



**MEETING NOTICE
INVITATION TO NEGOTIATE COMMITTEE
WEDNESDAY, JANUARY 16, 2013
7:30 - 8:30 a.m.
COUNTY – CITY BUILDING – 555 S 10TH ST
ROOM 113**

AGENDA

1. Approval of Minutes - January 9, 2013
2. Approval of the RFQ to be Issued by Region 5 Systems

MINUTES
COMMUNITY MENTAL HEALTH CENTER (CMHC)
INVITATION TO NEGOTIATE (ITN) COMMITTEE
WEDNESDAY, JANUARY 16, 2013
COUNTY-CITY BUILDING, ROOM 113
7:30 A.M.

Committee Members Present: Ron Sorensen, Community Mental Health Center (CMHC); C.J. Johnson, Region V Systems; Judy Halstead, Lincoln-Lancaster County Health Department (LLCHD); Lori Seibel, Community Health Endowment (CHE); Jane Raybould and Brent Smoyer, County Commissioners; Gary Lorenzen, Mental Health Foundation; Gail Anderson, CMHC Advisory Committee; J Rock Johnson, consumer advocate; Kerry Eagan, County Chief Administrative Officer (Ex-Officio); Scott Etherton, CMHC (Ex-Officio); and Wendy Andorf, CMHC (Ex-Officio)

Committee Members Absent: Captain Joe Wright, Lincoln Police Department (LPD).

Others Present: Linda Wittmuss, Associate Regional Administrator, Region V Systems; Amanda Tyerman-Harper, Region V Systems; Tami Walden, Consumer; Alan Green, Executive Director, Mental Health Association; Will Spaulding, Ph.D., University of Nebraska-Lincoln (UNL) Department of Psychology; Mary Sullivan, Consultant to CMHC and UNL; and Ann Taylor, County Clerk's Office

Sorensen called the meeting to order at 7:36 a.m.

1 APPROVAL OF THE JANUARY 9, 2013 MINUTES

Anderson noted concerns had been expressed at the last meeting regarding transportation issues for consumers and said she took the initiative, as a consumer, to contact Midwest Special Services, a transportation company with headquarters in Curtis, Nebraska. She said Midwest Special Services has a fleet in the Lincoln area and has expressed interest in becoming a provider. Anderson said she would like the minutes to reflect that consumers can take the initiative to look into matters that affect them.

J Rock Johnson asked that the fourth sentence in the fifth paragraph on Page 4 be amended to read as follows: *She also requested more specifics with regards to outcome measures.*

MOTION: Lorenzen moved and J Rock Johnson seconded approval of the minutes with that correction. Sorensen, C.J. Johnson, Halstead, Seibel, Raybould, Lorenzen, Anderson and J Rock Johnson voted aye. Wright and Smoyer were absent from voting. Motion carried 8-0.

2 APPROVAL OF THE REQUEST FOR QUALIFICATIONS (RFQ) BY REGION V SYSTEMS

C.J. Johnson gave an overview of the Region V Systems, Request for Qualifications (RFQ) for Community Behavioral Health Services document (Exhibit A), noting funding is projected to be \$1,394,214, based on a three-year average utilization of services at CMHC. He said the ITN process will be completed in phases: Phase 1 - Request for Qualifications; Phase 2 - Pre-Proposal Negotiations; and Phase 3 - Proposal Submission.

Smoyer arrived at the meeting at 7:44 a.m.

Lorenzen asked whether primary care physicians could provide medication management. Wittmuss said the service definition for medication management is basically restricted to a psychiatrist or an advanced practice registered nurse (APRN), with a psychiatric background, although there is some allowance for medical practitioners who can demonstrate training and experience in that particular area.

Lorenzen asked whether 24-hour Crisis Line is part of CMHC. Etherton said it is not.

Seibel asked how County funding fits with this. C.J. Johnson explained it is a separate pool of funding and was not included because they did not want potential providers to make assumptions that the funding would be ongoing. Andorf noted that some of the highest usage of County dollars is in the medication management area.

C.J. Johnson noted that Region V has set aside approximately \$200,000 for unknown costs and to make innovative changes, either in this programming or somewhere else in the system.

Sorensen said CMHC has been operating below the contract levels. He said staff layoffs affected the intake capability, which in turn impacted other services. Wittmuss said Region V was aware of that and based the numbers in the RFQ on the highest utilization of the core services. Tyerman-Harper said some the capacities were reduced, based on three-year averages. She added that funding of the outpatient service category was restored to the level it was at prior to cuts in 2012.

Andorf asked whether the current level of funding for The Heather (a community transition program) is reflected. C.J. Johnson said it was not because there are no guarantees that the State will allow Region V Systems (RVS) to continue its current rate of funding.

Sorensen noted the relationship between CMHC and the University of Nebraska-Lincoln (UNL) Department of Psychology and the training that is provided to UNL psychology students through CMHC.

C.J. Johnson discussed the evaluation methodology, noting some components of the RFQ and the provider capacities will be weighted (see Pages 8 and 10).

It was noted the Evaluation Committee is comprised of RVS staff. C.J. Johnson said an outside perspective could be helpful. Anderson and J Rock Johnson expressed interest in serving on the Committee. Lorenzen felt there should also be clinical representation.

Seibel referred to No. VIII, Section A and suggested further clarification of Subsection 3.b (see Page 10) is needed to indicate it is referring to the categories of provider interest shown in Subsection 1.c. (See Page 9).

Halstead asked why No. 2 under Assurances (see Page 11) is limited to compliance with the regulatory rules and regulations of the Nebraska Department of Health and Human Services (DHHS) and felt it should be expanded to all local and state regulatory rules and regulations.

Seibel questioned whether cultural competency should be addressed in the provider capacities section (see Page 10). Wittmuss explained it is covered in the original document and said that will likely be included in a Request for Proposals (RFP). She added that cultural competency it is a strong component in any accrediting body requirement.

J Rock Johnson referred to Item E under Provider Capacities (see Page 10) and suggested inclusion of staffing. She then referred to the sixth paragraph on Page 1 and suggested that the reference to restrictions on clarifying questions be made clearer. J Rock Johnson also suggested the following revisions:

- Reword the last sentence on Page 4 to read as follows: *It is the strategic intent of the ITN process to ensure that current consumers of CMHC continue to receive necessary recovery-based services and supports.*
- Reword Item III.2 on Page 5 to read as follows: *Adults with, or at risk, of experiencing disruption in functioning or impairments due to behavioral health issues, a majority of whom may have severe and persistent mental illness (SPMI), or serious mental illness;*

J Rock Johnson also referred to Item IV (Scope of Services) on Page 5 and said peer support is an emerging area and there isn't clear consensus on what some of the terms mean. She felt the wording was problematic but did not have language to suggest at this time. Tyerman-Harper explained that most of the language was taken from the CMHC Planning Committee Report. C.J. Johnson felt it could hinder the process if some of language were pulled out. J Rock Johnson said she would agree to leave the language in but would like the phrase *peer supported* changed to *peer support*. She also suggested that a link related to proposed peer counseling regulations be added to Item IV, Section A, Subsection 2a. Wittmuss said it may be better to make a statement that there are pending regulations.

J Rock Johnson questioned the language in Item VIII, Section A, Subsection 2b. Tyerman-Harper explained it is just distinguishing between the expectations of what needs to be submitted if the potential provider is already a member of the RVS Provider Network or if they are a new provider who wants to be considered but has not already provided that supporting documentation to RVS.

J Rock Johnson felt the definitions were somewhat misleading and felt they should be omitted and the information provided in another manner. C.J. Johnson stressed the need to provide as much information to potential providers as possible but said he will leave it up to the Committee whether to include definitions.

C.J. Johnson exited the meeting at 8:53 a.m.

Sorensen said the definitions relate specifically to the RFQ document and felt it should be left to RVS to decide whether to include them or not. J Rock Johnson asked that RVS review and possibly modify the definitions section.

Wittmuss said staff will make the recommended changes and send the document out to the Committee for final review and comment. She said Committee members may also provide questions for evaluating the provider capacity piece.

J Rock Johnson exited the meeting at 8:56 a.m.

Sorensen asked whether there will be a need for any further meetings. Wittmuss said possibly during the review of the qualifications piece. Raybould said she believes there could be an opportunity for the Committee to review the qualified proposals and provide input. Sorensen felt it should be up to the County Board as to whether the Committee will continue to have a role in the process.

3 ADJOURNMENT

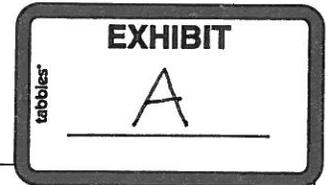
There being no further business the meeting was adjourned at 9:02 a.m.

Submitted by Ann Taylor, Lancaster County Clerk's Office.

NOTE: The RFQ document and the following attachments were provided to Committee members prior to the meeting: CMHC Annual Report 2010-2011; CMHC Annual Report 2011-2012; Report and Recommendations, CMHC Planning Committee, February 3, 2012; CMHC Staff Input Groups and Consumer Input Groups, Questions to Consider; Consumer Input Groups (Comments); CMHC Staff Input Groups (Comments); Invitation to Negotiate (ITN) Provider Input Group (Introduction and Purpose, ITN Process, Financial Specifications, General Instructions on Submission of Proposals to the ITN, General Discussion, ITN Evaluation Methodology, Rights and Responsibilities, Questions and Comments); Nebraska Department of Health and Human Services (DHHS), Division of Behavioral Health (DBH), Policies and Procedures; Number of Persons Served by Service Type; Behavioral Health Services Contract Summary, Fiscal Year (FY)2009-

FY2010, CMHC; Behavioral Health Services Contract Summary, FY2010-FY2011, CMHC; Behavioral Health Services Contract Summary, FY2011-FY2012, CMHC; Contracted Capacity and Average Utilization by Service Type for Region V Contracted Services; Information Regarding Cluster-Based Planning; Network Provider Contract for Behavioral Health Services; DHHS, FY2011-FY2012 Behavioral Health Rates, Community Mental Health and Substance Abuse Services; and Definitions (Attachments 1-17).

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 at 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: 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, 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 the necessary services and supports to aid in their recovery.

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 a risk of experiencing disruption in functioning or impairments due to behavioral health issues, a majority of whom may have severe and persistent mental illness (SPMI), or serious mental illness; and,
3. Adults who meet financial eligibility criteria (See Attachment D) and do not have coverage for services through other payer sources or who qualify for 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 supported programming which may include, but is not limited to, the operation of peer-run programs, and provision of peer recovery supports, 3) inclusive of consumers in program design at all levels of development and implementation, 4) evidence-based, 5) trauma informed, and 6) 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/behavioralhealth/Pages/beh_bhsvcddef.aspx.

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	
RFQ Announcement	February 1, 2013
RFQ Applications Received by RVS	February 15, 2013

Activity	Date/Time
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. Region V’s 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
2. Minimum Standards
3. Provider Capacities
4. Assurances

Proposals will be independently evaluated by members of the Evaluation Committee. The committee will consist of RVS staff 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 Request for Qualification Documents

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 (members of RVS' Provider Network need not complete Section B)
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

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 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.

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 regulatory rules and regulations set forth by the Nebraska Department of Health and Human Services that may have any impact on your agency's operations.
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**

CELEBRATING
35 years
OF SERVICE



Annual Report 2010-2011

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 Workshop** - 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).

2201 S. 17th Street
Lincoln, NE 68502

Tel: 402-441-7940

Fax: 402-441-8625

www.lancaster.ne.gov/cnty/mental

Lancaster County Board of Commissioners

Bernie Heier

Larry Hudkins

Jane Raybould

Deb Schorr

Brent Smoyer

Strengths-Based

Quality Care

Recovery

Hope

Wellness

Access

Choice

Evidence Based Programs

Services accredited by:



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

Persons Served

Duplicates included

Demographics

Unduplicated

N = 4,911

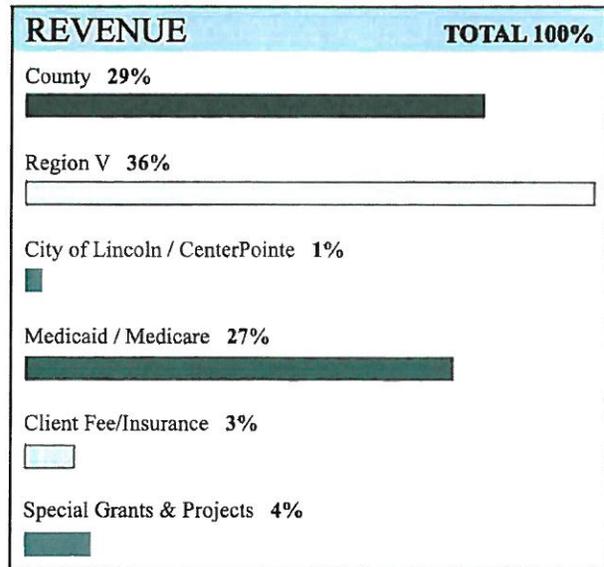
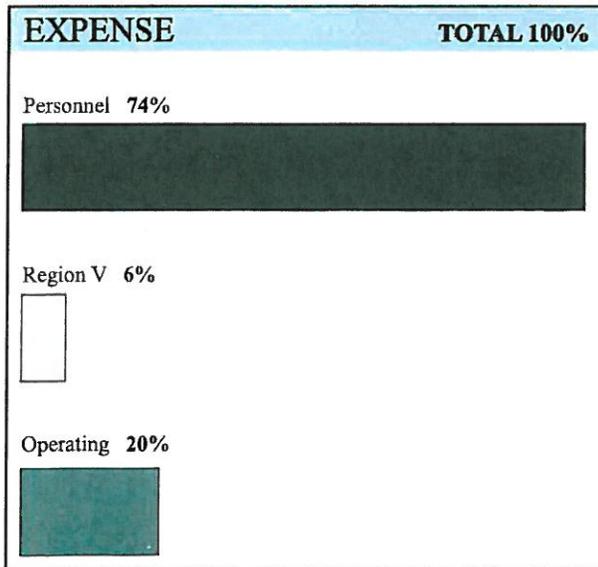
Program	Number
Community Support	1,085
Medical Services	1,909
Inpatient Psychiatric Services	347
Outpatient Therapy	883
Day Treatment / Partial Hospitalization	227
24 Hour Crisis Services	4,897
Day Rehabilitation Services	195
Homeless / Special Needs	253
Psychiatric Residential Rehabilitation	28
Crisis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

48% Women 52% 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



*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



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Annual Report 2011-2012

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.

Lancaster County
Board of Commissioners

Bernie Heier

Larry Hudkins

Deb Schorr

Brent Smoyer

Jane Raybold

CMHC was established by Lancaster County in 1976 in response to the Comprehensive Community Mental Health Centers Act passed by Congress in 1968. The Act provided that states and communities with funding incentives to establish community based mental health services so that persons with severe and persistent mental illness could receive treatment in the community rather than in state institutions. In February 2012, faced with economic and organizational issues, the Lancaster County Board appointed the CMHC Planning Committee to review the operations of CMHC. The committee recommended that a new service model and delivery system be developed to replace CMHC. ITN Committee was formed in May 2012, to develop and recommend to the County a service model that best meets the needs of consumers and a process for transitioning CMHC from County Governance to the private sector. A recommendation for a new service model is expected to be developed by December 31, 2012.

Programs & Services

- ◆ **Community Support** - Services that provide adults with mental illness a bridge of support, rehabilitation, advocacy and continuity to assist in obtaining the highest level of functioning possible as desired by the consumer who is moving along their own personal recovery path. Additional services within this program include the Independent Living Project, Transitional Living, The Harvest Project and Family Support Group
- ◆ **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.
- ◆ **Day Treatment / Partial Hospitalization Program** - Short term, intensive treatment provided through group format, 6½ 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** - Midtown Center (open Monday - Saturday) is a recovery - based service designed to provide individual treatment and rehabilitation to consumers managing a severe mental illness. Groups and activities focus on skill acquisition, illness management and rehabilitation skills in areas important to successful community participation.
- ◆ **Homeless / Special Needs Outreach** - Outreach and case management for adults who have a mental illness and are homeless, or near homeless or in contact with the criminal justice system.
- ◆ **Psychiatric Residential Rehabilitation** - Community Transitions Program at the Heather (CTP/H) is a coordinated effort between Community Mental Health, OUR Homes and the University of Nebraska Clinical Psychology Department providing individual assessment and treatment in a residential setting. A goal of CTP/H is to assist participants in the acquisition of skills necessary for independent living including illness/wellness management, occupational/ vocational skills, social/interpersonal skills and skills necessary to avoid relapse and rehospitalization. CTP/H subscribes to the Best Practices concept in mental health services.
- ◆ **Crisis Center** - An assessment and stabilization facility for adults placed on emergency protective custody by law enforcement in the 16 Counties of Region V.
- ◆ **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:



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

Persons Served

Duplicates included

Program	Number
Community Support	652
Medical Services	1706
Inpatient Psychiatric Services	19
Outpatient Therapy	719
Day Treatment / Partial Hospitalization	209
24 Hour Crisis Services	3865
Day Rehabilitation Services	176
Homeless Special Needs	190
Psychiatric Residential Rehabilitation	22
Crisis Center	595
Total Number Served	8153

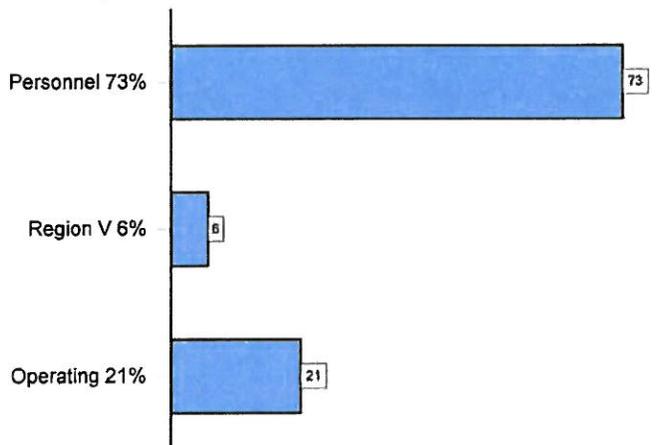
Demographics

N = 3903

47% 52%
Women Men

Age
18-34 29%
35-49 33%
50+ 38%

Expenses Total 100%



Black 7%
Hispanic 2%
Other 4%
Native American 2%
Asian 1%

**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 Bryan LGH 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 be 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.**

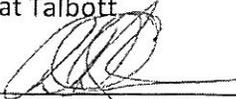
Respectfully submitted by the CMHC Planning Committee this 7th day of February, 2012.



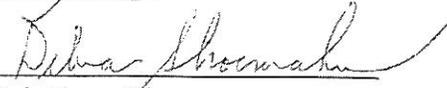
Pat Talbott



Lori Seibel



CJ Johnson



Deb Shoemaker



Dean Settle

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

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www.lancaster.ne.gov/cnty/mental

Lancaster County Board of Commissioners

Bernie Heier

Larry Hudkins

Jane Raybould

Deb Schorr

Brent Smoyer

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.
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- ◆ **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:



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

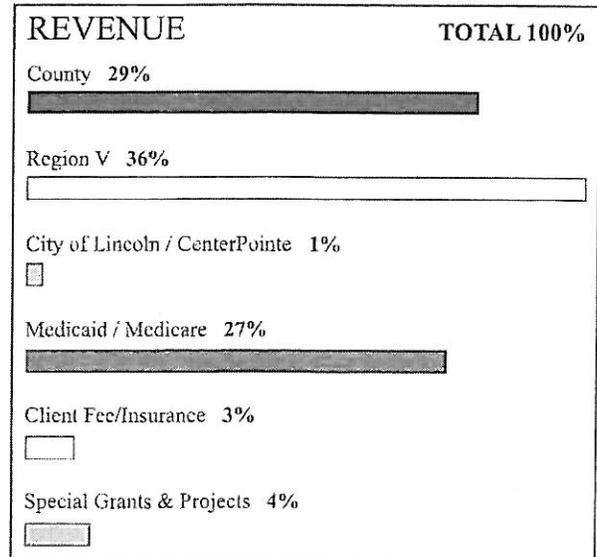
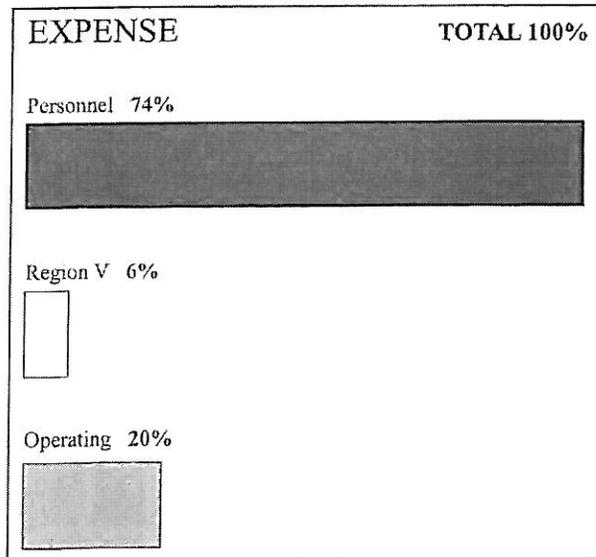
N = 4,911

48% Women 52% 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



*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 downturn 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 C

CMHC STAFF INPUT GROUPS

November 6, 2012

QUESTIONS TO CONSIDER

1. ARE THERE ANY QUESTIONS AS TO THE TIMELINE?
2. DOES THE DOCUMENT ADEQUATELY SPEAK TO TRANSITION?
3. ANY MAJOR CONCERNS/ISSUES WITH THE DOCUMENT?
4. WHAT WOULD YOU SEE/IDENTIFY AS CORE SERVICES?
5. DO YOU THINK CORE SERVICES NEED TO STAY "UNDER ONE ROOF"?
6. COULD CONSUMERS/HOW MIGHT CONSUMERS IN SUPPORT SERVICES, I.E. CS, RECEIVE MEDICATION SERVICES ELSEWHERE?
7. WHAT WOULD BE THE PROS AND CONS OF BIDDING OUT PRR (HEATHER) AND DR (MIDTOWN) FROM OTHER SERVICES?
8. ARE THERE ANY REASONS THAT ACT (PIER) COULDN'T CONTINUED TO BE CONTRACTED THROUGH THE OTHER 2 AGENCIES THAT ARE CURRENTLY A PART OF THAT COLLABORATION?
9. ARE THERE ANY REASONS THAT CS-MH AT OUR HOMES AND AREA AGENCY ON AGING COULDN'T CONTINUE TO BE CONTRACTED THROUGH THE OTHER AGENCIES THAT ARE CURRENTLY A PART OF THOSE COLLABORATIONS? (CenterPointe, Area Agency on Aging)
10. WHAT ARE THE PROS AND CONS OF LEAVING DAY TREATMENT UNDER THE CRISIS CENTER DURING AN INTERIM PERIOD?
11. WHERE IS THE BEST LOCATION FOR THE CRISIS LINE AND WHY?
 - *Data need: are calls primarily from current CMHC consumers or external?*
12. WHAT WOULD BE SOME ALTERNATIVES OR INNOVATIONS TO THE SERVICE ARRAY, THE DELIVERY SYSTEM, WHO PROVIDERS SERVICES, STANDARDS, ETC. IF YOU COULD DO SOME NEW THINGS?
13. HOW WOULD POTENTIAL APPLICANTS BEST DEMONSTRATE THE CAPACITY TO SERVE THIS POPULATION?
14. HOW WOULD POTENTIAL APPLICANTS BEST DEMONSTRATE AN UNDERSTANDING OF, COMMITMENT TO & IMPLEMENTATION OF THE PRINCIPLES OF RECOVERY?
15. HOW WOULD POTENTIAL APPLICANTS BEST DEMONSTRATE AN UNDERSTANDING OF, COMMITMENT TO & IMPLEMENTATION OF INTEGRATED MH & SA (CO-OCCURRING) SERVICES?

CONSUMER INPUT GROUPS

November 13, 2012

QUESTIONS TO CONSIDER

1. ARE THERE ANY QUESTIONS, OBSERVATIONS, RECOMMENDATIONS AS TO THE PROCESS OR TIMELINE?
2. WHAT ARE YOUR GREATEST CONCERNS ABOUT ALL OF THIS?
3. HOW CAN WE BEST KEEP YOU INFORMED?
4. WHAT WOULD YOU SEE/IDENTIFY AS CORE SERVICES PROVIDED BY THE CENTER?
5. DO YOU THINK THERE ARE SOME CORE SERVICES THAT SHOULD BE KEPT TOGETHER AND UNDER ONE ROOF?
6. SO, IF MM, OP, CS ARE CORE SERVICES, IF DR & PRR (MIDTOWN) WERE PART OF A SEPARATE ITN PROCESS, HOW WOULD THAT IMPACT THE CORE SERVICES? WOULD IT?
7. TELL ME A LITTLE ABOUT THE CRISIS LINE? HOW HAVE YOU USED IT AND WHY? – EMERGENCY, CRISIS, LEAVE MESSAGE, MAKE AN APPOINTMENT, JUST TO TALK?
8. WHAT ARE TOP 1-3 THINGS MOST IMPORTANT TO YOU TO MAINTAIN YOUR WELLNESS/RECOVERY?
9. WHAT DOES RECOVERY LOOK LIKE TO YOU?
10. WHAT OTHER KINDS OR TYPES OF PROGRAMMING OR SERVICES WOULD LIKE TO SEE THAT HELP SUPPORT RECOVERY THAT ISN'T AVAILABLE RIGHT NOW?
 - *Others have suggested: more education and training for housed people on how to sustain their homes and live in the community; more vocational rehabilitation programs which included programming on self-employment and business skill development, access to benefits planning, jobs, peer to peer type services, transportation, different programming for young people, warm line,*
11. WHAT WOULD BE SOME QUESTIONS TO ASK A PROVIDER ABOUT THEIR CAPACITY TO MEET CONSUMER NEEDS? If you were on the evaluating committee to pick a new provider/agency to provide these services what would you ask?
12. DO WE NEED MORE SERVICES AVAILABLE ON EVENINGS AND WEEKENDS?
13. WHAT ELSE DO YOU THINK WE SHOULD KNOW OR CONSIDER?
14. WHAT SHOULD WE MEASURE TO SEE IF THINGS ARE WORKING WELL?

ATTACHMENT C

**Consumer Input Groups
November 13, 2012**

General Comments (compiled from all three groups)

- At each session the facilitator provided a brief overview of why we are making these changes, driven by desires expressed by Lancaster County to get out of the “behavioral health business.”
- The function, origin and membership of the ITN committee were explained.
- The Health Management Associates (HMA) report was referenced, and the recommendation that an ITN process be used was mentioned. An ITN process is designed to invite potential applicants to the table to discuss what the system should look like; lets applicants demonstrate ability to do the work needed.
- Input has been sought through a number of forums including these focus groups for consumers.
- The timeline was referenced; i.e. expectation that the ITN document will be finalized by the end of January; potential applicants who have shown they are able to meet qualifications will be invited to the negotiations; goal is to have a new contractor in place by July 1 **at which time the transition process will begin to take place over time.**
- **The County has committed funding at the current level for two more years, the current building will remain available for two more years;** and the goal is for the transition process to be seamless so customers of CMHC can continue to receive the service they need. The County has not identified a dollar amount that will continue. The Region currently contributes about a third of the funding received by CMHC.
- In addition to the County’s wanting to make changes, there are other developments which will necessitate change. These include the cost of health care services, the Affordable Care Act, impact of possible Legislation, changes to Medicaid eligibility, movement toward integration of primary medical care and behavioral health,
- **Core services were most commonly defined as: case management (community support), medication management, outpatient, service coordination, and some elements of partial care.**
- Potential applicants will be asked to provide a transition plan in their application; the ITN document is intentionally left vague about what that should look like to allow for innovative approaches; the document did not wish to be prescriptive in that area.

Community Mental Health Center**9:00 a.m. to 12:00 p.m. (24 attendees)**

- Wittmuss facilitated this group and began by asking that everyone introduce themselves. Some attendees identified as family members.
- Another area of change identified by this group was the movement toward **recovery based services and shared decision making.**
- A participant voiced concerns about drastic changes and felt she would be unable to function without CMHC; all services work well together. To put consumer fears to rest it was suggested that therapists and case managers assure clients that the location will not change for now.
- Wittmuss commented that Region V/ITN is cognizant of the concerns that consumers have voiced, recognizing that change is frightening. July 1 does not mean that everything is new; a central component for an applicant is an application which has a transition plan that will take place over time.
- Wittmuss discussed the Affordable Care Act and commented that it is likely that behavioral health services will be covered under traditional insurance plans and that more people will be covered by Medicaid. NBHS funding currently provides services for persons in services that are not funded by Medicaid; as Medicaid covers more of the core services it may become possible to implement more new and innovative services such as supported employment, supported housing, transportation, and peer-run, recovery based programs.

- Low staff turnover was identified as a plus for customers of CMHC; one individual commented that she had experienced significant turnover while working with another service provider. **Other comments / concerns about services: lack of continuity / availability of services needed; don't have family support or classes, difficult to get a hold of them, difficult to get answers as a family member.**
- Question: are potential contractors for-profit? Out of state? Answer: nothing has been ruled out. Various entities were in attendance at the potential provider forum.
- **Immediate access to services was an important component of services at CMHC.**
- Question: will potential providers negotiate for all services or will the services be "chopped up." Answer: the intent is that core services will remain under one provider.
- Concerns were voiced that law enforcement does not understand persons with mental illness; "if this place closes, there will be more people in jail or at Cornhusker Place." Wittmuss commented that the Region has done a considerable amount of training with law enforcement regarding persons with mental illness, and also the importance of not re-traumatizing a client.
- **A participant commented that the paperwork you have to fill out is daunting; he would like to see a volunteer program, possibly peer-run, which would assist consumers in filling out applications for services and navigating the system in general.**
- CTP at the Heather, for persons discharging from LRC, was considered a core service by some as it helps individuals reorient to the community; "works well because personnel has been there for many years and have a great deal of experience; personnel is what makes it work; fear we lose good people in the transition"
- Day Rehab (at Midtown) was considered a core service by some; others felt that it could be managed by a separate entity.
- Consumer voice: "they need to be part of the core; need CTP and other programs to keep people in a lower level of care."
- Recovery was discussed: recovery is a process, but to one individual it meant "get out of bed every day, shower, be around people, don't want to sleep all the time, symptoms are manageable." Other components mentioned: not being hospitalized and / or making and keeping appointments, managing their home, ADLs, etc. Outcome measures for recovery based principles will be individualized. One individual felt the word "manage" was a better term than recovery. One consumer didn't believe recovery was possible . . .
- The importance of being able to come back to CMHC for **alumni group, family support group, and / or to attend various groups in partial care on an intermittent basis, as needed was named as a strength.**
- **One consumer defined case management as having someone take you grocery shopping, to other appointments, guide you through the ACCESS process, advocate for you, be available to talk to, etc. – more case management/service coordination than need for active rehabilitation services.** One consumer voiced fears that a peer would not be able to manage to support him as well as his case manager does.
- **The possibility of having two levels of assistance, peer and community support,** was discussed. The peer support would be able to help with such things as social activities and transportation, and work with some of the non rehab elements of case management.
- **What else would help? Liaison between physical and mental health;** a doctor who specializes in the interaction of the two disciplines. Medications prescribed for primary care and mental health can exacerbate symptoms in one arena or the other.
- **Crisis Line:** it is used in times of crisis, when someone needs to talk to someone and can't get a hold of a therapist after hours, etc; the line is also used to schedule appointments and apply for services. The question was asked whether this might be an opportunity for peer to peer services for some of these calls.
- **Weekend and evening services**—need more; people are isolated, they have too much free time and need more structure.
- Employment was a barrier to accessing services during regular work hours.
- Other strengths identified: CMHC provides support and connection, a safe place, no fear they will be discharged because "they are too much trouble," helps keep people out of the hospital, being able to talk to a familiar person so you don't have to repeat your "story," continuity of care,

- Substance abuse as an attempt to self-medicate was discussed. **The importance of integrating MH and SA services was emphasized by several.**
- The importance of taking personal responsibility was noted both regarding physical health and mental health.
- Evaluation criteria for potential applicants: If they were in the room, what would you ask them?: Availability, Staffing, Programming, what they say actually comes true, staff longevity, what has worked in the past / right now, measure their capacity to do this work, continuity—a comprehensive transition plan, cost to consumer, keep everything under one roof, should be knowledgeable about medications and side effects.
- Concerns with ACCESS Nebraska and lack of responsiveness was voice several times. Ability to navigate would be impossible without case management.
- Question: Why can't Region V take it over? Answer: It's not legal: Region V can do interim services, the Region is responsible for developing an array of services; would require statutory change; current system provides checks and balances
- J.Rock Johnson provided information about recovery noting that recovery involves having a voice, being educated and involved in your treatment; doesn't mean you are cured, it means you are better than you were. J.Rock's contact information: 402-474-0202
- **Wish list item: Recovery / Wellness Center**
- Wittmuss thanked attendees for their comments, noted that the ITN documents are posted on the web site, and Tyerman-Harper's contact information is on the web site if someone wishes to provide further comment.

1:00 p.m. (30 attendees)

Midtown Center

(For the next two forums, information captured are main ideas not previously stated in other consumer focus groups)

- Question: will Region V be selective in who is allowed to come to the table? Answer: Region V has the responsibility to ensure that individuals get the services they need; the same eligibility and approval processes will be in place. Region V will need to ensure that the new provider has the capacity to manage an entity as large as CMHC.
- There was emphasis on **retaining core services by also providing flexibility to develop new services** such as peer support programs and services based on recovery focused support and activities.
- The Crisis Center will remain with the County and will remain at the current location for at least two more years.
- Question: Are for-profits interested in CMHC? The concern was that a for-profit agency would pare those programs that were not financially successful. Answer: all contacts to date have been from non-profits. Johnson explained that the greater capacity you have the more you can spread your fixed costs across the agency; that is how non-profits benefit.
- Question: Will my services cost me more? Answer: Consumers should not have to pay more for services.
- Question: Will I be able to keep my case worker? Answer: We hope so; we will require that the new provider interview current staff, but will not be able to mandate that current staff be retained.
- Peers may be able to provide some services for some clients who do not need such high levels of care. One consumer voiced the opinion that peer services / recovery model services "would have made a huge difference years ago; I would have been more proactive in my recovery."
- There was concern about **continued access to medications** through the med management.
- **Location was discussed;** the County is committed to making the current building available for two years, and possibly longer. There was a great deal of input **regarding the importance of the current location** as far as being close to the hospital, grocery store, pharmacy, coffee house, bus route, etc.
- The concept of a limited liability corporation (LLC) was explained; it is possible that multiple entities could form a LLC to engage in the ITN process.
- Question: Will **substance abuse be more a part of this process?** Answer: We hope there is more attention paid to substance abuse issues; about 50 percent of persons who get EPC'd have SA issues.

- Funding cuts have caused the elimination of some weekend and other activities. This group had a number of comments about how persons with mental illness can be isolated and need these types of structured activities. **Community integration was important to this group.**
- **What alternative programs might you like to see? More recovery oriented services, strength-based, support “that would help people take charge of where they are headed.” Focus on person centered, shared decision making; education on how to talk to your doctor (such as Common Ground); supported education, a recovery / wellness center; a recovery plan that is more than words, programs that empower consumers, independent living program; showing them how to do something rather than doing it for them,**
- Consumers expressed concerns that **dropping to a lower level of peer support would make case management unavailable** the consumer began to decompensate. Johnson agreed that the system would have to be flexible enough to ensure a safety net was in place.
- **Some criteria for evaluation: language providers use, culture they display (suggested a walk through), staff competencies, hiring practices, training, policies,**

6:30 PM – 9:00 PM (21 attendees)

- Deb Schorr, Lancaster County Commissioner, attended this forum and added some additional reasons why the County was interested in making this change at this time: about budget, wait list, integration, Settle retired from CMHC, looking at the building; healthcare reform and how that will impact services; Schorr noted that these concerns were discussed over months and the decision to move ahead was not made lightly.
- The definition of recovery was discussed; it was noted that for most people that term refers to recovery from substance abuse.
- Concerns regarding **peer support workers who don’t have appropriate skills and training** were stated. One of the participants commented that there is a curriculum and a certificate for completing Intentional Peer Support training.
- Is there some way the agency can be **affiliated with something like PHC** and receive additional funding from Medicaid. Also want **on site the ability for somebody to see a primary care doctor.**
- **There are a lot of intersecting supports that a private entity might not be able to provide, legal advice for example.**
- Family members: as transition goes through, don’t forget the **family support group.**
- Require **support for people who do have co-occurring issues;** try to bring in supports for those types of persons.
- How to build in some type of **support groups for people transitioning out to the community**
- Most people with MI need support because they are isolated; don’t have family support, no money, don’t work; their self worth is down; need something for when you leave the building; you can call the crisis line, people need more support, forget to take their meds, don’t have structure in their lives; nothing to make them feel good about themselves; focus on **community integration.**
- **On children’s and / or adults side there is not a centralized place to get resources / find answers, need to be easier to navigate the system.**
- **Support groups for families;** Wednesday night group interferes with church night; wish there were more nights that it was offered; should be offered at different times and different days;
- ACCESS Nebraska has created a lot of problems for people; loss of cab vouchers, chore provision, poorly coordinated transportation services, long wait to get someone on line who can help,
- One gentleman spoke of grievances with his treatment, etc., and was invited to file a grievance with the Region.
- Staff turnover / burnout was discussed in this group. We need to provide adequate training so they are not overwhelmed; how do we promote people with lived experiences; natural burnout; need to be more conscientious about that. Consumers need consistency; turnover is costly to an agency;

ATTACHMENT C
November 6, 2012
Input Groups
CMHC Staff

At the beginning of each group Johnson or Wittmuss provided some history about the transition process commenting that Health Management Associates (HMA) had suggested that the Invitation to Negotiate (ITN) process be used. This process allows the committee to seek entities who are qualified / have the capacity and ability to run an organization like CMHC and bring them to the table in a collaborative way. A committee was formed which included persons from a variety of arenas tasked with the development of the ITN document / process. The draft document in its current form was approved by the County Commissioners and the Regional Governing Board; focus groups were prescribed, and input recommendations gathered through that process will be incorporated into the final document / process.

Johnson also commented on aspects of the timeline. It is anticipated that document / process will be finalized by the end of January with contracts being in place by July 1; John emphasized that there will be a timeline for a transition process to take place over a number of months following the July 1 implementation.

Attendees at each session were invited to introduce themselves and explain what role they play at CMHC.

Additional comments and questions can be directed to Amanda Tyerman-Harper; contact information is on the website

9:00 a.m. – 10:30 a.m. (5 attendees)

Consensus from previous input groups is that core services should be identified and remain together under one entity. Johnson posited that PIER / ACT team and the Harvest Project might be pulled out for a separate ITN process with the remaining partners taking over those services completely.

What are Core Services (identified by this group)?

- Medication Management
- Community Support / Case Management
- Outpatient
- Partial Care/Day Treatment (concerns were expressed about financial stability following implementation of the \$2 co-pay.)

Other Comments / Discussion

- These services are well integrated and allow programs to work together; the results of case management are readily apparent
- Low turnover of staff has been an asset to consumers providing continuity of care
- Consumers feel this is a safe place and some consumers come here routinely to “hang out” and socialize.
- Many staff members have been at CMHC for extended periods and expressed concerns about less pay, inferior benefits, and more staff turnover which affects the quality of care.
- Partial care was discussed further; in general staff members in attendance felt that partial provides a step down from hospitalization by providing groups to meet individual needs, providing CBT, allowing consumers a place to be around people who understand them. Partial also fills a gap for persons on the wait list for OP services; for these reasons partial care is considered a core service by many staff members.
- There was discussion about reimbursement for group therapy and the authorization process for consumers using partial care groups.
- The majority of users of day treatment utilize the full day partial spectrum rather than an occasional group.

- There was discussion regarding whether or not the Heather and Midtown were vital elements of the above identified core services. It was noted that the Heather serves relatively few individuals. As Midtown has become more rehab oriented a number of consumers no longer use the service. Difficulties in getting authorizations for Midtown were noted.
- Johnson commented that the Crisis Center will stay with the County; because the Crisis Center utilizes partial care the transition process will need to ensure that access to partial care is available, either in-house or by providing transportation. Concerns with transportation of EPC'd individuals were noted.
- Johnson inquired whether or not there are individuals who utilize only med services at CMHC; would it be detrimental to provide a different access point for those persons? Staff comment indicated that separating clients in this manner may be stigmatizing, and consumers who are only accessing med services may, at some point, need more support, and would then be required to change their access point. Concerns were noted regarding the insufficient number of psychiatrists and APRNs. It was also noted that consumers who have used up insurance benefits or have been refused services by other doctors in the community rely on CMHC to provide a safety net for med needs. Johnson inquired whether it would be possible to determine how many clients started out as med management only, and then required more services at a later time.
- There was discussion regarding whether or not the Crisis Line was a critical function of the identified core services. Staff comments included: it provides good communication—we know if one of our clients has called the crisis line; there are no HIPAA concerns when discussing these calls, and it was noted that individuals become clients after calling the crisis line.
- There are less than 30 case managers currently. There was discussion regarding how caseloads for case management are selected. Case managers do not necessarily specialize in the types of consumers they serve, but are given an opportunity to assume clients that they feel they could work well with. Thus each case manager may have a client population with somewhat similar needs.
- Johnson inquired what other service types / gaps might be essential to ensure that individuals on community support would be able to continue toward recovery. Some challenges have been noted with peer support. Transportation was deemed as a critical element. Housing needs are often referred to the Rental Assistance Program at Region V. Employment support is available through the AWARE program though there is a wait list for that program.
- Staff expressed concerns regarding the future and whether they would continue to be employed after the transition. Johnson explained that while the ITN process can ask that agencies interview everyone, it will not be possible to negotiate that. Johnson did note that the Region has had experience with transitioning families and staff, and worked hard to make sure they had employment. There will be no guarantee regarding salary and benefits.
- Johnson closed by stating that the ITN committee is attempting to move through this process in a thoughtful way and intends to remain transparent. Johnson thanked staff members for their input and stated that the comments affirm messages that were received at the provider forum. The fact that CMHC is a familiar location is a consideration; Sorensen also commented that the severity of the symptoms of the persons served at CMHC must be conveyed moving forward.

10:45 a.m.—12:15 p.m. (7 attendees)

This session was facilitated by Linda Wittmuss. Wittmuss briefly discussed the ITN document. Attendees commented that:

- the fiscal information regarding GA is missing;
- there is a lack of clarity regarding the ultimate wishes of the County; and
- evaluation criteria requires clarification. One clear message is that the Crisis Center will remain with the County.

Core Services Discussion (identified by this group)

- Partial care and the Crisis Center work well together with partial care facilitates discharge from the Crisis Center; partial care is also utilized by other existing services
- Medication Management: it was noted that there are individuals who only utilize med services at this time, but these individuals have access to all services.

- Lack of access to psych services in the community was noted; a number of consumers end up in MM at CMHC due to lack of funds
- A complimentary relationship exists between med services, community support, and outpatient; consumers are able to get services quickly if necessary.
- Psych res rehab and day rehab intersect with community support.
- The Crisis Line tends to be used by people seeking services ; there was discussion regarding a separate warm line perhaps using peers as Keya House does. Community Support service definition requires 24/7 access—the Crisis Line is used for that.
- Continuity of care across services—key point

Other Comments / Discussion

- It may be expedient to excise the ACT team and the Harvest Project (Emergency Community Support) from the remaining core services and the remaining providers in those contracts may be asked to assume the contract. For case managers whose clients intersect these services there may be some fiscal challenges and paper work challenges as it may be necessary to keep the services separate.
- Concerns regarding salary were noted. Should CMHC staff be hired in the transition process, the salary schedule of the hiring agency would be used.
- “Level 2” services for community support are not reimbursable; does this represent a gap in services? Would recovery support fill this gap? It was noted that consumers are reluctant to transition to recovery support. Challenges with the peer specialist position at CMHC were noted.
- “Wishes” included more staff and more psychiatric access, a voluntary level of care that is a step down from the Crisis Center; funding for voluntary admission to the hospital.
- Suggested measures to demonstrate commitment to the recovery philosophy included: infusion of peer services in all areas; quality, experience, knowledge, and training for staff; strength-based approaches; inclusion of consumer input; individualized goals and treatment plans; facility is a safe and comfortable place; buy-in to recovery principles.
- Emphasis on MH, SA, & physical health integration will be a requirement of the ITN. Most clients at CMHC do have a medical home due to the fact that they are Medicaid eligible. People’s Health Center has struggled to implement the behavioral health piece for CMHC. For some clients involvement by a case manager feels invasive; physicians do not
- Timeline: following revisions / clarification from input from the focus groups, the ITN document will be revised; the document will go back to the ITN committee for review and final approval by the Regional Governing Board and Lancaster County, hopefully by the end of January. The goal to have some kind of contractor(s) by the beginning of the next fiscal year; the transition planning and process may take 6-8 months or longer; initially a seamless transition, incorporation of existing staff, Division approval must take place, followed by a well-thought-out transition process.
- Other transition discussion: would **client charts** go with client to ensure that client history does not get lost in the transition; would client’s need to approve release of their charts, what happens to all the old charts? **Collaboration:** staff would like to see cooperation / collaboration between old and new staff to help in the transition process. **Location:** staff would like to see services remain in the current building as clients are comfortable here; Lancaster County has made retention of the building an option.
- Staff asked for clarity as core services are identified.
- Funding sources that are inter-mingled will need to be identified such as funding for sex offenders and transportation, etc. Other nuances that have been incorporated in service delivery must be identified, including access to homeless services through PATH grant funding (the homeless boys).
- Concerns remain with ACCESS Nebraska. Services are delayed, clients skip appointments, it is difficult to get a waiver for transportation, phone calls often result in long waits on hold; a majority of clients aren’t able to deal with ACCESS on their own.
- Crisis planning, WRAP plans, wellness planning should be incorporated in all services.

1:00 p.m. – 2:30 p.m. (12 attendees)

Johnson provided additional history regarding Health Management Associates who recommended the ITN process which allows stakeholders to be invited to the table in a less formal process than an RFP. Johnson commented that the focus will not be on getting potential agencies to provide program plans, etc; rather we will be seeking input on how they are going to transition the various services and programs over time. Ability to do a transition process which is as thoughtful as possible to current employees, will be assessed. Region V is committed to doing everything we can to ensure that employees move along with programs or end up becoming employed.

The timeline was reiterated; Johnson noted that major changes will not happen on July 1; the process could take 3-12 months or longer.

When asked what agencies have expressed interest, Johnson stated that he has been contacted by a number of non-profits in the area as well as a couple non-profits. Johnson has avoided direct discussions regarding this process so as to avoid contaminating the process in any way. CMHC staff inquired about the possibility of forming their own non-profit. In addition to funding issues, Johnson stated that the Region is required by statute to use some type of competitive bidding process.

Additional concerns / questions included: what happens to all the “stuff” that the county owns such as vehicles? What about individuals who are MHB commitments who are committed to this agency? Johnson suggested that negotiations will include equipment and other tangible items; regarding the MHB commitments those situation may have to be re-negotiated through their attorney and the courts.

Core Services Discussion (identified by this group)

- Last week consensus was that this location houses core services that should remain together as a package; these care service should be under a single entity. Concerns were expressed that services will not be comprehensive if services are unbundled.
- Core services were defined as: community support, medication management, outpatient, and partial.

Other Comments / Discussion

- The current 3-way contract for the PIER program was discussed and questions regarding whether it would be detrimental to core services to allow CenterPointe and Lutheran Family Services assume the full contract were noted.
- Concerns regarding moving consumers who only use medication management were noted. Staff members state that these consumers are often on General Assistance, and emergency community support is an element of that. These clients are served without compensation as are level two clients who return periodically for additional services. There has been an uptick in consumers seeking additional help since the ACCESS process came into play. The current process provides seamless assistance through informal assistance.
- Concerns with “unhooking the Heather and Midtown were similar in nature. Clients who use these programs often utilize other services, and the current level of communication would be missing. HIPAA concerns would also come into play. Midtown is one of the main providers of time for required time volunteering / programming for housing program.
- Crisis line: comments and concerns included: it is critical and keeps people out of the hospital; funding changed in March and evening / weekend staff took over and take calls from home—demographics for these calls are entered into the system, but call content is not. Having the Crisis line integrated with core services removes barriers around confidentiality. Clients and families depend on the crisis line as a way to communicate 24/7 with CMHC. The Crisis Line is not just used for emergencies but is used for requests for information, requesting services, and initial screenings for persons seeking an appointment.
- Walk-ins: therapists used to keep slots open for walk in traffic, but that is no longer the case.
- Johnson commented that at the State and Federal level there are a number of initiatives (integration of behavioral health and primary care, at-risk managed care, development of a safety net for vulnerable populations, extent of Medicaid coverage, etc.) that would be driving system change regardless of the current situation with Lancaster County. Funding will remain unchanged for the next two years; the

behavioral health system and the Regions will all undergo significant change within the next two years.

- Applicants will be screened to ensure they have the qualifications and capacity to handle this transition, an interest in utilizing the expertise of current staff, awareness of the population served, and a transition plan that is respectful of the history and integrity of current programs. Concern was also expressed that applicants are able to work with clients who have mental retardation but do not fit DD categories.
- Moving forward clarification will be required regarding nuances and inter-connectedness of current services, i.e. transportation, persons on GA, persons with co-pay issues, level two clients, etc. Current culture and practices will need to be identified.

2:45 p.m. – 4:15 p.m. (11 attendees)

Johnson reiterated the purpose of the focus groups which was to get input so they can return to the ITN committee and make recommendations on how the document can be changed or altered to clarify elements of the transition process. After the final focus groups are held, recommendations will be made to clarify the ITN process. Interested agencies will have to show that they have the qualifications and capability to provide the required services; through an RFQ process those qualified agencies will be invited to the table.

Johnson noted that the message he has received “loud and clear” is that a single entity should oversee core services. Johnson also reiterated elements of the timeline and noted that though contracts will begin July 1 the goal is for a smooth transition of current services and a well-thought-out plan for transition. Current staff members will remain employees of the county throughout the transition process. Lancaster County had originally committed to two years for continued funding / support.

Fears that the transition would follow the disastrous path of attempts to reform children’s services were noted. Privatization in that case resulted in loss of services and elevated costs. Johnson reminded attendees that the adult behavioral health system is capitated and a number of adjustments have been made over time when faced with cuts.

Core Services Discussion (identified by this group)

- CS / OP / MM / partial care (lots of nuances within those services)
- CLS (Community Living Skills), the Heather, and Midtown provide vital services to SPMI individuals with limited recovery / rehab options.

Other Comments / Discussion

- PIER / the ACT team: concerns were expressed re the ACT team, the difficulty of getting consumers into PIER, and the fact that the hospitalization rate for the PIER program has escalated. This group did not see PIER as a resource at this time due to these concerns.
- The emergency system is considered a priority; services are in place to ensure that individual’s needs are met if they come into the system, and also supports are in place so they don’t re-enter the system.
- Staff expressed concerns that services would be “chopped up.” Johnson noted that input continues to be collected, but it is one option that one entity would assume all the services as a package. Recommendations regarding which services will or will not be kept together will be determined by December.
- A number of clients come to CMHC for MM who don’t fit the service definition, i.e. they do not meet diagnostic criteria.
- CMHC currently serves over approximately 3,000 clients. Johnson expressed that it will be critical for CMHC to determine exactly how many are served and in which services.
- Johnson commented that the proposed RFQ process will be much simpler than the ITN document indicates. Fiscal audits will be reviewed, history / number of human resources managed, ability to meet minimum standards will be reviewed. Those entities which meet the initial criteria will be invited to the table as next steps and expectations are discussed.
- Leggiadro stated that applicant entities should be required to display the ability to integrate services.

- The suggestion was made that calling an agency and trying to get services is a good indicator of how well a agency communicates on all levels. Gathering input from other agencies about the applicant agency would be another way to learn how an agency is regarded by others. Isolated phone calls and a walk through would be good practice to learn more about an agency.
- Concerns were expressed regarding CenterPointe as a possible applicant; communication has been difficult for some staff at CMHC because of the substance abuse piece; concerns are that CMHC serves a very different type of clientele which CenterPointe may not be equipped to serve.
- Concerns were expressed that the good relationship that CMHC has with law enforcement and the supports provided may not be replicated by another provider.
- Other concerns:
 - The homeless population has been increasing
 - The public safety net is growing and revenue sources to support it are not growing
 - Liability issues: Lancaster County has 32 attorneys who have been able to provide advice and have gotten them out of some jams
 - The NRRI population needs to be part of the ITN and that liability must be assumed
 - Motivation for application must be thoroughly reviewed and understood to ensure it is not research driven.

Johnson closed by saying “I can’t tell you what it will look like in a year, but we’re focused on ensuring that people have their needs met and keeping them out of the ER. We believe that you need these community services.”

ATTACHMENT C

**ITN Provider Input Group
Lancaster County Extension Office
October 31, 2012**

Attended by 45 individuals

SECTION 1: INTRODUCTION AND PURPOSE1.4 Target Population

- Revisit target population and funding source(s)
- Describe payor sources
- Define SPMI and SMI
- Define who is currently served at CMHC
- Define populations in terms of funding priorities and service types serving them
- Clarify that population to be served is the current population being served by CMHC (are being served or have been served)
- Who does this eliminate from service?
- Include co-occurring population as target population / recognize and address substance abuse issues
- What is stated is what Region V Systems has the authority to let bid for. However, bidders must be prepared to serve Medicaid, Medicare, other TPL
- Lancaster County target should align with Region V target population
- Where does the General Assistance population fall?
- What is Lancaster County's continued commitment?
- Could add cluster based planning breakout

1.5 Scope of Service

- Second line doesn't make sense; need to clarify
- Clarify that the count of persons served is "duplicated"
- Alternative services may be less expensive (Review of Attachment A)
- Providers may apply for one or all services, but challenges are inherent in separating some services as they are inter-related, i.e. day treatment separated from ER system—day treatment supports the Crisis Center?
- 3000+ clients served at CMHC – what are their needs?
- Community Support—possible alternative service? Will continue to allocate some dollars for community support capacity;
- Foundational / core services will be maintained
- How will alternative or new services be paid for?
- Does the Region get Medicaid match back to assist in new services?
- Define base funding
- Set aside funding for alternative recommended services, look at different approaches, pilot project; maybe use post-commitment funds? Look at the crisis center budget;
- Need to ensure accountability, best practice, evidence-based practice, data / outcomes
- ITN process—want to get a sense of who is qualified to do these services, then bring those agencies to the table
- Ensure National Quality Measures are used in the evaluation process
- Services need to be integrated; one provider—not piecemeal; consumers use a number of services; lends to efficiency of service delivery and business practices
- ITN (Negotiate); need to keep in mind the people served;
- Not have competitive proposals come in first? Collaborate / seek agreement first? Do we want to take this step?
- Start with a Letter of Interest? / less formal process, concept paper

- Break down the funding categories to remove ambiguity – specific core required services and non-required / alternative services
- Clarify which service definitions we're operating under
- Administrative accountability is different than service types. Who is accountable? What is the response if outcomes don't occur? Speak more to accountability.
- Criteria: Do the services speak to best practice standards and use of evidenced base practices and how they are measured?
- Conflict in document is strict RFP language vs ITN language – hard to live in both worlds

1.7 Minimum Standards of Eligibility for Respondents

- 1.7 A.6: MH License required; not required for OP, etc.—clarify licensure issues
- 1.7 B. Minimum Programmatic Requirements: 3 key elements defined
- Relationship with Lancaster County: funding will come through the Region / provider(s) must be able to maintain a relationship with Lancaster County
- General Assistance: does this imply that services have to be provided free to these individuals who are eligible for GA? Not the intent of the statement; “eligible” would be better choice of words
- Are there funding streams contemplated for integrating primary care?

SECTION 2: INVITATION TO NEGOTIATE PROCESS

- Is there a plan for how collaboration among providers will happen? Seeking input on how this could happen
- Have to use a competitive process / wanted to avoid lengthy process / would like to have agencies discuss how best to move forward.
- Clarify what recovery support programs would be considered / define concept
- Limiting communication to ensure the integrity of the process
- Timeline reviewed; per the timeline contracts would be issued by July 1; proposal(s) will include a transition process; will contract for that transition process the proposal has suggested; provider will identify transition process timeline
- Will there be funding for the transition process? Can we utilize administrative funding for CMHC as their costs decrease?
- Define Recovery Support as it applies to the ITN

SECTION 3: FINANCIAL SPECIFICATIONS

- 3.2 Total funding is Region V minus Crisis Center
- Reimbursement methods may be changed to support transition process

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

- 4.2 – do we really need 50 hard copies / can we use electronic copies to some extent

GENERAL DISCUSSION:

- ITN process is much less formal than the way the process is outlined currently
- Should an RFQ process be incorporated—ITN committee will revisit this; this would formalize the process a little more;
- Where would that fit in the timeline? If we do an RFQ it could fit in before the Notice of Intent (#2) of the timeline
- Priority should be about defining the target populations and their needs
- Challenges – alternative ways of doing business, peer, recovery, etc., seen as an opportunity to develop alternative services;
- 4.3.II 1) Clarify language re the Development / Implementation Plan Page 18, last sentence: The Program Development phase: once things are in place and the development part is finished and acceptable to the State, the development phase of the project is finished.
- At a minimum provider has to be able to demonstrate that they have the capability / capacity to serve the population and provide data as required by the State

SECTION 6: ITN EVALUATION METHODOLOGY

- The vendor's (change word "vendor" to proposal or applicant) in last sentence in paragraph 2
- Evaluators should have expertise in areas of proposals scored / accountability
- If we add RFQ – challenge: may be entities who would want to subcontract for a component of a service; RFQ may have to allow persons who are only interested in a small piece to be at the table;
- Region V may suggest which agencies can be subcontracted with?
- Preferences of County and Region should be identified
- Submit proposals for core services separately?
- Consumer involvement in evaluation process—make a priority

SECTION 7: RIGHTS AND RESPONSIBILITIES

- 7.1 is that fair? "any and all" / clarify where that line would be
- 7.3 use "multiple" instead of up to three; will rework this section
- How do we weight the various sections--Will get a variety of input from the upcoming focus groups
- Are HMA references included? Need to look at evaluation components of that
- Consumer involvement must be weighted heavily as it is core to recovery based services

ITN COMMITTEE QUESTIONS / COMMENTS??

- Ensure people currently being served don't get lost / fall between the cracks / adds weight to the transition plan and / or services proposed
- When would the services be re-evaluated? (at least yearly)
- Flexible funding / pilot programs will be evaluated more frequently
- 7.3 speaks to keeping traditional services during the transition process / can it keep things stable?
- 7.1 and 7.2 looks at more development / change in the future
- Use a staged approach . . .
- First agencies should demonstrate that they could continue to run the organization
- Then tell us how you plan to promote additional elements of service development / has to show some potential to provide innovative services as a second stage
- Critical to maintain core services as one / they are inter-related (consumers support this)
- Substance abuse not addressed concurrently
- Integration with primary care will be a requirement within 5 years; will need to be incorporated; how do you offer it / how do you pay for it?
- Input from previous focus groups identified that many consumers do have a medical home
- Talking about those consumers who do not have access to primary care / use ER, etc. Those are the individuals we are interested in serving through integration
- Community Health Endowment will have some funding available to support integration—one of their identified priorities:
- Recovery-based is a core theme—questions about implementation or measurement
- Many places that consumer involvement can take place; requires some education and opportunity;
- Clarify what the focus should be as far as what we want to see initially moving forward;

Send any further comments / questions to Amanda Tyerman-Harper

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; 11/20/12

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. Financial eligibility criteria as specified in this policy and attached Fee Schedules;
 - 2. 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,
 - 3. 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.
5. For any authorized service in which the consumer does not have documented authorization as required by the Division and its Administrative Service Organization (ASO).

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 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 and the waiver is documented on the eligibility worksheet provided by DHHS or in the consumer's file if an alternative worksheet is utilized. 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. For the purposes of completing the Eligibility Worksheet, the following items are not included as taxable income: SSI, SSDI, child support or monetary assistance received from family or non-family members.

b. If the person receiving services is under the age of 19 and has not been designated by a court as emancipated, the custodial parent(s) alimony, wages, tips or other money received for a good or service must be used to determine financial eligibility.

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 to receive the service.

c. **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.

d. **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, 24-hour hotlines, or in a peer run hospital diversion program where individuals can stay less than 24 hours;
 - 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 where the column and row intersect is the amount or rate that can 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. A provider may not deny service to an individual solely on the basis of inability to pay a copayment. If a consumer is determined to have the ability to pay and is charged a copay amount, as determined by applying the Adjusted Monthly Income from the Eligibility Worksheet for NBHS Funded Service to the appropriate Fee Schedule (see Section V, Item A), but refuses to pay or is in arrears for the copayment amount, the provider may decline services to the individual until they have remitted payment(s).

D. 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.

E. 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.

F. 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.

G. 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.

H. 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 $(\text{Taxable Monthly Income} \times 12) \times 10\%$). 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.

Table 1: # of persons served by service type by Axis I FY10-FY12

CMHC

Attachment E

Service	Axis I	FY10	FY11	FY12	
Comm Supp - MH	Diag or cond deferred on Axis I	9	8	6	
	Disorders usually first diagnosed in infancy, childhood, or adolescence		1	1	
	No diag or cond on Axis I	4	4	4	
	Unknown	90	78	73	
	adjustment disorders	1	1	1	
	anxiety disorders	22	17	15	
	delirium, dementia, and amnesic and other cognitive disorders	1	0	0	
	impulse control disorders not elsewhere classified	5	4	2	
	mood disorders	278	276	247	
	schizophrenia and other psychotic disorders	287	281	259	
	sexual and gender disorder	1	1	1	
	substance related disorders	3	1	1	
		TOTAL	701	672	610
	Day Rehab - Full Day	Diag or cond deferred on Axis I	3	2	2
Disorders usually first diagnosed in infancy, childhood, or adolescence		0	0	1	
No diag or cond on Axis I		1	1	1	
Unknown		22	21	19	
anxiety disorders		1	1	1	
dissociative disorder		1	1	0	
impulse control disorders not elsewhere classified		2	2	0	
mood disorders		28	29	20	
schizophrenia and other psychotic disorders		73	73	66	
		TOTAL	131	130	110
Day Treatment - MH	adjustment disorders	0	3	1	
	anxiety disorders	1	6	4	
	impulse control disorders not elsewhere classified	1	0	0	
	mood disorders	67	65	53	
	other conditions that may be a focus of clinical attention	0	1	0	
	schizophrenia and other psychotic disorders	15	11	11	
	substance related disorders	1	0	1	
	TOTAL	85	86	70	
Medication Management	Diag or cond deferred on Axis I	8	7	7	

	Disorders usally first diagnosed in infancy, chilhood, or adolescence	31	33	42
	No diag or cond on Axis I	8	7	7
	Unspecified mental disorder	1	0	0
	adjustment disorders	60	68	91
	anxiety disorders	326	377	429
	delirium, dementia, and amnestic and other cognitive disorders	6	3	4
	dissociative disorder	2	2	2
	eating disorder	2	1	1
	impulse control disorders not elsewhere classified	12	16	19
	mental disorders due to a general medical condition	1	0	0
	mood disorders	1424	1477	1620
	other conditions that may be a focus of clinial attention	1	6	7
	personality disorders	1	2	2
	schizophrenia and other psychotic disorders	561	566	583
	sexual and gender disorder	68	64	74
	sleep disorder	1	1	2
	somatoform disorder	2	2	2
	substance related disorders	39	36	41
	TOTAL	2554	2668	2933
O/P-MH	Diag or cond deferred on Axis I	5	5	5
	Disorders usally first diagnosed in infancy, chilhood, or adolescence	31	33	42
	No diag or cond on Axis I	7	6	6
	Unspecified mental disorder	1	0	0
	adjustment disorders	60	68	91
	anxiety disorders	326	376	428
	delirium, dementia, and amnestic and other cognitive disorders	7	4	5
	dissociative disorder	2	2	2
	eating disorder	2	1	1
	impulse control disorders not elsewhere classified	13	17	19
	mental disorders due to a general medical condition	1	0	0
	mood disorders	1428	1479	1618
	other conditions that may be a focus of clinial attention	1	6	7
	personality disorders	1	2	2
	schizophrenia and other psychotic disorders	493	500	518

	sexual and gender disorder	68	64	74
	sleep disorder	1	1	2
	somatoform disorder	2	2	2
	substance related disorders	39	36	41
	TOTAL	2488	2602	2863
Psych Res Rehab - MH	Unknown	2	2	2
	mood disorders	8	6	3
	schizophrenia and other psychotic disorders	25	29	27
	substance related disorders	1	1	0
	TOTAL	36	38	32
Total		5995	6196	6618

Note:

1. Data Source: Magellan 2012 December data extract (open records as of 12/31/12 - cases may not be active)
2. The # of persons served is unduplicated within service type.
3. The # of persons served is duplicated between service types.
4. Last admission is selected if the person has more than one admissions for one service within FY.

**BH SERVICES CONTRACT SUMMARY
FY09-10
Community Mental Health Center**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Behavioral Health Services

Region or Agency: Community Mental Health Center
Date Submitted: September 1, 2010

A	B	C	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB
REVENUE SOURCES	FFS Rate	Units	State BH Division			Total State	Co Tax	Total St + Tax	Medicaid	1st/3rd Party	Private Insurance/ Other 3rd Party	Federal \$ - Other Sources	State \$ - Other Sources	Agency Fundraising/ Donations/ Interest/Othe	TOTAL OTHER REVENUES (Col U-Z)	GRAND TOTAL REVENUES (Col T+AA)	
SERVICES [List all providers under each service.]			FY10 State \$	FY10 State Rate \$	FY10 Reg Ctr Transfer \$	Federal Block Grant \$	TOTAL STATE BH REVENUES (Col D-Q)	Local Tax Match \$	TOTAL STATE + Tax Match \$ (Col R+S)	Medicaid	Client Fees	Private Insurance/ Other 3rd Party	Federal \$ - Other Sources	State \$ - Other Sources	Agency Fundraising/ Donations/ Interest/Othe	TOTAL OTHER REVENUES (Col U-Z)	GRAND TOTAL REVENUES (Col T+AA)
Mental Health Services - Adult																	
Community Support - MH	\$280.85	1,976	\$ 554,564	\$ -	\$ -	\$ -	\$ 554,564	\$ -	\$ 554,564	\$ 1,245,541	\$ 185	\$ 722	\$ 5,698	\$ (6,913)	\$ 77,533	\$ 1,322,967	\$ 1,677,531
Psych Res Rehab - MH	\$110.78	338	\$ 37,000	\$ -	\$ -	\$ -	\$ 37,000	\$ -	\$ 37,000	\$ 541,080	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 541,080	\$ 578,080
Psych Res Rehab - MH		NFFS	\$ 189,504	\$ -	\$ -	\$ -	\$ 189,504	\$ -	\$ 189,504	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 189,504
Day Rehabilitation - MH	\$54.16	2,011	\$ 87,000	\$ -	\$ -	\$ -	\$ 87,000	\$ -	\$ 87,000	\$ 425,447	\$ -	\$ -	\$ 31,366	\$ -	\$ -	\$ 456,813	\$ 543,813
Day Treatment - MH	\$195.72	469	\$ 71,793	\$ -	\$ -	\$ 20,000	\$ 91,793	\$ -	\$ 91,793	\$ 75,383	\$ 10,244	\$ 16,116	\$ 95,522	\$ -	\$ 2,153	\$ 199,416	\$ 291,211
Outpatient (Ind / Grp) - MH	\$85.88 / \$30.82	3,435 / 1,907	\$ 270,446	\$ -	\$ -	\$ -	\$ 276,446	\$ -	\$ 276,446	\$ 25,774	\$ 14,310	\$ 14,918	\$ 7,009	\$ 30,641	\$ -	\$ 92,652	\$ 369,098
Medication Management - MH	\$38.91	4,446	\$ 133,628	\$ -	\$ -	\$ -	\$ 133,628	\$ -	\$ 133,628	\$ 116,757	\$ 27,060	\$ 13,989	\$ 100,435	\$ 31,120	\$ 23,547	\$ 314,908	\$ 448,536
Emergency - 24HR Clinician - MH		NFFS	\$ 200,693	\$ -	\$ -	\$ -	\$ 200,693	\$ -	\$ 200,693	\$ 8,225	\$ 4,550	\$ 5,838	\$ -	\$ -	\$ -	\$ 18,611	\$ 219,304
Emergency - EPC - MH		NFFS	\$ 1,301,629	\$ -	\$ -	\$ -	\$ 1,301,629	\$ -	\$ 1,301,629	\$ 126,835	\$ 25,636	\$ 101,664	\$ 23,527	\$ 5,227	\$ 516,527	\$ 799,419	\$ 2,101,046
Emergency Comm Spprt - MH		NFFS	\$ 59,058	\$ -	\$ -	\$ -	\$ 59,058	\$ -	\$ 59,058	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 59,058
Mental Health Services - Children																	
TOTAL - Mental Health			\$ 2,911,313	\$ -	\$ -	\$ 20,000	\$ 2,931,313	\$ -	\$ 2,931,313	\$ 2,567,042	\$ 81,968	\$ 153,245	\$ 263,757	\$ 60,076	\$ 619,760	\$ 3,745,868	\$ 6,677,181
Substance Abuse Services - Adult																	
Emergency Crisis Assess - SA		NFFS	\$ 140,711	\$ -	\$ -	\$ -	\$ 140,711	\$ -	\$ 140,711	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 140,711
Substance Abuse Services - Children																	
TOTAL - Substance Abuse			\$ 140,711	\$ -	\$ -	\$ -	\$ 140,711	\$ -	\$ 140,711	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 140,711
TOTAL - CMHC			\$ 3,052,024	\$ -	\$ -	\$ 20,000	\$ 3,072,024	\$ -	\$ 3,072,024	\$ 2,567,042	\$ 81,968	\$ 153,245	\$ 263,757	\$ 60,076	\$ 619,760	\$ 3,745,868	\$ 6,817,892

** NOTE: Funds included in the Medicaid Column "U" should include all funds collected by the providers such as Medicaid FFS, Medicaid Managed Care

**BH SERVICES CONTRACT SUMMARY
FY10-11
Community Mental Health Center**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Behavioral Health Services

Region or Agency: Community Mental Health Center
Date Submitted: September 1, 2011

A	B	C	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB
REVENUE SOURCES			State BH Division				Total State	Co Tax	Total St + Tax	1st/3rd Party			Federal	State	Agency	Total Other	Total All
SERVICES [List all providers under each service.]	FFS Rate	Units	FY10 State \$	FY10 State Rate \$	FY10 Reg Ctr Transfer \$	Federal Block Grant \$	TOTAL STATE BH REVENUES (Col D-Q)	Local Tax Match \$	TOTAL STATE + Tax Match \$ (Col R+S)	Medicaid	Client Fees	Private Insurance/ Other 3rd Party	Federal \$ - Other Sources	State \$ - Other Sources	Agency Fundraising/ Donations/ Interest/Other	TOTAL OTHER REVENUES (Col U-Z)	GRAND TOTAL REVENUES (Col T+AA)
Mental Health Services - Adult																	
Community Support - MH	\$282.06	1,883	\$ 531,119	\$ -	\$ -	\$ -	\$ 531,119	\$ -	\$ 531,119	\$ 1,228,318	\$ 624	\$ 316	\$ 8,538		\$ 86,655	\$ 1,322,451	\$ 1,853,570
Psych Res Rehab - MH	\$111.34	263	\$ 29,282	\$ -	\$ -	\$ -	\$ 29,282	\$ -	\$ 29,282	\$ 539,558					\$ (27,518)	\$ 512,039	\$ 541,321
Psych Res Rehab - MH		NFFS	\$ 250,496	\$ -	\$ -	\$ -	\$ 250,496	\$ -	\$ 250,496							\$ -	\$ 250,496
Day Rehabilitation - MH	\$54.43	1,738	\$ 94,572	\$ -	\$ -	\$ -	\$ 94,572	\$ -	\$ 94,572	\$ 417,841					\$ (7,103)	\$ 410,738	\$ 605,310
Day Treatment - MH	\$198.70	557	\$ 99,562	\$ -	\$ -	\$ 20,000	\$ 109,562	\$ -	\$ 109,562	\$ 52,181	\$ 5,049	\$ 10,845	\$ 77,064		\$ 13,000	\$ 158,119	\$ 267,681
Outpatient (Ind / Grp) - MH	\$88.31 / \$30.97	2,708 / 1,858	\$ 290,348	\$ -	\$ -	\$ -	\$ 290,348	\$ -	\$ 290,348	\$ 31,547	\$ 12,803	\$ 12,789	\$ 11,399		\$ 863	\$ 69,201	\$ 358,549
Medication Management - MH	\$39.10	4,373	\$ 170,984	\$ -	\$ -	\$ -	\$ 170,984	\$ -	\$ 170,984	\$ 121,816	\$ 31,895	\$ 14,471	\$ 111,973		\$ (1,915)	\$ 278,239	\$ 449,223
Emergency - 24HR Clinician - MH		NFFS	\$ 201,696	\$ -	\$ -	\$ -	\$ 201,696	\$ -	\$ 201,696	\$ 7,218	\$ 4,529	\$ 2,293			\$ 43,385	\$ 57,425	\$ 269,121
Emergency - EPC - MH		NFFS	\$ 1,364,161	\$ -	\$ -	\$ -	\$ 1,364,161	\$ -	\$ 1,364,161	\$ 147,183	\$ 17,270	\$ 85,494	\$ 35,382		\$ 343,534	\$ 608,863	\$ 1,973,024
Emergency Comm Spprt - MH		NFFS	\$ 67,692	\$ -	\$ -	\$ -	\$ 67,692	\$ -	\$ 67,692							\$ -	\$ 67,692
Mental Health Services - Children																	
TOTAL - Mental Health			\$ 3,089,912	\$ -	\$ -	\$ 20,000	\$ 3,109,912	\$ -	\$ 3,109,912	\$ 2,543,842	\$ 71,970	\$ 108,208	\$ 244,356	\$ -	\$ 450,899	\$ 3,417,075	\$ 6,528,967
Substance Abuse Services - Adult																	
Emergency Crisis Assess - SA		NFFS	\$ 141,415	\$ -	\$ -	\$ -	\$ 141,415	\$ -	\$ 141,415	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 141,415
Substance Abuse Services - Children																	
TOTAL - Substance Abuse			\$ 141,415	\$ -	\$ -	\$ -	\$ 141,415	\$ -	\$ 141,415	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 141,415
TOTAL - CMHC			\$ 3,231,327	\$ -	\$ -	\$ 20,000	\$ 3,251,327	\$ -	\$ 3,251,327	\$ 2,543,842	\$ 71,970	\$ 108,208	\$ 244,356	\$ -	\$ 450,899	\$ 3,417,075	\$ 6,668,402

** NOTE: Funds included in the Medicaid Column "U" should include all funds collected by the providers such as Medicaid FFS, Medicaid Managed Care

**BH SERVICES CONTRACT SUMMARY
FY11-12
Community Mental Health Center**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Behavioral Health Services

Region or Agency: Community Mental Health Center
Date Submitted: September 1, 2012

REVENUE SOURCES SERVICES [List all providers under each service.]	FFS Rate	Units	State BH Division				TOTAL STATE BH REVENUES (Col D-Q)	Co Tax Local Tax Match \$	TOTAL STATE + Tax Match \$ (Col R+S)	Medicaid	1st/3rd Party Client Fees	Private Insurance/ Other 3rd Party	Federal \$ - Other Sources	State \$ - Other Sources	Agency Fundraising/ Donations/ Interest/Othe	TOTAL OTHER REVENUES (Col U-Z)	GRAND TOTAL REVENUES (Col T+AA)
			FY10 State \$	FY10 State Rate \$	FY10 Reg Ctr Transfer \$	Federal Block Grant \$											
Mental Health Services - Adult																	
Community Support - MH	\$282.06	1,610	\$ 485,157	\$ -	\$ -	\$ -	\$ 455,157	\$ -	\$ 455,157	\$ 1,200,365	\$ 6,650	\$ 8,785	\$ 43,449	\$ -	\$ 42,539	\$ 1,301,788	\$ 1,758,045
Psych Res Rehab - MH	\$111.34	306	\$ 34,070	\$ -	\$ -	\$ -	\$ 34,070	\$ -	\$ 34,070	\$ 578,817				\$ 11,644	\$ 590,461	\$ 624,531	
Psych Res Rehab - MH		NFFS	\$ 234,099	\$ -	\$ -	\$ -	\$ 234,099	\$ -	\$ 234,099							\$ 234,099	
Day Rehabilitation - MH	\$54.43	1,429	\$ 77,753	\$ -	\$ -	\$ -	\$ 77,753	\$ -	\$ 77,753	\$ 435,608			\$ 32,611	\$ 7,988	\$ 476,207	\$ 553,980	
Day Treatment - MH	\$196.70	401	\$ 54,156	\$ -	\$ -	\$ 20,000	\$ 74,156	\$ -	\$ 74,156	\$ 61,488	\$ 6,650	\$ 8,785	\$ 43,449	\$ 4,721	\$ 125,063	\$ 199,249	
Outpatient (Ind / Grp) - MH	\$66.31 / \$30.97	2,170 / 1,506	\$ 222,969	\$ -	\$ -	\$ -	\$ 222,969	\$ -	\$ 222,969	\$ 31,806	\$ 15,569	\$ 15,288	\$ 31,806	\$ 135,100	\$ 4,919	\$ 234,488	\$ 457,457
Medication Management - MH	\$38.10	3,343	\$ 126,724	\$ -	\$ -	\$ -	\$ 126,724	\$ -	\$ 126,724	\$ 108,953	\$ 31,696	\$ 14,791	\$ 98,821	\$ 14,972	\$ 269,433	\$ 398,157	
Emergency - 24HR Clinician - MH		NFFS	\$ 201,696	\$ -	\$ -	\$ -	\$ 201,696	\$ -	\$ 201,696	\$ -	\$ -	\$ -		\$ 6,227	\$ 6,227	\$ 207,923	
Emergency - EPC - MH		NFFS	\$ 1,540,136	\$ -	\$ -	\$ -	\$ 1,540,136	\$ -	\$ 1,540,136	\$ -	\$ -	\$ -		\$ -	\$ -	\$ 1,540,136	
Emergency Comm Spprt - MH		NFFS	\$ 67,692	\$ -	\$ -	\$ -	\$ 67,692	\$ -	\$ 67,692							\$ 67,692	
Mental Health Services - Children																	
TOTAL - Mental Health			\$ 3,014,452	\$ -	\$ -	\$ 20,000	\$ 3,034,452	\$ -	\$ 3,034,452	\$ 2,417,037	\$ 60,785	\$ 47,649	\$ 250,136	\$ 135,100	\$ 93,010	\$ 3,003,697	\$ 6,038,149
Substance Abuse Services - Adult																	
Emergency Crisis Assess - SA		NFFS	\$ 141,415	\$ -	\$ -	\$ -	\$ 141,415	\$ -	\$ 141,415	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 141,415	
Substance Abuse Services - Children																	
TOTAL - Substance Abuse			\$ 141,415	\$ -	\$ -	\$ -	\$ 141,415	\$ -	\$ 141,415	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 141,415	
TOTAL - CMHC			\$ 3,155,867	\$ -	\$ -	\$ 20,000	\$ 3,175,867	\$ -	\$ 3,175,867	\$ 2,417,037	\$ 60,785	\$ 47,649	\$ 250,136	\$ 135,100	\$ 93,010	\$ 3,003,697	\$ 6,179,564

** NOTE: Funds included in the Medicaid Column "U" should include all funds collected by the providers such as Medicaid FFS, Medicaid Managed Care

ATTACHMENT G

Community Mental Health Center of Lancaster County

Contracted Capacity and Average Utilization by Service Type for Region V Contracted Services

Average across FY10-12 (3 year)

Fee For Service	Average Units Contracted For	Average Units Used	Unit of Service
Community Support (non-Medicaid)	2100	1823	1 month
Psychiatric Residential Rehabilitation (non-Medicaid)	598	302	1 day
Day Treatment/Partial Hospitalization (non-Medicaid)	592	476	1 day
Day Rehabilitation (non-Medicaid)	1607	1727	1 day (5+hours) or ½ day (3+ hours)
Medication Management	4373	4054	15 minutes

Source: Region V Systems

WHAT IS A CLUSTER?

A Cluster Is A Subgroup Of A Larger Clinical Population That Shares Common Strengths, Problems, Treatment Histories, Social And Environmental Contexts, And/Or Life Situations.

- ***Clusters represent historical, holistic, bio-psychosocial pictures of patterns of behavior and life situations.***
- ***Clusters incorporate social policy and the effectiveness of treatments as they have influenced a person's overall life.***
- ***Research and experience suggest that members of different clusters often are working toward different service/recovery goals.***
- ***Members of different Clusters are likely to face different challenges along the way in their recovery, and require different types and intensities of services, supports, treatment, or rehabilitation options.***

TITLES OF 8 CLUSTER DESCRIPTIONS FOR ADULTS WITH SEVERE AND PERSISTENT MENTAL HEALTH ISSUES

Cluster 1

Adults With Chronic Physical Health Conditions and Psychiatric Disabilities

Cluster 2B

Adults with Severe Substance Abuse Problems & Less Severe Mental Health Problems

Cluster 3B

Younger Adults Who Are Severely Disabled But Are Not Convinced Of the Usefulness of Treatment

Cluster 4B

Adults Who Struggle With Anxiety And Who Focus On Their Physical Health Conditions

Cluster 2A

Adults With Serious Substance Abuse, Mental Health, & Community Living Problems

Cluster 3A

Adults Who Are Severely Disabled In Many Life Areas

Cluster 4A

Adults Who Struggle With Anxiety and Depression, And Who Avoid Growth Opportunities

Cluster 5

Adults Who Function Well In Their Communities

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 or 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. 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
<i>Less than \$500,000</i>	<i>Audit that meets Generally Accepted Auditing Standards</i>
<i>\$500,000 or more in federal payments</i>	<i>A-133 audit</i>

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	5) Therapeutic Community
2) Intensive Outpatient—SA	6) Halfway House
3) Intermediate Residential	7) Dual Disorder Residential
4) Short Term 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.
 2. 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.
 3. 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://www.revenue.ne.gov/tax/current/fw-4na.pdf> or
<http://www.revenue.ne.gov/tax/current/fill-inft4na.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 8⁹, 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:	For	:
Dennis Byars, Regional Governing Board Chair	Name	
823 North 8 th Street	Executive Director	
Beatrice, NE 68310	Address	

OR

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

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 Date
 Chair, Regional Governing Board

 Director Date

 Regional Administrator Date

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

Revised 5-3-11

LEVEL OF CARE	SERVICES	MH or SA	UM (Auth or Reg)	Unit	1.5% Rate Increase	.5% Rate Increase	no Change	no Change	Medicaid
					FY-10	FY-11	FY-12	FY-13	
Non-Residential Services (Adults)	LEVEL 1								
	Day Treatment	MH	Auth	Day	\$195.72	\$196.70	\$196.70	\$196.70	
	Partial Care	SA	Auth	Day	\$72.63	\$72.99	\$72.99	\$72.99	SAW
	LEVEL 2								
	Intensive Outpatient	SA	Auth	Hour	\$27.08	\$27.22	\$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	\$54.43	MRO
				1/2 Day/3 hrs	\$27.08	\$27.22	\$27.22	\$27.22	
	LEVEL 4								
	Assessment	MH, SA	Reg		^ Non Fee for Service (NFFS): State pays for all Lv 4 & 5 srves but two on a NFFS basis to the Reg to purchase capacity. Reg purchases units / rates OR capacity from providers.				
	Outpatient Therapy (Ind/Fm/Grp)	MH, SA	Reg						
	Intensive Case Mgmt/Intensive Community Srvc	MH, SA	Reg						
	Medication Management	MH	Reg	1/4 hr	\$38.91	\$39.10	\$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	\$111.34	MRO
	Dual Disorder Residential	SA	Auth	Day	\$211.72	\$212.78	\$212.78	\$212.78	SAW
	Short Term Residential	SA	Auth	Day	\$184.64	\$185.56	\$185.56	\$185.56	SAW
	Therapeutic Community	SA	Auth	Day	\$136.64	\$137.32	\$137.32	\$137.32	SAW
	Halfway House	SA	Auth	Day	\$62.78	\$63.10	\$63.10	\$63.10	SAW
	Intermediate								
	Intermediate Residential	SA	Auth	Day	\$152.64	\$153.40	\$153.40	\$153.40	SAW
	Secure Residential (incl Room & Bd)	MH	Auth	Day	\$366.36	\$368.20	\$368.20	\$368.20	Matched
	Secure Resid Room & Board Only (for Medicaid eligible only)	MH		Day			\$35.00	\$35.00	
Inpatient (A)	Acute Inpatient	MH	Auth	Day	\$687.03	\$690.47	\$690.47	\$690.47	
	Subacute Inpatient	MH	Auth	Day	\$515.27	\$517.85	\$517.85	\$517.85	
Emergency Services (Adults)	24 hr. Crisis Phone	MH, SA	NA						
	Crisis Assessment	MH	Reg		^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.				
	Crisis Assessment (LADC)	SA	Reg						
	Crisis Response Teams	MH	Reg						
	Mental Health Respite	MH	Reg						
	Emerg Community Support	MH, SA	Reg						
	Social Delox	SA	Reg						SAW
	EPC Srvc (INVOL)	MH, SA	Reg						

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

Revised 5-3-11

LEVEL OF CARE	SERVICES	MH or SA	UM (Auth or Reg)	Unit	1.5% Rate Increase	.5% Rate Increase	no Change	no Change	Medicaid
					FY-10	FY-11	FY-12	FY-13	
	Civil Protective Custody (INVOL)	SA	Reg						
Community Support Services (Adults)	Assertive Community Treatment (ACT)	MH	Auth	Day	\$44.31	\$44.53	\$44.53	\$44.53	MRO
	Assertive Community Treatment APRN(ACT)	MH	Auth	Day	\$41.16	\$41.37	\$41.37	\$41.37	MRO
	Community Support	MH	Auth	Month	\$280.65	\$282.06	\$282.06	\$282.06	MRO
	Community Support	SA	Auth	Month	\$230.19	\$231.34	\$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 Training	SA	NA						
Children / Youth Services	Middle Intensity								
	Crisis Inpatient - Youth	MH	Reg						
	Professional Partner	MH	Reg	Month	\$800.11	\$804.11	\$804.11	\$804.11	
	Day Treatment	MH	Reg						
	Home-Based 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

ATTACHMENT L

DEFINITIONS

Behavioral Health Advisory Committee (BHAC): The regional advisory committee to RVS comprised of 15-20 members including consumers, providers, and other interested parties.

Behavioral Health Services: Services, including, but not limited to: consumer-provided services, support services, inpatient and outpatient services, and residential and nonresidential services, provided for the prevention, diagnosis, and treatment of behavioral health disorders and the rehabilitation and recovery of persons with such disorders (71-804).

Commission on Accreditation of Rehabilitation Facilities (CARF): CARF International is an independent, nonprofit accreditor of health and human services.

Council on Accreditation (COA): COA is an international, independent, nonprofit, child and family service, and behavioral healthcare accrediting organization.

Community-based: Behavioral health services that are not provided at a regional center. Service and support strategies take place in the most inclusive, most responsive, most accessible, and least restrictive setting possible.

Consumer: User of behavioral health services.

Consumer-Directed: Services founded on participant's informed choice regarding the type, intensity and duration of services provided.

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

Crisis Center: Facility operated by Lancaster County that serves all counties in the RVS' geographic area by providing emergency care and crisis stabilization to persons in emergency protective custody (police custody requiring psychiatric evaluation) under the auspices of the Nebraska Mental Health Commitment Act.

Cultural and Linguistic Competence: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable effective work in cross-cultural situations that provides services that are respectful and/or responsive to cultural and linguistic needs. (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001)

Evidence-based Practices: For the purposes of the Invitation to Negotiate (ITN) process, an evidence-based practice is one that is based on accepted practices in the behavioral health profession and is supported by research, field recognition, or published practice guidelines.

Fee for Service: Services are reimbursed based on an established rate for a unit of service.

Integration: Integration of behavioral health care and physical health care that is intentional, ongoing, and committed coordination and collaboration between all providers treating an individual.

Non-fee for Service: Services in which actual expenses, i.e. personnel costs are reimbursed.

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

Peer: User of behavioral health services.

Peer Supported Programming: Non-clinical support services provided by peers that follow recognized wellness and recovery principles; and may include intentional peer support and peer-run services that are directed and delivered by peers.

Primary Care: Primary care is that care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.

Public Behavioral Health System: The statewide array of behavioral health services for children and adults provided by the public sector or private sector and supported in whole or in part with funding received and administered by the Nebraska Health and Human Services System, including behavioral health service provided under the medical assistance program established in section 68-1018.

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

Recovery-based: Services and systems that are founded on recovery principles and are integrated, comprehensive, flexible, and outcomes-driven. Services and systems are voluntary and provide informed choice in service acceptance and design; services are *holistic focusing on the physical, mental, spiritual, and social wellness of the individual*.

Regional Governing Board (RGB): Governance body to RVS; comprised of one (1) county commissioner from each of the counties in RVS' geographical area.

Person Centered: Care directed by the person served; driven by the person's strengths, capacities, preferences, needs, and desired outcomes of the individual.

Strength Based: Care and planning that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the person served, their family, and their community.

System of Care: Substance abuse and mental health services that are coordinated and developed into an integrated network of services accessible and responsive to the needs of substance abuse and mental health individuals served, their families, and community stakeholders.

The Joint Commission (TJC): An independent, nonprofit organization that accredits and certifies health care organizations and programs.

Trauma-informed Care: Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.