

*Promoting Comprehensive Partnerships in Behavioral Health*

**1645 N Street, Lincoln, Nebraska 68508**

**402-441-4343 • Toll Free: 1-877-286-4343 • Fax: 402-441-4335**

[**https://region5systems.net/**](https://region5systems.net/)

**Minimum Standards for Enrollment in the**

**Region V Systems Behavioral Health Provider Network**

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

|  |
| --- |
| 1. Does the provider have the capability to provide behavioral health services and fulfill its potential role in the Network? 2. Are the Division of Behavioral Health and the Network interested in purchasing the services the provider has to offer? 3. Does the provider demonstrate implementation of a person-centered philosophy in service delivery? 4. Does the provider demonstrate ethical practices in business and service delivery? 5. Does the provider demonstrate adherence to applicable legal requirements, health and safety requirements, and risk management practices? 6. Is the provider achieving the outcomes the Division of Behavioral Health and the Network are interested in purchasing? 7. Does the provider demonstrate fiscal viability and stability? 8. Does the provider have the capacity and ability to fulfill the mission of the network? |

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

**REGION V NETWORK MANAGEMENT RESPONSIBILITIES**

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

**ENROLLMENT CRITERIA**

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

**PROVIDER ENROLLMENT**

**Provisional Status**

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

In order for Region V Network Management to determine if the provider meets the Minimum Standards for provisional status, the ***Network Provider Enrollment Form (Attachment A)***, with supporting documentation, must be submitted and an on-site visit completed with the Network Provider.

A. **Enrollment Plan for Network Requirements**

Providers requesting provider enrollment in the Network will complete a ***Network Provider Enrollment Form*** and provide supporting documentation as outlined below.

* + 1. Demonstration of Capacity

Providers must furnish documentation of the following:

* Facility licenses, fire inspections and food permits, as required
* Professional licenses, as required
* Proof of Insurance
* Commercial General Liability ($1,000,000 minimum)
* Workers Compensation
* Commercial Automobile Liability
* Professional Liability ($1,000,000 minimum)
* Cyber Liability, if applicable
* Umbrella/Excess Liability ($1,000,000 minimum)
* Audited Balance Sheet demonstrating fiscal viability
* Medicaid provider enrollment (MC19 or MC20 form) if the service to be provided is eligible for Medicaid funding
* Program Narrative for each service to be provided in the Network that includes: Administrative & operational overview of provider
* Administrative & operational overview of provider
* A clear description of the services to be provided
* Need for the program
* Target population
* Organization of program
* Program goals
* Admission criteria
* Assessment process
* Specific program services
* Procedures for direct consumer involvement; how are consumers directly and actively involved in the development, implementation, and evaluation of the services to be provided
* Capacity
* Program staffing
* Quality assurance plan
* Facility needs

1. National Accreditation

Providers must comply with procedures as outlined in state regulations 206 NAC 5-001 to receive funds administered by the Division for service delivery. Providers must furnish documentation to Region V Systems, demonstrating the following:

1. Accreditation appropriate to the organization’s mission by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other nationally recognized accreditation organization(s) approved by the Director. 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.

1. Those organizations that do not have documentation of official award of accreditation by TJC, CARF, COA, or other nationally recognized accreditation organization(s) approved by the Director must submit an Accreditation Development Plan for progressively bringing the organization into accreditation status during a two-year period. During the time an organization is working toward accreditation under an Accreditation Development Plan, the organization must meet the standards for behavioral health services in 206 NAC 6. The Accreditation Development Plan must demonstrate a systematic approach toward achieving accreditation and must include:

* Policies and procedures to be followed during the accreditation development period including policies and procedures for protecting the life, safety, and rights of consumers served;
* A quality improvement program which follows the standards set by the national accreditation body which is being sought by the organization (TJC, CARF, COA, or other nationally recognized accreditation organization(s) approved by the Director);
* A written plan for accomplishing the accreditation. The plan must include the type of accreditation being sought (TJC, CARF, COA, other) that is appropriate to the organization’s mission and includes goals, measurable objectives, target dates, person(s) responsible, and deadlines for making application for accreditation and for scheduling accreditation survey; and
* A report on the results of a self-administered survey following the standards set by the national accreditation body which is being sought by the organization.

1. Quality Assurance

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

* + Utilization data - process-oriented information, including results of goals and objectives of the program itself.
  + Outcome data - outcome-oriented information which demonstrates results based on actual clinical status (e.g. increased function, increased health status, decreased symptoms, employment outcomes, improved housing, improved legal status, and other related outcomes).
  + Record of accepting system management referrals - demonstrates that the agency has accepted persons who meet the financial eligibility requirements.

1. Consumer Satisfaction

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

* Consumer Satisfaction survey and results
* Develop and implement a mechanism to track and resolve consumer complaints regarding the provider.
* Disclose the outcome or status of any malpractice suits (pending or recently adjudicated).

1. Error-Free Reporting

* The provider will identify its plan for ensuring that accurate information is provided to the Region and Division of Behavioral Health on a timely basis. The provider will demonstrate accuracy in billing, consumer service data, and other reporting requirements.

1. **On-Site Visit**

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

1. Evaluate the site where services are provided. When the service is not a “facility-based program,” the building or location visited is the site where the provider’s organized program, clinical, and financial record keeping function is established.
2. Verify that the provider’s clinical record keeping practices conform with the Program Narrative submitted and the Region’s Minimum Standards. This is a systematic review of the clinical records for conformity and the type of information included in treatment or rehabilitation plans. The intent of the review is not to judge the appropriateness of treatment.
3. Verify that the provider’s practice will conform to the Enrollment Plan submitted.

**ONGOING PROVIDER RETENTION PROCESS**

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

* Evidence of continued capacity to provide behavioral health services as outlined in the enrollment process and compliance with national accreditation standards;
* Provider audit performance;
* Compliance with information reporting to the Region and Division of Behavioral Health;
* A review of outcomes data and a demonstrated commitment to providing quality services.
* Consumer satisfaction; and
* On-site visit consistent with current enrollment standards.

**PROBATION**

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

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

* If a provider is placed on probation status, a Corrective Action Plan is mutually developed with Region V Systems to address the identified problems and submitted to Region V Systems within 30 days.
* Region V Systems will review the Plan of Correction.
* Region V Systems will conduct an on-site visit to determine compliance with the Plan of Correction.
* Region V Systems will make recommendation to the Regional Governing Board regarding continued provider status.

**Network Provider Enrollment Form**

**Attachment A**

1. **AGENCY IDENTIFICATION INFORMATION**

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

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

1. **AGENCY OVERVIEW**

Provide your agency’s Mission Statement:

**Attach** copies of your organization’s:

* Organizational Chart
* Strategic Plan

1. **LICENSES/CERTIFICATIONS**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Licensing/Certifying/**  **Inspection Body** | **Document**  **Number / Identifier** | **Date Issued** | **Expiration Date** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Staff licenses, as required (attach additional sheet if necessary):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Staff Name** | **Position** | **License Discipline** | **License**  **Number** | **Expiration Date** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. **INSURANCE**

Attach a copy of the following proof of insurance:

* Commercial General Liability ($1,000,000 minimum)
* Workers Compensation
* Commercial Automobile Liability
* Professional Liability ($1,000,000 minimum)
* Cyber Liability, if applicable
* Umbrella/Excess Liability ($1,000,000 minimum)

1. **FISCAL**

**Attach** a copy of the following agency’s most recent audited balance sheet.

1. **POLICIES AND PROCEDURES**

**Attach** a copy of the following agency policies and procedures:

* Client Rights
* Complaints/Grievances
* Confidentiality
* Continuity of Operations Policy/Plan
* Drug-Free Workplace
* Ethics
* Informed Consent
* Maintenance of Service Records
* Sentinel Event or Critical Incident
* Trauma Informed Services
* Wait List Management

1. **PROGRAM PLAN**

**Attach** a program plan/narrative for the service for which the provider is applying to be a provider in the network.

1. **NATIONAL ACCREDITATION**

**Attach** a complete copy of the most recent accreditation report.

1. **QUALITY ASSURANCE**

**Attach** a copy of the Agency’s Continuous Quality Improvement plan

1. **CONSUMER SATISFACTION**

**Attach** a copy of**:**

* Current Consumer Satisfaction Survey
* Policy/procedures for administration of Consumer Satisfaction Survey
* Most recent results/outcomes of Consumer Satisfaction Survey

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

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

Yes  No

If yes, please explain:

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

Yes  No

If yes, please explain:

1. **PRIMARY SOURCE VERIFICATION**

Does the agency conduct primary source verification on professional licenses?

Yes  No

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

Yes  No

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

Yes  No

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

Yes  No

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

Signature of Agency Director / CEO Date