**Appendix G**

**REGION V SYSTEMS**

**Minimum Standards**

**for Enrollment in**

**Region V’s Behavioral Health Provider Network**

Any provider wishing to be considered for eligibility as a member of Region V’s Behavioral Health Provider Network must meet the Minimum Standards as outlined. Minimum Standards are designed to answer the following questions:

|  |
| --- |
| 1. Does the provider have the capability to provide mental health and/or substance use disorder services?
2. Is the Region interested in purchasing the services the provider has to offer?
3. Are there any health and safety issues?
4. Is the provider achieving the outcomes the Region is interested in purchasing?
5. Does the provider participate in system coordination?
 |

The following outlines the Region V Network Management and provider roles in the Network.

**REGION V NETWORK MANAGEMENT RESPONSIBILITIES**

* Determining Minimum Standards for providers in the Region V Behavioral Health Network that includes the Department of Health and Human Services’ (DHHS) requirements.
* Determining capacity necessary to meet a minimum balanced system in Region V with the funds available.
* Enrolling providers according to the Enrollment Criteria.
* Determining enrollment status of providers.
* Providing technical assistance to providers.
* Maintaining an updated information system of enrolled providers.
* Reviewing outcome data reports provided by HHS or its system management agent.
* Providing HHS with provider enrollment information.
* Conducting reviews to determine the retention of providers.

**ENROLLMENT CRITERIA**

* Determination by Region V Network Management if the provider meets the Minimum Standards as described.
* Determination by Region V Network Management if the program capacity of the provider is needed in the Region.
* Determination by Region V Network Management if funds are available.
* Recommendation by Region V Network Management to the Regional Governing Board (RGB).
* Decision by RGB.

**PROVIDER ENROLLMENT**

**I. Provisional Status**

The decision to enroll a behavioral health provider as “provisional status” is based upon the Enrollment Criteria outlined above. Provisional status is a 12-month trial period where the provider has the opportunity to demonstrate the organizational ability to deliver services within Region V Behavioral Health Provider Network. Candidates will be considered eligible for a 12-month provisional status in Region V’s Network, according to the Enrollment Criteria, if a satisfactory Enrollment Plan is submitted as well as completion of a satisfactory on-site visit by Network Management. Candidates selected for provisional status must attend at least 80 percent of Network Provider meetings and any other system coordination meetings that apply to their services during the 12-month period

In order for Region V Network Management to determine if the provider meets the Minimum Standards for provisional status, the Enrollment Plan (Appendix A) must be completed in the order as follows:

A. **Enrollment Plan for Network Requirements**

 An Enrollment Plan must be completed, which is intended to provide Region V Network Management with an outline of how the provider has addressed each requirement below. Complete Attachment A (New Provider Enrollment Checklist), indicating whether the actual document requested is attached or if an Network Provider Enrollment Form Update (Attachment B) has been completed and attached.

* + 1. Demonstration of Capacity

Providers must furnish documentation of the following:

1. Facility licenses, fire inspections and food permits, as required
2. Professional licenses, as required
3. Proof of Insurance
* Workers Compensation
* Motor Vehicle Liability
* Professional Liability ($1,000,000 minimum)
* Directors/Officer’s Liability
* General Liability ($1,000,000 minimum)
1. Audited Balance Sheet - demonstrated fiscal viability as “a going concern”
2. Medicaid provider enrollment (MC19 or MC20 form) if the service to be provided is eligible for Medicaid funding
3. Program Narrative for each service to be provided in the Network that includes: **(DO NOT COMPLETE THIS IF YOU ARE ALSO COMPLETING A “CAPACITY DEVELOPMENT PLAN.”)**
* Administrative & operational overview of provider
* Purpose of program
* Need for the program
* Target population
* Organization of program
* Program goals
* Admission criteria
* Assessment process
* Specific program services
* Procedures for direct consumer involvement
* Capacity
* Program staffing
* Quality assurance plan
* Facility needs
1. State Certification or National Accreditation

Providers must comply with procedures as outlined in state regulations Title 203 and Title 204 to apply for state certification or state certification through national accreditation as follows:

 ***Mental Health and Mental Health/Substance Abuse Providers (Title 204)***

Option 1: NATIONAL ACCREDITATION: Large providers with total state/federal behavioral health revenue greater or equal to $75,000 annually or $6,250 per month

Option 2: ACCREDITATION DEVELOPMENT PLAN: Provider in the process of attaining National Accreditation with total state/federal behavioral health revenue greater or equal to $75,000 annually or $6,250 per month

Option 3: STATE CERTIFICATION: Small providers with total state/federal behavioral health revenue of less than $75,000 annually or $6,250 per month

 ***Substance Abuse Providers (Title 203)***

 Option 4: STATE CERTIFICATION: Substance abuse providers without national accreditation

 NOTE: The following are approved accreditation bodies for the behavioral health delivery system:

* Joint Commission on Accreditation of Health Care Organizations (JCAHO)
* The Rehabilitation Accreditation Commission (CARF)
* Council on Accreditation of Services for Families and Children, Inc. (COA)
* American Osteopathic Association (AOA) for hospital psychiatric services only
1. Quality Assurance

 The provider will provide information which demonstrates the operation of behavioral health services, which shall include:

* + 1. Utilization data - process-oriented information, including results of goals and objectives of the program itself.
		2. Outcome data - outcome-oriented information which demonstrates results based on actual clinical status (e.g. increased function, increased health status, decreased symptoms, employment outcomes, improved housing, improved legal status, and other related outcomes).

 c. Record of accepting system management referrals - demonstrates that the agency has accepted persons who meet the financial eligibility requirements.

4) Consumer Satisfaction

 The provider will produce or outline how it will be able to meet the following:

1. Consumer Satisfaction Report - which clearly identifies results from, at a minimum, the questions and response criteria outlined on the attached *“Region V Client Satisfaction Survey”* (Attachment 1).
2. Develop and implement a mechanism to track and resolve consumer complaints regarding the provider.
3. Disclose the outcome or status of any malpractice suits (pending or recently adjudicated).

5) Error-Free Reporting

1. The provider will identify its plan for ensuring that accurate information is provided to the Region, the Department, and the system management agent on a timely basis.
2. **On-Site Visit**

If a provider is selected by the Regional Governing Board to provide the services identified, Network Management will conduct an on-site visit. The on-site visit will be completed at the provider’s location to:

1. Evaluate the site where services are provided. When the service is not a “facility-based program,” the building or location visited is the site where the provider’s organized program, clinical, and financial record keeping function is established.
2. Verify that the provider’s clinical record keeping practices conform with the Program Narrative submitted and the Region’s Minimum Standards. This is a systematic review of the clinical records for conformity and the type of information included in treatment or rehabilitation plans. The intent of the review is not to judge the appropriateness of treatment.
3. Conduct a data audit to verify the information reported to HHS, if applicable.
4. Review quality assurance plans according to the requirements set in Title 203 or Title 204 for any provider that does not have national accreditation.
5. Verify that the provider’s practice will conform to the Enrollment Plan submitted.

**REGION V NETWORK CERTIFICATE RENEWAL**

After the successful completion of the 12-month provisional period and issuance of the Region V Network Certificate, the provider enters the Certificate Renewal category. Within the next year, a regular site visit, which includes a program review, unit audit, financial review, and continued compliance with minimum standards and contract requirements, will be conducted. Continued status as a certificate-holding member of the Region V Behavioral Health Provider Network is contingent upon the following:

* Continue to meet the requirements for initial enrollment in Section I.A.1) & 2). The Network Provider will annually submit documentation regarding demonstration of capacity and will remain in good standing with state certification or national accreditation.
* Demonstrate commitment to providing quality services as outlined in Section I.A. 3) 4) & 5).The Network Provider will comply with all quality improvement, consumer satisfaction, and error-free reporting requirements.
* Successful annual site visits
* Remain in good standing as outlined in Section B. 1)-5).
* Information used to meet the criteria in Section I. A. and I. B. must be verified and documented by Region V Network Management.

**PROBATION**

Region V Network Management can make a recommendation to the Regional Governing Board to place a provider on probationary status at any time for failure to satisfactorily comply with the *Minimum Standards for Enrollment in Region V’s Behavioral Health Provider Network.*

If a provider is placed on probationary status by the Regional Governing Board:

1. The provider must submit a Plan of Correction within 30 days.
2. Region V Network Management will review the Plan of Correction.
3. Region V Network Management will conduct an on-site visit to determine compliance with the Plan of Correction.
4. Region V Network Management will make a recommendation to the Regional Governing Board for future Network Certificate status.

**Region V Systems**

**Attachment A**

**Region V Systems**

**Provider Network New Provider Enrollment Checklist**

Prior to accepting a new provider into the network, the network team will conduct a due diligence process to determine whether the applicant demonstrates at a minimum the following items. Primary source verification of all information must be used.

**Name of Agency**:

**Date Completed**:

| **Item for Review** | **Yes** | **No** | **Comments** |
| --- | --- | --- | --- |
| Is the agency /service nationally accredited? |  |  | Obtain copy of most recent accreditation report. 206 NAC 5-001 |
| Can the agency show commitment to accessibility? |  |  | Accreditation process will check this. |
| Is there adherence to applicable health and safety requirements? |  |  | Accreditation process will check this. |
| Does the agency have ethical practices? |  |  |  |
| Is the agency able to fulfill the mission of the network? |  |  |  |
| Does the agency have the capacity to provide behavioral health services based upon verification of :1. compliance with applicable state standards/regulations/service definitions/ legal requirements,
2. licensure requirements, professional licensures,
3. appropriate insurance coverage and
4. fiscal viability/stability
 |  |  | 206 NAC 4-001.03J1. Workers’ Compensation
2. Motor Vehicle Insurance
3. Professional Liability - $1,000,000
4. Director and Officers’ Liability Insurance, and
5. General Liability - $1,000,000
 |
| Does the agency have the ability to perform/provide the service? |  |  | How long has the agency been performing the service? |
| Has the agency submitted the completed Network Enrollment Form? |  |  | Obtain Enrollment Form |
| Has the required paperwork been submitted (program narrative, BH-5, BH20’s, BAA) if applicable? |  |  | Obtain copies of required paperwork |
| Conduct an on- site visit of the location where consumers will be served verifying that clinical record keeping practices conform to the program plan submitted and meet the minimum standards as described in state regulations – 206 NAC 6- 007. |  |  | 206 NAC 4-001.03J |
| Conduct an agency orientation to the network that includes:1. forms/paperwork
2. overview/hx of Region 6
3. site visit process
4. billing/finance
5. outcome measures
6. meeting requirements
7. staff contacts
8. other (i.e. SAVE system, Financial Eligibility, etc.)
 |  |  | Date of Orientation: |
| Approval by the Division of Behavioral Health |  |  | Seek approval in writing. |

Region V Staff Date

**If Agency is Found Ineligible**

If the agency is found ineligible, the agency’s leadership should be given information in writing as to the reason and given information about resources that might improve their eligibility. Document resources provided below:

|  |
| --- |
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|  |
|  |
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|  |
|  |

Region V Staff Date

**Attachment B**

**Region V Systems**

1645 ‘N’ Street

Lincoln, NE 68508

Phone: 402-441-4343

FAX: 402-441-4335

**Network Provider Enrollment Form Update**

1. **AGENCY IDENTIFICATION INFORMATION**

|  |
| --- |
| Agency Name:  |
| Agency Phone Number:       | Fax Number:       |
| Mailing Address:       |
| Federal Tax Identification:       |  |
| Legal Status:[ ]  For Profit [ ]  Non-Profit [ ]  Public [ ]  Other |
| Name of Agency Director/CEO:       |
| Phone Number:       | Email:       |
| Name of Financial Officer/CFO:       |
| Phone Number:       | Email:       |
| Name of Contact Person:       |
| Phone Number:       | Email:       |
| Is Agency part of Larger Organization?[ ]  Yes (if yes, provide name, address, phone, fax below) | [ ]  No  |
| Larger Organization Name:       |
| Mailing Address:       |
| Phone Number:       | Fax Number:       |
| Identify foreign language(s) or sign language which the agency has capacity to speak fluently in treating clients: [ ]  Sign Language (SL)[ ]  Spanish (SP)[ ]  Other (specify)       |

|  |  |
| --- | --- |
| Identify racial/ethnic/cultural populations the agency has special competency to serve (please list): |       |
| The Organization’s services are available in the following Region V Counties (please list):  |       |

1. **AGENCY PHILOSOPHY**

|  |
| --- |
| Does this agency commit to the opportunity for consumer choice?[ ]  Yes [ ]  No |
| Does this agency screen for trauma?[ ]  Yes [ ]  No |
| Provide your agency’s Mission Statement:       |

1. **LICENSES/CERTIFICATIONS**

Facility licenses, fire inspections and food permits, as required (attach additional sheet if necessary):

|  |  |  |  |
| --- | --- | --- | --- |
| **Licensing/Certifying/****Inspection Body** | **Document****Number / Identifier** | **Date Issued** | **Expiration Date** |
|       |       |       |       |
|       |       |       |       |
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Staff licenses, as required (attach additional sheet if necessary):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Staff Name** | **Position** | **License Discipline** | **License****Number** | **Date Issued** |
|       |       |       |       |       |
|       |       |       |       |       |
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1. **FISCAL**

Agency fiscal year:

Submission date of next annual independent audit report:

1. **POLICIES AND PROCEDURES**

Attach a copy of the following agency policies and procedures:

* Accessibility
* Ethics
* Financial Eligibility
* Grievance
* Health and Safety
* Maintenance of Service Records
1. **PROGRAM PLAN**

Submit a current program plan for each service that receives Region funds.

1. **NATIONAL ACCREDITATION**

Date of last accreditation:

Date when accreditation expires:

Attach a complete copy of the most recent accreditation report.

1. **LEGAL ACTIONS / PENALTIES / SUSPENSIONS**

Has the agency had professional liability insurance refused, revoked, declined, or accepted on special terms?

[ ]  Yes [ ]  No

If yes, please explain:

Has the program been assessed a penalty, conviction, or suspension or is the facility currently under investigation by the Medicare or Medicaid programs?

[ ]  Yes [ ]  No

If yes, please explain:

1. **PRIMARY SOURCE VERIFICATION**

Does the agency conduct primary source verification on professional licenses?

[ ]  Yes [ ]  No

Does the agency conduct criminal history checks with law enforcement officials in any states in which persons considered for employment, clinical consultants, or volunteers have previously resided to see if there is any criminal record involving crimes against children?

[ ]  Yes [ ]  No

Does the agency conduct Adult Protective Services registry checks on clinical consultants and persons considered for employment?

[ ]  Yes [ ]  No

Does the agency conduct Child Protective Services registry checks on volunteers, clinical consultants and persons considered for employment?

[ ]  Yes [ ]  No

**I certify that the information presented in this document is true and accurate to the best of my ability:**

Signature of Agency Director / CEO Date