speaking at, videotaping, or recording its meetings. Id.

7. A public body may hold a meeting ontside the State of Nebraska ouly if all the following conditions are met: a. a member entity of the public body is located outside of the state and the meeting is in that member's jurisdiction, b. all out-of-state locations identified in the notice of meeting are located within public buildings used by members of the entity or at a place which will accommodate the anticipated audience, c. reasonable arrangements are made to accommodate the public's rights to attend, hear and

speak at the meeting, including making a telephone conference call available at an instate location to members, the public, or the press, if requested twenty-four hours in advance, d. no more than 25% of the public body's meetings in a calendar year are held out-of-state, e. out-of-state meetings are not used to circumvent any of the public government purposes established by the Open Meetings Act, f. reasonable arrangements are made to provide viewing at other instate locations for a videoconference meeting if requested fourteen days in advance and if economically and reasonably available in the area, and g. the public body publishes notice of the out-of-state meeting at least 21 days before the date of the meeting in a legal newspaper of statewide circulation. These requirements for out-of-state meetings were added to § 84-1412 by 2001 Neb. Laws. LB 250, § 2.

8. A public body shall, upon request, make a reasonable effort to accommodate the pnhlic's right to hear discussion and testimony at a public meeting. Public bodies shall make at least one copy of reproducible written material discussed at an open meeting available at the meeting or at the instate location for a telephone conference call or video conference for examination and copying by members of the public.

9. History. Many of the initial provisions in § 84-1412 dealing with the rights of the public were added as a result of LB 43 in 1983.

10. The language requiring a reasonable effort to allow all parties to hear a public meeting does not involve an absolute requirement that all persons present shall be able to hear. Floor Debate on LB 43, 88th Nebraska Legislature, First Session, March 21, 1983, at 1794-1795.

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CLOSED SESSIONS OF A PUBLIC BODY

Section 84-1410, pertaining to closed sessions of public body, has generated the most controversy of all the portions of the open meetings statutes. Section 84-1410(1) provides that any public body may hold a closed session by the affirmative vote of a majority of its voting members if a closed session is clearly necessary (1) for the protection of the public interest, or (2) for the prevention of needless injury to an individual, if such individual has not reqnested a public meeting. Closed meetings may not be held for discussion of the appointment or election of a new member to any public body. Nothiug in ' 84-1410 should be construed to require that any meeting be closed to the public.

1. Under § 84-1410(1), examples of reasons for a closed session include:

a. Strategy sessions with respect to collective bargaiuing, real estate purchases, pending litigation, or litigation which is imminent as evidenced by communication of a claim or threat of litigation to or by the public body.

b. Discussion regarding deployment of security persounel or devices.

c. Investigative proceedings regarding allegations of criminal misconduct.

d. Evaluation of the job performance of a person when necessary to prevent needless injury to the reputation of a person and if such person has not reqnested a public meeting.

These examples are not exclnsive; they are merely examples, and other reasons may exist. Goverument Committee Hearing on LB 325, 84th Nebraska Legislature, First Session (1975) at page 3; 1975-76 Rep. Att'y Gen. 150 (Opinion No. 116, dated August 29, 1975); Op. Att'y Gen. No. 65 (April 17, 1985).

2. LB 898 from 2006 amended some of the provisions of § 84-1410 pertaining to the mechanics of holding a closed session. The subject matter of the closed session and reason necessitating the closed session shall be identified in the motion to hold a closed session. The vote to hold a closed session must be taken in open session, and the entire closed session motion, the vote of each member on the question of holding a closed session, and the time when the closed session commences and ends mnst be recorded in the minntes. If the motion to close passes, then the presiding officer shall restate on the record immediately prior to the closed session the limitation of the subject matter of the closed session. The public body holding a closed session shall restrict its consideration of matters during the closed session to only those purposes set forth in the motion to close as the reason for the closed session. The meeting must be reconvened in open session before any formal action may be taken, and "formal action" in that context is defined in § 84-1410(2) to mean a collective decision or a collective commitment or promise to make a decision on any question, motion, proposal, resolution, order, or ordinance or formation of a position or policy. Under an amendment to § 84-1410(2) effected by LB 621 in 1994, formal actiou by the body in that context does not include, "uegotiating guidance given by members of the puhlic body to legal counsel or other negotiators in a closed [strategy] session

authorized [for collective bargaining, real estate purchases, etc.] under subdivision 1(a) of [Section 84-1410]."

3. Any member of the public body can challenge the continuation of a closed session if he or she determines that the session has exceeded the original reason for the closed session, or if he or she contends that the closed session is neither clearly necessary for the protection of the public interest or the prevention of needless injury to the reputation of an individual. Such a challenge can only be overruled by a majority vote of the members of the public body. Such challenge and its disposition shall be recorded in the minutes.

4. History. One of the purposes for the initial open meetings statute, LB 325 from 1975, was to tighten restrictions on closed or executive sessions of public bodies. Introducer's Statement of Purpose for LB 325, 84th Nebraska Legislature, First Session (1975). The fourth example of reasons for closed meetings was added by LB 43 in 1983. The provisions dealing with pending or imminent litigation and defining formal action in a closed session were added as a part of LB 1019 in 1992.

5. It is not entirely clear what vote of the public body is necessary to go into closed session. The statute states that "an affirmative vote of a majority of [the body's] voting members" is necessary for a closed session. On its face, the normal meaning of this language would presumably be a majority of those members present and voting. This is particularly true since the later subsection (3) of § 84-1410 requires a "majority vote of the members of the public body" to overrule a challenge to the continuation of the closed session. However, the legislative history of LB 325 makes it quite clear that the legislators intended to make the requirement for a closed session a vote of the majority of the body rather than a vote of the majority of those present and voting. Floor Debate on LB 325, 84th Nebraska Legislature, First Session, May 14 and May 20, 1975, at 4616, 5015. Moreover, there is some indication that "voting" members in § 84-1410(1) refers to particular members of bodies such as the Board of Regents which has both voting and non-voting members. Government Committee Hearing on LB 325, 84th Nebraska Legislature, First Session (1975) at 27-28. The safer approach is to authorize a closed session of the public body by a majority vote of the members of the body rather than by a majority vote of just those members present.

6. The landmark case for what is permissible in a closed session is Grein v. Board of Education of the School District of Fremont, 216 Neb. 158, 343 N.W.2d 718 (1984). Grein involved a closed session by a school board for discussion of the low bid on a construction project. The supreme court held that the closed session was improper. That case indicates:

a. Provisions of the statute permitting closed sessions must be narrowly and strictly construed. See also State ex rel. Upper Republican Natural Resources District v. District Judges of the District Court for Chase County, 273 Neb. 148, 728 N.W.2d 275 (2007).

b. The public interest which is protected in § 84-1410(1) is "that shared by citizens in general and by the community at large concerning pecuniary or legal rights and liabilities." 216 Neb. at 165, 343 N.W.2d at 723. See also Wasikowski v. The Nebraska Quality Jobs Board, 264 Neb. 403, 648 N.W.2d 756 (2002).

c. Good faith motivation for a closed session is not a cure for non-compliance with the public meetings laws.

d. The prohibition against decisions or formal actions in a closed session proscribes crystallization of a secret decision and then ceremonial acceptance in open session.

e. There is a guiding principle with respect to closed sessions: "If a public body is uncertain about the type of session to be conducted, open or closed, bear in mind the policy of openness promoted by the Public Meetings Laws and opt for a meeting in the presence of the public." 216 Neb. at 168, 343 N.W.2d at 724.

7. Pokorny v. City of Schuyler, supra, indicates that there is nothing in the open meetings statutes which requires that negotiations for the purchase of land be conducted in open meeting, but deliberations of a public body as to whether an offer to purchase should be made must be done in an open meeting.

8. In a case involving the revocation of a land surveyor's license, the supreme court held that a closed session was improper since there was no showing of either necessity or of the reasons set out in § 84-1410(1). Simonds v. Board of Examiners of Land Surveyors, 213 Neb. 259, 329 N.W.2d 92 (1983).

9. Neb. Rev. Stat. § 79-832 (1996), dealing with hearings involving cancellation, amendment or termination of a teacher's contract mandates a closed hearing upon an affirmative vote of a majority of the school board's members present and voting and upon specific request of the certificated employee

or the certificated employee's representative. However, under that section, formal action by the school board reqnires that the school board reconveue in open session. Stephens v. Board of Edncation of School District No. 5, Pierce County, 230 Neb. 38, 429 N.W.2d 722 (1988).

10. The provisions of the open meetings statutes dealing with closed sessions, in part, reflect the Legislature's judgment of the appropriate balance between the public's interest in open discussion of governmental issues and the rights of individuals, snch as state employees, to have their performance as employees considered in private if they so choose. Meyer v. Board of Regents of the University of Nebraska, 1 Neb. App. 893, 510 N.W.2d 450 (Neb. Ct. App. 1993).

11. If the primary pnrpose for a closed sessiou of a public body is authorized under the open meetings statutes, then any necessary discussion of incidental matters is also authorized. Meyer v. Board of Regents of the University of Nebraska, 1 Neb. App. 893, 510 N.W.2d 450 (Neb. Ct. App. 1993). In the Meyer case, the Nebraska Court of Appeals indicated that the University Board of Regents could preperly discuss the appointment of an interim president for the University during a closed session called to evaluate and consider the employment status of the president.

12. In Wasikowski v. The Nebraska Quality Jobs Board, 264 Neb. 403, 648 N.W.2d 756 (2002), the court held that if a person who is present at a meeting of a public body observes an alleged violatiou of the Open Meetings Act in the form of an improper closed session and fails to object, then that person waives his or her right to object to the closed session at a later date. However, that case appears to be legislatively overruled by LB 898 from 2006 which provides that it shall not be a defense to a citizen lawsuit under § 84-1414 (3) that the citizen attended the meeting and failed to object at that time.

13. There is no absolute evidentiary privilege which applies to all communications made during a closed session of a public body, and communications made during snch closed sessions are discoverable. State ex rel. Upper Republican Natural Resources District v. District Judges of the District Court for Chase County, 273 Neb. 148, 728 N.W.2d 275 (2007). However, to the extent that commnnications made during a closed session implicate other recognized privileges such as the attorney/client privilege, those communicatious are protected. Id.

14. The statutory provision allowing public bodies to hold closed sessions for "strategy sessions" regarding litigation or threatened litigation by necessity encompasses discussions and decisions regarding whether to make or reject a settlement offer. Sucb decisions regarding litigation strategy should not have to be discussed publicly, during an open session, in front of the body's opponent. Becker v. Allen, 1996 WL 106217, 1996 Neb. App. LEXIS 73 (Neb. Ct. App. 1996) (Not approved for publication). In addition, the strategic meetings which a public body has with its attorney when threatened with or engaged in litigation, in which the pnblic body may give direction to its attorney, are protected by the attorney-client privilege. Id.

15. Opinions of the Attorney General:

a. A closed session is not proper simply because matters permitting a closed session might arise. Snch a closed session is permitted only when such matters do arise and must be dealt with. Op. Att'y Gen. No. 94035 (May 11, 1994); Op. Att'y Gen. No. 11 (January 20, 1983).

b. Discussions of legal matters between a county board and a county attorney involving pending litigation or legal consequences of specific action are suitable for a closed session. 1975-76 Rep. Att'y Gen. 150 (Opinion No. 116, dated August 29, 1975).

c. A public body can go into a proper closed session for discussion of personnel matters and then reconvene for a pnblic vote with no lengthy explanation of the rationale underlying the decision. Op. Att'y Gen. No. 89063 (October 12, 1989).

d. The closed session exception for prevention of needless injury to reputation is for the protection of individual employees and not for the protection of governmental officers on the pnblic body. Id.

e. In Op. Att'y Gen. No. 98045 (November 4, 1998), the Attorney General indicated that detailed minutes of all matters discussed need not be maintained when a public body is meeting in closed or executive session, so long as the requirements of § 84-1410 pertaining specifically to the minute entries necessary for a closed session are met.

f. A county clerk, county attorney and connty treasurer acting as a group under § 32-567 (3) to make an appointment to fill a vacancy on a county board may not go into closed session for evalnation of the merits of the candidates based npon the express language of § 84-1410 (1). Op. Att'y Gen. No. 97050 (September 18, 1997).

g. The Attorney General has indicated informally that developing testimony for an upcoming Legislative hearing is not a proper reason for a state agency to go into closed session. On the other

hand, the Attorney General has also indicated informally that discussion of "sensitive medical and financial information" pertaining to specific individuals who applied for admission to a state home could be conducted in a closed session so long as the actual vote on admission was done in an open meeting.

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CIRCUMVENTION OF THE OPEN MEETINGS ACT

Section 84-1410(4) prohibits a person or a public body from circumventing the purpose of the open meetings statutes by failing to invite a portion of its members to a meeting or by designating itself as a snbcommittee of the whole body. That section also prohibits the use of any closed session, informal meeting, chance meeting, social gathering, e-mail, fax or other electronic commnnication for the purpose of circumventing the requirements of the open meetings statutes.

1. This provision was added to the open meetings statutes by LB 43 in 1983. This section was directed at the intentional circumvention of the open meetings statutes rather tban inadvertent acts. Government, Military and Veterans' Affairs Committee Hearing on LB 43, 88th Nebraska Legislature, First Session (1983) at 5.

2. 2004 Neb. Laws LB 1179 added e-mails, faxes aud other electronic communications to the list of mediums which could not be used to circumvent the requirements of the Open Meetings Act.

3. Similar language prohibiting the use of telephone conference calls, emails, faxes, or other electronic communications to circumveut any of the pnblic government purposes of the Open Meetings Act is contained in § 84-1411 (3).

4. The Attorney General has indicated that intent is a necessary element of the condnct prohibited by § 84-1410 (4), and that members of a public body can communicate with other members of that body by electronic means, even if that communication is directed to a quorum of the body, so long as there is no course of communication which becomes sufficiently involved so as to evidence an iutent or pnrpose to circumvent the Open Meetings Act. Op. Att'y Gen. No. 04007 (March 8, 2004).

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ACTIONS FOR ENFORCEMENT

Section 84-1414 sets out various enforcement options available to individuals who believe that the open meetings statutes have been violated.

1. Any motion, resolution, rule, ordinance, or formal action of a public body made or taken in violation of the public meetings statutes shall be declared void by the district court if the suit is commenced within 120 days of the meeting of the public body at which the alleged violation occurred. Any such motion or other action taken in substantial violation of the pnblic meeting statutes shall be voidable by the district court if the suit is commenced after more than 120 days but within one year of the meeting of the public body in which the alleged violatiou occurred. A suit to void any final action shall be commenced within one year of the action.

2. Under § 84-1414(3), any citizen of this state may commence a suit in the district court of the county in which the pnblic body ordinarily meets or in which the plaintiff resides for the purpose of requiring compliance with or preventing violations of the open meetings statutes, for the purpose of declaring an action of a public body void, or for the purpose of determining the applicability of the open meetings statutes to discussions or decisions of the public body. City of Elkhorn v. City of Omaha, 272 Neb. 867, 725 N.W.2d 792 (2007). The court may order payment of reasonable attorney's fees and court costs to a successful plaintiff in a suit brought under § 84-1414(3). Under LB 898 from 2006, it shall not be a defense to such a suit that the citizen attended the meeting and failed to object to violations at such time.

3. The Attorney General and the county attorney of the county in which the public body ordinarily meets shall euforce the provisions of the open meetings statutes.

4. History. The original version of § 84-1414(1), which was a part of LB 325 passed in 1975, simply provided that actions taken in violation of the public meetings statutes should be void. The void/voidable distinction was added by LB 43 in 1983. The apparent intent of that later language was to allow a court to void an action by a public body taken when there was any violation of the open meetings statutes if the action was filed within four months of the meeting in question. After four months, the violation of the open meetings statutes would have to be substantial to allow a court to void the action of the public body. In any event, no action could be brought after one year of the public

meeting in question. Floor Debate on LB 43, 88th Nebraska Legislature, First Session, March 22, 1983, at 1892.

5. The legislative history of LB 325 from 1975 indicates that the initial intent of that statute was to have the county attorney responsible for enforcement proceedings involving public bodies at a local level. The Attorney General would be responsible for enforcement against state entities. Floor Debate on LB 325, 84th Nebraska Legislature, First Session, May 14 1975, at 4620.

6. The Nebraska Supreme Court has indicated that action by a public body which is proper under the open meetings statutes may cure defects in actions previously taken by the same public body. In such an instance, an action by a public body which previously might have been declared void will be declared proper. Pokorny v. City of Schuyler, supra. On the other hand, under those circumstances, the original improper meeting itself is still void. Steenblock v. Elkhorn Township Board, 245 Neb. 722, 515 N.W.2d 128 (1994). Pokorny also indicates that the effect of an invalid public meeting under the open meetings laws is the same as if the meeting had never occurred.

7. A county lacks capacity to maintain an action to declare its official conduct void for non-compliance with the open meetings statutes. County of York v. Johnson, 230 Neb. 403, 432 N.W.2d 215 (1988).

8. Reading of a city ordinance in accordance with a city charter constitutes "formal action" of a city council which may be voided in a lawsuit under § 84-1414 (1). City of Elkhorn v. City of Omaha, 272 Neb. 867, 725 N.W.2d 792 (2007).

9. A number of Nebraska cases deal with waiver of rights under the Open Meetings Act by a failure to make a timely objection to violations of the Act. Stoetzel & Sons, Inc. v. City of Hastings, 265 Neb. 637, 658 N.W.2d 636 (2003) (if a person who attends a meeting of a public body believes that copies of documents discussed by the body should be made available to the public at the meeting, a timely objection should be made, or that person waives his or her right to object); Wasikowski v. The Nebraska Quality Jobs Board, 264 Neb. 403, 648 N.W.2d 756 (2002); Otey v. State, 240 Neb. 813, 485 N.W.2d 153 (1992); Witt v. School District No. 70, Frontier County, 202 Neb. 63, 273 N.W. 2d 669 (1979)(any person who has notice of a meeting and attends the meeting is required to object specifically to a lack of pnblic notice at the meeting or waive his rights to object on that ground under the open meetings statutes); Hauser v. Nebraska Police Standards Advisory Council, 264 Neb. 944, 653 N.W.2d 240 (2002) (if a person present at a meeting observes and fails to object to an alleged open meetings violation in the form of a failure to conduct roll call votes before taking action on questions or motions pending, that person waives his or her right to object at a later date); Alexander v. School District No. 17 of Thurston County, 197 Neb. 251, 248 N.W.2d 335 (1976) (where teachers had notice of a termination hearing, appeared, and no objection was made to a failure of the school board to give proper notice under the open meetiugs statutes, those teachers waived any objection they might have had to violations of the open meetings law). Those cases appear to be legislatively overruled by LB 898 from 2006 which provides that it shall not be a defense to a citizen lawsuit under § 84-1414 (3) that the citizen attended the meeting and failed to object at that time.

10. Actions for relief under the open meetings statutes are tried as equitable cases, given the fact that the relief sought is in the nature of a declaration that particular action taken in violation of the laws is void or voidable. Such cases are also considered as equitable cases on appeal. Stoetzel & Sons, Inc. v. City of Hastings, 265 Neb. 637, 658 N.W.2d 636 (2003); Hanser v. Nebraska Police Standards Advisory Council, 264 Neb. 944, 653 N.W.2d 240 (2002); Wolf v. Grubbs, 17 Neb. App. 292, 759 NW. 2d 499 (Neb. Ct. App. 2009); Hansmeyer v. Nebraska Public Power District, 6 Neb. App. 889, 578 N.W.2d 476 (1998), aff'd, 256 Neb. 1, 588 N.W.2d 589 (1999).

11. The Hansmeyer case also discusses the distinction between "void" and "voidable" under § 84-1414. "Void" means ineffectual and having no legal force or binding effect, while "voidable" means that which may be avoided or declared void, not absolutely void. In Hansmeyer, the court considered factors such as whether any purpose would be served or whether decisions were made in secret without public discussion in determining whether a voidable vote by the Nebraska Public Power District should, in fact, be voided.

12. Once a meeting has been declared void pursuant to the Open Meetings Act, the members of the public body involved are prohibited from considering any information which they obtained at the illegal meeting. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (Neb. Ct. App. 2009); Alderman v. County of Antelope, 11 Neb. App. 412, 653 N.W.2d 1 (2002).

13. The decision to award attorneys fees to a "successful plaintiff" in an action under § 84-1414 is discretionary with the trial court. Hansmeyer v. Nebraska Public Power District, 6 Neb. App. 889, 578 N.W.2d 476 (1998), aff'd, 256 Neb. 1, 588 N.W.2d 589 (1999). The court in Hansmeyer also held that the plaintiffs in that case were "snccessful plaintiffs" who could recover attorneys fees under § 84-1414

because there was a finding that a substantial violation of the open meetings statutes had occurred, and because the public body involved amended its practices to prepare proper agendas after the plaintiffs filed their action. The court reached that conclusion even though it ultimately determined that the improper action of the public body at issue should not be voided. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (Neb. Ct. App. 2009) also contains a discussion regarding the basis for an award of attorneys fees in that case, including the court's analysis of why it reduced a fee award on appeal.

14. Voiding an entire meeting is a proper remedy for violations of the Open Meetings Act. Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (Neb. Ct. App. 2009). The court in the Wolf case also specifically considered whether violations of the Open Meetings Act were "substantial" violations in determining whether it was appropriate to void actions of a county board when the enforcement lawsuit was filed more than 120 days after the meetings in question.

15. In Wolf v. Grubbs, 17 Neb. App. 292, 759 N.W.2d 499 (Neb. Ct. App. 2009) there was no evidence in the record which established that a county board had published notice of its meetings anywhere. The Court of Appeals held that in the absence of contrary evidence, it may he presumed that public officers faithfully performed their official duties. Id. In addition, absent evidence showing misconduct or disregard for the law, the regularity of official acts is also presumed. Id. In Wolf, the court also indicated that the plaintiffs had the burden at all times to show that it was more probable that notices of meetings were not posted than probable that they were.

16. The United States District Court for the District of Nebraska has indicated that it has supplemental jurisdiction over claims under § 84-1414 based upon 28 U.S.C. § 1367 (a). Buzek v. Pawnee County Nebraska, 207 F.Supp.2d 961 (D. Neb. 2002).

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CRIMINAL SANCTIONS

Sectiou 84-1414(4) provides that any member of a public body who knowingly violates or conspires to violate the Open Meetings Act, or who attends or remains at a meeting knowing that the public body is in violation of any provision of that Act, shall be guilty of a Class IV misdemeanor for a first offense, aud a Class III misdemeanor for a second or subsequent offense.

1. The legislative history of LB 325 from 1975 indicates that the criminal sanctions included in this section were originally directed at intentional behavior rather than at inadvertence. Government Committee Hearing on LB 325, 84th Nebraska Legislature, First Session (1975) at 16.

2. The criminal sanctions for violation of the open meetings statutes were first increased as a result of LB 1019 passed in 1992. Also, that same bill in 1992 added language which made knowingly remaining at or attending a meeting in violation of the open meetings statutes a crime. The present language which applies criminal sanctious to those members of a public body who remain at a meeting knowing that the public body is in violation of the open meetings statutes was added by LB 621 in 1994.

3. Under Neb. Rev. Stat. § 28-106 (2008), a Class IV misdemeanor is punishable by a fine of from $100 to $500 and no imprisonment. In addition, a Class III misdemeanor is punishable by up to 3 months imprisonment or up to a $500 fine, or both. A Class III misdemeanor has no minimum penalty.

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EXHIBIT

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General Assistance Guidelines

Including

Primary Health Care & Cremation/Burials

Revised and Reissued

~~Effective May 12, 2010~~

Effective

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CHAPTER 1

GENERAL PROVISIONS

The following general provisions and definitions shall apply to all Lancaster County General Assistance programs administered by the County unless specific requirements of a program provide otherwise, in which case the specific program requirements will control.

DEFINITIONS

The following definitions shall apply, unless the context would indicate otherwise:

1:100 Adequate Notice: Notice of case action which includes a statement of the action taken by the Caseworker, the reason for the action taken, or a change in State law and/or County regulations which requires the action taken.

1:101 Appeal: A request for a hearing by an applicant to have the County's action or inaction on their case reviewed. An appeal may be requested in writing or in person.

1:102 Applicant: An individual who applies for General Assistance, including burial assistance and/or medical assistance from Lancaster County.

1:103 Application: A written form prescribed by the County and signed by the applicant which indicates the applicant's desire to receive General Assistance benefits. The application must be signed by the applicant/client within ten (10) days immediately preceding the date it is received in the Lancaster County General Assistance Office. Prior to approving an application for assistance, the original copy of the application must be provided to the General Assistance Caseworker.

1:104 Application Date: The date an applicant's/client's signed and completed application is received in the Lancaster County General Assistance Office.

1:105 Assisted Living: Assisted living facilities are designed to care for people needing assistance with Activities of Daily Living (ADLs). Assisted living facilities offer help with ADLs such as eating, bathing, dressing, laundry, housekeeping, and/or assistance with administering medications. Assisted living is not an alternative to placement in a nursing home but is intended to provide an intermediate level of care for someone needing supervision on a daily basis.

1:106 Authorization Period: When an application includes a request for medical services, the authorization period will begin on the date the application is received in the Lancaster County General Assistance Office. An earlier authorization start date may be allowed for applications that include a request for retroactive medical services; however the time period for such retroactive medical services shall not exceed sixty (60) days. The ending date of

the authorization period for medical assistance is the actual date the case file is closed by the caseworker. When an application for assistance includes non-medical services, the authorization period will start on the first day of the month in which the application is received in the Lancaster County General Assistance Office. The ending date of the authorization period for non-medical services will be the actual date the case file is closed by the caseworker. The ending date of the authorization period for rent assistance shall be the last day of the month in which the case file is closed by the caseworker.

1:107 Applicant and/or Client: Anyone who has applied for, or is receiving, General Assistance benefits.

1:108 Clinic Physician: A licensed physician who provides medical care at the designated Primary Health Care Clinic and who approves medical care by outside providers.

1:109 Contributions: Verified payments which are paid to, or on behalf of, an individual or household.

1:110 Direct Cremation: A straightforward disposition of the body without a formal/public viewing, visitation or embalming.

1:111 Emancipated Minor: A child under the age of nineteen (19) who is considered an adult because he/she has married or moved away from the parent's home and has been providing for their own needs.

1:112 Equity Value: The fair market of a resource less any recorded liens or encumbrances and reasonable fees required to liquidate those resources.

1:113 Fair Market Value of Real Estate and Motor Vehicles: The fair market value of real estate will be determined in accordance with the property's appraised value for tax purposes. The fair market value of motor vehicles will be determined in accordance with the trade-in values set forth in the most recent Midwest Edition of the National Automobile Dealers Association (NADA) Used Car Guide.

1:114 Family Unit: An applicant is considered to reside as a family unit if he/she is presently living with a spouse, parent or stepparent in cases involving minor children.

1:115 Full-Time Student: An individual registered for full attendance at, and regularly attending, an established school, college or university or who has so attended during the most recent school term and intends to register for full attendance at the next regular term of the school.

1:116 Household: Individuals, regardless of relationship, who reside in the same dwelling unit.

1:117 Income: Income shall include:

1. Earned Income: Money received from wages, tips, salary, commissions or profits from

activities in which an individual is engaged as a self-employed person or as an employee.

2. In-Kind Income: The value of food, clothing, shelter or other items received in lieu of wages. For purposes of determining the value of in-kind income, the worker shall use the maximum payments specified for an item under the General Assistance provisions of Chapter 2, Section 2:203.
3. Unearned Income: Includes, but is not limited to, money received from:
   a. Government entitlement programs;
   b. Social Security benefits, Railroad Retirement or Veterans benefits;
   c. Pensions and annuities;
   d. Disability benefits from any source;
   e. Child support or alimony;
   f. Unemployment or Workers' Compensation;
   g. Inheritance, gifts, trust fund benefits, contributions, etc.;
   h. Returns/interest/dividends from securities, investments, interest on savings, etc.; and
   i. Income received from an insurance policy that supplements the client's income when he/she is hospitalized or receiving medical care.
4. Monthly Income: Monthly income shall mean any income received within the past thirty (30) days.
5. Vested Rights: The applicant is deemed to have a vested right to income if:
   a. The applicant has been approved to receive benefits under a state or federal program for the calendar month in which General Assistance is/was requested/applied for and will be received by the applicant within thirty (30) days following the application date; or
   b. The applicant has earned income in the calendar month in which General Assistance has been requested or applied for and such earnings will be paid to the applicant within thirty (30) days following the application date.
   c. If payments are received annually, semiannually or quarterly, the amount is prorated on a monthly basis. For determination of countable/net income, see Sections 2:103 through 2:111.

1:118 Indigent Person: A poor person whose net income and resources are below the General Assistance standards, as outlined herein, who does not have a parent, stepparent or spouse supporting him or her and who is unable to provide for their own needs through any other source.

1:119 Legal Settlement:

1. The term legal settlement shall be taken and considered to mean:
   a. Every person, except those hereinafter mentioned, who has resided one year continuously in any county shall be

deemed to have a legal settlement in such county.

b. Every person who has resided one year continuously within the State, but not in any one county, shall have a legal settlement in the county in which he/she has resided six months continuously.

2. The time during which a person has been an inmate of any public or private charitable or penal institution, or has received care at public expense in any type of care home, nursing home, or board and room facility licensed as such and caring for more than one patient or guest, and each month during which he/she has received relief from private charity or the poor fund of any county, shall be excluded in determining the time of residence hereunder as referred to in subsection (1) of this Section.
3. Every minor who is not emancipated and settled in his or her own right shall have the same legal settlement as the parent with whom he/she has resided.
4. A legal settlement in this State shall be terminated and lost by:
   a. Acquiring a new one in another state; or
   b. Voluntary and uninterrupted absence from this State for the period of one year with intent to abandon residence in Nebraska.

1:120 Medically Indigent: A poor person whose income and resources are determined under the General Assistance Guidelines to be insufficient to obtain medical care, who does not have a parent, stepparent or spouse supporting him or her and who is unable to provide for their medical care through any other source.

1:121 Medically Necessary: Treatment for a condition is medically necessary if the condition will worsen without medical intervention. ~~and interfere with the client's self-sufficiency or ability to work~~.

~~X:XXX Primary Care: Transitional Primary Care services to include treatment for potential life threatening specialty medical intervention, and medical and surgical interventions deemed necessary to enable clients to return to the work force.~~

1:122 Potential or Contingent Resources: Income and/or resources which are not in the immediate possession and control of the applicant but to which the applicant may be entitled. Resources shall also include services or other programs available to the applicant to meet their requested needs.

1:123 Request Date: The date the applicant contacts the County General Assistance Department and schedules an appointment to apply for benefits.

1:124 Resources/Assets: Personal and real property in which the applicant has a legal interest. Resources and assets shall also include services and other established programs that are

available within the community to meet the applicant's needs.

1:125 Responsible Family Member: The spouse, parent, or stepparent of any poor person.

1:126 Shared Living: A dwelling in which the client shares common areas such as entrance, cooking and food storage facilities and/or bathroom facilities with the property owner and/or with another resident.

1:127 Temporary Assistance: thirty (30) days. With Director's approval, the temporary assistance period can be extended an additional thirty (30) days but under no circumstances shall the temporary assistance period be extended or approved beyond a total of sixty (60) days. Temporary assistance may only be approved once during any 12 month period.

1:128 Unrelated Households: Persons who reside with, but who are not related to, the applicant as parent, stepparent or spouse.

1:129 Utilities: The term 'utilities' includes; water, electricity, gas/oil used for heating a residence, and garbage disposal services.

CLIENT AND AGENCY RESPONSIBILITIES

1:200 Client Responsibilities: The client is required to:

1. Provide complete and accurate information on the required application form, sign all required documents, provide two forms of identification (one of which must be a picture identification), provide verification and/or documentation of all information used to determine eligibility as requested by the Caseworker, and attend the personal interview as scheduled with a General Assistance Caseworker within twenty (20) days of notification.
2. Prior to a determination of eligibility, report a change in circumstances the next working day after the change. If eligibility has already been determined, then a change in circumstance must be reported no later than ten (10) days following the date of change. This includes information such as:
   a. An increase or decrease in monthly income and expenses;
   b. An increase or decrease in resources;
   c. A change in employment status;
   d. A change in the composition of the household regardless of whether the change involves a related or unrelated household member;
   e. A change in address and/or living arrangements;
   f. A change in incapacity or disability status; or
   g. Proof of employment search, as required.
3. Accept referral to any other public or private agency or organization which may be able to provide the requested assistance to the client.

4. Comply with the Action Plan provided by the General Assistance Caseworker.

1:201 Department Responsibilities: At the time of initial application and/or recertification, the Caseworker shall:

1. Provide an explanation of program requirements;
2. Explain the eligibility factors that require verification;
3. Obtain the client's written consent for needed verification;
4. Explore current and potentially available income and resources with the client;
5. Inform the client of his/her rights and responsibilities;
6. Act with reasonable promptness on the client's application for assistance as defined in Section 2:501;
7. Inform the client of medical services available and program restrictions on use of private medical providers; and
8. Provide the applicant/client with a notice of finding indicating approval (active), denied, pending, suspended, closed or any other case action which affects the client's eligibility status. A notice of finding will be sent to the applicant/client within 7 days from the date the application is received into the General Assistance Office if the need is short-term, and within 30 days from the date the application is received into the General Assistance Office if the need is continuous, unless circumstances beyond the control of the applicant/client and/or County necessitate delay.

APPEAL PROCEDURES

1:300 Right to Appeal: All applicants for General Assistance and County cremations/burials may request an appeal when their application:

1. Has not been acted upon within the time established under Section 2:501; or
2. Has been denied; or
3. Has not been granted in full; or
4. Has been reduced or terminated.

1:301 Time to Appeal: A request for an appeal must be made within thirty (30) calendar days following the date on which notice of the County's action is mailed to the client.

1:302 Appeal Procedure: All requests for appeals will be referred to a hearing officer, designated by the County Board, for a fair hearing. The following procedure will apply:

1. The client shall have the right to:
   a. Examine his/her General Assistance file prior to and during the hearing;
   b. Be represented in the proceedings by a lawyer, friend, relative or anyone else he/she may select;
   c. Present evidence; and
   d. Confront and cross-examine witnesses.

2. The hearing officer shall:
   a. Tape record the hearing;
   b. Make a decision within thirty (30) days following the hearing based upon the evidence adduced and the law;
   c. Provide the client a written copy of the decision setting forth findings and conclusions; and
   d. Preserve the tape of the hearing and all exhibits offered at the hearing for not less than sixty (60) days following entry of the hearing officer's decision.
3. Upon the request of either party or the hearing officer's own motion, the hearing may be continued and the hearing record held open for a period not to exceed ten (10) days, in order to obtain additional information or to verify new information.

1:303 Right to Judicial Review: Any person aggrieved by a decision rendered pursuant to Sections 1:301 and 1:302 may obtain a review of such decision by filing a petition in the District Court of Lancaster County, Nebraska, within thirty (30) days after service of the decision on the client. Service shall be completed upon mailing of the decision by the hearing officer in the normal course of business to the last known address of the applicant.

CHAPTER 2

GENERAL ASSISTANCE GUIDELINES

ELIGIBILITY FACTORS

2:100 Eligibility Criteria: In order to be eligible for General Assistance, the applicant must come within the definition of an indigent person as set forth in Section 1:118, meet the income and resource criteria set forth in Chapter 6, establish a need pursuant to Section 2:200 and meet the requirements set forth in 2:101 and 2:102.

2:101 Legal Settlement: To be eligible to receive General Assistance from Lancaster County, an applicant must either have a legal settlement in Lancaster County at the time of application, or must have fallen sick in Lancaster County.

2:102 Citizenship and Alienage: Recipients of assistance must qualify as either:

1. A citizen of the United States; or
2. A refugee lawfully admitted to the United States who can substantiate legal entry by means of documentary evidence and can provide documentation that they are not deportable.
3. A nonimmigrant alien or immigrant authorized to reside and work in the United States who can substantiate legal entry by means of documentary evidence and provide documentation from the Bureau of Citizenship and Immigration Services that they were admitted without a sponsor and that they are not deportable.
4. All applicants/clients are required to have on file with this office a US Citizenship Attestation Form as defined by Nebraska State Statute.

2:103 Ineligible Immigrants. Immigrants in a Legal Permanent Resident status with less than five years residency in the United States who do not qualify for the federal or state funded Medicaid programs, the SNAP program, Housing programs, and Social Security programs or who would not qualify for these same programs because of their immigration status will not be eligible for any form of assistance from the Lancaster County General Assistance program.

2:104 Resources: Equity value of all resources in the immediate possession or control of the applicant, unless otherwise exempt, will be considered as income for purposes of eligibility. Failure to take advantage of these resources would make an applicant ineligible for General Assistance. Such resources include but are not limited to:

1. Bank accounts, stocks, bonds, time certificates, mutual funds, cash value of life insurance, trust funds, revocable burial funds, etc.;
2. Personal property such as motor vehicles, leased vehicles, boats, campers, motorcycles, jewelry, etc.;

3. Real estate;
4. Business equipment including all business property, fixtures and machinery, including farm machinery, but excluding tools needed for a trade or profession which have an equity value of less than $2,000;
5. Livestock, poultry and crops; and
6. Potential Resources include, but are not limited to;
   a. Sponsorship. When a registered alien has a federally recognized sponsor, the income and resources of the sponsor will be considered in determining the eligibility of the applicant;
   b. Food baskets and food pantries;
   c. Placement in a shelter or temporary housing facility;
   d. Energy Assistance programs;
   e. Home Owners Insurance, Vehicle/Automobile Insurance, and Workers Compensation programs in situations where the client/applicant has or has access to a home owners insurance policy, a vehicle/automobile insurance policy or any other type of insurance coverage which provides health care benefits or medical care benefits/payments, unless such insurance does not provide coverage for a particular life threatening/life trauma situation and documentation of non-coverage is provided.

2:105 Exempt Resources: The following resources shall not be considered in determining an applicant's eligibility for General Assistance:

1. The home in which the client resides, unless the equity value exceeds $10,000.
2. Ownership of any additional properties will not be exempt regardless of equity value and will be considered to be an available asset/resource.
3. Household furnishings.
4. A motor vehicle which is presently being used to meet the applicant's transportation needs for employment and/or medical care which has a total value of greater than $6,000 is considered to be an available asset/resource and/or
5. A second vehicle with a total value of greater than $6,000 is also considered to be an available asset/resource if it is also being used for the applicant's transportation needs for employment and/or medical care and there is more than one licensed driver in the household.
6. In cases where additional vehicles are registered to the applicant and/or members of the household, the value of all additional vehicles will be considered to be an available asset/resource.

7. Irrevocable burial funds in effect at the time of the request for assistance.

2:106 Ownership of Resources: Real and/or personal property which appear on record in the name of the client and/or persons included in the family unit will be considered in determining eligibility. In cases of jointly owned property in the name of the client and an individual not included in the family unit, it shall be presumed that the client's interest in such property is proportionate to all other joint owners, unless sufficient evidence is presented to the contrary. In situations involving applicants/clients that are business owners and/or who are self employed, all business income less the cost of operations shall be considered as an available resource and the value of any and all business inventory shall be considered an available resource.

2:107 Potential Income: All applicants will be required to seek alternative sources of income to meet their past, present and future needs in order to be eligible. This includes applicants whose current income is not sufficient to meet their individual, family or household needs. In order to comply with this provision, an applicant, when applicable, shall:

1. Apply for any benefits or other programs to which he/she may be entitled to or eligible for including, but not limited to: Medicaid, The State and/or Federal Health Care Insurance Exchange, Prescription Assistance Programs, Energy Assistance Programs, Social Security, Supplemental Security Income, Veterans Benefits, Aid to the Aged, Blind or Disabled, Aid to Families with Dependent Children, Supplemental Nutrition Assistance Program (SNAP) (formerly called Food Stamps), Unemployment Compensation, Worker's Compensation, Housing Assistance Programs, etc.
2. Applicants/clients who, as a result of their own actions or inactions are determined to be ineligible for any of the benefits or programs listed above shall not be eligible for that same type of assistance or benefit through General Assistance.
3. General Assistance clients whose initial application for SSI and SSDI benefits from the Social Security Administration has been denied and whose Reconsideration or First Appeal has also been denied are required to participate in the work search requirement.
4. Make good faith efforts to secure employment, unless the client:
   a. ~~Is employed on a regular basis and working at least thirty-five (35) hours per week; or~~
   b. Is enrolled in a job training program through the Workforce Investment Act (WIA) and/or Vocational Rehabilitation; or
   c. Has a verified physical and/or behavioral health disability which precludes them from being employed. Such verification

shall be provided in the form of a written note and signed by a Physician, Physician Assistant, or Nurse Practitioner. In such cases, the client shall not be required to seek employment until a Physician, Physician Assistant, or Nurse Practitioner certifies that their condition no longer precludes employment; or

~~d. Is a single parent and has a child under the age of five (5) residing in the home.~~

5. Clients/Applicants who have had a claim for benefits previously denied by the Social Security Administration (SSI or SSDI) shall be required to comply with the employment search requirements as described in section 2:106(2) except when the current application on file with the Social Security Administration is based upon a medical condition that is different from the previous claim for benefits that was denied by the Social Security Administration. This provision shall also apply to clients/applicants who have failed to file a timely appeal or have abandoned their claim.
6. Make reasonable efforts to obtain possession and control of resources or income in which the applicant has a legal interest.

2:108 Projecting Income: In order to determine eligibility for medical services, the Caseworker shall consider the former and potential earning capacity of the client and responsible family members. For purposes of projecting income, the Caseworker shall:

1. When there has been no significant change in income, determine the average monthly gross income based upon the three (3) months immediately preceding the application. The monthly average is then multiplied by six (6) to determine initial eligibility;
2. When the client or responsible family members declare seasonal employment, use gross income as reported on IRS Form 1040 together with any unemployment benefits received in the previous year to determine average monthly income and multiply by six (6);
3. When there has been a significant change in income, use the period beginning with the month the change occurred. Such changes may include recent employment, termination, promotion, job change, reduced hours, change in amount of unearned income, etc.; and
4. Use the monthly gross income received immediately prior to the significant change if the applicant has suffered a loss or reduction of income prior to the request for General Assistance and such loss or reduction was a result of the voluntary actions or inactions of the client or responsible family members. Such actions or inactions include but are not limited to:

a. Failure to cooperate with any state or federal agency providing benefits to the applicant and which non-cooperation results in the loss or reduction of benefits;
b. Failure to work when employment is or was available within ninety (90) days prior to the request for General Assistance or has been offered to the applicant and it is or was within the applicant's physical and mental ability to perform the type of work involved; and
c. The applicant has been denied or suffered a reduction of benefits due to fraud or misrepresentation in applying for or receiving benefits from a state or local agency.

2:109 Verification: For purposes of complying with the provisions of Section 2:106 and before the applicant/client can be approved for ongoing assistance, the applicant/client must:

1. Provide verification from the appropriate agency that benefits have been applied for or the applicant has scheduled an appointment to apply for benefits;
2. When required, register with Nebraska Workforce Development and remain active with the agency until employment is found and/or the applicant no longer requires General Assistance. In addition, provide documentation that the applicant is actively searching for employment. Such documentation shall consist of a completed GA Form 3, Work Search form that includes at least ~~three (3)~~ five (5) prospective employers per week with whom the client has completed and filed an application for employment, provided the client has not used the same employment application to satisfy a job search requirement in the previous three (3) months. To qualify as a valid application, the application must be completed and filed with the employer within thirty (30) days preceding the date the GA Form 3 is due in the General Assistance Department.
3. Provide evidence that he/she has made every effort within their means to secure possession and control of resources in which they have a legal interest.

2:110 Net Income: Income described in Section 1:117 minus allowable deductions for:

1. State and federal income taxes, based on actual personal exemptions;
2. Social Security or Retirement and Survivors Disability Insurance (RSDI);
3. Mandatory pensions;
4. Premiums paid for major medical health insurance coverage;
5. Court ordered child support which has been paid during the current month on behalf of a child not in the household; and
6. Child care payments required for the employment of parent(s).

2:111 Excluded Income: The following income shall be disregarded when determining the amount of General Assistance which the client is eligible to receive:

1. Stipends received through the Job Training Partnership Act and/or the Vocational Rehabilitation Division of the Nebraska Department of Education. Such disregard shall be granted for an initial period of three (3) months beginning with the month in which the first payment is received. If after consultation with the appropriate agency it is determined the client requires additional time to complete his/her training program, the disregard may be extended for an additional three (3) months. In no event may the disregard be allowed for a period in excess of six (6) months.
2. Fifty percent of a client's gross earnings for a period not to exceed two (2) months, beginning with the month the first check is received, provided the client has been unemployed and receiving General Assistance for six (6) consecutive months prior to the month employment began. In all other cases the disregard shall not apply.
3. Pell Grants or other similar grants received as part of a rehabilitation program set forth under Section 2:300 (1) (a).

2:112 Verification and Documentation of Income and Resources: The Caseworker shall verify all income and the ownership and value of all resources declared by the client. All verification must be documented and contained in the case record prior to approval. The client's failure to provide the necessary documentation as requested by the Caseworker within a reasonable time shall be grounds for denial of the application or closing of the case file.

2:113 Right of Reimbursement: The applicant, in order to be eligible, shall authorize the County to be reimbursed for General Assistance granted if the applicant is found eligible for any supplemental security income program or other program of categorical assistance which provides retroactive benefits to the applicant from the date of application or the applicant has applied for replacement of a lost or stolen categorical warrant. An applicant shall also be required to repay any General Assistance obtained through misrepresentation or fraud.

2:114 Presumption of Eligibility: When an application for General Assistance includes a request for Primary Health Care benefits and has been signed but cannot be acted upon because all verification and documentation has not been obtained and, in the opinion of the assigned General Assistance Caseworker the client is in immediate need of medical services, temporary assistance may be granted based solely upon the applicant's declarations of income and

resources as true and accurate. The Caseworker shall then:

1. Determine eligibility based on the client's declarations; and
2. Inform the client that they will become financially responsible for the cost of such medical services if it is subsequently determined that they do not quality for Primary Health Care coverage.
3. The authorization to receive temporary assistance for medical services based upon the presumption of eligibility shall not exceed a period of thirty (30) days.
4. Temporary Assistance shall not be approved when a previous application for benefits was submitted and denied, or when an active case was closed or denied within the past six (6) months.

2:115 Additional Guidelines: In deciding eligibility issues which are not specifically addressed by these Guidelines, the Caseworker may rely upon the guidelines set forth in the ~~Food Stamp~~ SNAP Manual and the Aid to Dependent Children Manual which are maintained by the Nebraska Department of Health & Human Services (HHS). Copies of these manuals are available for inspection at the HHS offices located at the State Office Building, 301 Centennial Mall South, Lincoln, NE.

ASSISTANCE PROVIDED

2:200 Goods and Services Provided: The following items are payable or may be provided through the General Assistance program:

1. Food;
   a. Food assistance is provided through the Federal SNAP program administered by the Department of Health and Human Services.
2. Shelter (including deposit, rent and utilities);
   a. Payments for utilities will only be approved when the client/applicant can show that they have been denied by the Energy Assistance program administered by the Department of Health and Human Services.
3. Assisted living (cannot be authorized without a written statement from a physician on a Lancaster County GA Form 5, indicating the client is in need of the level of care provided by an assisted living facility);
4. Medical care provided through the Primary Health Care Clinic or authorized by a Clinic Physician, and/or Behavioral Health Services as provided through the Community Mental Health Center.
5. Transportation;
   a. Transportation Services are provided in the form of a Star Tran, low income, bus pass.
   b. Transportation assistance will not be authorized unless the client/applicant is found to be eligible for assistance from

General Assistance for shelter, primary medical care, or assisted living.

6. Personal Needs Items (including household supplies and personal care items);
   a. A Personal Need voucher will not be authorized unless the client/applicant is found to be eligible for assistance from General Assistance for shelter, primary medical care, or assisted living.
   b. Personal Needs vouchers are to be used only for the purchase of personal needs items. They are to be issued in amounts as shown in section 2:203 (2) and are to be used for non-food, personal needs items only. Such items include but are not limited to; personal hygiene items, paper products, and items deemed necessary to maintain a healthy living environment.
   c. Clients/applicants who use these vouchers for other than their intended use will receive one warning from their caseworker and upon commission of a second such offense, will no longer be eligible to receive a Personal Needs voucher.
7. Clothing;
   a. See section 2:203 (7) of this document,
8. Cremation/Burial expenses;
   a. See Chapter 4 of this document, and
9. COBRA or other health insurance payments.

2:201 Retroactive Eligibility for Medical Assistance: The date of eligibility beginning no earlier than sixty (60) days before the date of application if all of the following conditions are met:

1. A request for medical assistance was made by the client or someone on their behalf within sixty (60) days of the date of application;
2. The client received medical services for a life threatening or life trauma condition within sixty (60) days of the date of application and the provider complied with program requirements in the delivery of care; and
3. The client met all eligibility requirements during the entire retroactive period under consideration.
4. Exception: In the event the client is unable to complete an application within sixty (60) days of the date of request because of prolonged hospitalization, the sixty (60) day requirement may be waived, provided an application is completed within thirty (30) days following dismissal from the hospital and the conditions in paragraphs 1, 2, and 3 above are met. In such cases the medical eligibility date shall be the date the client was admitted to the hospital.

2:202 Standards for Payment:

1. All payments from General Assistance will be made on the basis of the qualified family unit and the maximum payment shall not exceed the standard established for each category. All

payments will be made directly to the vendor providing the goods or services.

2. General Assistance payments are not to be supplemented or augmented by other forms of payment nor are they intended to subsidize another form of payment.

2:203 Maximum Payments Per Month by Family Unit/Family Size:

1. Shelter:

Family Size	Maximum Rate
1	$375
2	$400
3	$475
4 or more	$550

a. Shared Living - $200 or a percentage of the total rent due divided by the number of family and non-family occupants, whichever is the lesser amount.
b. Clients/applicants are not allowed to supplement rent/shelter payments. This includes income in-kind received in exchange for work performed by the client/applicant. The total amount of rent assistance allowed cannot exceed the amounts indicated above regardless of the source of payment.
c. In addition to the income guidelines for non-medical assistance listed in Chapter Six, an individual may be denied rent assistance when it can be determined by the Caseworker that their current income and/or assets are sufficient to meet their needs.
d. An individual may elect to have all or part of the shelter allowance applied to his/her rent or utilities, any combination of which cannot exceed the maximum shelter rate except as shown below.
e. Payments for rent and/or utilities will not be granted when the applicant does not have legal settlement in the County unless extraordinary circumstances exist and can be verified by the Caseworker.
f. Deposits - Are allowed when required in addition to maximum shelter allowance to secure adequate and safe shelter. Deposits shall not exceed one (1) month's rent as provided in Section 2:203(1).
   i. Payment of deposits will not be granted when the applicant does not have legal settlement in the County unless extraordinary circumstances exist and can be verified by the Caseworker.
   ii. Payment of deposits shall not be approved more than twice in any twelve (12) month period unless extenuating circumstances exist and

can be verified. The application must be approved by the Director.

iii. When moving to a new domicile and requesting assistance for the deposit, the applicant/client shall provide the Caseworker with a statement from the previous landlord as to the reimbursement status of the deposit for the domicile being vacated. In cases where the client/applicant forfeits their deposit from the domicile being vacated due to their own negligence or abuse, assistance shall be granted only once during any twelve (12) month period.

g. Temporary Crisis - Shelter amounts may exceed the maximum standard allowed when the family crisis is due to an illness, injury or loss of a job and staying within the Guidelines would require the family to move from their established home. Payments may be approved for not more than two (2) months and must have Director's approval.

h. Housing Authority Waiting List - Shelter payments may exceed the maximum with Director's approval when it has been verified that the client is on the waiting list to receive a Housing Authority certificate and it is in the client's best interest to remain in their current home or move to a rented home that is approved for a housing certificate.

i. Once a shelter voucher has been issued to the vendor, the client cannot receive payment for an alternate living situation unless the voucher was issued in error or the client is required to obtain a new living situation due to circumstances beyond his/her control. In no case will payments be authorized in any one (1) month which would exceed the maximum shelter allowance specified herein.

2. Personal Needs Items:

Family Size	Maximum Rate
1	$15.00
2	$25.00
3	$30.00
4 or more	$35.00

3. Assisted Living: To qualify for placement in an Assisted Living facility, a completed GA Form 5 based upon current or recent treatment is required. An updated GA Form 5 must be submitted at the time of recertification.
   a. Family Size Maximum Rate Licensed Rate as Established by HHS
4. Food: All applicants will be required to apply for SNAP to meet this need. General Assistance will not be issued to supplement the SNAP allotment for which an applicant

may qualify, unless there are changed circumstances and the allotment cannot be changed for the current month. In these cases the ~~food stamp~~ SNAP tables issued by HHS will be used to determine the amount of the food order by household size and the number of days covered.

5. Transportation: A monthly bus pass may be issued to any current General Assistance client when requesting transportation assistance for medical appointments, job search activities, General Assistance/Emergency Assistance appointments and for acquiring food and personal needs items through the voucher system. If there is a physical disability which precludes the use of the bus service, the client should be referred to HHS for Social Services Block Grant (Title XX) transportation services or they may be issued a Handi Van pass. Alternative forms of transportation may be arranged at the discretion of the County General Assistance Director.
6. Transportation Outside of Lancaster County: Transportation may be provided to individuals who otherwise meet the eligibility criteria for Primary Health Care to locations outside of Lancaster County if the following conditions are met:
   a. The individual has not resided in Lancaster County for six (6) consecutive months and wishes to return to his/her place of residence, provided the individual has secured a place to stay upon their arrival and this information can be verified; or
   b. The individual has secured employment outside of Lancaster County and the prospective employer can confirm this information.
7. Clothing:
   a. Persons eligible for General Assistance and in need of clothing assistance should contact the Good Neighbor Community Center for a clothing selection appointment.
   b. The purchase of clothing for special needs may be authorized on a case-by-case basis upon approval by the General Assistance Director or Deputy Director.
8. Burials: See Chapter 4.
9. Health Insurance Premiums:
   a. COBRA payments may be approved for payment when it can be shown that the cost of the payments will result in a monetary savings to the county.

DISQUALIFICATION FROM PROGRAM PARTICIPATION

2:300 Ineligible Applicants:

1. Applicants who meet the financial eligibility criteria may still be denied Primary Health Care benefits if:

a) They are receiving or have been determined eligible to receive Medicare, Medicaid (including Medicaid with an excess income obligation), Veterans Health Care benefits and any other type of governmental health care benefits, including qualification as an "Essential Person" to someone in receipt of Medicaid.

b) They fail to comply with federal and/or state entitlement program guidelines which results in a denial of benefits.

c) They have a health insurance policy in effect, unless there is no coverage for a particular life threatening/life trauma situation and documentation of non-coverage is provided.

d) They refuse to use any resources (unless otherwise exempt) which are available to meet their medical needs, including applying for Medicaid as an Essential Person for someone in receipt of Medicaid from the Aid to the Aged, Blind and Disabled (AABD) program.

e) They have or have access to a home owner's insurance policy, a vehicle/automobile insurance policy or any other type of insurance coverage which provides health care benefits or medical care benefits/payments (be it full or partial coverage) unless such insurance does not provide coverage for a particular life threatening/life trauma situation and documentation of non-coverage is provided.

2. Applicants are also ineligible to receive General Assistance if the lack of income and/or resources is a result of the client's own actions or inactions:

a.) For purposes of this provision, full-time students will be presumed to lack income and/or resources as a result of their own actions in restricting their ability to engage in full-time employment, unless sufficient evidence is presented to the contrary. Part-time students may also be ineligible due to lack of income and/or resources as a result of their own actions when the Caseworker can determine that their student status is what prevents them from being gainfully employed.

b.) The provisions of this sub-section shall not apply if the client is enrolled as a full-time student as part of a plan of vocational rehabilitation or other approved program designed to enable the applicant to become self-sufficient, provided the plan specifies that the entire time required by the client to commence and complete the educational portion of the plan does not exceed twelve (12) months. For good cause shown, the twelve month time limit can be extended up to an additional six (6) months.

3. All clients/applicants shall be ineligible to receive any form of General Assistance if there is an outstanding, arrest warrant with any law enforcement agency in the client/applicants name.

4. When on two or more occasions the applicant/client uses inappropriate, threatening or vulgar language towards any

employee of Lancaster County or, after any single incident involving any form of threatening or violent behavior that is perceived to be potentially harmful towards an employee of Lancaster County, the applicant/client shall remain eligible for General Assistance benefits with the following procedural exceptions:

a. The applicant/client will be barred from the General Assistance Office area and will not be entitled to a face-to-face interview;
b. The applicant/client shall be provided with written notice of the actions that resulted in their being barred from the General Assistance Office;
c. The applicant/client will be required to provide all requested documentation via a courier that they arrange for or via the US Mail;
d. The application will then be adjudicated based upon the information and documentation provided by the applicant/client; and
e. The applicant/client will be mailed a letter informing them of the decision rendered by the Caseworker.

5. For purposes of this provision, an applicant/client who has been denied General Assistance by their County of Legal Settlement within 90 days preceding the submission of their application for General Assistance in Lancaster County shall be denied General Assistance from Lancaster County.
6. For purposes of this provision, clients who are approved for Social Security benefits will be given 10 working days to apply/re-apply for Medicaid. Clients who do not provide proof of application within 10 working days will have their file suspended until such time that they apply for Medicaid.
7. For purposes of this provision, clients who do not comply with their case plan shall be determined to be ineligible for General Assistance, have their current application closed, and shall be disqualified from program participation for a period of 90 days.

2:301 Disposal of Resources: If an applicant has disposed of, transferred or sold any resource at less than fair market value either before or after application for General Assistance, the applicant will be ineligible for the period of time in which the resource would have been available to meet the needs of the household. When a sale has occurred, this is determined by comparing the equity value of the resource at the time of sale to the value received. The difference is the amount which would have been available to meet the needs of the household.

Disposal of resources shall also include all situations in which an applicant/client has failed to retain rights to use of resources through

his/her own actions or inactions. Such situations include, but are not limited to, eviction from residence for failure to comply with terms in the lease agreement, failure to comply with month-to-month agreements between the tenant and landlord, and/or being banned from use of the food pantry system, SNAP program or other community resources.

2:302 Reduction or Loss of Income or Resources: If an applicant has suffered a loss or reduction in income or benefits and such loss or reduction is a result of the voluntary actions or inactions of the applicant, General Assistance will be denied. Such actions or inactions include, but are not limited to, the following:

1. Failure to cooperate with any state or federal agency providing benefits to the applicant and for which non-cooperation results in the loss or reduction of benefits;
2. Failure to work when employment is or was available within the last ninety (90) calendar days or, has been offered to the applicant, and it is or was within the applicant's physical and mental ability to perform the type of work involved. In the event the disqualification period falls within the 1st and the 31st of any month, General Assistance payments will be prorated from the date the disqualification ends to the last day of the authorization period:
   a. Applicants/clients who quit their current or former employment without just cause shall not be eligible for General Assistance benefits for a period of ninety (90) days from the last date of employment.
   b. Applicants/clients who are terminated from their current or former employment due to their own misconduct shall not be eligible for General Assistance benefits for a period of ninety (90) days from the last date of employment;
3. The applicant has failed or refused to pursue employment opportunities within the last ninety (90) calendar days. Such failure may consist of:
   a. Failure to complete a formal application for employment when required by the prospective employer;
   b. Failure to appear for a personal interview which has been arranged with a prospective employer; or
   c. Failure to accept referrals from Nebraska Workforce Development to apply to and/or interview with a prospective employer;
4. The applicant has been denied or suffered a reduction of benefits due to fraud or misrepresentation in applying for or receiving benefits from a state or federal agency; or
5. The applicant has, through fraud or misrepresentation, attempted to receive or did receive General Assistance to which they

were not entitled in the month immediately preceding the month of application.

2:303 Disqualification: Submitting a fraudulent application or willfully withholding information pertinent to the application shall be reasons for immediate termination of benefits or denial of a claim for General Assistance benefits. When an application is denied or benefits are terminated because of fraud or the willful withholding of information, the applicant shall be deemed ineligible for a period of ninety (90) calendar days from the date the case was denied or closed. The Caseworker will report all fraudulent applications to the General Assistance Director. The Director may notify the local law enforcement authorities if the situation warrants further investigation and possible legal action.

2:304 Suspension of General Assistance Benefits: A client's General Assistance benefits will be immediately suspended if the client becomes ineligible for such benefits. The client will be provided with a written Notice of Suspension, which shall include the reason for the suspension and what actions need to be taken by the client to regain eligibility. The client will have fourteen (14) days from the date indicated on the Notice of Suspension to cure the reason for his/her ineligibility and suspension. If the client fails to cure the reason for his or her ineligibility and suspension within fourteen (14) days, the client's case will be closed.

DETERMINATION OF BENEFITS

2:400 Documentation: When making a determination of benefits, it shall be the responsibility of the applicant/client to provide all documents determined by the Caseworker to be necessary in determining the level of assistance to be provided.

2:401 Determination: The General Assistance Caseworker shall determine the total amount of income and assets available. When this figure equals or exceeds the amounts listed in Chapter 6, the applicant is ineligible. When this figure is at or below the amounts listed in Chapter 6, the GA Caseworker will determine the level of benefits to be provided based upon the guidelines as provided in Chapter 6.

2:402 Periodic or Lump Sum Payments:

1. If an individual receives regular periodic payments, from whatever source, the Caseworker shall determine the number of times each year such payment is received. This figure is then multiplied by the amount of each payment and divided by twelve (12). This figure is the amount of monthly income to be shown in the applicant's budget each month.
2. When an applicant/client receives or has received a one-time, lump-sum payment, from any source within twenty four (24) months prior to application or since being

determined eligible for General Assistance, the following expenses, if documented and paid by the applicant/client, shall be deducted from the net amount received: shelter and utilities, food (Not to exceed the maximum SNAP allotment for the household size), medical bills and/or other costs for which the lump sum was intended, child support payments, and other reasonable and necessary living expenses. In addition, lump sum funds should be used to pay all medical bills for which General Assistance has been requested but which have not yet been paid. When a client receives a lump sum payment based upon third party liability, the client will reimburse the county for all expenses relating to the settlement received from the third party. The remainder of the lump sum shall be divided by 100% of the Federal Office of Management and Budget (OMB) Poverty Guideline for the appropriate household size to determine the number of months of ineligibility for General Assistance.

2:403 Recovery of Overpayments:

1. In the event that a person receives General Assistance benefits by providing fraudulent, inaccurate, deceptive, or erroneous information or through a misrepresentation of the facts, the County shall notify the client in writing that their case has been closed, that an overpayment has been declared, and that the overpayment status represents an indefinite bar to services and will remain in effect until the overpayment is repaid. A separate notice will also be sent with instructions to repay this amount or to contact the County General Assistance Office to arrange a repayment plan. The client will be allowed thirty (30) days to respond. Upon receipt of a response or at the end of the initial thirty (30) day period, a follow-up written notice will be sent to the client indicating the number of months deemed necessary to recover the overpayment. This is determined by dividing the unpaid overpayment balance by the monthly standard-of-need for the family unit size. Overpayments in an amount that is less than a single, monthly standard-of-need for the family unit size shall constitute ineligibility for the entire month. This period of ineligibility may be adjusted periodically, if a payment plan has been approved by the Department of General Assistance Director, and payments are being received.

CLASSIFICATION OF NEED

2:500 Case Categories: All applications for General Assistance will be identified according to whether the need is deemed continuous or short-term. A case will be considered to be

continuous if the need is expected to or does continue beyond thirty (30) days.

2:501 Action on Continuous and Short-Term Cases: General Assistance shall be furnished to all eligible individuals:

1. Within seven (7) days after the submission of the application if the need is short-term; or
2. Within thirty (30) days after the submission of the application if the need is continuous.
3. These conditions are contingent upon the availability of the client. In cases or situations where the client cannot be contacted except via the mail, the time limitation shall be waived.

2:502 Reporting Requirements for Continuous Cases: A case shall remain open as long as there is a need within the scope of the program and the client continues to meet all eligibility requirements. In addition, the client or a representative must:

1. Report any change in circumstances (e.g. living situation, income, resources, household size) within ten (10) days of the change; and
2. In cases where the client is required to search for employment, submit the required documentation of active employment search not later than the final week of the calendar month or before the specified date as directed by the Caseworker.
3. If there has been a change in the client's circumstances which would affect the amount of General Assistance the client was eligible to receive and General Assistance has already been provided pursuant to this Section, such change will be reflected in the following month which may result in an increase, decrease or denial of General Assistance for that month.
4. General Assistance which is received by an applicant as a result of the failure to report any information as required by this Section must be repaid to Lancaster County in accordance with the provisions of Section 2:403.

2:503 Eligibility Recertification: Continuous cases may be certified for up to a six (6) month period. Ongoing cases will be reviewed periodically depending on the circumstances of the case. All ongoing cases must be reviewed and eligibility recertified at least every six (6) months in order to remain open as a continuous case. In order to recertify eligibility, the applicant must:

1. Complete and sign a new General Assistance application in a face-to-face interview; and
2. Provide necessary verification on all points of eligibility.

CHAPTER 3

PRIMARY HEALTH CARE

Purpose: To furnish medical services for the medically indigent living in Lancaster County.

SCOPE OF MEDICAL SERVICES

3:100 Medical Coverage for Program Participants: All individuals enrolled in the General Assistance Program and approved for Primary Health Care will be eligible for ~~the following~~ services as outlined below:

1. Primary medical care and related health care services at no charge through the Primary Health Care Clinic of the Lincoln-Lancaster County Health Department (LLCHD).
2. Medical services provided by LLCHD and the General Assistance Program will be limited to those services provided for and covered by the Medicaid program.
3. Appointments for Primary Health Care will be made through the LLCHD's Community Health Services Division. At the time of appointment, the referral nurse will make an initial assessment of health care needs, and make the appropriate referrals ~~and screen for financial eligibility~~.
4. Specialty physician services and hospital outpatient or inpatient care when certified as medically necessary as defined under Section 1:121 and prior authorization is given by the Clinic Physician or his/her designated agent. The physician and/or medical facility to be utilized and the scope of medical services to be provided shall be determined by the Clinic Physician or his/her designated agent and the following factors shall be taken into consideration in making this decision:
   a. The most cost-effective method of intervention; and
   b. If the condition is chronic and non-life threatening, rehabilitative potential should exist and the number of therapy or counseling sessions should be specified.
5. Access to medical triage consultation and/or referral services after clinic hours and on weekends and holidays.
6. With prior approval from LLCHD Staff, GA clients who have special needs related to their health conditions and require Primary Care services outside of the normal scope of services offered at LLCHD by the may be approved to receive Primary Care services through a local provider.

3:101 Hospitalization/Emergency Care: Emergency room services will be provided to GA Clients who have been determined financially eligible for hospital and/or emergency room services provided the visit to the emergency room meets the criteria for a life threatening or life trauma condition. All hospital services provided in conjunction with inpatient care must be pre-authorized by the LLCHD staff.

3:102 Special Cases/Prisoners: Prisoners in the custody of the Lancaster County Correctional System shall receive Primary Health Care coverage during the term of their incarceration. Care will be provided by the designated medical staff in the jail supplemented by the Primary Health Care Clinic. Referral procedures for hospitalization and specialty care will be the same as those for other indigent patients.

SCOPE OF DENTAL SERVICES

3:200 Dental Coverage for Program Participants: Individuals enrolled in the General Assistance Program will be eligible for the following services:

1. Emergency dental care with limited treatment services through the LLCHD Dental Clinic to alleviate dental pain, control infection and prevent more costly deterioration at no fee for those clients that are actively enrolled in the General Assistance Program;
2. Specialty services or services that the LLCHD Dental Clinic is unable to provide when the emergency dental care is certified as necessary to alleviate dental pain, control infection and prevent more costly deterioration. Additionally, such services must be given prior authorization by the LLCHD Dental Clinic Manager or his/her designated agent. All referrals for specialty services will be made to a contract provider as the preferred provider and shall consider the following factors;
   a. The most cost effective method of intervention;
   b. The urgency for treatment needs;
   c. Medicaid Treatment Services/Reimbursement; and/or
   d. Whether the client is in good standing with the preferred provider;
3. A written treatment plan must be submitted to the LLCHD Dental Clinic Manager for his/her designated agent for prior authorization of treatment services.
4. For those clients that have established a dental home prior to General Assistance enrollment, such clients may remain with their established dental provider if the provider agrees to accept the usual and customary dental Medicaid reimbursement rates (not actual fee for cost that Federally Qualified Health Centers qualify for or FQHC look alike) and only for dental services that fall within the Scope of Dental Services as outlined in 3:200 of the General Assistance Guidelines. A written treatment plan must be submitted to the LLCHD Dental Clinic Manager or his/her designated agent for prior authorization of treatment services. Clients receiving dental care that does not fall within the scope of the General Assistance program will be responsible for the provider/program requirements, i.e., fees for service.

5. GA Clients who receive approval for services from a Contract Provider for any type of dental care, and who after the second time they fail to report at the appointed place and time shall forfeit any and all entitlements for future specialty dental services from a Contract Provider.

SCOPE OF PHARMACY SERVICES

3:300 Pharmacy services will be offered by licensed pharmacists in accordance with the standards and procedures established by the Nebraska Medicaid Program with the exception that no co-payment will be required. All pharmaceutical services are provided by the contract pharmacy.

3:301 Only prescription medications and over the counter medications are authorized as a reimbursable expense when pharmacy services are approved. All medical supplies and durable medical equipment must be pre-approved on a separate Service Request form.

3:302 All prescription medications will be issued as prescribed by the physician, however no more than a thirty (30) day supply of any one medication will be issued at any one time.

3:303 Replacement of lost or stolen drug products will be considered but the pharmacy provider must indicate this on the claim form. Replacement must be authorized by the General Assistance Department or Primary Health Care Clinic. The client must also have filed a police report prior to replacing controlled substances.

3:304 The dispensing fee will be the same as that allowed by the State Medicaid System. However, pharmacists shall not, under any circumstances, make a charge to the Lancaster County General Assistance Program which exceeds the pharmacy's usual and customary charges.

3:305 Medications and Pharmacy services provided by LLCHD and the General Assistance Program will be limited to those services provided for and covered by the Medicaid program.

3:306 When appropriate clients/applicants shall be required to apply for the Prescription Assistance Program as administered by the Lancaster County Medical Society (LCMS).

3:306 The LLCHD, LCMS, Lincoln Lancaster County Mental Health Clinic (LLCMHC) and General Assistance (GA) Staff will provide a monthly review of prescriptions filled to monitor for medical necessity and compliance with the requirement to participate in the Prescription Assistance Program.

SCOPE OF BEHAVIORAL HEALTH SERVICES

3:400 Behavioral Health Coverage for Program Participants: All individuals enrolled in the General Assistance Program and approved for

Primary Medical Care may be eligible for the following services:

1. Specialty physician services and hospital outpatient or inpatient care when certified as medically necessary as defined under Section 1:121 and prior authorization is given by the Clinic Physician or his/her designated agent and the following factors shall be taken into consideration in making this decision:
   a. The most cost effective method of intervention; and
   b. If the condition is chronic and non-life threatening, rehabilitative potential should exist, and the number of therapy or counseling sessions should be specified.
2. Emergency medical care for a life threatening or life trauma condition provided by a hospital in compliance with program requirements;
3. Behavioral health services requested by any individual with residency in another county other than Lancaster County will be referred to the county of residence to apply;
4. Behavioral health care services through the Lancaster County Community Mental Health Center (LCCMHC) or contracted provider for outpatient services as follows:
   a. Same-day care for emergency and Primary Health Care Clinic referrals; and
   b. By appointment for non-emergency and ongoing services.
5. Inpatient behavioral health services will focus on individuals in need of acute psychiatric inpatient services who are unable to access services at the Lincoln Regional Center. The following conditions must be met. Clients must be either:
   a. At risk of suicidal behavior;
   b. In acute psychosis unmanageable as an outpatient; or
   c. Persons in need of short-term stabilization away from crisis situations.
   d. In all cases, documentation must exist that efforts to place the individual at the Lincoln Regional Center have occurred.
   e. Adult Emergency Protective Custody cases will be handled by the Lancaster County Crisis Center.
6. All requests for assisted living within Lancaster County must include a Lancaster County GA Form 5 and have prior authorization from the Director of the Lancaster County General Assistance Office.

3:500 Behavioral Health Formulary Medications for treatment of behavioral health clients will be prescribed in accordance with Appendix C.

CHAPTER 4

CO UNTY CREMATIONS/BURIALS

4:100 County Services: If the estate of the decedent and/or the income and resources of responsible relatives are insufficient to meet the cremation or burial expenses, General Assistance may be authorized to meet these expenses if the provider of mortuary or cemetery services is covered under the current County contract or agrees in writing to provide these services in accordance with the provisions of the General Assistance Guidelines. It is the policy of Lancaster County that direct cremation, as defined in section 1:110 is the only option available. Exceptions to this policy are only for those situations where cremation is not an option due to legal considerations and must be approved by the County General Assistance Director or Deputy Director. Cremation must be approved by next of kin or responsible party. If the decedent's body is unclaimed by next of kin or a responsible party, then the County may authorize the body to be cremated or buried. The County Board's Chief Administrative Officer may authorize any such cremation or burial on behalf of the County. Approval of an application for county cremation services does not constitute approval or authorization to cremate.

4:101 County Fee Schedule: ~~The fee schedule for County cremations/burials set forth in Appendix B is effective March 1, 2007 and will continue through February 28, 2009. The fee schedule will be adjusted effective March 1 , 2009 based upon the change in the U.S. Bureau of Labor Statistics Kansas City, MO-KS Consumer Price Index - All Urban Consumers 1982-84 = 100 (CPI-U). The increase or decrease will be in the same percentage as the change in the Kansas City, MO-KS (CPI-U) from first half 2008 to first half 2009. Thereafter, the fee schedule in Appendix B shall be updated every two (2) years according to the formula set forth in this section.~~ A fee of $500 (Eight hundred dollars) will be paid for cremation services as outlined in section 4:102. This fee will be effective July 1, 2012 and renegotiated every three (3) years beginning in 2015.

4:102 Services Covered by County: The following services are included within the established fee structure as noted in Section 4:101, Allowable Expenses~~, and published in Appendix B~~:

1. Allowed Cremation Services:
   a. Required preparation;
   b. ~~One-time, brief newspaper notice (limited to name, age and date/time of service~~);
   c. ~~Alternative~~ Cardboard container ~~as selected by the mortuary~~;
   d. Plastic container for cremated remains ~~as selected by the mortuary~~;

e. Transportation from place of death to the mortuary;
f. Transportation to the place of cremation, if different from mortuary;
g. Crematory fee;
~~h. Private family viewing/visitation, no public viewing, as scheduled by the mortuary; and~~
~~i. Chapel services.~~

2. When direct cremation is not an option due to legal considerations which can be confirmed by the Lancaster County Attorney office burial services may be authorized. The services shown in item 3 (below) are to be included within the established fee structure as noted in Section 4:101, Allowable Expenses, ~~and published in Appendix B~~.

3. Allowed Burial Services:
   a. Embalming, dressing and casketing;
   ~~b. One-time, brief newspaper notice (name, age and time of service);~~
   c. Casket as selected by mortuary;
   d. Grave liner, if required by the cemetery (and any associated charges);
   e. Transportation from place of death to the mortuary (see also Section 4:104);
   f. Transportation to the cemetery;
   g. Visitation as scheduled by mortuary; and
   h. Chapel or graveside services.

4:103 Items Not Covered by County Cremation/Burial: The following items are not included or provided for in the County fee structure:
1. Chapel services;
2. Graveside Committal Service;
3. Flowers;
4. Organist;
5. Pallbearers;
6. Clergy fee;
7. Clothing;
8. Viewing/visitation, or preparation for viewing;
9. Transportation for the family;
10. Memorial cards or record book;
11. Telephone or telegraph notices;
12. Transportation of the deceased outside Lancaster County (see Section 4:104);
13. Headstone;
14. Funeral escort service; and
15. Burial of cremated remains except in accordance with Section 4:111.

4:104 Transportation Exceptions: A reasonable payment may be allowed to transport a Lancaster County resident from place of death outside the County (e.g. University Hospital) back to Lancaster County. Transportation of deceased from Lancaster County to a funeral home and/or cemetery in another county or state where other family members live or are buried may also be allowed when reasonable (e.g. to allow burial next to spouse). Cost for

transportation will be paid as billed, not to exceed the lesser of $.50/mile or $100.00.

~~If the initial transportation of the decedent is done by any mortuary other than the one selected to provide the services covered by the County, an additional transportation fee of $100.00 may be paid for this service.~~

4:105 Financial Eligibility Requirements: In order to be eligible for County cremation/burial services, the assets of the decedent's estate and/or the income, assets and resources of responsible relatives cannot exceed allowable expenses as defined in ~~Appendix B~~ section 4:101, Allowable Expenses.

4:106 Financial Participation: ~~If~~ When the financial eligibility requirements are met, County cremation/burial services may be authorized but only to the extent that the cost of services exceeds the assets of the decedent's estate and/or income and resources of responsible relatives.

EXAMPLE

Step	Amount
Step 1-Cost	
Cremation	$800
Step 2 – Assets of Decedent	
Cash	$200
Life Insurance	$100
TOTAL	$300
Step 3	
Total Cost	$8000
Minus Assets	$300
COUNTY PAYMENT AUTHORIZED	$500

4:107 Responsible Relatives: Includes spouse of the decedent and parents of a minor child.

4:108 Other Eligibility Requirements: In addition to meeting the financial eligibility criteria, any individual requesting County cremation/burial services on behalf of the decedent must agree in writing to the following terms and conditions:

1. They will accept the services as outlined above and understand that the funeral home will not provide additional items or services;
2. They have not made nor will they make financial arrangements to provide for services not covered by the County;
3. They will cooperate with the funeral home in securing income and assets of the decedent determined to be a set off against the County's responsibility; and
4. If the decedent did not own a burial plot at the time of death, interment will be arranged through a cemetery as determined by the County.

Violations of these conditions will forfeit the County's responsibility for participating in the costs of the services provided.

4:109 Treatment of Income of Responsible Relatives: In cases where the responsible relative has income, the following guidelines will apply:

1. Amount of monthly income (net amount)
   -(minus) Actual cost of housing, utilities and food or ADC standard of need, whichever is greater
   + (plus) Liquid resources
   = (equals) Amount to be applied to County services
2. In cases where the surviving spouse/dependent child is entitled to receive the burial benefit from the Social Security Administration, those funds will be reimbursed to the County General Assistance Department upon receipt.

4:110 Agency Procedures:

1. All requests for County cremations/burials must be in writing and signed by the person making the request.
2. If arrangements for cremation/burial services have been made with the mortuary in excess of the County fee schedule, assistance will be denied.
3. Both the applicant and the mortuary will receive written notice which will indicate if the request for County cremation/burial services is approved or denied and in the case of approvals, notify the mortuary and cemetery of the amount of the payment to be made by the County.
4. If funds exist which are to be applied to the cost of the cremation/burial services and the financial institution holding such funds requires a certified copy of the death certificate, an additional $11.00 may be paid to the mortuary to cover this expense.

4:111 Unclaimed Bodies: In cases where the decedent's body is unclaimed by next of kin or a responsible party and the State Anatomical Board does not want the body, cremation services will be provided. All cremated remains of unclaimed bodies shall be buried in an ossuary in the County section of Wyuka Cemetery. A fee of $55.00 shall be paid to Wyuka Cemetery per inurnment, which fee shall include a permanent recording of the burial.

4:112 Unusual Circumstances: When necessary to expend monies in excess of the amounts cited in ~~Appendix B~~ section 4:101, Allowable Expenses, approval shall be obtained from the County General Assistance Director or Deputy Director and the special circumstances documented in the case narrative. Situations may arise which require the Director's approval and must be negotiated on a case-by-case basis due to the infrequency of such requests. A reasonable

payment may be allowed for unusual circumstances not to exceed $250.00.

CHAPTER 5

ADMINISTRATIVE POLICY AND PROCEDURE

The following regulations will control the financial obligation of Lancaster County, Nebraska, to expend funds on behalf of any individual eligible to receive General Assistance, Primary Health Care coverage and/or a County cremation/burial.

GENERAL PROVISIONS

5:100 Completed Application: To be considered a completed application, the application must be signed by the applicant/client within ten (10) days immediately preceding the date it is received in the Lancaster County General Assistance Office. Prior to approving an application for assistance, the original copy of the application must be provided to the General Assistance Caseworker.

The County will assume no liability to provide program benefits to any individual who fails to complete a written application within the time specified by a program's requirements. A written request for General Assistance will not act as a substitute for such written application.

5:101 Availability of Funds: The obligation of the County to provide General Assistance under any program shall be subject to the availability of funds in the fiscal year.

5:102 Approved Vendors: Even though an individual is qualified to receive program benefits, the County shall not make payment for any service unless:

1. The provider of those services is approved as a vendor by the General Assistance Department and complies with the appropriate program regulations; and
2. The vendor agrees to reimburse the County in the event payment is made for goods or services which are subsequently not provided. Such reimbursement shall be in whole or in part based upon the actual goods or services provided.

PAYMENT PROCEDURES

5:200 Vendor Payments: Payments on behalf of eligible clients can be made only if the vendor will accept a County voucher and the vendor agrees to provide the goods or services through the authorization period.

5:201 Insuring Maintenance of Minimum Health and Decency: Even though an applicant is found eligible for General Assistance, payment will not be issued unless such payment will insure the maintenance of minimum decency and health for the client. Such situations include, but are not limited to, the following:

1. Utility shutoffs (The applicant has received a shutoff notice for non-payment and the maximum rate of payment allowable for the size of the household is insufficient to prevent the shutoff from occurring. General Assistance may also be denied if other assistance programs are available or the utility shutoff will not adversely affect the health, safety or welfare of the client.);
2. Foreclosure or eviction proceedings are pending and the maximum payment allowable for the size of the household is insufficient to prevent foreclosure or eviction;
3. The applicant's residence does not meet the minimum provisions of the applicable health codes;
4. Rental assistance may be denied to a client who is financially eligible if the client cannot demonstrate the ability to continue making rental payments after General Assistance has ceased; or
5. In situations where the vendor or property owner refuses to accept payments from the General Assistance program on behalf of the applicant/client.

5:202 Notice of Eligibility But Non-Issuance of Payment: In all cases in which the provisions of Sections 5:200 and 5:201 apply, the client will be notified in writing:

1. That they are eligible for General Assistance for the authorization period;
2. Of the maximum payment available for the items requested;
3. That payment will not be issued to the vendor; and
4. Once they have secured alternative living arrangements or the vendor has agreed to provide the goods and services through the authorization period, General Assistance will be issued.
5. If General Assistance is not issued during the authorization period, a notice of termination of benefits will be sent to the applicant. In the event that the applicant and vendor reach an agreement subsequent to the letter of termination, General Assistance may be issued if it will assist the client in avoiding relocation and if such agreement is reached within thirty (30) days of the date of the notice of termination.

5:203 Reimbursements: The General Assistance program does not reimburse any person or agency for payments made to a provider on behalf of a client.

GENERAL ASSISTANCE VENDORS

5:300 Landlords: In order to be an approved vendor eligible to receive General Relief Orders, the individual or organization receiving payment must either be:

1. The title holder of record of the real estate where the client resides; or
2. The designated agent of the title holder or record of the real estate where the client resides; or
3. The mortgage holder of record to the real estate where the client resides; or
4. The buyer of real estate on land contract. If the title of record is still in the name of the seller or trustee, a copy of the contract must be provided to the General Assistance Department.

5:301 Immediate family members shall not qualify as landlords and shall not be eligible to receive payments as approved vendors when the applicant's relationship to the landlord includes parent, stepparent, parent-in-law, grandparent, spouse, brother, sister, son, daughter, stepson and/or stepdaughter.

5:302 Assisted Living Facilities: In order to be an approved vendor eligible to receive General Relief Orders, the assisted living facility must be licensed as such by HHS.

5:303 Location of Property: In all cases the real estate or board and room facility must be located within the geographic boundaries of Lancaster County.

AUTHORIZED MEDICAL AND HOSPITAL SERVICES

Medical and hospital care delivered by a provider to a qualified Primary Health Care client will be reimbursed for such care based upon the Medicaid rate or at the rate actually charged by the provider, whichever is less, provided such care was delivered in compliance with the following sections.

5:400 Prior Authorization: All health services and hospital care must have prior authorization by the Clinic Physician of the Primary Health Care Clinic or his designated agent unless otherwise provided for herein. Prior authorization shall consist of:

1. A written referral from the Primary Health Care Clinic designating the provider, hospital and/or physician authorized to provide care, specifying the nature of the medical service being authorized and that the medical care is to be provided within a specified period of time:
   a. Individuals with chronic, long-term health problems will be referred to community physicians; and/or
   b. Individuals already established with a physician for treatment of long- term health needs may remain with that physician when approved by the LLCHD.
2. Verbal authorization by the Clinic Physician or designated agent if medical care is required after clinic hours, on weekends or holidays followed by a written referral the next working day.

5:401 Prescription Medications: Prescription medication may be issued by a provider to a qualified Primary Health Care patient upon dismissal from the hospital provided no more than a seven (7) day supply of medication is issued. If medication will be required beyond seven (7) days, the patient should be provided with a prescription.

5:402 Life Threatening/Life Trauma Condition: Any medical condition which, in the opinion of the County designated physician, requires the individual be either:

1. Admitted to an intensive care unit; or
2. Operated upon before the next working day for emergency, non-elective procedures; or
3. Designated an emergency admission because he/she requires hospital treatment to prevent possible mortality or increased morbidity.

5:403 Emergency Medical Care:

1. Providers may be reimbursed for emergency medical care and/or subsequent inpatient hospitalization provided:
   a. Emergency medical care was provided because of a life threatening or life trauma condition; and
   b. the medical provider notifies the Primary Health Care clinic or the General Assistance Department within seventy-two (72) hours of admission that they are providing medical care to a patient actively enrolled or potentially eligible for Primary Health Care coverage.
2. The Primary Care Clinic will notify the General Assistance Department when emergency treatment or hospitalization is authorized.
3. The hospital's Utilization Review Nurse completes a review of the patient within seventy-two (72) hours from the time of admission and upon completion of the review, contacts the Primary Health Care Clinic and gives the following information:
   a. Patient identification;
   b. Medical diagnosis; and
   c. Patient's physician.
4. The Clinic Physician, or designated agent and attending physician, certifies the medical treatment was for a life threatening or life trauma condition and only medically necessary care was provided and reports authorization to the General Assistance Department.
5. If emergency medical care is provided after normal business hours, on weekends or holidays, the Clinic Physician must give information required in paragraphs 2 and 3 above, to the Primary Health Care Clinic on the next business day.

5:404 Continued Hospitalization/Inpatient Review: The hospital Utilization Review Nurse shall again review the patient at the fiftieth (50th) percentile of the appropriate Diagnosis-Related Group, unless requested sooner by the Clinic Physician or designated agent. In any case, the

Clinic Physician or designated agent may at any time assign a County reviewing physician to evaluate the patient and treatment plan and determine whether:

1. Continued care should be authorized; or
2. Treatment could be provided on an outpatient basis.

Any determination so made shall be noted on the patient's medical records. In the event continued care is not authorized, Lancaster County shall not assume liability for payment of medical expenses incurred from and after the date such determination is made.

NON-REIMBURSABLE SERVICES

Medical services will be provided through the Primary Health Care Clinic and are therefore not reimbursable expenses when delivered by a provider unless specifically authorized by the Clinic Physician or designated agent.

5:500 Clinic Services: Lancaster County provides Primary Health Care Clinic services through LLCHD. Clinic hours will be at locations and times specified and staffed by licensed physicians or health professionals. All qualified clients shall have access to primary medical care through the Clinic.

5:501 Acute Care: The Primary Health Care Clinic shall provide acute care to all qualified Primary Health Care clients. This may include simple nursing services, rehabilitation, post-surgical monitoring, physical therapy, etc., which will not result in the loss of continuity of care.

5:502 Attending Physicians: The attending physicians may continue care provided the client completes an application and continuing care is approved by the Clinic Physician.

5:503 Follow-Up Care: All qualified Primary Health Care clients shall receive follow-up care through the Primary Health Care Clinic or by the previously approved attending physician upon discharge from any hospital.

5:504 Radiology Services: As the health need indicates, radiology services shall be provided at a designated site.

PAYMENT PROCEDURES FOR MEDICAL CARE

5:600 Submitting Charges: All medical providers seeking reimbursement from the General Assistance Program must include the appropriate Medicaid code designations for the services provided in order for the bill to be processed for payment. Any bills received that do not include this information shall be returned to the provider for correction and resubmission. All bills must be received and/or resubmitted

within ninety (90) days of the date of the last services provided or payment will be denied.

5:601 Payment of Charges: All bills submitted in compliance with Section 5:500 shall be approved or denied within a reasonable time, not to exceed sixty (60) days, unless:

1. An application for Primary Health Care coverage is pending, or the client has been denied coverage and is in the process of appealing the County's decision. In either case, the medical provider shall be notified of the delay and the reasons for such delay.
2. Medical bills for SSI pending clients will be paid to providers at the time of service only when the provider has signed a contract with Lancaster County agreeing that upon notification of approval for Medicaid, Medicare or any other payment source for services provided it will reimburse Lancaster County the appropriate amount and bill the appropriate agency.

5:602 Notice of Non-Coverage: If all or any portion of the medical expenses billed (other than adjustments to reflect the Medicaid rate or excess income obligation of the client) are denied because such expenses were for non-covered services, a Notice of Finding shall be issued to the client indicating that coverage has been denied and the reason for the denial. A copy of such notice shall also be forwarded to the medical provider(s).

CHAPTER 6

INCOME AND RESOURCE STANDARDS

6:100 The income and resource standards governing eligibility for the receipt of General Assistance shall be based on the OMB Poverty Guidelines, which shall be applied as follows:

1. Medical Assistance:
   a. Primary Health Care - In order to receive services from the Primary Health Care Clinic, or from authorized outside providers, the applicant's gross income must be equal to or below 100% of the OMB Poverty Guidelines as set forth in Appendix A, Part I and in effect during the authorization period.
   b. Hospitalization and Emergency Room Services - In order to receive assistance for hospitalization and/or emergency room services, the applicant's net income must be equal to or below 50% of the OMB income guidelines as set forth in Appendix A, Part II and in effect during the authorization period.
2. Rent, Deposit and Non-Medical Assistance - In order to receive assistance for non-medical (other than burial assistance), rent and/or deposit assistance, the applicant's net income must be equal to or below 50/70% of the OMB income guidelines as set forth in Appendix A, Part II and in effect during the authorization period.
3. Burial Assistance - In order to receive assistance for burial services as defined in Chapter 4, the decedents estate and/or the gross income and resources of a responsible relative must be equal to or below 100% of the OMB Poverty Guidelines as set forth in Appendix A, Part I and in effect during the authorization period.

6:101 Adjustments to OMB Poverty Guidelines: Annual adjustments to the OMB Poverty Guidelines shall become effective on the first day of the month following publication in the Federal Register. The guidelines in effect at the time of request shall govern initial eligibility determinations.

APPENDIX A

0 % OMB POVERTY GUIDELINE

Family Size	Monthly
1	$ 903
2	$ 1,215
3	$ 1,526
4	$ 1,838
5	$ 2,150
6	$ 2,461
7	$ 2,773
8	$ 3,085

For each additional household member, add $312. The 100% figure is used in determining eligibility for Primary Health Care. (See Section 6:100 (1) (a)).

50%~~/70%~~ OMB POVERTY GUIDELINE

Family Size	Monthly ($)
1	$452
2	608
3	763~~/1,069~~
4	919~~/1,287~~
5	1,075~~/1,505~~
6	1,231~~/1,723~~
7	1,387~~/1,942~~
8	1,543~~/2,160~~

For each additional household member, add $156 (or $218). The 50% figure is used in determining eligibility

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for non-primary care medical services (see Section 6:100 (1) (b)) and non-medical General Assistance (see Section 6:100 (2)). ~~The 70% figure is used in determining eligibility for shelter only, for households of three (3) or more individuals. (Effective 2-21-2008)~~

APPENDIX B

CONSUMER PRICE INDEX

ALL URBAN CONSUMERS – KANSAS CITY, MO-KS

INDEX FIRST HALF OF 2006 — 188.6
INDEX FIRST HALF OF 2008 — 200.9
CHANGE
12.3
PERCENTAGE CHANGE — 6.5%

CHANGE IN ALLOWABLE EXPENSES

1. FLAT FEE FOR MORTUARY SERVICES:

	Rate – Prior to 2/28/07	Percentage Increase	Rate Effective 3/1/07
A. Cremation	$990	6.5%	$1,108
B. Burial			
1. Adult Burial	$1,860	6.5%	$2,077
2. Child Burial	$990	6.5%	$1,108

2. FLAT FEE TO CEMETERY:

A. Cremation, plot open & closed fee	Not covered	N/A	N/A
B. Burial Plot open & closed fee (effective 3/1/07)	$675	5.0111%	$719

APPENDIX C B

Behavioral Health Formulary:

Use generic medications all the time unless contraindicated

Medications for the treatment of behavioral health conditions will be prescribed in accordance with the following formulary and evidence based practice.

1. Tier One: Medications to be prescribed as the first option for treatment as indicated:
   a. Anti-anxiety – Buspirone, Hydroxyzine,
   b. Antidepressant- Amitriptyline, Citalopram, Doxepin, Fluoxetine, Nortriptylin, Paroxetine, Trazodone, Wellbutrin, Effexor,
   c. Mood Stabilizer – Lithium Carb, Depakote, Depakote ER, Tegretol
   d. Antipsychotic- Fluphenazine, Haloperidol, Prochlorperazine, Prolixin Decanoate, Haldol Decanoate, Thioridazine, Thiothixene, Risperdal, Geodon,
   e. Parkinson's – Benztropine, Trihexphenadyl
   f. Thyroid – Levothyroxine
   g. Alzheimers- ACHE inhib, Exelon, Aricept, Namenda
2. Tier Two: Medications on Tier Two may be used only after use of the Tier One Medications has been unsuccessful.
   a. Anti-anxiety – Xanax, Klonopin, Ativan
   b. Antidepressant- Lexapro, Zoloft
   c. Mood Stabilizer – Lamictal
   d. Antipsychotic – Abilify, Clozaril,
   e. Sleep agents- Ambien, Sonata
3. Tier Three: Consists of all other medications prescribed for treatment of behavioral health conditions and its continued use will require specific review and approval by staff at Community Mental Health.

EXHIBIT
tabbies
G

Market Evaluation
Jan-13

EVALUATION OF DATA:

Pyschiatrist

LOCAL COMPETITOR PAY RANGES	SALARY BY RANGE DATA MIN	MID	MAX	Range	Comments
Douglas County	$191,605.00	$191,605.00	$191,605.00	0%	Contracted
Sedgwick County	$154,606.00	$176,270.50	$197,935.00	28%	Contracted
Nebraska Hospital Association-Comp Data Survey	$206,600.00	$206,600.00	$206,600.00	0%	
Towers Watson	$200,000.00	$200,000.00	$200,000.00	0%	
State of Nebraska	$130,018.00	$204,314.00	$284,801.00	119%	
Local Physician Network		$188,028.00			
Current Lancaster County Pay Range	$213,183.00	$213,183.00	$213,183.00		30 hrs per week
AVE of Market Range Data	$176,565.80	$194,469.58	$216,188.20		
Market % diff from Midpoint	17.2%	8.8%	-1.4%		
Market % diff from Midpoint After Adjustment	#DIV/0!	#DIV/0!	#DIV/0!		

INDICATES County IS LOW	
Increase one pay grade	
INDICATES County IS HIGH	

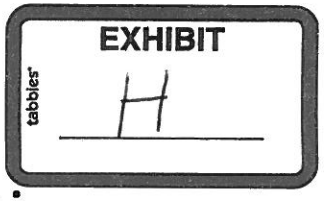
	SALARY BY INCUMBENT DATA 25%	50%	75%	# Orgs Reporting	Comments
County Staff AVE					
AVE reported salary	#DIV/0!	#DIV/0!	#DIV/0!		# BLGH Staff =
Market % diff from County data	#VALUE!	#DIV/0!	#DIV/0!		
After X % Adjustment	#VALUE!	#NAME?	#NAME?		
Market % diff from County data after Adjustment	#VALUE!	#NAME?	#NAME?		

Hourly Rates (2080 hours)

Douglas County	$92.12	$92.12	$92.12
Sedgwick County	$74.33	$84.75	$95.16
Nebraska Hospital Association-Comp Data Survey	$99.33	$99.33	$99.33
Towers Watson	$96.15	$96.15	$96.15
State of Nebraska	$62.51	$98.23	$136.92
Local Physician Network		$90.40	
Average Hourly of Market Data	$84.89	$93.49	$103.94

Lancaster County (2080 hours) $ 102.49
On call 24/7

RECOMMENDATIONS:

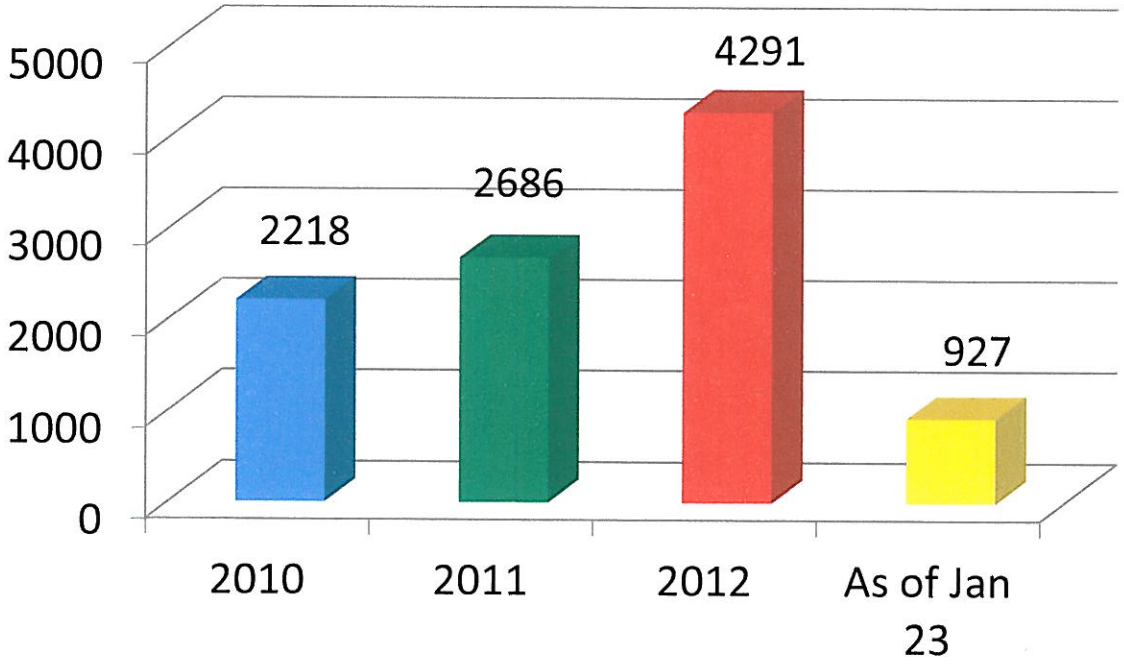


Request For New Records System Specialist Position
Lancaster County Sheriff's Office

- Current and Ongoing Issues Affecting Need for New Records Systems Specialist
  - Dramatic Increase in Handgun Purchase Permit applications
  - Increase in Sex Offender Registry verifications, status changes and updates
  - Documented increase in overtime hours for RSS staff due to lack of staff
  - Resignation of 3 personnel in Records System Staff due to lack of manpower causing extremely heavy workload

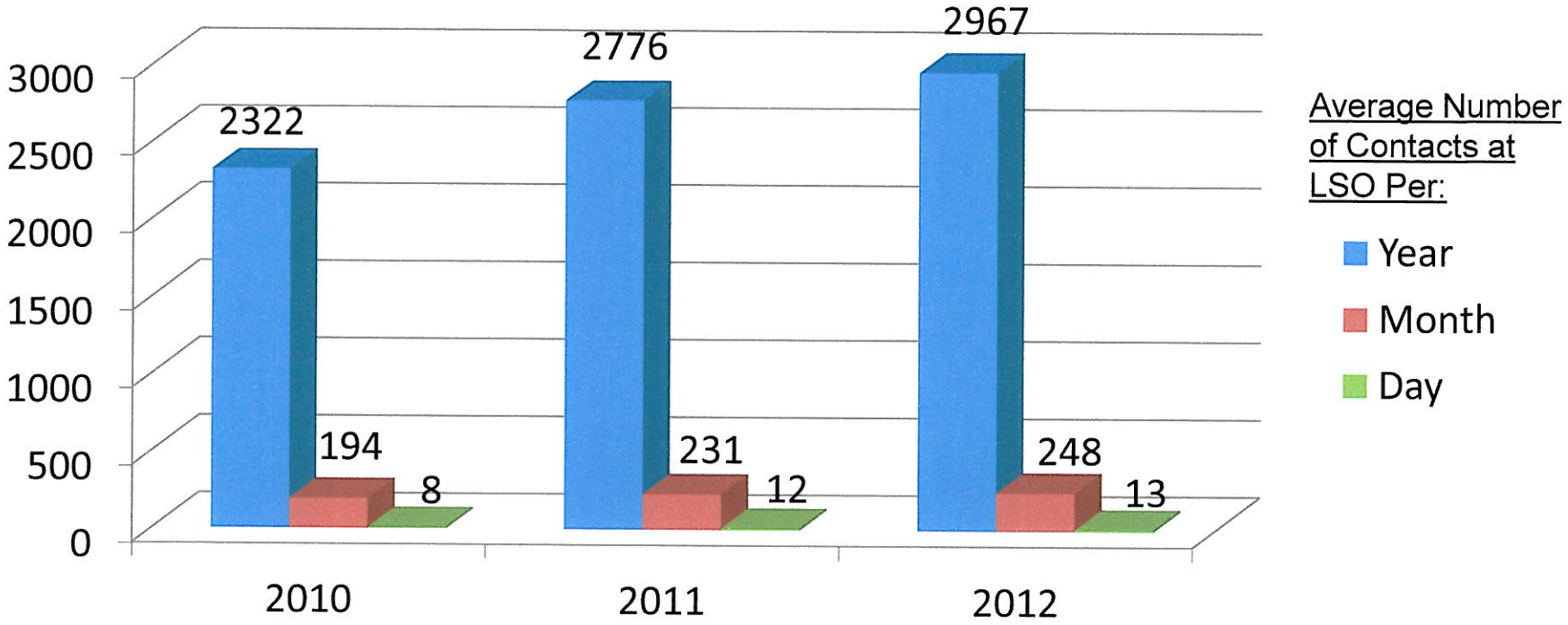
Increase in Handgun Purchase Permit Applications

Purchase Permit Increase Over Last Three Years



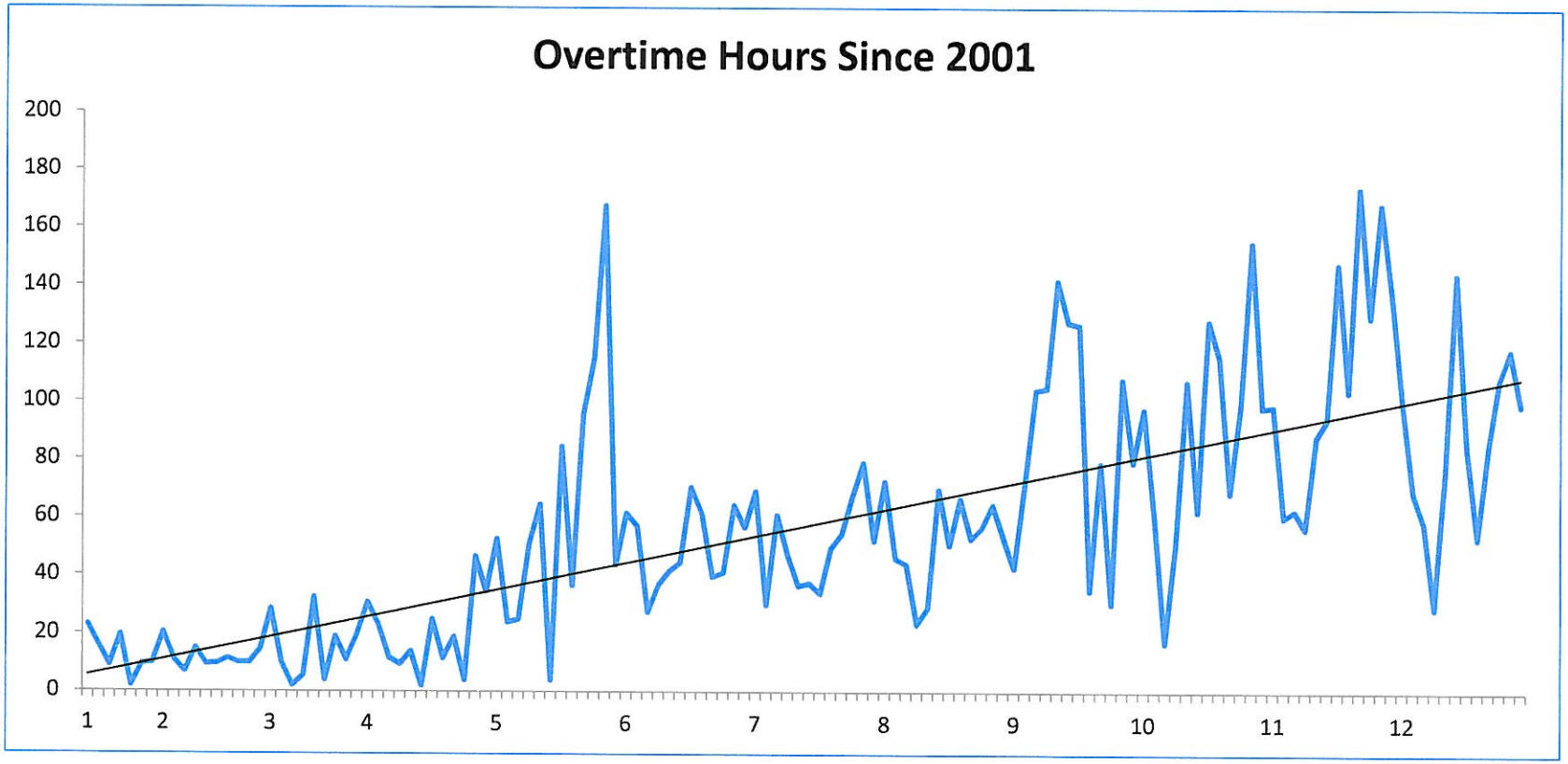
- Increase 2010 to 2011 = 20.5%
- Increase 2011 to 2012 = 60%
- Increase 2010 to 2012 = 93.5%
- At current pace 2013 could double from 2012

Increase in Sex Offender Registrations, Verifications, Status Changes and Updates



- 4039 Registered offenders in the State of Nebraska - Jan 2013
- 654 of those offenders reside in Lancaster County – Jan 2013
- Lancaster County offenders make up 16% of State Total
- Lancaster County offenders make approx. 5 visits to Sheriff's Office per year
- Increase in number of offenders to LSO from 2010 to 2012 = Approx. 28%
- The average offender contact at LSO is approximately 10-15 minutes

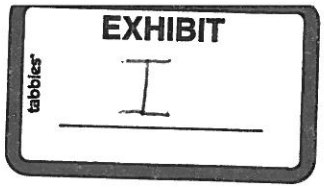
Documented Increase in Overtime



- There has been a 500% average increase in overtime hours within the Records Division in the last 10 years.

Loss of Records System Staff

- Over the last year, a turnover of 50% of the Records System staff has occurred.
- This turnover is attributable to the increased duties and lack of staff to address the duties.
- Due to the increased duties and lack of staff, ability to take earned time off has become difficult and driven up the amount of overtime required to meet these needs.
- Further loss of personnel and turnover is anticipated without added assistance to the Records System staff
- Without more Records System personnel, meeting the required statutory scheduling of Handgun Permit turnaround and verification, update and changes of sex offenders cannot be met.



Five-Year Summary of Gun Applications

YEAR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
2008	177	198	202	152	120	115	126	146	149	234	250	352	2,221
2009	349	278	357	299	143	169	155	159	191	207	167	150	2,624
2010	192	229	236	171	156	131	147	176	180	194	195	202	2,209
2011	278	257	293	220	177	158	174	220	172	184	236	249	2,618
2012	329	305	363	247	200	199	247	298	247	282	415	895	4,027