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

Co-Occurring Disorders Residential Treatment Provider Network Operational Procedures

Introduction:
The Health and Human Services Commission ("HHSC")/Department of State Health Services ("DSHS") has assigned the duties of the Local Authority for mental health services in Harris County to **The HARRIS CENTER for Mental Health and IDD ("The HARRIS CENTER"), (formerly known as MHMRA of Harris County)**. All references to DSHS will include the Health and Human Services Commission. Pursuant to Section 412.60 of the Texas Administrative Code, which governs this function, the local mental health authority must issue a Request for Applications ("RFA") to procure community services through open enrollment. The HARRIS CENTER may obtain clarification and confirmation of information submitted by the provider during the application process. The HARRIS CENTER must award a contract to all providers whose application packets are complete and who demonstrate compliance to all guidelines specified in the FY2018 HHSC/DSHS Interlocal Cooperation Contract System Agency Contract http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm.

Application Process:
Providers may contact the Jail Diversion Program Director, Thomas Mitchell to request an application or to answer questions regarding the application process.

The HARRIS CENTER for Mental Health and IDD
Attn: MH Authority Support Services
9401 Southwest Freeway
Houston, Texas 77074
or
Via e-mail to: mhnetworkdevelopment@TheHarrisCenter.org

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

2. Applications may be submitted by the following three methods:
   a) By faxing to the attention of Network Development**, 713-970-3387**. Application and documents must be legible for processing.
   b) By emailing as an attachment to: priscilla.ramirez@TheHarrisCenter.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:

The HARRIS CENTER for Mental Health and IDD
Attn: MH Authority Support Services.
9401 Southwest Freeway
Houston, Texas 77074
or
Via e-mail to: mhnetworkdevelopment@TheHarrisCenter.org

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

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

Application Licenses/Certificate Procedures and Requirements

Verification of Applicable Licenses/Certificates
Prior to provision of services, provider must warrant and guarantee that all staff members possess current licenses (LCDC at a minimum). This information will be verified by contacting the issuing board. Consent to conduct verification is included in the application packet. In addition, Providers must be compliant with FY2018 Interlocal Cooperation System Agency HHSC/DSHS Contract Section 3.12 "Compliance With Rules."

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

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

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

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

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

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

Operational Standards Review
1. Information is posted in relation to complaints, appeals and duty to report processes

2. Confidentiality policies, consumer rights and privacy notices are provided to consumers
3. Access and Availability Audits
4. After Hours Availability Audits
5. Satisfaction Surveys - DSHS conducts annual consumer satisfaction surveys as a mechanism to obtain feedback and quality of care concerns regarding network providers. The HARRIS CENTER may also conduct periodic patient satisfaction surveys.

Disclosure Requirements:

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

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

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

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

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

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

Quality Requirements & Procedures

Quality of Care:
The HARRIS CENTER has comprehensive Utilization Management and Quality Management Programs that monitor and evaluate the care and services provided to consumers. Any issue that is a source of concern regarding a consumer's treatment is reviewed as a quality of care concern. Any occurrence which could indicate that the provider demonstrates a probable future of substandard professional performance is subject to review.

Quality Management Initiatives

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

- Records are kept in a secure, confidential and organized manner. Records are retrievable. Records are maintained for a period of at least seven (7) years.
- Discharge plans and/or follow up plans are noted
- Planning and training for responding to severe weather, disasters, and bioterrorism

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

Outcomes Measurement

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

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

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

Network Requirements:

1. Training (See Exhibit D) - Mandatory training will be offered to new providers' staffs within 30 days of approval for the network and prior to service delivery. Annual updates will be scheduled and active network providers will be notified for mandatory attendance. Additional training may be deemed necessary based on changes that occur in procedures or regulations. Providers will be notified of any ad hoc training sessions that may occur.
   Documentation Requirements- Contractor shall follow documentation procedures as delegated by the Agency.
2. Notification of Change:

Provider must provide written notification of change within five (5) days of the occurrence for the following:

    a) Change of Address
    b) Change of Phone Numbers
    c) Any other material changes that affect access and availability to consumers

3. Notices to Agency:

Contractor shall notify the Agency within ten (10) business days of any events effecting licensure of its employees, such as suspension, revocation, threatened loss or any way in which the Contractor/Provider might be limited in providing Covered Services. Any loss of Contractor's Professional Liability Insurance

or material change in the policy must also be reported to the Agency within ten (10) business days of notification of this event.

a) No Discrimination: Contractor agrees to render Covered Services to Consumers in the same manner and in accordance with the same standards as it offers to non-The HARRIS CENTER Consumers and consistent with existing medical, ethical, and legal requirements for providing continuity of care to any patient.

b) Covered Services: Contractor represents and warrants to the Agency that Covered Services shall be provided to all Consumers in an appropriate, timely, and cost effective manner. Further, Contractor represents and warrants to the Agency that Contractor shall furnish such services according to the generally accepted substance abuse treatment and mental health practices and applicable laws and regulations.

Payment/Billing Information

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

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

Contracting for Services:

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

Appeal Procedure for Denial of Access to Network:

1. Function and Timeline
   a) The Co-Occurring Disorders Program Committee of The HARRIS CENTER may make a negative decision based on (but not limited to) one of the following:
      1) State license encumbered or not current
      2) Malpractice insurance is not in effect

3) Affirmative responses to questions related to malpractice history, sanctions, or other negative history which the Committee believes may compromise the professional effectiveness or performance of applicant
4) Information from outside sources concerning the provider's qualifications or legal history which the Committee believes may compromise the professional effectiveness or performance of appellant
5) Variance of information supplied on the application and information obtained from an outside source(s)

b) Appeal Timeline

The provider must submit an appeal in writing to the Committee within thirty (30) days from the written notification of the Committee's decision. The request for appeal must specify the reason(s) the provider feels the decision was inappropriate or incorrect.

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

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