Department of Health and Human Services
Division of Behavioral Health

Network Operations Manual

Final February 2022

This page left blank intentionally

TABLE OF CONTENTS

INTRODUCTION

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

OVERVIEW

I. VALUES AND CONCEPTS

Transformation Pillars:

Building upon the past strategic plan the Quadruple Aim continues to provide a framework optimizing health system performance.

- Improving individual's experience of care
- Improving provider's experience of care
- Improve the health of populations
- Reducing the per capita cost of care

The Behavioral Health System 2022-2024 strategic plan addresses four distinct areas of focus setting a clear path forward for the continued delivery of behavioral health services with excellence:

- Enhance Behavioral Health INFLUENCE
- Implement an INTEGRATIONS strategy
- Promote stakeholder INCLUSION
- Drive INNOVATION and improve outcomes

II. Demonstrate and drive VALUEata Driven Quality Improvement (QI) Activities

DBH and Region Behavioral Health Authority (RBHA) will utilize information from a variety of sources, including statewide and regionally generated data, to make data driven decisions regarding allocation of funding. Data used should be generated from the Centralized Data System (CDS), including utilization, waitlist and capacity data, and from the Electronic Billing System (EBS) using available reports. Prevention planning should utilize the Nebraska Prevention Information Reporting System (NPIRS) data system. Other data supporting RBHA decision making regarding allocations should be made available to DBH upon request. Integration of data across the behavioral health system will evolve over the life of the 2022-2024 strategic plan.

III. Balanced Array

DBH and the RBHAs will develop and manage a comprehensive, continuous and integrated system of care and service array of mental health and substance use disorder, prevention, treatment, rehabilitative, and recovery support services with sufficient capacity for designated geographic area throughout the contract year. The expectation is to fund an array of services within a continuum of services that supports access and choice.

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 (RBHA), 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 RBHA, and their contracted service providers, and references interface with staff at the Regional Centers.

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. Based on the service being accessed and/or the 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 RBHA through DBH. The exception to this condition is indicated in #4 below.
2. **Who are Clinically Eligible:** Individuals must be clinically eligible for services, meeting utilization guidelines as outlined in the Behavioral Health Services and Utilization Guidelines a.k.a. Continuum of Care Manual (or most recent version) and when the service is authorized it is also 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) Civil commitments to inpatient psychiatric care are committed to the care of DHHS. Outpatient commitments are committed directly to community-based providers.
4. **Laws 2009, 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, Nebraska Behavioral Health System (NBHS) providers who are requesting reimbursement from DBH/RBHA must verify lawful presence for any person for whom they are requesting reimbursement for services (Appendix I). There are exceptions:

   No verification of lawful presence 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 lawful presence: Emergency Protective Custody hold, Mental Health or Substance use Crisis Assessment, Emergency Psychiatric Observation, Crisis Response Teams and 24-hour Crisis Lines. Additionally, if accessed involuntarily (e.g. the service is mental health board or court ordered), verification is not required for all other covered services approved by the DBH however, the consumer must meet all other clinical and financial eligibility criteria.

   a. RBHA and providers will track any persons who are denied due to Laws 2009, LB403. DBH will report the number of persons denied services to the Legislature;
   b. RBHA and providers will register for e-verify and verify work eligibility for all new employees; RBHA 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.
5. **Age Waivers:** With DBH approval, youth who are 17 or 18 years old who meet financial and clinical eligibility criteria, 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 E).

6. **Medicaid Eligibility:** If the individual is enrolled in Medicaid and Medicaid has denied the service, the DBH funding will not cover the shared service. For information on appealing a Medicaid denial, please see the Medicaid provider handbook. The individual is also able to appeal denials, and that information is found in the Medicaid member handbook.

D. Maintain Waitlist Data

The DBH and RBHA are required to monitor, review, and perform programmatic, administrative, quality improvement and fiscal accountability and oversight functions on a regular basis with all subcontractors. Both entities are required to review to promote an appropriate array of services/continuum of care within the state and the RBHA. This includes gathering and maintaining waitlist and capacity data, which should be continuously reviewed to determine the State and RBHA's continued capacity for providing an appropriate array of services/continuum of care.

In addition, the Federal Substance use Block Grant regulations (45 CFR Part 96) require that each state develop a process to report treatment capacity and waitlist information, ensure the maintenance of reporting, and to make that information available.

Purpose of Treatment Capacity and Waitlist Management:

1. To ensure individuals receive timely access to services;
2. To ensure compliance with State and Federal requirements on the placement of priority populations into treatment services, including the provision of interim services;
3. To reduce the length of time any client is to wait for treatment services;
4. To place individuals into the appropriate recommended treatment services as soon as possible; and
5. To provide information necessary in planning, coordinating, and allocating resources.

Waitlist and capacity management involves data collection to assist in identifying specific categories of individuals meeting specific priorities that are awaiting treatment and identifies available network treatment services/facilities for these individuals.

Process for entering waitlist and capacity data

DBH has established Treatment Capacity and Waitlist Management processes as part of the Centralized Data System. This information shall be gathered by all state funded and RBHA contracted services. The provider shall enter and maintain waitlist information into the Centralized Data System for all individuals seeking treatment, regardless of payer source. The CDS User Manual provides direction on how to enter waitlist information.

E. Priority Populations for Admission

Our system prioritizes admission and services 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 Use Prevention and Treatment Block Grant Admission Priorities**

   a. For providers* who are receiving SUD state or federal dollars, the Substance Use 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 use disorder services. Interim substance use disorder 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 human immunodeficiency virus (HIV), tuberculosis (TB).

   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 than 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.

F. Priority Populations

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

1. **Community Mental Health Services 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 use 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 use and Mental Health Services Administration, 2006).

    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 Use 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).

G. Purchasing Services

Behavioral Health Services can be purchased as follows:

1. **RBHA Contracts** - Behavioral health services are purchased through the RBHA contracts with DHHS/Division of Behavioral Health. Each RBHA contracts with community-based providers to provide an array of community-based services, including inpatient care. RBHA may also provide services directly, as approved by DBH and in accordance with Nebraska Administrative Code 206.

2. **Letters of Agreement** - RBHAs 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 RBHA but who is contracted with another RBHA for this service. Letters are developed on an individual basis (one letter for each consumer served) between the funding RBHA 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.

H. Services and Supports

Behavioral health services purchased through our system include, but are not limited to, 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 Behavioral Health Services and Utilization Guidelines (a.k.a. Continuum of Care Manual).**
2. **RBHA developed services** - A RBHA may propose to pilot a service to fill a need or gap in their catchment area during the RBHA budget planning process. The RBHA may propose a service definition and outcomes for consumers as a result of receiving the service. A RBHA 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 RBHA must resubmit an updated service definition with the regional budget plan.
3. **Service enhancements** - Components added to a standard service that are not already a minimal expectation of the service but will increase quality and efficiency of the services delivered. 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 B). The RBHA will work with the provider to develop outcomes for the service enhancements. The service enhancement and the related outcomes must be approved by DBH prior to funding the service with state or federal dollars. Ongoing funding of service enhancements are subject to realization of outcomes as proposed.
4. **Specialized discharge planning** - For individuals discharging from Lincoln Regional Center, RBHA may choose to develop a specialized service plan which includes non-traditional services in order to facilitate discharge (Appendix C). Upon discretion of the Director of Behavioral Health or designee, 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.” Room and board may also be paid for under specialized discharge, a.k.a. Plan for One funding. Room and board requests that would fall under specialized discharge a.k.a. Plan for One funding will need required documentation submitted and approval by the DBH. These individuals must be at risk to admit or readmit to the Lincoln Regional Center.
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 or crisis stabilization 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. A state rate has been established and the RBHA may pay for inpatient post-commitment care until the individual is admitted to the LRC or substance use disorder residential treatment program. It is expected that IPPC days are only reimbursed once an individual has been found clinically ineligible for crisis stabilization or for continued inpatient acute or subacute authorization in the CDS. When inpatient post-commitment

care is paid for an individual on a waitlist and the individual ends up not being admitted to Lincoln Regional Center or a substance use disorder residential service, repayment will need to be made back to DBH.

7. **Room and board** - DBH has established rates for individuals who are served in Secure Residential Treatment, and due to SSI/SSDI ineligibility, are unable to pay for room and board. For these individuals, DBH/RBHA will pay the state approved rate to cover this charge. Once the individual becomes SSI/SSDI eligible, DBH/RBHA will no longer pay for any portion of Room and Board.
8. **Flexible Funding** – Flex funds are 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. The use of flex funds must follow the allowable cost guidelines outlined in Appendix D.

PART II: DIVISION OF BEHAVIORAL HEALTH 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 RBHA, including approval of regional budgets and audits of RBHA;
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.
12. Ensure that community-based behavioral health services are provided in the most integrated setting appropriate based on an individualized, recovery-oriented, and person-centered assessment of the consumer.

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 RBHA. 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 submission of a budget plan on which to base upcoming fiscal year contracts. DBH will include an allocation chart in which funding for the upcoming fiscal year is allocated to the RBHA, including tax match requirements for the RBHA based on allocated state funding. RBHA are required to submit an annual regional budget plan to DBH. Upon receipt of the plans, detailed review and approval of the RBHA's budget plan, 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. 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 service 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. RBHA will conduct the review for their network providers. DBH will conduct these reviews when purchasing services directly.

   In addition, following the completion of the fiscal year, DBH will conduct a network compliance review to ensure RBHAs met the conditions of 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 receiving all necessary information 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 (EBS) for providers and RBHA for the submission of monthly reimbursement requests to the DBH. EBS is the sole source of funding information to be used for service cost analysis and to determine purchasing efficiency.
7. **Nebraska Prevention Information Reporting System** - DBH will maintain the Nebraska Prevention Information Reporting System (NPIRS) in order to gather demographic and programmatic information relating to prevention activities through the Behavioral Health system. Unless otherwise stated, contracted RBHA and organizations who operate under any DBH prevention funding shall enter all information related to prevention programming. DBH will provide reports, as needed, to analyze the programs, policies, and activities that are occurring across the state to help support National Outcome Measures (NOMS).
8. **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 used by the RBHAs as a basis to establish RBHA fee schedules. A RBHA fee schedule may not deviate from the parameters set by DBH.
9. **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. RBHA are also encouraged to periodically competitively bid out existing services paid on an expense basis to ensure the most cost-efficient provider is being utilized,
10. **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.
11. **Systems coordination** - DBH will provide leadership and facilitation of statewide system coordination activities for all statewide systems teams, as needed.
12. **Alternative compliance** - DBH may approve a request for alternative compliance as defined in 206 NAC, to further the development and implementation of recovery-oriented and person-centered community-based behavioral health services. To apply for alternative compliance from a regulation requirement, a provider must submit a written request to their RBHA. (Appendix F).

    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 protects the rights, health, and safety of the consumers;

    c. It does not relieve the provider of the responsibility to comply with other pertinent regulatory requirements; and

    d. It contains documentation of evidence of how alternative compliance with the regulation would enhance quality, accessibility, public safety, and cost effectiveness.

PART III: REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA) RESPONSIBILITIES

A. Roles and Functions of the Regional Governing Board

The Regional Governing Board is an entity established in each behavioral health RBHA by the counties which governs the RBHA. The board consists of one county board member from each county in the RBHA. 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 include:

1. Appointment of a Regional Administrator who is responsible for the administration and management of the RBHA.
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 RBHA provides funding for the operation of the behavioral health authority and for the provision of behavioral health services in the RBHA.

   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 RBHA, 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 RBHA 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 (71-808).
4. Approve an annual regional budget plan (RBP) to be submitted to DBH for approval.
   a. Monitor and approve changes to the RBP that may be made during the course of the year.
   b. Assuring additional tax match can be match, if necessary.

B. Roles and Functions of the RBHA

The RBHA is the regional administrative entity responsible for development and coordination of a network of publicly funded providers within each RBHA. The RBHA must encourage and facilitate the involvement of consumers in all aspects of service planning and delivery within the RBHA.

DBH contracts with RBHAs for system coordination and network management in the provision of community-based behavioral health services across Nebraska. Under contractual obligations each RBHA 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; implement, and complete audit of services purchased from subcontractors

(providers); and establish processes to actively monitor utilization, cost efficiency of services, and movement of all funds managed by the RBHA;
3. Develop and maintain a RBHA quality assurance/improvement plan; 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.
5. Must be located in physically accessible offices and provide all materials in accessible formats as required by ADA and the ADA Accessibility Guidelines.
6. Ensure that recovery-oriented and person-centered community-based behavioral health services are provided in the most integrated setting appropriate for each consumer's needs.

C. RBHA Network Management

1. **Needs assessment and strategic planning** - The RBHA will participate in DBH's strategic planning process (see page 13) 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. The RBHA will develop a strategic plan based on the strengths, needs and opportunities for improvement of the RBHA. The RBHA's strategic plan shall 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). For more information, review Appendices I, J and K.
3. **Exception** - The RBHA is not required to bid services that the RBHA directly provided prior to July 1, 2004. There are two conditions for which a service may be considered to be new:
    a. The RBHA 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 RBHA's intent to contract for the new service, the expected/desired amount of the bid, use appropriate criteria and must comply with all requirements per 206 NAC. 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 is outlined in Appendix H.
6. **Network enrollment requirements** - The RBHA shall develop policies and procedures for determining eligibility for enrollment.

    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. Continuous quality improvement plan or process, including partnerships and work with RBHA, DBH, and DHHS;

c. Compliance with guidelines, state statutes, standards and regulations, and federal regulations and requirements relative to the allocation of funds and provisions of subcontracts;

d. Capacity to be accountable for reporting and completing accurate data within the Centralized Data System;

e. Development and/or continual maintenance of a Continuity of Operations Plan;

f. Utilization of a "no refusal" approach to admitting persons determined eligible by the DBH utilization criteria for community based BH services. Establish a process for monitoring and enforcement.

g. Methods to ensure denials for admission to MH or SA treatment are not solely based on participation of consumer in Medication Assisted Treatment;

h. Continuous development of co-occurring (or complexity) capability for all programs

i. Continuous development of providers in the provision of trauma informed care;

j. Staff utilization in Electronic Billing System to submit only charges to be paid with funds from DBH as well as participation in technical assistance and trainings related to use of EBS;

k. Provision of voter registration assistance to clients per National Voter Registration Act;

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

m. Fiscal viability, including fiscal and budgetary systems that provide appropriate accounting for and spending of contracted funds, including clear tracking and designation of federal funding;

n. Verified demonstration of compliance with state or national accreditation standards. RBHA will require the provider to indicate their status of accreditation appropriate to the organization's mission by the standards set by The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, or other nationally recognized accreditation organization approved by the Director;

o. 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. To substance use disorder prevention funds;

   ii. To individual practitioners or small groups of individual practitioners providing outpatient services; or

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

7. **Sentinel Event:**

   a. In the event of death or serious injury to any RBHA-funded client currently in our system, providers will notify the RBHA who in turn will notify DBH no later than forty-

eight (48) hours after they have been notified of the incident including any/all information requested by the DBH.

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

   i. Follow up with providers regarding sentinel event reported to the RBHA 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. RBHA shall conduct an analysis of all sentinel event reported to the RBHA by providers occurring within the RBHA at least annually. The analysis should include trends and causes, and any needed remediation appropriate by either the provider or the RBHA. This analysis should be submitted to the DBH after the close of the fiscal year in a format specified by the DBH.

c. At least annually, DBH, based upon the RBHA' reports, should develop a statewide summary, including trends and causes of sentinel event, and any remediation appropriate to be provided by DBH.

d. The RBHA 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

e. If no Sentinel Events occur in the Region during the Fiscal Year, the RBHA will send to DBH a statement indicating such at the end of the Fiscal Year.

8. **Contract for direct provision of service** - If the DBH 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 when the RBHA is a provider. 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.

9. **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. The RBHA must have policies and procedures that, at a minimum, ensure no person covered under the RBHA, a current or prospective provider, or any individual member of either organization:

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

   b. Misuses confidential information;

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

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

e. 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 detail the method to identifying, reporting, and resolving potential conflicts of interest. All disclosures, reports, and resolutions must be in writing and be available for review by the DBH.

10. **Participation in Nebraska behavioral health system meetings** - RBHA will attend and participate in meetings in which support the development, coordination, maintenance and monitoring of goals and activities.

11. **Division of Behavioral Health notification** - The RBHA must notify DBH of:

    a. **Service Changes** – If a service provider is terminating a service that was approved in the RBP they will need to notify RBHA in writing within 20 days of its occurrence any changes regarding services 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 Event** – see #7 above for more details.

D. Network System Coordination

The RBHA will fulfill the following system coordination functions and 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 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 RBHA's prevention system to ensure that prevention services are available, accessible and that duplication of efforts are minimized. The prevention system funds must comply with requirements set forth by the state and federal government in the attainment and continuation of federal prevention funding. See the DBH Prevention System Manual for complete prevention system expectations.

    a. Prevention system activities shall promote protective factors, as allowable by the funding sources or DBH priority, and decrease risk factors, and build prevention capacity and infrastructure at the state/tribal and community level. Prevention activities shall also be culturally and linguistically competent.

    b. Prevention initiatives funded through the DBH 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 RBHA and organizing and preparing any supporting documentation required by the Department.

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. Monitor providers to ensure that commitment orders are properly closed through the clerk of the court.

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, mental health crisis center and the Lincoln Regional Center).

d. Manage the LRC Mental Health Board waitlist by working with the community-based hospitals and/or mental health crisis centers to make sure only the individuals who are clinically appropriate are added to the waitlist. They will also work with the community-based hospitals and/or mental health crisis centers to make sure the necessary admissions paperwork is filled out and submitted to the Network Administrator and LRC.

e. 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

f. Implemention of the LRC hospital action plan and submission of data required for the plan.

g. Consult with Department of Corrections' staff as requested to assist with discharge planning for consumers, who are clinically and financial eligible, from correctional facilities.

h. 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.

i. Participate in statewide emergency system coordination activities and other calls as scheduled by DBH.

j. Assist with DBH implementation and operationalizing a bed registry strategy within the Region.

k. Collaborate with DBH regarding 988 crisis service system implementation.

l. Ensure consumer level data for the Emergency System is submitted through the CDS or other designated DBH data system.

m. Ensure implementation of the emergency system flow including the DHHS/Region/Community Hospital/LRC hospital action plan.

3. **Youth system coordination** - The RBHA will collaborate with DBH and youth serving agencies including Division of Children and Family Services, Managed Care Organizations 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 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. Work with providers on co-occurring capability for providers of services for youth so that family systems can receive an integrated approach to treatment.

4. **Consumer system coordination** - The RBHA will participate in the development of regional and/or DBH planning for recovery-oriented community-based services, that promote and facilitate educational opportunities & other activities that enhance recovery, resiliency, and whole health wellness for consumers and their families. Expectations include:

   a. 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.

   b. 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.

   c. 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.

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

e. Provide assistance and coordination of opportunities for consumer feedback and participation in statewide and RBHA events and initiatives.

5. **Housing coordination** - The RBHA will provide leadership, planning activities and system problem solving for RBHA housing issues for persons with extremely low incomes who have behavioral health disorders. Work will include collaboration with local housing partners and other system partners. The RBHA shall administer the Housing Assistance Program to serve as source of funding for housing for target populations. Expectations for housing coordination includes but is not limited to:

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

   b. Participation 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.

   See the DBH Housing Assistance Program Manual to review program requirements, activities and other provisions regarding housing assistance.

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 RBHA'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 RBHA. The plan must reflect coordination of its disaster preparations and response with the other emergency responders in the RBHA'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 the match (county tax and non-federal, non-tax) is adequate to meet statutory requirements and only report funds expected to be expended on behavioral health services to meet this requirement. 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 RBHA including:

a. A projection of expenditures and revenues for all services. The projections should utilize input from stakeholders, address the RBHA's needs assessment and strategic plan. Historical units purchased and persons served should be the primary consideration in the budgeting process.

b. Provider budgets submitted to the RBHA must match the allocation awarded and clearly identify the expense-based services being supported with the funds. If subsequent funds are requested by the provider in a shift, the provider must submit a revised budget clearly indicating how the additional funding is being used. The revised budget must be submitted to DBH for approval prior to any additional funding being awarded to the provider. 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 RBHA 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 audits of the RBHA and providers. 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.

c. A projection of other revenues, for each community behavioral health provider and the RBHA that is intended to use to meet statutory match must be included.

d. The plan should be data driven, utilizing data on length of service, waitlist and capacity, needs assessment, emergency system or other CDS or EBS data.

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

2. **Ongoing review of utilization and drawdown** - RBHA shall review the monthly expenditures for all services in the contract as well as expenditures related to priority populations (e.g.,WSA), other identified priority services (e.g., housing, supported employment), and maintenance of effort (e.g., total MH spending, total SUD spending). RBHA will compare this drawdown to budgeted amount, historical performance, and other related factors for service utilization (e.g. changes in the number or capacity of providers) and make recommendations for contract shifts/adjustment as needed in advance of the end of the year. Final shifts in the year to simply 'spend down' funding will not be allowed.

3. **Billing and Payment Basics** – RBHA will follow the most recent version of the Billing and Payment Basics document. See Appendix L for the Billing and Payment Basics document.

4. **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 RBHA and their subcontractors/subrecipients no later than September 1 following the close of the fiscal year. See Appendix M for instructions on RBHA Actuals.

F. Network and Provider Monitoring

RBHA, 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 RBHA is a direct provider of services, DBH is responsible for the oversight functions for the services provided directly by the RBHA.

1. **Network review to promote an appropriate array of services/continuum of care within the RBHA** - 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 RBHA
    b. Target population to be served
    c. Adult/youth mix of services
    d. Access to consumers with health disparities
    e. Utilization by levels of care and by service
    f. Capacity and waitlist data
    g. Provider denial of service information
3. **Evaluation of service delivery** - Systematic evaluation of provider service delivery assists the RBHA in determining whether to retain/recontract with a currently contracted provider of services. Contractor retention is to be determined through a performance review that at a minimum includes the following:
    a. Evidence of continued capacity to provide behavioral health services as outlined in enrollment process and compliance with state/national accreditation standards.
    b. Provider audit performance, as outlined in the audit manual;
    c. Consumer satisfaction;
    d. Compliance with information reporting to DBH;
    e. On-site visit consistent with current enrollment standards;
    f. Inclusion of consumers in development, implementation, and evaluation of services.
4. **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.
    c. Information provided by or through federal funding agencies or federal monitoring visits.
5. **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). 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 use

disorder services are used to pay for services for consumers who meet clinical eligibility criteria, who meet financial eligibility criteria and a citizen attestation is on file for all non-emergency services.

b. Program fidelity reviews - The program fidelity review will monitor compliance with the services definition and other state regulatory guidelines.

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).

8. **Consumer Rights and Grievances –** The RBHA will develop a process to ensure providers are providing consumer rights for the individuals receiving behavioral health services. The RBHA will also ensure providers have established a written consumer grievance policy. The consumer rights and the necessary components of the consumer grievance policy are detailed in Appendix K.

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

G. Quality Improvement

1. **Data collection and reporting** - The RBHA, network providers and any behavioral health providers subsequently funded under a DBH RBHA 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 RBHA and its providers and as such the RBHA will hold itself and network treatment providers accountable for data accuracy and ensure data requirements are completed in full as specified in by DBH. Additional data reporting requirements may be included in contracts or in an alternate 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.

2. **Data monitoring and evaluation** - RBHA's will monitor and evaluate data on indicators and performance measures as defined or otherwise approved by DBH. The central data system (CDS) and electronic billing system (EBS) will serve as the primary source for data collection. The RBHA will:

a. Maintain a RBHA continuous quality improvement system that evaluates provider performance and consumer outcomes using monthly, quarterly and annual reports which demonstrate progress toward meeting regional and statewide network and system goals. Identify RBHA-specific continuous quality improvement (CQI) activities to improve the service system.

b. 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.

c. Organize a CQI partnership and process in which all providers have an opportunity to engage collaboratively in making progress toward regional and statewide goals. Through use of a Regional Quality Improvement Team (RQIT), the RBHA 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 RBHA.

d. Ensure services effectively meet co-occurring needs and are trauma informed as demonstrated through measurement at a minimum of every 2 years by the Compass-EZ and the trauma-informed care (TIC) assessment. The Compass-EZ and the trauma-informed care (TIC) assessments will be completed by providers during odd fiscal years and the RBHA will turn in all provider assessments to DBH within 30 working days after the fiscal year has ended.

e. Ensure that services are of high quality and provided in a cost-effective manner as demonstrated through data reporting with CDS and EBS.

f. Participate in CQI meetings (including scheduled data and CDS user calls and webinars) and support implementation of CQI including all DBH priorities.

PART IV: NETWORK OPERATION MANUAL APPENDICES

Appendix A – Federal Oversight Requirements for Substance Use Prevention and Treatment Block Grant (SAPTBG), Community Mental Health Services Block Grant (CMHSBG), Federal Mandates and State Mandates

A. GENERAL REQUIREMENTS

1. The RBHA and SAPTBG funded providers will continue to meet all SAPTBG requirements listed below and included in 45 CFR Part 96.
2. The RBHA 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 RBHA 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 RBHA) for managing and monitoring the RBHA 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 RBHA 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. 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 RBHA 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 RBHA 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 follow-up information must be documented and available upon request by the RBHA 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 RBHA must provide documentation to DBH within 7 days of reaching 90 percent of capacity to admit individuals to a treatment program.
2. The RBHA 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 RBHA 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 RBHA will immediately contact DBH. The RBHA and DBH will then collaboratively problem-solve to immediately resolve the situation.
5. The RBHA will comply with and ensure provider compliance with waitlist and capacity reporting expectations.
6. The RBHA will ensure that their providers have 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 RBHA will ensure that individuals on the waiting list are provided with the best estimated timeframe for admission to treatment.
9. The RBHA will ensure that individuals are placed on the waiting list for the appropriate level of care as many times as the individual request treatment.
10. The RBHA 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 choose to receive treatment outside the RBHA's catchment area, the sending and receiving RBHA will collaborate to ensure that treatment occurs.

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/RBHA 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 RBHA 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, childcare;
    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 childcare 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. Childcare 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 the regional budget plans that demonstrate how a provider will meet the requirements to be a "qualified" provider must be maintained by the RBHA and be made available to DBH upon request.

H. TUBERCULOSIS (TB) SCREENING AND SERVICES

1. RBHA 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.

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 RBHA 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 RBHA 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 RBHA 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 RBHA 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 RBHA 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

RBHA 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 RBHA will notify DHHS of any form being used in the RBHA 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 RBHA or other source, with documentation of training kept at the RBHA and made available to DBH upon request. The RBHA will ensure that each network provider has received training within the time period.

K. CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

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

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

The RBHA 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

RBHA 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. FEDERAL MANDATES

FEDERAL REQUIREMENTS APPLICABLE FOR COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT (CMHSBG) AND SUBSTANCE USE PREVENTION & TREATMENT BLOCK GRANT (SAPTBG)

1. Block grant funds are to be directed toward four purposes:
    a. To fund priority treatment and support services for individuals without insurance or who cycle in and out of health insurance coverage
    b. To fund those priority treatment and support services not covered by Children's Health Insurance Programs (CHIP), Medicaid, Medicare or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery
    c. For SABG funds, to fund primary prevention: universal, selective and indicated prevention activities and services for persons not identified as needing SUD treatment; and,

d. To collect performance and outcome data for mental health and substance use, determine the ongoing effectiveness of promotion/SUD prevention, treatment and recovery support services and to plan the implementation of new services. (Source: *FFY2020-2021 Block Grant Application*, page 8-9, U.S Department of Health & Human Services, Substance use and Mental Health Services Administration, OMB No. 0930-0168, Expiration Date: 4/30/2022)

2. Federal funds cannot be used to purchase inpatient services or for any other purpose prohibited in the document, Federal regulations or any contract that may result from this RBP.
3. Federal funds cannot be used to pay the salary of an individual at a rate in excess of the current Federal Executive Schedule Level 1 ($213,600). (Source: https://www.federalpay.org/ses/2019)
4. If a provider expends more than $750,000 or more of Federal funds in a 12-month fiscal period, a Certified Public Accountant (CPA) will be engaged to conduct an audit in accordance to the Single Audit Act. No federal funds can be used to pay for any portion of the audit if the provider did not expend $750,000 or more of Federal funds in the fiscal year.
5. The RBHA and CMHSBG and/or SAPTBG funded providers will attest in contract that:
   a. Neither the entity nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded by any Federal department or agency from receiving Federal funds
   b. The provider is not delinquent on any federal loan
   c. The provider will maintain a Drug Free Workplace
   d. No Federal funds will be used to engage in inherently religious activities, such as worship, religious instructions, proselytization, and/or any other prohibited activity
   e. The provider has no potential conflict of interest that would affect the Federal funds and agree to disclose in writing to DHHS any potential conflict of interest
   f. f. The provider has not violated any Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal funds and agrees to disclose in writing to DHHS any such violations
6. The RBHA and providers receiving CMHSBG and/or SAPTBG funds must:
   a. Participate in needs assessments conducted by the State Behavioral Health Authority and/or the RBHA
   b. Ensure Federal Confidentiality procedures are in place and offer on-going training to their workforce specific to Federal Confidentiality (42 CFR part 2), including the penalties for non-compliance
   c. Improve the process for referrals of individuals to the treatment modality that is most appropriate for the individuals
7. No Federal funds may be used, directly or indirectly, to influence or attempt to influence any:
   a. Elected or appointed official;
   b. Employee of an elected or appointed official or any specific piece of legislation.
8. Federal funds may only be used for expenses that are allowed under federal cost principles, whether they are charged on a direct or indirect cost method.
9. The following information is not an all-encompassing listing but reflects some common costs. It is the responsibility of any agency receiving federal and state funds to understand and pay expenses appropriately per applicable cost circular.
   a. **Allowable Costs**
      i. Travel costs for transportation, lodging, subsistence, and related items incurred by employees who are in travel status on official business, as determined by

the entity's established travel policies or the State of Nebraska policy (if applicable).

ii. Compensation paid by the organization for services of employees rendered during the period of the award.

iii. Cost of equipment, if the equipment is necessary for the functioning of the grant. DHHS approval is needed prior to purchase of the equipment. Depreciation costs for equipment is NOT allowable.

b. **Unallowable Costs**

i. Making contributions and donations by the organization to others.

ii. Advertising solely to promote the non-profit organization.

iii. Costs of promotional items and memorabilia, including models, gifts and souvenirs.

iv. Costs of alcoholic beverages.

v. Bad debts, including losses (whether actual or estimated).

vi. Payments to collection agencies.

vii. Costs of entertainment, including amusements, diversion, and social activities, and any costs directly associated with such costs (such as tickets to shows or sports events, meals, lodging rentals, transportation, and gratuities). This includes activities designed for employee morale.

viii. Costs of organized fund raising, including financial campaigns, endowment drives, solicitation of gifts and bequests, and similar expenses incurred solely to raise capital or obtain contributions.

ix. Costs of membership in any organization, country club or social or dining club.

x. Making contributions and donations by the organization to others.

xi. Meals, unless the employee is in travel status.

xii. Snacks at meetings or events unless specifically allowed by the grant.

xiii. Supplanting of costs. Federal funds may not be used to pay any costs that are already being paid for from any other sources, including another Federal grant, i.e., costs normally paid from State general funds cannot be charged to a Federal grant.

xiv. Stipends or incentive payment to participants.

xv. All Federal funds paid to a provider must be clearly identified as such, including the specific source and amount. These funds must be clearly identified in providers' accounting records as being Federal funds by source and audited appropriately.

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

xvii. The RBHA will allocate and expend Federal and State funding to ensure DBH can meet all required Maintenance of Efforts including:

1. For Mental Health:
   a. Amount of State Funds Expended for Mental Health Services must meet or exceed average of prior two years;
   b. Amount of State Funds Expended for Children's Mental Health Services must meet or exceed amount of funds expended in 2008 ($4,108,818)
2. For Substance Use:
   a. Amount of State Funds Expended for Substance Use Services must meet or exceed average of prior two years expenditures;
   b. Amount of State & Federal Funds Expended for Pregnant Women & Women with Dependent Children Services must meet or exceed amount of funds expended in 1994 ($753,713) (*threshold may be

updated to 2008 level);

c. A minimum of 20% of every SAPTBG award must be spent on Primary Prevention;

Should the State experience an interruption of SAPTBG and MHBG funding due to failure to meet MOE levels the RBHA must maintain relationships to meet the block grant requirements specified in these guidelines to facilitate the reactivation of these services immediately after the reinstatement of funds.

O. 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 RBHA and any sub-contractor(s). Allowable and unallowable costs must be tracked and recorded in accordance with the provisions specified in the contract. Expenses from prior year are unallowable.

1. Mental health services and substance use disorder services must be funded at a level adequate to ensure expenditures do not fall below the amount 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. 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.
4. No state funds may be used for fundraising activities.
5. No state funds may be used to pay for abortions.
6. 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 RBHA 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 number 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. **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 (please refer to billing basics for guidance).

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.

xv. Legal fees or retainers for operation of the RBHA or for service provision.

xvi. Purchases for consumers other that what is allowed by the flex fund policy.

xvii. Payment of funds to compensate a provider the difference between the rate received by a third-party payer (e.g. insurance, Medicaid) and the rate established by the State or RBHA for a service.

7. 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 RBHA and all providers must comply with the state standards for behavioral health listed below. Any RBHA 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 RBHA, as applicable

   d. State approved service rates when available

Appendix B – Guidelines for Capacity Development Plan, Service Enhancements and Rate Enhanced Rate/ Rate Enhanced Expense

A. CAPACITY DEVELOPMENT PLAN GUIDELINES

A 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

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 use disorder 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) Describe how the program will work or is working to make progress toward co-occurring capability through assessment using the Compass-EZ, improvement plan, etc.

o) 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.

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

c) Develop reporting, financing, and quality assurance systems.

d) Develop a plan to begin to serve people.

e) State certification development plan/timeline 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.

BUDGET

The budget section should include the following five sections:

a) Itemized Annual Operating Budget

Use Form BH-20 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-20 Summary page details the Revenue and Expense Summary
    - Revenue Summary [Ensure revenues expected for the service are reported from ALL other funding sources (i.e., Medicaid)]
    - Expense Summary [include the federally approved indirect cost rate or approved de minimis rate from the DBH]
- 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 - Other Expenses
- BH-20g – Administration Expenses

b) One Time Development/Start-up Budget

Use Forms BH-20 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-20 Summary pages
    - Revenue Summary
    - Expense Summary
- BH-20c - Personal Services Expenses
- BH-20d - Operations Expenses
- BH-20e - Travel Expenses
- BH-20f - Other Expenses
- BH-20g – Administration 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. Please address the following items separately in the narrative:

- 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.

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

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.

B. 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. Funding for service enhancement expenses may only be requested proportionate to the percent of NBHS funded consumers in the service at each agency location. There must be attestation made that all other sources of revenue for the enhancement have been explored and eliminated. Each service enhancement will need to have identified outcomes and data collection and evaluation processes determined. The outcomes must be measurable and adequately show why funding the service enhancement results in better outcomes for the individual.

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 DBH. If funding is approved, each service along with the provider must be identified as separate line items in the EBS and any contractual budget attachment in the appropriate section. Any document which only identifies the provider will be returned for revision.

SUBMISSION REQUIREMENTS for SERVICE ENHANCEMENTS

a) Service enhancement submissions must include:
   1. Program narrative
   2. An evaluation processes
   3. Service enhancement outcomes
   4. Itemized operating budget and budget narrative for the service(s). Use Forms BH20c-g to develop the detailed budget for the service enhancement.

C. RATE ENHANCED RATE/ RATE ENHANCED EXPENSE

In exceptional cases, there may be a request to pay an additional rate on top of an established unit rate. Rate Enhanced Rate reimbursement allows a provider to be reimbursed with an additional rate for each unit of service delivered. Rate Enhanced Expense reimbursement allows for a provider to be reimbursed on an expense basis (up to the DBH approved budgeted amount) after all contracted units of service have been reimbursed.

Rate Enhanced Rate and Rate Enhanced Expense reimbursement may be requested when the service is reimbursed on a fee for service basis. In most cases, Rate Enhanced Rate / Rate Enhanced Expense reimbursement is requested in order to support necessary capacity / access to service. When Rate Enhanced Rate / Rate Enhanced Expense reimbursement is requested to support better consumer outcomes, the process and documentation required of Service Enhancement must be used and outcomes identified and data collection and evaluation completed to justify continued rate enhanced rate reimbursement.

Rate enhanced rate/expense funding is not intended for and should not be used to establish a new service or expand the capacity of an organization or service.

Rate enhanced rate/ rate enhanced expense justification must include the following:

I. Program Narrative

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

PROGRAM NARRATIVE

The Program Narrative is a written plan that describes, in detail, how the additional funds will address the barrier to be addressed through rate enhanced reimbursement.

a) If multiple providers of the same service are requesting a rate enhancement, the RBHA may submit one narrative as long as it clearly identifies the specific service the funding supports as well as the specific dollar amount supporting each provider(s).

b) If multiple services within a provider agency will be supported 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 RBHA.
   3. Thoroughly describe the need for Rate enhancement rate or rate enhancement expense 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 DBH contracted state or federal funds for;
        i. Break out the percentage of NBHS individuals and other sources
      - 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 rate enhance rate/expense would logically lead to the continuation of an existing approved NBHS service.
   4. Describe how the provider will work with the RBHA to address the issues/barriers which lead them to requiring rate enhanced rate/expense 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 rate enhanced rate/expense 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.

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 must directly charge specific costs for administrative purposes and may not apply a percentage rate of costs 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 - Other Expenses
- BH-20g – Administration 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. 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.
- Provide all sources of revenue the agency receives in all the applicable locations.
- 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.

Appendix C – 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 or are at high risk for admission and/or readmission to Lincoln Regional Center.

The RBHA may allocate funding for specialized discharge planning Plan for One or receives additional funding from the DBH for this budgeted lined item. If a RBHA receives additional funding from the DBH for specialized discharge planning, the funds can only be used for specialized discharge planning and is not to be shifted into another contracted service. The additional funds will be used for individuals prioritized by the DBH. The DBH will work with the RBHA on these specific cases. Room and board requests that would fall under specialized discharge a.k.a. Plan for One funding will need required documentation submitted and approval by the DBH.

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 RBHA 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 RBHA funding will be needed.

Appendix D – Flex Funds Guidelines

Flex Funds:

The Division of Behavioral (DBH) allows the allocation of flex funds by the Regional Behavioral Health Authorities (RBHA) for non-Medicaid enrolled individuals. This policy addresses two types of flex funding community support flex funding and emergency flex funding.

Purpose: Flex funding is to obtain the resources necessary to meet a consumer's identified treatment/rehabilitation goals as stated in the individualized service plan that cannot be provided through other funding mechanisms or more traditional service provision modalities.

Payment of Last Resort: The RBHA/provider shall attempt to use all other sources of funding prior to utilizing flex funds. These efforts shall be documented thoroughly on the DBH specified form. Flex funds are not for ongoing distribution but for limited periods of time, defined by the DBH as no more than three consecutive months in the same category.

Allocation and Payment: Flex funds are to be their own budgeted line item and not imbedded into an expense reimbursement service or system coordination. Flex funds are to be billed by specific providers. They may not be billed to the DBH from the RBHA as a lump sum. The RBHA may be a provider that bills the DBH for flex funds. Anytime the flex funds requested are over $500 the provider must get written permission from the RBHA. Flex Funds are not to exceed $5,000 per consumer within twelve consecutive months.

A. Prohibition on use of funds:
    1. To pay for items that are included/built into the service rate (i.e. medications, room and board, food and etc.).
    2. To pay for physical health medication or devices (i.e. hearing aids, eyeglasses, contacts, life alert, dentures etc.).
    3. To pay for physical health appointments (i.e. dental, eye, hearing, physicals, etc.).
    4. To pay for memberships (i.e. gym memberships).
    5. To pay therapeutic animals or training animals.
    6. To pay for storage or storage fees.
    7. To pay for refreshments (i.e. candy, soda, etc.).
    8. To pay for nicotine/tobacco products (excluding cessiation products)
    9. To provide cash to or for consumers
    10. To pay for guardianship expenses
    11. To pay for items that are not pertinent to treatment and recovery.

B. Submission and Documentation:

1. The Provider will document and track how the flex funds are expended for each individual receiving funding. The documentation will state what type of flex fund is being used, what was purchased with the flex funds, what treatment/rehabilitation goal is being met and what other resources have been explored.
2. The Provider agrees to comply to submit claims for flex fund resources on the forms specified by the DBH.
3. The RBHA will use the newest version of flex fund form provided by the DBH to track the flex funds or other form as approved by the DBH. The RBHA will submit this form to the DBH quarterly. The due date is 30 days after the quarter has ended. If this date falls on a weekend or holiday, forms are due the next business day.
4. The RBHA shall ensure that the flex fund expenditures do not exceed budgeted amounts.
5. The flex funds will be monitored by the RBHA/DBH to evaluate cost effectiveness and the impact of the flex fund resources on consumer outcomes.
6. The consumer receiving assistance shall be registered in an appropriate service through the DBH's centralized data system (CDS), in order to track utilization patterns and to ensure appropriate follow up.
7. RBHA agrees to submit supporting documentation, at the request of the DBH, to substantiate any flex fund that are questioned by the DBH. The RBHA must track use of flex funds by consumer by month by expense to ensuring compliance with the policy. The Tracking Document should be made available to the DBH upon request.
8. The DBH will review the RBHA's quarterly flex fund documentation and provide feedback, if needed. Should the review show the flex funds going to an unallowable expense and no exception requested has been submitted and approved, the DBH reserves the right to ask for payback.

I. Community Support Flex Funds

The community support flex funds are available to consumers who are authorized and enrolled in the community support service. Community support flex funds may be utilized to help obtain the resources necessary to meet identified treatment/rehabilitation goals (as outlined on the service plan) that cannot be provided through other funding mechanisms or more traditional service provision modalities.

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 (this does not include physical health medications)

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. The emergency system flex funds must be used to address needs that will meet the following priorities: resolution of a potential crisis and stabilization within the community, 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 and recovery and transition of a consumer who has received care.

A. The emergency system flex funds can be used for the following:
   1. Transportation (self, e.g., gas, minor car repair)
   2. Transportation (EPC related)
   3. Transportation (taxi, bus, handi-van, truck for moving, other)
   4. Housing (one-time deposit on apartment)
   5. Housing (rent per month)
   6. Housing (purchase furnishings)
   7. Utilities
   8. Food
   9. Initial Clothing Needs
   10. Emergencies
   11. Laboratory Work
   12. Medications (this does not include physical health medications)

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. 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.
   3. A reduction in the number of times the consumer requires Emergency Protective Custody action.
   4. The consumer will experience a reduction in recidivism to higher levels of care.
   5. 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.
   6. Consumers will voluntarily seek treatment.

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

Exceptions: Request of an exception to this policy may be made to the DBH in the form of a written email to DHHS.DBHNetworkOperations@nebraska.gov. Exceptions to the flex fund policy must be approved prior to billing.

Any expense billed through flex funds which is deemed unallowable must be reinbursed to the department within 30 days of notice. Failure to submit repayment may lead to stopped payments for future flex fund usage.

Appendix E – Age Waiver 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: Ensure the youth is NOT a State Ward or that the services is NOT covered by Medicaid and/or CFS; only then would you fill out an age waiver.
13. 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. 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 current services and why adult services are more appropriate.

c. Describe program modifications/enhancements.

16. Electronically Sign and Date Form: Once that is done, you will be prompted to save a copy.

17. Save a Copy and Send to Region: Save a copy and send form to the Region contact listed in the dropdown. Use the Email Subject Line: Age Waiver Request.

18. Select Submit: Request will be sent to assigned field representative for the region. If you need contact information for the field representative for your region, contact your Regional Network Representative.

The form will prompt you to enable JavaScript, you must do this to continue.

19. Today's Date: Enter Month, Day and Year (MM/DD/YYYY) example: 02/17/2017

20. Choose Region for Email Address: Dropdown will contain email address to send a copy to.

21. Contact Name: Provider's Contact person for Age Waiver Request, enter First & Last Name

22. Provider Name: Please provide entire name of Provider

23. Contact's Email: Double check, your authorization will be sent to this email

24. Provider Address: Include P.O. Box if necessary, Street address, City, State & Zip

25. Provider Phone Number: (Area Code) XXX-XXXX

26. Youth's Name: First Name, Middle Initial, Last Name

27. Youth's Date of Birth: MM / DD / YYYY

28. Age Today: This will calculate automatically and you cannot change it.

29. Check Box: Ensure the youth is NOT a State Ward or that the services is NOT covered by Medicaid and/or CFS; only then would you fill out an age waiver.

30. 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.

31. 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

32. Narrative: Describe each area as instructed

a. Describe level of care and how it meets the specific treatment / rehabilitative needs.

b. Describe current services and why adult services are more appropriate.

c. Describe program modifications/enhancements.

33. Electronically Sign and Date Form: Once that is done, you will be prompted to save a copy.

34. Save a Copy and Send to Region: Save a copy and send form to the Region contact listed in the dropdown. Use the Email Subject Line: Age Waiver Request.

35. Select Submit: Request will be sent to assigned field representative for the region. If you need contact information for the field representative for your region, contact your Regional Network Representative.

Appendix F – Alternative Compliance Instructions

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

Division of Behavioral Health
Alternative Compliance Request (ACR)

Pete Ricketts, Governor

Procedure & Instructions

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 ACR form per DBH policy.

A. **As of 8/1/17**. The request MUST be submitted to DBH by the RBHA and include all required information and documentation prior to consideration.

B. **Updated Submission Procedure.** The Provider will NOT submit the ACR directly to DBH unless the RBHA is the Provider. The Provider must submit the ACR form directly to their RBHA. The RBHA is responsible for submitting a completed ACR Packet, on behalf of the Provider, to DBH. Consideration of the ACR will not be made until all three components of the ACR Packet are completed and submitted to DBH. Any partial submissions will be denied and returned.
The ACR Packet must include all three of the following components:

   1. A Completed ACR Form.
   2. Providers' Governing Board Approval Letter (check if RBHA is Provider).
   3. RBHA's Governing Board Approval Letter (dated within current fiscal year).

C. **Note:** The ACR form will no longer automatically be submitted to DBH when electronically signed; that feature has been removed. The entire ACR packet will consist of the 3 attachments outlined above and will be submitted by the RBHA to DHHS.DBHNetworkOperations@nebraska.gov. Subject: **RBHA # ACR**.

D. The date on which the fully compliant ACR Packet is received by the DBH Network Operations mailbox will be considered the receipt date.

E. The ACR will be forwarded to the DBH Director for review.

F. The DBH Director will issue a decision, within 30 days of the receipt date, via secure email and by certified mail to the RBHA, RBHA's Governing Board and Provider.

G. If the ACR is **APPROVED**, the Provider must adhere to the following requirements:

   1. Alternative Compliance will be for a specified time period not to exceed the end of the program certification as specified under Title 206;
   2. The provider must receive written approval from the DBH before implementing alternative compliance; and
   3. The provider must meet all the conditions prescribed by the DBH in granting AC. Failure to comply with the specified conditions voids the authorization for AC.

H. If the ACR is **DENIED**, the Provider may aggrieve the decision and submit an appeal through their RBHA to the DBH Director within thirty (30) business days of the date of issuance of the decision.

Form Basics: Enable JavaScript, if prompted.

- ***Today's Date:*** example: 02/17/2017
- ***Choose RBHA Email Address***: Dropdown of email to send ACR form to.
- ***Contact's Name***: Provider's Contact Person (First & Last Name)
- ***Contact's Email***: Copy of Approval/Denial will be sent to this email
- ***Name of Provider***: Full name (Enter RBHA information if they are Provider)
- ***Provider Address, City, ST, Zip & Phone Number***: (Area Code) XXX-XXXX

Explanation of ACR Form components. The ACR can only be made on regulations in 206 NAC,. The ACR form was developed by DBH to include all regulation-required components as cited in 3-002.01. ***See references.***

(1) 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.
- ***Select 206 NAC CHAPTER per 3-002.01 (002.01(A)) with dropdown***
- ***Select Corresponding Chapter's Subchapter with dropdown.***

(2) Reasons for the request for alternative compliance;
- ***Reasons for the ACR per 3-002.01 (002.01(B))***

(3) If appropriate, activities or performance criteria to replace the requirement of the regulation and the date the provider is expected to attain compliance;
- ***Steps to support future compliance & attainment date per 3-002.01 (002.01(C))***

(4) The signature of the organization/program director or individual provider;
- ***Provider Signature per 3-002.01 (002.01(D))***

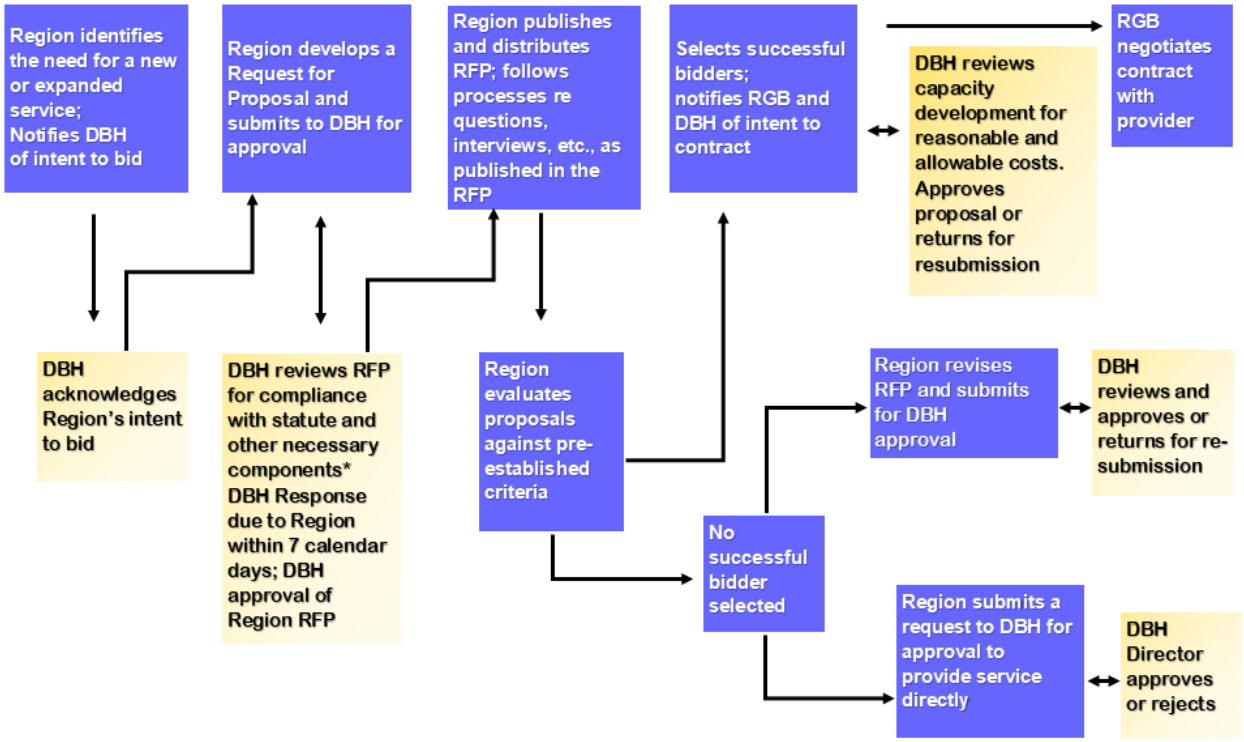
(5) Authorization from the provider's governing body to request AC.
- ***Checkbox - Provider's Governing Board Letter attached per 3-002.01 (002.01(E))***

(6) Approval by the Regional Governing Board when the provider is under contract with the RBHA;
- ***Checkbox - RBHA's Governing Board Letter attached per 3-002.01 (002.01(F))***

(7) Documentation of evidence for how the AC would enhance all of the following criteria. All four must be completed:

- ***Document how AC will enhance QUALITY per 3-002.01 (002.01(G))***
- ***Document how AC will enhance ACCESSIBILITY per 3-002.01 (002.01(G))***
- ***Document how AC will enhance PUBLIC SAFETY per 3-002.01 (002.01(G))***
- ***Document how AC will enhance COST EFFECTIVENESS per 3-002.01 (002.01(G))***

Appendix G – Service Development Flow Chart



Appendix H – RFP

- 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 of 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 approved 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.
Network Enrollment Requirements:	• See Network Enrollment Requirements on page 18 #6

Other requirements:	• 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; • A clear description of the service(s) to be provided; • A clear description of the minimum qualifications for prospective; • Accurate data related to the service (as available); • The process to be used to evaluate and score the submission to determine the successful bidder; and • The process for appeal

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.

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.

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

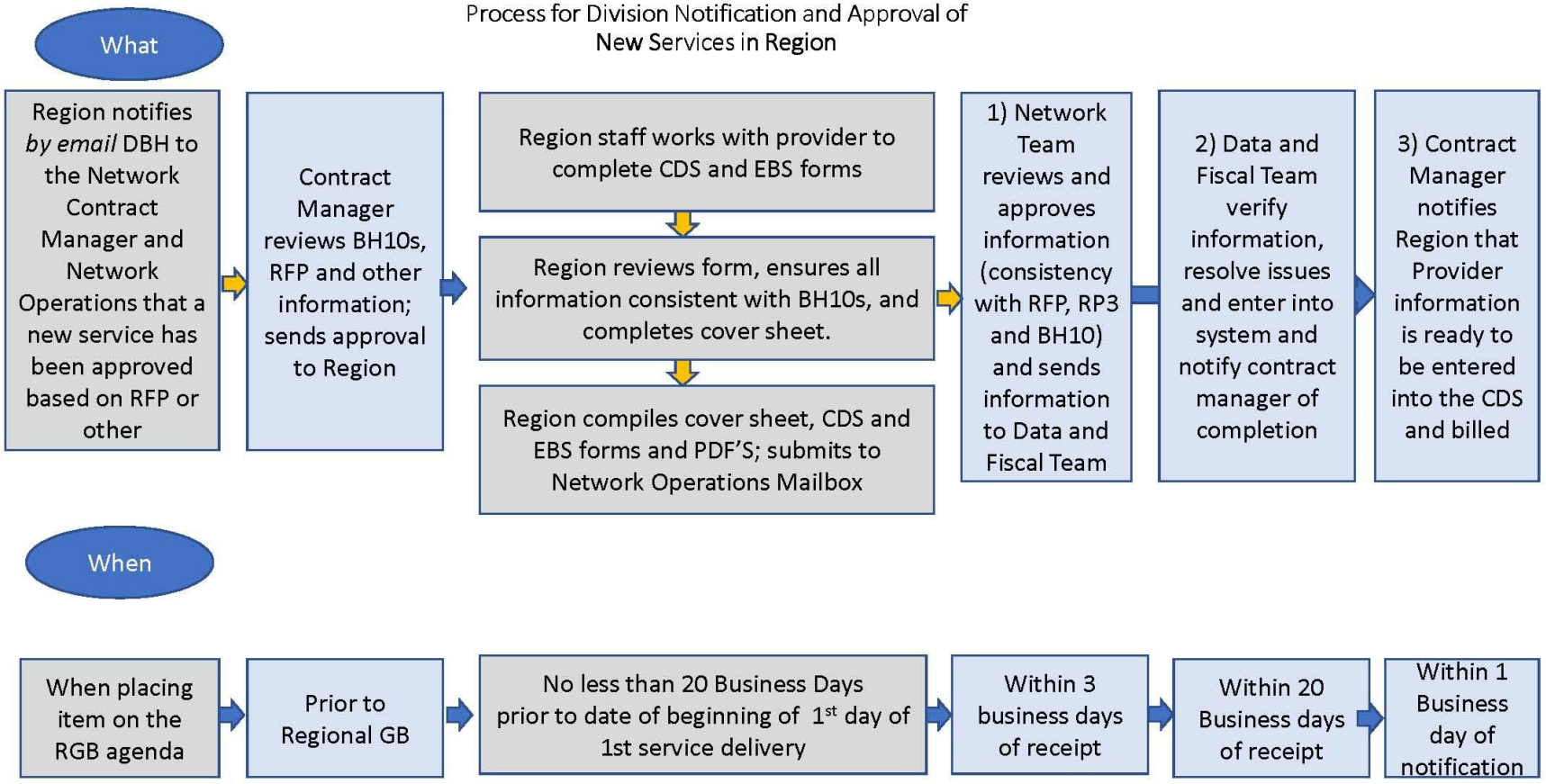
b. Submit a request to the Director of DBH for approval for the RBHA to act as a provider for that service. Such a request must include verification that:

   i. There has been a public bidding process for services;

   ii. There are no qualified and/or? 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.

- 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 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. 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 equipment may be identified for purposes of the award. However, the competitive bids must be solicited before final funding for the equipment can be paid and cannot exceed the lowest bid received for the 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) Providers should obtain a federally approved indirect cost rate or approved de minimis rate from the DBH. • A successful bidder may not seek additional funding from DHHS for items that were not included in the proposal submitted after award by a RBHA; • 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 project; • Includes formal evaluation of program plan, process and services provided.


Process for Division Notification and Approval of New Services in Region
What
Region notifies by email DBH to the Network Contract Manager and Network Operations that a new service has been approved based on RFP or other
Contract Manager reviews BH10s, RFP and other information; sends approval to Region
Region staff works with provider to complete CDS and EBS forms
Region reviews form, ensures all information consistent with BH10s, and completes cover sheet.
Region compiles cover sheet, CDS and EBS forms and PDF'S; submits to Network Operations Mailbox
1) Network Team reviews and approves information (consistency with RFP, RP3 and BH10) and sends information to Data and Fiscal Team
2) Data and Fiscal Team verify information, resolve issues and enter into system and notify contract manager of completion
3) Contract Manager notifies Region that Provider information is ready to be entered into the CDS and billed
When
When placing item on the RGB agenda
Prior to Regional GB
No less than 20 Business Days prior to date of beginning of 1st day of 1st service delivery
Within 3 business days of receipt
Within 20 Business days of receipt
Within 1 Business day of notification

Appendix I – Laws 2009, 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 RBHA:

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. RBHA 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. RBHA and providers will register for e-verify and verify work eligibility for all new employees.
4. RBHA will include this provision in their subcontracts.
5. RBHA will check their retirement systems to see if they fall under this law and act accordingly.

Changes for the Division of Behavioral Health:

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. DBH (through DHHS) will have to verify eligibility to work for all new hires.

Appendix J – 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.

Appendix K – Consumer Rights and Grievance Policy Components

A. **Consumer Rights:**

The following rights apply to consumers receiving behavioral health services through Nebraska's public behavioral health system. All consumers have the right to:

1. Be treated respectfully, impartially, and with dignity;
2. Communicate freely with individuals of their choice including, but not limited to, family, friends, legal counsel, and his/her private physician;
3. Have clinical records made available to themselves and individuals of their choice by his/her written request;
4. Actively and directly participate in decisions which incorporate independence, individuality, privacy, and dignity and to make decisions regarding care and treatment;
5. Refuse treatment or therapy, unless treatment or therapy was authorized by the consumer's legal guardian or was ordered by a mental health board or court;
6. Have privacy and confidentiality related to all aspects of care;
7. Be protected from neglect; physical, emotional or verbal abuse; and exploitation of any kind;
8. Actively and directly participate in developing an individual treatment, rehabilitation, and recovery plan and decision-making regarding his/her behavioral health care;
9. Receive care from providers who adhere to a strict policy of non-discrimination in the provision of services;
10. Be free of sexual exploitation and, harassment;
11. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed in a timely manner; and
12. Receive behavioral health services in the most integrated setting appropriate for each consumer based on an individualized and person-centered assessment and incorporated into the individual treatment rehabilitation and recovery plan.

B. **Consumer Grievances:**

Each provider must establish a written consumer grievance policy with the following components:

1. Consumers and as applicable, their legal representative(s) and family of their choosing must be informed of and given a copy of written procedures for addressing and resolving grievances established by each provider;
2. Consumers, families, staff, and others must have access to the provider's grievance process;
3. The consumer's grievance must be responded to by the provider in a timely manner and the provider must document its response to the consumer;

4. If the consumer's grievance is not addressed satisfactorily through the provider's complaint process, the provider must give adequate information, including telephone numbers and addresses, to the consumer to enable the consumer to contact the Division of Behavioral Health, Office of Consumer Affairs; the Division of Public Health, Facility Complaint Intake and the Investigations Section, the designated Protection and Advocacy organization for Nebraska; the Consumer Specialist of the RBHA; the office of the Ombudsman; the Department's System Advocate, and the vendor who is contracted for system management. This information must also be readily available to consumers, families, staff, and others.

Appendix L – Payment and Billing Basics

I. ALLOWABLE/UNALLOWABLE COSTS:

Office of Management & Budget (OMB) Super-Circular, as defined in 2 CFR 200, provides specific guidelines of allowable and unallowable costs, and what can be charged to the federal government under a federal award, and for any state funds combined with these funds. Compliance with these circulars is required for all award recipients and compliance testing is a component of the agencies CPA audit.

It is the responsibility of the RBHA to verify and ensure all funds requested are allowable. For more information, see the RBP Guidelines and the 2 CFR 200.

Additional clarification on allowable or unallowable costs are detailed in this manual and in specific contracts or subawards.

II. PROVIDER BILLINGS TO RBHA

1. Each provider must submit to the RBHA a Provider Payment Request (PRR) that includes an electronic signature of a person authorized by the provider to submit the form.
2. The provider must enter all units provided into CDS, using the approved unit designations and limits. For more information see the Unit Designation sheet in this manual.
3. The provider will review for accuracy the units received from CDS into the PRR for each service and complete the forms required for services paid on an expense basis reflected in the PRR. If the number of units received from CDS is wrong for one or more services, the provider must amend the counts in CDS and wait one hour for the revisions to be submitted to EBS for inclusion in the PRR. Instructions for how to update the information on the PRR may be found in the EBS manual.
4. Forms associated with a NFFS service paid as expense reimbursement must be completed, and reflect actual expenses incurred for the billing period. All expenses on the forms must be reduced by all revenue received for the service by other sources (e.g., client fees, third party payers, refunds, etc.). If a provider is not being reimbursed actual expenses, before final payment is made for the contract year, the RBHA must receive documentation of actual expenses for the year to ensure payments have not exceeded actual expenses.
   (Note: Item II.4. applies to RBHA billings for services or work performed by the RBHA.
5. If a Provider Payment Request is incorrect, the RBHA must reject the document to the provider for correction.
6. For all per diem and/or bed based services the date of admission will reimbursed at a full day rate and the date of discharge will not be reimbursed. Partial units will not be allowed.
7. Providers may bill for substance use units of service for persons who are Medicaid Fee for Service (FFS) non-managed care who do not have a Share of Cost. A Provider may not bill for any persons who are on a Share of Cost and have not met their individual obligation under any circumstance. This includes FFS individuals. Providers must complete Report a Data Issue for CDS and clearly state in the narrative that the person is a Medicaid FFS individual and that you are requesting approval for substance use services. Instructions to compete the report is on the CDS website under System

Documentation and Training and is titled "Medicaid and CDS Conflicting Information." Further instructions for entering the individual into CDS and service documentation will be provided during the data review process. The Provider must retain the Medicaid denial form(s) in the consumer file. RBHA must check this documentation during annual review to ensure no payment is being requested or made for a denial of Medicaid due to Share of Cost.

8. The RBHA is responsible to ensure there are sufficient budgeted funds available to pay for services submitted on PRRs prior to submitting an MRR to the DBH. If an MRR request exceeds available dollars, the RBHA may hold units or reject BH forms in the amount necessary to meet available dollars. Failure to do this at the RBHA level may result in a payment being rejected by the DBH or having a payment returned that is less than the requested amount.
9. In the event that funds are not paid due to insufficient funding being available on a service, it is the RBHA's responsibility to ensure adequate funds are moved during the next quarterly shift to allow the held funds to be paid. Failure to do so may result in the funds being denied.

III. RETRO PAYMENT FOR MEDICAID OR THIRD-PARTY DENIALS

1. If there was a change in Medicaid status resulting in a denial of eligibility for reasons other than Share of Cost or medical necessity, or there is a conflict between information received on the NMES/C1 and the information in CDS, the provider must follow the procedures to Report a Data Issue outlined for handling these cases issued by DBH's Data Team. Instructions to compete the report is on the CDS website under System Documentation and Training and is titled "Medicaid and CDS Conflicting Information." At no time may the provider be reimbursed for individuals who are on Share of Cost designation or for services in which the denial is due to the consumer not meeting medical necessity. To request payment for the service, provider must register the consumer and service in CDS to submit to EBS within 60 days of the Medicaid denial. Payments found to be the result of claims submission being made after 60 days of denial must be repaid to the DBH.
2. If an individual has been denied Medicaid status and subsequently receives retroactive Medicaid approval, all funds received by the provider for the care of the individual for this retroactive period must be reimbursed to the RBHA in full. If the reimbursement is received in the same fiscal year, the RBHA must instruct the provider to reduce the units in CDS to subtract these funds from the next request for payment sent to the RBHA. If the reimbursement received is for units in a prior fiscal year, the RBHA must instruct the provider to reduce the units for the provider in CDS, and then complete a BH-PFY Reimbursement for the service in the next request for payment sent to the RBHA.
3. Billing for denied insurance claims must be completed per provisions detailed in Division of Behavioral Health Financial Eligibility Policy II.B. as incorporated into NAC 6-005. RBHA must ensure this is being followed by providers prior to submitting the claim to DHHS in EBS. Any funds paid to the provider and subsequently returned must be returned in full. Partial unit funding may not be retained to offset any loss due to a lower unit price being received form the insurance company.

IV. RBHA ROLL UP AND SUBMISSION TO DBH

Each RBHA submits a Master Reimbursement Request (MRR) in EBS for the billing period. It is the RBHA's responsibility to ensure there is sufficient funds available by service for the payment being requested for that service prior to submitting the MRR. If

sufficient funds are not available, the RBHA should reduce units or revise expenses to the available amount. Failure to do so may result in the MRR being rejected until adjustments are made or a portion of the payment will be held until funds in the service become available.

V. BILLING TIMEFRAMES

For billing timeframes and deadlines, please see the State to RBHA contract.

VI. TURNAROUND or UTILIZATION DOCUMENTS (TADS)

1. Prior to or at the end of the month, the provider accesses the CDS website and enters encounter data. The provider may print the TAD, but the printed documents are not required to be submitted to the DHHS.
2. Handwritten corrections of names or alterations which add units on TADs will not be accepted and payment will not be processed for any units claimed in this manner.
   If units of service from prior months are entered or altered in CDS, the modified units will be submitted to EBS within 1 hour and be reflected after refreshing an existing PRR or on the next PRR created by the provider. For more information on how to do this, see EBS manuals.
3. Errors in data entry that result in held units or inaccurate billing must be corrected by the provider within 30 days. Failure to do so may result in denial of future payments.

VII. PREVIOUS FISCAL YEAR BILLING REQUIREMENTS

Funds in the contract are to purchase services performed during the contract period. The Previous Fiscal Year (PFY) mechanism was set up primarily for providers to reimburse units originally billed to the state but subsequently reimbursed by a third party, and for limited billing of units in defined circumstances outlined in NAC 206 or Billing Basics. This said, it should be stressed that funding from the RBHA is required to be payer of last resort and billing this prior to billing other third parties calls this into question.

1. PFY Billing process should not be used to:
   - **A.** Bill units “missed” or not paid due to no funds remaining in the contract in prior fiscal years
   - **B.** Bill partial units to compensate for any difference between funds paid the provider by another payer and provider, RBHA or state rate (See NAC 206, NAC 471 Chapter 3, and provider agreements with insurance plans)
   - **C.** Bill denied Medicaid service for a Medicaid enrolled individual
   - **D.** Bill for denied insurance claims that do not meet the 206 regulations
   - **E.** Bill for service in which the consumer is deemed eligible to pay the cost or for a Medicaid recipient to meet a share of cost obligation.
   - **F.** Bill for units not recorded in CDS or without an associated encounter number
   - **G.** Bill for expense reimbursement not paid in the previous year
     Pay an amount for a service that was paid as an expense reimbursement in prior fiscal year
2. All past units billed must meet have:
   - **A.** Been performed in the last two (2) months of the prior contract period but not billed due to unforeseen or unavoidable circumstances (documented to RBHA the reason prior to submission). Repeated (more than once) limitations, slow or incorrect entry

into a provider's data/billing system will not qualify as an 'unforeseen or unavoidable' circumstance.

B. Been previously filed with insurance per the guidelines in NAC 206, denied for payment, and billed to the RBHA on the first billing cycle after receipt of the insurance denial.

C. Not include units denied by Medicaid for a Medicaid service to a Medicaid enrolled individual.

3. All past units being reimbursed must reimburse the cost of the unit paid in full to the provider. The provider may not retain a portion of the unit to compensate for costs not met by the third-party reimbursement rate.

4. All units billed through PFY process are subject to auditing and the RBHA must treat PFY units as a separate service when determining sample size.

VIII. HELD UNITS

RBHA must monitor all units held in billings and ensure these units are included in subsequent shifts as appropriate. Units to be paid by other sources (e.g., county funds) may not be entered into CDS for subsequent submission and holding in EBS.

Appendix M – Instructions for RBHA Actuals

1. Due September 1 to the Division of Behavioral Health each year for the previous fiscal year ending June 30.
2. Provides support for required county and non-county match per 71-808(c):
   a. "…Shall provide funding for the operation of the behavioral health authority and for the provision of behavioral health services in the RBHA. The total amount of funding provided by counties under this subsection 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 nonfederal sources."
3. Dollar amounts must be listed by agency per service utilizing BH10 form or other DHHS designated format.
4. Column headings shall be in the following order:
   a. County - Money received from county boards and expended for the operation of the behavioral health authority or for the provision of services in the RBHA.
   b. Medicaid - amount received and expended for treatment of behavioral health consumers, including Medicaid Disproportionate Share (DSH).
   c. Client Fees – copayments or other assessments for cost of care paid by consumers which supported the provision of services, including room and board fees.
   d. Private Insurance/Other 3rd Party Payers - Insurance company payments used to pay for behavioral health services.
   e. Federal Funding* - Medicare and Medicare Disproportionate Share (DSH) payments, VA benefits, Federal grants or other sources of Federal revenue used to pay for behavioral health services. (See starred (*) instruction under State Other Sources.)
   f. Other RBHA – Funds/Revenue received from contracts with other RBHA Behavioral Health Authorities (outside of behavioral health RBHA in which program physically resides).
   g. State Other Sources* – Probation, DHHS Children & Family Services, DHHS Public Health (e.g., Tobacco Free Nebraska), Department of Education, Nebraska Crime Commission, Vocational Education, Department of Education, or other state agencies used to pay for behavioral health services. *Funding from state agencies may be state funds, federal funds or a combination of both. Agencies should report any federal funds received from a state agency under "Federal Funding" and not under State Other Sources.
   h. Agency - Fundraising, United Way, donations, interest, and other agency generated revenue used to pay for provision of behavioral health services.
5. Dollars reported in Medicaid, Other RBHA, and Federal Funding do not qualify as part of the required match funding but are required to demonstrate overall cost of services.
6. Amounts reported for an agency may be compared with agency's audited financials to ensure feasibility of amount reported.

PART V: NETWORK OPERATION MANUAL REVISIONS

A. Quarter 1- FY18

- Pg. 10, Item 7 - Suspension of provision that DBH will not pay for room and board for those Medicaid eligible in Secure Residential who are receiving SSI. This suspension will be reviewed prior to FY19.
- Pg. 39, Appendix A - Added - *Sample Script-FIS Info-Signature Form-Rev Aug 2017*.
- Pg. 40, Appendix A - Added - *DBH FIS Chart Checklist Sample*.
- Pg. 59, Appendix G - Added - *Alternative Compliance Instructions-Rev Aug 2017*.
- Pg. 61, Appendix G - Added - *DBH Alt Compliance Request (ACR) Form-Rev Aug 2017*.
- Pg. 62, Appendix G - Added - *Alternative Compliance for Accreditation Flow Chart*.

B. Quarter 2 – FY18

- Pg. 7, - NBHS - Added new section - *D. Authority to Maintain Waitlist Data*
- Pg. 20, Item 18 - Added clarification of Sentinel Events language
- Pg. 72, Appendix J - Added:
- Process for DBH Notification & Approval of New Services Flow Chart
- New Services Approval Cover Sheet

A. Quarter 1- FY19

- Pg. 7, Section D – Waitlist Data information. Authority for waitlist data maintenance granted by NAC206 and Federal Substance use Block Grant regulations (45 CFR Part 96). Gives purpose and process of data collection.
- Pg. 11, #7 – Room and Board will be paid for SSI and SSDI ineligible consumers with Plans for One until those consumers become eligible.
- Pg. 17-18, #6 – Proposed additions to Network enrollment requirements. Additions include numerous items highlighted in Network Compliance reviews as needing verification.
- Appendix C (PP 46-50) in old NOM – Removed (Pilot Project Guidelines)
- Appendix J (PP 74-80) in old NOM – Removed (New Services section)
  Appendix M in old NOM – Removed (Network Management Team Charter)

B. Quarter 2- FY20

- All language citing 206 regulations were updated or removed from the Network Operations Manual.
- References to Civil Protective Custody hold were removed.
- State Regulation Sections was removed:
    - 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 SPMI means an individual who is age 19 and older, 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:
        - Vocational/educational;

        - Social skills; or
        - Activities of daily living.
        - This designation is required for individuals served in Community Support Mental Health, Day Rehabilitation, Psychiatric Residential Rehabilitation, and Assertive Community Treatment.
- Language added to Service Enhancements on page 10.
- Language added to Specialized Discharge Planning on page 10.
- Language added to IPPC on page 10.
- #12 added to Page 14 und DBH Responsibilities
- Language added to #6 Electronic Billing System on page 14.
- #7 Nebraska Prevention Information Reporting System added to page 14.
- Language added to #8 Service Development on page 14.
- #11 Alternative Compliance below language was deleted:
    - It conforms to good and customary administrative management and programmatic practices;
- #4 under Roles and Functions of the Regional Governing Board language was added.
- #5 under Roles and Functions of the RBHA was added
- #6 under Roles and Functions of the RBHA was added
- Majority of RFP language was moved to the RFP Appendix.
- Critical Incident language was grouped together on page 18.
- Under Network Enrollment Requirements below language was deleted:
    - Enumeration in all subcontracts of statutory match requirements for providers, including amounts and provisions for reporting estimated and actual county and non-county funding being utilized to meet the statutory requirement by category;
- Under Network Enrollment Requirements language was revised.
- Under Prevention Coordination below language was deleted:
    - All funded prevention activities shall be entered into the Nebraska Prevention Information Reporting System (NPIRS) no later than thirty (30) days from the date of the activity.
- Under Emergency Coordination language was added.
- Under Youth System below language was deleted:
    - Collaborate with regional network providers, family advocacy organizations and other youth serving agencies to engage in activities that address the needs of youth/young adults who are in need of behavioral health services.
- Provide transitional services/transition teamwork for eligible youth transitioning into the adult behavioral health service system using agreed upon processes.
- 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.
- Under Consumer System below language was deleted:
    - Participate in DBH meetings/conference calls and related statewide activities.
    - 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.
    - 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.
- Under Housing Coordination language was added.
- Under Financial Management language was added.
- Under Ongoing review of utilization and drawdown language was added.
- Under Network and Provider Monitoring below language was deleted and cleaned up. Much of this section is outlined in the Audit manual.
- Under Network and Provider Monitoring #8 was added.
- Under Quality Improvement language cleaned up.

- Division and RBHA Joint Leadership and Management of Section was deleted.
- Federal Mandates were added to Appendix A.
- Federal Interim Services Forms were removed from manual.
- Rate Enhanced Rate and Rate Enhanced Expense language was added to Appendix B.
- Room and Board language added to Specialized Discharge Planning Appendix C.
- Flex Fund Appendix language cleaned up and timeframe for DBH removed on exception requests.
- Age Wavier form removed from Appendix E.
- Alternative Compliance Form removed from Appendix F.
- RFP language added to Appendix H.
- Alternative Compliance Flow Chart removed from manual.
- Network Management Expectations removed from manual.
- Recovery and creating a recovery oriented system of care (ROSC) language removed from manual.
- Consumer Rights and Grievance Policy components Appendix K added.
- Billing and Payment Basics Appendix L added.
- Instructions for RBHA Actuals Appendix M added.
- Language changed from critical incident to sentinel event.
- Page 26- under Quality improvement the following language was added "The Compass-EZ and the trauma-informed care (TIC) assessments will be completed by providers during odd fiscal years and the RBHA will turn in all provider assessments to DBH within 30 working days after the fiscal year has ended.
- Page 35- under state mandate unallowable cost added language to refer to billing basics for guidance for PFY.
- Page 42- Rate Enhanced Rate / Rate Enhanced Expense section added the following language "Funding for Rate Enhanced Rate / Rate Enhanced Expense reimbursement expenses may only be requested proportionate to the percent of NBHS funded consumers in the service at each agency location."
- Page 43- Rate Enhanced Rate / Rate Enhanced Expense section under program narrative added the following language "Break out the percentage of NBHS individuals and other sources"
- Page 44- Rate Enhanced Rate / Rate Enhanced Expense section under budget narrative added the following language "Provide all sources of revenue the agency receives in all the applicable locations"

C. Quarter 3 – FY20

- Pg. 50, Appendix F - Added - Alternative Compliance Instructions-Rev Jan 2020.
- Pg. 53, Appendix F - Added - Alternative Compliance for Accreditation Flow Chart.
- Pg. 66, Appendix L- Added bullet 6

D. Quarter 2 – FY22

- Page 5: Overview section added to outline Values and Concepts
- Page 7: Under Laws 2009, LB403: language was updated.
- Page 10-11: Under Services and Supports- replaced Lime Book with Continuum of Care Manual
- Page 19: Updated language for sentinel events.
- Page 21-22: Added language to reflect bed registry strategy, 988 implementation, and LRC action plan. (f-m)
- Page 35: Unallowable Costs, added payments to collection agencies. (vi)
- Page 39: Appendix B, Under Program Narrative, added letter (n)
- Page 41: Appendix B, Budget, Updated BH20 forms and added bullet points under (c)
- Page 45: Appendix B, Budget, Updated language under first bullet point, BH20
- Pg 48: Appendix D, Flex Funds added language to allocation and payment/added items to list for prohibited use of funds

- Page 49: Appendix D, Added language for due date if date falls on weekend or holiday and requirement for exceptions to be approved prior to billing.
- Page 52: Appendix E, Age waiver instructions updated to reflect where requests should be submitted
- Form was updated to reflect changes
- Updated contents page numbers for accuracy.