MENTAL HEALTH GENERAL REVENUE FUNDED SERVICES
OPEN ENROLLMENT REQUEST FOR APPLICATION
JANUARY 30, 2014

The **Mental Health and Mental Retardation Authority (MHMRA) of Harris County,** as the Local Authority, is a contractor of the Texas Department of State Health Services (DSHS) established to plan, coordinate, develop policy, develop and allocate resources, supervise, and ensure the provision of community based mental health and mental retardation services for the residents of Harris County, Texas.

Pursuant to Texas Administrative Code §412.60, **Mental Health and Mental Retardation Authority of Harris County,** as a DSHS designated Local Authority, has the authority to assemble a network of service providers to provide the following services to the designated population of persons with mental illness who reside in Harris County. The funds allocated by DSHS are referred to as General Revenue (GR)-funds.

I. SERVICES SOUGHT

This Request for Application seeks participation from applicants for the purpose of offering a comprehensive array of services and supports, within Harris County for individuals with mental illness who meet the designated population. Any qualified applicant can submit an application to provide General Revenue funded services. For a description of services, see http://www.dshs.state.tx.us/mhcommunity/LPND/definitions.shtm.

The grid below indicates which services in Harris County are being sought as well as the % of service capacity the Local Authority intends to procure. Please note that contracting for lower service packages is required prior to providing any higher acuity packages (counseling being the one exception) as stated in our Local Plan FY '08, '10, and '12. This plan can be reviewed at http://www.mhmraharris.org/Mental-Health-External-Provider-Network.asp.

ROUTINE SERVICES	Average Current Service Capacity	% Capacity sought to procure
Adult Co-Occurring Disorders Residential Treatment Services	849 *(of total crisis services procured)*	Up to 65%

Priority and Target Population

1. Adult Mental Health (MH) Priority Population - Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.

2. Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe major depression with GAF under 50.

3. Child and Adolescent Mental Health Priority Population - children ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance

abuse, mental retardation, autism or pervasive developmental disorder) who attachment serious emotional, behavioral or mental disorders and who:

a. have a serious functional impairment; or
b. are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
c. are enrolled in a school system's special education program because of a serious emotional disturbance.

II. MINIMUM REQUIREMENTS

At minimum Applicants must be qualified providers. Thus they must:

1. Meet the minimum qualifications of the DSHS performance contract http://www.dshs.state.tx.us/mentalhealth.shtm and local plan http://www.mhmraharris.org/epn.asp;
2. Demonstrate ones ability to provide services in compliance with DSHS contract requirements;
3. Comply with TRR (Texas Resiliency and Recovery) @ http://www.dshs.state.tx.us/mhsa/trr/;
4. Be able to provide services in the language as dictated by the person receiving services and/or utilization of translator by prior approval of the Authority;
5. Engage and involve consumers, legally authorized representatives, and families in the policy and practice levels within the applicant's organization or individual practice; and
6. Have the ability to accept routine appointments within 10 days and urgent appointments within 2 days for all new referrals until the applicant's capacity is reached or utilization/referral is not indicated.

Notwithstanding the above, Applicants must be eligible/registered to do business in Texas. In any situation where a consortium of providers is applying, a single entity responsible for services must be identified and the financial agent must be an organization with a demonstrated ability to manage funds. See other applicant credentialing requirements in Attachment B.

III. RESPONSIBILITIES

Local Authority Responsibilities

The Local Authority will be responsible for service coordination/case management and facilitating an individual's selection of service providers, authorizing services, reviewing claims and paying for appropriate, authorized services rendered by the service providers in its Network. The Local Authority is also responsible for utilization management and quality assurance. The Local Authority ensures that contracted services addressing the needs of the Priority Population are provided as required by DSHS, comply with the rules and standards adopted under Section 534.052 of the Texas Health and Safety Code, and Chapter 412, Subchapter G of the Texas Administrative Code. The Local Authority does not guarantee any referral volume to any service provider within its Network of Providers. To review the Local Authorities FY14 Service Targets and Capacity go to http://www.dshs.state.tx.us/mhcommunity/LPND/LMHAs/harris-county.shtm.

Service Provider Responsibilities

The service provider will be responsible for maintaining all original documentation reflecting service provision regarding treatment and/or services rendered to the Local Authority's individuals with mental illness, and allow the Local Authority access to such records upon request. The service provider is required to comply with all state and federal laws regarding the

confidentiality of consumers' records and nondiscrimination. The service provider will actively assist in the disbursement of consumer and advocate satisfaction surveys. The service provider will obtain prior authorization, provide acceptable levels of care, and maintain acceptable levels of liability insurance, and appropriate licenses and accreditations. The service provider also agrees that its name may be used, along with a description of its facilities, care, and services in any information distributed by the Local Authority listing its service providers. The service provider must comply with the rules and standards adopted under Section 534.052 of the Texas Health and Safety Code and applicable local, state, and federal laws, rules and regulations.

IV. INSTRUCTIONS FOR SUBMISSION OF APPLICATIONS

Application Process:

Providers may contact MHMRA's Mental Health (MH) Network Management Coordinator to request an application or to answer questions regarding the application process.

MHMRA of Harris County
Attn: MH Authority Support Services
7011 Southwest Freeway
Houston, TX 77074
713-970-3400 (option 4) Phone
713-970-3387 Fax
mhnetworkdevelopment@mhmraharris.org

1. Provider application packet must include all the required information to be considered including all supporting documents requested and all attachments.

2. Applications may be submitted by the following three methods:

   a) By faxing to the attention of Cami Manley, Mental Health-Network Management Department, MHMRA Authority Support Services at fax number 713-970-3387. Application and documents must be legible for processing.
   b) By emailing as an attachment to: mhnetworkdevelopment@mhmraharris.org The supporting documents are required for processing. Providers may scan these documents to enable electronic submission. Documents must be legible for processing.
   c) By mailing to the following address:

      MHMRA of Harris County
      Attn: MH Authority Support Services
      7011 Southwest Freeway
      Houston, TX 77074

3. Complete applications will be processed, credentials verified, and a determination made within 60 days of receipt of application. Provider will be notified by letter of acceptance or denial of decision. In the case of a denial, provider will be advised of appeal procedures.

4. Absence or falsification of the application or material omission of information requested in the application may result in denial of network privileges. The Local Authority reserves the right to reject any and all applications, to waive technicalities, and to accept any advantages deemed beneficial to the Local Authority and the individuals served.

5. The entire response to this Request for Application shall be subject to disclosure under the Texas Public Information Act, Chapter 552 of the Texas Government Code. If the applicant believes information contained therein is legally accepted from disclosure under the Texas Public Information Act, the applicant should conspicuously (via bolding, highlighting and/or enlarged font) mark those portions of its response as confidential and submit such information under seal. Such information may still be subject to disclosure under the Public Information Act depending on opinions from the Attorney General's office.

6. RFA will remain open for a 2 year time period unless LMHA has received enough applications to meet service capacity as described in this application.

EXHIBIT A

CONTRACTOR:

CONTRACT ID#:

CONTRACT PERIOD: **_____, 2013 to August 31, 2014**

SERVICE: Co-Occurring Disorders Residential Treatment Services

SERVICE DESCRIPTION: Intensive residential treatment and supportive residential treatment program. Must have a minimum of three (3) years documented experience of working with individuals with co-occurring psychiatric and substance use disorders. Contractor must be willing to permit MHMRA case managers access to enrolled consumers during regular business hours for case management and counseling. Contractor will serve up to forty (40) consumers for an average length of stay not to exceed ninety (90) days.

PERFORMANCE TARGETS; Clinical progress in each level of care will be assessed on an ongoing basis. Assessment of outcomes is necessary at two levels:

- Individual outcomes measure the effectiveness of treatment by assessing the response to treatment in relation to defined outcomes. The clinical team will use the Well-Being Index (WHO, 1998 version), the Clinical Global Impression (CGI) and such other measures of recidivism and re-occurring crisis episodes as needed to assess individual outcomes. Clinical outcomes will be used to determine the need for treatment modification on an ongoing basis.

- System outcomes measure the effectiveness of the service delivery system by utilizing aggregated individual outcomes and cost data.

RATE AND RATE DESCRIPTION: **$79.00 per bed day per consumer for intensive residential treatment**

$69.00 per bed per day per consumer for supportive residential treatment

POOLED NOT TO EXCEED:

UNIT(S) INVOLVED: **9225**

EXHIBIT B

PRINCIPLES AND PRACTICES OF CONTRACTING WITH THE COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAMS DIVISION

Introduction

The CPEP Division of MHMRA of Harris County provides services to a number of eligible consumers in Harris County. To be eligible for the co-occurring disorders program, a consumer must:

1. Have a diagnosis of major depressive disorder, bipolar disorder or schizophrenia, schizoaffective disorder or schizophreniform;
2. Have a diagnosed substance abuse disorder;
3. Be a current resident of Harris County;
4. Adult (over age 18) and voluntary;
5. Have a capacity to make a decision to enter into voluntary treatment;
6. Have a history of two or more admissions to a psychiatric hospital within the past six months and/or a history of substance abuse rehabilitation admissions or recommendations for substance abuse rehabilitation or Harris County Incarceration within the last 6 months;
7. Not in need of acute care interventions;
8. Documented history of substance abuse/dependence which impacts MH treatment adherence;
9. Willingness to engage and participate in group and individual treatment modalities;
10. Patient is unable to be appropriately treated in a less intensive treatment setting (demonstrated failure in traditional outpatient services);
11. Patient able to comply with residential rules and regulations;
12. Medically stable and not in acute withdrawal;
13. Not bed confined or having medical complications which would significantly hinder participation in residential treatment; and a
14. Capacity to benefit from rehabilitation interventions (i.e. no significant cognitive impairments and/or limitations such as moderate/profound MR, brain injury, etc)

Within the limits of funding and other contract requirements, consumers will choose which services they receive from MHMRA and its Contract Providers. The underlying goal of all programs operated, or funded, by MHMRA of Harris County is to assist persons with mental health and substance abuse issues to develop the skills and access the community supports and resources necessary to learn, work, and live with dignity as contributing members of the community. The CPEP Division will not fund services which segregate consumers from the general treatment community, or do not work toward integrating consumers with mental illness into the community.

General Contract Information

The CPEP Division maintains an open enrollment process for all contract providers who meet the requirements of the contract and places no artificial limits on the number of providers within the Co-occurring Disorders Treatment Provider Network. Because of this, there are several facts that contract providers should be aware of:

- Having a valid contract with MHMRA does not guarantee that any particular provider will receive referrals for services. Referrals are based solely on consumer choice of available programs.
- The contracting process with MHMRA can be quite lengthy, requiring review by several Departments in the Agency and final approval by the Board of Directors. MHMRA staff may not authorize payments under any contract that has not been approved by the MHMRA Board.

Payment\Billing Information

The procedure for submitting an invoice for payment to MHMRA is described elsewhere in this Contract. There are, however, several basic principles that guide MHMRA staff when processing Contractor invoices for payment:

- MHMRA will only pay for services that have been properly authorized. In the CPEP Division, written authorizations are issued to document service start and end dates. Written authorization to begin services may only come from the Unit Director of the Co-occurring Disorders emergency service or designee.
- MHMRA will not pay for services provided for a consumer before the start date of a contract. MHMRA is not obligated to pay for any services rendered before a formal, written and signed contract is in place.
- Payment for authorized services occurs once per month. Each provider, in order to assure that they have the best chance of receiving timely payment for services rendered, should submit their invoices to Unit Director of the Co-occurring Disorders Program or designee by the 5th of each month.
- MHMRA will not pay for services billed to the Agency later than 30 days past the end of the month in which services were performed. For example, an invoice for services provided in March 2008 must be submitted to MHMRA no later than April 30, 2008, or payment will not be made for that invoice.

Consumer Choice

MHMRA uses the concept of consumer choice to assure that consumers are afforded the same choices that every other member of the community have as their right. There are three areas regarding the choices presented to consumers that require further explanation here. Violation of these principles will result in MHMRA removing a provider from the list of agencies given to consumers when choosing services and service providers.

- No solicitation of consumers (or their families) currently being served by another provider is permitted. Such behavior is considered inappropriate and unethical.
- No action will be taken to change the services for which a consumer is authorized unless that consumer has informed his/her Case Manager that he/she wants to make a change in services.
- Providers may not initiate changes in any consumer's service provider. Changes may only come from the consumer and must be authorized by the Case Manager.

EXHIBIT C
Agency Guidelines
Pre-Requisite Information, Application/Contracting Process, Quality Requirements, and Appeal Processes

Co-Occurring Disorders Residential Treatment Provider Network Operational Procedures

Introduction:
The Texas Department of State Health Services (DSHS) has assigned the duties of the Local Authority for mental health services in Harris County to Mental Health and Mental Retardation Authority of Harris County (MHMRA). Pursuant to Section 412.60 of the Texas Administrative Code, which governs this function, the local mental health authority must issue a Request for Applications (RFA) to procure community services through open enrollment. MHMRA may obtain clarification and confirmation of information submitted by the provider during the application process. MHMRA must award a contract to all providers whose application packets are complete and who demonstrate compliance to all guidelines specified in the FY2014 DSHS Performance Contract at http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

Application Process:
Providers may contact the unit director of the Co-Occurring Disorders Unit to request an application or to answer questions regarding the application process.

MHMRA of Harris County
Attn: MH Authority Support Services
7011 Southwest Freeway
Houston, Texas 77074
or
Via e-mail to: mhnetworkdevelopment@mhmraharris.org

1. Provider application packet must include the following information to be considered:
   a) Completed and signed network application
   b) Signed statement agreeing to provide specific services at rate of payment prescribed
   c) Attached copies of DSHS state license, proof of malpractice and/or liability insurance, a statement guaranteeing that all staff of the providers are licensed to provide substance abuse services and/or mental health services, and written explanations or supporting documents accompanying any affirmative responses on application questionnaire
   d) Attached verification of criminal background checks on all staff members

2. Applications may be submitted by the following three methods:
   a) By faxing to the attention of Network Development**, 713-970-3387**. Application and documents must be legible for processing.
   b) By emailing as an attachment to: mende.snodgress@mhmraharris.org
      The supporting documents are required for processing. Providers may scan these documents to enable electronic submission. Documents must be legible for processing.
   c) By mailing to the following address:

MHMRA of Harris County
Attn: MH Authority Support Services.
7011 Southwest Freeway
Houston, Texas 77074
or
Via e-mail to: mhnetworkdevelopment@mhmraharris.org

3. Complete applications will be processed, Licenses verified, and a determination made within 60 days of receipt of application. Provider will be notified by letter of acceptance or denial of decision. In the case of a denial, provider will be advised of appeal procedures.

4. Absence or falsification of the application or material omission of information requested in the application may result in denial of network privileges.

Application Licenses/Certificate Procedures and Requirements

Verification of Applicable Licenses/Certificates
Prior to provision of services, provider must warrant and guarantee that all staff members possess current licenses (LCDC at a minimum). This information will be verified by contacting the issuing board. Consent to conduct verification is included in the application packet. In addition, Providers must be compliant with FY2014 DSHS Performance Contract Section 3.12 "Compliance With Rules."

Re-verification of Applicable Licenses/Certificates
Providers must undergo an annual process of re-certifying with MHMRA to continue to provide services. An updated application must be submitted, along with confirmation that professional licenses have been renewed, DSHS licensing is current, and professional liability and general liability insurance is current. Providers are verified in the same manner as in the initial verification process. Additionally, provider performance will be considered through a profile of activities with the Agency such as:

- Claims submission - timely submissions, clean submissions
- Data submission - timely submissions, accurate and complete submissions
- Utilization - appropriate use of services, quality of care indicators, positive outcome measures achieved

All providers considered for re-verification into the network will be reviewed and decisions to grant continued privileges with the network will be based on verification warranties and the profile that the provider establishes. This process is subject to all levels of appeal that apply to the initial verification process.

Site Review Criteria:
A representative of MHMRA's Quality Management Department will evaluate each provider's office prior to initial verification process. Reviews will be conducted to ensure that providers are compliant with Mental Health Community Standards. Following are the general areas for review:

Safety Review
1. ADA compliance
2. Clean and safe environment
3. Occupancy permits and standards

Record Systems Review
1. Valid assessment
2. Treatment plan is current and based on assessment and medical necessity
3. Progress notes are completed for each service, reflect treatment plan goals and services rendered
4. Progress notes include start and stop time for services rendered
5. Progress notes are signed and dated
6. Progress notes are completed by person with valid credentials for service rendered
7. Records are maintained according to State and Federal confidentiality guidelines

Operational Standards Review
1. Information is posted in relation to complaints, appeals and duty to report processes
2. Confidentiality policies, consumer rights and privacy notices are provided to consumers
3. Access and Availability Audits
4. After Hours Availability Audits

5. Satisfaction Surveys - DSHS conducts annual consumer satisfaction surveys as a mechanism to obtain feedback and quality of care concerns regarding network providers. MHMRA may also conduct periodic patient satisfaction surveys.

Disclosure Requirements:

Professional Liability
Provider must provide any information regarding their malpractice history for the last five years. This information will be verified through the National Practitioner Data Bank (NPDB). Consent to conduct verification is included in the application packet.

Additionally, provider must address and warrant the following within the application:

1. That none of the licensed staff members have been the subject of a professional liability suit, arbitration, or settlement for the last 5 years. In the event of such suit, arbitration or settlement, the facility must warrant that the action does not demonstrate probable future substandard professional performance.
2. That in the last 5 years, the facility has not been involuntarily terminated as a contract care provider or, if such a termination has occurred, evidence that this history does not demonstrate probable future substandard professional performance.
3. Over the last 5 years, provider's employees have not sustained criminal conviction or indictment for substance related offenses or acts of moral turpitude or, if an employee(s) has such a history, the provider must warrant that this does not demonstrate probable future substandard professional performance. ("Conviction" is defined here as a plea or verdict of guilty or a plea of nolo contendere).

Sanctions imposed by licensing board
Provider must disclose adverse actions against its employees resulting in sanctions or limitations against their professional licenses. This information must be reported within 30 days of notification of such information.

Sanctions imposed by Local Authority
Failure to comply with MHMRA's procedures or with general obligations under the Agency may result in the following actions:

1. Case Managers and/or the Consumer Services Team Leader for Co-Occurring Disorders unit will document provider non-compliance and will refer the investigation of the complaint to the Quality Management Department.
2. The Quality Management representative will address the issue directly with the provider via a phone call, letter or visit.
3. Providers are responsible for completing a plan of improvement on all items that are out of compliance; failure to do so will be reviewed by the Agency and may be subject to contract termination and/or:
   a) Temporary suspension of network privileges
   b) Termination of network privileges
   c) Recoupment of funds

Quality Requirements & Procedures

Quality of Care:
MHMRA has comprehensive Utilization Management and Quality Management Programs that monitor and evaluate the care and services provided to consumers. Any issue that is a source of concern regarding a

consumer's treatment is reviewed as a quality of care concern. Any occurrence which could indicate that the provider demonstrates a probable future of substandard professional performance is subject to review.

Quality Management Initiatives

1. Access and Availability Audits - MHMRA conducts random quarterly audits to ensure that consumers are receiving services according to contract.
2. Treatment Record Audits and Data Submission Compliance - MHMRA conducts treatment record documentation audits at least annually to check provider's treatment records for compliance with the described standards. The providers will receive notification of the audit 30 days prior to the audit beginning. Providers will be asked to submit blinded records, which will be audited based on the criteria listed below. Once the audit is complete, the scores will be communicated to the provider. If the provider does not meet compliance, an action plan will be implemented and another audit scheduled. MHMRA has set a performance goal of at least 95% compliance. Criteria to be evaluated include the following:
    - Consumer Name or ID number on all pages
    - Biographical/personal data such as address, employer info, school info, age, marital status, phone number, emergency contacts, legal status, consents and guardianship information is noted
    - Employee's credentials and signature on each entry
    - All entries are dated
    - Record is legible
    - Presenting problem/chief complaint is listed including psychological and social conditions affecting client's medical/mental health/substance use status
    - Medical treatment history is documented such as significant illnesses, surgeries, pregnancies and/or accidents
    - History of and/or cigarette, current alcohol or substance abuse is documented in detail for each consumer
    - Psychiatric history is documented including previous dates, provider, facilities, interventions, and family information
    - Special status situations (SI, HI), severe deterioration and elopement potential are documented including referrals to appropriate CPEP programs, as needed
    - Each record indicates medications and dosages of each
    - Allergies and adverse reactions are clearly documented including no known allergies to drugs or other substances
    - DSM IV five axis diagnosis is consistent with symptoms, history and other assessment data (if there is an employee on staff who is licensed to perform multi-axial diagnoses)
    - Treatment plans/actions are based on medical necessity and consistent with diagnosis(es) and substance use disorders and have measurable objectives and timeframes. The consumer's understanding of the treatment goals which s/he has helped to set must be documented
    - Progress notes reflect treatment goals and consumers strengths and limitations
    - Referrals to maintain continuity of care are documented
    - Prevention and educative services are documented
    - Records are kept in a secure, confidential and organized manner. Records are retrievable. Records are maintained for a period of at least six (6) years.
    - Discharge plans and/or follow up plans are noted
    - Planning and training for responding to severe weather, disasters, and bioterrorism

3. Data Submission Compliance – Contractor shall follow documentation procedures as delegated by the Agency. All documentation shall be on Agency approved forms and shall be submitted to the Agency within 72 hours of completion for data entry into the system.
4. Satisfaction Surveys - MHMRA conducts provider satisfaction surveys as a mechanism to obtain feedback and suggestions for improvement from providers. Surveys will be mailed to providers on a yearly basis, and will assess satisfaction with the agency in the areas:
    a) Outpatient clinic appointment process
    b) Phone wait time
    c) Utilization management process
    d) Case manager availability, support and consultation
    e) MHMRA staff's professional behavior and courtesy
    f) Overall service

Outcomes Measurement

1. Personal responsibility or health outcomes and consumer-provider partnership in treatment decisions are primary tools of successful treatment. Clinical progress in each level of care will be assessed on an ongoing basis. Assessment of outcomes is necessary at two levels:

    - Individual outcomes measure the effectiveness of treatment by assessing the response to treatment in relation to defined outcomes. The clinical team will use the Well-Being Index (WHO, 1998 version), the Clinical Global Impression (CGI) and such other measures of recidivism and re-occurring crisis episodes as needed to assess individual outcomes. Clinical outcomes will be used to determine the need for treatment modification on an ongoing basis.

2. System outcomes measure the effectiveness of the service delivery system by utilizing aggregated individual outcomes and cost data

Network Requirements:

1. Training (See Exhibit D) - Mandatory training will be offered to new providers' staffs within 30 days of approval for the network and prior to service delivery. Annual updates will be scheduled and active network providers will be notified for mandatory attendance. Additional training may be deemed necessary based on changes that occur in procedures or regulations. Providers will be notified of any ad hoc training sessions that may occur.
   Documentation Requirements- Contractor shall follow documentation procedures as delegated by the Agency.
2. Notification of Change:
   Provider must provide written notification of change within 5 days of the occurrence for the following:
    a) Change of Address
    b) Change of Phone Numbers
    c) Any other material changes that affect access and availability to consumers
3. Notices to Agency:
   Contractor shall notify the Agency within 10 business days of any events effecting licensure of its employees, such as suspension, revocation, threatened loss or any way in which the Contractor/Provider might be limited in providing Covered Services. Any loss of Contractor's Professional Liability Insurance or material change in the policy must also be reported to the Agency within 10 business days of notification of this event.
    a) No Discrimination: Contractor agrees to render Covered Services to Consumers in the same manner and in accordance with the same standards as it offers to non-MHMRA Consumers and consistent with existing medical, ethical, and legal requirements for providing continuity of care to any patient.
    b) Covered Services: Contractor represents and warrants to the Agency that Covered Services shall be provided to all Consumers in an appropriate, timely, and cost effective manner. Further, Contractor represents and warrants to the Agency that Contractor shall furnish such

services according to the generally accepted substance abuse treatment and mental health practices and applicable laws and regulations.

Payment/Billing Information
The procedure for submitting an invoice for payment to MHMRA is described elsewhere in the Contract. There are however, several basic principles that guide MHMRA staff when processing Contractor submissions for payment:

- MHMRA will only pay for services that have been properly authorized.
- MHMRA will not pay for services provided for a consumer **before** the start date of a contract.
- MHMRA is not obligated to pay for any services rendered before a formal, written and signed contract is in place.
- The payment amount will be based on an Agency pre-approved Invoice, which shall reflect services, provided by the Contractor, and is approved by the Agency employee(s) authorized to approve billing(s) as set forth in the Agreement.
- Payment shall be made within 30 days of receipt of the approved Invoice. Payment may be delayed, adjusted or withheld, where a deficiency is noted in goods, services, or invoices received. MHMRA retains the right to offset payments for future claims paid where a deficiency is noted after payment has been processed.
- Invoices for services must be received no later than 30 calendar days after the date on which services were rendered. Claim forms for services received later than 30 days after the date on which the services were rendered will be denied due to untimely filing.
- Warranty: By submitting an invoice, Contractor warrants and represents that the services for which the claim is made were provided to the Consumer. The Agency shall have the right to review Contractor's records, upon reasonable notice and during business hours, to verify that such services were rendered.

Contracting for Services:
Providers will be required to sign a standardized Professional Services Contract with MHMRA. The contract contains guidelines and requirements for entering into an agreement with the Agency for the provision of services to a specific consumer population. The elements of the resulting contract are non-negotiable. Once a provider is accepted, the contract will be executed and a copy forwarded to the provider for his or her records.

Appeal Procedure for Denial of Access to Network:
1. Function and Timeline
    a) The Co-Occurring Disorders Program Committee of MHMRA may make a negative decision based on (but not limited to) one of the following:
        1) State license encumbered or not current
        2) Malpractice insurance is not in effect
        3) Affirmative responses to questions related to malpractice history, sanctions, or other negative history which the Committee believes may compromise the professional effectiveness or performance of applicant
        4) Information from outside sources concerning the provider's qualifications or legal history which the Committee believes may compromise the professional effectiveness or performance of appellant
        5) Variance of information supplied on the application and information obtained from an outside source(s)

    b) Appeal Timeline
    The provider must submit an appeal in writing to the Committee within 30 days from the written notification of the Committee's decision. The request for appeal must

specify the reason(s) the provider feels the decision was inappropriate or incorrect.

2. Level I Appeal
    a) Appeal of the original Committee decision is a Level I Appeal.
    b) Level I Appeal is heard at the next Committee Meeting or before the expiration of 30 days (whichever occurs first). The hearing is presided over by the CPEP Deputy Director who is a non-voting member with at least 3 other members of the committee present who are voting members.
    c) The Level I Appeal brings information to the Committee that it did not have at the time of the initial provider determination or corrects any misinformation that may have been considered in its initial decision.
    d) The Committee conducts a hearing and minutes are taken.
    e) The Level I Appeals Committee notifies the provider of its decision via letter. If decision is upheld, the provider is apprised of the right to appeal. If accepted into provider network, the provider is giving information about entry into network and training requirements and trained within 30 days of acceptance.

3. Level II Appeal
    a) The provider requesting review of the Level I Appeal decision must do so in writing within 30 days of determination to initiate the Level II Appeal Process specifying reason(s) why the potential provider considers the decision inappropriate.
    b) Co-Occurring Disorders Program staff date stamps the appeal and notifies CPEP Deputy Director and the Committee that the appeal must be reviewed within 30 days from the date received. The applicant is notified in writing of receipt of appeal by the next business day.
    c) Level II appeal is heard by the CPEP Deputy Director and one other CPEP Unit Director who did not participate in any meeting for Level I appeal. The decision is made within 30 days of receipt for Level II appeal and is the final decision.
    d) Provider will receive written notification of Committee's decision within 14 days of decision. If upheld, there are no further appeals under the plan. If overturned, provider receives acceptance letter under separate cover along with information regarding provider training and is trained regarding network procedures within 30 days of acceptance into the network.

EXHIBIT D
TRAINING REQUIREMENTS

Course	Refresher/ Frequency	Type of Training	Svc. Pkgs.	Length of Training	Who Needs?	Provided by
Basic Pharmacology	Annually	On-line	All	varies	All	MHMRA
Consumer Rights	Annually	On-line	All	varies	All	MHMRA
CPR/First Aid	Annually	Attend & participate	All	CMH-3 hrs	All	MHMRA
Cultural Diversity	Annually	On-line	All	varies	All	MHMRA
Course	**Refresher/ Frequency**	**Type of Training**	**Svc. Pkgs.**	**Length of Training**	**Who Needs?**	**Provided by**
HIPPA Privacy & Security	Annually	On-line	All	varies	All	MHMRA
Infection Control	Annually	On-line	All	varies	All	MHMRA
Principles of Crisis Intervention (PMAB)	Annually	On-Line	All	varies	All	MHMRA
Professional Code of Conduct	Annually	On-line	All	varies	All	MHMRA
Seizure Assessment	Annually	On-line	All	varies	All	MHMRA
Workplace Safety	Annually	On-line	All	varies	All	MHMRA
Suicide/Homicide	Annually	On-line	All	varies	All	MHMRA

Note: All Attend & Participate courses can be taken through the MHMRA Human Resources Department. All on-line courses are accessible via the internet; however, you must be approved to take the courses through the website. Training that is duplicated at your agency can be substituted for required MHMRA courses as long as it meets the course objective. Course substitutions must be approved by the MHMRA Quality Management Department. For questions and/or answers, you may contact Network Management @ mhnetworkdevelopment@mhmraharris.org. Certain trainings require a demonstration of competency before the service can be provided. A recommendation is that each unlicensed rehabilitative provider receives weekly clinical supervision by a licensed professional. Additional trainings are taken by MHMRA staff and are available to improve quality of care if provider makes requests to MHMRA.

Certain trainings allow for the ability to show a demonstration of competency via exam instead of attending the training all before the service can be provided. These courses/exams are required for staff listed under Who Needs column (waived staff do not need to take exam nor course). Passing the competency exam in Elogic will serve as a demonstration of competency if score not less than 70% on first and only attempt. If not able to pass competency exam, provider must attend/take training.