Mental Health Crisis Center of Lancaster County

FY 2019-2020
(July 1, 2019 - June 30, 2020)

NETWORK PROVIDER CONTRACT FOR BEHAVIORAL HEALTH SERVICES

THIS AGREEMENT, hereinafter called the "Contract," made and entered into, by and between the REGIONAL BEHAVIORAL HEALTH AUTHORITY, a Nebraska Interlocal Agreement Agency, hereinafter called "Region V," and Mental Health Crisis Center of Lancaster County, hereinafter called the "Network Provider," as a member of Region V's Behavioral Health Provider Network, hereinafter called the "Network."

WITNESSETH:

WHEREAS, Region V is authorized and required to provide comprehensive behavioral health services within Butler, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, and York Counties, hereinafter called "Region V," under the provisions of the Nebraska Behavioral Health Services Act, LB 1083, adopted by the 98th Legislature, second session 2004, hereinafter called the "Act";

WHEREAS, the Division of Behavioral Health of the Nebraska Department of Health and Human Services (hereinafter referred to as DHHS), is authorized to carry out certain responsibilities for the administration of the Act;

WHEREAS, the Act authorizes Region V to contract with public and private agencies and organizations in order to provide for the comprehensive system of services required;

WHEREAS, the Nebraska Legislature and the County Boards of Region V have authorized funds, under terms of the Act, to Region V for the purpose of providing and securing the required services;

WHEREAS, Region V desires to obtain the services of the Network Provider for the performance of behavioral health program responsibilities mandated under the Act and is contracting with the Network Provider for the purpose of obtaining such services;

WHEREAS, the Network Provider is desirous of receiving from Region V such funding as is appropriate and necessary to perform certain behavioral health responsibilities of Region V and hereby accepts such responsibilities on behalf of Region V;

WHEREAS, Region V and the Network Provider mutually recognize, accept, and agree that the purpose for which the Contract is entered into as being the provision of comprehensive behavioral health services by the Network Provider within Region V;

WHEREAS, in an effort to ensure the provision of services, Region V has established a Behavioral Health Provider Network;

WHEREAS, the Network Provider has submitted a Request for Approval to Region V to provide behavioral health services and accordingly has been approved for provision and reimbursement of services;

NOW, THEREFORE, in consideration of the above preamble, which is hereby made an integral part of the Contract, the parties hereto mutually agree to the following provisions:

I. CONTRACT TERM AND TERMINATION

A. TERM: This contract is in effect for a twelve-month period, from July 1, 2019, through June 30, 2020.

B. TERMINATION: This contract may be terminated at any time upon mutual written consent or by either party for any reason upon submission of written notice to the other party at least thirty (30) days prior to the effective date of termination. Region V may also terminate this contract in accord with the provisions designated in Sections IX or XII A-E. In the event either party terminates this contract, the Network Provider shall provide to Region V and DHHS all work in progress, work completed, and materials provided by Region V in connection with this contract immediately.

II. DOCUMENTS INCORPORATED BY REFERENCE

All references in this contract to laws, rules, regulations, guidelines, directives, attachments, state and Federal requirements, Behavioral Health Service Definitions, and DHHS Requirements, which set forth standards and procedures to be followed by the Network Provider in discharging its obligations under this contract shall be deemed incorporated by reference and made a part of this contract with the same force and effect as if set forth in full text, herein.

III. TERMS DEFINED

A. BEHAVIORAL HEALTH (BH) SERVICES: services that include mental illness and mental health treatment, substance use disorder and prevention and treatment services, as well as, mental health and substance use rehabilitation, recovery, and support services. For the purposes of this Contract, "MH" shall mean mental health and "SUD" shall mean substance use disorder.

B. DHHS: is the Nebraska Department of Health and Human Services.

C. DBH: is the Division of Behavioral Health Community Based Services. For the purposes of this contract, the Division of Behavioral Health Community Based Services shall be referred to as DHHS.

D. NEBRASKA BEHAVIORAL HEALTH SYSTEM (NBHS): the publicly funded behavioral health system of care as managed by DBH and includes the six Regional Behavioral Health Authorities and the three Regional Center Hospitals that manages and provides mental health and substance abuse disorder treatment and prevention services for residents of the State of Nebraska.

E. NETWORK PROVIDER: an entity that receives Federal and/or State funds from a Region through a subaward, contract or other agreement and is responsible for ensuring compliance with all state and Federal statutes, regulations, rules, conditions and limitations associated with these funds.

F. REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA): means the regional administrative entity responsible for the development and coordination of publicly funded behavioral health services for each Behavioral Health Region, and receives State and Federal funds from DHHS. The RBHA is responsible for ensuring compliance with all state and Federal statutes, regulations, rules, conditions and limitations associated with these funds. For the purposes of this contract, the Regional Behavioral Health Authority shall be referred to as "Region V."

IV. BEHAVIORAL HEALTH SERVICE ALLOCATION

A. TOTAL CONTRACT AMOUNT: Region V shall pay the Network Provider a total amount not to exceed $1,175,975 for the services specified herein. Network Provider shall be eligible to provide and receive reimbursement for service(s) as outlined in Attachment A.

B. FEDERAL BLOCK GRANT FUNDING: The contract amount includes funds contracted to the Nebraska Department of Health and Human Services by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS). Funds are passed through to Region V and subsequently passed through from Region V to the Network Providers. Funds included in the Network Provider's allocation include Substance Abuse Prevention & Treatment Block Grant (SAPTBG) funds and Block Grant Funds for Community Mental Health Services (MHBG) as specified below.

1. $ 0 of MHBG (CFDA 93.958, FINA SM010034-18)
2. $ 0 of SAPTBG (CFDA 93.959)
3. $ 1,021,388 of State funds allocated for Mental Health Services; and
4. $ 154,587 of State funds allocated for Substance Use Disorder Services.

C. SERVICE PROVISION EXEMPTION: The Network Provider would be exempt from providing services throughout the Contract period only if the service being provided is Fee for Service (FFS), and contracted capacity for that service was met during the Contract year. If the provider elects to discontinue services under this exemption, the Network Provider:

1. Would have ten (10) business days to notify Region V, in writing, that it has fulfilled its contractual obligation, specifying the date this occurred.
2. Would not be eligible for unexpended revenue funds.
3. Would be subject to all other terms and conditions of the Contract

V. REGION V DUTIES AND RESPONSIBILITIES

Region V is designated as regional administrative entity or Regional Behavioral Health Authority (RBHA) responsible for the network development, management and system coordination of a network of publicly funded providers and services in Region V's geographic area of responsibility. As such, Region V agrees to provide the services in accordance with described goals, objectives, and budgets as specified in the approved Regional Budget Plan and all State statutes, standards, regulations, and Federal requirements as specified in all attachments hereto in order to meet the behavioral health needs of persons who meet DHHS Clinical and Financial eligibility criteria.

The network management and system coordination roles and functions to which Region V must comply, and ensure provider compliance, are outlined in the following documents, copies of which can be found at www.region5systems.net:

A. FY20 Region 5 Agreement/Contract with DHHS,

B. FY20 Regional Budget Plan Guidelines

C. The most recent approved versions of the following:
1. Electronic Billing System Manual
2. Centralized Data System Manual(s)
3. Nebraska Behavioral Health Network Operations Manual
4. Nebraska Behavioral Health Services Audit Manual
5. DBH Peer Support Definition

VI. NETWORK PROVIDER DUTIES AND RESPONSIBILITIES

The Network Provider must meet and agree to the following criteria to be an approved behavioral health provider, to be eligible for funds passed through the Region from DHHS, and to be included in the NBHS.

A. PROVIDER ENROLLMENT AND RETENTION:

1. The Network Provider must be enrolled in the Regional Network and must demonstrate the capacity to provide behavioral health services, implementation of a person-centered philosophy that guides service delivery, fiscal stability and ethical practices in business and service delivery. The Network Provider shall demonstrate adherence to applicable legal requirements, health and safety requirements, risk management practices, capacity to fulfill the mission of the network, ability to fulfill its potential role in the network and conformance to accreditation standards applicable to its operations. This shall be verified through documentation of (a) facility licenses, fire inspections, food permits, and any other licensing required for the specific service; (b) professional licenses; (c) insurance (requirements for workers' compensation, motor vehicle liability, professional/director's /officer's liability, and general liability coverage); (d) fiscal stability and viability through an independent CPA audited financial statement; (e) accreditation and (f) program plans for each service (admission and discharge criteria, assessment procedures, consumer input, staffing, quality improvement). The provider shall participate in any modification or revisions of this system as it is revised by the State and Region.
2. The Network Provider must meet and maintain all requirements of the Minimum Standards to become enrolled as and remain a member in good standing of Region V's Behavioral Health Provider Network.
3. The Network Provider shall maintain State licensure, as applicable.
4. The Network Provider shall provide the services as specified in the agency's Request for Approval, and the approved Regional Budget Plan, as defined by state standards and regulations, and Federal requirements.
5. Region V and DHHS reserve 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 Network Provider agrees to submit claims to Region V for individuals who meet the Clinical Criteria for an identified level of care and the Financial Eligibility Criteria set by DHHS and Region V.
6. The Network Provider agrees to comply with the State standards for behavioral health listed below. A provider that does not comply will not be eligible for continued funding under this contract or continued enrollment in the network.
    a. State approved standards of care and service definitions,
    b. State approved clinical eligibility criteria (utilization criteria),
    c. State approved financial eligibility criteria and fee schedule,
    d. State approved service rates as identified in Attachment A of this Contract.

B. DRUG-RELATED WORKPLACE POLICIES AND REQUIREMENTS:

1. Network Provider agrees, in accordance with 41 USC §701 et al., to maintain a drug-free workplace by: (1) publishing a drug-free workplace statement; (2) establishing a drug-free awareness program; (3) notifying employees as consistent with 41 U.S.C. §8103(a)(1)(c); (4) taking actions concerning employees who are convicted of violating drug statutes in the workplace; (5) notifying Region V within 10 days after receiving notice of an employee drug conviction; (6) imposing sanctions against employees as required by 41 U.S.C. §8104; and (7) in accordance with 2 CFR §180.230, identify all workplaces under its Federal agreements.

2. The Network Provider agrees, in accordance with Public Law 103-227, also known as the Pro-Children Act of 1994 (act), that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local government, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers who sole source of applicable Federal funds is Medicare of Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 for each violation and / or the imposition of an administration compliance order on the responsible entity. By signing this agreement, the Network Provider certifies that the organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

C. LIABILITY AND INSURANCE REQUIREMENTS: The Network Provider agrees to purchase and maintain adequate insurance coverage to cover their exposure to all liabilities. A current copy of the coverage certificate must be on file with Region V at all times. Subsequent renewal certificates must be on file with Region V within seven (7) business days after expiration for the following kinds of coverage:

COMMERCIAL GENERAL LIABILITY	
General Aggregate	$1,000,000
Products / Completed Operations Aggregate	$1,000,000
Personal / Advertising Injury	$1,000,000 per occurrence
Bodily Injury / Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$10,000 any one person
Abuse & Molestation	Included
Contractual Liability	Included
If higher limits are required, the Umbrella / Excess Liability limits are allowed to satisfy the higher limits.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits – All States	Statutory – State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury / Property Damage	Minimum as set by State law
Include All Owned, Hired & Non-Owned Automobile Liability	Included
Motor Carrier Act Endorsement	Where Applicable
Region V and the State of Nebraska will not provide any insurance coverage for vehicles operated by the Network Provider.	
UMBRELLA / EXCESS LIABILITY	
Over Primary Insurance	$1,000,000
SUBROGATION WAIVER	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	

LIABILITY WAIVER
"Commercial General Liability & Commercial Automobile Liability policies shall be primary and any insurance or self-insurance carried by the Region V and the State shall be considered excess and non-contributory."

PROFESSIONAL LIABILITY	
Professional Liability (Medical Malpractice)	Limits consistent with Nebraska Medical Malpractice Cap
Qualification Under Nebraska Excess Fund	
All Other Professional Liability (Errors & Omissions) – Director and Officers' Liability or a Fidelity bond for all members of boards and commissions.	$1,000,000 Per Claim / Aggregate

D. REPORTING REQUIREMENTS: The Network Provider shall provide all records necessary, for purposes of ensuring compliance with minimum standards and provisions of this Contract, to Region V as outlined in the *Provider Reporting Requirements*, Attachment B.

1. The Network Provider shall be fiscally accountable to Region V for all sources and expenditures of funds. The Network Provider agrees to maintain and submit all data, clinical, fiscal, and programmatic records and reports as specified by Region V and/or DHHS. Such records shall be available for inspection by authorized representatives of DHHS and the Federal government with the express understanding that any inspection will comply with Federal and state laws and regulations regarding confidentiality.
2. The Network Provider shall annually submit a non-audited report of ACTUAL revenues and expenditures for mental health and substance abuse services (actuals) reimbursed under this Contract, to Region V by August 15 after the end date of this Contract. These revenues and expenditures will be utilized to meet the statutory match requirement by category as designated by DHHS.
3. As directed by Region V, Network Provider agrees to submit data and/or information to promote the continuous quality improvement process within the Nebraska Behavioral Health System, both at a state and Regional level.
4. The Network Provider shall submit a Request for Approval/Budget Plan for behavioral health services to Region V annually by the deadline set by the Region.
5. The Network Provider shall provide a current listing of its agency board members' names and addresses with officers designated. This list shall be submitted to Region V on or before November 1, 2019. The Network Provider shall report to Region V any changes within twenty (20) days of their occurrence.
6. The Network Provider agrees to participate in the capacity/waiting list management system within the Centralized Data System (CDS) as established by DBH. In doing so, the Network Provider shall adhere to the following capacity/wait list reporting requirements:
   a. Persons waiting for services in this contract, regardless of funding source, should be placed on the wait list in the CDS in real time for the following services:
      - Assertive Community Treatment-MH
      - Community Support-MH/SUD
      - Secure Residential-MH
      - Dual Disorder Residential-MH/SUD
      - Supported Employment-MH/SUD
      - Halfway House-SUD
      - Intensive Outpatient-SUD
      - Intermediate Residential-SUD
      - Respite-MH/SUD
      - Psychiatric Residential Rehabilitation-MH
      - Short Term Residential-SUD
      - Therapeutic Community-SUD

   b. Persons entered into the CDS wait list should include persons who:

1) Have been assessed to need the level of service requested and such assessment is available and indicates the consumer's willingness to enter into the services once offered;
2) Cannot be admitted to a service immediately due to lack of capacity in the service;
3) Are available to be admitted to the service (not incarcerated etc.)

c. For services anticipated to be funded using State and/or Region funding, an encounter shall be created using the information designated in the CDS prior to admission. For individuals who are not anticipated to be funded by DBH, a unique identifier shall be used in the creation of the encounter.

d. Capacity reporting for all services in this contract should be completed in the CDS every Monday, reporting capacity utilization for the previous week.

7. The Network Provider shall comply with all reporting requirements for persons placed in its services pursuant to the Mental Health Commitment Act.

8. The Network Provider agrees to submit all subcontracts including Letters of Agreement and Memorandums of Understanding, as approved by DHHS and Network Management, entered into in order to carry out the contracted services within this Contract to Region V within 60 days of signature of said subcontracts agreements.

9. The Network Provider agrees to develop and maintain a network Continuity of Operations Plan (COOP) to ensure availability of services in the event of a disaster. A copy of the COOP will be provided to the Region upon request.

10. The Network Provider shall agree to routine audits and verifications by Region V and/or DHHS of the services purchased, program fidelity, and Federal block grant requirements as set forth in the Regional Site Visit Policy and Procedures and Audit Manual.

11. The Network Provider agrees to secure at its own expense an independent annual financial audit by a certified public accountant (CPA). The Network Provider shall follow the applicable cost principles set forth in 2 CFR 200 Subpart F. Such audits are to be received by the Region no later than four months after the end of the provider's fiscal year. Audits must be prepared and issued by an independent certified public accountant licensed to practice. Audit requirements are dependent on the total amount of Federal funds received by the Network Provider, as set forth below:

Amount of Annual Federal Payments	**Audit Type**
$100,000 to $749,999	Financial Statement Audit
$750,000 or more in Federal expenditures.	Single Audit

12. The Network Provider agrees to immediately notify Region V if a provider's licensure is denied or revoked in any services, or in the event that the provider places a consumer in imminent jeopardy of their health and safety.

13. The Network Provider agrees to notify the Region in the event of a death or serious physical or injury to any active client in any program or service with the Network Provider, regardless of payer source. Active being defined as a client who has admitted and consented to services and has an open record; official discharge has not occurred.

    Additionally, the Network Provider agrees to notify the Region in the event of any death or serious injury to any staff member or community member that occurs during the course of service delivery or work with persons served.

    Notifications should be sent to Region V at networkmanagement@region5systems.net. Notifications should occur no less than 48 hours from the time the provider learns of the death or injury. If an incident report is completed, it should be forwarded to Region V no later than 30 days following the incident.

14. The Network Providers agrees to submit a quarterly quality review of services provided that reviews quality of services, appropriateness of services, patterns of service utilization,

and timeliness of documentation in a mutually agreed upon reporting format. Sample must be representative of both current and closed records. Review must be performed by personnel who are trained and qualified and not the sole reviewer of the services for which he or she is responsible and not solely responsible for the selection of records to be reviewed.

15. The Network Provider agrees to use outcome measurement tools i.e. DLA20, Basis-24 to measure consumer outcomes and shall report outcomes quarterly to Region V for the following services:
    - Assertive Community Treatment-MH
    - Community Support-MH/SUD
    - Day Rehabilitation-MH
    - Dual Disorder Residential-MH/SUD
    - Emergency Community Support-MH
    - Emergency Protective Custody-MH
    - Halfway House-SUD
    - Hospital Diversion-MH
    - Intensive Community Services-MH
    - Intensive Outpatient/Adult-SUD
    - Intermediate Residential-SUD
    - Outpatient Psychotherapy-MH/SUD
    - Psychiatric Residential Rehabilitation-MH
    - Recovery Support-MH/SUD
    - Secure Residential-MH
    - Short Term Residential-SUD
    - Supported Employment-MH
    - Therapeutic Community-SUD
16. The Network Provider agrees to submit consumer satisfaction and perception of care data bi-annually to Region V.
17. The Network Provider providing any of the services listed below agrees to assign a cluster membership and certainty rating to persons served in these services and submit cluster membership/certainty data quarterly to Region V.
    - Assertive Community Treatment-MH
    - Community Support-MH/SUD
    - Day Rehabilitation-MH
    - Dual Disorder Residential-MH/SUD
    - Emergency Community Support-MH
    - Halfway House-SUD
    - Intensive Community Services-MH/SUD
    - Intensive Outpatient-SUD
    - Intermediate Residential-SUD
    - Outpatient Psychotherapy-MH/SUD
    - Psychiatric Residential Rehabilitation-MH
    - Short Term Residential-SUD
    - Therapeutic Community-SUD

E. ADMINISTRATIVE MEETING REQUIREMENTS:

1. The Network Provider shall participate in administrative meetings called by Region V for purposes of planning, program development and regional coordination of services.
2. The Network Provider shall participate in at least 80 percent (cumulative average) of all Network Provider meetings, and all Regional Quality Improvement Team (RQIT) meetings.

F. ADMISSIONS AND WAITING LIST MANAGEMENT:

1. The Network Provider shall keep other affiliates aware of all resources and services that are offered.
2. Network Providers, including inpatient and emergency services providers, must have the capacity to provide a complete mental health or substance abuse specific assessment/evaluation, in accordance with the State regulations and service definitions, to determine the needs and placement of any consumer for whom authorization and payment from the State for an NBHS service(s) is requested. Capacity is defined as direct staff or formal agreement with an appropriate Nebraska licensed or certified professional.
    a. A substance-abuse specific assessment/evaluation including the results of a valid, reliable substance abuse psychometric tool such as the Addictions Severity Index (ASI) must be completed PRIOR to admission to any NBHS non-emergency

substance-abuse service. Providers of emergency and crisis center services receiving substance abuse emergency services funding for a Crisis Assessment must have documentation of a substance abuse-specific assessment / evaluation, completed by a Licensed Alcohol and Drug Abuse Counselor (LADAC) or completed by a professional within their scope of practice who has specific training in substance abuse disorders.

b. The results of the assessment/evaluation MUST be communicated at the time of authorization to any NBHS mental health or substance abuse service is requested.

c. The results from the substance abuse assessment/evaluation, including appropriate service placement recommendations based upon the assessment/ evaluation, MUST be communicated to the Mental Health Board if a hearing for involuntary commitment is held.

3. Network Providers receiving Federal Block Grant funds agree to comply with the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) requirements as outlined in Attachment C including the waitlist management process/system as set by Region V and DHHS.

4. Network Providers shall give priority status for admission to services to Region V residents for Region V contracted capacity. Network Providers agree to notify Region V before admitting out-of-Region residents to Region V contracted service capacity.

5. Consistent with State Priority Guidelines and Federal Block Grant requirements, the Network Provider shall give priority status for admission to emergency, inpatient, residential, and non-residential behavioral health services reimbursed under this Contract to persons in the following order, recognizing the expectation that co-occurring disorders may exist in all priority populations:

   a. Mental Health community service priorities:

      1) Persons mental health board committed and being treated in a Regional Center who are ready for discharge;
      2) 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;
      3) Persons committed to outpatient care by a Mental Health Board
      4) All others.

   b. Substance abuse community services priorities (including Federal block grant requirements) are below:

      1) Pregnant injecting drug users
      2) Other pregnant substance users
      3) Other injecting drug users
      4) Women with dependent children including women who are working to regain custody of their children
      5) Mental Health Board commitments ready for discharge
      6) All others

6. The Network Provider shall not make admission into a behavioral health program contingent upon a consumer receiving any other service offered by the Network Provider.

7. The Network Provider agrees there shall be a “no refusal” approach to admitting persons determined eligible by DHHS’ Centralized Data System for community-based BH services in the Region’s network.

   a. A Network Provider who does not comply (1) may not be eligible for funding under this Contract; or (2) may have funds withheld pending compliance with the Contract requirements.

   b. The Network Provider shall work with the Regional Center and Region V to facilitate effective and timely discharges for persons transitioning from the inpatient care to community-based services. Providers agree to promptly review referrals for admission made by the Lincoln Regional Center, Lancaster County Mental Health Crisis Center, Mary Lanning or other hospitals serving Region V

consumers. Providers agree to provide prompt notice, including reason/ rationale for denial of services, to the Region in accordance with policy and procedures set forth by the Region.

8. Network Providers must agree to use their best efforts to ensure continuity of care to link the consumer to other community behavioral health services and providers so behavioral health care is not interrupted. This shall include coordinating consumer care through other providers, Region V, the Regional Centers, and System Management.
9. The Network Provider agrees that no person shall be denied access to mental health or substance abuse treatment solely based on participation in Medication Assisted Treatment for a substance use disorder. Medication Assisted Treatment refers to a range of pharmacotherapy available to detoxify, maintain or otherwise medically manage clients to treat addiction. Providers agree to serve consumers utilizing medications as prescribed by a physician.
10. The Network Provider must ensure it has a policy requiring a psychosocial screening within two (2) weeks of admission for every youth seeking substance use disorder treatment, unless such screen has been conducted within the last six (6) months and is received by the treatment program.
    a. Screening must assess suicide risk and other developmental, psychological, and familial factors which may indicate the client's need for MH services.
    b. Screening must be developed in consultation with a professional, as allowed within their scope of practice.
    c. Screening must be administered in consultation with a professional, as allowed within their scope of practice.
    d. Should screening show the need for further assessment or MH services, the provider shall initiate a referral for such services within one (1) week.

G. FINANCIAL ELIGIBILITY REQUIREMENTS: The Network Provider agrees to charge persons receiving services fees in accordance DHHS' and Region V's financial eligibility policy and fee schedules.

1. The Network Provider shall make reasonable efforts to collect appropriate reimbursement for its services.
2. The Network Provider, as a program funded in whole or in part under DHHS funds, must not deny or suspend services to persons residing in Nebraska because of inability to pay scheduled fees, including preadmission deposits, co-payments, and/or other payments required from the consumer.
3. The Network Provider shall have on file with Region V a current copy of its sliding fee schedule policies and shall submit amended versions of its sliding fee schedule, and policies, within sixty (60) days of its revisions.
4. In processing financial eligibility, the Network Provider agrees to verify the lawful presence in the United States of any person who has applied for public benefits administered by said agency. The Network Provider shall require all applicants for public benefits to provide written attestation that: (1) he/she is a United States citizen; or (2) he/she is a qualified alien under the Federal Immigration and Nationality Act, 8 U.S.C 1101 et seq.

   If an individual identifies as a qualified alien, the Provider shall make request to Region V following policy and procedures to verify eligibility for public benefits through the Systematic Alien Verification for Entitlements (SAVE) Program. The exception to this condition is that in the absence of other payers, services that are ordered by a Mental Health Board or by a Court order may be reimbursed by the Region/DHHS.

   Due to emergency exemption, the following services do not require attestation of citizenship or lawful presence: Emergency Protective Custody hold, Mental Health or Substance Abuse Crisis Assessment, Emergency Psychiatric Observation, Crisis Response

Teams, and 24 hour Crisis Lines. If accessed involuntarily by the consumer through Mental Health Board or Court Order, emergency services also include Acute Inpatient, Sub Acute, Crisis Stabilization, Social Detoxification, and Hospital Diversion.

H. FEDERAL FINANCIAL PARTICIPATION REQUIREMENTS (MEDICAID): The Network Provider agrees that if they deliver a service reimbursable by Medicaid, they will also be an authorized network provider through Medicaid's ASO unless denied due to lack of business need. The provider must bill Medicaid directly for all persons eligible for Medicaid. This requirement does not include Social Detoxification or Halfway House services.

I. CLIENT DATA REQUIREMENTS IN THE CENTRALIZED DATA SYSTEM (CDS) AND REGION V SYSTEMS COMPASS: The Network Provider agrees to accurate and accountable participation in all reporting and record keeping systems, including the Centralized Data System (CDS) and Region V Systems Compass, and information requests required by Region V and DHHS for all behavioral health services funded under this Contract. The mechanisms for reporting this information: direct entry into CDS/Compass, interface with electronic health record (EHR), upload capabilities as defined by the systems, and other reporting mechanisms as defined by Region V Systems. The Network Provider agrees that the accuracy of the data is dependent on the data input by Network Providers

1. The Network Provider must agree to serve all clinically and financially appropriate referrals authorized by DHHS consistent with capacity. The CDS appeals process shall be available on all denied authorizations.
2. The Network Provider must agree to comply with information reporting to DHHS though the CDS which is required to maximize all Federal funding.
3. The Network Provider agrees to the following client data requirements in CDS as follows:
   a. Authorized Services: Network Providers must receive Prior Authorization from CDS for consumers to receive any FFS service to be eligible for payment with funds under this Contract. Medication Management services are excluded from the prior authorization requirement. Prior authorization applies to the following services:

Adult Services:

1) Community Support	• Community Support • Assertive Community Treatment (ACT)
2) Residential	• Intermediate Residential • Short-Term Residential • Therapeutic Community • Dual Disorder Residential • Halfway House • Psychiatric Residential Rehabilitation • Secure Residential
3) Non-Residential	• Intensive Outpatient • Day Rehabilitation

   b. Registered Services: Network Providers must Register required consumer information in the CDS for consumers receiving NFFS, services in order to be eligible for expense reimbursement payment with funds under this Contract. Registered services do not require prior authorization.

Adult Services:

1) Community Support
- Intensive Community Services
- Supportive Living
- Recovery Support

2) Non-Residential
- Medication Management
- Assessment/Evaluation
- Outpatient Therapy
- Supported Employment
- Peer Support

3) Emergency Services
- Emergency Protective Custody
- Crisis Assessment
- Social Detox
- Emergency Community Support
- Short-Term Respite
- Hospital Diversion
- Crisis Response Team
- 24 Hour Crisis Line
- Inpatient Post-Commitment

Children's Services:
- Outpatient Therapy
- Intensive Outpatient
- Professional Partner
- Crisis Response Team (SOC)

c. Capacity Access Guarantee (CAG) Services: The Network Provider who receives CAG funding agrees to work in collaboration with Region V to develop and implement a mechanism to share registration data for all persons served regardless of primary funder for all services receiving Capacity Access Guarantee funds. Examples of data sharing may include direct entry into Region V's COMPASS software, interface between the provider's EMR and Region V's COMPASS or specific provider EMR reports than can be submitted on agreed upon intervals of time.

d. Alternative Data Requirements: For services not included in the CDS, the Network Provider will ensure the regular submission of data for system management using a Provider Log or entry of encounters into Region V Systems Compass (electronic management system). If Provider Logs are submitted, they will include the name of the service provided, the month, the consumer's name, date of birth, and Social Security number. These Logs will be submitted along with monthly billing documents. This applies to the following services:

Children's Services
- Youth Assessment
- Therapeutic Consultation

e. Special Data Input Timelines: The Network Provider shall ensure the following special timelines for data input are adhered to:

1) *Procedure for Consumers in the Commitment Process*. Data input for Registrations for consumers served in EPC/Crisis Centers must be completed by the end of the first 48 hours after admission to the EPC/Crisis Center service.

2) *Procedure for Adult and Children in NFFS Services*. Registration of consumer demographic, non-clinical information for all non-emergency NFFS services for adult and children's services shall be entered into the online data system within seven days of admission to the services, except as outlined in #3 below.

3) *Procedure for Adult and Children in NFFS Outpatient Therapy Services*. Any Non-Residential services, which specifically require a psychiatric

diagnosis, shall have up to 21 working days from the service admission date to submit registration information.

4) *Procedure for Admission of a Committed Person to an Inpatient or Outpatient Service (Residential or Non-Residential) at a Community Provider or a State Regional Center*.

a) BH Acute and Subacute Inpatient commitments shall be committed to DHHS. Region V and DHHS shall determine the placement location of an inpatient commitment at a regionally contracted community hospital provider or at a State Regional Center.

b) BH outpatient commitments shall be to the Residential or Non-Residential community service provider.

c) Registration of consumer demographic, non-clinical information, including change of legal status and commitment date, must be updated in the CDS no later than 48 hours following the commitment.

f. Data input for persons discharged from services must be completed within 10 days of discharge or when requested by the Region if the open registration is affecting admission or prohibiting a consumer from receiving other services.

g. The Network Provider agrees to discharge compliance thresholds as identified in Attachment D.

J. STATEWIDE QUALITY IMPROVEMENT INITIATIVES:

1. The Network Provider agrees to participate in quality improvement initiatives to enhance service provision to individuals with co-occurring disorders and complex needs. The Network Provider agrees to participate and use data gathered from participation in the Compass EZ to drive the Provider's quality improvement initiatives.
2. The Network Provider agrees to participate in quality improvement initiatives to increase the knowledge of trauma informed care in the provider's workforce and increase the provision of trauma informed care services to persons served. The Provider agrees to participate and use data from participation in the Fallot & Harris Trauma Informed Care assessment to drive the Provider's quality improvement initiatives. The Network Provider shall ensure that all staff providing behavioral health services are informed about the effects of psychological trauma, consistently screen for trauma symptoms and history of traumatic events, provide ongoing assessment of trauma symptoms and problems related to trauma, offer services that are recovery-oriented and trauma-sensitive and understand that re-traumatization may occur if safe, effective, responsive services are not available.
3. The Network Provider agrees to participate in the Region's ongoing efforts to track data trends and continued implementation of a data-driven Continuous Quality Improvement plan. Measures will be reviewed at minimum quarterly using a Results Based Accountability (RBA) approach to understand how much, how well and whether people are better off because of the services they receive.

K. CONTINUOUS QUALITY IMPROVEMENT: The Network Provider shall maintain a program of continuing evaluation of the quality and effectiveness of each of its behavioral health programs and services. In support of quality improvement, the Network Provider agrees to:

1. Submit data that measures effectiveness, efficiency, access to services including waiting lists, denials and referrals determined to be ineligible, satisfaction, elements from completed assessments of the persons served, service utilization, complaints, and appeals, critical incidents, financial performance and other data necessary to evaluate network and contract performance.
2. Use valid measurement tools and conduct outcomes measurement across services as identified in Section VI.D.15;

3. Monitor consumer outcomes in relationship to established targets, identified trends, and actions for improvement, for purposes of performance improvement and achieving optimal outcomes for the persons served through programs and services;
4. Participate in the analysis of aggregate data as recommended by the Regional Quality Improvement Team;
5. Participate in quality initiatives as requested including but not limited to co-occurring care, cluster-based planning, trauma informed care, and integration of primary and behavioral health care.
6. Complete quality improvement action plans as identified by Region V Systems.

L. NATIONAL VOTER REGISTRATION: Network Providers agree to comply with Title 42 Public Health and Welfare, Chapter 20 Elective Franchise, Subchapter I-H National Voter Registration in establishing procedures to provide voter register assistance to persons served.

VII. FUNDING ASSURANCES

A. Office of Management & Budget (OMB) Super Circular as defined in 2CFR 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 agency's CPA audit.

The Network Provider, as a recipient of federal and state funds, to verify and ensure all funds requested are allowable. For more information, see 2 CFR 200 and *Attachment C-Federal Block Grant Requirements*.

B. The Network Provider agrees to provide an accounting to Region V for all sources and expenditures of funds for any service(s) reimbursed by Region V and DHHS, as outlined in this Contract (Attachment A), for the duration stated herein.
1. Such accountability shall include separate accounting for MH and SUD services, and any reports, audits, program reviews, documents, or papers of a financial nature which DHHS or the Region requires or may request.
2. The Network Provider shall maintain separate accounting of fund sources used to pay for MH services and the fund sources used to pay for SUD services. Records shall be available for inspection by authorized representatives of Region V, DHHS, or the Federal government, upon request with the express understanding that any inspection will comply with Federal and state laws and regulations regarding confidentiality.

C. The Network Provider agrees that income received by the Network Provider from charges for services provided under this Contract shall remain in the account of the Network Provider and shall be used for the provision of services.

D. The Network Provider agrees that the funds under this Contract are intended for the provision of behavioral health services and related administrative services as specified in the contract; therefore, funds received under the terms of this Contract shall not be used to litigate legal actions against Region V, DHHS or the state.

E. Reimbursement from all sources shall not exceed the cost of services.

F. The Network Provider shall not bill for services when a signed copy of a subcontract has not been provided to Region V by September 27, 2019.

G. The Network Provider shall ensure that all Federal funds paid to the Provider are 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.

H. The Network Provider shall ensure that funds are not used to supplant current funding of existing activities. Supplant means to replace funding of a recipient's existing program with funds from a Federal grant.

I. The Network Provider agrees to only submit billings for services provided to individuals who meet the Clinical Criteria for an identified level and care and the Financial Eligibility Criteria set by DHHS and Region V. The Network Provider agrees to deduct copayments from consumers and other third-party payments received for the service prior to billing any service paid on an expense reimbursement basis. If the expenses reimbursement billed is a Capacity Access Guarantee (CAG), Capacity Development (CD), Service Enhancement (SE), or Pilot Project for a service paid on a Region or State rate, the provider must apply any excess funds generated by the primary service against the CAG, CD, SE, or Pilot Project prior to billing.

J. The Network Provider agrees to be actively monitoring for Medicaid eligible individuals using an appropriate electronic system. The Network Provider will not submit reimbursement requests for services for any Medicaid eligible individual receiving Medicaid eligible services.

The Network Provider may bill for all substance abuse units of service for persons who are Medicaid Fee for Service (FFS) non-managed care who do not have a Share of Cost. Individuals meeting this criterion must be entered into CDS and services documented as appropriate. If the service is a covered benefit, a provider may not bill for persons who are on a Share of Cost and have not met their individual obligation under any circumstance. The provider must retain the Medicaid denial form(s) in the consumer file. The Region will check this documentation to ensure no payment is being requested or made for a denial of Medicaid due to Share of Cost

K. The Network Provider agrees that no more than 15% of funds may be used for indirect expenses/costs unless the provider has a federally approved cost rate.

L. The Network Provider agrees that at no time will compensation or payment of any kind be provided in advance of services actually performed

M. The Network Provider will ensure that any correspondence submitted to Region V or DHHS reflects the appropriate service names as identified in the DBH Electronic Billing System (EBS) and Centralized Data System (CDS).

N. The Network Provider is eligible for reimbursement for post-commitment days as outlined in Attachment E.

VIII. BILLING AND PAYMENT

A. Payments under this contract shall be made by Region V as approved in the Regional Budget Plan subject to receipt and approval of any reports required to be submitted and any supporting documentation required.

1. NFFS services, including Capacity Access Guarantee services, shall be paid on a rate through reimbursement for actual expenses that have not been reimbursed through other payment sources, or through another reimbursement method, based on the approved Regional Plan and Budget. The amount paid to the Network Provider shall not exceed the total amount allocated in this Contract for each service as specified in Attachment A.

2. FFS for all services paid on a fee basis for a unit of service shall be paid based upon the capacity approved in the Regional Budget Plan at the service rates set by Region V and DHHS. The amount paid to the Network Provider shall not exceed the total amount allocated in this Contract for each category as specified in Attachment A.
3. Reimbursement to a Network Provider above the amount in Attachment A must be approved by the Regional Governing Board at a duly constituted meeting of the Board.

B. The Network Provider agrees to participate in the CDS and EBS. Prior to or at the end of the month, the Network Provider agrees to access the CDS website and enter encounter data. Using the EBS, each provider must submit to the Region a Provider Payment Request (PRR) that includes an electronic signature of a person authorized by the provider to submit the form.

C. The Network Provider agrees to submit Provider Reimbursement Requests (PRR) in the EBS per guidelines outlined in the Electronic Billing System Manual.

D. If there was a change in Medicaid status, such as a denial of eligibility, for reasons other than Share of Cost or medical necessity, to request payment for the service provided, the provider must register the consumer and service in CDS to submit to EBS within 60 days of the Medicaid denial. Requests made after 60 days of denial will not be reimbursed by the Division and/or Region. 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.

E. 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 Region. If the reimbursement is received in the same fiscal year, the provider must reduce the units in CDS to subtract these funds from the next request for payment sent to the Region. If the reimbursement received is for units in a prior fiscal year, the provider must 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 Region.

F. Billing for denied insurance claims must be completed per provisions detailed in *Region V's Financial Eligibility Policy & Procedures.*

G. The Network Provider shall submit billing, through EBS, for actual and allowable costs on the 7th of each month to Region V. When the 7th falls on a weekend or holiday, the reimbursement claim must be received by Region V on the Friday before the weekend or the last working day before the holiday.

H. The Network Provider agrees that if the billing does not make the submission deadline set above, the bill may not be paid until the following month to ensure sufficient time for processing.

I. A billing that has incorrect or incomplete information will not be accepted or processed until such time that the information is accurate and complete. In the event a billing is delayed because of missing or inaccurate information, Region V will process billing as soon as possible after all documents have been approved.

J. Requests for payments submitted by the Network Provider shall contain sufficient detail to support payment. Any terms and conditions included in the Network Provider's request shall be deemed to be solely for the convenience of the parties.

K. Final invoices must be submitted within sixty (60) days of end of contract term or will not be paid. Failure to meet these deadlines may result in Region V disallowing costs or taking any other available remedy, as provided herein.

L. 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 Region but subsequently reimbursed by a third party, and for a limited billing of units in defined circumstances. The PFY billing process should not be used to:

1. Bill units "missed" or not paid due to no funds remaining in the contract in prior fiscal years
2. Bill partial units to compensate for any difference between funds paid the provider by another payer and provider, region or state rate
3. Bill denied Medicaid service for a Medicaid enrolled individual
4. Bill for services in which the consumer is deemed eligible to pay the cost or for a Medicaid recipient to meet a share of cost obligation
5. Bill for units not recorded in CDS or without an associated encounter number
6. Bill for expense reimbursement not paid in the previous year
7. Pay an amount for a service that was paid as an expense reimbursement in prior fiscal year

All past units billed must have:

1. Been performed in the last two (2) months of the prior contract period but not billed due to unforeseen or unavoidable circumstances. Repeated limitations, slow or incorrect entry into a provider's data/billing system will not qualify as unforeseen or unavoidable circumstance.
2. Not include units denied by Medicaid for a Medicaid service to a Medicaid enrolled individual.

IX. REMEDIES FOR NON-COMPLIANCE/PAYMENT DELAY, REDUCTION, OR DENIAL

Providers agree to reduction in payments based upon any failure to comply with the Contract conditions herein, as determined by audits, reviews conducted under this Contract, and/or any reviews conducted by Region V and/or the DHHS under Federal and/or state rules and regulations. Such reviews include compliance with all data input requirements verified through the Centralized Data System.

As consistent with applicable law, Region V may, if the Network Provider fails to comply with federal statutes, regulations, or the terms and conditions of the agreement:

1. Impose any of the specific conditions listed in 45 CFR § 75.207 or 2 CFR § 200.207, as applicable;
2. Temporarily withhold any payments pending the correction of the deficiency by the Network Provider;
3. Disallow all or part of the cost of the activity or action not in compliance;
4. Wholly or partly suspend or terminate this agreement;
5. Recommend suspension or debarment proceedings be initiated by the federal funding agency; and
6. Take any other remedies that may be legally available.

If Region V imposes items 3, 4, or 6 above, Region V may withhold future payments or seek repayment to recoup costs paid by Region V.

As this Agreement is a contract for services as defined in Chapter 73 of the Nebraska Revised Statutes, the following provisions apply:

Corrective Action Plan: If the Network Provider fails to meet the Scope of Work as set forth in the Agreement. Region V may require the Provider to complete a Corrective Action Plan (hereafter "CAP").

1. Region V shall set a deadline for the CAP to be provided to the Region, but shall provide the Provide reasonable notice of said deadline. In its notice, the Region shall identify the issue to be resolved.
2. The CAP will include, but is not limited to, a written response noting the steps being taken by the Provider to resolve each issue(s), including a date that the issue(s) will be resolved.

3. If the Provider fails to provide a CAP by the deadline set by Region V, fails to provide Region with a CAP demonstrating the issues regarding performance will be remedied, or fails to meet the deadline(s) set in the CAP for resolution of the issue(s), Region V may withhold payments (for the work or deliverables) related to the issues identified by Region V, or exercise any other remedy set forth in this Agreement or available under law.

Breach of Agreement: Region V may, in its sole discretion and considering the gravity and nature of the noncompliance, allow the Network Provider to correct a failure or breach of agreement within a period of thirty (30) days or longer ("cure period"). If Region V provides a cure period, it shall provide notice, which shall be delivered by Certified Mail, Return Receipt Requested, or in-person with proof of delivery. Allowing a Network Provider a cure period to correct a failure to comply does not waive the Region's right to take other action listed above for the same or different failure to comply that may occur at a different time. If Network Provider failed to cure the failure or breach within the cure period, Region V may terminate the Agreement, in whole or in part upon written notice to the Network Provider.

Nothing in this provision shall preclude the pursuit of other remedies as allowed by law.

X. GENERAL PROVISIONS

A. ACCESS TO RECORDS AND AUDIT RESPONSIBILITIES: The Network Provider agrees to the following terms regarding access to records and audit responsibilities:

1. The Network Provider shall provide access to Region V and DHHS, or its authorized representative, to any documents, papers, or other records pertinent to this agreement, in order to make audits, examinations, excerpts, and transcripts. The Provider shall provide the same access to the Federal Funding Agency, the Inspectors General, the Comptroller General of the United States, or any of their authorized representatives. These rights also includes timely and reasonable access to the Provider's personnel for the purpose of interview and discussion related to such documents, papers or other records. These rights are not limited to the retention periods included herein but continue as long as the records are retained by the Provider.
2. The Network Provider shall maintain all financial records, supporting documents, statistical records, and all other records pertinent to the agreement, for 3 years from the date of submission of the final expenditure report.
3. In addition the foregoing retention periods, all records must be retained as specified in 2 CFR§ 200.333 (a) through (f) or 45 CFR§ 75.361 (a) through (f), as applicable. This includes, but is not limited to: if any litigation, claim, or audit is started before the expiration of the three year period, the records must be retained until all litigation, claims, or audit findings involving the records have been resolved and final action is taken.
4. The above access to record and retention requirements apply for block grant subawards/agreements.
5. If the federal law requires a different record retention length, that shall apply. These include but are not limited to subawards with funding from the EPA and HUD, and may be more fully set forth herein.
6. As required by law, records that fall under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and all associated rules and regulations, including but not limited to the policies and procedures identified in 45 CFR § 164.316, shall be maintained for 6 years from the date of their creation or date when the policy or procedures were last in effect.

B. ACKNOWLEDGEMENT OF FUNDING: As required by United States Department of Health and Human Services (hereinafter "HHS") appropriations acts, all recipients of HHS federal awards must acknowledge federal and DHHS funding when issuing statements, press releases, requests for proposals, bid invitations, and other documents describing projects or programs funded in whole

or in part with federal and/or DHHS funds. If the agreement utilizes funds from HHS, the Network Provider is required to state: (1) the percentage and dollar amounts of the total program or project costs financed with federal and DHHS funds; and (2) the percentage and dollar amount of the total costs financed by nongovernmental sources. For all publications that result from work under this agreement not included above, and for any publications supported by a federal agency other than HHS, the Network Provider shall acknowledge the program or project was supported by the CFDA, name of award, federal agency and DHHS.

C. AUDIT AND ACCOUNTING RESPONSIBILITIES

1. The Network Provider shall comply with all applicable federal audit requirements, including but not limited to those in 2 CFR§ 200 Subpart F or 45 CFR § 75 Subpart F; an audit required by these regulations must be prepared and issued by an independent auditor in accordance with generally accepted government auditing standards. A copy of the audit is made electronically available or sent to Region V Systems.
2. The Network Provider shall comply with 2 CFR §§ 200.508 through 200.512 or 45 CFR §§ 75.508 through 75.512, as applicable, including but not limited to: (a) procure or otherwise arrange for the audit required by this part in accordance with § 200.509 (§ 75.509), and ensure it properly performed and submitted when due in accordance with § 200.512 (§ 75.512); (b) prepare appropriate financial statements, including the schedule of expenditures of Federal awards in accordance with § 200.510 (§ 75.510); (c) promptly follow up and take corrective action on audit findings, including preparation of summary schedule of prior audit findings and a corrective action plan in accordance with § 200.511 (§ 75.511); (d) provide the auditor with access to personnel, accounts, books, records, supporting documentation, and other information as needed for the auditor to perform the audit required by law.
3. In addition to, and in no way in limitation of any obligation in this agreement, the Network Provider shall be liable for audit exceptions, and shall return to Region V/DHHS all payments made under this agreement for which an exception has been taken or that has been disallowed because of such an exception, upon demand from Region V/DHHS.
4. The Network Provider shall maintain its accounting records in accordance with generally accepted accounting principles. Region V/DHHS reserves the rights to require Provider to submit required financial reports on the accrual basis of accounting. If Provider's records are not normally kept on the accrual basis, Provider is not required to convert its accounting system but shall develop and submit in a timely manner such accrual information through an analysis of the documentation on hand (such as accounts payable).

D. ANTI-DISCRIMINATION: The Network Provider shall comply with all applicable local, state, and Federal statutes and regulations regarding civil rights and equal opportunity employment, including, but not limited to, Title VI of the Civil Rights Act of 1964; 42 U.S.C §§ 2000d et seq., the Rehabilitation Act of 1973; 29 U.S.C. §§ 794 et seq., the Americans with Disabilities Act of 1990; 42 U.S.C. §§ 12101 et seq., and the Nebraska Fair Employment Practice Act, NEB. REV. STAT. §§ 48-1101 to 48-1125. Violation of said statutes and regulations will constitute a material breach of contract. The Network Provider further agrees to insert similar provisions in all sub-contracts for services allowed under this Contract under any program or activity.

E. ASSIGNMENT: The Network Provider agrees not to assign or transfer any interest, rights, or duties under this Contract to any person, firm, or corporation without prior written consent of Region V. In the absence of such written consent, any assignment or attempt to assign shall constitute a breach of this Contract.

F. COMPLIANCE WITH LAW: The Network Provider shall comply with all applicable law, including but not limited to all applicable federal, state, county and municipal laws, ordinances, rules, and regulations.

G. CONFIDENTIALITY: Any and all information gathered in the performance of this contract either independently or through Region V or DHHS, shall be held in the strictest confidence and shall be

released to no one other than Region V or DHHS without the prior written authorization of Region V and DHHS, provided that contrary contract provisions set forth herein shall be deemed to be authorized exceptions to the this general confidentiality provision. This provision shall survive termination of this contract.

H. CONFLICTS OF INTEREST: In the performance of this Contract, the Network Provider agrees to avoid all conflicts of interest and all appearances of conflicts of interest. The Network Provider shall not acquire an interest either directly or indirectly which will conflict in any manner or degree with performance and shall immediately notify Region V in writing of any such instances encountered.

I. COSTS: Under this agreement, Region V/DHHS shall only pay for the allowable costs (as defined in this section) incurred during the Period of Performance. To be allowable, all costs must be (a) necessary for the performance of the agreement activities; (b) reasonable, as provided in 2 CFR§ 200.404 or 45 CFR § 75.404; (c) allocable to the federal award, as provided in 2 CFR § 200.405 or 45 CFR § 75.405; (d) consistent with all other requirements of the Cost Principles; and (e) consistent with all other law, regulation, policy, or other requirements applicable to the state or federal funds involved.

J. DATA OWNERSHIP AND COPYRIGHT: Except as otherwise provided in the Federal Notice of Agreement, Region V and / or DHHS shall own the rights in data resulting from this project or program. The Network Provider may not copyright any of the copyrightable material and may not patent any of the patentable products produced in conjunction with the performance required under this agreement without written consent from Region V and / or DHHS. Region V, DHHS and any Federal granting authority hereby reserve a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use the copyrightable material for Federal or state government purposes. This provision shall survive termination of this agreement.

K. DEBARMENT, SUSPENSION OR DECLARED INELIGIBLE: The Network Provider certifies that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. The Network Provider certifies that it is registered with the System of Award Management (SAM) (https:www.sam.gov), in good standing, and that the entity will maintain annual certification in accordance with Federal Acquisition Regulations. Failure to comply with this section, including maintaining an active registration and/or good standing with SAM, may result in withholding of payments or immediate termination of the agreement.

L. FEDERAL FINANCIAL ASSISTANCE: The Network Provider agrees that its performance under this Contract will comply with all applicable provisions of 45 C.F.R. §§ 87.1–87.2 (2005) et seq. The Network Provider further agrees that it shall not use direct Federal financial assistance to engage in inherently religious activities, such as worship, religious instruction, and/or proselytization.

M. FORCE MAJEURE: Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under this contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of this contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. Upon such notice, all obligations of the affected party under this contract which are reasonably related to the Force Majeure Event shall be suspended, and the affected party shall do everything reasonably necessary to resume performance as soon as possible. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under this contract.

N. GOVERNING LAW: This contract shall be governed in all respects by the laws and statutes of the United States and the State of Nebraska. Any legal proceedings against Region V, DHHS or the State of Nebraska regarding this contract shall be brought in Nebraska administrative or judicial forums as defined by Nebraska State law. The Network Provider will comply with all Federal and Nebraska statutory and regulatory law.

O. HOLD HARMLESS: The Network Provider shall defend, indemnify, hold, and save harmless Region V Systems and the State of Nebraska and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State of Nebraska, arising out of, resulting from, or attributable to the willful misconduct, negligence, error or omission of the Network Provider, its employees, consultants, representatives, and agents, except to the extent such Network Provider's liability is attenuated by any action of the State of Nebraska which directly and proximately contributed to the claims.

Region V and DHHS, if liable, is limited to the extent provided by the Nebraska Tort Claims Act, the Nebraska Agreement Claims Act, the Nebraska Miscellaneous Claims Act, and any other applicable provisions of law. Region V and DHHS do not assume liability for the actions of its Network Providers.

P. HUMAN TRAFFICKING PROVISIONS: The Network Provider shall comply and be subject to the requirements of the Trafficking Victims Protection Act of 2000, 22 USC §§ 7101 et seq. During the period of time that the agreement is in effect, the Network Provider and its employees may not (a) engage in forms of trafficking in persons; (b) procure a commercial sex act or (c) use forced labor in the performance of the agreement.

Q. INDEPENDENT ENTITY: The Network Provider is an Independent Entity and neither it nor any of its employees shall, for any purpose, be deemed employees of Region V or DHHS. The Network Provider shall employ and direct such personnel as it requires to perform its obligations under this agreement, exercise full authority over its personnel, and comply with all workers' compensation, employer's liability and other Federal, state, county, and municipal laws, ordinances, rules and regulations required of an employer providing services as contemplated by this agreement.

R. INTEGRATION: This written Contract represents the entire agreement between the parties, and any prior or contemporaneous representations, promises, or statements by the parties, that are not incorporated herein, shall not serve to vary or contradict the terms set forth in this Contract.

S. LIST OF EXCLUDED INDIVIDUALS AND ENTITIES: Region V Systems is prohibited from hiring an individual or entity who is on the federal Office of Inspector General's *List of Excluded Individuals and Entities* (LEIE). By entering into a contract/agreement with Region V Systems for remuneration for services, your name (and/or entity's name associated with services provided) will be verified through the federal LEIE database. Payment for services will be delayed and/or denied if your name/entity's name is documented in this database.

T. LOBBYING: If the Network Provider receives Federal funds through Region V and DHHS, for full or partial payment under this Contract, then no State or Federal appropriated funds will be paid, by or on behalf of the Network Provider, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Contract or (a) the awarding of any Federal Agreement; (b) the making of any Federal grant; (c) the entering into of any cooperative agreement; and (d) the extension, continuation, renewal, amendment, or modification of any Federal Agreement, grant, loan, or cooperative agreement. If any funds other than State or Federal

appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Contract, the Network Provider shall complete and submit Federal Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

U. MANDATORY DISCLOSURES: The Network Provider must disclose to the State, in a timely manner and in writing, all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting this subaward in accordance with 2 CFR §200.113 or 45 CFR § 75.113, as applicable. Failure to make required disclosures can result in any of the remedies described in §200.338 or 45 CFR § 75.371, as applicable, including suspension or debarment. (See also 2 CFR part 180 et seq. and 31 U.S.C. § 3321).

V. NEBRASKA NONRESIDENT INCOME TAX WITHHOLDING: The Network Provider acknowledges that Nebraska law requires the Network Provider to withhold Nebraska income tax if payments for personal services are made in excess of six hundred dollars ($600) to any independent contractor who is not domiciled in Nebraska or has not maintained a permanent place of business or residence in Nebraska for a period of at least six months. This provision applies to individuals, to a corporation if 80% or more of the voting stock of the corporation is held by the shareholders who are performing personal services, and to a partnership or limited liability company if 80% or more of the capital interest or profits interest of the partnership or limited liability company is held by the partners or members who are performing personal services. The parties agree, when applicable, to properly complete the Nebraska Department of Revenue Nebraska Withholding Certificate for Nonresident Individuals Form W-4NA or its successor which is available at: http://www.revenue.nebraska.gov/tax/current/fill-in/f_w4na.pdf.

W. NEBRASKA TECHNOLOGY ACCESS STANDARDS (NTAS): The Network Provider shall review the Nebraska Technology Access Standards and ensure that products and/or services provided under the contract comply with the applicable standards. In the event such standards change during the Network Provider's performance, the State may create an amendment to the contract to request that contract comply with the changed standard at a cost mutually acceptable to the parties. NTAS standards can be found at http://nitc.nebraska.gov/standards/index.html

X. NEW EMPLOYEE WORK ELIGIBILITY STATUS: The Network Provider shall use a Federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A Federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. § 1324a, known as the E-Verify Program, or an equivalent Federal program designated by the United States Department of Homeland Security or other Federal agency authorized to verify the work eligibility status of a newly hired employee.

If an individual or sole proprietorship, the following applies:

1. The individual must complete the United States Citizenship Attestation part of the I-9, available on the Department of Administrative Services website at www.das.state.ne.us.
2. If the individual indicates on such attestation form that he or she is a qualified alien, the individual agrees to provide the U.S. Citizenship and Immigration Services documentation required to verify the individual's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
3. The Provider understands and agrees that lawful presence in the United States is required and the Provider may be disqualified or the agreement terminated if such lawful presence cannot be verified as required by NEB. REV. STAT. § 4-108.

Y. ORDER OF PREFERENCE: Unless otherwise stated in an amendment to this agreement, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference:

1. Amendments to the Agreement with the most recently dated amendment having highest priority;
2. This Agreement and any attachments to this Agreement.

These documents constitute the entirety of the agreement. Any ambiguity or conflict in the agreement discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of interpretation as established in the State of Nebraska, unless other rules are set forth according to federal law.

Z. PROMPT PAYMENT: If applicable, payment will be made in conjunction with the State of Nebraska Prompt Payment Act, Neb. Rev. Stat. §§ 81-2401 to 81-2408 (2004).

AA. PUBLIC COUNSEL: In the event the Network Provider provides health and human services to individuals on behalf of Region V and DHHS under the terms of this Contract, the Network Provider shall submit to the jurisdiction of the Public Counsel under Neb. Rev. Stat. §§ 81-8,240 to 81-8,254 (2004) with respect to the provision of services under this Contract.

BB. RESEARCH: The Network Provider shall not engage in research utilizing the information obtained through the performance of this subaward without the express written consent of DHHS and/or Region V. The term "research" shall mean the investigation, analysis, or review of information, other than aggregate statistical information, which is used for purposes unconnected with this contract.

CC. SEVERABILITY: If any term or condition of this Contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if this Contract did not contain the particular provision held to be invalid.

DD. SUBCONTRACTORS: The Network Provider shall not subcontract any portion of this contract without prior written consent of Region V and DHHS. In subcontracting or subawarding any portions of this agreement, the Network Provider shall follow 2 CFR § 200.318 through 200.326 or 45 CFR § 75.327 through § 75.335, as applicable. The Network Provider shall ensure that all subcontractors comply with all requirements of this contract and applicable Federal, state, county and municipal laws, ordinances, rules and regulations.

EE. SURVIVAL: All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this agreement, including but not limited to those clauses that specifically state survival, survive the expiration or termination of this agreement.

FF. WHISTLEBLOWER PROTECTIONS: The Network Provider shall comply with the provisions of 41 U.S.C. 4712, which states an employee of a contractor, subcontractor, grantee, or subrecipient may not be discharged, demoted or otherwise discriminated against as a reprisal for "whistleblowing." In addition, whistleblower protections cannot be waived by an agreement, policy, form, or condition of employment.

1. The Network Provider's employees are encouraged to report fraud, waste, and abuse. The Network Provider shall inform their employees in writing they are subject to federal whistleblower rights and remedies. This notification must be in the predominant native language of the workforce.
2. The Network Provider shall include this requirement in any agreement made with a subcontractor or subrecipient.

XI. CHANGES TO THE CONTRACT

A. The Network Provider may propose changes to this Contract with Region V for the Contract period. Such proposed changes may reflect adjustments in program services, expense categories, service usage as indicated through utilization management, and/or capacity development plans but must continue to meet the requirements set by the fund source. Any adjustments will require a clear written request, supported by data and narrative to justify the request, and subsequent approval from Region V and DHHS prior to implementation.

B. The Network Provider shall request in writing to Region V for approval of programmatic changes. Region V shall approve or disapprove in whole or in part in writing within thirty (30) days of receipt of such request.

C. The Network Provider shall submit proposed changes or amendments to the Contract on or before March 7, 2020. No amendments will be considered after that date unless an emergency exists and the Network Provider can demonstrate need.

D. This Contract may not be modified except by amendment made in writing and signed by both parties or by their duly authorized representatives. No alteration or variation of the terms and conditions of this agreement shall be valid unless made in writing and signed by both parties.

XII. TERMINATION OF CONTRACT

A. ASSURANCE OF PERFORMANCE: If Region V in good faith has reason to believe that the Network Provider does not intend to, is unable to, or has refused to perform or continue to perform all material obligations under this contract, Region V may demand in writing that the Network Provider give a written assurance of intent to perform. Failure by the Network Provider to provide written assurance within the number of days specified in the demand may, at Region V and/or DHHS' option, be the basis for termination of this Contract.

B. FUNDING AVAILABILITY: Region V may terminate the contract, in whole or in part, in the event funding is no longer available. Should funds not be appropriated, Region V may terminate the contract with respect to those payments for the fiscal years for which such funds were not appropriated. Region V shall give the Network Provider written notice thirty (30) days prior to the effective date of any termination. The Network Provider shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Network Provider be paid for a loss of anticipated profit.

C. BREACH OF CONTRACT: Region V may immediately terminate the contract, in whole or in part, if the Network Provider fails to perform its obligations under the contract in a timely and proper manner. Region V may, by providing a written notice of default to the Network Provider, allow the Network Provider to cure a failure or breach of contract within a period of thirty (30) days or longer at Region V's discretion considering the gravity and nature of the default. Said notice shall be delivered by Certified Mail, Return Receipt Requested or in person with proof of delivery. Allowing the Network Provider time to cure a failure or breach of contract does not waive Region V's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. Region V may, at its discretion, contract for any services required to complete this contract and hold the Network Provider liable for any excess cost caused by the Network Providers' default. This provision shall not preclude the pursuit of other remedies for breach of contract as allowed by law.

D. LOSS OF LICENSURE: Region V will immediately terminate this contract with the Network Provider upon notification that the Network Provider's licensure is denied, or revoked in any service, or in the event that the Network Provider places a consumer in imminent jeopardy of their health and safety.

E. FRAUD OR MALFEASANCE: Region V may immediately terminate this contract for fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by the Network Provider, its employees, officers, directors, volunteers, shareholders, or subcontractors.

F. PROVIDER CHANGES: The Network Provider shall report to Region V within twenty (20) days of its occurrence any of the following changes, including changes regarding services offered which are different than the services agreed to in this contract:

1. Changes in ownership, legal status, control, or management of the Network Provider.
2. Changes in the capacity and/or type(s) of services offered.
3. Region V may immediately terminate and/or amend this Contract, or any portion thereof, based on the changes reported, within thirty (30) days of receiving the report from the Network Provider or upon notice from the Division.

XIIV. NOTICES

Notices shall be in writing and shall be effective upon receipt. Written notices, including all reports and other written communications required by this contract shall be sent to the following addresses:

For Region V:

Dennis Byars, Regional Governing Board Chair
823 North 8th Street
Beatrice, NE 68310

AND

C.J. Johnson, Regional Administrator
Region V Systems
1645 N Street
Lincoln, NE 68508

For: Mental Health Crisis Center of Lancaster County

Scott Etherton
Executive Director
825 'J' Street
Lincoln, NE 68508

XIV. EFFECTIVENESS

The Contract shall become effective upon execution by the legal representatives or authorized representatives of both parties.

A. The Headings set forth in this Contract are for convenience only and will not control or affect the meaning or construction of the provisions of this Contract.

B. This Contract may be signed in counterpart originals, which collectively shall have the same legal effect as if all signatures had appeared on the same physical document

C. This Contract may be signed and exchanged by facsimile transmission, with the same legal effect as if the signatures had appeared in original handwriting on the same physical document.

XV. SIGNATURES AND CERTIFICATIONS

A. AUDIT CERTIFICATION:

☐ As the Network Provider, we expect to expend less than $750,000 from all Federal Financial Assistance sources including commodities, during our fiscal year. Therefore, we are not subject to the audit requirements of 2 CFR 200 and do not need to submit our audited financial statements to DHHS.

☐ As the Network Provider, we expect to expend $750,000 or more from all Federal Financial Assistance sources, including commodities in our current fiscal year. Therefore, we are subject to the single audit requirements of 2CFR 200.

If this information changes, and Network Provider is subject to a Single Audit or no longer subjected to a Single Audit, Network Provider shall notify the Region immediately.

B. EXECUTIVE COMPENSATION REPORTING REQUIREMENT: At the time of execution of this Contract, Network Provider must notify DHHS, in writing, if it is required to report executive compensation pursuant to the Federal Funding Accountability and Transparency Act. Pub. L. 109-282, as amended by section 6202 of Pub. L. 110-252, and associated regulations at 2 CFR §§ 170 et seq. This is required for Network Providers who receive more than $25,000,000 or more in annual gross revenue in federal contracts, subcontracts, awards or subawards, and meet the other regulatory criteria listed in those sections. If Network Provider meets these criteria, it must fill out an executive compensation disclosure attachment. Network Provider shall notify DHHS immediately if funding it receives changes such that it must report salaries under this requirement.

☐ As the Network Provider, we receive more than $25,000,000 or more in annual gross revenue in federal contracts, subcontracts, awards or subawards, and meet the other regulatory criteria listed in those sections.

☐ As the Network Provider, we DO NOT receive more than $25,000,000 or more in annual gross revenue in federal contracts, subcontracts, awards or subawards, and meet the other regulatory criteria listed in those sections.

IN WITNESS THEREOF, the parties have duly executed this agreement hereto, and each party acknowledges the receipt of a duly executed copy of this agreement with original signatures.

MENTAL HEALTH CRISIS CENTER OF LANCASTER COUNTY		REGIONAL BEHAVIORAL HEALTH AUTHORITY	
_____		_____	
Chair, Lancaster County Board Of Commissioners	Date	Regional Governing Board Representative	Date
_____		_____	
Director	Date	Regional Administrator	Date

Behavioral Health Service Rates

ATTACHMENT A

July 1, 2019 - June 30, 2020

Mental Health Crisis Center											

SERVICE	Amend. #	RATE	MAX CAPACITY	REGION V CONTRACT							
				STATE			FEDERAL			COUNTY	TOTAL
				CASH FUNDS	COST MODEL	GENERAL FUNDS	CFDA #	FAIN #	FUNDS	FUNDS	FUNDS
MENTAL HEALTH											
Fee-For-Service											
Post Commitment Days		$237.74	n/a			POOL					POOL
Emergency-EPC (Rural Co Reimb)		$208.00	n/a							REIMB	REIMB
NonFee-For-Service											
Emergency-EPC		n/a	n/a	$374,534		$642,982					$1,017,516
Emergency Flex Funds		n/a	n/a			$3,872					$3,872
SUBSTANCE USE DISORDER											
Fee-For-Service											
None											
NonFee-For-Service											
Emergency-Crisis Assessments		n/a	n/a	$8,617		$145,970					$154,587
GRAND TOTAL AGENCY				**$383,151**	**$0**	**$792,824**			**$0**	**$0**	**$1,175,975**

Provider Reporting Requirements

DUE DATE (data being reported)	Data/Report	To Whom
August 15, 2019	Actuals	networkmanagement@region5systems.net
August 16, 2019	FY20 Fee Schedules	networkmanagement@region5systems.net
October 1, 2019	Subcontracts	networkmanagement@region5systems.net
October 31, 2019	CPA Audit (for agencies on FY schedule)	networkmanagement@region5systems.net
October 31, 2019 (April-June 2019)	Quality Review	CQI@region5systems.net
October 31, 2019 (July-September 2019)	• Cluster Assignment Data • Complaints, Appeals & Critical Incidents • Consumer Recovery Outcomes	CQI@region5systems.net
November 1, 2019	Agency Board List	networkmanagement@region5systems.net
January 31, 2019 (October-December 2019)	• Cluster Assignment Data • Complaints, Appeals & Critical Incidents • Consumer Recovery Outcomes	CQI@region5systems.net
January 31, 2020 (July-September 2019)	Quality Review	CQI@region5systems.net
January 31, 2020 (July-December 2019)	Perception of Care	CQI@region5systems.net
April 30, 2020 (January-March 2020)	• Cluster Assignment Data • Complaints, Appeals & Critical Incidents • Consumer Recovery Outcomes	CQI@region5systems.net
April 30, 2020 (October-December 2019)	Quality Review	CQI@region5systems.net

DUE DATE (data being reported)	Data/Report	To Whom
May 30, 2020	CPA Audit (for agencies operating on a calendar year)	networkmanagement@region5systems.net
July 31, 2020 (January-March 2020)	Quality Review	CQI@region5systems.net
July 31, **2020** (January-June 2020)	Perception of Care	CQI@region5systems.net
July 31, 2020 (April-June 2020)	• Cluster Assignment Data • Complaints, Appeals & Critical Incidents • Consumer Recovery Outcomes	CQI@region5systems.net
October 31, 2020 (April-May 2020)	Quality Review	CQI@region5systems.net

Weekly - Mondays by noon	Capacity/Utilization	CDS
Real time	Waitlist	CDS
Monthly by the 7th of the month	Agency Billing	EBS
1st Monday of month (data for previous month)	Ineligibles/Denials	CQI@region5systems.net
October 7th, January 7th & April 7th	Contract Amendment Requests	networkmanagement@region5systems.net

Federal Block Grant Requirements

I. FEDERAL REQUIREMENTS APPLICABLE FOR COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT (CHMSBG) AND SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG)

A. The Federal Block Grant funds included in this Contract are contingent upon ongoing availability of Community Mental Health Services Block Grant (CFDA #93.958) and Substance Abuse Prevention and Treatment Block Grant (CFDA #93.959) funds from the Federal government.

B. The Network Provider agrees that Federal Block Grant Funding shall be used to:
1. Fund priority treatment and support services for individuals without insurance or who cycle in and out of health insurance coverage;
2. Fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance offered through the exchanges and that demonstrate success in improving outcomes and / or supporting recovery;
3. Fund universal, selective and targeted prevention activities and services; and
4. Collect performance and outcome data to determine the ongoing effectiveness of behavioral health prevention, treatment and recovery support services and to plan the implementation of new services on a nationwide basis.

C. Network Provider agrees that all programs receiving CMHSBG and / or SAPTBG funding will:
1. Participate in Needs Assessments conducted by the State Behavioral Health Authority and / or the Region;
2. Be accredited;
3. Participate in any DHHS designated Independent Peer Review to assess the quality, appropriateness and efficacy of treatment services when selected.
4. Demonstrate quality, appropriateness and efficacy of treatment as required by 42 USC § 300x-53(a)(1)(A);
5. 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, and;
6. Improve the process for referrals of individuals to the treatment modality that is most appropriate for the individuals.

D. All block grant funds not expended under the terms of this Contract shall be retained by DBH.

E. Publications: As required by United States Department of Health and Human Services (hereinafter "DHSS") appropriations acts, all DHHS recipients must acknowledge Federal and DHHS funding when issuing statements, press releases, requests for proposals, bid invitations, and other documents describing projects or programs funded in whole or in part with Federal and DHHS funds. Recipients are required to state: (1) the percentage and dollar amounts of the total program or project costs financed with Federal and DHHS funds; and (2) the percentage and dollar amount of the total costs financed by nongovernmental sources. When Federal dollars are used, the Network Provider agrees that all publications that result from work under this agreement will acknowledge that the project was supported by specifying the grant Number and the Federal Agency responsible for the grant.

F. The Network Provider agrees that no Federal Block Grant Funding shall be used to:
1. Lobby the Nebraska Legislature or the United States Congress.
2. 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.
3. Pay the salary of an individual at a rate in excess of Level I of the Executive Schedule, or $199,700 per year.
4. Purchase inpatient hospital services.
5. Make stipend and incentive payments to intended recipients of health services.
6. Purchase or improve land, purchase, construct, or permanently improve any building or other facility or purchase major medical equipment.

7. Satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds.
8. Provide financial assistance to any entity other than a public or non-profit private entity.
9. Provide for expenses that are not allowed under Federal cost principles, whether they are charged on a direct or indirect cost method.
10. To, directly or indirectly, influence or attempt to influence any elected or appointed official or employee of an elected or appointed official or any specific piece of legislation.

G. The Network Provider attests that:
1. 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;
2. The provider is not delinquent on any Federal loan;
3. The provider will maintain a Drug Free Workplace; and
4. No Federal funds will be used for inherently religious activities such as worship, religious instruction, or proselytization, and / or any other prohibited activity.
5. The provider has no potential conflict of interest that would affect the Federal funds and agrees to disclose in writing to Region V and DHHS any potential conflict of interest.
6. 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 Region V and DHHS any such violations.
7. The provider as a recipient of federal funds agrees to understand and pay expenses appropriately per applicable cost circular.

H. No Federal funds will be awarded to any provider who has demonstrated an inability to meet any requirement associated with the funds.

I. If a provider expends more than $750,000 or more of Federal funds for fiscal years ending December 31, 2016, or later, a Certified Public Accountant (CPA) will be engaged to conduct an audit in accordance to the Single Audit Act.

J. Upon completion or notice of termination of these grants (applies to Federal dollars only), the following procedures shall apply for close-out of the grant:
1. Provider shall follow all invoicing and liquidation requirements contained in this agreement.
2. The Provider will not incur new obligations after the termination or completion of the grant, and shall cancel as many outstanding obligations as possible. The Region shall give full credit to the Provider for the Federal share of non-cancelable obligations properly incurred by the Provider prior to termination, and costs incurred on, or prior to, the termination or completion date.
3. Consistent with the terms of the federal award, and after all reports are received, the Region shall make any necessary adjustments upward or downward in the federal share of costs.
4. The Region shall make prompt payments, as consistent with the terms set forth herein, for all actual and allowable costs under the terms of this agreement.
5. The Provider shall immediately return to the Region any unobligated balance of cash advanced or shall manage such balance in accordance with the Region's instructions.
6. Within a maximum of 90 days following the date of expiration or completion, the Provider shall submit all financial, performance, and related reports required by the Region Reporting Requirements. The Region reserves the right to extend the due date for any report and may waive, in writing, any report it considers to be unnecessary.
7. The Provider shall assist and cooperate in the orderly transition and transfer of grant activities and operations with the objective of preventing disruption of services.
8. Close-out of this grant shall not affect the retention period for, or state or Federal rights of access to, Provider records, or the Provider's responsibilities regarding property or with respect to any program income for which the Provider is still accountable under this grant. If no final audit is conducted prior to close-out, the Region reserves the right to disallow and recover an appropriate amount after fully considering any recommended disallowances resulting from an audit which may be conducted at a later time.

II. FEDERAL REQUIREMENTS FOR COMMUNITY MENTAL HEALTH BLOCK GRANTS (CMHSBG)

Network Providers receiving Community Mental Health Services Block Grant funds agree to ensure the following services are provided and requirements are met as listed below and included in 45 CFR Part 96:

A. Community Mental Health Services Block Grant funds are 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).

B. If a Community Mental Health Center is funded with CMHSBG funds, the Center shall provide:
1. Services to individuals residing in Region V's geographical area (referred to as a "service area").
2. Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility are provided.
3. 24-hour hour-a-day emergency care services.
4. Day Treatment or other partial hospitalization services or psychosocial rehab services.
5. Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.
6. Services are provided within the limits of the capacities of the center, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.
7. Services are available and accessible, and in a manner that preserves human dignity and assures continuity and high-quality care.

III. FEDERAL REQUIREMENTS FOR SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG)

A. Network Provider agrees that all programs receiving SAPTBG funding will comply with 45 CFR Part 96 and continue to meet all the SAPTBG requirements below:
1. Ensure that continuing education is provided to the SAPTBG Prevention and Treatment workforce, and document such training.
2. Provide updated and accurate information in all SAPTBG reporting requirements.
3. As requested by Region V and DBH, attend SAPTBG training provided.
4. Provide the Region V and DBH with the name and contact information of the individual responsible for managing and monitoring the "Waiting List" for all Priority Populations.
5. Provide required data to monitor Priority Populations on a waiting list and receive interim services.
6. 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.
7. Give preference to the following priority populations for any program receiving SAPTBG funding, in the following order: (a) pregnant-injecting drug users, (b) other pregnant substance users, (c) other injecting drug users, and (d) women with dependent children.
8. Not provide services in a penal or correctional institution
9. Submit data as determined by the Region and DHHS for the SAMHSA National Outcomes Measures (NOMS).

B. SUBSTANCE ABUSE ASSESSMENTS
1. If an individual identified as a priority population has not received a substance abuse 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 individual should immediately receive treatment. In the event that capacity does not exist for the individual to immediately receive treatment, the individual will receive Interim Services within 48 hours (from the time the evaluation report is documented) and will receive Interim Services until treatment is available.

C. INTERIM SERVICES FOR PRIORITY POPULATIONS

Interim Substance Abuse Services are services that are provided until an individual is admitted to a treatment program to reduce the adverse effects of substance abuse, promote health, and reduce the risk of transmission of disease. Network Providers agree to provide the delivery of Interim Services in the following manner:

1. 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 abuse evaluation.
2. Interim Services for injecting drug users must include counseling and education about human immunodeficiency virus (HIV), tuberculosis (TB), 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 if necessary.
3. Interim Services for injecting drug abusers must also include education on HIV transmission and the relationship between injecting drugs and communicable diseases.
4. Case management services must also be made available in order to assist client with obtaining HIV and or TB services.
5. All referrals and or follow-up information pertaining to priority populations and interim sources must be documented and this documentation must be maintained by the program and provided to Region V or DBH upon request.
6. Interim Services for pregnant women must also 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, 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. All referrals and or follow-up information must be documented and made available upon the request of the Region V and/or DBH.

D. 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 abuse 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 abuse 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.

E. CAPACITY/WAITLING LIST MANAGEMENT for PRIORITY POPULATIONS

1. The Network Provider must provide documentation to the Region within 7 days of reaching 90% of capacity to admit individuals to a treatment program.
2. The Network Provider in collaboration with Region V 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 Network Provider 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 Network Provider should immediately contact Region V. Region V will notify DBH. All parties will then collaboratively problem-solve to immediately resolve the situation.
5. Network Providers will ensure that individuals on the “Waiting List” are tracked utilizing a unique patient identifier.
6. The Network Provider will ensure that a mechanism is in place that allows for maintaining at least weekly contact with those individuals on the “Wait 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 services again. Reasonable efforts should be made to encourage individuals to remain on the "Waiting List".

8. The Network Provider will ensure that individuals on the "Waiting List" are provided with the best estimated timeframe for admission to treatment.
9. The Network Provider will ensure that individuals are placed on the "Waiting List" as many times as they request treatment.
10. The Network Provider will ensure that individuals on the "Waiting List" are admitted into treatment at the earliest possible time, to the most appropriate level of care, and within a reasonable geographic area that is acceptable to the individual.
11. Should the individual chose to receive treatment outside Region V, the sending and receiving management entities will collaborate to ensure that treatment occurs, and will do so in consultation with Region V and the DBH Capacity Management System.

F. SAPTBG WOMEN'S SET ASIDE PROGRAMS (WSA)

1. The provider within the Nebraska Behavioral Health System, Region V service area designated as receiving funding to provide services for women and women with dependent children (WSA) is St. Monica's.
2. The amount set aside for women's services shall be expended on individuals who have no other financial means of obtaining such services as set aside for and as provided in 45 CFR §96.124(e) and §96.137. For women with dependent children in their care and custody or for women who are attempting to regain physical custody of their children, Network Providers receiving WSA funding will serve the family as a unit as evidenced by the provision, facilitation, or arrangement of the following:
    a. Admission of women and their children to residential services (when program serves children),
    b. Primary medical care for women, including referral for prenatal care while the woman is receiving treatment services,
    c. Primary pediatric health care when appropriate, including immunizations for their children and pediatric treatment for perinatal effects of maternal substance abuse,
    d. Based on assessment information, gender-specific therapeutic interventions and or services for women which my address issues of relationships, sexual and physical abuse, and/or parenting, and child care while the women are receiving these services.
    e. Therapeutic interventions for children in custody of women, including interventions which address developmental needs, issues of sexual and physical abuse/neglect,
    f. Provide sufficient case management and transportation to ensure that women and their children have access to services listed above.
    g. Childcare needs, while the women are receiving services, which facilitate engagement in treatment.
    h. Coordinate with the Division of Children and Family Services as appropriate with treatment and discharge planning.
    i. The Network Provider is responsible to maintain documentation which illustrates facilitation or provision of the above listed services and ensure that any changes are reported and on file with Region V.
3. Copies of all Letters of Agreement, Memorandums of Understanding, or any provider subcontracts that result, that demonstrate how a provider will meet the requirements to be a "qualified" provider, must be received by Region V within 30 days of the full execution of this contract.
4. Providers serving women will publicize the availability of these services and publicize that a pregnant woman will receive priority admission. This may be done by means of street outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of treatment distributed to the local community network of community-based organizations, health care providers, and social service agencies.
5. If a provider of women's services has insufficient capacity to provide treatment, the facility shall notify Region V.

G. TUBERCULOSIS (TB) SCREENING AND SERVICES

1. Network Providers receiving SAPTBG funds shall:
   a. Report active cases of TB to the Division of Public Health Tuberculosis Program Manager and adhere to all reporting requirements as set forth including NRS Sec.71-502, 71-1626 and 173 NAC Chapters 1-6, which can be found at: http://dhhs.ne.gov/Pages/reg_t173.aspx.
   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. Network Providers receiving SAPTBG funding will routinely make TB services available to each individual receiving treatment for substance abuse and to monitor such service delivery.
3. The Network Provider 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. Documentation of screening testing, referral, and any necessary follow-up.
   g. Report any active cases of TB to state health officials, and.
4. The Network Provider is responsible to provide Region V and DBH with documentation which illustrates facilitation or provision of the above listed services and ensure that any changes are reported and on file with Region V.

H. STERILE NEEDLE DISBURSEMENT AND HIV/AIDS

1. Network Provider will ensure that no SAPTBG funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.
2. The Network Provider shall not carry out any testing for the etiologic agent for Acquired Immune Deficiency Syndrome unless such testing is accompanied by appropriate pre-test and post-test counseling.

I. CHARITABLE CHOICE

The Network Provider must comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54. [See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provision and Regulations.] The Network Provider will provide Region V with any form being used in the Region to communicate the consumers' right to request another provider based on religious preferences.

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

J. CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

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

Level of Care	Service Type	Service	Discharge Compliance Threshold Based on No Utilization	Contractual Expectation for Discharge
Adult Community Integration/Support	Authorized	Assertive Community Treatment - MH	No TADS units claimed for 1 month	10 days
		Community Support - MH	No TADS units claimed for **2** months	10 days
		Community Support - SUD	No TADS units claimed for **2** months	10 days
		Day Rehabilitation - MH	No TADS units claimed for 1 month	10 days
	Registered	Mental Health Respite - MH	No TADS units claimed for 1 month	10 days
		Recovery Support - MH	No TADS units claimed for **3 months**	10 days
		Supported Employment - MH	No TADS units claimed for **12 months**	10 days
		Supportive Living - MH	No TADS units claimed for 1 month	10 days
Adult Emergency Services	Registered	Inpatient Post Commitment Treatment Days - MH	No TADS units claimed for 1 month	10 days
		24 Hour Crisis Line - MH	No TADS units claimed for 1 month	10 days
		CPC Services - SUD	No TADS units claimed for 1 month	10 days
		Crisis Assessment - SUD	No TADS units claimed for 1 month	10 days
		Crisis Response Teams - MH	No TADS units claimed for 1 month	10 days
		Emergency Community Support - MH	No TADS units claimed for 1 month	10 days
		Emergency Protective Custody - MH	No TADS units claimed for 1 month	10 days
		Hospital Diversion Less than 24 hours - MH	No TADS units claimed for 1 month	10 days
		Hospital Diversion Over 24 hours - MH	No TADS units claimed for 1 month	10 days
		Social Detoxification - SUD	No TADS units claimed for 1 month	10 days
Adult Inpatient	Authorized	Acute Inpatient Hospitalization - MH	No TADS units claimed for 1 month	10 days
		Sub-acute Inpatient Hospitalization - MH	No TADS units claimed for 1 month	10 days
Adult Non-Residential	Authorized	Intensive Outpatient / Adult - SUD	No TADS units claimed for 1 month	10 days
	Registered	Assessment - SUD	No TADS units claimed for 1 month	10 days
		Intensive Community Services - MH	No TADS units claimed for 1 month	10 days
		Medication Management - MH	No TADS units claimed for **12 months**	10 days
		Outpatient Psychotherapy - MH	No TADS units claimed for **3 months**	10 days
		Outpatient Psychotherapy - SUD	No TADS units claimed for **3 months**	10 days
Adult Residential	Authorized	Dual Disorder Residential - SUD	No TADS units claimed for 1 month	10 days
		Halfway House - SUD	No TADS units claimed for 1 month	10 days
		Intermediate Residential - SUD	No TADS units claimed for 1 month	10 days
		Psychiatric Residential Rehabilitation - MH	No TADS units claimed for 1 month	10 days
		Secure Residential - MH	No TADS units claimed for 1 month	10 days
		Short Term Residential - SUD	No TADS units claimed for 1 month	10 days
		Therapeutic Community - SUD	No TADS units claimed for 1 month	10 days
Youth Non-Residential	Registered	Intensive Outpatient / Youth	No TADS units claimed for **3 months**	10 days
		Assessment - SUD (Youth)	No TADS units claimed for 1 month	10 days
		Outpatient Psychotherapy - MH	No TADS units claimed for **3 months**	10 days
		Outpatient Psychotherapy - SUD	No TADS units claimed for **3 months**	10 days
		Professional Partner - MH	No TADS units claimed for 1 month	10 days

Post-Commitment Days

Pursuant to 2001 Neb. Laws LB 692 § 20(3), the Network Provider shall be eligible to provide and receive reimbursement for post-commitment days.

Post-commitment shall mean that an individual has been committed pursuant to a Mental Health Board-ordered treatment disposition but is unable to access that service.

I. Network Provider agrees to the following to receive post-commitment day reimbursement:

A. The Network Provider shall provide assessment and stabilization services for those individuals who remain post-commitment with the Network Provider.

1. The Network Provider shall register each individual held for EPC with the System Management Agent.

2. The Network Provider shall enter with the System Management Agent the date of commitment for each individual being held post-commitment.

3. Within 24-hours of the date of discharge, the Network Provider shall enter the discharge information.

B. The service provided by the Network Provider shall not include Mental Health Board-ordered treatment as provided in the Mental Health Act.

C. Appropriate treatment, that is within the scope of services available from the Network Provider, consistent with the Board of Mental Health's recommendation, shall be provided to each individual classified as post-commitment.

D. To be eligible for reimbursement of post-commitment days, the Network Provider shall submit a claim for reimbursement to Region V according to Section IX of the Network Provider Contract.

1. Post-commitment days shall be reimbursed at the rate specified in Attachment A, up to the maximum dollar amount available to Region V. Payment for post-commitment days from the funding available to all Region V providers will be available on a first-come, first-served basis.

2. Rates paid for inpatient post-commitment treatment days may be lower but shall not be higher than the State approved rate per day including physician charges as listed for acute inpatient in Attachment A.

E. If any other insurance or third-party payor pays the Network Provider any amount for post-commitment days, then Region V is not obligated to pay. If any other insurance company or third-party payor denies payment as non-covered for any reason, Region V will pay for post-commitment days according to the terms of this Contract.