MENTAL HEALTH GENERAL REVENUE FUNDED SERVICES
OPEN ENROLLMENT REQUEST FOR APPLICATION
JUNE 1, 2013

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 FY'10, and FY'12. These plans can be reviewed at http://www.mhmraharris.org/Mental-Health-External-Provider-Network.asp.

ROUTINE SERVICES	**Average Current Service Capacity**	**% Capacity sought to procure**
Psychiatric Diagnostic Interview Examination	1337	Up to 20%
Pharmacological Management	Included in above capacity	
Medication Training and Support-Individual/Group	Included in above capacity	
Rehabilitation Services – Individual/Group	Included in above capacity	

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 exhibit 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 a 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 one's ability to provide services in compliance with DSHS contract requirements;
3. Comply with RDM (Resiliency and Disease Management) http://www.dshs.state.tx.us/mhprograms/RDM.shtm;
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 FY12-FY13 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 or if the end of a LPND planning cycle occurs.

Exhibit A-SP 3-Adult Mental Health Services
DESIGNATION OF SERVICES

CONTRACTOR:

CONTRACTOR ID#:

CONTRACT PERIOD: Date of Contract

SERVICE DESCRIPTION: (Ex) Adult – Service Package 3
only services listed below apply

ROUTINE SERVICES	**Pages**	**Service Code**	**Data Entry code**	**Medicaid rate or MHMRA cost** (Under approval of data mgmt competency)	**Medicaid rate or MHMRA cost minus %5** (Inclusive of data mgmt by Authority)	**Units of measure**
Psychiatric Diagnostic Interview Examination	Pg 4	90792	90792	$113.91 By MD $104.80 By ANP	$108.21 by MD $99.56 by ANP	Flat fee
Pharmacological Management	Pg 4	99212	99212	$22.14 By MD $20.36 By ANP	$21.03 By MD $19.34 By ANP	Flat fee
		99213	99213	$33.27 By MD $30.61 By ANP	$31.61 By MD $29.08 By ANP	
		99214	99214	$46.73 By MD $42.99 By ANP	$44.39 By MD $40.84 By ANP	
		99215	99215	$71.93 By MD $66.18 By ANP	$68.33 By MD $62.87 By ANP	
Pharmacological Management	Pg 4	M0064	7000	$38.76 By MD $35.66 By ANP	$36.82 By MD $33.88 By ANP	Flat Fee
Medication Training and Support-Individual	Pg 5	H0034	7600	$13.53	$12.85	1 unit= 15 min
Medication Training and Support-Group	Pg 5	H0034	7600	$ 2.71	$2.57	1 unit= 15 min
Adult Individual Rehabilitation Services	Pg 5	H2014	3199	$25.02 skills training	$23.77 skills training	1 unit= 15 min
		H2017	3200	$26.93 psychosocial rehab	$25.58 psychosocial rehab	
Adult Group Rehabilitation Services	Pg 5	H2014	3199	$5.00 skills training	$4.75 skills training	1 unit= 15 min
		H2017	3200	$5.39 psychosocial rehab	$5.12 psychosocial rehab	

PERFORMANCE MEASURE OUTCOMES (See Attachment):

The undersigned hereby certifies that he/she has the authority over all of the proposal documents and agrees to abide by the terms, certifications and conditions including the rate of reimbursement indicated within the RFA. The above reflect Medicaid rates at the adult age range of 21-999 years as well as a rate which is 5% below full rate for data entry services completed by the Authority on the provider's behalf. The provider may choose to either manage their own patient data upon proven competency in their ability to manage the data or elect to have the Authority manage and complete the data entry of services on the provider's behalf. These rates may change with Medicaid rate or agency cost changes.

Authorized Signature: _____

Printed Name: _____

Title: _____

Date: _____

POOLED CONTRACT NOT TO EXCEED $200,000.00.

PAYMENT DOCUMENTATION: Billing due by 2nd business day after the month in which services were rendered. The remaining pages describe in detail the type, frequency, quantity, and durations of services with defined goals, outputs, and measurable outcomes which directly relate to program objectives and consumer needs.

Information Item G
ADULT SERVICE DEFINITIONS

This is directly from DSHS contract: http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm

Adult SERVICE DEFINITIONS

#	Service	Description
1.	Outreach.	Activities provided to reach and link to services individuals who often have difficulty obtaining appropriate behavioral health services due to factors such as acute behavioral symptomatology, economic hardship, homelessness, unfamiliarity with or difficulty in accessing community behavioral health care services and other support services, fear of mental illness, and related factors. This service may be provided in a variety of settings, including homes, schools, jails, streets, shelters, public areas, or wherever the individual is found.
2.	Hotline *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1)*	A continuously available telephone service that provides information, support, referrals, and screening and intervention that responds to callers 24 hours per day, 7 days per week.
3.	Screening *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1)*	Activities performed by a Qualified Mental Health Professional – Community Services (QMHP-CS) to gather triage information to determine the need for in-depth assessment. The QMHP-CS collects this information through face-to-face or telephone interviews with the individual or collateral.
4.	Extended Observation *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1), (2), (3)*	Up to 48 hour emergency and crisis stabilization service that provides emergency stabilization in a secure and protected, clinically staffed (including medical and nursing professionals), psychiatrically supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment. Individuals are provided appropriate and coordinated transfer to a higher level of care when needed.
5.	* Psychiatric Diagnostic Interview Examination *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3)*	Psychiatric Diagnostic Interview Examination. A licensed professional practicing within the scope of his or her license must provide this service and document as described in the most current version of Title 25 Texas Administrative Code (TAC), Part 1, Chapter 412, Subchapter G, Section 412.322(b) *Mental Health (MH) Community Services Standards.*
6.	Pre-Admission Assessment *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3)*	Pre-Admission QMHP-CS Assessment – A face-to-face assessment of the individual conducted by a QMHP-CS for the purposes of determining eligibility for services which includes gathering and documenting the information in accordance with 25 TAC, Part 1, Chapter 412, Subchapter G, Section 412.314(d)(2) and Section 412.322(a)(1)-(10) *MH Community Services Standards.*
7.	Engagement Activity	Activities with the client or collaterals (in accordance with confidentiality requirements) in order to develop treatment alliance and rapport with the client and includes activities such as enhancing the individual's motivation, providing an explanation of services recommended, education on service value, education on adherence to the recommended service package and its importance in recovery, and short term planned activities designed to develop a therapeutic alliance and strengthen rapport. This service shall not be provided in a group.
8.	* Routine Case Management *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a) (4), (5)*	Primarily site-based services that assist an adult, child or adolescent, or caregiver in gaining and coordinating access to necessary care and services appropriate to the individual's needs. Routine Case Management activities shall be provided in accordance with 25 TAC, Part 1, Chapter 412, Subchapter I, *and MH Case Management Services.* Contractor shall not subcontract for the delivery of these services.
9.	* Counseling *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3)*	Individual, family and group therapy focused on the reduction or elimination of a client's symptoms of mental illness and increasing the individual's ability to perform activities of daily living. Cognitive-behavioral therapy is the selected treatment model for adult counseling services. Counseling shall be provided by a Licensed Practitioner of the Healing Arts (LPHA), practicing within the scope of his or her own license or by an individual with a master's degree in a human services field pursuing licensure under the direct supervision of an LPHA, if not billed to Medicaid. This service includes treatment planning to enhance recovery and resiliency.

#	Service	Description
10.	Consumer Peer Support	Activities provided between and among clients who have common issues and needs that are client-motivated, initiated, and/or managed and promote wellness, recovery, and an independent life in the community. Contractor may use General Revenue funding to assist in the delivery of services provided under Resiliency and Disease Management, or provide outreach through peer facilitated services, e.g., drop in centers, peer counseling, peer support groups, and peer led education groups. This service does not include Mental Health Rehabilitative Services provided by "Peer Providers."
11.	* Respite Services *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(4)*	Services provided for temporary, short-term, periodic relief for primary caregivers. Program-based respite services are provided at temporary residential placement outside the client's usual living situation. Community-based respite services are provided by respite staff at the client's usual living situation. Respite includes both planned respite and crisis respite to assist in resolving a crisis situation.
12.	* Supplemental Nursing Services *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(6)*	A service provided to a client by a licensed nurse or other qualified and properly trained personnel working under the supervision and delegation of a physician or Registered Nurse (RN), as provided by state law, to ensure the direct application of a psychoactive medication to the client's body by any means (including handing the client a single dose of medication to be taken orally), and to assess target symptoms, side effects and adverse effects, potential toxicity, and the impact of psychoactive medication for the client and family. This service includes such activities as checking a client's vital signs, refilling pill packs, monitoring self-administration of medications, pill pack counts, conducting lab draws, and evaluating the severity of side effects during a home visit. This service does not include physician services, nursing services incidental to physician services, case management, or the rehabilitative services of "psychiatric nursing services" or "medication related services." This service may be provided in a clinic setting, client home, or other community setting.
13.	* Pharmacological Management *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3), (6)*	A service provided by a physician or other prescribing professional which focuses on the use of medication and the in-depth management of psychopharmacological agents to treat a client's signs and symptoms of mental illness.
14.	* Provision of Medication *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(6)*	Ensuring the provision of psychoactive medication benefits to clients registered in the Client Admission and Registration system (CARE), who have no source of funds for such, as determined to be medically necessary and as prescribed by an authorized provider of Contractor.
	MEDICATION SERVICES	
12.	* Supplemental Nursing Services *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(6)*	A service provided to a client by a licensed nurse or other qualified and properly trained personnel working under the supervision and delegation of a physician or Registered Nurse (RN), as provided by state law, to ensure the direct application of a psychoactive medication to the client's body by any means (including handing the client a single dose of medication to be taken orally), and to assess target symptoms, side effects and adverse effects, potential toxicity, and the impact of psychoactive medication for the client and family. This service includes such activities as checking a client's vital signs, refilling pill packs, monitoring self-administration of medications, pill pack counts, conducting lab draws, and evaluating the severity of side effects during a home visit. This service does not include physician services, nursing services incidental to physician services, case management, or the rehabilitative services of "psychiatric nursing services" or "medication related services." This service may be provided in a clinic setting, client home, or other community setting.
13.	* Pharmacological Management *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3), (6)*	A service provided by a physician or other prescribing professional which focuses on the use of medication and the in-depth management of psychopharmacological agents to treat a client's signs and symptoms of mental illness.
14.	* Provision of Medication *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(6)*	Ensuring the provision of psychoactive medication benefits to clients registered in the Client Admission and Registration system (CARE), who have no source of funds for such, as determined to be medically necessary and as prescribed by an authorized provider of Contractor.

#	**REHABILITATIVE SERVICES**	
15.	* Crisis Intervention Services *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1), (3), (7)*	Interventions in response to a crisis in order to reduce symptoms of severe and persistent mental illness or emotional disturbance and to prevent admission of an individual or client to a more restrictive environment. Shall be provided in accordance with 25 TAC, Part 1, Chapter 419, Subchapter L, *and MH Rehabilitative Services*. The provision of Crisis Intervention Services to collaterals is limited to the coordination of emergency care services as defined, and outlined in the provision of crisis services within 25 TAC, Part 1, Chapter 412, Subchapter G, *MH Community Standards.*
16.	* Medication Training and Support *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(6)*	Instruction and guidance based on curricula promulgated by DSHS. The curricula includes the Patient/Family Education Program Guidelines referenced in TAC §419.468(3) (relating to Guidelines), and other materials that have been formally reviewed and approved by DSHS. Shall be provided in accordance with 25 TAC, Part 1, Chapter 419, Subchapter L, *MH Rehabilitative Services.*
17.	* Psychosocial Rehabilitative Services *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1), (3), (7)*	Social, educational, vocational, behavioral, and cognitive interventions provided by members of a client's therapeutic team that address deficits in the individual's ability to develop and maintain social relationships, occupational or educational achievement, independent living skills, and housing, that are a result of a severe and persistent mental illness. This service includes treatment planning to facilitate recovery. Shall be provided in accordance with 25 TAC, Part 1, Chapter 419, Subchapter L, *MH Rehabilitative Services.*
18.	* Skills Training and Development Services *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3), (7)*	Training provided to a client that addresses the severe and persistent mental illness and symptom-related problems that interfere with the individual's functioning, provides opportunities for the individual to acquire and improve skills needed to function as appropriately and independently as possible in the community, and facilitates the individual's community integration and increases his or her community tenure. This service may address skill deficits in vocational and housing areas and includes treatment planning to facilitate recovery. Shall be provided in accordance with 25 TAC, Part 1, Chapter 419, Subchapter L, *MH Rehabilitative Services.*
19.	* Day Programs for Acute Needs *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3), (7)*	Day programs for acute needs provide short-term, intensive treatment to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting. Shall be provided in accordance with 25 TAC, Part 1, Chapter 419, Subchapter L, *MH Rehabilitative Services.*
	SPECIALIZED SERVICES	
20.	*Flexible Funds *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(4)*	Funds utilized for clinical or non-clinical supports, justified in the treatment plan, to assist clients in developing and maintaining healthy community integration. These supports must also be directly related to the individual's mental illness and recovery process. <u>Non-Clinical Supports</u> - Services for assisting individuals to facilitate and support independent living, which are directly related to the individual's mental illness and recovery process. Services include, but are not limited to: assistance with rent and utility deposits, initial rent/utilities or temporary rental/utilities assistance, housewares, or other necessities. <u>Clinical Supports</u> - An array of specialized services in the community that the Local Mental Health Authority does not provide which would assist the individual in his/her treatment. Examples include, but are not limited to: residential COPS-D or detox services, or medical/dental assistance related to the individual's behavioral health disorder.

21.	* Supported Employment *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3), (7)*	Intensive services designed to result in employment stability and to provide individualized assistance to clients in choosing and obtaining employment in integrated work sites in regular community jobs. Includes activities such as assisting the individual in finding a job, helping the individual complete job applications, advocating with potential employers, assisting with learning job-specific skills, and employer negotiations. This service includes treatment planning to facilitate recovery. Concurrent rehabilitative training should be identified as a separate encounter with the appropriate rehabilitative service code.
22.	* Supported Housing *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3)*	Activities to assist clients in choosing, obtaining, and maintaining regular, integrated housing. Services consist of individualized assistance in finding and moving into habitable, regular, integrated (i.e., no more than 50 percent of the units may be occupied by clients with serious mental illness), and affordable housing. Includes: <u>Housing Assistance</u> - Funds for rental assistance (unless the Contractor has and documents evidence that housing is affordable for people on Supplemental Security Income (SSI) or that rental assistance funds are guaranteed from another source). To receive rental assistance, clients must be willing to make application for Section 8/Public Housing or have a plan to increase personal income so housing will become affordable without assistance. Housing assistance without services and supports cannot be counted as supported housing. <u>Services and Supports</u> - Assistance in locating, moving into and maintaining regular integrated housing that is habitable. This service includes treatment planning to facilitate recovery. While activities that fall under "services and supports" cannot be billed as rehabilitative services, concurrent rehabilitative training should be identified as a separate encounter with the appropriate rehabilitative service code.
23.	*Assertive Community Treatment (ACT) Urban ACT and Rural ACT *This service model satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3), (7)*	ACT is a team-based program that provides treatment, rehabilitation and support services to clients who have a history of multiple hospitalizations (two or more in 180 days or four or more in two years) or at least one hospitalization of greater than 30 days duration in the last two years. Clients identified as needing ACT services shall be prioritized for supported housing, supported employment, and co-occurring psychiatric and substance use disorder (COPSD) services as needed. ACT uses an integrated services approach merging clinical and rehabilitation staff expertise (e.g., psychiatric, substance abuse, vocational/employment, supported housing) within one mobile service delivery system. Accordingly, there will be minimal referral of clients to other programs for treatment, rehabilitation, and support services. Limited use of group activities designed to reduce social isolation, or address substance use/abuse issues is also acceptable as part of ACT. ACT includes an Urban ACT program and Rural ACT program serving clients with an LOC-R = 4. The Urban ACT team serves a client base of 60 or more within a local service area or has a population density of 300 or more persons per square mile in the local service area. The Rural ACT team serves a client base of less than 60 within a local service area. The Urban ACT and Rural ACT programs shall follow the program description, Fidelity Measures, rules and guidelines for Urban ACT and Rural ACT. <u>Urban ACT:</u> The Urban ACT team shall maintain a small client-to-staff ratio of 10:1. Urban ACT is a self-contained program with staff members dedicated to the ACT team. The client-to-staff ratio shall take into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered. Flexibility, accessibility, and timeliness of service delivery are reflected in the team's ability to provide needed support and skills training to clients and their natural support system on evenings and weekends as needed. For all the Urban

		ACT consumers combined the Urban ACT team shall provide an average of 10 service hours per month; and a minimum of 3.5 hours of service per client per month. Services are provided away from the office 80 percent of the time. The Urban ACT team shall maintain 24 hour responsibility and availability for covering and managing psychiatric crises for Urban ACT clients. Urban ACT team staffing shall include .15 full time equivalent (FTE) psychiatrist for every 30 consumers (or. 25 per 50 consumers) who works directly with and is assigned to the ACT team and at least 1.0 dedicated FTE RN providing direct services. Eighty percent of the ACT team members must have at least a bachelor's degree or be licensed. This service includes treatment planning to facilitate recovery. <u>Rural ACT:</u> The Rural ACT team must maintain a small caseload to include no more than eight ACT consumers (client-to-staff ratio of 8:1) in addition to consumers served in other service packages. Total caseload should be lower than caseloads for staff who serve consumers in service packages other than ACT. The client-to-staff ratio shall take into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered; as well as to provide the intensity of services needed based on the clinical severity for consumers in ACT and to meet service requirements for the consumers they serve in any of the service packages. Flexibility, accessibility, and timeliness of service delivery are reflected in the team's ability to provide needed support and skills training to clients and their natural support system on evenings and weekends as needed. For all the Rural ACT consumers combined the Rural ACT team shall provide an average of 10 service hours per month; and a minimum of four hours of service per client per month. Services are provided away from the office 80 percent of the time. The Rural ACT team shall maintain 24 hour responsibility and availability for covering and managing psychiatric crises for Rural ACT clients. The psychiatrist shall be available to provide services to individuals in ACT services and shall be available for consultation by Rural ACT team staff at all times. An RN shall be a part of the Rural ACT team, although the RN may also have other duties within a community mental health center. Eighty percent of the ACT team members must have at least a bachelor's degree or be licensed. This service includes treatment planning to facilitate recovery.

#	**RESIDENTIAL SERVICES**	
24.	* Inpatient Hospital Services *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1), (2)*	Hospital services staffed with medical and nursing professionals who provide 24 hour professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute psychiatric crisis. Staff provides intensive interventions designed to relieve acute psychiatric symptomatology and restore patient's ability to function in a less restrictive setting. The hospital shall be contracting with or operated by Contractor.
25.	* Crisis Stabilization Unit *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1), (2)*	Short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected clinically staffed, psychiatrically supervised, treatment environment that is licensed under and complies with a crisis stabilization unit licensed under Chapter 577 of the Texas Health and Safety Code and Title 25, TAC, Part 1, Chapter 411, Subchapter M (relating to Standards of Care and Treatment in Crisis Stabilization Units).
26.	* Crisis Residential Treatment *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1), (2)*	Short-term, community-based residential treatment to persons with some risk of harm or who may have fairly severe functional impairment who require direct supervision and care but do not require hospitalization.
27.	* Residential Treatment	Twenty-four hour specialized living environments. Includes administration of medications, room and board, and all daily living needs. Adult Foster Care, Personal Care Homes, and Assisted Living Facilities are included in this category.
	CRISIS SERVICES	
28.	* Crisis Flexible Benefits	Non-clinical supports that reduce the crisis situation, reduce symptomatology and enhance an individual's ability to remain in the home or community. Benefits in adult mental health services include spot rental, partial rental subsidies, respite, utilities, emergency food, housewares, clothing, transportation assistance, and residential services.
29.	* Safety Monitoring	Ongoing observation of an individual to ensure the individual's safety. An appropriate staff person must be continuously present in the individual's immediate vicinity, provide ongoing monitoring of the individual's mental and physical status, and ensure rapid response to indications of a need for assistance or intervention. Safety monitoring includes maintaining continuous visual contact with frequent face-to-face contacts as needed.
30.	* Crisis Follow-Up and Relapse Prevention *This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3)*	A service provided to or on behalf of individuals who are not in imminent danger of harm to self or others but require additional assistance to avoid recurrence of the crisis event. The service is provided to ameliorate the situation that gave rise to the crisis event, ensure stability, and prevent future crisis events.
31.	* Crisis Transportation	Transporting individuals receiving crisis services or Crisis Follow-up and Relapse Prevention services from one location to another. Transportation is provided in accordance with state laws and regulations by law enforcement personnel, or, when appropriate, by ambulance or qualified staff.

SECTION I. STATEMENT OF WORK

B. Adult Services

1. Community Services
   a) Contractor shall provide the community-based services outlined in Health and Safety Code Chapter 534, §534.053, which are incorporated into services defined in Information Item G.
   b) Contractor shall establish a reasonable standard charge for each service containing an asterisk (i.e., *) in Information Item G.

2. Populations Served
   a) 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.

   b) Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe major depression.

   c) Initial Eligibility:
      (1) An individual age 18 or older who has a diagnosis of:
         (a) schizophrenia as defined in the following Diagnostic and Statistical Manual, Fourth Edition - Text Revision (DSM-IV TR) diagnostic codes: 295.10, 295.20, 295.30, 295.40, 295.60, 295.70, 295.90.
         (b) bi-polar disorder as defined in the following DSM-IV TR diagnostic codes: 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.89.
         (c) major depression as defined in the following DSM-IV TR diagnostic codes: 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, and 296.36; with a Global Assessment of Functioning (GAF) of 50 or below at intake.
      (2) An individual age 18 or older who has a diagnosis other than those listed in I.B.2.c.1. and whose current Global Assessment of Functioning (GAF) is 50 or less and needs on-going MH services; or
      (3) An individual age 18 or older who was served in children's MH services and meets the children's MH priority population definition prior to turning 18 is considered eligible for one year.

1. Individuals with only the following diagnoses are excluded from this provision:
   (a) Substance Abuse as defined in the following DSM-IV TR diagnostic codes: 291.0, 291.1, 291.2, 291.3, 291.5, 291.81, 291.89, 291.9, 292.0, 292.11, 292.12, 292.81, 292.82, 292.83, 292.84, 292.89, 292.9, 303.00, 303.90, 304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 305.00, 305.1, 305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90.
   (b) Mental Retardation as defined in the following DSM-IV TR diagnostic codes: 317, 318.0, 318.1, 318.2, 319.
   (c) Pervasive Developmental Disorder as defined in the following DSM-IV TR diagnostic codes: 299.00, 299.10, 299.80.

2. Service Determination:
   (1) In determining services to be provided to the priority and target populations, the choice of and admission to medically necessary services is determined jointly by the individual seeking service and Contractor.
   (2) Criteria used to make these determinations are the recommended LOC (LOC-R) of the individual as derived from the UA, the needs of the individual, Utilization Management (UM) Guidelines, and the availability of resources. Clients authorized for care by Contractor through a clinical override are eligible for the duration of the authorization.

3. Continued Eligibility for Services:
   (1) Reassessment by the provider and reauthorization of services by Contractor determines continued need for services. This activity is completed according to the UA protocols and UM Guidelines.
   (2) Assignment of diagnosis in CARE is required at any time the Axis I diagnosis changes and at least annually from the last diagnosis entered into CARE.
   (3) The LPHA's determination of diagnosis shall include a face-to-face interview with the individual.
   (4) Eligibility for clients whose diagnosis is Major Depression includes a GAF of 50 or below at intake only. Changes in GAF scores after the initial eligibility determination do not make clients ineligible.

4. Documentation Required*:*
   In order to assign a diagnosis across all 5 axes to an individual, documentation of the required diagnostic criteria, according to DSM-IV TR, as well as the specific justification of GAF score, shall be included in the client record. This information shall be included as a part of the required assessment information.

5. UA Requirements:
   (1) The DSHS-approved UA for Adults includes the following instruments:
      (a) Texas Recommended Assessment Guidelines (TRAG);
      (b) Diagnosis-Specific Clinical Rating Scales; and
      (c) Community Data.
   (2) The above instruments are required to be completed once an individual has been screened and determined in need of assessment by Contractor. The initial assessment is the clinical process of obtaining and evaluating historical, social, functional, psychiatric, developmental or other information from the individual seeking services in order to determine specific treatment and support needs.

(3) Staff administering the instruments must have documented training in the use of the instruments and must be a QMHP-CS, with the exception of the Diagnosis-Specific Clinical Rating Scales which may be administered by a QMHP-CS or Licensed Vocational Nurse (LVN);
(4) The UA shall be administered according to the timeframes delineated in Information Item C at http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

i) Assessments in CARE:
Information shall be submitted through WebCARE or through an approved batch process to the CARE system according to the timeframes established by DSHS.

3. Service Requirements
Contractor shall:

(a) Comply with UA requirements for adults in accordance with Section I.B.8. The UA is not required for individuals whose services are not funded with funds paid to Contractor under this Program Attachment;

(b) Implement a Patient and Family Education Program (PFEP) in accordance with psychosocial treatment recommendations and information for patient/family education available at: http://www.dshs.state.tx.us/Mental-Health/. Recommendations and information related to medications used to treat mental illness may be found at the following website: http://www.nimh.nih.gov/health/publications/mental-health-medications/complete-index.shtml. If clients and/or their families and caregivers have not been educated about their diagnosis, the reason for the lack of education shall be documented in the clinical progress note.

(c) Implement Resiliency and Disease Management (RDM) and apply to all clients whose services are funded with Program Attachment funds:
(1) Develop a service delivery system in accordance with the most current version of DSHS's UM Guidelines, Adult TRAG and Fidelity Instruments;
(2) Ensure that each adult who is identified as being potentially in need of services is screened to determine if services may be warranted;
(3) Ensure that clients seeking services are assessed to determine if they meet the requirements of priority population and if so, a full assessment is conducted and documented using the most current version of the DSHS UA instruments. Individuals whose services are not funded with contract funds are exempt from inclusion in RDM regardless of priority population status;
(4) Make available to each client recommended and authorized for a LOC, as indicated by the TRAG, all services and supports within the authorized LOC (LOC-A):
(a) If a non-Medicaid eligible individual cannot be served in the recommended LOC, or if the individual refuses the recommended LOC, individual may be served at the next most appropriate LOC. If no services are available at the next most appropriate LOC, the non-Medicaid eligible individual shall be placed and monitored on a waiting list;
(b) Medicaid-eligible individuals may not have services denied, reduced, suspended, or terminated due to lack of available resources; and
(c) If a Medicaid-eligible individual refuses the recommended LOC, the individual may be served at the next most appropriate LOC as long as the services within that LOC are appropriate and medically necessary to address the individual's mental illness.
(5) Ensure Medicaid-eligible individuals are provided with any medically necessary Medicaid-funded MH services within the recommended LOC without undue delay;
(6) Ensure that Cognitive-Behavioral Therapy is provided by an LPHA, practicing within the scope of a license, or when appropriate and not in conflict with billing requirements, by an individual with a master's degree in a human services field (e.g., psychology, social work, counseling) who is pursuing licensure under the direct supervision of an LPHA;
(7) Ensure that providers of services and supports within RDM are trained in the DSHS-approved evidence-based practices prior to the provision of these services and supports. DSHS-approved evidence-based practices are:
(a) Assertive Community Treatment: Dartmouth Assertive Community Treatment;
(b) Counseling: Cognitive Behavioral Therapy;
(c) Psychosocial Rehabilitation: SAMHSA Illness Management and Recovery;
(d) Supported Employment: Dartmouth Psychiatric Research Center – Individual; Placement and Support or SAMHSA Supported Employment; and
(e) Supported Housing: SAMHSA Permanent Supported Housing.
(8) Ensure that supervisors of services and supports within RDM are trained as trainers in the DSHS-approved evidence-based practices or have provided the evidence–based practices prior to the supervision of the evidence-based practices;
(9) Use the uniform assessment and other relevant clinical information to document the assessment of individuals seeking services and to reassess current clients in services when update assessments are due or significant changes in functioning occur, to determine the recommended LOC for a client;
(10) Utilize information from the TRAG and other relevant clinical information to:
(a) Recommend a LOC;
(b) Determine whether the client should be transferred to another provider; and
(c) Determine if a client should be discharged from services.
(11) Use the flexible funds that shall be made available by Contractor, in accordance with the UM Guidelines;
(12) Assertive Community Treatment (ACT) includes Urban ACT and Rural ACT programs serving clients with an LOC-R = 4. The baseline of numbers of individuals who need ACT services for Urban ACT and Rural ACT shall be determined by data reports based on the combined average number of clients with an LOC-R = 4 over the last two quarters of FY2010 and the first two quarters of FY2011. The Urban ACT team serves a client base of 60 or more within a local service area or has a population density of 300 or more persons per square mile in the local service area. The Rural ACT team serves a client base of less than 60 within a local service area. ACT services provided by Contractor shall meet the minimum UM Guidelines for Service Package 4, and shall follow the most current Urban ACT or Rural ACT services Fidelity Instrument, as well as, the rules and guidelines for Urban ACT or Rural ACT;

(13) Contractor shall serve individuals with monies allocated through Crisis Redesign, for engagement, transition, and intensive ongoing services in accordance with UM Guidelines. CARE Report III shall be completed in accordance with Information Item D and submission timelines as outlined in Information Item S. Performance measures are outlined in Section II. G.; and
(14) Maintain access to WebCARE even if it utilizes an approved batch process.

(d) Submit encounter data for all services according to the procedures, instructions and schedule established by DSHS, including all required data fields and values in the current version of the DSHS Community Mental Health Service Array. The current version of DSHS Community Mental Health Service Array (i.e., Report Name: INFO Mental Health Service Array Combined) can be found in the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW), in the General Warehouse Information, Specifications subfolder.

(e) Comply with the following Medicaid-related items:
(1) Contract with DSHS to be a provider of Medicaid MH Rehabilitative Services;
(2) Contract with DSHS to be a provider of Medicaid MH Case Management and with Health and Human Services Commission (HHSC) to participate in Medicaid Administrative Claiming;
(3) Recognize that funding earned through billings to Texas Medicaid and Healthcare Partnership (TMHP) for Medicaid MH Case Management and Medicaid MH Rehabilitative Services represents the federal share and the State match; and
(4) Submit billing for the provision of Medicaid MH Case Management and Medicaid MH Rehabilitative Services to TMHP.

(f) Utilize non-contract funds and other funding sources (e.g., any person or entity who has the legal responsibility for paying all or part of the services provided, including commercial health or liability insurance carriers, Medicaid, or other Federal, State, local, and private funding sources) whenever possible to maximize Contractor's financial resources. This includes:
(1) Enroll in the CHIP and bill CHIP for services covered under that plan;
(2) Become a Medicaid provider and bill Medicaid for services covered under that plan;
(3) Provide assistance to individuals to enroll in such programs when the screening process indicates possible eligibility for such programs;
(4) Comply with the Charges for Community Services Rule as set forth in Title 25, Part 1, Chapter 412, Subchapter C of the Texas Administrative Code to maximize reimbursement from individuals with an ability to pay for services provided;
(5) Bill all other funding sources for services provided under this Contract before submitting any request for reimbursement to DSHS; and
(6) Provide all billing functions at no cost to the client.

(g) Provide services to all clients without regard to the client's history of arrest, charge, fine, indictment, incarceration, sentence, conviction, probation, deferred adjudication, or community supervision for a criminal offense.

(h) Develop and implement written procedures to identify clients with Co-Occurring Psychiatric and Substance Use Disorders (COPSD), identify available resources, provide referrals and continuity of care for ongoing services as necessary to address the client's unmet substance use treatment needs in accordance with 25 TAC, Chapter 411, Subchapter N. Nothing herein shall prohibit a physician from considering a client's substance use in prescribing medications.

(i) Conduct all initial and on-going diagnostic assessments face-to-face or by televideo with the individual to determine priority population eligibility.

(j) Submit financial data regarding co-pays, deductibles, and premiums related to Medicare Part D or other information related to expenditures for medications as requested by DSHS and in the form and format prescribed by DSHS.

(k) Implement crisis services in compliance with the standards outlined in Information Item V.

(l) Submit encounter data on Pre-Admission Screening and Resident Review (PASRR) individuals in accordance with Information Item O. Complete and submit Form O in accordance with the instructions set forth in Information Item O.

SECTION II. SERVICE TARGETS, OUTCOMES, AND PERFORMANCE MEASURES

Contractor shall meet the following service targets, performance measures, and outcomes:

A. Adult Services

Adult service performance measures shall be assessed 37 calendar days following the close of the second and fourth quarters. Detailed information pertaining to calculations and data sources can be found in Information Item C at: http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

1. Adult Number Served Target:
a) Target: (First and second quarter aggregate and a third and fourth quarter aggregate)

b) Sanctions Associated with this Target are the following:
(1) If the total number served is greater than or equal to 100%, there is no recoupment;
(2) If the total number served is 90% to 99% of the target, and the minimum hours threshold for maintaining service capacity is met, there is no recoupment;
(3) If the total number served is 90% to 99% of the target, and the minimum hours threshold for maintaining service capacity is not met, the recoupment is 1.4% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
(4) If the total number served is 85% to 89%, the recoupment is 2.8% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;

(5) If the total number served is 80% to 84%, the recoupment is 5.6% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
(6) If the total number served is 75% to 79%, the recoupment is 11.2% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds; and
(7) If the total number served is <75%, the recoupment is 22% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds, in addition to other remedies and sanctions specified in Article 19 of the General Provisions.

2. UA Completion Rate:
a) At a minimum 90% of all adults served or authorized for services during the first and second quarter, or the third and fourth quarter have a completed and current Uniform Assessment.

b) Sanctions Associated with this Measure are the following:
(1) Greater than or equal to 90%, there is no recoupment;
(2) From 80% to 89%, the recoupment is 1.4% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
(3) From 70% to 79%, the recoupment is 2.8% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
(4) From 60% to 69%, the recoupment is 5.6% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication Funds; and
(5) Less than 60%, the recoupment is 11.2% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication Funds.

3. Service Capacity Measures
a) Minimum Target – Adults receiving at least the minimum number of hours based on service encounters for adults authorized in Service Packages 1 through 4 shall meet the following service capacity thresholds:
(1) Service Package 1 – 0.5 hours minimum per person, with an LOC-R of 2, 3 or 4 (underserved by choice), per month;
(2) Service Package 2 – 1.5 hours minimum per person per month;
(3) Service Package 3 – 3 hours minimum per person per month; and
(4) Service Package 4 – 3.5 hours minimum per person per month.

At least 80% of adults are receiving the minimum number of hours each month. This is a first and second quarter aggregate and a third and fourth quarter aggregate across Service Packages 1 through 4.

b) Sanctions Associated with the Measure for Service Packages 1 through 4 are the following:
(1) Greater than or equal to 80%, there is no recoupment;
(2) From 70% to 79%, the recoupment is 0.2% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
(3) From 65% to 69%, the recoupment is 0.3% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
(4) From 40% to 64%, the recoupment is 0.6% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds; and
(5) Less than 40%, the recoupment is 1.0% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds.

c) If Contractor meets the expected target for level of functioning, housing, and hospitalization within 30-days of a crisis episode, then DSHS will not impose a sanction for failure to meet the Service Capacity Measures specified in this section. Expected targets for these outcomes are listed in Information Item C.

4. Assertive Community Treatment (ACT) Average Hours
Adults receiving services based on service encounters for all adults authorized in Service Package 4 shall meet the following service capacity thresholds:
a) Average Hours per Service Package:
Service Package 4 – an average of 10 hours per month. Adults in Service Package 4, on average, receive 10 hours per month. This means that across 100% of adults in service package 4, the average number of service hours provided is equal to or greater than 10. This is a first and second quarter aggregate and a third and fourth quarter aggregate for Service Package 4.

b) Sanctions Associated with this Measure are the following:
(1) Greater than or equal to 100%, there is no recoupment;
(2) From 90% to 99%, the recoupment is 0.15% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
(3) From 80% to 89%, the recoupment is 0.2% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
(4) From 75% to 79%, the recoupment is 0.3% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds;
(5) From 40% to 74%, the recoupment is 0.6% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds; and
(6) Less than 40%, the recoupment is 1.0% of Contractor's current 2 quarters funding for adult MH services excluding New Generation Medication funds.

c) If Contractor meets the expected target for level of functioning, housing, and hospitalization within 30-days of a crisis episode, then DSHS will not impose a sanction for failure to meet the Service Capacity Measures specified in this section. Expected targets for these

outcomes are listed in Information Item C.

5. Adult Service Targets – Supported Employment and Supported Housing

   a) Beginning in FY2013, the monthly average of all adults served in a Full Service Package during the fiscal year who have received a supported employment service encounter is greater than or equal to 3%.
   b) Beginning FY2013, the monthly average of all adults served in a Full Service Package during the fiscal year who have received a supported housing service encounter is greater than or equal to 3%.

6. Disease Management Outcomes – Adult Mental Health Services:
   Adult service outcomes shall be measured 37 calendar days following the close of the fourth quarter. Contractor shall not be subject to sanctions or remedies for each outcome minimum achieved. For adult service outcome minimums that are not achieved by the end of Program Attachment term, remedies and sanctions may be imposed as described in Section 19.02 of the General Provisions with the exception of recoupment under Section 19.02.b.1.

   1. Functioning. Target – 38% of all adults served during the fiscal year have acceptable or improving functioning.
   2. Criminal Justice Involvement. Target – 44% of all adults served during the fiscal year have acceptable or improving criminal justice involvement.
   3. Employment. Target – In FY2013, at least 14.7% of adults in a Full Service Package shall receive a score of "1" (Independent/Competitive/Supported/Self Employment) on Paid Employment Type. This score is recorded on the Adult Uniform Assessment, Section 4: Community Data, B. Paid Employment Type.
   4. Housing. Target – 72% of all adults served during the fiscal year have acceptable or improving housing.
   5. Co-Occurring Substance Use. Target – 87% of all adults served during the fiscal year have acceptable or improving co-occurring substance use.
   6. Crisis Avoidance. Target - Percent of all adults with time in crisis shall not exceed 2.3% for those authorized for a LOC during the fiscal year.
   7. Time between Assessment and First Service Encounter. Target - 77% of all adults served during the fiscal year receive their first service encounter (not including screening/assessment) within 14 days of their intake assessment.

B. Children's Services OMITTED

C. New Generation Medication
Information pertaining to calculations and data sources is in Information Item D at http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

Target: Adults and Children served with New Generation Medications are counted toward this target.

D. Legislative Budget Board – Reported from CARE
Information pertaining to calculations and data sources is in Information Item C at http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

Percentage of adults and children discharged from state facilities with a community support plan.
a) The number of adults and children discharged from state MH campus-based facilities (state hospital, state center) to Contractor that have a community support plan.

b) Target: Shall not be less than 95%.

E. Additional Adult and Children Outcomes – Reported in CARE
These measures will be automatically tracked through the CARE system and reported Fiscal Year to date:

1. Re-admissions of adults and children:
   Target - Re-admissions are less than or equal to: 5% in the 1st quarter; 10% in the 2nd quarter; 15% in the 3rd quarter; and 20% in the 4th quarter.

2. Follow-up within seven days:
   a) Face-to-face follow-up contacts with individuals discharged from a state facility or state-funded community mental health hospital (including the Montgomery County Mental Health Treatment Facility) within seven days are greater than or equal to 75%; and
   b) Follow-up disposition of individuals discharged from a state facility or state-funded community mental health hospital (including the Montgomery County Mental Health Treatment Facility) within seven days is greater than or equal to 95%.

F. Crisis Response System Outcome Measures
Crisis response system outcomes shall be measured 37 calendar days following the close of the fourth quarter. Contractor shall not be subject to sanctions and remedies for each outcome minimum achieved. For crisis response system outcome minimums/maximums that are not achieved by the end of the Program Attachment term, remedies and sanctions may be imposed as described in Section 19.02 of the General Provisions with the exception of recoupment under Section 19.02.b.1.

1. Crisis Episodes resulting in Psychiatric Maximum Target - No more than 22% of adults, children, and adolescents with a crisis episode are admitted to a State or Community Mental Health Hospital within 30 days after the start of the crisis episode.

2. Community Linkage Minimum Target - No less than 23% of adults, children, and adolescents with a mental health community LOC-A = 0 will be followed by a mental health community LOC-A = 1 - 5, and/or a service contact at a DSHS-funded substance abuse treatment facility, or at an Outreach, Screening, Assessment and Referral (OSAR) provider within 14 days after the crisis episode.

3. Crisis Follow Up Minimum Target - No less than 90% of adults, children, and adolescents with a mental health community LOC-A = 5 have a crisis follow-up service encounter within 30 days of the LOC-A = 5.

G. ***Crisis Redesign Service Targets***
Information pertaining to calculations and data sources is in Information Item C at http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

1. Adults, children, and adolescents served in SP5 "Transitional Services."
   a) Target FY 2012: Expected targets are listed in Information Item C.
   b) Target FY2013: Expected targets are listed in Information Item C.
   c) Remedies and Sanctions associated with this Target will be imposed in accordance with General Provisions, Section 19.02.

2. Adults served in "Intensive Ongoing Service Packages."
   a) Target FY 2012: Expected targets are listed in Information Item C.
   b) Target FY2013: Expected targets are listed in Information Item C.
   c) Remedies and Sanctions associated with this Target will be imposed in accordance with General Provisions, Section 19.02.
   1.

3. Children/Adolescents served in "Intensive Ongoing Service Packages."
   a) Target FY 2012: Expected targets are listed in Information Item C.
   b) Target FY 2013: Expected targets are listed in Information Item C.
   c) Remedies and Sanctions associated with this Target will be imposed in accordance with General Provisions, Section 19.02.

SECTION III. SERVICE AREA
Counties:
SECTION IV. SOLICITATION DOCUMENT
Exempt Governmental Entity
SECTION V. RENEWALS
N/A
SECTION VI. PAYMENT METHOD

SECTION VII: BILLING INSTRUCTIONS NA
SECTION VIII: BUDGET

Source of Funds:

Local Match Requirement: $

EXHIBIT B
LICENSING, CREDENTIALING, AND EDUCATIONAL REQUIREMENTS

Credentialing Criteria

The following criteria, information and components are required for a service provider to be included in the Local Authority's network of providers. Licensed agencies will be evaluated and reviewed by Credentialing Committee.

1. Minimum requirements for all services being sought:
   - Age of staff must be over 18, has a high school diploma or a General Education Development (GED) credential; or has documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:
     - written competency-based assessment of the ability to document service delivery and observations of the individuals to be served; and
     - at least three personal references from persons not related by blood that indicate the ability to provide a safe, healthy environment for the individuals being served.
   - Current drivers license for each person that will potentially provide transportation to Local Authority consumers.
   - Current Insurance Verification including:
     - Professional and general liability
     - Vehicle (if transporting consumers is likely), complete Exhibit F.
     - Workers Compensation
   - Verification of criminal history checks, primary source verification, and Texas Standard applications for all staff potentially working with Local Authority consumers will be provided to MHMRA.
   - Life Safety code review for site assessment if not certified by a state agency.
   - If applicable, documentation from certifying agency:
     - Texas Department of State Health Services
     - Texas Department of Assistive and Rehabilitative Services (DARS)

2. Qualifications of providers by service: (Services must be delivered by staff with these MINIMUM qualifications)

   a. Pharmacological management services = MD (psychiatrist), RN, PA, Pharm.D., APN
   b. Routine Case Management = QMHP or CSSP
   c. Psychotherapy-CBT = LPC, LCSW, LMFT, Licensed Psychologist
   d. Rehabilitative Services = QMHP, Licensed medical personnel, CSSP, or Peer Provider (consult Rule for specific credential requirements for sub-component services)
   e. Supported Employment = QMHP or CSSP
   f. Supported Housing = QMHP or CSSP
   g. For providers serving persons with co-occurring psychiatric and substance abuse disorder, competencies for serving this population must be demonstrated as defined by DSHS standards
   h. Qualifications of Providers – SP-4 (Assertive Community Treatment-ACT Services):
      All teams must adhere to established DSHS Mental Health Community Standards regarding expertise in housing, employment, substance abuse, and psychiatric treatment. Each service provider must be a QMHP, or upon waiver from the local authority, have a high school diploma with three years of experience in providing services to persons with mental illnesses. Seventy-five percent of the ACT team members must hold a bachelor's level degree or above. Service providers must receive clinical supervision from a Licensed Practitioner of the Healing Arts. Any individual that meets the minimum

qualifications as a provider of this service can provide ongoing administrative/programmatic supervision of this service.

3. Description for Credentialing requirements:

A. Minimum Requirements for all credentialing listed below:

1. Absence of a history of involvement in a professional liability suit, arbitration or settlement; or, in the case of an applicant with this history, evidence that history of professional liability claims does not demonstrate probable future substandard professional performance.
2. Absence of a history of denial or cancellation of professional liability insurance; or, in the case of an applicant with this history, evidence that this history does not demonstrate probable future substandard professional performance.
3. Absence of physical or mental health problems which may interfere with the ability to practice as the listed Job Description listed below.
4. Absence of a history of professional disciplinary action; or, in the case of an applicant with this history, evidence that this history does not demonstrate probable future substandard professional performance.
5. Absence of a history of criminal conviction or indictment; or, in the case of an applicant with this history, evidence that this history does not demonstrate probable future substandard professional performance. (A conviction within the meaning of this criterion includes a plea or verdict of guilty or a conviction following a plea of nolo contendre).
6. Absence of information to indicate a pattern of inappropriate utilization management of medical resources.
7. Absence of any other information which may indicate probable future substandard professional performance.
8. Absence of any other information which demonstrates that the provider has engaged in conduct unbecoming to a professional.
9. Absence of falsification or material omission of information requested in the credentialing process.

B. All additional requirements for each specific Job Descriptions listed below:

1. Psychiatrists

   As a prerequisite to acceptance for participation, and to maintain participant status in the mental health provider network, a physician must demonstrate to the satisfaction of MHMRA's Credentialing Committee that he or she satisfies the following criteria.

   a) Graduation from an accredited school of medicine.
   b) Completion of an accredited clinical post-graduate training program in the American Board of Medical Specialties (ABMS) specialty of psychiatry.
   c) Valid, current, unencumbered medical license for the state of Texas.
   d) Valid, current unrestricted Drug Enforcement Agency (DEA), and Department of Public Safety (DPS) certificates
   e) Current clinical privileges at a licensed hospital; or, evidence that the applicant does not require hospital privileges in order to deliver satisfactory professional services at a specific level of care.

2. Clinical Psychologists

   All providers must demonstrate to the satisfaction of MHMRA's Credentialing Committee that they satisfy the criteria listed below as a prerequisite to acceptance for participation or for continuation as a Psychologist in the mental health provider network.

a) Graduation from an accredited doctoral program in child development, child psychology, or clinical or counseling psychology.
b) Valid, current, unencumbered license for the state of Texas.

3. Clinical Social Worker
All providers must demonstrate to the satisfaction of MHMRA's Credentialing Committee that they satisfy the criteria listed below as a prerequisite to acceptance for participation or for continuation as a Social Worker in the mental health provider network.
a) Graduation from an accredited Master's program, which grants an MSW or equivalent degree, recognized for independent practice.
b) Valid, current, unencumbered license for independent practice in the state(s) in which the applicant will provide care for participants.

4. Licensed Professional Counselor
All providers must demonstrate to the satisfaction of MHMRA's Credentialing Committee that they satisfy the criteria listed below as a prerequisite to acceptance for participation or for continuation as a LPC in the mental health provider network.
a) Graduation from an accredited Master's program, which grants an MA, MS, or equivalent degrees recognized for independent clinical practice.
b) Valid, current, unencumbered license for independent practice issued by the Texas State Board of Examiners of Professional Counselors.

5. Licensed Marriage and Family Therapist
All providers must demonstrate to the satisfaction of MHMRA's Credentialing Committee that they satisfy the criteria listed below as a prerequisite to acceptance for participation or for continuation as a LMFT in the mental health provider network.
a) Graduation from an accredited Master's program, which grants an MA, MS, or equivalent degrees recognized for independent clinical practice.
b) Valid, current, unencumbered license for independent practice issued by the Texas Board of Marriage and Family Therapy.

6. Psychiatric Nurse
All providers must demonstrate to the satisfaction of the MHMRA's Credentialing Committee that they satisfy the criteria listed below as a prerequisite to acceptance for participation or for continuation as a Psychiatric Nurse in the mental health provider network.
a) Graduation from an accredited Masters degree program in Psychiatric Nursing which confers a MSN (Masters of Science in Nursing), MN (Masters in Nursing), or MS (Masters of Science).
b) Valid, current, unencumbered RN license for the state of Texas with a valid, current, unencumbered certificate or license for Psychiatric Mental Health Advanced Nurse Practitioner in the state of Texas with prescriptive authority: (1) a valid, unencumbered and unrestricted DEA registration; or, evidence that the DEA registration is not required in his or her practice and (2) written verification of prescriptive authority or privilege granted by the state of Texas.

7. QMHP-CS or qualified mental health professional-community services
All providers must demonstrate to the satisfaction of the MHMRA's Credentialing Committee that they satisfy the criteria listed below as a prerequisite to acceptance for participation or for continuation as a QMHP-CS in the mental health provider network.

a) An individual credentialed to provide QMHP-CS services (including those referenced in §412.314(a)-(b) and §412.315(a) of this title (relating to Crisis Services and Assessment and Treatment Planning, respectively) who has demonstrated competency in the work to be performed and:
b) Has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major (as determined by the LMHA or MMCO in accordance with §412.312(c) of this title (relating to Competency and Credentialing)) from an accredited college or university in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
c) A registered nurse.

8. CSSP or community services specialist

All providers must demonstrate to the satisfaction of the MHMRA's Credentialing Committee that they satisfy the criteria listed below as a prerequisite to acceptance for participation or for continuation as a CSSP in the mental health provider network.

a) A staff member who, as of August 31, 2004:
   (i) has received:
      (1) a high school diploma; or
      (2) a high school equivalency certificate issued in accordance with the law of the issuing state; and
   (ii) has had three continuous years of documented full time experience in the provision of MH case management svcs; &
   (iii) has demonstrated competency in the provision and documentation of MH case management services in accordance with this subchapter and the MH Case Management Billing Guidelines.

EXHIBIT C

Agency Guidelines

Pre-Requisite Information, Application/Contracting Process, Quality Requirements, Reimbursement Criteria, and Appeal Processes

Mental Health Provider Network Operational Procedures

Note: MHMRA will clarify for individual contractors which sections do not apply during the contract negotiations; not all services are procured out in full therefore not all requirements apply.

Introduction

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. As the local mental health authority, MHMRA may obtain clarification and confirmation of information submitted by the provider during the application process and ensure those applicants will demonstrate compliance to all guidelines specified in the FY2012-13 DSHS Performance Contract at http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm and http://www.dshs.state.tx.us/mhcontracts/renewal.shtm.

Pursuant to Texas Administrative Code §412.60, MHMRA of Harris County 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.

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, or 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 exhibit 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 one's ability to provide services in compliance with DSHS contract requirements;

3. Comply with RDM (Resiliency and Disease Management) http://www.dshs.state.tx.us/mhprograms/RDM.shtm;

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 Exhibit 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 FY12-13 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. If the service provider is not a Medicaid or Medicare provider, the potential contractor will apply to become a Medicaid or Medicare provider if providing Medicaid/Medicare billable type services and be approved to become a Medicaid and Medicare provider. The service provider will maintain status as a Medicaid provider in order to minimize service disruption for consumers obtaining Medicaid benefits. 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.

EXHIBIT C

Agency Guidelines

Pre-Requisite Information, Application/Contracting Process, Quality Requirements, Reimbursement Criteria, and Appeal Processes

Application Credentialing Procedures and Requirements

Credentialing Requirements (See Exhibit B, Credentialing Criteria)

As a prerequisite to acceptance for participation, and to maintain participant status in our provider network, the provider must demonstrate to the satisfaction of the MHMRA Authority Services Credentialing Committee that he or she satisfies the provider criteria listed in Exhibit B as well as meeting all agency training requirements as listed in Exhibit D. Prior to provision of services, this information will be verified by contacting the issuing entity. Consent to conduct verification is included in the application packet. In addition, Providers must be compliant with FY2012-13 DSHS Performance Contract Section 3.12 "Compliance with Rules."

Re-credentialing

Providers must undergo an annual credentialing review and a re-certification at least every 3 years with MHMRA to continue to provide services. Annual renewals must be submitted of licensure, certificates, and professional liability insurance coverage before due dates. Provider credentials are verified in the same manner that occurred at the initial credentialing process. Additionally, provider performance will be considered through a profile of his or her activities with the Agency such as:

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

The Credentialing Committee reviews all providers considered for re-credentialing into the network, and renders its decisions to grant continued privileges with the network based on the credentials review and the profile that the provider establishes. This process is subject to all levels of appeal that apply to the initial credentialing process.

Site Review Criteria:

A representative of MHMRA's Quality Management Department will evaluate each provider's office prior to initial credentialing. Provider locations must pass this review prior to seeing consumers. Elements of the review will include:

a) ADA compliance
b) Clean and safe environment
c) Occupancy permits and standards
d) Service fraud and abuse standards

Record Systems Review

(Compliance with payer requirements and federal billing guidelines)

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.

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. Care Managers and/or the Network Management Coordinator 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

IV. 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 in regards to the services that could impact a consumer's treatment is reviewed as a quality of care concern.

Quality Management Initiatives

1. Access and Availability Reviews - MHMRA conducts random quarterly reviews of ≥10% of providers to ensure that appointments are offered to consumers according to their degree of urgency.
    a) Routine appointments must be offered within 10 days of the request
    b) Urgent appointments must be offered within 24 hours
    c) Emergent appointments within 2 hours

2. After Hours Availability Reviews - MHMRA conducts after hours availability audits of providers to ensure that after hours clinical care is available seven days per week, twenty-four hours per day, every day for urgent and emergent situations. These reviews are conducted quarterly on a minimum of 10% of network providers who are chosen at random.
    a) For emergent situations, providers must respond face to face within 20 minutes. Emergent is defined as imminent danger or life threatening.
    b) For urgent situations, providers must respond face to face within 2 hours. Urgent is defined as not life threatening but requiring care within 48 hours.

3. 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 at least 30 days prior to the audit beginning. Providers will be asked to make available blinded records submitted by Quality Management, 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
- Provider'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 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 for patients 12 years of age and older
- Assessment and intervention with children, adolescents and families
- Clinical specialties directly related to the services to be performed
- Age appropriate clinical assessment including the uniform assessment
- Age appropriate engagement techniques (e.g., motivational interviewing)
- Age appropriate rehabilitative approaches
- Use of telemedicine equipment if applicable
- Utilization management guidelines
- Appropriate interactions with an individual who has a physical disability such as a hearing or visual impairment
- Psychiatric history is documented including previous dates, provider, facilities, interventions, family information, and for children/adolescents: prenatal, perinatal, and full developmental history
- Special status situations (SI, HI), severe deterioration and elopement potential are documented including referrals to appropriate providers/facilities and/or revised compliance with written protocols
- Each record indicates medications, dosages of each, dates of initial prescriptions/refills, relevant labs if appropriate and medication consents
- Allergies and adverse reactions are clearly documented including no known allergies to drugs or other substances
- Proficiency in specimen collection
- DSM IV five axis diagnosis is consistent with symptoms, history and other assessment data
- Developing and implementing an individualized treatment plan
- Treatment plans/actions are based on medical necessity and consistent with diagnosis(is) and have measurable objectives and timeframes as well as the understanding of the patient of the treatment goals which s/he has helped to set
- Consumer's mental status exams are documented
- Progress notes reflect treatment goals and consumers strengths and limitations
- Proper documentation of services provided
- Referrals are recommended when indicated reflecting coordination and continuity of care between PCP/other providers
- Prevention and educative services are documented
- Peer-provider or consumer-operated service model
- PCP/Pediatrician coordination is documented and proper release of information is in place
- 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

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 consumer referral process
    b) Phone wait time
    c) Utilization management process
    d) Care manager availability, support and consultation
    e) Staff's professional behavior and courtesy
    f) Provider status turn-around time
    g) Overall service

5. To ensure and maintain MHMRA's standard for quality management, the provider must submit their policy and procedures regarding how concurrent quality reviews are conducted with the related timeframes for such reviews. If MHMRA finds deficiencies, provider must be willing to revise their policy and procedures. Provider must submit copies of quality review as requested by MHMRA. Additionally, MHMRA staff may attend quality reviews conducted by the provider.

6. To ensure and maintain MHMRA's standard for quality management, the provider must submit their policy and procedures regarding the supervision of Physician extenders if such professionals are utilized within their practice model and how concurrent quality reviews are conducted with the related timeframes for such reviews. If MHMRA finds deficiencies, provider must be willing to revise their policy and procedures. Provider must submit copies of supervision documentation as requested by MHMRA.

Outcomes Measurement

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 per Diagnosis Specific Symptom Rating Scales, Fidelity, and RDM requirements. Assessment of outcomes is necessary on at least two levels:

1. Individual outcomes measure the effectiveness of treatment by assessing the response to treatment in relation to defined outcomes. The clinical team will use the Uniform Assessment Packet and encounter data to assess individual outcomes.

2. System outcomes measure the effectiveness of the service delivery system by utilizing aggregated individual outcomes cost data and encounter data. Use of this data is essential to evaluate effectiveness and efficiency. Use of this data will inform TDSHS and local authorities of system quality and efficiency, and will provide a basis for a root cause analysis of success as well as deficiencies.

3. Specific fidelity scales, developed by DSHS, measure the extent and faithfulness of implementation of Mental Health Resiliency and Disease Management (RDM) for purposes of quality improvement and accountability to DSHS and by extension to the Texas Legislature and the citizens of Texas. Providers should familiarize themselves with the DSHS fidelity guidelines for RDM services at http://www.dshs.state.tx.us/mhprograms/RDMFidelityToolkit.shtm.

FIDELITY IN DSHS SERVICES

A. ADULT MENTAL HEALTH PROGRAMS
    1) Patient and Family Education Program
    2) Cognitive Behavior Therapy (CBT) for the Treatment of Depression
    3) Psychosocial Rehabilitation

4) Urban Assertive Community Treatment (Urban ACT)

B. CHILDREN'S MENTAL HEALTH PROGRAMS
1) Child and Adolescent Patient and Family Education Program
2) Cognitive Behavioral Therapy for Children and Adolescents with Anxiety and Depression

3) Skills Training for Children and Adolescents with Externalizing Disorders and Their Parents and Caregivers

Network Requirements depending on services contracted:

1. Training (See Exhibit D) - Contract training will be provided to new providers 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 participation/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. Providers are responsible for tracking the due dates of all their trainings.

2. Documentation Requirements- Contractor shall follow documentation procedures as delegated by the Agency. See Provider training materials for format and timeframe requirements. All documentation shall be on Agency approved forms and shall be submitted to the Agency within 48 hours of completion for data entry into the system to ensure payment. All documentation is subject to review by the Agency upon request.

3. Formulary- Providers must follow the Agency formulary and prescribing guidelines as set forth by the Agency. Exceptions to these guidelines require prior written approval by the MHMRA-Medical Director for Mental Health Services.

4. Notification of Change: Provider must provide written notification of change within 10 days of the occurrence for the following:
    a) Change of Address
    b) Change of Phone Numbers
    c) Change of Appointment Availability for New Consumers
    d) Any other material changes that affect access and availability to consumers

5. Lab work. Provider will use MHMRA's lab work contractor unless able to provide service at same rate.

6. Nursing services. Provider will schedule EKGs and injections with MHMRA nurses at one of our clinic locations unless able to provide service at same rate. Provider must follow agency guidelines.

7. Pharmacy. Provider will use one of MHMRA's pharmacies at any of the 4 clinic locations or assigned clinic location unless able to provide service at same rate or unless client has a private insurance plan and can use any approved pharmacy. Pharmacy must be aware of client's return appointment and TRAG assessment dates at time of script refill.

8. PAP. Prescription Assistance Program for medication. Provider will assist in completing applications within designated timeframes.

9. Requirements. Provider will be knowledgeable and compliant with DSHS timelines for due dates of client materials (i.e.-TRAG due by 90th day).

10. Providers contracting with MHMRA will be responsible for the completion of the TRAG assessment within deadlines prescribed by the DSHS contract (currently every 90 days) and

potentially responsible for timely data entry into DSHS Webcare electronic system. If either of these is not met, there will potentially be a penalty or lack of payment for services.

11. No shows. Providers will adhere to a good faith effort in trying to reschedule clients with missed appointments and document such attempts in clinical chart. MHMRA will not pay for no show appointments. A Discharge Summary for clients no longer receiving care will be required.
12. MAP. Providers will be knowledgeable about client's monthly ability to pay for services which MHMRA assesses yearly (or in event of change) at financial review and collects from client directly. The financial review is required to be renewed yearly and providers need to be aware of these deadlines for claim submissions.

13. Client choice. Provider will offer clients a choice of providers within our network at every treatment plan review or every 90th day. A client's signature acknowledging their decision needs to be recorded.

14. Meetings. Providers will attend regularly scheduled Provider meetings for operational guidelines updated when required.

15. Providers will grant electronic access to medical records for MHMRA Authority staff and if unable, paper copies may be required to be provided to MHMRA Authority prior to claims processing to ensure compliance with contract requirements.

Reimbursement Criteria

1. Billing

a) MHMRA is responsible for processing claims for consumers who receive authorized services from a provider. All non-emergency services must be pre-authorized. All emergency services must be authorized within 24 hours or 1 business day of service initiation.
b) The payment amount will be based on a CMS-1500 /UB-92 Claim Form or on an Agency pre-approved Invoice, which shall reflect the services, provided by the Contractor, and is approved by the Agency employee(s) authorized to approve billing(s) as set forth in the Agreement.
c) Claim forms for services must be received no later than the 2nd business day or 5th day after the month in which services were rendered depending on contract arrangement. Claim forms for services received later than the 2nd business day or 5th day on which the prior month services were rendered will be denied due to untimely filing.
d) Payment shall be made within 30 days of receipt of the Claim form or 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. Payments will not be further paid if data is being upstream claimed to another payor until MHMRA receives payment from such payor.
e) Claim Appeals shall be submitted within 30 days from the initial EOB date to the following mailing address:

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

f) Consumers cannot be billed for services that are not covered by the Benefit Plan. A provider may not require a down payment prior to providing allowable services to eligible consumers.
g) A provider who furnishes services not covered by Benefits, including those services which have been determined as not medically necessary, must obtain the consumer's signature acknowledging that the consumer understands their responsibility for payment of uncovered services.

h) Consumers cannot be balance billed for the amount that is not paid by MHMRA. The consumer must not be billed for services denied or reduced as a result of errors made in claims filing, claims preparation, missed filing deadlines, or failure on the part of the provider to follow the appropriate process. Providers cannot bill consumers for the completion of a claim form even if it is the provider's standard office policy. Any provider that knowingly attempts to bill or recover money from a consumer in violation of the above conditions will be subject to expulsion from the provider network.

i) Any provider who has submitted a claim and received a denial or a partial payment may appeal the claims determination. In order to appeal a claims determination, the provider must submit an appeal letter to MHMRA within 30 days of claims denial. This letter should include supporting documentation that justifies the appeal review. MHMRA will review the information and issue a determination within 30 days.

j) MHMRA's expectation is that providers will continue service provision as long as clinically indicated (and with consumer consent) for consumers who obtain other non GR benefits (such as receiving Medicaid benefits or private insurance). The contractor will be available to provide services to these clients as private clients not under contract with MHMRA when appropriate.

2. Payments

a) Coordination of Benefits: Contractor will collect information concerning duplicate coverage at the time of treatment and will provide such information to the Agency in administering the coordination of benefits within 7 days of receipt of such information.

b) Warranty: By submitting a claim, 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.

3. Modification of Existing Fee Schedule

It is at the sole discretion of the Agency to modify the existing fee schedule upon written notice to the Contractor. Current fees are based upon Medicaid rates or provider costs minus 5% for administration (rounded to the nearest dollar) and are subject to change as rates/costs change. Where Medicaid rates do not exist, Medicare rates can be substituted or provider costs can be utilized. If the provider can demonstrate the ability to accurately manage contract data independently from Network Management authority staff, the 5% administrative fee can be waived.

4. Notices to Agency

Contractor shall notify the Agency within 10 business days of any events effecting licensure such as suspension, revocation, threatened loss or any way in which the Contractor would 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 and with the same time availability as it offers to non-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 medical and mental health practices and applicable laws and regulations.

5. Billable Service Requirements (omission of any element could result in claim denial)

    a) Current diagnosis by a Physician or LPHA -data entered into electronic system or provided to Authority
    b) Uniform Assessment – RDM (UA-RDM) completed by a QMHP
    c) Symptom Rating Scales completed by a QMHP
    d) UA – RDM data entry into DSHS WebCare
    e) Treatment Plan completed by a QMHP
    f) Determination of Medical Necessity by a LMHA LPHA
    g) Service provision by a QMHP or LPHA
    h) Document service that meets Medicaid documentation requirements
        i) Name of the individual to whom the service was provided
        ii) Name the type of service
        iii) A summary of the activities that occurred
        iv) State the specific skill(s) on which client was trained
        v) State the specific methods used to provide training
        vi) Date, start & end time, and location (not overlapping)
        vii) Correlate the specific treatment plan goal that was the focus of the service
        viii) State the progress or lack of progress in achieving treatment plan goals
        ix) Signature of the staff member providing the service & credentials

6. The requirements listed above represent only a partial listing of the requirements related to service delivery. Please review the following for additional requirements:

    a) DSHS LMHA Performance Contract at: http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm
    b) To view the RDM Clinical Guidelines including the service package definitions and service descriptions for the service package(s) or discrete service specified in this RFP go to: http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm
    c) For more information, see the RDM Program Manual (PDF, 659 KB) at: http://www.dshs.state.tx.us/mhprograms/RDM/documents/RDM_Program_Manual.pdf
    d) Texas Administrative Code Rules:
        i) Chapter 404, Subchapter E, Rights of Persons Receiving Mental Health Services
        ii) Chapter 405, Subchapter K, Deaths of Persons Served by TDMHMR Facilities or Community Mental Health and Mental Retardation Centers (rev.6/95)
        iii) Chapter 411, Subchapter G, Community MHMR Centers
        iv) Chapter 412, Subchapter G, Mental Health Community Services Standards
        v) Chapter 414, Subchapter A, Client-Identifying Information
        vi) Chapter 414, Subchapter K, Criminal History Clearances
        vii) Chapter 414, Subchapter L, Abuse, Neglect, and Exploitation in Local Authorities and Community Centers
        viii) Chapter 419, Subchapter L, Medicaid Rehabilitative Services

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.

V. Appeal Procedure for Denial of Access to Network:

1. Function and Timeline

    a) The Credentialing Committee of MHMRA may make a negative decision based on (but not limited to) one of the following :
        i) State license encumbered or not current
        ii) Malpractice insurance is not in effect
        iii) Affirmative responses to questions related to malpractice history, sanctions, or other negative history which the Credentialing Committee believes may compromise the professional effectiveness or performance of appellant
        iv) Information from outside sources concerning the provider's qualifications or criminal history which the Committee believes may compromise the professional effectiveness or performance of appellant
        v) Variance of information supplied on the application and information obtained from an impartial outside source including but not limited to: Medicare, Medicaid, or any federal health care program sources; Federation of State Medical Boards (FSMB) information; National Practitioner Data Bank (NPDB) information, hospital disciplinary action; and other sources considered relevant by the Committee.

2. Provider Denial of Credentials

    a) The Credentialing Committee will notify a provider in writing within thirty (30) calendar days of the committee's credentialing or re-credentialing decision.
    b) All committee decisions to deny credentialing must be completed in writing and must have a majority vote. Reasons for the denial must be communicated to the provider in writing. The notification will also outline the provider appeals process and related timelines.
    c) A provider has a right to one copy of his/her provider file per credentialing period. However, Professional References will not be released with the provider file unless authorization to do so is obtained from the person that submitted the reference. The provider must put the request in writing to obtain copy of their file and the Credentialing Committee will respond within 30 days. The provider is responsible for the costs of the copies.
    d) The practitioners, physicians, or providers have the right to review the information submitted in support of their credentialing application with the exceptions noted above.

3. Provider Appeals

    a) Providers have 30 days from notification of denial or termination of credentialing privileges to file an appeal in writing. All appeals must include information related to the reason for the denial and provider must provide additional information to support appeal.
    b) The Credentialing Committee has 30 days from receipt of an applicant's written appeal to consider the appeal. The Committee's decision to accept or deny the appeal is placed in writing to the provider within 30 days of that determination.

EXHIBIT D- SP 3
TRAINING REQUIREMENTS

Course	Refresher/ Frequency	Type of Training	Svc. Pkgs	Length of Training	Who Needs?	Provided by
Basic Mental Illness	Initial Competency / Sample audit periodically	Attend & Participate	All	4 hours	QMHP, RN, LVN, Waive for Licensed	MHMRA
Basic Pharmacology	Initial Competency / Sample audit periodically	On-line	All	varies	All staff- Waive for MD, RPh	MHMRA
Clinical Documentation and Progress Note Training	Initial Competency / Sample audit periodically	Attend & participate	All	4 hrs	PN writers	MHMRA
Consumer Rights	Initial Competency / Sample audit periodically	On-line	All	varies	All	MHMRA
CPR (Adult)	Must maintain current certification	Attend & participate	All	4 hrs	All	MHMRA
Cultural Diversity	Initial Competency / Sample audit periodically	On-line	All	varies	All	MHMRA
First Aid	Must maintain current certification	Attend & participate	All	4 hrs	All	MHMRA
HIPPA Privacy & Security	Initial Competency / Sample audit periodically	On-line	All	varies	All	MHMRA
Infection Control	Initial Competency / Sample audit periodically	On-line	All	varies	All; Waive for MD, RN, LVN	MHMRA
MH Clinical Engagement / Motivational Interviewing	Annually	Attend & participate	All	8 hrs	Rehab & CM providers	MHMRA
MH COPSD	Initial Competency /sample audit periodically	On-line	All	Varies	QMHP, RN, LVN	DSHS
MH Rehabilitation Training	Annually	Attend & participate	All	8 hrs	MH Rehab providers	MHMRA
MH Treatment Planning	Initial Competency / Sample audit periodically	Attend & participate	All	8 hrs	MH Tx Plan	MHMRA
MH Uniform Assessment – TRAG*	Initial Competency / Annually	Attend & participate	All	5 hrs	MH TRAG assessors	MHMRA
PMAB 3.1 & 3.2	Initial Competency / Annual refresher	Attend & Participate	All	8 hours initial 4 hours refresher 2 hr test option	All	MHMRA
Principles of Crisis Intervention (PMAB 1)	Initial Competency / Annual refresher	Online	All	varies	QMHP, RN, LVN	MHMRA
Seizure Assessment	Initial Competency / Sample audit periodically	On-line	All	varies	All; Waive for MD, RN, LVN	MHMRA
Suicide/Homicide	Initial Competency / Sample audit periodically	On-line	All	varies	QMHP, RN, LVN, Waive for Licensed	MHMRA
Supervised Self-Administration of Medication	Initial Competency / Sample audit periodically	Attend & participate	All	3 hrs	Required for med delivery	MHMRA
Patient and Family Education (PFEP) or other required similar training from state	Initial Competency / Annually	Attend & participate	All	3 hrs	MH PFEP providers	MHMRA
Diagnosis Specific Symptom Rating Scales	Initial Competency / Annually	Attend & participate	All	3 hrs	TRAG assessors	MHMRA

Note: All Attend & Participate courses can be taken through the MHMRA Human Resources Department. All on-line courses are accessible via the internet @ https://gm1.geolearning.com/geonext/mhmra/login.geo however you must be approved to take the courses through this 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 Geo learning 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.

*New required trainings for FY 14 are being added by DSHS for CBT and RDM redesign (TRAG). These required trainings and due dates will be additional trainings required before service provision and can be found @ http://www.dshs.state.tx.us/mhprograms/RDM.shtm.

Exhibit E
ASSURANCES

Applicant must assure the following:

1. That all addenda, exhibits and/or attachments to the Application as distributed by the Local Authority have been received.
2. That the criteria for approval are met.
3. That the applicant is not currently held in abeyance or barred from the award of a federal or state contract.
4. That the applicant is not currently delinquent in its payments of any franchise tax or state tax owed to the state of Texas, pursuant to Texas Business Corporation Act, Texas Civil Statutes, Article 2.45.
5. No attempt will be made by the Applicant to induce any person or firm to submit or not to submit an application, unless so described in the application document.
6. The Applicant does not discriminate in its services or employment practices on the basis or race, color, religion, sex, national origin, disability, veteran status, or age.
7. That no employee of the Local Authority or DSHS, and no member of the Local Authority's Board of Trustees will directly or indirectly receive any pecuniary interest from an award of the proposed contract. If the applicant is unable to make the affirmation, then the applicant must disclose any knowledge of such interests.
8. Applicant accepts the terms, conditions, criteria, and requirements set forth in the Application.
9. Applicant accepts the Local Authority's right to cancel the Application at any time prior to contract award.
10. Applicant accepts the Local Authority's right to alter the timetables for procurement as set forth in the Application.
11. The application submitted by the Applicant has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition.
12. Unless otherwise required by law, the information in the application submitted by the Applicant has not been knowingly disclosed by the Applicant to any other Applicant prior to the notice of intent to award.
13. No claim will be made for payment to cover costs incurred in the preparation of the submission of the application or any other associated costs.
14. Local Authority has the right to complete background checks and verify information.
15. The individual signing this document and the contract is authorized to legally bind the Applicant.
16. The address submitted by the Applicant to be used for all notices sent by the Local Authority is current and correct.

_____	_____	_____
Signature of Applicant	Title of Organization/Provider	Date

Exhibit F
VEHICLE SAFETY REPORT

This form must be completed for each vehicle which may be used while transporting individuals receiving services.

Vehicle Custodian/owner: _____ Phone#: _____
License Plate Number: _____ Mileage: _____
Type and Model of Vehicle: _____
Name of Insurance Carrier: _____

Items to be Circled:

Required for individuals safety and comfort

Inspection sticker expiration date: _____

Is current insurance card in vehicle?	Yes or No
A/C and Heating systems are operable?	Yes or No
Are jumper cables in vehicle?	Yes or No or n/a
Is a First aid kit in vehicle?	Yes or No
Seat belts all lock	Yes or No
Condition of tires, including spare:	Ok or need replacing _____
Lights (head, tail, backup, turn)	Ok or need replacing _____
Mileage of last oil change: _____	(and does not exceed 3500 miles)
Mileage of last transmission service: _____	(and does not exceed 30,000 miles)
Interior of vehicle, condition	Ok or need cleaning _____
Fluid levels:	Ok or need refilling or service

Additional recommended

Is Fire extinguisher in vehicle?	Yes or No
Is Fire extinguisher secured?	Yes or No or n/a
Is Flash light w/charged batteries?	Yes or No or n/a
Is First aid kit secured?	Yes or No or n/a
Is Biohazard kit in vehicle?	Yes or No
Is Biohazard kit secured?	Yes or No or n/a
Is Seat belt Saf-Cut installed?	Yes or No

This is to acknowledge that I am responsible for obtaining the necessary repairs or equipment to insure the vehicle is in a safe condition to transport individuals receiving services. I also understand that the Local Authority at any time may inspect my vehicle to ensure validity of the information provided.

_____ _____ _____
Vehicle custodian/Owner Title Date

EXHIBIT G
STAFF ROSTER

Organization/Facility Name: ____________________ Date: _________________________________

STAFF NAME	POSITION	DATE OF LAST CRIMINAL HX CHECK	DATE GRADUATED HS OR GED	PROFESSIONAL LICENSE/ DEGREE	TDL EXP. DATE

Exhibit H

Detailed information needed from Provider: Submissions should be limited to ten (10) pages plus exhibits and forms.

A. GENERAL

1. **Capacity/Transition**. What is your capacity?

Identify the percentage of your practice time dedicated to the following patient population and modality categories:

Population	% of Practice
Child (up to age 12)	
Adolescent (13 - 17)	
Adult (18 - 64)	
Geriatric (65+)	

Business Lines	% of Practice
Group Health (PPO)	
Capitation (HMO)	
Medicaid	
Medicare	
Other	

2. **Experience with providing Mental Health Services:**

Provide detailed explanation of your experience with treating the chronically mentally ill with diagnosis of MDD<50/ Schizophrenia/Bipolar for each age level:

CHILD (up to age 12)
ADOLESCENT (13 - 17)
ADULTS (18- 64)
GERIATRICS (65+)

3. How do you plan on transitioning consumers to your services? Please answer the following questions in relation to transitioning consumers to your facility.

a) Meet appointment timeframes for routine, urgent, emergent appointments per the TAC requirements.
b) Ensure after hours availability for emergency care (information in how to obtain that care).
c) Request case management for cases needing additional service linkage/monitoring from MHMRA Authority.
d) Demonstrate good faith efforts to engage patients in care with subsequent documentation of these efforts.
e) Communicate to the LMHA when patients cannot be located so additional case management resources can be deployed.

f) Offer patient choice to change providers at each treatment plan review AND provide LMHA handout for patient to make independent choice at any time if applicable.
g) Communicate to the LMHA when a consumer is choosing to transfer providers within 2 business days if applicable.
h) Communicate to the LMHA when a patient needs are not being met and another level of care is needed or TRAG assessment indicates another SP that provider is not contracted to perform if applicable.

4. **Training.** List current staff training requirements and frequencies. Training that is duplicated at your organization/providers can be substituted for these sessions as long as it meets the course objective. Substitution reviews must be approved by Quality Management.

5. **Noncompliance.** Describe the organization's/provider's history of working with persons who are not compliant with treatment. Describe the organization's/provider's ability to treat persons with disabilities. Detail the specific population to be served under this proposal. Include ages and levels of severity. How have services been made accessible for those who are difficult to reach, either due to geography or dissatisfaction with service delivery?

6. **Special Needs**. Describe the organization's/provider's ability to work with persons who are hearing impaired, persons who have limited language skills and persons who speak a language other than English. Describe the organization's ability to work with persons with physical impairments and adaptive equipment. Describe how the organization/provider ensures cultural competency on the part of staff with regard to ethnic, racial, religious and sexual orientation differences.

7. **Transportation**. Describe the facility (ies) proximity to public transportation.

B. FINANCIAL

1. **Business Status**. Is the organization/provider incorporated as "Profit", "Not-for-profit", or "Other"? If "other", please explain.

2. **Subcontractors.** Describe any arrangements to subcontract part or all of these services. Name all subcontractors and provide information on their staff credentials, licenses and certifications.

3. **CEA.** Provide a copy of a Certified External Audit for the past three years. Label as **Exhibit I.**

4. **Taxes.** Provide a copy of the most recent Tax Statement (IRS Form 1120, Form 990 as applicable). Label as **Exhibit J.**

5. **Financial Statement.** Provide a current Financial Statement including Cash Flow. Label as **Exhibit K.**

6. **Report.** Submit the most current Annual Report available. Label as **Exhibit L.**

7. **Viability**. Provide evidence of continued financial viability to ensure your capabilities to support this service. **Completion of the Cash Flow Projection template labeled as Exhibit M is required.** The Cash Flow Projection is for the contract period. This will indicate the financial viability of the business to pursue its contracted obligations during the contract period. All should be attached as explanatory notes for the projection as well as any other additional financial viability materials-all labeled as **Exhibit M.**

C. RISK ASSESSMENT

1. **Violations** (including abuse, neglect, exploitation, or other rights violations). If individual or organization has had any violations, explain in detail. Describe or attach any policies and

procedures regarding consumer abuse, consumer neglect, or rights violations and the training of staff on these issues. If attaching policies and procedures, label as **Exhibit N**.

2. **Taxes.** Does the organization/provider have a Letter of Good Standing that verifies that it is not delinquent in State Franchise Tax? Corporations that are non-profit or exempt from Franchise Tax are not required to have this letter, but will have a 501C IRS Exemption form from the Comptroller's Office. Attach and label as **Exhibit O**. Is the Provider delinquent in the payment of any Child Support Payments? If so, explain.

3. **Liability Coverage**. Provide a Certificate of Insurance showing liability insurance coverage (property and vehicles, including riders) and including directors' and officers' professional liability, errors and omissions, general liability, and medical malpractice insurance - Label as **Exhibit P**.

4. **Workers Compensation**. Provide the name of Workers' Compensation carrier if the organization/provider has Workers' Compensation coverage, or self funding documents if self funded - Label as **Exhibit Q**.

5. **Bond.** Are employees or agents of the organization bonded? What is your policy regarding criminal history checks on employees?

6. **MOU**. Describe any contracts, Memoranda of Understanding, or employment relationship the organization/provider has with other state, city or county agencies in the Harris County community.

7. No employee of the Local Authority or DSHS, and no member of the Local Authority's Board of Trustees can directly or indirectly receive any pecuniary interest from an award of the proposed contract. If such a situation exists, please explain in detail. Label as **Exhibit R.**

D. INFORMATION SYSTEMS

Can the organization/provider information system report the following categories of data? Label as **Exhibit S.**

a) Consumer name
b) Admissions and Discharges to services
c) Date, Number, type, and duration of services (by Local Authority service codes)
d) Number and types of restraints authorized by behavior intervention plan
e) Number, type and severity of medication errors/adverse drug reactions for Local Authority consumers
f) Deaths and suicide attempts of Local Authority consumers
g) Serious injury or illness of Local Authority consumers
h) Confirmed abuse, neglect, or exploitation of Local Authority consumers
i) Allegations of homicide/attempted homicide/threat with a plan by a Local Authority consumer

E. INSURANCE COVERAGE

1. What type of insurance do you accept? Please list all types.

_____
_____
_____
_____

2. Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier or had an individual policy cancelled or individual surcharge placed on you based on your individual practice and/or application? _____Yes _____No

3. Have you filed a claim under your general, professional auto or other liability insurance in the last three years? ___Yes ___No

F. Additional Disclosure Information

1.	Do you have a consumer appeals process?	Yes or No
2.	Do you have an incident report process?	Yes or No
3.	Do you have a confidentiality/consumer rights process?	Yes or No
4.	Do you have an internal quality improvement process?	Yes or No
5.	Do you have an internal utilization management process?	Yes or No
6.	Do you have a consumer satisfaction measure?	Yes or No
7.	Do you have a service outcome measure?	Yes or No
8.	Do you maintain a file on each person receiving services?	Yes or No
9.	Do you have a disaster response plan?	Yes or No

G. RISK PROFILE

1. Attach a copy of Proposer's Risk Management Plan and a copy of your Security Manual/Procedures –Label as **Exhibit T**.

2. Does anyone working for Proposer providing direct care or in management have any criminal convictions? If yes, explain. Describe the process, if any, for checking on previous convictions of employees or applicants for employment. (See Local Authority's Bars to Employment). Attach any policies and procedures regarding the hiring and retention of persons with criminal histories –Are criminal history checks done on all Proposer staff at least annually? Label as **Exhibit T1**.

3. Has Proposer had any judgments or settlements entered against it in the last ten (10) years? If yes, describe in detail. Has either the Proposer or any of its employees ever had any validated/confirmed fraud, client abuse, client neglect, or rights violations claims? If yes, describe in detail. Describe the process, if any, for checking on previous confirmed fraud, client abuse, client, neglect, or rights violations of employees or applicants for employment, such as through CANRS, the Nurse Aide Registry, and/or the Employee Misconduct Registry. Describe or attach any current policies and procedures regarding client abuse, client neglect, or rights violations and the training of staff on these issues – Label as **Exhibit T2**.

4. Has Proposer been placed on vendor hold within the past five (5) years by any funding agency or company? If yes, describe in detail. Is Proposer currently held in abeyance or barred from the award of a federal or state contract? Has this occurred in the last 5 years? If yes, describe in detail. Has Proposer or any of its affiliates ever had contracts cancelled by state, federal or local governmental entities? If yes, describe in detail. Has the proposer ever been investigated by the state or federal investigation agencies related to OIG compliance. Label **Exhibit T3**.

5. Has Proposer ever filed bankruptcy? If yes, describe in detail. Has Proposer ever defaulted on any business lease arrangement? If yes, describe in detail. Label **Exhibit T4**.

6. Has Proposer ever been investigated for any HIPAA violations, confidentiality, or security breaches in relations to Provider's health record? Provide the details and the disposition of such investigations. **Exhibit T5.**

7. Attach any policies and procedures regarding medical records, prescription pad, and medication

management, storage, security and access; infection control (including TB screening), food preparation, handling and service; required postings for client rights protection, and emergency contact, fire drill compliance – Label as **Exhibit U**.

8. Provide description of consumer complaint process. Label as **Exhibit U1.** Within last 2 years.
    - Number and duration of all incidents of Client restraint and seclusion.
    - Number, type, and severity of medication errors and adverse drug reactions for Clients.
    - Elopements, unauthorized departures, and Against Medical Advice discharges of Clients.
    - Deaths (all causes) and suicide attempts of Clients.
    - Serious injury or illness of Clients.
    - Confirmed abuse, neglect or exploitation of Clients.
    - Allegations of homicide/attempted homicide/ threat with a plan by a Client.
    - Fire drills with evacuation scores

EXHIBIT M

(Name of Company)

CASH FLOW PROJECTION FOR (Contract Period)

For the (No. of) months ending (end of contract term)

	Months												
	1	2	3	4	5	6	7	8	9	10	11	12	Total
Total Cash, beginning (A) or (D of previous mo.)													
Additional Sources of Cash:													
Cash revenues													
Collection of receivables													
Interest income													
Sale of property													
Loan													
Additional capitalization													
Total Additional Sources of Cash (B)													
TOTAL CASH AVAILABLE (C=A+B)													
Disbursements:													
Salaries- Officers													
Salaries													
Fringe Benefits													
Travel													
Repairs & Maintenance													
Rent													
Taxes & Licenses													
Advertising													
Office Supplies													
Medical Supplies													
Insurance													
Security													
Telephone													
Utilities													
Interest Expense													
Bank Charges													
Miscellaneous Expense													
Charitable Contributions													
Capital Outlay													
Other disbursements (attach schedule)													
Total Disbursements (D)													
Total Cash Available, ending (D= C+D)													