Department of Health and Human Services

Division of Behavioral Health

Network Operations Manual

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INTRODUCTION

This Network Operation Manual (NOM) will be effective July 1, 2017 and all revisions will documented in Part VI.

PART I: NEBRASKA BEHAVIORAL HEALTH SYSTEM

A. Nebraska Behavioral Health System Composition

The Nebraska Behavioral Health System is comprised of:

1. Nebraska Department of Health and Human Services - Division of Behavioral Health (DBH)
    a. Community-based services section
    b. Lincoln, Norfolk and Hastings Regional Centers
2. Regional Behavioral Health Authorities, including Regional Governing Boards
3. Regionally contracted service providers

B. Purpose of the Nebraska Behavioral Health System

The purposes of the public behavioral health system are to ensure:

1. The public safety and the health and safety of persons with behavioral health disorders;
2. Statewide access to behavioral health services, including, but not limited to, (a) adequate availability of behavioral health professionals, programs, and facilities, (b) an appropriate array of community-based services and continuum of care, and (c) integration and coordination of behavioral health services with primary health care services;
3. High-quality behavioral health services, including, but not limited to, (a) services that are research-based and consumer-focused, (b) services that emphasize beneficial treatment outcomes and recovery, with appropriate treatment planning, case management, community support, and consumer peer support, (c) appropriate regulation of behavioral health professionals, programs, and facilities, and (d) consumer involvement as a priority in all aspects of service planning and delivery; and
4. Cost-effective behavioral health services, including, but not limited to, (a) services that are efficiently managed and supported with appropriate planning and information, (b) services that emphasize prevention, early detection, and early intervention, (c) services that are provided in the least restrictive environment consistent with the consumer's clinical diagnosis and plan of treatment, and (d) funding that is fully integrated and allocated to support the consumer and his or her plan of treatment.

This manual focuses on the joint work of the community-based services section of the Division of Behavioral Health, the Regional Behavioral Health Authorities, and regionally contracted service providers, and references interface with staff at the Regional Centers (Appendix L).

C. Service Eligibility

The System purchases services for Adults and Youth:

1. **Who are Financially Eligible:** The community-based system funds mental health and substance use disorder services for individuals who are **financially eligible**. Financial eligibility is based on a consumer's income, family size, and in disability related medical debt incurred by the consumer (6-005 CONSUMER ELIGIBILITY AND PAYMENT FOR SERVICES at http://dhhs.ne.gov/Documents/Title-206-Complete.pdf) Based on the service being accessed and/or the other factors one of three sliding fee schedules are used to determine the amount a consumer is responsible for paying, if any. Individuals must be Nebraska residents and have lawful presence in the United States to have services funded by the Region through DBH. Individuals will be asked to sign attestation of citizenship by the provider prior to initiating services (see LB403 below). The exception to this condition is that in the absence of other payers, services that are ordered by a mental health board or by a court order may be reimbursed by the Region/DBH.
2. **Who are Clinically Eligible:** Individuals must be clinically eligible for services, meeting utilization guidelines as outlined in the Nebraska Administrative Code Title 206: Behavioral Health Services and Ulilization Guidelines a.k.a. Lime Book (or most recent version) and when appropriate, verified for clinical eligibility by DBH's Central Data System.
3. **Who are Civilly Committed:** DBH funds services as directed by a mental health board (for those who are dangerous due to mental illness) or law enforcement officer (for those who are publicly intoxicated or under the influence and danger to self or others) when no other payer source is available to pay for those services. Civil commitments to inpatient care are committed to the care of DHHS. Outpatient commitments are committed directly to community-based providers.
4. **LB403:** State law mandates that no state agency or political subdivision will provide public benefits to a person not lawfully present in the United States. Therefore, NBHS providers who are requesting reimbursement from DBH/Regions must verify lawful presence for any person for whom they are requesting reimbursement for services (Appendix K). There are exceptions:

   > No verification of citizenship is necessary for individuals who are seeking assistance for health care services or products that are necessary for the treatment of an emergency medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of the any bodily organ or part. DHHS has designated the following services do not require attestation of citizenship or lawful presence: Emergency Protective Custody hold, Civil Protective Custody hold, Mental Health or Substance Abuse Crisis Assessment, Emergency Psychiatric Observation, Crisis Response Teams and 24 hour Crisis Lines. If accessed involuntarily for the consumer (e.g. mental health board or court ordered), emergency services also include Acute Inpatient, Sub acute, Crisis Stabilization, Social Detoxification, and Hospital Diversion/Crisis.

5. **Age Waivers:** With DBH approval, youth who are 17 or 18 years old may be served in an adult service when it is clinically and developmentally appropriate, and when their treatment and/or rehabilitation needs can best be met in adult services (Appendix B).

D. Priority Populations for Admission

Our system prioritizes admission and funding for populations to meet State Priority Guidelines and Federal Block Grant Requirements.

1. **State-level community services admission priorities:**
    a. Persons mental health board committed and being treated in a Regional Center who are ready for discharge
    b. Persons who are mental health board committed to inpatient care being treated in a community inpatient setting or crisis center and who are awaiting discharge
    c. Persons committed to outpatient care by a mental health board
    d. All others

    Community-based service providers will prioritize these populations for admission to services above others waiting for the service. These priorities were recommended to DBH Administration at the Network Operations Workgroup on March 7, 2017, and subsequently approved.

2. **Substance Abuse Prevention and Treatment Block Grant Admission Priorities**
    a. For providers* who are receiving SUD state or federal dollars, the Substance Abuse Block Grant priority populations for admission include:
        i. Pregnant injecting drug users;
        ii. Other pregnant substance users;
        iii. Other injecting drug users;
        iv. Women with dependent children who have physical custody or are attempting to regain custody of their children;
        v. All others

        *Includes the Housing Assistance Program if funded by state or federal SA funding

    b. For categories i.- iii. specified above, if a priority consumer is not admitted to treatment, providers must provide interim substance abuse services. Interim substance use services are services that are provided until an individual is admitted to a treatment program to reduce the adverse effects of substance use, promote health, and reduce the risk of transmission of disease (Appendix A).
    c. Also, for persons on the wait list, providers may also provide engagement services, which is another substance use service, typically a less intense service that the service to which they are referred, that enhances the individual's motivation in the recovery process until the individual is admitted to the level of service clinically indicated. Engagement services may also identify and attend to an individual's immediate needs, even if the problems cannot be resolved instantly.

Note: A provider may be presented with a situation where competing priorities for services exist. In these situations, the provider may request assistance from DBH's Network Administrator to reconcile such a situation and remain in compliance with priority population admission expectations.

E. Priority Populations for Funding

Guidance for funding for priority populations and other funding parameters are included in the Mental Health Block Grant and the Substance Abuse Prevention and Treatment Block Grant. In addition, DBH has designated services/funding be included for persons with severe and persistent mental illness (SPMI).

1. **Mental Health Block Grant** - Specifies Mental Health Block Grant funds are to be used for services for adults with serious mental illness and youth with severe emotional disturbance. These classifications describe adults/youth whose mental illness severely interferes with or limits major life activities.

    a. As defined by federal regulation, a serious mental illness is a condition that affects "persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the most recent American Psychiatric Association Diagnostic and Statistical Manual that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities" such as maintaining interpersonal relationships, activities of daily living, self-care, employment, and recreation. (Substance Abuse and Mental Health Services Administration, 2013, p. 11). This definition has since been amended to also exclude dementias and mental disorders due to a general medical condition (Substance Abuse and Mental Health Services Administration, 2006). This diagnosis is required for individuals funded by Housing Related Assistance Program.

    b. The term serious emotional disturbance (SED) is used to refer to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. More specifically, it refers to limitations in two or more areas including (1) school/work role performance, (2) home role performance, (3) community performance, (4) behavior towards others, (5) moods/emotions, (6) self-harm behavior, (7) substance use and (8) thinking.

2. **Substance Abuse Prevention and Treatment Block Grant** - Provides guidance on expenditure of funds including primary prevention, specialized services for pregnant women and women with dependent children, and other funding parameters. For more information on funding requirements (Appendix A).

3. **State Regulations** - NBHS provides funding for persons with a severe and persistent mental illness (SPMI). As defined by State regulation **471 NAC 2-000**, an adult with a with **SPMI** means an individual who is age 19 and old, has a primary diagnosis of schizophrenia, major affective disorder, or other major mental illness under the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Developmental Disorders or Psychoactive Substance Use Disorders may be included if they co-occur with the primary mental illnesses listed above. They also must be at significant risk of continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed mental health services are not provided, and this pattern has existed for 12 months or longer or is likely to endure for 12 months or longer; and has a degree of limitation that seriously interferes with the individual's ability to function independently in an appropriate and effective

manner, as demonstrated by functional impairments which substantially interferes with or limits at least two of three areas:

a. Vocational/educational;

b. Social skills; or

c. Activities of daily living.

This designation required for individuals served in Community Support Mental Health, Day Rehabilitation, Psychiatric Residential Rehabilitation, and Assertive Community Treatment.

F. Purchasing Services

Behavioral Health Services can be purchased as follows:

1. **Regional Contracts** - Behavioral health services are purchased through the regional contracts with DHHS/Division of Behavioral Health. Each Region contracts with community-based providers to provide an array of community-based services, including inpatient care. Regions may also provide services directly, as approved by DBH and in accordance with Nebraska Administrative Code 206.
2. **Letters of Agreement** - Regions may also use a Letter of Agreement to fund a service for an individual with a provider who is not currently under contract with the Region but **who is contracted with another Region** for this service. Letters are developed on an individual basis (one letter for each consumer served) between the funding Region and the provider. The letter must include the individual's name and rate paid for the service. The agreement should have an end date or specify other condition, such as "until the consumer no longer meets clinical eligibility." The agreement must accompany billing documents in order for the provider to be reimbursed.

G. Services and Supports

Behavioral health services purchased through our system include, but are not limited to, consumer-provided services, support services, inpatient and outpatient services, and residential and nonresidential services, and are provided for the prevention, diagnosis, and treatment of behavioral health disorders and the rehabilitation and recovery of persons with behavioral health disorders. Services and supports include:

1. Services listed in the **Nebraska Administrative Code Title 206: Behavioral Health Services and Utilization Guidelines (a.k.a. Lime Book)** at **http://dhhs.ne.gov/behavioral_health/Documents/LimeBook.pdf,** a set of standards that specify requirements for services funded by DBH. These standards are attached and incorporated in regulations and are posted on the Department's website.
2. **Regionally developed services** - A Region may propose to pilot a service to fill a need or gap in their catchment area during the Region budget planning process. The Region may propose a service definition and outcomes for consumers as a result of the receiving the service. A Region may only propose a new service when development or expansion of a service with a statewide service continuum will not adequately address this need/gap. These services are proposed as pilot projects in the Regional budget plan and are not an enhancement of a current service but considered a stand-alone service. If approved by DBH, the Region must resubmit an updated service definition with the regional budget plan (Appendix C).

3. **Service enhancements** - Components added to a standard service that is not a minimal expectation of the service, but will increase quality and efficiency of the services delivered. Most common service enhancements include adding a mental health professional to a substance use disorder service or vice versa to increase ability to serve individuals with co-occurring disorders, or use of a peer to utilize lived experience to enhance the service. Service enhancements may be used to provide the clinical expertise to serve special populations whose needs cannot be met by traditional behavioral health services (Appendix D). The service enhancement must be approved by DBH during the regional budget planning process prior to funding the service.
4. **Specialized discharge planning** - For individuals discharging from Lincoln Regional Center, Regions may choose to develop a specialized service plan which includes non-traditional services in order to facilitate discharge (Appendix E). Upon discretion of the Director of Behavioral Health, plans may be funded for individuals at risk to admit or readmit to Lincoln Regional Center. These plans are referred to as “plans for one.”
5. **Prevention services** - Programs, policies, or practices that are delivered prior to the onset of a disorder and whose interventions are intended to prevent or reduce the risk of developing a behavioral health condition.
6. **Inpatient post-commitment days** - The care for DBH funded mental health board committed individuals who do not continue to meet acute or sub-acute care criteria at local hospitals or crisis centers. These individuals are on the wait list for either the Lincoln Regional Center or a substance use disorder residential services may be reimbursed under inpatient post-commitment day funding. The Region may establish a rate and pay for care at the hospital or crisis center until the individual is admitted to the LRC or substance use disorder residential treatment.
7. **Room and board** - DBH has established rates for individuals who are served in Secure Residential Treatment, and due to SSI ineligibility, are unable to pay for room and board. Once the individual becomes SSI eligible, DBH/Region will no longer pay for any portion of Room and Board. Room and board may also be paid for using specialized discharge, a.k.a. plans for one funding (#4 above) for room and board for other services upon receipt and approval of plans for one for a consumer discharging from Lincoln Regional Center.
8. **Flexible Funding** - Used to purchase supports to eliminate barriers for consumers discharged from a higher level of care or prevent a consumer from moving to a higher level of care. Typically, flex funds are used to purchase medications, transportation, etc. Flex funds are intended to be the payment of last resort and used only on a temporary basis for utilization of funds and required documentation (Appendix F). Additional flex funding cannot be established within a program plan. The use of flex funds must follow all the allowable cost guidelines outlined in this manual.

PART II: DIVISION RESPONSIBILITIES

A. Roles and Functions of the Division of Behavioral Health

The Division of Behavioral Health (DBH) is the preeminent behavioral health authority for the state of Nebraska. The primary functions of DBH are to direct the administration and coordination of the public behavioral health systems. The DBH primary role and functions include:

1. Administration and management of DBH, regional centers, and any other facilities and programs operated by DBH;
2. Integration and coordination of the public behavioral health system;
3. Comprehensive statewide planning for the provision of an appropriate array of recovery-oriented and person-centered community-based behavioral health services and continuum of care;
4. Coordination and oversight of Regional Behavioral Health Authorities, including approval of regional budgets and audits of Regional Behavioral Health Authorities;
5. Development and management of data and information systems associated with the delivery of DBH funded behavioral health services;
6. Prioritization and approval of all expenditures of funds received and administered by DBH including the establishment of rates to be paid and reimbursement methodologies for behavioral health services and fees to be paid by consumers of such services;
7. Cooperation with the DHHS' Division of Public Health in the licensure and regulation of behavioral health professionals, programs, and facilities;
8. Cooperation with the DHHS' Division of Medicaid and Long Term Care in the provision of behavioral health services under the Medical Assistance Program;
9. Promotion of activities in research and education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals and access to Behavioral Health programs and services;
10. Coordination of the integration and management of all funds appropriated by the Legislature or otherwise received by DBH from any other public or private source for the provision of behavioral health services; and
11. Ensuring the statewide availability of an appropriate array of recovery-oriented and person-centered community-based behavioral health services and continuum of care and the allocation of such funds to support the consumer and his or her recovery-oriented and person-centered plan of treatment.

B. Statewide Network Planning, Monitoring and Leadership

DBH will ensure the statewide availability of an appropriate array of recovery-oriented and person-centered community-based behavioral health services and continuum of care and the allocation of such funds to support the consumer and his or her recovery-oriented and person-centered plan of treatment. To accomplish this responsibility, DBH will perform the following activities:

1. **Needs assessment** - DBH will conduct a Statewide Needs assessment in order to gather information to plan for the provision of an appropriate array of recovery-oriented and person-centered community-based behavioral health services and continuum of care. Appropriate data and stakeholder feedback will be gathered and will be a basis for decision-making and planning. The Needs Assessment will be disseminated to the public upon completion and will be the basis for strategic planning for the system.
2. **Strategic planning** - DBH will develop a five year comprehensive strategic plan with measurable goals, objectives, strategies and metrics for the statewide system. The plan will be publicly disseminated and will drive the work of the system, including work accomplished through the contracts with the six Regional Behavioral Health Authorities. Data based decision making will be key in accomplishing the work of the system. DBH will develop a work plan which outlines the activities necessary to achieve the goals outlined in the strategic plan.
3. **Budget planning and contracting** - DBH will develop regional budget plan guidelines to be disseminated to the RBHAs outlining requirements and necessary in the submission of a budget plan on which to base upcoming fiscal year contracts. DBH will include an allocation chart in which regional funding for the upcoming fiscal year is allocated to the Region, and outlines total funding, federal, state and other funds available, and tax match requirements for the Region based on allocated state funding. Regions are required to submit an annual regional budget plan to DBH. Upon receipt of the plans, detailed review and approval of the Region's budget plan by DBH, DBH will initiate a contract for network management services and funding for services with the Regional Behavioral Health Governing Board.
4. **Auditing and oversight of services** - In collaboration with the RBHAs, DBH will develop processes and protocols for oversight of services purchased through the Regional Behavioral Health Authorities. Such oversight will include a **program fidelity review** conducted at least every 3 years to ensure adherence to service definitions, state and federal requirements, and other conditions of the contract. In addition, a **services purchased review** will be conducted every year to verify that services billed are tied to units of service or appropriately incurred expenses. These written procedures are outlined in **The Nebraska Behavioral Health Audit Manual.** Regions will conduct the review for their network providers. DBH will conduct these reviews when the Region is the direct provider of the service.

   In addition, following the completion of the fiscal year, DBH will conduct a network compliance review to ensure RBHAs met the conditions of DBH to Region contract including the receipt of all deliverables referenced in the contract. Such review will be conducted within the 1st quarter of the following fiscal year. DBH will respond in writing to the RBHA administrator within 30 days of the review with findings and request for plan of correction as appropriate.

5. **Centralized data system** - DBH will maintain a centralized data and information system (CDS) in order to gather demographic and service utilization data for individuals served in the RBHA system. Unless otherwise specified, contracted providers are required to enter data into the system. DBH will develop and disseminate reports regarding services and service recipients which will be the basis for addressing issues and unmet service needs in the system.
6. **Electronic billing system** - DBH will maintain an electronic billing system for providers and Regions for the submission of monthly reimbursement requests to the Division.
7. **Rates and reimbursement** - DBH will establish rates to be paid and reimbursement methodologies for behavioral health services contracted by the RBHAs. DBH will also develop a financial eligibility policy and fee schedules to be adopted by the RBHA, which includes uniform copays for individuals receiving services.
8. **Service development** - DBH will monitor the service development processes by the RBHAs, including approval of bidding processes, approval of intent to contract with providers, adherence to regulation for bidding, and other service development processes, as reflected in Nebraska Revised Statute 71-809.
9. **Continuous quality improvement** - DBH defines CQI as an ongoing process of using data to plan, identifying opportunities for improvement, implementing changes, studying and analyzing results and celebrating improvements. DBH will provide leadership for system improvement which is data-driven and serves to further the completion of the statewide strategic plan.
10. **Systems coordination** - DBH will provide leadership and facilitation of statewide system coordination activities for all statewide systems teams.
11. **Alternative compliance** - DBH may approve a request for alternative compliance (from a Region or network provider) for any regulation in 206 NAC Chapters 4 through 7, unless otherwise stated in these regulations, as deemed appropriate to further the development and implementation of recovery-oriented and person-centered community-based behavioral health services. To apply for alternative compliance with a regulation, a provider must submit a written request to DBH (Appendix G).

    DBH will base a determination for alternative compliance on the following information in the providers' proposal:

    a. It is consistent with the intent of the specified regulation;
    b. It conforms to good and customary administrative management and programmatic practices;
    c. It protects the rights, health, and safety of the consumers;
    d. It does not relieve the provider of the responsibility to comply with other pertinent regulatory requirements; and
    e. It contains documentation of evidence of how alternative compliance with the regulation would enhance quality, accessibility, public safety, and cost effectiveness.

PART III: REGIONAL RESPONSIBILITIES

A. Roles and Functions of the Regional Governing Board

The Regional Governing Board is an entity established in each behavioral health region by the counties which governs the Regional Behavioral Health Authority (RBHA). The board consists of one county board member from each county in the Region. Board members serve for staggered terms of three years and until their successors are appointed and qualified. Board members must serve without compensation but will be reimbursed for their actual and necessary expenses. The primary functions of the Regional Governing Board will include:

1. Appointment of a Regional Administrator who is responsible for the administration and management of the Regional Behavioral Health System.
2. Utilization of a regional advisory committee consisting of consumers, providers, and other interested parties and other task forces, subcommittees, or other committees as it deems necessary and appropriate to carry out its duties under this section.
3. Ensure that each county in a behavioral health region provides funding for the operation of the behavioral health authority and for the provision of behavioral health services in the region. See 206 NAC 4-002.01A and B at http://dhhs.ne.gov/Documents/Title-206-Complete.pdf.

   The total amount of funding provided by counties shall be equal to one dollar for every three dollars from the General Fund. At least forty percent of such amount shall consist of local and county tax revenue, and the remainder shall consist of other non-federal sources. The Regional Governing Board, in consultation with all counties in the region, shall determine the amount of funding to be provided by each county. Any general funds transferred from regional centers for the provision of community-based behavioral health services after July 1, 2004, and funds received by a Regional Behavioral Health Authority for the provision of behavioral health services to children under section 71-826 shall be excluded from any calculation of county matching funds under this subsection.
4. Approve an annual regional budget plan (RBP) to be submitted to DBH for approval.

B. Roles and Functions of the Regional Behavioral Health Authority (RBHA)

The Regional Behavioral Health Authority (RBHA) is the regional administrative entity responsible for development and coordination of a network of publicly funded providers within each behavioral health region. The RBHA must encourage and facilitate the involvement of consumers in all aspects of service planning and delivery within the region.

DBH contracts with RBHAs for system coordination and network management in the provision of community-based behavioral health services (mental health and substance use disorder) across Nebraska. Under contractual obligations each Region must:

1. Develop, maintain, and provide system planning, coordination, monitoring and leadership to a provider network in their geographical area to meet the behavioral health needs of persons eligible for the DBH's clinical and financial eligibility criteria;
2. Provide effective financial management to include the development of an annual budget plan; establish, implement, and complete audit of services purchased from subcontractors (providers); and establish processes to actively monitor utilization and movement of all funds managed by the Region;

3. Develop and maintain a regional quality assurance/improvement system; and,
4. Participate and contribute to the statewide Nebraska Behavioral Health System through active participation and collaboration in meetings, planning, and initiatives to improve services (Appendix H).

C. Regional Network Management

1. **Needs assessment and strategic planning** - The RBHA will participate in DBH's strategic planning process (see page 12) that includes needs assessment for target population of consumers. The needs assessment will lead to identification of problems or barriers in the system, and identification of services and supports to remediate. Regions may also conduct a regional needs assessment as needed. The RBHA will develop a strategic plan based on the strengths, needs and opportunities for improvement of the Region. The Region's strategic plan should demonstrate consistency with DBH's strategic plan.
2. **Service development** - The RBHA is responsible for contracting for publicly funded (non-Medicaid) behavioral health services for consumers within its designated catchment area. The RBHA must contract all behavioral health services developed after July 1, 2004 through an open, public competitive bidding process to purchase new services (Nebraska Revised Statute 71-809).
3. **Exception** - The Region is not required to bid services that the Region provided directly prior to July 1, 2004. There are two conditions for which a service may be considered to be new:
    a. The Region was not providing the service on July 1, 2004.
    b. The service definition was developed after July 1, 2004.
4. **DBH notification** - Prior to conducting a public bid process for a new behavioral health service, DBH must be notified of the Region's intent to contract for the new service and must comply with all requirements, per **206 NAC §4-001.03E at http://dhhs.ne.gov/Documents/Title-206-Complete.pdf**. This may be completed during the region budget plan process or as needed during the course of the fiscal year.
5. **Requests for proposals (RFP)** - Following notification of DBH, the RBHA will develop an RFP which includes the following proposal information:
    a. Complete information - that includes name and address of the provider agency, and general information about the provider (e.g. license if applicable, national accreditation).
    b. Demonstrates understanding of the service, includes rationale and any current, valid data to justify why this program should be developed at the agency applying and describes and demonstrates understanding of the needs the **target population** to be served.
    c. Provides a general overview of **how the program will be organized** and includes information about how the provider's resources are coordinated and directed to meet the needs of the consumers through the proposed program.
    d. Lists and explains the **goals of the program** which describe specific, measurable desired outcomes **from a consumer's point of view**, and which includes a description of the processes for consumer complaints, grievances, and abuse/neglect reporting.

e. Describes the **quality improvement plan** used for this program, directed at desired outcomes for the consumer.

f. Describes how the program is working to make progress toward **working with individuals with complex needs** including coordination or integration with primary care.

g. Includes a budget justification narrative, Includes a BH-20 Provider Budget Summary or,

h. Includes a Provider Budget BH20 c-h. for both service development and ongoing provision (unless paid FFS for ongoing service);

i. Staffing needs by position, number of full-time equivalents (FTEs), and their respective salary and fringe costs separately:

   i. Operating costs

   ii. Travel expenses

   iii. Capital outlays

   iv. Indirect administration

   v. Other expenses including professional fees, evaluation and consultant needs

j. The **Development/Implementation Timeline Plan** will be developed on **Form BH5.** The development plan includes an implementation schedule (Appendix J).

6. **Network enrollment requirements** - The RBHA shall develop policies and procedures for determining eligibility for enrollment and include these requirements in the RFP. The ability to meet network enrollment requirements should be documented by each bidder in their service proposal to the RBHA.

   At a minimum, the network enrollment requirements must address:

   a. Compliance with all applicable state standards and licensure requirements for program, facilities, and staff members;

   b. Professional licenses and endorsements;

   c. All applicable insurance coverage including but not limited to: worker's compensation, motor vehicle liability, professional liability, directors/officers liability, and general liability coverage; and

   d. Fiscal viability, including fiscal and budgetary systems that provide appropriate accounting for and spending of contracted funds

   e. Verified demonstration of compliance with state or national accreditation standards. Region will require the provider to indicate their status of accreditation appropriate to the organization's mission by the Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other nationally recognized accreditation organization(s) approved by the Director.

   f. Documentation of accreditation must include a complete copy of the most recent official accreditation report, documentation of the most recent official award of accreditation; and a complete copy of the plan of correction submitted in response to the official accreditation report, if applicable. The accreditation requirements do not apply to the following:

      i. Substance abuse prevention funds; or

ii. When a nationally recognized accreditation organization appropriate to the organization's mission cannot be identified.

g. **Critical incident minimum standards for providers** - The Regions will require providers to have a written policy regarding:

i. Definition of a critical incident,

ii. How to investigate, including follow up;

iii. Documentation requirements, and

iv. Notifications required when a critical incident occurs

Regions will require providers to have procedures that address prevention, reporting, documentation, remedial actions and timely debriefings for critical incidents occurring within a provider agency. Providers will have a system and be able to demonstrate that personnel are trained in and aware of reporting requirements. Regions shall review the provider's "annual incident summary" during both the services purchased and program fidelity reviews to determine compliance and appropriate actions taken to address identified needs.

7. **Capacity development plan** - The RBHA shall require that a capacity development plan for behavioral health services be submitted by the each bidder. The plan will include a program narrative and an itemized operating budget, including any startup costs related to the provision of the service (Appendix D).

8. **Other requirements** - The RFP must also contain:

a. A clear description of the process by which consumers are directly and actively involved in the development, implementation, and evaluation of the services to be provided, including the Network Enrollment requirements as described below;

b. A clear description of the service(s) to be provided;

c. A clear description of the minimum qualifications for prospective bidders;

d. Accurate data related to the service (as available);

e. The process to be used to evaluate and score the submission to determine the successful bidder; and

f. The process for appeal.

9. **Request for proposal (RFP) development** - The RBHA will provide a copy to DBH's network administrator prior to the release of the bid. DBH's network administrator will notify the Regional Administrator (or their designee) within seven calendar days of receipt regarding DBH approval or need for revisions to the RFP process document.

10. **Publish and distribute RFPs** - The RBHA will publicize and distribute the RFP. Approved RFP's must be released with adequate public notice before notification of award to ensure an open and fair competitive process. Each RBHA is expected to make reasonable efforts to contact all potentially eligible bidders.

11. **Receipt, evaluation, determination of successful bidder and approval to contract** - Each proposal received must be recorded and evaluated according to the published criteria in the RFP. If the RBHA identifies a qualified and willing provider through the public bid process, they must obtain written DBH and Regional Governing Board approval to contract. The Regional Governing Board should then negotiate a contract with the qualified and willing provider(s) identified. DBH's approval of the annual regional

budget plan and funding allocation may serve as the written approval for the purposes of this requirement. When conducted midyear, approval must be obtained from DBH in writing prior to entering into a contract. Upon notice of award to the successful bidder, all proposals must be open to public inspection upon request (Appendix J).

12. **Onsite Visit** - Documented completion of an on-site visit for all contracted providers and programs before enrollment, service provision and reimbursement to any consumer receiving services funded by DBH. This on-site visit must include review and verification of the following minimum areas:
    a. Verification of compliance with **206 NAC §4-001.03J**; and
    b. Verification that the clinical record keeping practices conform with the program plan submitted and meet the minimum standards as described in **206 NAC §6-007**; and
    c. Primary source verification of all information used to meet the criteria in items1-3 (see http://dhhs.ne.gov/Documents/Title-206-Complete.pdf).
13. **Federal financial participation by network providers (Medicaid)** - If a provider delivers a service covered by Medicaid/Heritage Health, the Region must verify that the provider is an enrolled and credentialed network provider through each Heritage Health managed care organization unless denied by them due to lack of business need. Providers of Social Detoxification or Halfway House services are exempted from this requirement.
14. **Absence of successful bid** - If the RBHA does not identify a qualified and willing provider through the public bid process, the RBHA may:
    a. Revise the RFP and reissue it for public bid, or
    b. Submit a request to the Director of DBH for approval for the RBHA to act as a provider for that service. Such a request must include verification that:
        i. There has been a public bidding process for services;
        ii. There are no qualified and willing providers to provide such services; and
        iii. The Director may approve the request or return the request with further instructions. If the request is approved, the RBHA will receive written authorization from the Director of DBH.
15. **Contract for direct provision of service** - If the Division contracts with RBHA for the direct provision of a service, the RBHA must comply with all applicable rules of DBH relating to the provision of behavioral health services including rules that establish definitions of conflicts of interest for the RBHAs and procedures if a conflict of interest arises. The RBHA is required to establish and maintain a separate budget and separately account for all revenue and expenditures for the provision of the service.
16. **Conflict of interest** - The RBHA must have policies and procedures that guard against a conflict of interest between the RBHA, a current or prospective provider, or any individual member of either organization. For the purposes of these regulations, a conflict of interest exists when an organizational matter to be acted upon confers a personal benefit, financial or otherwise, direct or indirect, to a member of the Regional Governing Board, an employee, a volunteer, a student, a consultant, or person related by kinship, or personal or professional association. Per regulations The RBHA must have policies and procedures that, at a minimum, ensure no person mentioned above is

the recipient of gifts or gratuities, with financial value or otherwise, from individuals or organizations doing business with the RBHA or a provider;

a. Misuses confidential information;

b. Uses the organization's personnel, resources, property, or funds for personal financial gain;

c. Employs persons related by kinship or personal or professional association without prior written approval from the RBHA; or

d. Uses or attempts to use any official position to secure unwarranted privileges or exemptions for themselves or others.

The RBHA must have policies and procedures that address any conflict of interest between the RBHA in its role as administrator and any provider including the RBHA in its role as a provider and how the conflict is resolved. **206 NAC § 4-001.04A at** http://dhhs.ne.gov/Documents/Title-206-Complete.pdf

17. **Participation in Nebraska behavioral health system meetings -** Regions will attend and participate in Network meetings as scheduled and which support the development, coordination, maintenance and monitoring of Network goals and activities.

18. **Division notification** - The RBHA must notify DBH of:

    a. **Program Changes** - In writing within 20 days of its occurrence any changes regarding programs offered by the Regional Governing Board and/or a provider which are different from the approved regional budget plan, any changes in ownership, the governing body's responsibilities or structure, or control of program(s), and any changes in the capacity and/or type(s) of services. DBH may immediately terminate and/or amend the contract containing funds administered by DBH, or any portion thereof, based on the changes reported by the RBHA/provider.

    b. **Sentinel Events** - In the event of death or serious injury to any client in the course of delivering or receiving BH services in the Region, providers will notify the Region who in turn will notify DBH no later than forty-eight (48) hours after they have been notified of the incident and provide the following information:

        i. The consumer's or staff member's names involved in the incident;

        ii. The date of incident, accident or death;

        iii. Service(s) the consumer was receiving, and if known;

        iv. The cause of accident or death.

    a. Regions may use this information in oversight of service delivery and to ensure continuity of care, and:

        i. Follow up with providers regarding sentinel events reported to the Region to ensure the provider has addressed causes, trends, actions for improvement, results of improvement plans, necessary education and training of personnel, prevention of reoccurrence, internal and external reporting requirements;

        ii. Regions shall conduct an analysis of all sentinel events reported to the Region by providers occurring within the Region at least annually. The analysis should include trends and causes, and any needed remediation appropriate by either the provider or the Region. This analysis should be submitted to the Division after the close of the fiscal year in a format specified by the Division.

iii. At least annually, DBH, based upon the Regions' reports, should develop a statewide summary, including trends and causes of critical incidents, and any remediation appropriate to be provided by DBH.

D. Network System Coordination

The RBHA will fulfill the following system coordination functions. The RBHA will identify a RBHA staff contact for each of the system coordination roles.

1. **Prevention coordination** - Prevention systems are purposeful partnerships of agencies, organizations, and individuals who come together with a shared commitment of supporting wellness in their community. Activities led by prevention systems seek to produce sustained outcomes in preventing the onset and reducing the progression of substance use disorders and mental illness and related consequences among communities. Furthermore, prevention systems are designed to operate at the community level embracing the local culture while leading the development of strong, sustainable, community-based prevention activities focused on pro-social and normative changes. The RBHA will coordinate local community coalitions and other community activities within the Region's prevention system to ensure that prevention services are available, accessible and that duplication of efforts are minimized. The prevention systems funded must comply with requirements set forth by the state and federal government in the attainment and continuation of federal prevention funding.
    a. Prevention system activities shall promote protective factors and decrease risk factors, and build prevention capacity and infrastructure at the state/tribal and community level.
    b. Prevention initiatives funded through the state of Nebraska must follow the strategic prevention framework and include the following:
        i. Universal prevention: activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk;
        ii. Selective prevention: activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average;
        iii. Indicated prevention: activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.
    c. Funded prevention initiatives will include strategies that address the targeted audience and desired outcome and ensure expenditures for prevention initiatives reflect objective analysis of data, evidence-based or promising practices, and alignment with the community's strategic prevention plan.
    d. Initiatives will include an evaluation plan that describes the plan to collect, analyze, and disseminate process, outcome, and impact evaluation data, including plans to monitor for continuous improvement and plans to use lessons learned from evaluation to improve the performance of the funded initiative.
    e. The Prevention Coordination staff of the RBHA will be responsible for providing technical assistance to funded prevention initiatives in the region and organizing and preparing any supporting documentation required by the Department. See the **DBH Prevention Handbook** for prevention system expectations.

2. **Emergency coordination** - The RBHA will coordinate and sustain a community-based emergency system designed to meet the needs of individuals experiencing a behavioral health crisis/emergency situation. Expectations include:
    a. Coordinate activities and collaborate with community-based partners to ensure that individuals experiencing a behavioral health crisis receive the least restrictive and most appropriate services located within their community.
    b. Collaborate with county attorneys and local mental health boards on local system issues, identified through individual cases and/or aggregate data.
    c. Assist with facilitating seamless transitions of individuals to the most appropriate level of care by participating in case review and treatment team meetings and other activities designed to develop appropriate discharge plans for individuals receiving treatment in the emergency system (e.g., community-based hospitals, and the Lincoln Regional Center).
    d. Partner in the development and implementation of specialized discharge planning to facilitate timely discharge of consumers who have been receiving treatment at Lincoln Regional Center for longer than 180 days and have been determined to be discharge ready (Appendix D).
    e. Consult with Department of Corrections' staff as requested to assist with discharge planning for consumers from correctional facilities with the expectation that individuals in the correctional system have co-occurring mental health and substance use disorders.
    f. Engage in activities that promote quality improvement by reviewing emergency system data, preparing reports, monitoring outcome measures, and providing technical assistance to community providers when needed and as appropriate.
    g. Participate in statewide emergency system coordination activities and other calls as scheduled by DBH.
3. **Youth system coordination** - The RBHA will collaborate with DBH, family advocacy organizations and other youth serving agencies including Division of Children and Family Services and Administrative Office of Probation in the planning for, and development of the system of care infrastructure for youth and their families experiencing behavioral health disorders. Expectations include:
    a. Engage in activities that promote quality improvement by participating in statewide youth system coordination, and providing technical assistance when needed and as appropriate to providers to increase their ability to incorporate family-centered practice and system of care principles into their practices.
    b. Coordinate activities and collaborate with community-based partners to ensure that children and youth with behavioral health disorders receive the most appropriate services located within their community whenever possible.
    c. Collaborate with regional network providers, family advocacy organizations and other youth serving agencies including the Division of Children and Family Services to engage in activities that address the needs of youth/young adults who are in need of behavioral health services.
    d. Provide transitional services/transition teamwork for eligible youth transitioning into the adult behavioral health service system using agreed upon processes.

e. Work with providers on co-occurring capability for providers of services for youth, as well as youth with SED who have families and caregivers who are using substances, so that family systems can receive an integrated approach to treatment.

f. Collaborate with DBH, family advocacy organizations and other youth serving agencies including the Division of Children and Family Services, and, Administrative Office of Probation in the planning for, and development of, the system of care infrastructure for youth and their families experiencing behavioral health disorders.

4. **Consumer system coordination** - The regional consumer specialist serves as an integrated member of regional leadership. They will participate in the development of regional and or DBH planning for recovery-oriented community-based services, i.e. expansion of peer services, development of Peer Bridger program, development of standards/regulations, etc. They should promote and facilitate educational opportunities & other activities that enhance recovery, resiliency, and whole health wellness for consumers and their families.

   a. Participate in DBH meetings/conference calls and related statewide activities.

   b. Engage in activities that promote quality improvement and provide technical assistance when needed and as appropriate, specifically as it relates to implementation of recovery oriented systems of care and trauma-informed care.

   c. Utilize personal lived experience to advocate for voice and choice, integration of consumers as a priority, reduction of behavioral health stigma, facilitation of meaningful involvement of consumers and their families, and in the development program policies and procedures.

   d. Provide co-reflection opportunities for the peer support workforce within the region and participate in and support peer support workforce development initiatives in partnership with the Office of Consumer Affairs.

   e. Implement formal and strategic system links with other key stakeholders by building intentional partnerships to expand consumer and family involvement in service planning and delivery.

   f. Manage and maintain a behavioral health consumer advisory committee. This shall include, but not be limited to, maintaining a charter, bylaws, application procedures, and participation expectations.

   g. Build and maintain partnerships with the family peer support organization within the region.

   h. Participate in annual programmatic reviews of network providers who provide peer support services to review for the inclusion of recovery and trauma-informed care principles in service delivery.

   i. Provide assistance and coordination of opportunities for consumer feedback and participation in statewide and regional events and initiatives.

5. **Housing coordination** - The RBHA will provide leadership, planning activities and system problem solving for regional housing issues for persons with extremely low incomes who have behavioral health disorders. Work will include collaboration with local housing partners. The RBHA may, but is not required to administer the Housing Assistance Program to serve as source of funding for housing for target populations. See the **DBH Housing Assistance Program Manual** to review program requirements,

activities and other provisions regarding housing assistance. Expectations for housing coordination include but is not limited to:

a. Participation in DBH meetings/conference calls and related statewide activities.

b. Participation as requested in activities related to fidelity monitoring for the Supported Housing service.

c. Ensure Supported Housing compliance with data reporting and outcome performance measures as set by DBH.

6. **Disaster planning and coordination** - The RBHA must have the capacity to respond to the psychosocial needs of people affected by a disaster within the Region's assigned geographic area, consistent with the state disaster plan and have a written plan prepared to meet the disaster-generated psychosocial needs for the people residing within the region. The plan must reflect coordination of its disaster preparations and response with the other emergency responders in the Region's assigned geographic area. The RBHA must work in cooperation with the local emergency management organization and DBH to organize, recruit, and train qualified behavioral health staff to respond in times of disaster. The behavioral health personnel designated to serve as part of the disaster response team must have received training to develop skills for providing psychosocial support after disaster. See the **Statewide Disaster Plan** in manuals**.**

E. Financial Management

The RBHA will provide financial management of all funds designated in its contract with DBH. This includes development and submission of an annual regional budget plan, ongoing oversight through the fiscal year, and development and submission of a report for DBH which indicates actual expenditure of funds as required by DBH.

1. **Regional budget plan (RBP)** - The RBHA must develop an annual financial plan, referred to as the regional budget plan or RBP, to provide financial oversight of all funds received through DBH, including fee for service (FFS), non-fee for service NFFS), and network management/system coordination funds. The RBHA will ensure local match (tax and non-tax) is expended. The RBHA must annually submit the RBP in a format specified by DBH.

   The RBP must include, but is not limited to a proposed budget that projects expenses and the allocation of funds for the recovery-oriented and person-centered community-based services (FFS and NFFS) to be offered in the region including:

   a. A projection of expenditures and revenues for all services. The projections should utilize input from stakeholders, address the Regions' needs assessment and strategic plan. Historical performance should also be a key consideration.

   b. A projection of all other revenues from all sources, including other insurers, for each community behavioral health provider and the RBHA in a manner specified by DBH.

   c. The plan should be data driven, utilizing data on length of service, waitlist and capacity, needs assessment, emergency system or other data as specified in the RBP guidelines.

   d. The plan must demonstrate adequate allocation of funding to meet all state and federal funding requirements, including maintenance of efforts are met and priority populations served (Appendix A).

e. The RBHA must certify in writing to DBH that the required matching funds have been allocated as required in statute. The RBHA must certify that required match funds in each region have been appropriated for expenditure during the fiscal year for which the match has been allocated. The match dollars must be expended for community behavioral health services and for the operation of the RBHA as reported in the RBP, or as amended, if applicable. The amounts of match dollars certified to DBH by the RBHA and expended during the fiscal year must appear in the annual audit of the RBHA. The RBHA must annually submit to DBH a report summarizing the actual expenditure of funds and revenues received from all sources, in a manner specified by DBH.

2. **Ongoing review of utilization and drawdown** - Regions will review the monthly expenditures for all services in the contract. Regions should compare to this drawdown to historical performance, consider other related factors for service utilization and make recommendations for contract shifts/adjustment as needed.

3. **Actuals** - The RBHA will submit an annual report which demonstrates the amount all funds expended in the contract, including state, federal and other funding sources and the contract item on which they were expended by the Region and their subcontractors/subrecipients no later than September 1 following the close of the fiscal year.

F. Network and Provider Monitoring

Regional Behavioral Health Authorities, are required to monitor, review, and perform programmatic, administrative, quality improvement and fiscal accountability and oversight functions on a regular basis with all subcontractors. If the Region is a direct provider of services, DBH is responsible for the oversight functions for the services provided directly by the Region.

1. **Network review to promote an appropriate array of services/continuum of care within the region** - The following factors should be continuously reviewed to determine the RBHA's continued capacity for providing an appropriate array of services/continuum of care:

   a. Demographics of region

   b. Target population to be served

   c. Geo-access of providers

   d. Adult/youth mix of services

   e. Access to consumers with health disparities

   f. Utilization by levels of care and by service

   g. Capacity and waitlist data

   h. Provider denial of service information

This review may inform the need to shift funds, discontinue or reduce services, or develop new capacity. This information must be shared with DBH with requesting shift of funds requiring Division approval.

2. **Evaluation of service delivery** - Systematic evaluation of provider service delivery assists the Region in determining whether to retain/contract with a currently contracted provider of services. Contract retention is to be determined is determined through a performance review that at a minimum includes the following:

a. Continued compliance with demonstration of capacity to provide behavioral health services as outlined in enrollment process and compliance with state/national accreditation standards.

b. A review of data demonstrating the operation of the service outlined in the current contract;

c. Consumer satisfaction;

d. Compliance with information reporting to DBH;

e. On-site visit consistent with current enrollment standards;

f. Completion of all provider enrollment forms and reports specified by DBH; and

g. Inclusion of consumers in development, implementation, and evaluation of services.

3. **External monitoring process** - The RBHA will use internal and external measures for oversight of services purchased through the contract between DBH and the RBHA these measures are performed by entities outside of the Nebraska Behavioral Health System (NBHS), and include as appropriate:

   a. Annual fiscal audit as conducted by a certified public accountant, if deemed necessary according to state law, and

   b. Maintenance of accreditation by a nationally recognized accrediting body if deemed necessary by state law.

4. **Internal measures performed by entities within NBHS** - The RBHA will use internal measures for oversight of services purchased through the contract between DBH and the RBHA, and include as appropriate:

   a. Services purchased verifications (unit/expense reimbursement).

   b. The services purchased verification will verify that a unit of service billed was provided to a consumer by a consumer file review. In addition, the verification will ensure that funds used to reimburse service providers for mental health and substance abuse services are used to pay for services for consumers who meet clinical eligibility criteria and who meet financial eligibility criteria.

   c. Financial eligibility includes meeting the criteria as specified in DBH approved regional financial eligibility and fee schedules and citizenship and lawful presence in the state and the country. Citizenship/lawful presence is 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.

   d. The RBHA will ensure that providers of non-emergency services will use the systematic alien verification for entitlements if a person applies for NBHS funds for a person who attests they are a “qualified” alien. If the consumer is Medicaid-eligible, this will have been already determined by Medicaid. Attestation can be presumed to be true until verification otherwise.

   e. Regions and providers will track any persons who are denied due to LB403. DBH will report the number of persons denied services to the Legislature;

   f. Regions and providers will register for e-verify and verify work eligibility for all new employees; Regions will need to include this provision in the provider subcontracts. Regardless of citizenship/lawful presence status receiving emergency services or

inpatient or outpatient treatment mandated by a mental health board or for individuals mandated into the care of DHHS by a court order (Appendix K).

5. **Program fidelity reviews** - The program fidelity review will monitor compliance with the services definition and other state regulatory guidelines. In addition, the review will monitor fidelity to Substance Abuse Block Grant by conducting a Substance Abuse Prevention and Treatment Block Grant (SAPTBG) program fidelity review at least every three years. The process monitors program plans and services delivered to ensure consistence and conformance with SAPTBG requirements (waitlist and interim services, tuberculosis and HIV requirements, confidentiality and charitable choice) for agencies designated as, and providing services for, specified priority consumer populations (IV drug users, pregnant women, women with dependent children) (Appendix A).
6. **Internal controls (self-review & monitoring)**
    a. In compliance with the COSO (Committee of Sponsoring Organizations) documents:
        i. Standards for internal control in federal government
        ii. Internal control integrated framework
7. **Financial reliability of sub-recipients**
    a. Pre-award and ongoing
        i. Required use of a form or checklist for risk assessment
        ii. Sub-recipient required to relate financial data to performance accomplishments of the federal award
    b. Audit findings – systematic review and follow-up
    c. Written policies
        i. Cash management
        ii. Allowable costs-in accordance with cost principles (**2 CFR 200**).

The written procedures outlined in the **Nebraska Behavioral Health Audit Manual** provides a systematic approach (across all Regions and DBH) to the oversight of network management, including the monitoring and reviewing of services in the network. See systems manuals for further information.

8. **Denial of services** - The RBHA will have a mechanism to monitor to ensure behavioral health treatment providers in the network **do not deny services to consumers who are clinically and fiscally eligible.** This includes but is not limited to:
    a. Denials of consumers who utilize medications prescribed by a physician and/or appropriately licensed professional (e.g. medication assisted treatment).
    b. Denials of consumers who reside in Nebraska who have an inability to pay scheduled fees, including preadmission deposits, co-payments, and/or other payments required from the consumer.
9. **Region as a direct provider** - When the Region is a provider of direct services to consumers or employs persons who work directly with consumers:
    a. The Region shall not audit itself for any services provided and paid for through the contract with state or federal funds.

b. When the Region provides services directly, they will work with DBH to ensure that the following is conducted:

   i. Services purchased verification and expense reimbursement verification reviews annually

   ii. Program fidelity review every three years

c. The Region and DBH have mutual responsibility for the coordination and scheduling of these reviews. The same regional procedures used to audit Region network providers will be used if DBH completes the review.

d. The Region will maintain a conflict of interest policy available to DBH upon request.

G. Quality Improvement

1. **Data and reporting** - The RBHA, network providers and any behavioral health providers subsequently funded under a DBH Region contract will comply with record keeping and reporting practices as required by DBH. The accuracy of the data is dependent on the data input by the Region and its providers. The RBHA will hold itself and network treatment providers accountable for requirements as specified in by DBH.

2. **Data collection** - RBHA's will collect data on indicators and performance measures as defined by DBH. The central data system and electronic billing system will serve as the primary source for data collection. Outcome data reporting requirements may be included in contracts or in a written document and will outline data to be collected and specific indicators and performance measures related to the emergency systems, youth systems, consumer and family system, and the network management system, as well as any federal block grant outcome measurement reporting requirements. The RBHA will:

   a. Ensure that the services provided incorporate best practice, evidence based practice, and effective practices and are integrated, recovery oriented, trauma-informed and consumer directed.

   b. Maintain a regional continuous quality improvement system that evaluates provider performance and consumer outcomes using monthly, quarterly and annual reports data to meet statewide network and system goals. Identify Region-specific continuous quality improvement (CQI) activities to improve the service system.

   c. Develop and implement strategies and/or initiatives that strengthen the expertise within the behavioral health workforce by coordinating and/or facilitating technical assistance and/or professional training.

   d. Organize a CQI partnership and process in which all providers have an opportunity to engage collaboratively in making progress on co-occurring capability. The Region will provide support to the partnerships, coordinate opportunities for training, technical assistance and consultation, and will be responsible for supporting metrics of progress across the region as measured by the Compass-EZ and the trauma-informed care (TIC) assessment.

   e. Ensure that services are of high quality and provided in a cost-effective manner.

   f. Participate in CQI meetings (including scheduled data and centralized data system user calls and webinars) and implementation of CQI including all DBH priorities. Outcome data reporting requirements may be included in contracts or in a written document and will outline data to be collected and specific indicators and performance measures related to the emergency systems, youth systems, consumer

and family system, and the network management system, as well as any federal block grant outcome measurement reporting requirements (Appendix L).

PART IV: DIVISION AND RBHA JOINT LEADERSHIP AND MANAGEMENT OF THE SYSTEM

A. Division Director and Regional Administrator Meetings

The DBH Director, Deputy Directors, Finance Officer, Regional Center CEO, Regional Administrators and other staff as requested will meet monthly to discuss pertinent issues to the NBHS System.

B. Division and Regional Administrator Weekly Calls

DBH Director, Deputy Directors and Regional Administrator will hold 30 minute weekly calls for information updates and issue identification regarding the NBHS System.

C. Network Management Meetings

Division and regional staff will meet as needed to identify and resolve network operation issues (Appendix L).

D. Fiscal Manager Meetings

The fiscal team for DBH, network team and regional staff will schedule and conduct monthly calls to answer questions and resolve issues relating to fiscal management and other issues as appropriate.

E. Tuesday Data Calls

DBH and regional CQI and network staff will participate in regularly scheduled calls to review pertinent data and make recommendations, based on the data, for system improvement.

F. Audit Workgroup Meetings

DBH and regional network staff will meet quarterly to discuss barriers, problems and issues with the services purchased and program fidelity reviews to ensure standard compliance and resolve issues relating to the reviews.

G. System Coordination Meetings

DBH and regional systems coordination staff will meet as needed to identify and resolve issues and make needed systems improvement within their respective systems.

PART V: NETWORK OPERATION MANUAL APPENDICES

Appendix A – Federal Oversight Requirements for Substance Use Prevention and Treatment Block Grant (SAPTBG) and State Mandates

A. GENERAL REQUIREMENTS

1. The Region and SAPTBG funded providers will continue to meet all SAPTBG requirements listed below and included in 45 CFR Part 96.
2. The Region is responsible for ensuring that a process is in place which provides for continual accountability and monitoring of SAPTBG requirements.
3. SAPTBG funding may not be used to provide services in a penal or correctional institution of the state in an amount that exceeds SAPTBG funding that the state used for this purpose in FFY91 (1991 amount = $0).
4. Any Region and/or provider receiving SAPTBG funding will:
    a. Ensure that continuing education is provided to the SAPTBG prevention and treatment workforce, and document such training annually;
    b. Provide updated and accurate information in all SAPTBG reporting requirements;
    c. As requested by DBH, attend SAPTBG training provided;
    d. Provide DBH with the name and contact information of the individual responsible (for each provider agency and Region) for managing and monitoring the Region waiting list for all priority populations;
    e. Provide required data to monitor priority populations on a waiting list who receive interim services;
    f. Actively publicize within the catchment area the availability of services for pregnant women and IV drug users to include the fact that these persons receive such preference and therefore will be given admission priority.
5. Preference should be given to the following priority populations in the order listed below for any programs receiving SAPTBG funding:
    a. Pregnant injecting drug users
    b. Other pregnant substance users
    c. Other injecting drug users
    d. Women with dependent children
6. The Region and providers must submit data as determined by DBH for the SAMHSA national outcomes measures (NOMS).

B. PRIMARY PREVENTION

1. Primary prevention activities funded with SAPTBG must utilize the SPF process and be directed at individuals not identified to be in need of treatment.
2. Funded prevention activities must utilize the six primary prevention strategies identified in 45 CFR §96.125 and be provided in a variety of settings for both the general population as well as targeting sub-groups who are at high risk for substance use.
3. Funded prevention activities must emphasize and utilize evidence based practices for prevention efforts whenever possible.

4. Ensure that SAPTBG funded community coalitions and their workforce are offered training specific to federal confidentiality and charitable choice (42 CFR parts 2 and 54) including the penalties for noncompliance.
5. Federal funds cannot be used to contract with a for-profit entity.
6. Ensure that SAPTBG funded community coalitions and their workforce are offered training specific to federal confidentiality and charitable choice (42 CFR parts 2 and 54) including the penalties for noncompliance.
7. Primary prevention strategies that prevent substance use that also positively impacts mental health by linking common risk and protective factors may be funded only if the strategies that have a positive impact on the prevention of substance use.

C. SUBSTANCE USE ASSESSMENTS

1. If an individual identified as a priority population has not received a substance use assessment and is requesting treatment, the individual shall be given an appointment for the assessment within 48 hours, and receive the assessment within 7 business days.
2. Upon completion of the assessment (written report), the eligible individual should immediately receive treatment services. In the event that capacity does not exist for the individual to immediately receive treatment, the individual will receive interim services within 48 hours (from the time the assessment report is documented) and will receive interim services until treatment is available.

D. INTERIM SERVICES FOR PRIORITY POPULATIONS

1. Interim substance use services are services that are provided until an individual is admitted to a treatment program to reduce the adverse effects of substance use, promote health, and reduce the risk of transmission of disease. Interim substance use services are services that are provided until an individual is admitted to a treatment program. The Region will ensure compliance of providers with the delivery of interim services in the following manner:
    a. Interim services should be provided between the time the individual requests treatment and the time they enter treatment. Interim services must be provided within 48 hours and until the individual can receive the appropriate treatment service, based upon the level of care identified in the substance use evaluation.
    b. Interim services for injecting drug users must include counseling and education about human immunodeficiency virus (HIV), tuberculosis (TB), including education on HIV transmission and the relationship between injecting drugs and communicable diseases, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and the steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB treatment services as necessary.
    c. Case management services must also be made available in order to assist client(s) with obtaining HIV and or TB services.
    d. All referrals and or follow-up information pertaining to priority populations and interim services must be documented and this documentation must be maintained by the program and provided to the Region upon request and/or the request of DBH.
    e. Interim services for pregnant women must include counseling on the effects of alcohol and drug use on the fetus and a referral for prenatal care, counseling and education about HIV and TB as specified above (see b). All referrals and/or follow-up

information must be documented and made available upon the request of the Region and/or DBH.

E. INTRAVENOUS SUBSTANCE USERS/SPECIAL CONSIDERATIONS

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

F. CAPACITY/WAITING LIST MANAGEMENT for PRIORITY POPULATIONS

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

G. WOMEN'S SUBSTANCE USE SET ASIDE SERVICES (WSA)

1. The amount set aside for women's services shall be expended on individuals who have no other financial means of obtaining such services as provided in 45 CFR §96.124(e) and §96.137.
2. Women's substance use set aside services for women who are not eligible for Medicaid must be funded at a level adequate to ensure expenditures do not fall below the amount expended in the previous year. Federal funds may not supplant state funds for this purpose.
3. Women's substance use set aside services must meet all criteria required by the SAPTBG.
4. Providers serving women will publicize the availability of these services and publicize that a pregnant woman will receive priority admission. This may be done by means of street outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of treatment distributed to the local community network of community-based organizations, health care providers, and social service agencies.
5. If a Region and/or provider of women's services has insufficient capacity to provide treatment, the facility shall notify DBH or its system management agent.
6. To be eligible to receive SAPTBG set-aside funds, the following services must be demonstrated by the provision, facilitation, or arrangement of the following:
    a. Primary medical care for women, including referral for prenatal care while the woman is receiving treatment services, child care;
    b. Primary pediatric care, including immunization, for their children;
    c. Gender-specific substance use treatment and other therapeutic intervention for women which may address issues of relationships, sexual and physical abuse and parenting, and child care while the women are receiving these services;
    d. Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, their issues of sexual and physical abuse, and neglect;
    e. Sufficient case management and transportation to ensure that women and their children have access to services outlined above;
    f. Child care needs, while the women are receiving services, which facilitate engagement in treatment;
    g. Coordinate with the Division of Children and Family Services as appropriate with treatment and discharge planning.
7. Copies of all letters of agreement, memorandums of understanding, or any provider subcontracts that result from this RBP that demonstrate how a provider will meet the requirements to be a "qualified" provider must be maintained by the Region and be made available to DBH upon request.

H. TUBERCULOSIS (TB) SCREENING AND SERVICES

1. Region will ensure that all providers receiving SAPTBG funds shall:

a. Report active cases of TB to the Division of Public Health tuberculosis program manager and adhere to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6, which can be found at: www.dhhs.ne.gov/reg/t173.htm

b. Maintain infection control procedures that are consistent with those that are established by the State's infection control office;

c. Adhere to state and federal confidentiality requirements when reporting such cases.

2. The Region will ensure that providers receiving SAPTBG funding will routinely make TB services available to each individual receiving treatment for substance use and to monitor such service delivery.

3. The Region shall establish procedures that ensure that the following (TB) services are provided, either directly or through arrangements/agreements with other public or non-profit private entities:

a. Screening of all admissions for TB

b. Positive screenings shall receive test for TB

c. Counseling related to TB

d. Referral for appropriate medical evaluations or TB treatment

e. Case management for obtaining any TB services

f. Report any active cases of TB to state health officials

g. Document screening, testing, referrals and/or any necessary follow-up information

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

I. STERILE NEEDLE DISBURSEMENT AND HIV/AIDS

The Region will ensure that no SAPTBG funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug. The Region will ensure that SAPTBG funded programs will not perform testing for the etiologic agent for acquired immune deficiency syndrome (AIDS) unless such testing is accompanied by appropriate pre-test and post-test counseling.

J. CHARITABLE CHOICE

Regions and providers must comply with 42 U.S.C. 300x-65 and 42 CFR part 54 [See 42 CFR 54.8(c)(4) and 54.8(b), charitable choice provision and regulations]. The Region will notify DHHS of any form being used in the region to communicate the consumers' right to request another provider based on religious preferences.

Network providers will receive training in the area of charitable choice at minimum once every two years. Training may be provided by the Region or other source, with documentation of training kept at the Region and made available to DBH upon request. The Region will ensure that each network provider has received training within the time period.

K. CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Regions and providers must comply with 42 CFR Part 2 regarding confidentiality of alcohol and drug abuse patient records. Regions will monitor for provider compliance.

L. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FEDERAL (CMHSBG) REQUIREMENTS

REQUIREMENTS - The Region and CMHSBG funded providers will continue to meet all CMHSBG requirements listed below and included in 45 CFR Part 96:

1. Children's mental health services must be funded at a level adequate to ensure expenditures do not fall below the amount expended the previous year.
2. CMHSBG funds may only be used to establish or expand an organized community-based system for providing mental health services for adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED).
3. If a community mental health venter is funded with CMHSBG funds, the center must provide:
    a. Services to individuals residing in a defined geographic area ("service area");
    b. Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and consumers who have been discharged from inpatient treatment at a mental health facility;
    c. 24 hour-a-day emergency care services;
    d. Day treatment or other partial hospitalization services, or psychosocial rehabilitation services;
    e. Screening for patients being considered for admissions to state mental health facilities to determine the appropriateness of such admission;
    f. Services to any individual residing or employed in the service area of the center regardless of the consumer's ability to pay for such services, within the capacity of the center;
    g. Services that are available and accessible and in a manner which preserves human dignity and assures continuity and high quality care.

M. NATIONAL VOTER REGISTRATION

Regions and providers will comply with Title 42 Public Health and Welfare, Chapter 20 Elective Franchise, Subchapter I-H, National Voter Registration, in establishing procedures to register to vote in elections for federal office.

N. STATE MANDATES - GENERAL REQUIREMENTS:

All costs incurred, either direct or indirect, pertaining to the contract must be included in the financial records of the contractor. These costs apply to the Region and any sub-contractor(s). 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.

1. Mental health services and substance use services must each be funded at a level adequate to ensure expenditures do not fall below the amount indicated expended in the previous year.

2. Funds must be expended on services which deliver quality mental health and substance use (prevention and treatment) services.
3. Services funded with healthcare cash funds must meet the parameters limiting the award and use of these funds as originally described in LB692 which are listed below:
    a. Decrease number of post commitment days;
    b. Decrease number of individuals taken into emergency protective custody;
    c. Decrease number of admissions to the Regional Center for substance use treatment;
    d. Ensure services are equitably provided in all counties within the Region, based on need.
4. No state funds may be used, directly or indirectly, to influence or attempt to influence any elected or appointed official or employee of an elected or appointed official or specific legislation.
5. No state funds may be used for fundraising activities.
6. No state funds may be used to pay for abortions.
7. Items that are allowable or unallowable with federal funds typically have the same status when being purchased with state funds. In addition to items stated in federal funding:
    a. **Allowable costs**: Allowable costs include costs for the infrastructure necessary to develop, maintain and evaluate a community-based continuum of care for behavioral health services.
        i. Meals for staff at regional or state events who may not be in travel status or only in travel status for one day (no overnight) if allowed by agency policy.
        ii. Meals to/for consumers that are a normal part of service provision.
        iii. Purchasing of limited amount of promotional items related to specific prevention strategy activity (e.g., red ribbons) but must not be purchased in excess of what is needed for the event.
    b. **Allowable with prior approval by DBH**, the use of state funds for alteration, renovation, or minor remodeling of real property is allowable under the following conditions only:
        i. Alteration or renovation is needed to accomplish the objectives of the mental health program and is approved by DBH
        ii. The space involved will actually be occupied by the region/provider
        iii. The costs of alterations or remodeling are the result of a competitive bidding process
        iv. 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
        v. There is, prior to alteration or renovation of rented space, a lease approved by DBH
        vi. The costs related to purchase of adequate insurance coverage to cover the region/provider's exposure. The region/provider shall annually file a certificate of coverage showing the kinds of coverage with the contract authority.

c. **Unallowable costs:** Any costs not properly related to carrying out the purpose of the activities and services under this contract are unallowable. Costs determined to be unallowable and not eligible for support by funds administered by DBH include but are not limited to:

   i. Meals/food for internal staff meetings or trainings.

   ii. Rewards, celebrations or gifts to or on behalf of employees (e.g., birthdays, anniversaries, funeral flowers, T-shirts, coffee mugs, etc.).

   iii. Depreciation

   iv. 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.

   v. Contributions to a restricted fund or any similar provision for unforeseen events.

   vi. Any personal costs unrelated to the provision of approved services and/or costs of personal gifts.

   vii. Costs of amusements, social activities, and related expenses for employees and governing body members, except when an authorized consumer treatment/rehabilitation/recovery program.

   viii. Costs of luncheons or dinners held to award employees.

   ix. Costs of a personal nature unrelated to the provision of approved program

   x. Costs of alcoholic beverages.

   xi. Costs resulting from violations of, or failure to comply with federal, state and local laws and regulations.

   xii. Costs relating to lobbying or attempts to influence/promote legislative action by local, state or federal government.

   xiii. Costs of lawsuits or other legal or court proceedings against DHHS, its employees or state of Nebraska.

   xiv. Costs related to purchase and/or rental of cars, trucks or similar vehicles.

8. DBH reserves the right 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 Region and all providers must comply with the state standards for behavioral health listed below. Any Region or provider who does not comply with these standards will not be eligible for reimbursement for services performed or for continued enrollment in the statewide network.

   a. State approved standards of care and service definitions

   b. State approved clinical eligibility criteria (utilization criteria)

   c. Financial eligibility criteria and fee schedule approved by state or region, as applicable

   d. State approved service rates when available

Appendix B – Age Waiver Instructions & Form

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Behavioral Health
Age Waiver Request Instructions

Providers requesting adult behavioral health treatment and/or rehabilitation services for youth aged seventeen (17) or eighteen (18) must complete and submit an Age Waiver Request Form per DBH policy. Procedural changes were required for the Centralized Data System (CDS) as of 07/01/2016.

1. The form will prompt you to enable JavaScript, you must do this to continue.
2. Today's Date: Enter Month, Day and Year (MM/DD/YYYY) example: 02/17/2017
3. Choose Region for Email Address: Dropdown will contain email address to send a copy to.
4. Contact Name: Provider's Contact person for Age Waiver Request, enter First & Last Name
5. Provider Name: Please provide entire name of Provider
6. Contact's Email: Double check, your authorization will be sent to this email
7. Provider Address: Include P.O. Box if necessary, Street address, City, State & Zip
8. Provider Phone Number: (Area Code) XXX-XXXX
9. Youth's Name: First Name, Middle Initial, Last Name
10. Youth's Date of Birth: MM / DD / YYYY
11. *Age Today: This will calculate automatically and you cannot change it.*
12. Check Box State Ward or Medicaid Covered: Ensure the youth is NOT a State Ward as they are covered by Medicaid and/or CFS; this confirms they are not a Medicaid client.
13. If you choose an Authorized Service: Select acceptable service from drop down list.
    a. Location of Service: Type in Location that service will be provided (i.e., satellite offices)
    b. CDS Encounter Number(s): You must have the Authorized service "authorized in CDS" BEFORE submitting an age waiver request – CDS Encounter number must be entered.
       - Go to the CDS website and log into your account. https://dbhcds-dhhs.ne.gov/
       - Once you're in the site click on you name in the upper right hand corner of the window. Click on System Documentation and Training link for an explanation of how to create an encounter video number DBHCDS_03_CreatinEncounter.
14. If you choose a **Registered Service**: Select acceptable service from drop down list.
    a. Location of Service: Type in Location that service will be provided (i.e., satellite offices)
    b. DO NOT ENTER INTO CDS UNTIL AFTER AGE WAIVER IS APPROVED BY DBH
15. Narrative: Describe each area as instructed
    a. Describe level of care and how it meets the specific treatment / rehabilitative needs.
    b. Describe program modifications/enhancements…
    c. Describe current services and why adult services are more appropriate.
16. Electronically Sign and Date Form: It will require you to provide an email, please do this.
17. Select Submit: Request automatically goes to DHHS.DBHNetworkOperations@nebraska.gov
18. Save a Copy and Send the attachment to Region: Save a copy and send form to Region contact listed with the **Email Subject Line: Age Waiver Request.** This helps identify requests in the secure mailbox.

*Within three (3) business days of receipt of all required information, the DBH will notify the Region and Provider via secure email of the Age Waiver Request approval or denial with further instructions.

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services Division of Behavioral Health
Age Waiver Request
Email To: DHHS.DBHNetworkOperations@nebraska.gov

This Section to be filled out by Provider (by Region if they are Provider) Today's Date:

Choose Region for Email Address | Contact Name:

Provider: | Contact's Email:

Provider Address, City, State and Zip | Phone Number (include area code)

Youth's Name: (First, MI, Last) | Youth's Date of Birth 01/01/2000 | Age Today 17.00

I have confirmed this youth is NOT a State Ward and/or service is NOT Medicaid covered.

Request for **Authorized** Service
AUTHORIZED SERVICE | Location of Service | CDS Encounter #

Request for **Registered** Service
REGISTERED SERVICE | Location of Service | Do NOT Enter Registered in CDS Prior to Approval

Narrative: For all services provide a very brief summary based on the sections below:
The level of care requested will meet these specific treatment/rehabilitative needs including:

Describe program modifications/enhancements that will ensure service is patient-focused & developmentally appropriate:

Describe services the youth is currently receiving and why adult services would be more appropriate:

❖ If youth has other insurance coverage, provide the denial of the service(s) requested in separate email.

Signature:

This section for DBH use only:

☐ This Request for an Age Waiver as written above has been **APPROVED**.

For **Authorized** Services: (a) Locate in CDS (b) Put Approval Date in CDS notes (c) ADMIT YOUTH INTO SERVICES
For **Registered** Services: (a) Enter into CDS (b) Put Approval Date in CDS notes (c) ADMIT YOUTH INTO SERVICES

☐ This Request for an Age Waiver as written above has been **DENIED**, (a) Put denial date if in CDS (b) End Encounter.

Comments:

DBH Representative Signature: _____ Date: _____

All sections must be completed. After submission save PDF and email to DHHS and the Region email listed above
Note: Do not attach additional documentation for Authorized Services - this is already utilized in CDS approval.

DBH (02/17)

Appendix C – Pilot Project Guidelines

Pilot project guidelines should be used if the Region chooses to develop capacity for a service that does not have an approved, statewide service definition. If the service that is being developed has an approved statewide service definition, see the **Capacity Development Plan Guidelines** for behavioral health services. If the service being proposed is meant to enhance or support a service that has an approved, statewide service definition, see the **Service Enhancement Guidelines** for behavioral health services (Appendix D).

A pilot project will be considered if consumer need has been identified and when development or expansion of a service with a statewide service definition would not adequately address. A pilot project is not an enhancement of a current service; it is a stand-alone service.

Pilot projects will be approved by the division as part of the annual regional budget planning process. If it is necessary to begin a pilot project outside of the RBP timeline, approval by the Division Director is necessary to waive this requirement.

The format specified below must be used to apply for approval for funding a pilot project:

I. Proposed service definition

II. Program narrative

III. Outcomes and evaluation plan

IV. Development and implementation timeline plan

   A. **BH5**-Goals and objectives-one form is completed for each goal

V. Budget and narrative budget justification

   A. **BH20 Budget Summary and BH20c-h** for annual ongoing budget

   B. **BH20 Budget Summary and BH20c-h** for one-time budget (all expenses and revenues expected)

   C. Budget narrative justification that explains (1) the one-time expenses and why they are needed, and (2) the ongoing annual expenses and why they are needed.

The provider/program requesting to develop a pilot project using state and/or federal funds must be a member of a regional behavioral health provider network or be working with the appropriate Region to become a network member.

I. PROPOSED SERVICE DEFINITION

A Region proposed service definition that follows the standard format of the Division of Behavioral Health should be submitted to the Division. This definition should clearly describe the service to be purchased, and expectations for consumer outcomes.

II. PROGRAM NARRATIVE

The program narrative is a written plan that describes, in detail, the program to be developed. The applicant should provide the following information thoroughly and completely.

The Region should work with the Division to develop a draft service definition prior to releasing an RFP/RFQ.

Typically, the information requested below is submitted as part of the Region's RFP/RFQ process, and the proposal selected for funding through that process may be submitted to the

Division in lieu of a pilot project plan.

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

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

C. Thoroughly describe the need for the program using current, valid data to justify why this program should be developed at the agency applying, in this geographic area, and for the purpose detailed above. Include the source and time period for the data. Include an explanation of why this need would logically lead to the development of the program being proposed. Explain how current services are not meeting the needs of the community that the pilot project will address.

D. Describe the target population to be served. Provide demographic information to include:
   1. Age
   2. Gender
   3. Racial/ethnic identity
   4. Geographic location
   5. Special considerations related to the target population

E. Provide a general overview of how the program will be organized. Include information about how the provider's resources (facility space, personnel-current/new, equipment, other) and administrative structure are coordinated and directed to meet the needs of the consumers through the proposed program.

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

G. Thoroughly describe admission criteria and procedures for consumers to access the program or how the behavioral health and/or Medicaid service definition admission criteria will be used in this program.

H. Describe the assessment process and procedures which will be used in the program. Include an explanation of what information will be gathered for each consumer and how consumers in this program will be screened for other problems (i.e., substance abuse problems - if developing a mental health program). If more detailed procedures need to be developed, include this in the Program Development/Implementation Schedule.

I. List and include complete explanations of the specific services to be provided directly to the consumer:
   1. How individual treatment or rehabilitation planning will be done with the consumer and what is included in this individual plan.
   2. What services will be provided within this program. (Examples include: Peer Support, Community Support, and Residential Services)
   3. How the services will be coordinated with other programs.

4. The provisions for periodic reassessment and individual plan revision.
5. Discharge planning procedures, criteria, and follow-up.
6. The projected average length of stay in the program for the consumer to successfully reach the desired outcomes as specified in the goals (see F above).
7. How the program activities are designed to meet the developmental stage of the consumers to be served.

J. Describe the procedures for direct consumer involvement in the program. Include an explanation of:
   1. How potential consumers will be informed about the program and consumer rights.
   2. How meaningful participation of consumers will continue to be incorporated into the development, evaluation, and ongoing modification of the program.

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

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

M. Identify the specific facility needs of the program and explain how this program will meet those needs. Identify how the provider will secure adequate square footage. Include an explanation of the relationship of this program within the operation of the provider agency.

N. Discuss how the state licenses and national accreditations that the program/provider currently holds are appropriate for this service or the plan to obtain the appropriate licenses and/or accreditation.

O. Discuss how the program will be will be person/family-centered, recovery oriented, culturally and linguistically competent, trauma-informed, co-occurring capable and incorporate best practices.

III. OUTCOMES and EVALUATION PLAN

A. Describe in detail the consumer outcomes that will be measured in this pilot project. This should include a detailed description of all the consumer data to be collected as part of this project, the outcome measurement tools that will be used, and the frequency of data collection.

B. Provide a proposed timeline for evaluation of the pilot project. Indicate when preliminary data on consumer outcomes will be available and project a date when formal evaluation of the project will be complete. The completion date of the pilot project evaluation may vary depending on the anticipated length of service but should be no more than 18 months from the start date of the service. The evaluation plan should include what outcome results will trigger continuation, revision, or termination of the service. Funding for a project in pilot status will not exceed 24 months.

IV. DEVELOPMENT and IMPLEMENTATION TIMELINE PLAN

The development/implementation timeline plan will be developed on Form BH5. The

development plan includes an implementation schedule. The information will explain in detail the development process and show a clear step-by-step plan of how the program will be developed over a given period of time. The program development plan will conclude when the agreed upon capacity or timeline has been reached and an evaluation has been completed by the Region of the program plan, the process, and the services provided. The Region will submit the result of the evaluation to the Division. The Region may submit the final progress report, with the signature of the Regional Administrator and any comments by the Region in lieu of an evaluation.

The development/implementation timeline plan will have several BH5 forms that will identify the goals and objectives needed to develop and implement a service capacity. The capacity development goals should include, at a minimum, the following:

1. Develop administrative structures and personnel for service.
2. Develop facility for providing service, if needed.
3. Develop program plan, program operating policies and procedures, operation plan.
4. Develop an authorization/referral system for service. (This includes working with Heritage Health/Medicaid to develop the appropriate registration/authorization procedures and/or a service definition).
5. Develop reporting, financing, and quality assurance systems. (This includes developing a standardized billing procedure and/or rates for the service with the DBH).
6. Develop a plan to begin to serve people.
7. Attain appropriate state licenses and/or national accreditation as applicable.

Instructions for completing **Form BH5**. Identify specific goals to address development issues (different from program goals for consumers as stated above).

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

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

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

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

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

V. BUDGET

The budget section should include:

1. *Itemized Annual Operating Budget*

   Use **BH20 Provider Budget Summary** and **Forms BH20(c-h)** to develop detailed budget for the service.

2. *One Time Development / Start-up Budget*

   Use **BH20 Provider Budget Summary** and **Forms BH20(c-h)** to develop start-up.

3. *Budget Justification Narrative*

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

1. *Annual Operating Budget*. Explain and justify all items included in the annual operating budget including

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

2. *One Time Development/Start Up Budget*. Explain and justify all items included in the start-up (one-time) cost budget.

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

PILOT PROJECT PROGRESS REPORTS

Pilot project progress reports will be required for any project approved. These reports should include the mandatory data reporting form developed by the Division of Behavioral Health. Depending on the individual situation, the Region may require the provider to report monthly, bi-monthly or quarterly to communicate the details of the progress made toward completion of the goals listed on the BH-5, the preliminary evaluation data, any preliminary recommendations for changing the program. The Region will review these provider reports and forward them to the Division on a quarterly basis.

Due Dates for Progress Report: Due dates for progress reports will be identified in the contract. **The Region is responsible for reviewing and forwarding provider progress reports to the Division quarterly, at a minimum**.

Appendix D – Guidelines for Capacity Access Guarantee, Capacity Development Plan and Service Enhancement

A. CAPACITY ACCESS GUARANTEE (CAG)

To be eligible for Capacity Access Guarantee (CAG) funding, the service must be categorized as a “Fee for Service (FFS)” in the State to Region Contract and meet one or more of the following criteria:

1. Capacity cannot be guaranteed; the region wants to ensure service is always provided.
2. Inability to accurately predict utilization baseline data.
3. Inabilities to define, measure, and/or quantify a "unit" of service.

CAG funding is not intended for and should not be used to establish a new service, expand the capacity of an organization or service, or enhance an existing service.

Capacity Access Guarantee justification must include the following:

I. Program Narrative

II. Itemized Operating Budget and Budget Narrative for the service(s)

I. PROGRAM NARRATIVE

The Program Narrative is a written plan that describes, in detail, how the additional funds will address the barrier the program is facing to adequately provide the service(s).

A. If multiple services within the same level of care will be supported by the funding, one narrative may be submitted for those services as long as it clearly identifies the specific service the funding supports as well as the specific dollar amount supporting each service(s).

B. If multiple services will be supported and those services are in different levels of care, separate narratives and budgets must be submitted for each service. The amount of funding for each service must be clearly identified.

C. The provider should provide the following information in as thorough and complete detail as possible:

   1. Name and address of the provider agency
   2. Describe the purpose of the request. Provide an explanation of why the provider is not capable of providing the service(s) under the current funding received from the Region.
   3. Thoroughly describe the need for CAG using current, valid data to justify why this program should receive the funding including:

      - Total number of consumers served in the program during the previous 12 consecutive months;
      - Number of consumers served in the previous 12 consecutive months the program received Division contracted state or federal funds for;
      - Information about any barriers which prohibit consumers from accessing this service from another provider;

- Explanation of why utilization baselines cannot be established (if applicable);
- Explanation of how and why the provider has been unable to define, measure, and/or quantify a 'unit' of service (if applicable); and,
- Any change in the provider's financial status experienced in the previous 12 consecutive months.
- Report the source and time period for any data reported. Include an explanation of why the CAG would logically lead to the continuation of an existing approved NBHS service.

4. Describe how the provider will work with the Region to address the issues/barriers which lead them to requiring CAG funding. This must include establishing utilization baselines or implementing changes to allow for the program to define, measure and/or quantify a 'unit' of service if applicable.
5. Discuss any change in capacity anticipated for the program given the CAG funding. Program capacity means the total number of bed or slots available for consumers at any given point in time. Daily census means the number of individual consumers who can be served on a single business day.

II. BUDGET

The budget section should include the following two sections:

A. Itemized Operating Budget for the Service(s) being funded:

Use a **BH-20 Provider Budget Summary** and **Forms BH-20c through BH-20g** to develop the detailed budget for each service. If the funding will be applied to more than one service, it must be clearly identified as such.

- BH-20 - Provider Budget Summary [Report revenues from ALL other funding sources (i.e., Medicaid); Providers without a federally approved indirect cost rate may not use more than 15% of the total funds for administrative expenses. If the provider has a federally approved indirect cost rate, the approved rate may be used for indirect costs, but a copy of the federal approval notice must be submitted with the request.
- BH-20c - Personal Services Expenses [Include all staff to be employed to provide the service(s) included in this request.
- BH-20d - Operations Expenses
- BH-20e - Travel Expenses
- BH-20f - Capital Expenses
- BH-20g - Other Expenses

B. Budget Justification Narrative

This narrative will explain in detail why the costs listed on the budget itemization form are necessary and how those costs were calculated. The applicant should review the Regulations for allowable and unallowable costs. Please address the following items separately in the narrative:

- Staffing needs by position, number of full-time equivalents (FTEs), and their respective salary and fringe costs separately.

- How ongoing operational, travel, capital outlay, personnel, professional fees, and consultant needs and costs were determined.
- Describe the project's facility and space requirements and explain why the amount is needed.

B. CAPACITY DEVELOPMENT PLAN GUIDELINES

Capacity Development Plan for Behavioral Health Services must be submitted and approved before state and/or federal funds can be used to develop a new service. The format specified in the Guidelines for Capacity Development must be used to apply for approval for funding a new service.

A Modified Capacity Development Plan must be used to apply for approval of funding for expansion of an existing service. A copy of the Modified Capacity Development Plan Guidelines may be requested from the Division of Behavioral Health Services.

Capacity Development must include the following:

I. Program Narrative

II. Development and Implementation Timeline Plan

III. Detailed Budget

I. PROGRAM NARRATIVE

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

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

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

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

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

E. Provide a general overview of how the program will be organized. Include information about how the provider's resources (facility space, personnel-current/new, equipment, other) and administrative structure are coordinated and directed to meet the needs of the consumers through the proposed program.

F. List and explain the goals of the program which describe specific, measurable desired outcomes from a consumer's point of view. Explain what a consumer will want to gain from this program. The goals should have a direct relation to the program purpose and should deal specifically with issues related to the services to be delivered in the

program. The goals should address expected short and long term benefits for the target population. Program goals do not include organization management or program development goals. These goals are different than those identified on the BH-5.

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

H. Describe the assessment process and procedures which will be used in the program. Include an explanation of what information will be gathered for each consumer and how consumers in this program will be screened for other problems.

I. List and include complete explanations of the specific services to be provided directly to the consumer:

   1. How individual treatment or rehabilitation planning will be done with the consumer and what is included in this individual plan.
   2. What is involved in the services to be provided within this program.
   3. How the services will be coordinated with other programs.
   4. The provisions for periodic reassessment and individual plan revision.
   5. Discharge planning procedures, criteria, and follow-up.
   6. The projected average length of stay in the program for the consumer to successfully reach the desired results as specified in the goals (see F above).
   7. How the program activities are designed for and appropriate to the developmental stage of the consumers to be served.

J. Describe the procedures for direct consumer involvement in the program. Include an explanation of:

   1. How potential consumers will be informed about the program and consumer rights.
   2. How meaningful participation of consumers will be incorporated into the development, evaluation, and ongoing modification of the program.

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

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

M. Describe the quality assurance plan which be used for this program and directed at desired outcomes for the consumer. Explain how information and data will be gathered to evaluate the program, what quality indicators will used, how it will be used, and who will be involved in making this happen. Include the details of the quality improvement functions the agency plans to use in this program.

N. Identify the specific facility needs of the program and explain how this program will meet those needs. How will the provider secure adequate square footage. Include an explanation of the relationship of this program within the operation of the provider agency.

II. DEVELOPMENT AND IMPLEMENTATION TIMELINE PLAN

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

Use a separate form for each goal. The Department will provide capacity development funding to accomplish the capacity development goals that include, at a minimum, the following:

A. Develop administrative structures and personnel for service.

B. Develop facility for providing service, if needed.

C. Develop program plan, program operating policies and procedures, operation plan, authorization/referral system for service.

D. Develop reporting, financing, and quality assurance systems.

E. Develop a plan to begin to serve people.

F. State certification development plan/time line and an infectious disease policy and disaster plan.

Instructions for completing Form BH-5.

Identify specific **goals** to address development issues (different from program goals for consumers as stated above).

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

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

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

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

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

III. BUDGET

The budget section should include the following five sections:

A. Itemized Annual Operating Budget

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

- BH-20a - Revenue Summary [Ensure revenues expected for the service are reported from ALL other funding sources (i.e., Medicaid)]

- BH-20b - Expense Summary [Ensure that indirect administration is not more than 10% of total.
- BH-20c - Personal Services Expenses [Ensure that all staff to be employed to provide the service are reported on this form]
- BH-20d - Operations Expenses
- BH-20e - Travel Expenses
- BH-20f - Capital Expenses
- BH-20g - Other Expenses

B. One Time Development/Start-up Budget

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

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

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

D. Annual Operating Budget**:** Explain and justify all items included in the annual operating budget including

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

E. One Time Development/Start Up Budget - Explain and justify all items included in the start-up (one-time) cost budget.

- Staffing needs by position, number of full-time equivalents (FTEs), and their respective salary and fringe costs separately.

- How long it will take to develop the service and why.
- How ongoing operational, travel, capital outlay, personnel, professional fees, and consultant needs and costs were determined.
- Describe the how the agency will procure the project's facility and space requirements, and explain why the amount is needed.
- Identify amounts and sources of any other revenues to be used or received with this project, in addition to the state and/or federal funds being requested with this proposal.

Capacity Development Progress Reports

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

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

Modified Capacity Expansion Plan

To expand current program capacity in an existing service.

Eligibility:

A modified capacity expansion plan for behavioral health services must be submitted and approved before state and/or federal funds can be used to expand an existing service.

C. SERVICE ENHANCEMENT

A service enhancement is used to promote consumer recovery in community-based services. The intent of the funding is to provide additional support for providers to deliver services which minimize the use of higher levels of care and prevent discharge of consumers because of the provider's capacity to meet complex needs.

Eligibility:

The funding may not be used to replace or expand an existing service. Service enhancement is not in itself a *stand-alone* service. All enhancements must fit within the established scope and parameters of other NBHS services with the DBH and Regional strategic plan. Funding for service enhancement positions may only be requested proportionate to the percent of NBHS funded consumers in the service at each agency location. All other sources of revenue for the enhancement have been explored and eliminated. All other applicable services have been determined unavailable, inappropriate or inaccessible.

Exclusions:

The funding may not be used to provide an existing component of a Medicaid service. No state or federal funds may be used for service enhancement without prior approval by the Division. If

funding is approved, each service along with the provider must be identified on a separate line item on the billing forms and any contractual budget attachment in the appropriate section. Any document which only identifies the provider will be returned for revision.

Reporting:

To ensure that DBH funding is not used to supplement other payer sources who restrict or forbid this practice, agencies must submit a report indicating every payer source separately and the average percentage of individuals billed to each of these payer sources in each service and location if the service is provided at more than one agency location. The average must be over the most recent 12-month period available. The percentage must total 100 and be reflective of actual revenues billed.

I. SUBMISSION REQUIREMENTS for SERVICE ENHANCEMENTS

A. Service enhancement submissions **must include**:

1. Program narrative
2. An evaluation process
3. Itemized operating budget and budget narrative for the service(s). Use **Forms BH20c-h** to develop the detailed budget for the service enhancement.

Appendix E – Specialized Discharge Planning Guidelines

Specialized Discharge Planning Guidelines and Emergency Systems A.K.A. Plans for One

Specialized discharge planning is intended to assist in timely transitions of consumers from the Lincoln Regional Center to the community. The purpose of this funding is to facilitate discharge for consumers who have been receiving treatment at Lincoln Regional Center for longer than 180 days or, at the discretion of the Director of the Division of Behavioral Health or designee, are at high risk for admission and/or readmission to Lincoln Regional Center.

The funding allows for a combination of services provided by both in-network and out-of-network providers. Funding can be used for development of wraparound or innovative service approaches that meet individualized needs. The Region is responsible for ensuring the quality and effectiveness of any non-traditional services paid for with this funding. Specialized discharge plans must be approved by DBH in order to be reimbursed. Specialized plans are approved for expenditure within the fiscal year. The format specified below must be used to apply for approval for funding a Specialized Discharge Plan.

Specialized Discharge Plan

A. Plan narrative

1. Justification of need for specialized discharge plan/program. Include relevant background information on consumer and justify why a 'traditional' service or services would meet consumer need.
2. Provide an overview of the plan's organization and key components
    a. Services that will be provided within this program (e.g., Peer Support, Community Support, and Residential/Housing Services) to ensure consumer need is met
    b. Crisis planning efforts that will be in place (e.g., law enforcement and hospital involvement).
    c. Provisions for periodic reassessment and individual plan revision
    d. Discharge planning procedures, criteria, and follow-up
    e. Projected length of stay in the program
    f. Program staffing
    g. Facility needs, if any
    h. Budget information, using forms **BH20c-g**, to project implementation costs

B. Outcomes and evaluation

Describe in detail the consumer outcomes that will be measured. This should include a detailed description of all the consumer data to be collected as part of this project, the outcome measurement tools that will be used, and the frequency of data collection.

C. Plan for sustainability

Describe plans to sustain funding for this program beyond the fiscal year. Will other funding sources be sought? Estimated time for expenditures: how long do you project Region funding will be needed.

Appendix F – Flex Funds Guidelines

I. Community Support Flex Funds:

The community support flex funds are available to consumers who faced barriers with discharge from a higher level of care (i.e. Lincoln Regional Center, Secure Residential) to a lower level of care (i.e. Residential Care Facilities, Assisted Living Facilities). The community support flex funds may be utilized to help obtain the resources necessary to meet identified treatment/rehabilitation needs that cannot be provided through other funding mechanisms or more traditional service provision modalities. Region/provider shall attempt to use all other sources of funding prior to utilizing flex funds. These efforts shall be documented thoroughly.

A. The community support flex funds can be used for the following:

1. Transportation (self, e.g., gas, minor car repair)
2. Transportation (taxi, bus, handi-van, truck for moving, other)
3. Housing (one-time deposit on apartment)
4. Housing (rent per month)
5. Housing (purchase furnishings)
6. Utilities
7. Food
8. Initial clothing needs
9. Emergencies
10. Laboratory work
11. Medications

B. Documentation:

1. The Regional Behavioral Health Authority will document and track how the community support flex funds are expended; Regions are encouraged to utilize the forms for tracking. A **BH4c** must be completed for each consumer.
2. A monthly financial report must be submitted to the Division that accounts for the utilization of the community support flex funds resources.
3. The Regional Behavioral Health Authority shall ensure that the community support flex fund expenditures do not exceed budgeted amounts.
4. The community support flex funds will be monitored by the Division to evaluate cost effectiveness and the impact of the community support flex fund resources on consumer outcomes.
5. The Regional Behavioral Health Authority agrees to comply to submit claims for community support flex fund resources on the forms specified by the Division. In addition, the Regional Behavioral Health Authority agrees to submit supporting documentation, at the request of the Division, to substantiate any community support flex fund claims that are questioned by the Division.

II. Emergency System Flex Funds:

The emergency system flex funds may only be used for goods and/or services that assist with stabilizing or preventing a crisis situation for a consumer. Region/provider shall attempt to use all other sources of funding prior to utilizing emergency system flex funds. These efforts shall be documented thoroughly. Emergency system flex funds are not to exceed $5,000 per consumer within 12 consecutive months.

A. The emergency system flex funds must be used to address needs that will meet the following priorities:
   1. Resolution of a potential crisis and stabilization within the community.
   2. Preventing an individual from being taken into emergency protective custody (EPC), avoiding a mental health board commitment (MHBC), or reducing the need for a higher level of care.
   3. Recovery and transition of a consumer who has received care.

B. To be eligible for the emergency system flex funds, the supports provided must be related to one or more of the following desired outcomes:
   1. The consumer's crisis will be resolved and the consumer will not require a higher level of care.
   2. Eligible persons receiving medication assisted treatment are able to obtain or remain in behavioral health services while on the prescribed medication. Funds utilized for this purpose must be tracked separately and reported.
   3. If the consumer is taken into emergency protective custody (EPC) and is in a higher level of care, the consumer will successfully transition to the community in a timely manner.
   4. A reduction in the number of times the consumer requires emergency protective custody action.
   5. The consumer will experience a reduction in recidivism to higher levels of care.
   6. Consumers will voluntarily seek treatment.

C. Emergency system flex funds must not be used for:
   1. Inpatient treatment
   2. Residential treatment
   3. Ongoing funding

D. Documentation:
   1. The Regional Behavioral Health Authority will document and track how the emergency system flex funds are expended, Regions are encouraged to utilize the attached "Emergency System Flex Funds: Individual Summary" forms for tracking. A **BH4c** must be completed for each consumer.
   2. The consumer receiving assistance shall be registered through the DBH designated data system, in order to track utilization patterns and to ensure appropriate follow up; and,
   3. It is expected that the goods and/or services to be purchased must directly relate to the achievement of the desired outcomes identified below and be documented in the consumer's crisis plan.
   4. The Regional Behavioral Health Authority must have a documented approval process for any unusual expenses or exceptions/waivers, and be made available to DBH upon request.

Appendix G – Alternative Compliance Form

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DEPT. OF HEALTH AND HUMAN SERVICES

Division of Behavioral Health

Alternative Compliance Request Instructions

Procedural changes were required for the Centralized Data System (CDS) as of 07/01/2016. To apply for Alternative Compliance (AC) under the provisions in the Nebraska Administrative Code (NAC) Title 206: Behavioral Health Services, a provider must complete and submit an AC request form per DBH policy. The current policy remains in effect, with procedural required for the CDS. The request MUST include all of the required information and evidence of the documentation to make a determination to grant alternative compliance.

1. The form will prompt you to enable JavaScript, you must do this to continue.
2. Today's Date: Enter Month, Day and Year (MM/DD/YYYY) example: 02/17/2017
3. Choose Region for Email Address: Dropdown has email addresses to send a final copy to.
4. Contact Name: Provider's Contact person for Alternative Compliance, enter First & Last Name
5. Contact's Email: Double check, your authorization will be sent to this email
6. Name of Provider or Region: Enter full name
7. Provider Address, City, State and Zip Include P.O. Box if necessary
8. Phone Number: (Area Code) XXX-XXXX
9. 206 NAC- 3-005 Alternative Compliance: To apply for alternative compliance with a regulation, a provider must submit a written request to the division (This Form). The request form must be completely filled out and include all applicable items below before submitting for consideration.
10. Only regulations in Chapters 4-7 can be made and the request must include:
    a. Citation of the specific regulation for which alternative compliance is being requested; include the chapter number, section, sub-section and language from the regulation citing.
    b. Reasons for the request for alternative compliance;
    c. If appropriate, activities or performance criteria to replace the requirement of the regulation and the date the provider is expected to attain compliance;
    d. The signature of the organization/program director or individual provider;
    e. Authorization from the provider's governing body to request alternative compliance;
    f. Approval by the regional governing board when the provider is under contract with the Regional Behavioral Health Authority; and
    g. Documentation of evidence of how alternative compliance with the regulation would enhance quality, accessibility, public safety and cost effectiveness.

To fulfill a. above, you must fill in the appropriate regulation Chapter and Sub-chapter. There are 4 dropdowns. You must select an answer for all 4 dropdowns, either the identified sub-chapter or the response "REQUEST NOT FOR CHAPTER _"

Example: If you select **Sub-chapter on Accreditation in Chapter 5**, then you would also select the following:

The Chapter 4 dropdown: "REQUEST NOT FOR CHAPTER 4"

The Chapter 5 dropdown: "5-001 Accreditation"

The Chapter 6 dropdown: "REQUEST NOT FOR CHAPTER 6"

The Chapter 7 dropdown: "REQUEST NOT FOR CHAPTER 7"

11. Purpose of the Request: Per 3-005.01 #7.

    To fulfill g. above. Documentation of evidence of how alternative compliance with the regulation would enhance quality, accessibility, public safety and effectiveness. (ALL 4 sections must be answered)
    a. Documentation of how AC with the above regulation would **enhance quality**:
    b. Documentation of how AC with the above regulation would enhance accessibility:
    c. Documentation of how AC with the above regulation would enhance public safety:
    d. Documentation of how AC with the above regulation would enhance cost effectiveness:

12. Check box for required Approval Letters: Both boxes will be checked. You will send your Approval Letter(s) PDF in a separate e-mail.

13. Select Signature Field to Sign: This will automatically detect and electronically Sign and Date the Form using your local desktop e-mail client. If not, please follow instructions to set up your signature information and password. You will then be prompted to save a version of the form for your records.

14. Select Submit: Request automatically goes to DHHS.DBHNetworkOperations@nebraska.gov
    a. If you forgot a required field and have to go back and add it, you MUST save the Form again! 🖫

15. Open a new e-mail and attach your Form and Approval Letters: Send form and approval letters to the Region contact listed in the form with the

    Email Subject Line: Alternative Compliance Request AND Send to the Region Email Addresses chosen at the top of the Form.

16. Upon receipt of the Request for Alternative Compliance, DBH will provide notification to the region/provider. Any request submitted without all of the required information and/or documentation will not be accepted. Notification of this decision will be provided to the region/provider. The region/provider may resubmit the request for consideration including the required information/documentation.

17. Upon receipt of the fully completed request and all required documentation and attachments, the request will be forwarded to the DBH Director for review. The DBH Director will issue a decision, within 30 days, via secure email and by certified mail to the provider, with a copy to the regional governing board when the provider is under contract with the RBHA.

18. If the DBH grants alternative compliance, the region/provider must adhere to the following requirements:

    a. Alternative Compliance will be for a specified time period not to exceed the end of the program certification as specified under Title 206;

    b. The provider must receive written approval from the Division before implementing alternative compliance; and

    c. The provider must meet all the conditions prescribed by the Division in granting alternative compliance. Failure to comply with the specified conditions voids the authorization for alternative compliance.

19. If alternative compliance is denied, the provider/region may aggrieve the decision and submit an appeal to the DBH Director within thirty (30) business days of the date of issuance of the decision.

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Nebraska Department of Health and Human Services
Division of Behavioral Health Alternative Compliance Request
Email To: DHHS.DBHNetworkOperations@nebraska.gov

This Section to be filled out by Provider or Region Today's Date

Copy Region: Choose Region for Email Addresses

Contact's Name: Contact's Email:

Name of Provider or Region:

Provider Address, City, State and Zip* Phone Number* (area code)

206 NAC 3-005 ALTERNATIVE COMPLIANCE: Request with a regulation in Chapters 4 through 7.

SELECT 206 NAC CHAPTER

Select Sub-chapter of 4 or Choose "REQUEST NOT FOR CHAPTER 4"

Select Sub-chapter of 5 or Choose "REQUEST NOT FOR CHAPTER 5"

Select Sub-chapter of 6 or Choose "REQUEST NOT FOR CHAPTER 6"

Select Sub-chapter of 7 or Choose "REQUEST NOT FOR CHAPTER 7"

Purpose for this Request: All conditions below must be addressed.
Documentation of how this alternative compliance with the above regulation would **enhance quality:**

Documentation of how this alternative compliance with the above regulation would **enhance accessibility:**

Documentation of how this alternative compliance with the above regulation would **enhance public safety:**

Documentation of how this alternative compliance with the above regulation would **enhance cost effectiveness:**

Steps that will be taken to support future compliance:

Governance Approval Letters must be attached with the request before request is considered (Both Are Required).

☐ I have attached a signed letter from our **Provider's** Governing Board requesting Alternative Compliance (Check if Region is Provider)

☐ I have attached a signed letter from our **Region's** Governing Board requesting Alternative Compliance

Signature

This section for DBH use only:

☐ This Request for Alternative Compliance as written above has been **APPROVED**.

☐ This Request for Alternative Compliance as written above has been **DENIED.**

Comments:

After submission save PDF and email to DHHS and the Region emails listed above along with all required documentation attached.

DBH (02/17)

Appendix H – Network Management Expectations

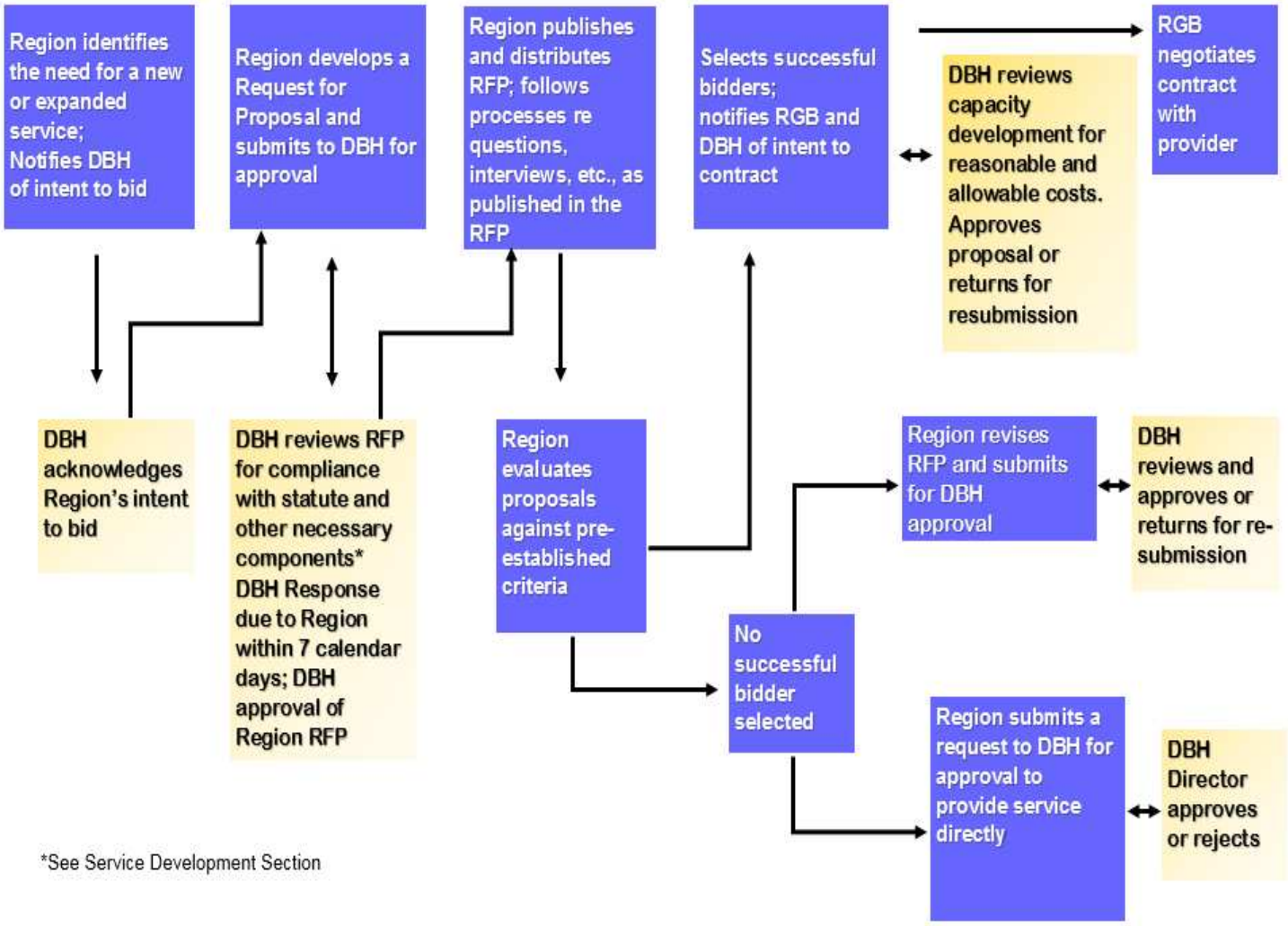
A. Expectations:

1. Maintain, at a minimum, the following regional administrative functions:
    a. Regional administration
    b. Fiscal management
    c. Network development and contract management
    d. Quality improvement
    e. Utilization management
    f. Consumer involvement and advocacy
    g. Access to core services as specified in this document.
    h. System development, monitoring and auditing to ensure that consumers served are clinically and financially eligible for NBHS funding.
2. Develop and manage a comprehensive, continuous and integrated system of care and service array of mental health and substance use disorder treatment, prevention, rehabilitative and support services with sufficient capacity for designated geographic area.
    a. Identify, recruit, enroll, retain, monitor, and continually evaluate a network of providers (herein referred to as the Network) according to State and Federal standards, regulations, and laws.
    b. Provide direct technical assistance to the provider with necessary 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.
    c. Verify all documentation and ensure that providers enrolled in the Network comply with the provider responsibilities and selection criteria in accordance with Region provider enrollment minimum standards.
    d. Ensure that the Network has the capacity to provide the federally mandated substance use prevention services and substance use treatment services and meet federally required timeframes for priority populations.
3. Develop an annual financial plan, as specified in this document to provide financial oversight of (1) all FFS and NFFS funds received from DBH; (2) the network management funds; (3) the funds for any service the Region directly provides, (4) ensure all federal maintenance of efforts are met, and (5) ensure local match (tax and non-tax) is expended.
4. Actively participate with the Division in the implementation of initiatives, strategies and related goals and objectives, including, but not limited to RBA performance indicators, 2016 Bridge strategic work plan and development of access standards as evidenced by:
    a. Attendance and participation in meetings and conference calls;
    b. Submission of required data and reports;
    c. Sharing of information with network providers as agreed upon in network management meetings and Region Administrator meetings.
5. 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.

6. Submit a list of any changes from the previous year of trauma specific services that providers are utilizing.
7. Develop and implement educational and readiness strategies for network providers to increase providers' understanding of and participation in Nebraska's managed care organizations (MCO) changes and challenges.
8. Within the current service array, ensure services/programs have the clinical expertise to serve special populations whose needs cannot be met by traditional behavioral health services.
9. Develop and implement strategies and/or training that promote and represent the ethnic and gender needs of the community and incorporates the National Standards for Culturally and Linguistically Appropriate Services (CLAS) within the network (Appendix L).
10. Monitor, with reports as required by DBH, network of behavioral health treatment providers to (1) comply with the authorization and registration processes and timelines, (2) that providers are accepting consumers into service who meet clinical guidelines and financial eligibility requirements (3) enter data accurately into the DBH designated system for consumer authorization and registration (CDS) as well as the Division's electronic billing system (EBS) when available, and, (4) comply with the terms and requirements of any subsequent contract related to data and system management.
11. Conduct unit, expense verification and program fidelity reviews of all services of Regional network prevention and treatment providers as outlined in the approved audit workbook.
12. Continue working toward sustainment of suicide prevention, mental health promotion and other prevention efforts, by integrating these efforts into established prevention practices.
13. Participate in DBH and Regional disaster preparedness, response, and recovery activities in accordance with the Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan, available at: http://www.disastermh.nebraska.edu/resources/currentplan.php.
14. Ensure behavioral health treatment providers in the treatment network do not deny service to eligible consumers who utilize medications prescribed by a physician and/or appropriately licensed professional. (e.g. medication assisted treatment).
15. Ensure the funding operation of a housing assistance program as described in the **DBH Housing Assistance Handbook.**
16. The Region is encouraged to pursue national accreditation as a network.
17. The Region will provide leadership, advocacy, planning activities, and system problem solving for consumers with Behavioral Health disorders. They will coordinate activities and collaborate with community-based partners to ensure that consumers with behavioral health disorders receive the most appropriate services located within their community whenever possible.

Appendix I – Service Development Flow Chart



Appendix J – Service Review Criteria

- Requirements - Program Plan -	
Component	**Standard**
Complete Proposal	• All required sections were submitted with the proposal in a timely manner as specified in the RFP
Proposal includes name and address of the provider agency, and general information about the provider (e.g. license if applicable, national accreditation).	• The description of the provider includes adequate information about the provider including mission, philosophy, services currently provided, licensure, target population currently served, etc. • The provider is nationally accredited or has a plan for accreditation
Proposal demonstrates understanding of the service.	• The proposal reflects the description, staffing, admission criteria, and assessment process, specific service components provided directly to the consumer, service capacity, and outcomes consistent with the service definition. The target population is specified.
Proposal includes rationale and any current, valid data to justify why this program should be developed at the agency applying.	• Consistent with needs assessment and DBH strategic plan, the proposal demonstrates alignment and uses data to support rationale for this provider providing the service.
Proposal describes and demonstrates understanding of the needs the **target population** to be served.	• The proposal demonstrates recognition of the needs of the target population, including addressing any architectural, environmental, attitudinal, communication, cultural/language and integration barriers the target population of the service may experience.
Proposal provides a general overview of **how the program will be organized** and includes information about how the provider's resources are coordinated and directed to meet the needs of the consumers through the proposed program.	• Staffing and organizational structure reflect the requirements of the service (clinical requirements, staff/consumer ratios, job descriptions) and requirements for administrative/ supervisory responsibilities • Facility space is adequate for number of persons served, is trauma informed and meets confidentiality and privacy needs, • Equipment is provided when necessary to meet the service description • Includes consumer implementation in service planning and involvement • Includes details regarding any intended use of telehealth

Proposal lists and explains the **goals of the program** which describe specific, measurable desired outcomes **from a consumer's point of view**.	• Consistent with the service definition • Have a direct relation to the program purpose and should deal specifically with issues related to the services to be delivered in the program • Address expected short and long term benefits for the target population • The goals, objectives and activity descriptions fit the needs of the target population; • Demonstrates compliance with utilization management criteria.
The Proposal includes a description of the processes for consumer complaints, grievances, and abuse/neglect reporting. The proposal includes:	• System for reporting, investigating, and resolving allegations of abuse, neglect and exploitation • Complaint and Grievance procedure and documentation of actions taken toward resolution • Written policies and procedures to be followed when a violation or alleged violation of consumer and staff relationship is reported verbally or written to any person • How will the consumer and consumer rights be protected, continue to receive services during the investigation process and until a resolution is reached. How is this demonstrated?
Proposal describes the **quality improvement (QI)** plan used for this program, directed at desired outcomes for the consumer. The proposal includes:	• Identification of a responsible person for the QI Program • Identification of the monitoring and evaluation process and persons responsible for both quality improvement and quality assurance. • Identification of specific measurable indicators and targets/triggers and baseline data that is expected to improve based on service • Targets/Triggers are predetermined values that will assist in determining when further evaluation is warranted • Includes process outcomes for development and specific consumer outcome indicators • Implementation of quality improvement activities • Documentation of quality improvement activities • Reporting results to administrators, governing body, owner as applicable • Data sources for outcomes measurement is identified. • Provision for consumer/family participation in QI processes • How findings are used to correct identified problems and revise facility policies and procedures • Documentation of an annual review of QI activities and outcomes
Proposal describes how the program is working to make progress toward **working with individuals with complex needs** including coordination or integration with primary care.	• The proposal reflects the ability to provide trauma informed care, culturally and linguistically competent services, co-occurring behavioral health disorders, etc.

- Budget Justification -	
Includes a budget justification narrative.	• All proposed expenditures of the program, as outlined by the BH20 c-g, are explained in detail in the budget narrative.
Includes a BH-20 Provider Budget Summary.	• Proposal totals and subtotals are accurate • The budget summary includes a list of revenues from every payer source from the last available 12 month period with percent of total revenues indicated; the percentage must total 100 and be reflective of actual revenues billed. If this is a new service for provider and actual revenues are not available, provide 12-month projected revenue by source. • If the service is a Medicaid reimbursable service, the provider must be a Medicaid/Heritage Health provider. • When the service is paid for by third party insurance, explanation of why the provider is not enrolled in the insurance provider networks is required.
Includes a Provider Budget BH20 c-h. for both service development and ongoing provision (unless paid FFS for ongoing service) • Staffing needs by position, number of full-time equivalents (FTEs), and their respective salary and fringe costs separately. • Operating costs • Travel expenses • Capital outlays • Indirect administration • Other expenses including professional fees, evaluation and consultant needs.	• Costs essential to providing the service as required by the service definition or specific RFP requirements are eligible to be included. Each bidder must submit two complete Provider Budgets (BH20 c-h): one detailing startup costs and one detailing ongoing costs related to the service. Actual or projected revenues by source for ongoing service provision must be included. • Expenditures and cost calculation listed in detail on each tab (c-h). • Any renovations or equipment must be outlined in the original proposal, include an estimated cost or competitive bid amount, and be clearly tied to provision of the new service and not general physical upkeep. If the RFP response only includes estimates and a minimum of three (3) comparable competitive bids have not been received, a maximum amount for the renovation or equipment may be identified for purposes of the award. However, the competitive bids must be solicited before final funding for the renovation or equipment can be paid and cannot exceed the lowest bid received for the renovation or equipment. Bids must be retained for at least a year and may be requested by DHHS at any time. • Provide lease / sublease for any space being used for the service • Indirect cost (IC) is less than 15% of total budget or agency has a federally approved IC document. Without federal approval, IC expenses must be identified in request and verifiable in accounting records. • A successful bidder may not seek additional funding from DHHS for items that were not included in the proposal submitted after award by a Region. • All other potential payers for equipment, or other proposed expenditures must be exhausted • All ongoing costs related to provision of the service included in budget.
The **Development/ Implementation Timeline Plan** will be developed on Form BH5. Plan includes an implementation schedule.	• Explains in detail the development process, showing a clear step-by-step plan of how the program will be developed over a given period of time • Includes timelines for any renovation or improvement project. • Includes formal evaluation of program plan, process and services provided.

Appendix K – LB403 Overview

1. No state agency or political subdivision shall provide public benefits to a person not lawfully present in the United States
    a. Every agency (hereinafter consider agency to include “or political subdivision”) shall verify lawful presence for any person who has applied for public benefits administered by an agency.
    b. After October 1, 2009 – no employee of a state agency shall be authorized to participate in any retirement system unless they are:
        i. A citizen, OR
        ii. A qualified alien under the Immigration and Nationality Act (as it existed on Jan. 1, 2009)
2. Public benefits means any grant, contract, loan, professional license, commercial license, welfare benefit, health payment or financial assistance benefit, disability benefit, public or assisted housing benefit, postsecondary education benefit involving direct payment of financial assistance, food assistance benefit, of unemployment benefit or any similar benefit provided by or for which payments or assistance are provided to an individual, a household, or a family eligibility unit by an agency of the US, or the state.
3. Verification is **NOT** required for:
    a. Any purpose not restricted by law
    b. Assistance for health care services or products…that are necessary for the treatment of an emergency medical condition…manifesting itself by acute symptoms of sufficient severity…such that the absence of immediate medical attention could reasonably be expected to result in:
        i. Placing the patient’s health in serious jeopardy
        ii. Serious impairment of bodily functions, or
        iii. Serious dysfunction of the any bodily organ or part
    c. Disaster relief
    d. Public health assistance (immunizations and prevention of communicable diseases)
    e. Assistance necessary for the protection of life and safety, crisis counseling and intervention, and short-term shelter, which:
        i. Deliver in-kind services at the community level, and
        ii. Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the income or resources of the recipient.
4. Verification requires that the applicant “attest” in a format prescribed by the Department of Administrative Services (DAS) that:
    a. He or she is a US citizen or
    b. A qualified alien
5. State agencies may adopt electronic filing of the attestation if such attestation is substantially similar to the format prescribed by DAS.

6. If the applicant attests to “qualified alien” status:
    a. Eligibility shall be verified through the SAVE system
    b. Until the verification is made such attestation may be presumed to be proof
7. State agencies who administer public benefits shall provide an annual report including the total number of applicants for benefits and the number of applicants rejected by this act
8. Every public employer and public contractor shall register with and use e-verify to determine work eligibility status of new employees
    a. Every contract between a public employer and public contractor shall contain a provision requiring the public contractor to use e-verify to determine work eligibility status of new employees.
    b. This section does NOT apply to contracts awarded prior to the operative date of the act.

Changes for the regions:

1. As of October 1, 2009 providers of non-emergency services will have to use SAVE if a person applies for NBHS funds for a person who attests they are a “qualified” alien
    a. If they are Medicaid-eligible, this will have been taken care of by Medicaid.
    b. Attestation can be presumed to be true until verification otherwise
        i. Which means that they can bring someone right in for services and not have to wait for the verification to come back (work it out later).
2. Regions and providers WILL consistently track any persons who are denied due to this law since we will have to report back to the Legislature.
3. Regions and providers will register for e-verify and verify work eligibility for all new employees.
4. Regions will include this provision in their subcontracts.
5. Regions will check their retirement systems to see if they fall under this law and act accordingly.

Changes for the division:

1. Annual report to the Legislature regarding the number of people affected by this law.
2. New section that must be included in contracts and subcontracts.
3. Will need to monitor compliance on these provisions
4. Division (through DHHS) will have to verify eligibility to work for all new hires.

Appendix L – Service Standards for Participation in Network Initiatives

A. **<u>The National Standards for Culturally and Linguistically Appropriate Services</u> (CLAS)** Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

1. **Principal standard:**
    a. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
2. **Governance, leadership, and workforce:**
    a. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
    b. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
    c. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
3. **Communication and language assistance:**
    a. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
    b. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
    c. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
    d. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
4. **Engagement, continuous improvement, and accountability:**
    a. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
    b. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
    c. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
    d. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
    e. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
    f. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
    g. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

B. **Creating a welcoming environment**

1. The services provided incorporate best practice, evidence based practice, and effective practices and are integrated, recovery oriented, trauma-informed and consumer-directed.
    a. The views and perspectives of consumers and families are valued as they participate in the CQI process.
    b. Services are welcoming, inspiring, accessible and appropriate to each consumer's needs.
    c. Services are designed to welcome and engage individuals and families with complexity who are likely to have the greatest challenges, with front line staff engaged as change agents/champions in the CQI process.

C. **Creating a trauma-informed network**

1. Trauma-informed care is an approach that aims to engage people with histories of trauma, recognize the presence of trauma symptoms, and acknowledge the role that trauma has played in their lives.
2. Trauma-informed care is grounded in and directed by a thorough understanding of the neurological, biological, psychological, and social effects of trauma and the prevalence of these experiences in persons who receive mental health services. It takes into account knowledge about trauma — its impact, interpersonal dynamic, and paths to recovery — and incorporates this knowledge into all aspects of service delivery.
3. Trauma-informed care also recognizes that traditional service approaches can re-traumatize consumers and family members. Additionally, trauma-informed care is a person-centered response focused on improving an individuals' all around wellness rather than simply curing mental illness.
4. Trauma-informed care is about creating a culture built on five core principles:
    a. Safety: Ensuring physical and emotional safety
    b. Trustworthiness: Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries
    c. Choice: Prioritizing consumer choice and control
    d. Collaboration: Maximizing collaboration and sharing of power with consumers
    e. Empowerment: Prioritizing consumer empowerment and skill-building

D. **Insuring success using results-based accountability (RBA)**

Results-based accountability (RBA) is a disciplined way of thinking and taking action that communities can use to improve the lives of children, youth, families, adults and the community as a whole. It can also be used to improve the performance of programs, agencies and service system.

1. Key principles of RBA include:
    a. Maintain language discipline
    b. Start at the end and work backwards to means—turn the curve
    c. Identify the appropriate level of accountability:
        i. Population or community
        ii. Program

d. Performance measures

i. How much do we do?;

ii. How well do we do it?;

iii. Is anyone better off?

e. Effective questions of performance accountability

E. **Creating a recovery oriented system of care**

A recovery-oriented system of care (ROSC) is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those at risk of alcohol and drug problems.

1. The central focus of a ROSC is to create an infrastructure or, system of care, with the resources to effectively address the full range of substance use problems within communities. The specialty substance use disorder field provides the full continuum of care (prevention, early intervention, treatment, continuing care and recovery) in partnership with other disciplines, such as mental health and primary care, in a ROSC. A ROSC encompasses a menu of individualized, person-centered, and strength-based services within a self-defined network. By design, a ROSC provides individuals and families with more options with which to make informed decisions regarding their care. Services are designed to be accessible, welcoming, and easy to navigate. A fundamental value of a ROSC is the involvement of people in recovery, their families, and the community to continually improve access to and quality of services.
2. ROSC goals can be identified as:
   a. To prevent
   b. To intervene early
   c. To support recovery
   d. To improve outcomes

F. **Reinforcing the need for primary care integration**

A comprehensive health care system must support mental health integration that treats the patient at the point of care where the patient is most comfortable and applies a patient-centered approach to treatment. Integration is also important for positively impacting disparities in health care in minority populations.

Regions are encouraged to move toward behavioral health and primary care integration.

Appendix M – Network Management Team Charter

A. PURPOSE:

1. Under the assignment and direction of the Division of Behavioral Health (DBH) and the six Regional Administrators, the network operations team is convened to develop recommendations for its policies, procedures, processes, operating standards, practices and guidelines for the Nebraska behavioral health system (NBHS): a community-based public non-Medicaid system. In addition, the team structure provides an opportunity for cross system learning and communication essential to an efficient and effective system.
2. The work has 5 core components: 1) recovery oriented care; 2) access to care; 3) population health management; 4) coordinated care and 5) data driven decision making.
3. The team will evaluate, operationalize and implement directives and tasks as assigned.

B. BACKGROUND:

As the public healthcare environment and NBHS continues to evolve uniform operational parameters to best achieve and demonstrate consistent and efficient structure, improved health outcomes and cost effectiveness are necessary.

C. TEAM MEMBERSHIP:

Subject to agenda, the team is comprised of the technical expertise and experience with provider network and fiscal management, and experience with measurement of behavioral health outcomes/quality and consumer experience.

D. DBH Team Members:

1. Services Administrator, Quality and Data Performance Administrator, DBH Network Services Specialists, Division Finance Officer or Designee; Administrator of the OCA; Regional Center staff as requested;
2. Regional team members as designated by Regional Administration: Network Managers, Fiscal Managers, Quality Improvement Managers, and System Coordinators as needed;
3. Other: Medicaid Behavioral Health Administrator as requested.

E. FREQUENCY OF MEETING:

Quarterly or as needed

F. DECISION MAKING OPTIONS:

Consensus, unanimous, majority, executive rule.

G. REPORTING:

The team will report activities and progress to the DBH and Regional Administration Team. The reporting will occur through the publication of meeting minutes and scheduled briefings as prepared by facilitators.

PART VI: NETWORK OPERATION MANUAL REVISIONS

A. 07/01/2017