

**MENTAL HEALTH GENERAL REVENUE FUNDED SERVICES
OPEN ENROLLMENT REQUEST FOR APPLICATION
JUNE 1, 2012**

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 and FY'10. This plan can be reviewed at <http://www.mhmraharris.org/Mental-Health-External-Provider-Network.asp>.

ROUTINE SERVICES	Projected LMHA Capacity	% Capacity sought to procure
Psychiatric Diagnostic Interview Examination	477	Up to 60%
Pharmacological Management	Included in Above Capacity	
Medication Training and Support-Individual	Included in Above Capacity	
Medication Training and Support-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.mhmrharris.org/ept.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 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 4-Children Mental Health Services
DESIGNATION OF SERVICES**

CONTRACTOR:

CONTRACTOR ID#:

CONTRACT PERIOD: Date of Contract

SERVICE DESCRIPTION: (Ex) Children – Service Package 4
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 2	90801	1100	\$119.57 By MD \$110.00 By ANP	\$113.59 By MD \$104.50 By ANP	Flat fee
Pharmacological Management	Pg 3	90862	7000	\$43.79 By MD \$40.28 By ANP	\$41.60 By MD \$38.27 By ANP	Flat fee
Pharmacological Management	Pg 3	M0064	7000	\$31.44 By MD \$28.92 By ANP	\$29.87 By MD \$27.48 By ANP	Flat Fee
Medication Training and Support-Individual	Pg 3	H0034	7600	\$13.53	\$12.85	1 unit= 15 min
Medication Training and Support-Group	Pg 3	H0034	7600	\$3.38	\$3.21	1 unit= 15 min

PERFORMANCE MEASURE OUTCOMES (See Attachment):

Populations Served	Pg 7
Service Requirements	Pg 7-8
Service Targets	Pg 9-10
Service Capacity Measures	Pg 10
Disease Mgmt Outcomes	Pg 10-11
Additional Outcomes	Pg 11

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 child age range 0-20 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 \$300,000.00.

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
CHILD SERVICE DEFINITIONS**

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

CHILDREN'S SERVICE DEFINITIONS:

	Service	Description
1	Outreach	Activities provided to reach and to link services to 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 and their family are found.
2	Hotline <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1)</i>	A continuously available telephone service that provides information, support, referrals, screening and intervention that responds to callers 24 hours per day, 7 days per week.
3	Screening <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1)</i>	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, caregiver, or collateral. The service includes screenings to determine if the individual's need is emergent or urgent (which is conducted prior to the face-to-face assessment to determine the need for emergency services).
4	Extended Observation <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1), (2),(3)</i>	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 <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3)</i>	Psychiatric Diagnostic Interview Examination provided by a licensed professional practicing within the scope of their license must provide this service and document as described in the most current version of Title 25 Texas Administrative Code (TAC), Part 1, 412, Subchapter G, Section 412.315(a)(5) <i>MH Community Services Standards</i> .
6	Pre-Admission Assessment <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3)</i>	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 described in the most current version of 25 TAC, Part 1, Chapter 412 Subchapter G, Section 412.315, <i>MH Community Services Standards</i> , (a)(1)-(a)(4) and (a)(6)-(a) (9). Contractor is required to complete the Uniform Assessment (UA) to determine if the individual is eligible for a Level of Care (LOC), should be enrolled into services, or placed on a waiting list. This service shall be provided to all individuals who have been screened and who appear to have a need for services through Contractor regardless of current resource availability or provider capacity.
7	Engagement Activity	Short term planned activities with the client or collaterals (provided in accordance with confidentiality requirements) to develop treatment alliance and rapport with the client that includes but not limited to activities such as: enhancing the individual's motivation to participate in services, explaining services recommended, educating on service value, adherence to the recommended service package and its importance in recovery. This service shall not be provided in a group.

	Service	Description
8	<p>* Routine Case Management</p> <p><i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(4), (5)</i></p>	<p>Primarily site-based services that assist a child/adolescent, or caregiver in obtaining 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, <i>MH Case Management Services</i>. <u>Contractor shall not subcontract for the delivery of these services.</u></p>
9	<p>* Intensive Case Management</p> <p><i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(4), (5)</i></p>	<p>Activities to assist a client and their caregiver obtain and coordinate access to necessary care and services appropriate to the individual's needs. Wraparound Planning is used to develop the Case Management Plan. Intensive Case Management activities shall be provided in accordance with 25 TAC, Part 1, Chapter 412, Subchapter I, <i>MH Case Management Services</i>. <u>Contractor shall not subcontract for the delivery of these services.</u></p>
10	<p>* Counseling</p> <p><i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3)</i></p>	<p>Individual, family, and group therapy focused on the reduction or elimination of a client's symptoms of emotional disturbance and increasing the individual's ability to perform activities of daily living. Cognitive behavioral therapies are the selected treatment model for CMH counseling services. There are RDM approved CBT protocols for treating CMH consumers for depression, anxiety and trauma-based disorders. LPHAs are allowed to use Play Therapy as a treatment alternative for children ages 3-8 or children who for developmental reasons are not able to cognitively benefit from CBT. Children ages 3-5 may receive DSHS approved Early Childhood Mental Health Counseling as part of their mental health treatment. Trauma-Focused Cognitive Behavior Therapy is the approved counseling evidence-based practice for children with trauma disorders or children whose functioning or behavior is affected by their history of traumatic events. Licensed Practitioners of the Healing Arts (LPHA)s trained in DSHS approved Early Childhood Mental Health Counseling shall provide this counseling modality for children ages 3-5.</p>
11	<p>* Respite Services</p> <p><i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(4)</i></p>	<p>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.</p>
MEDICATION SERVICES		
12	<p>* Supplemental Nursing Services</p> <p><i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(6)</i></p>	<p>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.</p>
13	<p>* Pharmacological Management</p>	<p>A service provided by a physician or other prescribing professional</p>

	Service	Description
	<i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3), (6)</i>	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 <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(6)</i>	Ensuring the provision of psychoactive medication benefits to clients registered in the Client Assignment and Registration System (CARE), who have no source of funds for such, as determined to be medically necessary and as prescribed by an authorized representative of Contractor.
		REHABILITATIVE SERVICES
15	* Crisis Intervention Services <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1), (3), (7)</i>	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, <i>MH Rehabilitative Services</i> . 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, <i>MH Community Standards</i> .
16	* Medication Training and Support <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(6)</i>	Service to provide 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 which have been formally reviewed and approved by DSHS. Shall be provided in accordance with 25 TAC, Part 1, Chapter 419, Subchapter L, <i>MH Rehabilitative Services</i> .
17	* Skills Training and Development Services <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3), (7)</i>	Training provided to a client and the primary caregiver or legally authorized representative (LAR) that addresses the serious emotional disturbance 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 includes treatment planning to facilitate resiliency. Must be provided in accordance with 25 TAC, Part 1, Chapter 419, Subchapter L, <i>MH Rehabilitative Services</i> .

	Service	Description
	SPECIALIZED SERVICES	
18	* Family Case Management <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3), (4)</i>	Activities to assist the client's family members in accessing and coordinating necessary care and services appropriate to the family members' needs. The need for Family Case Management shall be documented in the client's Case Management Plan.
19	* Family Training <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3)</i>	Training provided to the client's primary caregivers to assist the caregivers in coping and managing with the client's emotional disturbance. This includes instruction on basic parenting skills and other forms of guidance that cannot be considered rehabilitative skills training. Concurrent rehabilitative training should be identified as a separate encounter with the appropriate rehabilitative service code.
20	* Family Partner <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(4)</i>	Family Partners are experienced and trained parents or primary caregivers of a child or adolescent with a serious emotional disturbance. Family Partners are active members of the intensive Case Management/Wraparound team process. Family Partners are instrumental in engaging families in services. They provide peer mentoring and support to the primary caregivers; introduce the family to the treatment process; model self-advocacy skills; provide information, referral and non-clinical skills training; assist in the identification of natural/non-traditional and community support systems; and document the provision of all family partner services, including both face-to-face and non face-to-face activities.
21	* Parent Support Group <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(4)</i>	Routinely scheduled support and informational meetings for the client's primary caregivers.
22	* Flexible Funds <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(4)</i>	<p>Funds utilized for non-clinical supports that augment the service plan to reduce symptomatology and maintain quality of life and family integration. Non-clinical supports shall be:</p> <ol style="list-style-type: none"> 1. Included as strategies in the client's Case Management Plan; 2. Based on the preference of the client and family and focus on the outcomes they choose; 3. Monitored for effectiveness by the Case Manager and adjusted based on effectiveness; 4. Available through General Revenue (GR) funding; and 5. Not readily available through other sources (e.g., other agencies, volunteers) <p>Community supports that may be purchased through Flexible Funds include but are not limited to: tutors, family aides, specialized camps, therapeutic child-oriented activities, temporary child care, temporary kinship care, initial job development and placement activities, initial independent living support, transportation services, short-term counseling for family members who do not meet the child or adult priority population definitions. Authorization of flexible funds should be provided in a timely manner. In cases of emergencies, Flexible Funds should be available within 24 hours of a request by the family. If respite services are provided with Flexible Funds, they should be identified with Procedure Codes H0045ETHA, H0045HA, T1005ETHA, or T1005HA.</p>

	Service	Description
	RESIDENTIAL SERVICES	
23	* Inpatient Hospital Services <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1), (2)</i>	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.
24	* Children's Crisis Residential Treatment <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(1), (2)</i>	Twenty-four hour, usually short-term residential services provided to a client demonstrating a psychiatric crisis that cannot be stabilized in a less restrictive setting. This service may use crisis beds in a residential treatment center or crisis respite beds.
	CRISIS SERVICES	
25	* Crisis Flexible Benefits	Non-clinical supports that reduce the crisis situation, reduce symptomatology, and enhance the ability of the child to remain in the home. Examples in children's mental health services include home safety modifications, child care to allow the family to participate in treatment activities, and transportation assistance.
26	* Safety Monitoring	Ongoing observation of an individual to ensure the individual's safety. An appropriate staff person shall 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.
27	* Crisis Follow-Up and Relapse Prevention <i>This service satisfies the requirements of Title 7 of the Texas Health and Safety Code §534.053(a)(3)</i>	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.
28	* 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

C. Children's 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) Child and Adolescent Mental Health (MH) 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 development 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 serious emotional disturbance.
 - b) Age Limitations:
 - (1) Children under the age of three who have a diagnosed physical or mental condition are to be served through the Early Childhood Intervention (ECI) program;
 - (2) Youth 17 years old and younger must be screened for CMH services. Youth 18 years or older must be screened for Adult Mental Health services; and
 - (3) Clients receiving Children's MH Services who are approaching their 18th birthday and continue to be in need of services shall either be transferred to Adult MH Services or referred to another community provider, dependent upon the individual's needs. Children reaching 18 years of age who continue to need services may be transferred to Adult MH Services without meeting the adult target population and served for up to one additional year.
 - c) Service Determination:
 - (1) In determining services and supports to be provided to the child and family, the choice of and admission to medically necessary services and supports are determined jointly by the child and family seeking services and supports and by Contractor;
 - (2) Criteria used to make these determinations are from the recommended LOC (LOC-R) of the individual as derived from the Uniform Assessment (UA), the needs of the individual, utilization management guidelines and the availability of resources;
 - (3) The Global Assessment of Functioning (GAF) is not used to determine eligibility for services; and
 - (4) Clients authorized for care by Contractor through a clinical override are eligible for the duration of the authorization.
 - d) 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 Utilization Management (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; and
 - (3) The LPHA's determination of diagnosis shall include a face-to-face or televideo interview with the individual.
 - e) Documentation required:

In order to assign a diagnosis across all 5 axes to an individual, documentation of the required diagnostic criteria, according to the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (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 part of the required assessment information.
 - f) UA requirements:

DSHS-approved UA for children and adolescents includes the following instruments:

 - (1) Child/Adolescent Texas Recommended Assessment Guidelines (CA-TRAG); and
 - (2) Community Data;
 - (a) The above instruments are required to be completed once an individual has been screened and determined in need of assessment from 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.
 - (b) Staff administering the instruments shall be a QMHP-CS and have documented training in the use of the instruments.
 - (c) The UA shall be administered according to the timeframes delineated in Information Item C located at <http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtml>.
 - (d) 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 children in accordance with Section I.B.6. The UA is not required for individuals whose services are not funded with funds paid to Contractor under this Program Attachment.
 - b) Children's MH case managers can access and use <http://www.hhs.state.tx.us/tim/timhome.shtml> as required in Texas Government Code (TGC) §531.0244.
 - c) Provide PFEP in accordance with the guidelines available from SAMHSA (located at <http://www.nimh.nih.gov/health/publications/mental-health-medications/complete-index.shtml>) or alternative guidelines approved by DSHS, on a schedule determined by DSHS. 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.
 - d) Apply RDM to all client services funded with contract funds in accordance with the following standards:
 - (1) Provide services in accordance with the most current version of DSHS' Resiliency and Disease Management UM Guidelines, CA-TRAG, Fidelity Instruments, and Information Item V (for Crisis Services);
 - (2) Each child or adolescent who is identified as being potentially in need of services shall be screened to determine if services may be warranted;

- (3) Children and adolescents seeking services are assessed to determine if they meet the requirements of priority population and if so, a full assessment shall be conducted and documented using the most current version of the DSHS UA instruments, including the CA-TRAG. Individuals whose services are not funded with Program Attachment 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 CA-TRAG, all services and supports within the authorized LOC (LOC-A);
 - (1) If a non-Medicaid eligible child or adolescent cannot be served in the recommended LOC (or if the child, adolescent, or the LAR of the child or adolescent refuses the recommended LOC), the child or adolescent may be served at the next most appropriate LOC. If no services are available at the next most appropriate LOC, the non-Medicaid eligible child or adolescent shall be placed and monitored on a waiting list;
 - (2) Medicaid-eligible children and adolescents may not have services denied, reduced, suspended, or terminated due to lack of available resources; and
 - (3) If a Medicaid-eligible child, adolescent or the LAR of a child or adolescent refuses the recommended LOC, the child or adolescent 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 child or adolescent's emotional disturbance. The LOC should not be reduced if the child, adolescent, or LAR refuses family partner services or family support groups only;
- (5) Medicaid-eligible children and adolescents shall be provided with any medically necessary Medicaid-funded MH services within the recommended LOC without undue delay;
- (6) Counseling services shall be 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 masters degree in human services field (e.g., psychology, social work, counseling) who is pursuing licensure under the direct supervision of an LPHA;
- (7) Providers of services and supports within RDM shall be trained in the DSHS-approved evidence-based practices prior to the provision of these services and supports. DSHS-approved evidence-based practices are described in Information Item G;
- (8) Supervisors of services and supports within RDM shall be 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 CA-TRAG to document the assessment of individuals seeking services and to reassess current clients in services when update assessments are due or service needs have changed to determine the recommended LOC for a client;
- (10) Set aside for Flexible Funds totaling \$1,500 per child for 10% of those children eligible to receive Service Packages 2.1, 2.2, 2.3, and 2.4. Use of Flexible Funds should occur in accordance with the UM Guidelines;
- (11) Hire or contract with a Family Partner (i.e., the experienced parent or primary caregiver of a child or adolescent with serious emotional disturbance) to provide peer mentoring and support to parents/primary caregivers of children and adolescents. Family Partner services are available in all Service Packages, but Contractor shall service a minimum of 15% of children and adolescents receiving services in Service Packages 2.1, 2.2, 2.3 and 2.4;
- (12) Ensure the Family Partner receives the appropriate training and supervision;
- (13) Family support groups shall be available to the parents of clients with serious emotional disturbances;
- (14) 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
- (15) Maintain access to WebCARE even if Contractor utilized an approved batch process.
- e) 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 MBOW in the CA General Warehouse Information, Specifications subfolder.
- f) Comply with the following Medicaid-related requirements:
 - (1) Contract with DSHS to be a provider for Medicaid MH Rehabilitative Services and Medicaid MH Case Management;
 - (2) Contract with HHSC to participate in Medicaid Administrative Claiming;
 - (3) Recognize that funding earned through billings to Texas Medicaid & 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.
- g) 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. Contractor shall comply with the following requirements:
 - (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) Allow clients that are otherwise eligible for DSHS services, but that cannot pay a deductible required by a third party payor, to receive services up to the amount of the deductible and to use DSHS funds to pay for the deductible;
 - (5) Maintain appropriate documentation from the third party payor reflecting attempts to obtain reimbursement;
 - (6) Bill all other funding sources for services provided under this Program Attachment before submitting any request for reimbursement to DSHS; and
 - (7) Provide all billing functions at no cost to the client.
- h) Expend Social Services Block grant (SSBG) funds to provide comprehensive community MH services to clients with serious emotional disturbance. Contractor shall utilize the SSBG under 42 USC §1397 (also known as Title XX of the Social Security Act) for the provision of the following services to clients in the priority population and report this information on Form L.
 - (1) Case management services, which are services or activities for the arrangement, coordination, and monitoring of services to meet the needs of clients and families. Component services and activities may include individual service plan development, monitoring, securing, and coordinating services; monitoring and evaluating client progress; and assuring that clients' rights are protected;

- (2) Counseling services, which are services or activities that apply therapeutic processes to personal, family and situational problems in order to bring about a positive resolution of the problem and improve individual and family functioning or circumstances. Problem areas may include:
 - (a) Family relationships;
 - (b) Parent-child problems;
 - (c) Depression;
 - (d) Child abuse;
 - (e) Anxiety; or
 - (f) Drug abuse when in conjunction with a serious emotional disturbance.
 - (3) Services for clients in foster care, which are those services or activities associated with the provision of an alternative family life experience for abused, neglected or dependent children, between birth and the age of majority, or the basis of a court commitment or voluntary placement agreement signed by the parent or guardian. Services may be provided to clients in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, pre-adoptive homes or supervised independent living situations. Component services or activities may include assessment of the client's needs, case planning and case management to assure that the client receives proper care in the placement, counseling of the client, the client's parents and the foster parents, and referral and assistance in obtaining other necessary support services;
 - (4) Prevention and Intervention Services which are those services and activities designed to provide early identification and timely intervention to support families and prevent or ameliorate the consequences of abuse, neglect, or family violence, or to assist in making arrangements for alternate placements or living arrangements where necessary. Such services may also be provided to prevent the removal of the client from the home. Component services may include assessment and evaluation of the extent of the problem, counseling, developmental and parenting skills training, respite, and service coordination; and
 - (5) Special services for clients involved or at risk of involvement with criminal activity, which are those services or activities for clients who are, or who may become, involved with the juvenile justice system. Component services or activities are designed to enhance family functioning and modify the client's behavior with the goal of developing socially appropriate behavior. Services may include the following:
 - (a) Skills training; and
 - (b) Family training.
- i) 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.
 - j) Develop and implement written procedures to identify clients with Co-Occurring Psychiatric and Substance Use Disorders (COPSD), identify available resources, and 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, part 1, chapter 411, Subchapter N. Nothing herein shall prohibit a physician from considering a client's substance use in prescribing medications.
 - k) Conduct all initial and on-going diagnostic assessments face-to-face or by televideo with the individual to determine priority population eligibility.
 - l) Implement crisis services in compliance with the standards outlined in Information Item V.
 - m) Submit encounter data on 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 (OMITTED)

B. Children's Services

Children's 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. Children Number Served Targets

- a) Target: (first and second quarter aggregate, and 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%, 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%, 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 children's 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 children's 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 children's 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 children's 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 children's 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 children 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 Contractors current 2 quarters funding for children's 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 children's 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 children's MH services excluding New Generation Medication funds;
 - (5) Less than 60%, the recoupment is 11.2% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds.
3. Ohio Scales Completion Rate
 - a) Minimum Target - 85% of Ohio Scales are completed by the parents or primary caregivers at intake, every 90 days during treatment and at planned discharge;
 - b) Sanctions Associated with this Measure are the following:
 - (1) Greater than or equal to 85%, there is no recoupment;
 - (2) From 75% to 84%, the recoupment is 0.06% of Contractors current 2 quarters for children's MH services excluding New Generation Medication funds.
 - (3) From 65% to 74%, the recoupment is 0.3% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds;
 - (4) Less than 65%, the recoupment is 2.4% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds.
4. Service Capacity Measures:
 - a) Minimum Target – Children and adolescents receiving at least the minimum number of hours based on service encounters for those authorized in Service Packages 1.1, 1.2, 2.1, 2.2, 2.3, 2.4 and 4 must meet the following service capacity thresholds:
 - (1) Service Package 1.1 – 1.5 hours minimum per month;
 - (2) Service Package 1.2 – 1.5 hours minimum per month;
 - (3) Service Package 2.1 – 5 hours minimum per month;
 - (4) Service Package 2.2 – 3.5 hours minimum per month;
 - (5) Service Package 2.3 – 3.5 hours minimum per month;
 - (6) Service Package 2.4 – 3.5 hours minimum per month; and
 - (7) Service Package 4 – 0.5 hours minimum per month with an LOC-R of 1.1, 1.2, 2.1, 2.2, 2.3, 2.4 and underserved due to consumer choice.

At least 80% of children and adolescents receive 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 1.1 through 4.
 - b) Sanctions Associated with this Measure 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 Contractors current 2 quarters funding for children's MH services excluding New Generation Medication funds.
 - (3) From 60% to 69%, the recoupment is 0.3% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds in which minimums are not met;
 - (4) From 50% to 59%, the recoupment is 0.6% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds in which minimums are not met;
 - (5) From 40% to 49%, the recoupment is 1.0% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds in which minimums are not met;
 - (6) Less than 40%, the recoupment is 1.5% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds in which minimums are not met.
 - c) If Contractor meets the expected target for level of levels for Ohio scale functioning, Ohio scale problem severity, 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 target levels are listed in Information Item C.
5. Service Target for Family Partner Services
 - a) Service Target – 15% of children and adolescents authorized to receive Service Packages 2.1, 2.2, 2.3, or 2.4 receive Family Partner Services each client month as evidenced by Procedure Code H0038HA.
 - b) Sanctions Associated with this Measure are the following:
 - (1) Greater than or equal to 15%, there is no recoupment;
 - (2) From 9% to 14%, the recoupment is 0.15% of Contractors current 2 quarters for children's MH services excluding New Generation Medication funds;
 - (3) From 6% to 8%, the recoupment is 0.3% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds;
 - (4) From 3% to 5%, the recoupment is 0.6% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds; and
 - (5) Less than 3%, the recoupment is 1.2% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds.
6. Minimum Hours Per Child or Adolescent for Family Partner Services.
 - a) Minimum Target – 10 % of children and adolescents authorized in Service Packages 2.1, 2.2, 2.3, or 2.4 receive a minimum of 60 minutes of Family Partner services each client month as evidenced by Procedure Code H0038HA.
 - b) Sanctions Associated with this Measure:
 - (1) Greater than to equal to 10%, there is no recoupment;
 - (2) From 5% to 9%, the recoupment is 0.15 % of Contractors current 2 quarters for children's MH services excluding New

- Generation Medication funds;
 - (3) From 3% to 4%, the recoupment is 0.3% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds; and
 - (4) Less than 3%, the recoupment is 1.2% of Contractor's current 2 quarters funding for children's MH services excluding New Generation Medication funds.
7. **Disease Management Outcomes – Child and Adolescent Mental Health Services:**
Children's service outcomes shall be measured 37 calendar days following the close of the fourth quarter. For children's service outcome minimums that are not achieved by the end of this Program Attachment Term, remedies and sanctions associated with outcomes may be imposed as described in Section 19.02 of the General Provisions.
1. **Functioning.** Minimum Target – 38% of all children served during the Fiscal Year (FY) have clinically acceptable or improving functioning.
 2. **Problem Severity.** Minimum Target – 42% of all children served during the FY have clinically acceptable or improving problem severity.
 3. **Juvenile Justice Involvement Avoidance.** Minimum Target – 92% of all children served during the FY avoid arrest or avoid re-arrest.
 4. **School Behavior.** Minimum Target – 71% of all children served during the FY have clinically acceptable or improving school behavior.
 5. **Co-Occurring Substance Use.** Minimum Target – 87% of all children served during the FY have acceptable or improving co-occurring substance use.
 6. **Crisis Avoidance.** Minimum Target – Percent of all children with time in crisis will *not* exceed 1.7% for those recommended and authorized for a LOC during the FY.
 7. **Time between Assessment and First Service Encounter.** Minimum Target – 65% of all children served during the FY receive their first (not screening/ assessment) service encounter within 14 days of their intake assessment.

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.

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

EXHIBIT B
LICENSING, CREDENTIALING, AND EDUCATIONAL REQUIREMENTS

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 contendere).
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.

EXHIBIT B
LICENSING, CREDENTIALING, AND EDUCATIONAL REQUIREMENTS

- 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.

EXHIBIT B
LICENSING, CREDENTIALING, AND EDUCATIONAL REQUIREMENTS

- 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 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

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<http://www.mhmraharris.org/eptn.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 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 contractor will apply to become a Medicaid or Medicare provider if providing Medicaid/Medicare billable type services. 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.

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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 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.

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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 $\geq 10\%$ 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

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- 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

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- 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

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- 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.

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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 after the month in which services were rendered depending on contract arrangement. Claim forms for services received later than the 2nd business 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

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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)

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- 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 provided 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

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- 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 4 CAS
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 hrs	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, Infant, Child)	Must maintain current certification	Attend & participate	All	Adult-4 hrs CMH-3 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 staff- Waive for MD, RN, LVN	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 staff- Waive for MD, RN, LVN	MHMRA
MH COPSD	Initial Competency /sample audit periodically	On-line	All	Varies	QMHP, RN, LVN, LPHA; Waive for MD	DSHS
MH Treatment Planning	Initial Competency / Sample audit periodically	Attend & participate	All	4 hrs	MH Tx Planners	MHMRA
MH Uniform Assessment - TRAG	Initial Competency / Annually	Attend & participate	All	4.5 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	On-line	All	varies	All	MHMRA
Seizure Assessment	Initial Competency / Sample audit periodically	On-line	All	varies	All staff- Waive for MD, RN, LVN	MHMRA
Suicide/Homicide	Initial Competency / Sample audit periodically	On-line	All	varies	QMHP, RN, LVN	MHMRA
Supervised Self-Administration of Medication	Initial Competency / Sample audit periodically	Attend & participate	All	3 hrs	Required for med delivery only	MHMRA
Patient and Family Education (PFEP) or other required similar training from state	Initial Competency / Annually	Attend & participate	All	3 hrs	PFEP providers	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.

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 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	Business Lines	% of Practice
Child (up to age 12)		Group Health (PPO)	
Adolescent (13 - 17)		Capitation (HMO)	
Adult (18 - 64)		Medicaid	
Geriatric (65+)		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's 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.

