Department of Health and Human Services
Division of Behavioral Health

Network Operations Manual

July 1, 2024

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

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INTRODUCTION

This Network Operation Manual (NOM) will be effective July 1, 2024.

OVERVIEW

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 providing care
- Improve the health of populations
- Reducing the per capita cost of care

The Behavioral Health System 2022-2024 strategic plan addresses five 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 across public and private systems
- Promote stakeholder INCLUSION
- Drive INNOVATION and improve outcomes
- Demonstrate and drive VALUE

Data Driven Quality Improvement (QI) Activities

The DBH and Region Behavioral Health Authorities (RBHAs) utilize statewide and regionally generated data from various sources to drive decisions regarding funding, outcomes, and quality of services. Primary data sources include utilization, waitlist, and capacity from the Centralized Data System (CDS), reviews of quarterly outcomes, and reports from the Electronic Billing System (EBS). Prevention planning utilizes the Nebraska Prevention Information Reporting System (NPIRS) data system. Other data supporting RBHA allocation decisions-must be made available to DBH upon request. Integration of data across the behavioral health system will evolve throughout the 2022-2024 strategic plan.

Balanced Array

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

PART I: NEBRASKA BEHAVIORAL HEALTH SYSTEM

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 and Norfolk Regional Centers
2. Regional Behavioral Health Authorities (RBHA), including Regional Governing Boards (RGB)
3. Regionally contracted service providers

Purpose of the Nebraska Behavioral Health System

The public behavioral health system ensures:

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
    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
    d. The prioritization of consumer involvement in all aspects of service planning and delivery
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.
    d. Funding that is fully integrated and allocated to support the consumer and their plan of treatment.

This manual focuses on the joint work of the DBH community-based services section, the RBHA and their contracted service providers, and references collaboration with staff at the Regional Centers.

Service Eligibility

The System purchases services for Adults and Youth:

1. **Who are Nebraska residents:** Individuals must be Nebraska residents and have lawful presence in the United States per Neb. Rev. Stat. §§ 4-108 through 4-114 (Laws 2009, LB403) to have services funded by the RBHA through DBH. Nebraska Behavioral Health System (NBHS) providers requesting reimbursement from DBH/RBHA must verify lawful presence for any person for whom they are requesting reimbursement for services.

DHHS has designated the following services do not require attestation of lawful presence but must meet all other clinical and financial eligibility criteria:

a. Emergency Protective Custody hold,
b. Acute Inpatient Services,
c. Subacute Inpatient Services,
d. Withdrawal Management ASAM Level 3.2 or 3.7,
e. Crisis Stabilization,
f. Emergency Psychiatric Observation,
g. Crisis Response Teams, and
h. 24-hour Crisis Lines

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.

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.

RBHA and providers will track any persons who are denied due to Neb. Rev. Stat. §§ 4-108 to 4-114 (Laws 2009, LB403). DBH will report the number of persons denied services to the Legislature. RBHA will also include this provision in their subcontracts.

*Regardless of citizenship/lawful presence status, persons receiving emergency services identified above, or inpatient or outpatient treatment services mandated by a mental health board, or for individuals mandated into the care of DHHS by a court order, may be eligible for DHHS services.

2. **Who are Financially Eligible**: Financial eligibility is based on a consumer's income, family size, and their disability-related medical debt. Based on the service being accessed, one of three sliding fee schedules are used to determine the amount, if any, a consumer is responsible for paying. See Appendix A.

3. **Who are Clinically Eligible:** Individuals must be clinically eligible for services by meeting admission and utilization guidelines as outlined in the most recent version of the. Continuum of Care Manual, (when the service is authorized, and verified for clinical eligibility by DBH's Central Data System.

4. **Who are Mental Health Board Committed:** DBH funds services for individuals who are mental health board committed when no other payor source is available to fund services.

5. **Age Waivers:** With DBH approval, youth who are 17 - 18 years old who meet financial and clinical eligibility criteria, may be served in an adult service when clinically and developmentally appropriate, and when their treatment and/or rehabilitation needs can best be met in adult services. The form and instructions to request an age waiver is located on the DBH website, under the Regulations, Contracts, and Guidance tab. Please complete the form and email to the DBH Network Operations mailbox.

If a consumer is Medicaid eligible and Medicaid has denied the service, 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 guidebook.

Maintain Waitlist Data

The DBH and RBHA are required to monitor, review, and perform programmatic, administrative, quality improvement, fiscal accountability, and oversight functions regularly with all subcontractors. 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 along the continuum of care.

In addition, the Federal Substance Use Block Grant (45 CFR Part 96) requires that each state develops a process to report treatment capacity and waitlist information, ensure the maintenance of reporting, and 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 admit individuals into the appropriate recommended treatment services as soon as possible.
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 established Treatment Capacity and Waitlist Management processes as part of the Centralized Data System (CDS). Any CDS required information must be gathered by all state funded and RBHA contracted providers. The provider shall enter and maintain waitlist information into the Centralized Data System for all individuals waiting for the designated levels of treatment, regardless of payer source. The CDS User Manual provides direction on how to enter waitlist information. Providers will document the reason the individual is on the waitlist in CDS.

During monthly contract meetings, DBH will review services that have an active waitlist or services that are at or above capacity with the RBHA. Quarterly, DBH will strategize with the RBHA to address waitlist and capacity needs based upon the data collected for that quarter.

Purchasing Services

Behavioral Health Services can be purchased as follows:

i. **RBHA Contracts** - Behavioral health services are purchased through the RBHA as a result of contracts with DHHS/Division of Behavioral Health. Each RBHA then 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.

ii. **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 is contracted with the provider from 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 must have an end date, not to exceed the end of the fiscal year.

iii. **Core Services** - An ongoing Letter of Agreement for any core services as outlined in Appendix B will not be allowed unless concerted efforts to contract for the service in region were unsuccessful.

Services and Supports

Behavioral health services purchased through the Nebraska Behavioral Health 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 Continuum of Care Manual.**
2. **New Statewide Services** - An RBHA may propose new services to fill a need or gap in the state service array. An RBHA may only propose a new service when development or expansion of a service with a statewide service definition will not adequately address this need/gap. Refer to Appendix C for the process to propose a new service.
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 service 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. The RBHA will work with the provider to clearly identify how the service enhancement goes above and beyond the minimum requirements. Outcomes will be developed that directly correlate to the purpose of the enhancement. The RBHA will use the Intent to Propose document located on the DBH website. The RBHA will submit data quarterly for the approved outcomes. Ongoing funding of service enhancements are subject to realization of outcomes as proposed. Refer to Appendix C for the process to propose a Service Enhancement Plan.
4. **Plans for One** - For individuals discharging from Lincoln Regional Center, RBHA may choose to develop a Plan for One, which includes non-traditional services to facilitate discharge (Appendix D). 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. Room and board may also be paid for under Plans for One funding. Room and board requests that would fall under Plans for One funding will need required documentation submitted and approval by the DBH. Plans may be funded for individuals discharging from, or at risk to re-admit to Lincoln Regional Center.
5. **Prevention services** - Programs, policies, or practices 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 (LRC) or a substance use disorder residential service. A state rate has been established and the RBHA may pay for inpatient post-commitment care (IPPC) 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 LRC 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 funding is to obtain the items, resources, or services 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. The use of flex funds must follow the allowable cost guidelines outlined in Appendix E.

Priority Populations – Federal Funding Guidance

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 (SMI) and youth with severe emotional disturbance (SED). 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. This definition has since been amended to also exclude dementias and mental disorders due to a general medical condition.
    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 see Appendix K.

State Funded Priority Populations for Admission

Our system prioritizes admission and services for populations meeting State Priority Guidelines and Federal Block Grant Requirements. Community-based service providers will prioritize these populations for admission to services above others waiting for the service.

1. **Admission Priorities for State-level community services:**
   a. Persons who are 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

2. **Admission Priorities for Substance Use Prevention and Treatment Block Grant:**
   a. Pregnant injecting drug users
   b. Other pregnant substance users
   c. Other injecting drug users
   d. Women with dependent children who have physical custody or are attempting to regain custody of their children.
   e. All others

3. If a priority consumer who fall into categories 2.a. – c. 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) and tuberculosis (TB).

4. For all consumers on the wait list, providers may provide engagement services, which is another substance use service. It is typically a less intense service than the service they are being referred to, but that enhances the individual's motivation in the recovery process until they are 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.

CAPACITY/WAITING LIST MANAGEMENT for PRIORITY POPULATIONS for SUBSTANCE USE PREVENTION AND TREATMENT BLOCK GRANT

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 treatment. 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 requests 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.

SUBSTANCE USE ASSESSMENTS for PRIORITY POPULATIONS

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. If 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.

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 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.

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.

PART II: DIVISION OF BEHAVIORAL HEALTH RESPONSIBILITIES

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 the RBHA, including approval of regional budgets and audits of the RBHA. See Region Budget Guidelines and Division of Behavioral Health Audit Manual for details and processes.
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.
11. Ensuring the statewide availability of an appropriate array of recovery-oriented and person-centered community-based behavioral health services along the continuum of care, and the allocation of such funds to support the consumer and their 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.

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 along the continuum of care, and the allocation of such funds to support the consumer and their recovery-oriented and person-

centered plan of treatment. To accomplish this responsibility, DBH will perform the following activities:

1. **Needs assessment** - DBH conducts a Statewide Needs assessment 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 develops a 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 activities necessary to achieve the goals outlined in the strategic plan.
3. **Budget planning and contracting** - DBH develops regional budget plan guidelines for RBHAs. This outlines requirements to submit a budget plan for upcoming fiscal year contracts. DBH includes an allocation chart for the upcoming fiscal year detailing funding for the RBHA, including tax match requirements based on 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 initiates a contract for network management services and funding for services with the RGB.
4. **Auditing and oversight of services** - In collaboration with the RBHAs, DBH develops processes and protocols for oversight of services purchased. Such oversight includes 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 occurs annually to verify that services billed are tied to units of service or appropriately incurred expenses. Refer to the Nebraska Behavioral Health Audit Manual for complete guidance. RBHAs conduct reviews of their network providers. DBH conducts these reviews when purchasing services directly, and provides audit monitoring of the region.

   After the fiscal year, DBH conducts a network compliance review ensuring RBHAs met all contract conditions. Reviews occur during the 1st quarter of the following fiscal year. DBH responds in writing to the RBHA administrator within 30 days of receiving all necessary information with findings, and a request for a corrective action plan if needed.
5. **Centralized data system** - DBH maintains a centralized data and information system (CDS) 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 maintains an electronic billing system (EBS) for providers and RBHA to submit 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 maintains the Nebraska Prevention Information Reporting System (NPIRS) to gather demographic and programmatic information relating to prevention activities through the Behavioral Health system. Unless otherwise stated, contracted RBHAs and organizations who operate

under any DBH prevention funding shall enter all information related to prevention programming within 30 days of the activity. DBH provides reports, as needed, to analyze the programs, policies, and activities occurring across the state to help support National Outcome Measures (NOMS).

8. **Rates and reimbursement** - DBH establishes rates to be paid and reimbursement methodologies for behavioral health services contracted by the RBHAs. DBH also develops a financial eligibility policy and fee schedules for RBHAs to use when establishing RBHA fee schedules. A RBHA fee schedule may not deviate from the parameters set by DBH.
9. **Service development** - DBH monitors the RBHAs service development processes, including approval of bidding processes and intent to contract with providers, adherence to regulation for bidding, and other service development processes, as reflected in Nebraska Revised Statute 71-809.
10. **Continuous quality improvement** - DBH defines CQI as an ongoing process of using data to plan, identify opportunities for improvement, implement changes, study, and analyze results, and celebrate improvements. DBH provides leadership for system improvement which is data-driven and serves to further the statewide strategic plan.
11. **Systems coordination** - DBH provides 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, a provider must submit a written request to their RBHA. The alternative compliance form and instructions are located on the DBH website.

    DBH bases a determination for alternative compliance on the following information:

    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.
    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

Roles and Functions of the Regional Governing Board

The Regional Governing Board (RGB) is established in each RBHA by the counties governing 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 are reimbursed for their actual and necessary expenses. The primary functions of the RGB 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 RGB, 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 occur during the year.
    b. Assure additional tax match can be matched, if necessary.
    c. The RGB may authorize submission of a preliminary RBP, by the Regional Administrator, prior to final RGB approval. Contracts will not be issued without final RGB approval.

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 meeting 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 an RBHA quality assurance or improvement plan.
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 in physically accessible offices and provide all materials in accessible formats as required by the 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.

RBHA Network Management

1. **Needs assessment and strategic planning** - The RBHA will participate in DBH's strategic planning process (page 15), including a needs assessment for target population(s) 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 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). Service Standards for Participation in Network Initiatives is located in Appendix F. Prior to conducting a public bidding process for a new behavioral health service, the RBHA must follow the Guidelines For Service Expansion and New Service Development located in Appendix C.

   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.
3. **Network enrollment requirements** - The RBHA shall develop policies and procedures to determine eligibility for enrollment consistent with requirements in Appendix F.
4. **Division of Behavioral Health notification** -
   a. **The RBHA must notify DBH of Service Changes -** The following changes require written notification to the RBHA within 20 days:
      i. A service provider terminating a service that was approved in the RBP.
      ii. Any changes regarding services offered by the Regional Governing Board and/or a provider which are different from the approved regional budget plan.
      iii. Any changes in ownership, the governing body's responsibilities, or structure; or
      iv. Any changes in control of program(s), 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:**
A Sentinel Event is defined as death or serious injury to any current RBHA funded consumer.

i. In the event of death or serious injury to any RBHA-funded client currently in our system, providers will notify the RBHA, who will in turn notify DBH no later than 48 hours after receiving notification of the incident, including all information requested by the DBH.

ii. RBHA may use this information in oversight of service delivery and to ensure continuity of care, and:
   a. Follow up with providers regarding sentinel events 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, and internal and external reporting requirements;
   b. RBHA shall conduct an annual analysis of all sentinel events reported by providers to the RBHA. 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.

iii. DBH, based upon the RBHA's reports, may develop a statewide summary, including trends and causes of sentinel events, and any appropriate remediation.

iv. The RBHA will require providers to have a written policy regarding:
   a. Definition of a sentinel event,
   b. How to investigate, including follow up;
   c. Documentation requirements, and
   d. Notifications required when a sentinel event occurs

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

5. **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 relating to the provision of behavioral health services. The RBHA must establish and maintain a separate budget and account for all revenue and expenditures for the provision of the service.

6. **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. Soliciting or accepting 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.
e. Uses, or attempts to use, any official position to secure unwarranted privileges or exemptions for themselves or others.
f. Assisting or encouraging consumers in an endeavor that directly benefits the provider or RBHA.
g. Having a financial interest in the consumer's business or employment arrangement.
h. Using consumers to conduct business or services that results in profit to the provider or RBHA.
i. Providing financial or personal assistance to consumers beyond that which the provider or RBHA has agreed to provide under the service agreement.
j. Recommending purchases to consumers or employees of RBHA from companies in which the provider or provider's family has any financial interest.
k. Using their position to secure personal or business privileges from consumers or employees of the RBHA.
l. Offering or giving to consumers anything of value, including a gift, loan, contribution, or reward beyond what is provided under the service agreement.

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 identify, report, and resolve potential conflicts of interest. Additionally, the RBHA must demonstrate compliance with regulations in NAC 206 regarding conflicts of interest. All disclosures, reports, and resolutions must be in writing and be available for review by the DBH.

7. **Participation in Nebraska behavioral health system meetings** - RBHA will attend and participate in meetings that support the development, coordination, maintenance, and monitoring of goals and activities developed by DBH in conjunction with the RBHA.
8. **Regional Governing Board and Regional Provider Meetings** – The RBHA will provide DBH with a schedule of Regional Governing Board and Regional Provider Meetings for each Fiscal Year.

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 and monitor local community coalitions, other community-based partnerships and 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, decrease risk factors, and build prevention capacity and infrastructure at the state/tribal and community level. Prevention activities shall also be culturally and linguistically appropriate.

b. Prevention initiatives funded through the DBH must follow the strategic prevention framework and IOMs, as defined in the Prevention System Manual.

c. Funded prevention initiatives will include strategies that address the priority population 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 and monitoring of funded prevention community-based partnerships in the RBHA and organizing and preparing any supporting documentation required by the Department.

2. **Justice BH/Emergency Coordination** - The RBHA will provide leadership and resource development with system partners to improve diversion, engagement, connection, and intervention of services by successfully promoting access, coordinating, and sustaining a community-based emergency and crisis service system designed to meet the complex needs of individuals experiencing a behavioral health crisis or emergency by building a robust prevention, treatment, and recovery system. Expectations include:

   a. Identification of behavioral health crisis system cores services.

   b. Capacity Development with system partners for a prevention continuum including, suicide prevention, treatment, recovery, adult, youth, and integrated systems of care.

      i. Partnering with the Administrative Office of the Courts and Probation (AOCP), Justice Behavioral Health Partners, etc.

      ii. Continue to strategize/recommend capacity development related to 988 "someone to call, someone to respond, somewhere to go" partnerships. Core services have been identified with due dates as to when an RFP must be issued (see DBH/RA Communication #26). Crisis/Emergency services development including opportunities to connect individuals for Psychiatric Emergency Observation, urgent care, open access appointments, same day services, etc.

      iii. Identify strategies to divert individuals from emergency rooms and jails.

   c. Coordinate activities and collaborate with community-based partners to ensure that individuals experiencing a behavioral health crisis receive the least restrictive and most appropriate level of care and services located within their community.

   d. Collaborate with county attorneys and local mental health boards on system issues, identified through individual cases and/or aggregate data.

   e. Partner on strategies to improve system flow to and from all levels of care.

i. 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 (LRC)).

ii. Review/monitor referrals made to the LRC Mental Health Board waitlist by working with the community-based hospitals and/or 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 crisis centers to make sure the necessary admissions paperwork is filled out and submitted to the Network Administrator (currently not being submitted to RA's) and/or designee and LRC. Partner in the development and implementation of specialized discharge planning to facilitate timely discharge of consumers receiving treatment at LRC.

iii. Consult with Department of Corrections' staff as requested to assist with discharge planning for consumers who are clinically and financially eligible, and who have citizenship/lawful presence, from correctional facilities.

iv. Participate in decreasing the LRC Court waitlist through promotion of diversion strategies, connections to services, and development of community-based options to help decrease higher levels of care.

v. Promote Sequential Intercept Mapping and/or Stepping Up initiatives. Continue to partner with, and develop, early intercept services, supports, and processes at the local level.

f. Engage in activities that promote quality improvement by reviewing emergency system data, preparing reports, monitoring outcome measures, and providing technical assistance to community providers when needed, and as appropriate.

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

h. Assist DBH with implementing and operationalizing a bed registry strategy within the Region.

i. Ensure consumer level data for the Emergency System is submitted through the CDS or other data systems as designated by DBH.

j. Emergency coordinators will work with the Division of Behavioral Health (DBH) to ensure effective delivery of community-based, crisis-prevention, and crisis response system services. Emergency coordinators will distribute and ensure utilization of the 988 Manual. Emergency coordinators will ensure providers are entering consumer data in the Central Data System (CDS) in a timely manner, as reflected in the 988 Manual.

3. **Youth System Coordination** - The RBHA will collaborate with DBH and youth serving agencies including the Division of Children and Family Services, Managed Care Organizations, and the AOCP in planning, and developing the system of care infrastructure for youth and families experiencing behavioral health disorders. Expectations include:

a. Expand behavioral health services for youth in each Region based upon needs as identified by stakeholders and any needs assessments conducted.

b. Engage in activities that promote quality improvement by participating in statewide youth system coordination and providing technical assistance and as appropriate to providers to increase the ability to incorporate system of care principles into their practices.

c. 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.

d. Work with providers on co-occurring capability of youth services so families receive an integrated treatment approach.

4. **Consumer System Coordination** - The RBHA will participate in the development of regional and/or DBH planning for recovery-oriented community-based services, which promote and facilitate educational opportunities & other activities that enhance recovery, resiliency, and whole health wellness for consumers and their families. Expectations include:
    a. Works in a close collaborative relationship with state administrator to address and identify the needs of Consumers within the RBHA.
    b. Engage in activities that promote quality improvement and provide technical assistance specifically as it relates to implementation of recovery-oriented systems of care and trauma-informed care.
    c. Utilize personal lived experience to advocate for voice and choice, integration of consumers as a priority, reduction of behavioral health stigma, facilitation of meaningful involvement of consumers and their families, and in the development of program policies and procedures. Provide quarterly reports to the Office of Consumer Affairs that captures these activities.
    d. 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.
    e. Manage and maintain a behavioral health consumer advisory committee that meets quarterly. This shall include, but not be limited to, maintaining a charter, application procedures, and participation expectations.
    f. Provide assistance, coordination and opportunities for consumer feedback and participation in statewide and RBHA events and initiatives.
    g. Participate in the RBHA grievance procedures and policies including coordination with the Office of Consumer Affairs.
    h. Report on engagement through the provision of education to consumers. These reports would include type of education/training, number of participants and satisfaction of those taking the education/training.
    i. Attend monthly meetings with state administrators. These meetings will address state and regional collaboration and contract compliance.

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 Supported Housing 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 Supported Housing 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 that is 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 a disaster. See the Statewide Disaster Plan - the Nebraska Behavioral Health All-Hazards Disaster Response & Recovery Plan.

7. **Continuous Quality Improvement Coordination**

   RBHA engagement and participation with DBH and other state partners promoting efficient data collection processes, effective data reporting and analysis, development of infrastructure to drive change, including, but not limited to, RQIT, State Quality Improvement Team (SQIT), and cross system CQI infrastructure.

   Improve the efficiency and effectiveness of services, including, but not limited to:

   a. CDS/EBS functionality
   b. Reviewing required fields and address high number of unknown responses.
   c. Inventory and create alignment of state and national outcome measures. This relates to driving value per the behavioral health system strategic plan.
   d. Value based contracting initiatives.
   e. System flow and crisis system metrics.
   f. Aligning data dashboards
   g. Data report development and implementation
      i. Familiar faces
      ii. EPC diversion and increase days between EPCs
      iii. Community tenure
      iv. Readmissions
   h. Refresh consumer surveys and align with DBH strategic plan to improve consumer and family voice in the planning and evaluation of services.

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 throughout 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. Refer to the appropriate Fiscal Year's Region Budget Plan Guidelines for more information.
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). The RBHA will compare this drawdown to the 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/adjustments per contract requirements.
3. **Billing and Payment Basics** – RBHA will follow the Billing and Payment Basics document, see Appendix H.
4. **Actuals** - The RBHA will submit an annual report demonstrating the amount of all funds expended in the contract, including state, federal, and other funding sources expended by the RBHA and their subcontractors/subrecipients for behavioral health services no later than September 1 following the close of the fiscal year. See Appendix I for instructions on RBHA Actuals.

Network and Provider Monitoring

The RBHA is required to monitor, review, and perform programmatic, administrative, quality improvement, and fiscal accountability and oversight functions regularly with all subcontractors. If the RBHA is a direct provider of services, the DBH is responsible for the oversight functions for the services provided directly by the RBHA.

A. **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 to provide an appropriate array of services/continuum of care:

   a. Demographics of the RBHA
   b. Target population(s) to be served
   c. Mix of adult and youth services
   d. Access for consumers with health disparities
   e. Utilization by levels of care and service
   f. Capacity and waitlist data
   g. Provider denial of service information

B. **Evaluation of service delivery** - Systematic evaluation of provider service delivery assists the RBHA in determining whether to retain/recontract with a currently contracted service provider. Contractor retention is to be determined through a performance review that includes the following at a minimum:

   a. Evidence of continued capacity to provide behavioral health services as outlined in the 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. Inclusion of consumers in development, implementation, and evaluation of services.

NOTE: The RBHA will notify DBH and follow requirements found in 172 Nebraska Administrative Code (NAC) if a licensed provider or licensed clinician as defined by 172 NAC 94 in the network has a licensure denied, revoked, suspended, or refused renewal in any service and/or, places a consumer in imminent jeopardy of their health and safety. The RBHA will take the following next steps:

- If the licensure issues are with the agency, the RBHA will terminate any contract and agreement as appropriate.
- If the licensure issues are with an individual provider/clinician, the RBHA will work with the contracted agency to ensure that the provider/clinician does not serve any DBH funded individuals.

C. **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 conducted by a certified public accountant, if deemed necessary according to federal and/or 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.

D. **Internal monitoring process** - The RBHA will use internal measures for oversight of services purchased through the contract between DBH and the RBHA, and include as appropriate:

   a. Services purchased verifications (unit/expense reimbursement).
   b. Program fidelity reviews to monitor compliance with the service definition and other state regulatory guidelines.

See the DBH Audit Manual for additional information.

E. **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 awards.
   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).

F. **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 J.

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.

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, as such, the RBHA will hold itself and its network treatment providers accountable for data accuracy and ensure data requirements are completed in full as specified by DBH. Additional data reporting requirements may be included in contracts or an alternative 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) 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 to demonstrate progress towards 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 where 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 within 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: Financial Eligibility Policy
Department of Health and Human Services (DHHS)
Division of Behavioral Health (DBH)

FINANCIAL ELIGIBILITY POLICY

Effective Date: 3/1/98

Revision Date: 6/1/01, 4/1/02, 1/30/03, 11/13/07, 7/18/12; 11/20/12; 7/26/2021; 11/20/2021; 5/23/22

Purpose: The Department of Health & Human Services Division of Behavioral Health has established Financial Eligibility Standards for consumers of behavioral health services. The Division of Behavioral Health will reimburse service providers for mental health and substance use disorder services for consumers who meet clinical eligibility criteria and who meet the following financial eligibility criteria. "Each regional behavioral health authority shall adopt a policy for use in determining financial eligibility of all consumers and shall adopt a uniform schedule for fees and copays, based on the policy and scheduled developed by the Division to be assessed against consumers utilizing community-based behavioral health services in the region…. Each regional behavioral health authority shall assure that its policy and schedule of fees and copays are applied uniformly by the providers in the region." (Neb. Rev. Stat §71-809, Sec 2)

Rationale: Pursuant to Nebraska Revised Statutes §71-804, §71-806 and §71-809, as amended; to ensure compliance with same.

I. Payer of Last Resort

1. The Division of Behavioral Health is the Payer of Last Resort for behavioral health services for consumers who meet:

a. Financial eligibility criteria as specified in this policy and Fee Schedules;

b. Citizenship/lawful presence as defined by Neb. Rev. Stat. §4-108 to 4-114 and living in the state voluntarily with the intent of making Nebraska his/her home; and,

c. For individuals regardless of citizenship/lawful presence status receiving emergency services or inpatient or outpatient treatment mandated by Mental Health Board or for individuals mandated into the care of DHHS by a court order.

2. The Division of Behavioral Health will not reimburse:

a. For Medicaid and Medicare eligible services provided to eligible consumers. If the consumer has accrued personal needs allowance and creates savings that disqualify him/her from a benefit such as Medicaid, the full cost of the service must be assessed to the consumer until he/she qualifies for the Medicaid benefit. No additional compensation in excess of the amount paid by Medicaid or Medicare claim may be billed to the Division.

b. For any portion of services required to be paid by a Medicaid recipient to meet a share of cost obligation.

c. For mental health or substance use disorder services that are eligible for or covered under other health insurance benefits, including Medicare, that were denied by an insurance company due to provider error or insufficient documentation, that were not submitted to the insurance company as outlined in Section II. or that was not submitted to the insurance company by request of the consumer.

d. For any service in which the consumer is deemed eligible to pay the cost of the service.

II. For any authorized service in which the consumer does not have documented authorization as required by the Division. **Services Paid by the Division of Behavioral Health**

1. For persons who meet the Division's clinical eligibility and financial eligibility criteria, the provider will be:

a. Paid the rate set by the Division of Behavioral Health for services provided which are pre-authorized within the Division's Centralized Data System (CDS) or registered services that have a statewide rate established.

b. Paid a Region-determined rate for services provided which are registered with the CDS and approved by DBH;

c. Paid or reimbursed for allowable uncompensated expenses (expense reimbursement) for services provided which are registered within the CDS or otherwise documented as required by the Division of Behavioral Health, not to exceed the actual cost of the service less any copayment and third-party payment received for the service.

d. Paid for denied insurance claims only for the conditions and parameters cited in II.1.d.1 through II.1.d.13 below.

1. The provider may bill the Region or Division for services performed for consumers eligible for DBH funded services after the denial of insurance benefit has been received as long as conditions in this section are fully met.

Failure to meet any conditions, including failure to complete a pre-authorization as required by the insurance company, will result in denial of payment for the claim.

2. Denied claims for a service may be billed to the Division as long as:

   i. All services performed were submitted to the insurance company within sixty (60) calendar days after the date of service and the date of submission documented for subsequent review and tracking.

   ii. The denial is not due to provider error or for failure to submit required information.

   iii. The denied claim is subsequently billed to the Division within sixty **(**60**)** calendar days of receiving the insurance denial. If the billing cannot be submitted due to the consumer's admission date being greater than 90 calendar days in the past, the following timelines apply:

      a. A CDS change request must be made to Division within sixty **(**60**)** calendar days of receiving the insurance denial; and,

      b. The billing to the Division must be made within **(**60**)** calendar days of receiving confirmation the CDS admission date has been changed.

3. The provider may also, at the risk of violating any third party or insurance company agreement, bill allowable costs incurred in the performance of services that may be covered by the Division prior to billing any third party or insurance company. In doing this, the provider assumes all risk and penalties associated with any act that may be deemed a violation of a third-party agreement or insurance company agreement and may not bill any penalty or subsequent loss of revenue for services to individuals ineligible for DBH services to the Division. The Division reserves the right to seek reimbursement for any payment for which it would have been eligible for if the third-party agreement or insurance company agreement had not been violated.

4. Except when it may pose a danger to the consumer (see II.B.7), before any cost incurred in the performance of services that may be covered by a consumer's insurance can be billed to the Division, all services performed must be submitted to the insurance company within 60 (sixty) working days after the date of service and the date of submission documented for subsequent review and tracking.

5. After the service is billed to the Division, if the service is subsequently deemed to be covered by insurance and payment is remitted to the provider for the provision of the service, all funds received from the Division for the date of service being reimbursed must be reimbursed back to the Division on the next payment request.

6. If the service is deemed not covered by insurance or payment is denied due to the consumer's deductible not being met, a copy of the Explanation of Benefits must be placed in the consumer's file.

7. Once a consumer deductible has been met and the insurance company submits payment for services to the provider, no additional costs beyond this payment may be billed to the Division. This provision may be waived at the sole discretion of the Division only for an individual on a Plans For One that is coming out of or is at risk of going into the LRC. Requests may be submitted to DBH to allow the Region to pay the consumer's coinsurance balance after their deductible has been met.

8. A provider may bill for services rendered to a consumer that has exhausted all insurance benefits if the person continues to meet financial eligibility criteria, the service is deemed medically necessary by the insurance company for treatment and timelines identified.

9. In the event a provider receives insurance payments after the end of the fiscal year for services paid by the Division in the previous year, the provider must reimburse the Division these funds on the next payment request to the Region.

10. In the event an agency is ceasing operation or will no longer be under contract with a Region prior to all insurance claims for DBH eligible consumers being processed, prior to the end of the contract, the Region must review all documentation to determine an estimated amount of funds that may be due to the Division and this amount be subtracted from the final bill submitted by the provider to the Region for payment by the Division. The Division also reserves the right to conduct this review and determine the amount to be reimbursed for any service provided by the Region or if a Region fails to conduct the review.

11. A provider may waive the filing of insurance forms if doing so will pose a danger to the consumer and the waiver is documented on the eligibility worksheet provided by DHHS or in the consumer's file if an alternative worksheet is utilized. Situations where this can happen include instances when domestic violence or child abuse is happening in the home.

12. Summary of benefits and coverage may be obtained from the consumer. It may be necessary to assist the consumer by assisting in contacting the insurance company.

13. Preauthorization may be obtained via written or telephone contact with the insurance company. If the preauthorization is being obtained via telephone, two staff persons from the provider are required to document the date, time, services, and approval or reason for denial from the insurance agency. This documentation must be entered into the consumer file.

III. Terms

1. For the purposes of financial eligibility:

a. **Taxable Income** is defined as alimony, wages, tips, or other money received for a good or service. This information can be obtained by review of, paycheck records, SSI/SSDI eligibility, Medicaid eligibility, and/or a signed statement from the client. For purposes of the Eligibility Worksheet, the taxable income of the consumer and other adult dependents should be used to determine Taxable Monthly Income. For the purposes of completing the Eligibility Worksheet, the following items are not included as taxable income: SSI, SSDI, child support or monetary assistance received from family or non-family members.

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

c. **Liability** is defined as money owed to another person or agency to secure items such as housing or transportation and is limited to liabilities included on the Eligibility Worksheet. The information can be obtained by review of previous monthly statements or a signed statement from the consumer.

d. **Client Fees** is defined as any Co-pay, Room and Board Fee that is required to be paid to receive the service.

e. **Co-pay:** Also known as copayment; fixed amount required to be paid for each appointment or unit of service. The co-pay amount may not exceed the amount designated by the DBH or the Region for the service.

f. **Room and board**: Fixed per day amount required to be paid by the consumer for meals and the use of a bed in residential facilities. The room and board fee may not be in excess of actual costs incurred for these services by the provider.

g. **Dependent**: Any person married or cohabitating with the consumer or any child under the age of 19 who depends on the consumer's income for food, shelter and care. Dependents may include parents, grandparents or adult children if the individual(s) are living with the consumer, and they are dependent on the consumer's income for their food, shelter, or care.

h. **Daycare**: Refers to the funds paid to a place, program, organization or other third party for the care and well-being of one or more children under the age of 19 while parent(s) or other primary caregiver is working, in school, or in treatment.

i. **Rate** is defined as a) the rate set by the Division of Behavioral Health for services provided which are pre-authorized with the Administrative Services Organization or registered services that have a statewide rate established; b) a Region-determined rate for services provided which are registered with the Administrative Services Organization (ASO) or otherwise documented as required by the Division or Region.

j. **Cost** refers to the specific expenses incurred by an agency for providing a unit of service or the average costs of serving all customers within a given service when a Division or Region rate has not been determined for reimbursement purposes.

This includes personnel, occupancy, supplies, administrative expenses, and similar types of expenditures. In determining the specific costs, a provider may include a substantiated allowance for uncollectible client fees but may not include funds in excess of actual cost (i.e., profit) per state regulations.

IV. Consumer Eligibility:

1. Prior to billing the Region and/or Department, the provider must determine if the consumer is financially eligible for the Division of Behavioral Health to pay for services. The Division of Behavioral Health and/or the Network Manager may request verification of consumers' financial eligibility from any provider.

2. To determine if a consumer meets financial eligibility criteria, on the HHS/Division of Behavioral Health Financial Eligibility & Fee Schedule:

a. Complete the Eligibility Worksheet for the consumer to determine the Adjusted Monthly Income amount.

b. Locate the adjusted monthly income amount on the schedule.

c. Locate the total number of family members dependent on the taxable income.

d. Consumers who by Adjusted Monthly Income and number of family members dependent on the taxable income fall within the shaded areas on the chart are eligible for services funded by Division of Behavioral Health. Costs (as defined in Section II) associated with performance of services to eligible consumers may be billed to the Division.

e. Consumers who by Adjusted Monthly Income and number of family members dependent on the taxable income fall within the un-shaded area of the HHS/Division of Behavioral Health Financial Eligibility Schedule are not financially eligible for payment by the State. No costs associated with performance of these services may be billed to the Division.

V. Copayment Amount:

1. To determine the maximum copayment to be requested from a consumer, on the DHHS/Division of Behavioral Health Financial Eligibility Schedule:

a. Locate the Adjusted Monthly Income amount on the appropriate schedule:

i. **Hardship Fee Schedule**: For individuals who have met one or more of the hardship criteria.

ii. **Emergency Access Services Fee Schedule**: For individuals receiving assistance from Crisis Response Team, Emergency Community Support, Housing Related Assistance, 24-hour hotlines, or in a peer run hospital diversion program where individuals can stay less than 24 hours.

iii. **Financial Eligibility Fee Schedule**: For all individuals eligible to receive DBH funded services but who are not eligible for other approved fee schedules.

b. Locate the total number of family members dependent on the taxable income.

c. The box where the column and row intersect is the amount or rate that can be charged to the consumer for each appointment or unit of service.

d. The RBHA shall adopt a policy for use in determining the financial eligibility of all consumers and shall adopt a uniform schedule of fees and copays, based on the policy and schedule developed by the Division, to be assessed against consumers utilizing community based behavioral health services in the region. Each RBHA shall assure that its policy and schedule of fees and copays are applied uniformly by the providers in the Region.

VI. General Provisions

1. A provider may not deny service to an individual solely on the basis of inability to pay a copayment. If a consumer is determined to have the ability to pay and is charged a copay amount, as determined by applying the Adjusted Monthly Income from the Eligibility Worksheet for NBHS Funded Service to the appropriate Fee Schedule (see Section V, Item A), but refuses to pay or is in arrears for the copayment amount, the provider may decline services to the individual until they have remitted payment(s).

2. The assessment of a consumer's financial eligibility is an ongoing process. The consumer's financial eligibility status must be re-assessed annually or when known changes occur such as changes in taxable income or number of dependents. The re-assessment may increase or decrease the co-pay obligations of the consumer.

3. Consumers who refuse to provide financial information shall be charged full cost of services. The provider may not bill the Division of Behavioral Health for any service for which the consumer is responsible due to failure to provide financial information or signed statement.

4. Any fees or copayments for Substance Abuse Education and Diversion programs are determined by the Region or other provider and are not subject to provisions of this policy.

5. Residential levels of care will receive payment based on the Division's established rates. In addition to room and board fees, a copayment may also be assessed. Room and board fee may not be in excess of actual costs (as defined in Section III.1.f) incurred for these services by the provider. All copayments charged must be in compliance with the DHHS Division of Behavioral Health Financial Eligibility and Fee Schedule.

6. For persons on whom payment of such fees would impose extreme hardship, an alternative fee schedule developed by the Division may be used following the same method as describe in Sections IV and V. Criteria for "hardship" will include:

a. Severe and persistent mental illness

b. Serious emotional disorder in youth 19 or under

7. Medical bills or medical debt in excess of 10% of the taxable annual income (as determined by taking (Taxable Monthly Income x 12) x 10%). A hardship may not be granted for non-medical related debt. If required, documentation of the debt may be obtained from statements or invoices from hospitals, doctors, labs, pharmacy, or similar medical related entities. Debt that is not medical in nature may not be used to determine eligibility for hardship.

8. Eligibility for the alternative hardship fee must be clearly documented on the Eligibility Worksheet.

Appendix B: Core Service Expectations

A. **Core Service Requirements**

Effective as of January 15, 2024, the Division of Behavioral Health will begin the process of bringing core services online in each of its regions. Regions shall show evidence of attempting to bring services online by way of RFI. If a provider shows interest, an RFP must be submitted.

If the RFP does not render a provider, the regions may contract out of the region to provide the service or may provide the service themselves. **If the service is being offered in your region by a provider not enrolled with the RBHA, the RBHA must utilize a LOA process to address individual consumer needs for this service. All providers must meet network enrollment standards.**

B. **FAQ:**

Can existing providers add a new service without an RFP? No, an RFP must be issued for all new services.

Can a region contract from an RFI if only one provider responds? A provider cannot be directly contracted off an RFI, an RFP must be submitted. An RFI or RFP must be released annually for any Core Service not in existence in the region. An Intent to Propose document does not need to be submitted for these specific core services listed below.

THE TIMELINE FOR ESTABLISHING THESE SERVICES IS AS FOLLOWS:

1. **Mental Health Core Services - Phase 1 (RFI/RFP by July 1, 2024)**
   24 Hour Crisis Line
   Acute Inpatient Hospitalization (Adult)
   Mental Health Assessment and Addendum (Adult and Youth)
   Community Support (Adult)
   Crisis Response (Adult and Youth)
   Day Support (Adult) **or** Day Rehabilitation (Adult)
   Emergency Community Support (Adult)
   Medication Management (Adult and Youth)
   OP Psychotherapy: Individual, Group, Family (Adult and Youth)
   Mental Health Peer Support (Adult)
   High Fidelity Wraparound (Professional Partner Program) (Youth)
   Supported Employment (Milestone 5/Extended Services) (Adult)

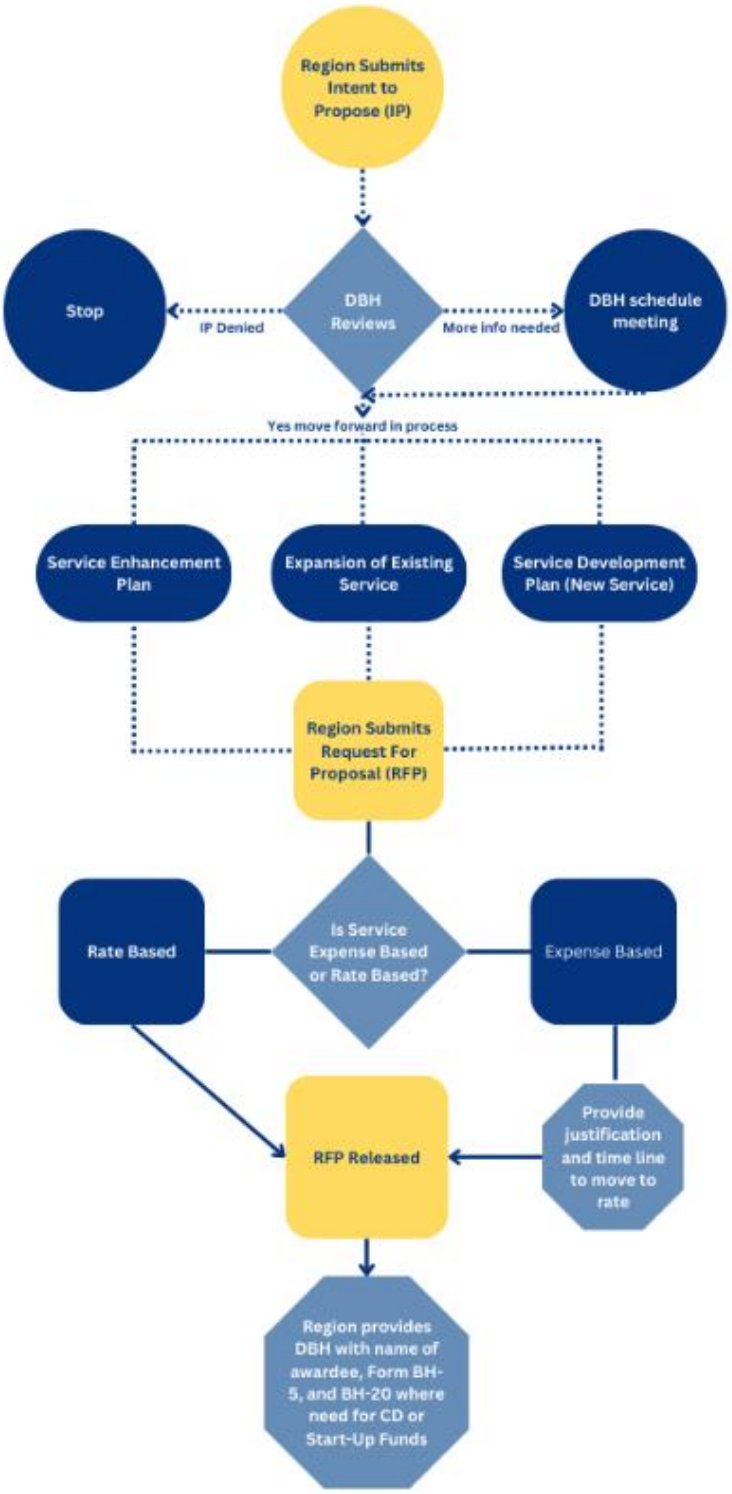
2. **Substance Use Core Services - Phase 1 (RFI/RFP by July 1, 2024)**
   SUD Assessment and Addendum (Adult and Youth)
   SUD Community Support (Adult)
   SUD Intensive Outpatient (Adult)
   MAT for Opioid and Alcohol (Adult)
   SUD OP Psychotherapy (Individual, Group, Family) (Adult and Youth)
   Social Detox (Adult) **or** Medically Managed Inpatient Withdrawal Management (Adult)

3. **Mental Health - Phase 2 (RFI/RFP by January 1, 2025)**
   Crisis Stabilization (Adult)
   ACT or Intensive Community Services (Adult)
   Mental Health Respite (Adult)
   Substance Use - Phase 2 (RFI/RFP by January 1, 2025)
   Halfway House (Adult)
   Short-term Residential (Adult)

4. **Mental Health - Phase 3 (RFI/RFP by July 1, 2025)**
   Dual Disorder Residential (Adult)
   Psych Residential Rehabilitation (Adult)

5. **Substance Use - Phase 3 (RFI/RFP by July 1, 2025)**
   SUD Peer Support (Adult)
   Therapeutic Community SUD (Adult) **or** SUD Intermediate Residential (Adult)

Appendix C: Guidelines For Service Expansion, New Service Development, Service Enhancements, and Rate Enhancements



FLOWCHART DEFINITIONS:

A. Intent to Propose (IP) - provides upfront information to determine if a proposal should move forward or indicate need for changes in DBH systems. Form is located on the DBH website.
B. Service Enhancement Plan (SEP) – used when the intent of the funding is to provide additional support, above and beyond, for providers to deliver services.
C. Expansion Of Existing Service (EES) - utilized when the proposed service is an existing service in DBH's continuum of care manual and the intent is to increase capacity (add providers, increase units, etc.).
D. Service Development Plan (SDP) - used when the approved proposed service does not currently exist in DBH's Continuum of Care Manual.
E. Request For Proposal (RFP) - required in all instances when a region is expanding capacity for existing services, proposing a pilot/new service, or rendering an existing service in their catchment area.
F. Capacity Development Funding (CD) – used only for expense-based services to supplement provider operating cost until progress is made to move the payment method from expense-based to rate based.

1. INTENT TO PROPOSE (IP)

The first step in the process is submission of an Intent to Propose (IP). An IP is a foundational document that serves as basis for future documents in the proposal development process. The document is intended to provide upfront information to determine if a proposal should move forward or indicate need for changes in DBH systems. The information from the IP can be re-used in future documents (SEP, EES, RFP, CD, etc.) to save time. The IP will be used to propose Region Initiative Trainings. Please note Region Training Initiatives are not intended to be for Region staff.

The IP should include the following:

1. Program Narrative
    a. Describe the program to be funded and the need for the program using current data and why this need would logically lead to the development of the program being proposed.
    b. Describe the target population to be served and provide specific details about demographics and the behavioral health conditions addressed by the services (MH, SUD, Both).
2. Budget Overview
    a. Estimated cost, including if the service will be reimbursed on an expense or fee for service basis and provide rationale. Identify the type of funding to be used (Federal, Opioid, etc.).
3. Service Information*
    a. Indicate if a new service is being proposed or if an existing service will be used. If a new service, provide rationale as to why the service could not be met by an existing service in the Continuum of Care Manual.

Process Comment: *DBH (Network, Clinical, and Fiscal) will review IP document and render a response within seven days. Responses include: Move to Next Step, Denied, More Information Needed.*

***This step is not required for Region Initiative Trainings.**

2. SERVICE ENHANCEMENT PLAN (SEP), EXPANSION OF EXISTING SERVICES (EES), OR SERVICE DEVELOPMENT PLAN (SDP)

The next step in the process depends on the type of plan being proposed in the IP. There are three types of plans utilized in this phase of the process; a) Service Enhancement, b) Expansion of Existing Services, or c) Service Development.

A. SERVICE ENHANCEMENT PLAN

A Service Enhancement Plan is utilized when the proposed service is an existing service in DBH's Continuum of Care Manual.

A SEP should include the following:

a. Program narrative (taken from the IP)
b. An evaluation process.
c. Service enhancement outcomes
d. Itemized operating budget and budget narrative for the service(s). Use Forms BH20 (Appendix L) to develop the detailed budget for the service enhancement.

Process Comment: *DBH will review SEP document and render a response within seven days. Responses include: Approved, Denied, More Information Needed. Approvals will move to the next phase which is either Request For Proposal (RFP) Development or to submit a shift. During review, DBH will assess if there has been a demonstrated need for expansion by reviewing the Region's budget, past billings for this service, waitlist and capacity reports.*

B. SERVICE DEVELOPMENT PLAN (SDP)

A Service Development Plan (SDP) is used when the approved proposed service does not currently exist in DBH's Continuum of Care Manual. The plan must outline data that justifies the needs for the service, a funding model, and an explanation as to how existing services in the Continuum of Care Manual does not meet the existing need. Regions will be expected to provide the following:

A. Service Definition:

Must follow formatting structure as other service definitions outlined in the Continuum of Care manual to include:

a. Service Name
b. Funding Source - Outlines the primary funding source for the service (Default is "Behavioral Health"
c. Setting - Defines the setting, such as a community setting, facility, hospital etc.
d. Facility or Professional License - Defines the license required of the facility or individual offering the service (Default is "As required by the DHHS Division of Public Health")
e. Basic Definition - Provides a narrative overview of the services explaining the intent, goals, and purpose of the service.
f. Service Expectations -
    1. Outlines the specific requirements and activities for implementing the service, including deliverables and

documentation that will be audited as a part of the provision of the service.
2. Must clearly outline required documentation for the service. Ex: Assessments, screeners, treatment plans, and progress notes.
3. Services must acknowledge delivery in a culturally competent manner.
4. Services must acknowledge crisis services are made available 24/7.

g. Length of Services - Outlines anticipated length of stay.
h. Staffing - Must Include roles eligible to render the service.
i. Staffing Ratio - Ratio of staff to individuals served.
j. Hours of Operation - Hours of Operation for the Program
k. Individual Desired Outcomes - Anticipated outcomes for the individual served following the service being rendered.
l. Admission Criteria - Clinical criteria for the individual to be eligible for the service.
m. Continued Stay Criteria - Criteria by which the individual will be reviewed to remain in the service.

B. Service Justification
   a. What data or information specifically justifies the need for a new service?
   b. Why are services in the existing service array insufficient to meet the need?
   c. If the service is an evidence-based practice, is there a plan to monitor adherence to the model? Are all components present? (ex: audit criteria, service fidelity review)
   d. Is the service an authorized service? If so, is a utilization management process indicated?

Process Comment: *DBH will review the SDP document and render a response within seven days. Responses include: Approved, Denied, More Information Needed. DBH will meet with regions to render technical assistance as needed. Approvals will move to the next phase which is RFP Development and initiate service build in data systems.*

C. SERVICE EXPANSION PLAN (SE PLAN)

A Service Expansion Plan is required when a region wants to expand capacity of an existing service in their service array. When the intent is solely to shift funding, the Region will be directed to submit a Shift Form for the service. When the intent is to increase capacity (add providers, increase units, etc.), an RFP is required.

A SE Plan should include the following:

a. Program narrative (taken from the IP)
b. An evaluation process.
c. Service enhancement outcomes
d. Itemized operating budget and budget narrative for the service(s). Use Forms BH20 (Appendix L) to develop the detailed budget for the service enhancement.

D. RATE ENHANCEMENT PLAN (REP)

In exceptional cases, there may be a request to pay an additional rate on top of an established unit rate. This request is appropriate when the Rate Enhancement would support better consumer outcomes. Like a Service Enhancement Plan, a Rate Enhancement is only utilized when service provision is above and beyond what is outlined in the service definition in the Continuum of Care Manual. Rate Enhancement funding is not intended, and should not be used, to establish a new service or expand the capacity of an organization or service.

A REP should include the following:

a. Program narrative (taken from the IP)
b. An evaluation processes.
c. Service enhancement outcomes
d. Itemized operating budget and budget narrative for the service(s). Use Forms BH20 (Appendix L) to develop the detailed budget for the service enhancement.

Process Comment: *DBH will review REP document and render a response within seven days. Responses include: Approved, Denied, More Information Needed. Approvals will move to the next phase which is either Request For Proposal (RFP) Development or to submit a shift. During review, DBH will assess if there has been a demonstrated need for a rate enhancement by reviewing the Region's budget, past billings for this service, waitlist and capacity reports.*

E. REQUEST FOR PROPOSAL (RFP)

A Request for Proposal (RFP) is required in all instances when a region is expanding capacity for existing services, proposing a pilot/new service, or rendering an existing service in their catchment area. There may be exceptions to this requirement based on the identified funding source in the IP. This will be discussed during the review of the IP. An RFP should not be submitted until an IP has been approved. The below components are required in each RFP.

A. Cover Page that includes contact information for the Region, the title of the service being proposed, and date of RFP submission to DBH.

B. Proposal Administrative Information that includes the date the RFP will be released, the date the RFP submissions are due back, and outlines how to submit a response to the RFP.

C. Executive Summary outlining background information about the region such as who the region is, how the region came to be, and what the purpose of the region is.

D. Proposal Purpose that articulates the demonstrated need for the service supported with local data and how the RFP will address the need. It should also include anticipated goals of the service and how outcomes and data will be measured to

address the intended target. This section should demonstrate clinical relevance and need.

E. The Scope must include the service(s) to be offered, any affects for Priority Populations, financial eligibility requirements, requirements to bill Medicaid for Medicaid-eligible consumers, and establishment of lawful presence.

F. A Bidding Information section should be included that outlines:

   a. Funding amount available
   b. Funding source
   c. Reimbursement method – if expense-based service include explanation as to why it could not be established on a rate or a plan to move to a rate.
   d. Non-transfer of Funding Statement
   e. Use of Subcontractor(s) as applicable
   f. The timeline for the RFP activities including a bidder's conference.
   g. Communication and Contact Policy
   h. RFP Submission Instructions
   i. Proposal Format for bidders
   j. Instructions for bidders to complete the Budget using a BH20 (see Appendix L).
   k. The process to review and evaluate RFP submissions.
   l. How a proposal will be selected and awarded.
   m. Any appeals process that includes, but not limited to, Conflict-of-Interest claim on any Request for Proposal issued related to this Subaward. Information should reflect procedure identified in the RBHA policy related to conflict of interest as required by 206 NAC 004.02.

G. Intent to use Capacity Development (CD) Funds. DBH will approve the use of CD funding one time to be expended within six months of service development. If the provider has been unable to reach full capacity, up to an additional six months may be approved by DBH. The provider must provide a completed BH20 outlining how the funding will be utilized. On the BH20 all costs must be itemized and not lumped together or titled "miscellaneous". CD funding may be used to:

   a. Develop administrative structures and personnel for service.
   b. Develop program plan, program operating policies and procedures, operation plan, authorized referral system for service.
   c. Develop reporting, financing, and quality assurance systems.
   d. Develop a plan to begin serving consumers.
   e. State certification development plan/timeline and an infectious disease policy and disaster plan.

   For all funding sources <u>except</u> for Opioid Settlement Funds, CD funding may <u>NOT</u> be used for:
   a. Construction costs
   b. Recreation/gym equipment

c. Landscaping costs
d. Employee bonuses/retention bonuses
e. Fundraising costs

If CD funding is approved, the provider will need to develop a Development and Implementation Plan using Form BH-5. Use one form per identified goal. The plan must include an implementation schedule explaining in detail the development process and show a clear step-by-step plan of how the program will be developed over the given time period. A progress report will be required, depending on the situation, monthly, bi-monthly, or quarterly outlining the progress made towards completion of goals developed, progress in developing the service, and progress made towards moving payment from expanse-based to a rate. A BH-5 should be used to report progress.

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 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 period must be within the proposed service development 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.

Process Comment: *DBH will review the RFP document and render a response within seven days. DBH will utilize the Proposal Development Rubric located on the DBH website when reviewing RFP's.*

The Regions should use the below table when evaluating RFP submissions from bidders.

- 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 the provider's name, address, and general information (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 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.	• 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.	• 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 in Appendix G.
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
- 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 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 cost 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, the estimated cost must be the maximum amount for the equipment for purposes of the award. Actual cost paid may be lower based on the final cost of the equipment. • 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** 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.

H. BUDGET

The budget section should include the following five sections:

1. <u>Itemized Annual Operating Budget</u>

Use Form BH-20 (see Appendix L) to develop the detailed budget for the service. Also included is a list of the specific items that would be in that budget section. List each expense separately, do not "lump" expenses together. All expenses must directly correlate to the service being proposed. DBH will return budgets that do not meet the below criteria.

a. BH-20 Summary page details the Revenue and Expense Summary
   i. Revenue Summary
      - Ensure revenues expected for the service are reported from ALL other funding sources (i.e., Medicaid).
   ii. Expense Summary
      - Include the federally approved indirect cost rate or approved de minimis rate from the DBH.

b. BH-20c1 - Personnel Services Expenses
   - Ensure that all staff positions to provide the specific service are reported on this form. Each position must be listed separately.

c. BH-20c2-Fringe Benefits
   - List for each staff listed on BH-20c1.

d. BH-20d – Supplies/Operating Expenses

e. BH-20e - Travel Expenses
   - List each expense separately to include mileage and rate.

f. BH-20f – Contracts/Consultants

g. BH-20g –Equipment
   - List each equipment expense, including property capitalized separately.

h. BH-20h-Indirect
   - Provide a copy of the preapproved federal rate.

2. <u>One Time Development/Start-up Budget</u>

Use Forms BH-20 (see Appendix L) 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. List each expense separately, do not "lump" expenses together. All expenses must directly correlate to the service being proposed. DBH will return budgets that do not meet the below criteria.

a. BH-20 Summary page details the Revenue and Expense Summary
   i. Revenue Summary
      - Ensure revenues expected for the service are reported from ALL other funding sources (i.e., Medicaid).
   ii. Expense Summary
      - Include the federally approved indirect cost rate or approved de minimis rate from the DBH.

b. BH-20c1 - Personnel Services Expenses
    - Ensure that all staff positions to provide the specific service are reported on this form. Each position must be listed separately.

c. BH-20c2-Fringe Benefits
    - List for each staff listed on BH-20c1.

d. BH-20d – Supplies/Operating Expenses

e. BH-20e - Travel Expenses
    - List each expense separately to include mileage and rate.

f. BH-20f – Contracts/Consultants

g. BH-20g –Equipment
    - List each equipment expense, including property capitalized separately.

h. BH-20h-Indirect
    - Provide a copy of the preapproved federal rate.

3. Budget Justification Narrative

This narrative will detail why the costs listed on the budget itemization forms for sections A and B are necessary and how those costs were calculated. Please address the following items separately in the narrative:

a. Describe the project's facility and space requirements and explain why the amount is needed.

b. 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.

4. Annual Operating Budget

Explain and justify all items included in the annual operating budget including.

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

b. How ongoing operational, travel, equipment, personnel, professional fees, consultant needs, and costs were determined.

c. Describe the project's facility and space requirements and explain why the amount is needed.

d. 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.

5. One Time Development/Start Up Budget

Explain and justify all items included in the start-up (one-time) cost budget. See section G above regarding CD Funding allowable and unallowable expenses.

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

b. How long it will take to develop the service and why.

c. How ongoing operational, travel, equipment, personnel, professional fees, consultant needs, and costs were determined.

d. Describe the how the agency will procure the project's facility and space requirements and explain why the amount is needed.

e. 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.

F. Provider-Service Change Request

The Provider-Service Change Request form is located on the DBH website. This form must be completed PRIOR to an approved new service being developed, a service ending, the provider adds another location, or the provider changes locations.

G. 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

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.

Appendix D: Plans for One and Emergency Systems Guidelines

Plans for One are intended to assist in timely re-integration 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, 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. Plans for One funding is intended as transitional funding to support a consumer's re-integration into the community. Application and submission of a formal PF1 should be a collaborative effort and include the consumer, guardian (if applicable), the discharge entity, receiving entity and regional representative. Plan for One funding is not intended to provide indefinite funding for specialized services.

The RBHA may allocate funding for Plans for One or receive additional funding from the DBH for this budgeted lined item. If a RBHA receives additional funding from the DBH for Plans for One, the funds can only be used for Plans for One and may not 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 cases. Room and board requests or additional funding services covered by insurance that would fall under Plans for One funding will need required documentation submitted and approved by the DBH (see "DBH Instructions for Filling out Plans for One Application" for details). Plans for One are effective from approval until the date identified in the application, not to exceed the end of the current state fiscal year, or to the end of the current year, whichever comes first. After that, a new application must be submitted for approval.

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. Plans for One must be approved by DBH to be reimbursed and are approved for expenditure within the fiscal year. The format specified below must be used to apply for approval for funding a Plans for One.

Plans for One

A. Plan application

   Please complete all fields in the Plan application. The "Instructions for Filling out Plans for One Application" provide further instructions on how to complete the form and what information is required. Describe in detail the consumer outcomes that will be measured. DBH will work with the Region to develop outcomes for these plans as applicable.

B. All Applications must include a BH-20 attached. Use Forms BH20 (Appendix L) to project implementation costs.

C. Email the final documents to the designated DBH staff member and CC your assigned region representative or the Network Administrator. These documents contain PHI, so please **do not** send them to the general DBH email box or network operations email box.

   These documents must be sent securely.

Appendix E: Flex Funds

Flex funds are utilized by the Regional Behavioral Health Authorities (RBHA), and their providers for non-Medicaid enrolled individuals. Flex funds may also be used for Medicaid enrolled individuals for items, resources, or services not required to be provided by Medicaid Managed Care Organizations (MCOs) as outlined in the Medicaid State Plan and for eligible persons with other third-party insurance for items and services not covered by their plan.

Purpose:

Flex funding is to obtain the items, resources, or services 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 and provider shall attempt to use all alternative funding sources prior to utilizing flex funds. These efforts shall be documented thoroughly and maintained in the client file. Documentations must be made available to DBH upon request.

Allocation and Payment:

Flex funds are to be recorded in a RBHA's budget as a separate line item and not imbedded into an expense reimbursement service or system coordination. Flex funds can be billed by specific providers or the RBHA. Flex Funds cannot exceed $5,000 per consumer per state fiscal year.

Allowable use of funds:

1. Transportation (self, e.g., gas, minor car repair, taxi, bus, handi-van, truck for moving, other)
2. Housing/Storage (one-time deposit on residence, rent, temporary housing, motels, campground fees, purchase of home furnishings, cleaning products, and storage unit fees while in residential-level treatment)
3. Utilities (electric, gas, sewer/water, propane)
4. Phones (phones, phone cards and monthly service plans)
5. Food
6. Bedbug remediation
7. Clothing Needs
8. Laboratory Work related to MH/SUD medications
9. Medications related to MH/SUD
10. Legal identification (certified birth certificate, state ID card, etc.)
11. Tobacco cessation products
12. Adaptive equipment (any tool device or machine to assist with a task of daily living such as: wheelchairs, scooters, walkers, canes hearing aids, eyeglasses/contacts, dentures)
13. Daycare expenses to attend a DBH treatment appointment FOR NON-RESIDENTIAL SERVICES. Reasonable time being billed shall align with the treatment time.

Prohibited use of funds:

1. To pay for items that are included/built into an existing service definition that has been approved by DBH as either a permanent or pilot (i.e., medications, room and board, food, transportation etc.).
2. To pay for physical health appointments (i.e., dental, eye, hearing, physicals, etc.).
3. To pay for consumer share-of-cost

4. To pay for out-of-network behavioral health services or appointments
5. To pay for memberships (i.e., gym memberships).
6. To pay for therapeutic or companion animals
7. To pay for refreshments (i.e., candy, soda, etc.).
8. To pay for nicotine/tobacco products (excluding cessation 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
12. To pay for items and care related to companion animals
13. To pay for items, resources, or services required to be provided by Medicaid Managed Care Organizations (MCOs) as outlined in the Medicaid State Plan or covered by person's insurance plan.
14. Cable television, streaming services (video/audio)

A. Submission and Documentation:

1. The Provider agrees to bill monthly for flex funds by consumer using the EBS. The process for doing so can be found in the EBS manual.
2. The RBHA shall ensure that the flex fund expenditures do not exceed budgeted amounts.
3. The flex funds will be monitored by the RBHA and DBH to evaluate cost effectiveness and the impact of flex fund resources on consumer outcomes.
4. The consumer receiving assistance shall be registered in an appropriate service through the DBH's centralized data system (CDS) to track utilization patterns and ensure appropriate follow up.
5. RBHA agrees to submit supporting documentation, at the request of the DBH, to substantiate any flex funds that are questioned by the DBH.
6. The DBH will review the RBHA's monthly flex fund utilization and provide feedback if needed. Should the review show the flex funds going to an unallowable expense or ineligible consumer, the DBH reserves the right to ask for payback.

B. Consumer Eligibility for Usage of Flex Funds

Flex funds are <u>only</u> available to eligible consumers meeting financial and service requirements that are enrolled in service(s) within the RBHA network. For newly eligible consumers, they must enroll in a minimum of one (1) CDS or approved pilot service, within 60 days.

<u>Exceptions</u>: There will be no exceptions to this policy. Flex funds must only be used on expenses listed as allowable above. Any expense billed through flex funds which is deemed unallowable must be reimbursed to the department within 30 days of notice. Failure to submit repayment may lead to stopped payments for future flex fund usage.

Appendix F: Service Standards for Participation in Network Initiatives

A. **The National Standards for Culturally and Linguistically Appropriate Services (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 public.

B. **Creating a welcoming environment**

1. The services provided incorporate best practices that are effective and evidence-based, 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 method of thinking and taking action that communities can use to improve the lives of youth, adults, and families. It can also improve the performance of programs, agencies, and service systems.

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?

Effective questions of performance accountability.

Appendix G: NBHS Provider Credentialling and Network Enrollment Minimum Standards

NBHS PROVIDER CREDENTIALLING AND NETWORK ENROLLMENT MINIMUM STANDARDS	Documentation - NBHS Network Management	Documentation - Accrediting Bodies	Documentation NBHS Network Management re: Un-Accredited Provider (incl Small Agency)	Documentation NBHS Network Management re: Individual Practitioner / Small Group Provider Practice	NOTES
PROVIDER ENROLLMENT					
Completed Provider Enrollment Form	X		X	X	
Provisional Enrollment Status, if applicable.					
Continued, Ongoing, or Retention Enrollment Status					
Provider Probation Status					
On-site Visit (Initial Check)	X		X	X	
IRS Form W-9	X		X	X	
DEA registration Certificate and state controlled substance certificate as applicable	X		X	X	
Legal Actions/Penalties. Suspensions	X		X	X	
Disclosure of Ownership/Controlling Interest & Convictions Statement					
Office of Inspector General (OIG) Search as applicable (Federal funding) (Annual)	X		X	X	*1/yr.*
HUMAN RESOURCES					
Organizational Chart	X	X	X	I/A*	** If Applicable*
List of Board of Directors	X	X	X	I/A	
Professional Staff List including:	X	X	X	X	
-Staff Name	X	X	X	X	
-Title	X	X	X	X	
-Program	X	X	X		
-Education Level & Institution(s)					
-Residency/Internship/Training for Clinical Expertise or Other Specialties (as applicable)					
-Curriculum Vitae Listing					
- Minimum for 5 year work history					
Provider Credentials/Professional Licenses and/or #'s and/or Certificates (as applicable)-primary source verification	X	X	X	X	
Medicaid Provider Enrollment Letters and/or #s (as applicable)	X		X	X	
ACCREDITATION / LICENSES					
National Accreditation Certificate & Report & Quality Improvement & Accreditation Plan (QIAP)	X	X			
If not accredited by nationally recognized body, site evaluation (by location) results from a government agency are required - see network policy on unaccredited providers/accreditation plan; distinct standards	X		X		
On-site QA Review using NAC 206 until National Accreditation is Received	X		X	X	
Facility State Licenses	X	X	X		
Fire Inspections / Occupancy Report	X	X	X		
Food Permits (as required)					

INSURANCE					
Commercial General Liability	X	X	X	I/A	
Workers' Compensation	X	X	X	I/A	
Commercial Automobile Liability	X	X	X	I/A	
Directors/Officers Liability	X	X	X	I/A	
Umbrella/Excess Liability					
Professional Liability	X	X	X	X	
Abuse & Molestation Liability	I/A	I/A	I/A	I/A	
Cyber Liability	I/A	I/A	I/A	I/A	
Malpractice Insurance	I/A	I/A	I/A	I/A	
PROGRAM PLANS					
Program plan for each funded service	X	X	X	X	
Continuity of Operations Plan	X	X	X		
POLICIES & PROCEDURES					
Internal disaster plan that includes protecting the life and safety of participants (could be in COOP)	X				
Any youth who have not attained age 21years shall be prohibited from using tobacco products on agency premises or at agency functions	X				
Americans with Disabilities Act	X	X	X		
EOE / Affirmative Action		X			
Chronic Infectious Diseases		X			
Informed Consent for Treatment (inclusive of HIPAA & use of patient information)	X	X	X	X	
Rights & Responsibilities of Persons Served	X	X	X	X	
Code of Ethics		X	X		*Auditable*
Compliance with Voter Registration Bill (LB76) passed in 1994					*Auditable*
Confidentiality of Case Records	X	X	X	X	
Consent to Criminal Background Checks (including fingerprinting) - HR policy	X	X	X	X	
Criminal Background/Central Registry Check Policy to include the following: *1 Policy & Procedure, addresses next step if "failed"*	X		X		**Provider P & P: checks made on hire**
-Sex Offender Registry			X		
-Nebraska Child Abuse & Neglect Registry			X		
-Nebraska Adult Abuse & Neglect Registry			X		
-Criminal Records Check by the NE State Patrol			X		
-Department of Motor Vehicles (as applicable)			X		
-Out-of-State background checks on newly hired employees, interns, volunteers who have resided in NE less than 2 yrs.			X		
Drug-Free Workplace Policy and documented training	X	X	X		

Drug-Free Workplace Policy and documented training	X	X	X		
Grievance & Appeals procedures in regards to employees & participants; includes how participant's rights will be protected when report is received	X	X	X	I/A	Posted in-office or included on consent to treat paperwork reviewed w / individual
Complaints Procedures; processing of complaints	X	X	X	I/A	
Continuing Education / Training for Employees		X	X		
Record Management / Retention to include the following:		X	X	X	
-Timeline of client record retention following discharge		X	X	X	
-Methods for disposal of client records		X	X	X	
-Listing of documents included in personnel files		X	X	X	
-How information regarding personnel is accessed		X	X	X	
Sexual Harassment		X	X		
Cultural Diversity / Competence		X	X		
Accessibility	X	X	X	I/A	
Financial Eligibility					Audit, contract
QUALITY ASSURANCE					
Quality Assurance and Performance Improvement Plan	X	X	X		
OUTCOME MEASUREMENT					
Specific to contracted network services					
FISCAL MANAGEMENT					
CPA Audit OR Audited Balance Sheet	X		X		

Definitions:

NBHS Provider Credentialling: the process of establishing that providers (individuals or agencies) have proper qualifications to perform the work. This important safety check requires contacting various entities to verify that the provider has the correct licenses and certificates.

Credentialling is required before a provider is eligible for reimbursement and validates the entity meets standards for delivery of quality care, wherein the payer (NBHS, Medicaid, Private Plans, etc.) verifies education, experience, licenses, certifications, affiliations, malpractice, and any adverse clinical occurrences.

NBHS Provider Enrollment: the process of adding a provider to a plan or an NBHS network of providers so that the provider can be reimbursed for services provided to consumers.

Credentialling is part of the enrollment process and there will be some redundancy. To be an enrolled provider means the provider follows the Payer's specific application and credentialling process and, if approved, signs a contract and is considered "in-network." Standards for enrollment is essential to reimbursement and for assuring quality of the network.

This document operationalizes minimum uniform credentialling and enrollment standards for the NBHS provider network consisted with title 206 NAC regulations.

NOTES:
Reviewed/Approved 12-13-2023 NBHS Network Management.
TBD: Clarity on definitions/parameters for " small agency, small group practice (of individual providers)

8/2022 Agreements:

* Providers do not need to submit enrollment standards to all Regions contracted with, only their home Region.
* What documentation would be provide to other Region? *A: Attestation note, checklist of their minimum standards for non-accredited providers met.*
* Current status - Regions 1,3,4 network management maintains a checklist of minimum standards for non-accredited provider; *Regions 5 & 6 limit enrollment to accredited providers.*
* Minimum standards are posted on Regional websites; incorporated as appendices in Network Operations Manual.

Appendix H: Budget, Payment and Billing Basics

Language in the executed contract terms will take precedence over the Appendix K of this manual should a conflict arise between the two sections.

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.

The parameters of this Appendix apply the RBHA as applicable regardless of billing as a regional administrative/coordinating body or as a provider of a services.

II. PROVIDER BILLINGS TO RBHA

1. Each provider must submit to the RBHA a Provider Reimbursement 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. Partial units must conform to the incremental value designated on the Unit Designation sheet. For more information, see the current Unit Designation sheet.
3. The provider will review for accuracy the units received from CDS into the PRR for each service at the actual provider location service is rendered, 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. The provider must ensure units entered into CDS have been imported to the PRR prior to submitting this request to the RBHA. This may require the provider to select the “refresh” button on the PRR.
5. On any billing form that includes fields for the encounter and/or CDS consumer identification number, the fields must be completed at the time of billing. For consumers covered by Medicaid that are approved by DBH to be billed in these services, the designated alternative encounter and consumer identification number must be used. The RBHA must deny payment for the service until information is completed accurately.

6. 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, Medicaid, private insurance, 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.

7. If a Provider Payment Request is incorrect or does not meet the criteria identified in this section, the RBHA must reject the document to the provider for correction.

8. For daily and/or bed-based services the date of admission will reimburse at a full day rate and the date of discharge will not be reimbursed. Partial units will not be allowed.

9. 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. 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.

10. 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 will result in a payment being rejected by the DBH or having a payment returned that is less than the requested amount.

11. If 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 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.1.d.1 through II.2.i-iii a&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 from 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. DHHS reserves the right to withhold funds from payments on any request submitted. The amount and reason for the reduced payment will be provided to the RBHA.

V. BILLING TIMEFRAMES

RBHA shall requests for payment to DHHS monthly for approved services. Subrecipient shall submit billing for allowable costs to the DHHS Electronic Billing System (EBS) or in a manner specified in writing by DHHS no later than the 12th day of the month following the month service was delivered. A billing that has incorrect or incomplete information will not be accepted or processed until such time that the information is accurate and complete.

1. At no time will compensation or payment of any kind be provided in advance of services actually performed.
2. RBHA shall ensure that any correspondence submitted to DHHS reflects the appropriate services names as identified in the EBS and Centralized Data System (CDS).
3. DHHS will make all reasonable efforts to make payment by electronic deposit to the Subrecipient's designated financial institution by the 25th of each month.
4. The parties agree that the following exceptions apply:
5. When the 12th of the month falls on a weekend or holiday, the billing must be to DHHS on the Monday after the weekend or the first working day after the holiday.
6. If one or more state holidays falls between the 12th and the 25th of the month, the payment deposit will be delayed a corresponding number of days.
7. In the event of an amendment to the Subaward, payment may be delayed until the amendment is processed and executed.
8. During the final shift in June, payment may be delayed until the shift is fully processed.
9. In the event a billing is delayed because of missing or inaccurate information, DHHS will process billing as soon as reasonably possible after all documents have been approved. In this case, payment to the Subrecipient will be made on the 25th of the following month or seven (7) working days after acknowledgement of the receipt of completed billing is sent to the Division, whichever is later.
10. Subrecipient will only submit billings for services provided to individuals who meet the Clinical Criteria for an identified level of care and the Financial Eligibility Criteria set forth in Appendix A (Financial Eligibility Policy).

11. Subrecipient must ensure providers are deducting copayments from consumers and other third-party payments received for the service prior to billing any service paid on an expense reimbursement basis.
12. If the expense reimbursement billed is a rate enhancement, Capacity Development (CD), or Service Enhancement (SE) for a service paid at a Region or State rate, the provider must apply all revenues received or generated from all sources by the primary service that exceed the cost of the service against the rate enhancement, CD, or SE prior to billing.
13. Subrecipient shall not submit reimbursement requests under this Subaward for any Medicaid benefit services provided for Medicaid-eligible individuals.
14. Subrecipient shall ensure subcontractors are actively monitoring for Medicaid eligible individuals using Medicaid provided methods.
15. Subrecipient shall not retain any federal funds payable or subcontractors that are received in payment for more than 72 (seventy-two) hours after receipt.

VI. BUDGET CHANGES.

1. Regional Governing Board approval is required for all budget changes or funding shifts.
2. All shifts must be submitted on the required applicable DHHS shift request form, one form for approval and one form for notifications and include additional documentation as appropriate.
3. Shift requests requiring prior approval by DHHS include:
    a. Shifts into Region administration, coordination or provided services.
    b. Shifts impacting Maintenance of Effort (MOE) (in/out of SUD or MH category)
    c. Shifts impacting Set Aside funds (Prevention, First Episode Psychosis, Housing, Women Set Aside, Crisis, Recovery),
    d. Shifts into or out of Capacity Development and/or Rate Enhancement.
    e. A written justification for how the increase will be used including what expenses the increase will pay for, why the expense cannot be covered by other means, and steps the provider will take to ensure service continues should the funds not be awarded.
4. Documentation for shifts requiring DHHS approval include:
    a. Completed signed approval shift form.
    b. For expense-based services requiring approval, original, or subsequently DHHS approved, provider(s)'s revenue and expense budget (complete BH20 or BH20 Prevention as applicable) for the service(s) reflecting the actual funding amount contracted/awarded by the Subrecipient to the network provider. Forms completed must be on current fiscal year version of the forms.
    c. Provider(s)'s revised revenue and expense budget (complete BH20 or BH20 Prevention as applicable) for the service(s) indicating the expenses the new funds would be utilized to purchase. Forms completed must be on current fiscal year version of the forms.

d. Revised Prevention Work Plan if prevention funds are being between strategies or providers.

5. Documentation for notification of shifts require completed signed notification shift document.

6. Shift form(s) must be submitted by the 20th of the month. If the 20th falls on a weekend or holiday, the form(s) must be submitted by the next business day.

7. DHHS will review and respond in writing within four (4) business days after a completed and signed approval shift form is received by DHHS.

8. If applicable, any additional Spending Authority will require additional Tax Match and submission of revised attestation by the Regional Governing Board.

VII. 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. Units of service entered must conform with the unit designation for the service, including partial units.

   In the event additional documentation is required to be provided to DHHS for a service, the RBHA must submit completed information from the provider to DHHS by the date the billing is due to DHHS. Failure to submit completed data will result in the funds being held or denied.

2. 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.

VIII. 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.

h. Pay an amount for a service that was paid as an expense reimbursement in prior fiscal year.

2. All past units billed must 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 included 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.

IX. 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.

X. MISSING UNITS

For NFFS services, the RBHA will notify DBH when no units have been entered into EBS, because no units were billed for that month. DBH will notify the RBHA when units have not been entered but billings have been received. The units should then be corrected in EBS. Billing may be returned if there are missing units that DBH has not been notified about.

Appendix I: 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.

Amounts reported for an agency may be compared with agency's audited financials to ensure feasibility of amount reported.

Appendix J: 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. The provider must also share and coordinate this information with the Regional Consumer Specialist of each behavioral health region allowing the Regional Consumer Specialist to track and advocate for consumers. This tracking will be shared with the Office of Consumer Affairs.

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 K: Federal Oversight Requirements for Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS), Community Mental Health Services Block Grant (CMHSBG), Federal Mandates and State Mandates

A. GENERAL REQUIREMENTS

1. The RBHA and SUPTRS funded providers will continue to meet all SUPTRS 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 SUPTRS requirements.
3. SUPTRS funding may not be used to provide services in a penal or correctional institution of the state in an amount that exceeds SUPTRS funding that the state used for this purpose in FFY91 (1991 amount = $0).
4. Any RBHA and/or provider receiving SUPTRS funding will:
   a. Ensure that continuing education is provided to the SUPTRS prevention and treatment workforce, and document such training annually
   b. Provide updated and accurate information in all SUPTRS reporting requirements
   c. As requested by DBH, attend SUPTRS training provide
   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 SUPTRS 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 in CDS as determined by DBH for the SAMHSA national outcomes measures (NOMS).

B. PRIMARY PREVENTION

1. Primary prevention activities funded with SUPTRS must utilize the SPF process and be directed at individuals not identified to need treatment.
2. Funded prevention activities must utilize 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 SUPTRS 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.
7. Comprehensive approach to primary prevention may, at times, require all six primary prevention strategies (information dissemination, education, alternative activities, problem identification and referral, community-based process, and environmental) to be funded and implemented, the determination as to whether all, or some of, the six strategies need to be supported, is best determined by DBH and RBHAs in collaboration with communities served. DBH encourages the allocation of funding to:
    a. Reflect state-and-community level data on substance use disorders
    b. Respond to, and in align with, prevention programming priorities of individual communities
    c. Promote community-based organizations to use all, or select group, of prevention strategies
    d. Impact communities and the state.

C. 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 SUPTRS.
4. Providers serving women must 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 SUPTRS 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, 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 the 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.

D. TUBERCULOSIS (TB) SCREENING AND SERVICES

1. RBHA will ensure that all providers receiving SUPTRS 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 Neb. Rev Stat. §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 SUPTRS funding will routinely make TB services available to everyone 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.

E. STERILE NEEDLE DISBURSEMENT AND HIV/AIDS

The RBHA will ensure that no SUPTRS or other SAMHSA 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 SUPTRS 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. (Consolidated Appropriations Act, 2016 (Pub. L. 114-113)

F. 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 charitable choice at minimum once every two

years. Training may be provided by the RBHA or another 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.

G. 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.

H. 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 center 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.

I. 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.

J. FEDERAL MANDATES

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

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. The Consolidated Appropriations Act, 2023 (Public Law No: 117-328), signed into law on December 29, 2022, restricts the amount of direct salary to Executive Level II of the Federal Executive Pay scale. Effective January 1, 2023, the salary limitation for Executive Level II is $212,100.

4. SAMHSA grant funds may not be used to purchase, prescribe, or provide marijuana or treatment using marijuana. See, e.g., 45 CFR § 75.300(a) (requiring HHS to ensure that Federal funding is expended in full accordance with U.S. statutory and public policy requirements); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana).

5. If a provider expends more than $750,000 of Federal funds in a 12-month fiscal period, a Certified Public Accountant (CPA) will be engaged to conduct an audit in accordance with 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.

6. The RBHA and CMHSBG and/or SUPTRS 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. 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

7. The RBHA and providers receiving CMHSBG and/or SUPTRS 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

8. 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.

   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.
   c. SAMHSA grant funds may not be used to purchase, prescribe, or provide marijuana or treatment using marijuana.

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

xi. Snacks at meetings or events unless specifically allowed by the grant.
xii. 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.
xiii. Stipends or incentive payment to participants**.**
xiv. 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.
xv. No federal funds will be awarded to any provider is who has demonstrated an inability to meet any requirement associated with the funds.
xvi. 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 SUPTRS award must be spent on Primary Prevention.

Should the State experience an interruption of SUPTRS 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.

K. 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 either purchase 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 to be payer of last resort for consumers who meet the clinical criteria for an identified level of care and who are without the financial resources to pay for care. The 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 L: BH-20 AND SERVICE FUNDING CATEGORIES

Funding Categories for BH-20

The listing of expenses included under each category is not intended to be all inclusive nor exclusive. It is intended to provide common examples of the type of expenditures to include in each category. Please read through the entire document before completing the BH-20. Subject to Change. See Federal Cost Principles 200 CFR and NOMs Appendix K for unallowable costs.

There may be changes to what is allowed and not allowed not listed within the Funding Category list and BH20 Form. The most updated version of the BH20 form supersedes the Funding Category outlined below.

DIRECT COSTS

1. Personnel Wages/Salaries: Personnel expenses that can be directly associated with the service being purchased (via time coding or time study).

- ☐ Permanent salaries/wages
  - Including Administrative (time study required)
- ☐ Temporary salaries/wages
- ☐ Overtime pay
- ☐ Comp time pay
- ☐ Vacation leave expense
- ☐ Sick leave expense
- ☐ Holiday leave expense
- ☐ Military leave expense
- ☐ Funeral leave expense
- ☐ Civil leave expense
- ☐ Injury leave expense

2. Employer taxes and Fringe benefit expense: Fringe benefits directly associated with the service being purchased.

- ☐ Retirement plans expense
- ☐ Social security benefits expense
- ☐ Life/accident insurance
- ☐ Health insurance
- ☐ Unemployment comp insurance
- ☐ EAP
- ☐ Health Saving Plan/Flexible Spending Plan

3. Supply/Operating Expenses: Operational costs that can be directly associated with a particular service being purchased w/established methodology and consistent application.

- ☐ Postage
- ☐ Communication (i.e., phone/voice mail/e-mail)
- ☐ Data processing/computer hardware/software
- ☐ Conference/professional development
- ☐ Job applicant (i.e., recruitment expenses)
- ☐ Utilities (i.e., elec./water/gas)
- ☐ Rental expenses (i.e., bldg./equip)

- Internet services
- Publications/newsletter/printing
- Training materials (booklets, pamphlets, curriculum, videos, etc.)
- Copying
- Professional dues/subscriptions
- Registration Fees
- Insurance (i.e., liability, building, auto)
- Program marketing/advertising (necessary for program or recruitment)
- Repair/maintenance (i.e., bldg./equip/vehicle)-under capitalization threshold)
- Office supplies
- Office equipment (under capitalization threshold)
- Workshops/retreats/trainings/classes
- Education services

4. Travel Expenses: Expenses for travel incurred while providing the service being purchased per agency travel policy and applicable state or federal requirements.

- Board and lodging (includes meals for longer than one day stay)
- Meals – one day travel
- Commercial transportation
- Agency owned transportation
- Mileage – personal vehicle

5. Contracts/Consultants: Other expenses directly associated with the service being purchased in relation to the service required.

- Consultants (rendered by person who are members of a particular profession or possess a special skill who are not officers or employees of the non-federal entity
- Contracts for other services (i.e., non-employee physicians, nurses, etc.)

6. Equipment Expenses: Expenses for tangible personal property (including information technology systems) that has a useful life of more than one year and a per unit acquisition cost based on the organizations capitalization definition or $5,000, whichever is less.

7. Indirect: Preapproved Federal Rate or Preapproved DHHS indirect cost rate (copy of approval must be attached).