The Harris Center for Mental Health and IDD
9401 Southwest Freeway Houston, TX 77074
Board Room #109

Audit Committee Meeting
October 15, 2024
8:30 am

I. **DECLARATION OF QUORUM**

II. **PUBLIC COMMENTS**

III. **MINUTES**

A. Approval of the Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, July 16, 2024
(EXHIBIT A-1)

IV. **REVIEW AND COMMENT**

A. FY24 Audit Update
(Stanley Adams)

B. Compliance Department Report
(EXHIBIT A-2 Demetria Luckett)

C. FY2025Q1 Audit Report
(EXHIBIT A-3 David Fotjik)

V. **EXECUTIVE SESSION**

*** As authorized by Chapter §551.071 of the Texas Government Code, the Board of Trustees reserves the right to adjourn into Executive Session at any time during the course of this meeting to seek legal advice from its attorney about any matters listed on the agenda.**

VI. **RECONVENE INTO OPEN SESSION**

VII. **CONSIDER AND TAKE ACTION AS A RESULT OF THE EXECUTIVE SESSION**

VIII. **INFORMATION ONLY**

A. Compliance Department Binder
(EXHIBIT A-4)

B. Internal Department Binder
(EXHIBIT A-5)

IX. **ADJOURN**

Veronica Franco

Veronica Franco, Board Liaison
Robin Gearing, PhD
Chairperson, Audit Committee
The Harris Center for Mental Health and IDD

EXHIBIT A-1

BOARD OF TRUSTEES
THE HARRIS CENTER *for*
MENTAL HEALTH AND IDD
AUDIT COMMITTEE MEETING
TUESDAY, JULY 16, 2024
MINUTES

Mr. J. Lykes, Committee Chair, called the meeting to order at 8:33 a.m. in Room 109, 9401 Southwest Freeway, noting a quorum of the Committee was present.

Committee Members in Attendance: Dr. L. Moore, Mr. G. Womack, Mr. J. Lykes,

Committee Member in Absence: Dr. M. Miller

Other Board Member Present: Dr. L. Fernandez-Wische-videoconference, Dr. R. Gearing

I. **DECLARATION OF QUORUM**

Dr. Gearing called the meeting to order at 8:33 a.m. noting that a quorum was present.

II. DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS

III. PUBLIC COMMENTS

There were no requests for Public Comment.

IV. MINUTES

Approval of Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, February 20, 2024.

MOTION: GEARING SECOND: WOMACK

THEREFORE, BE IT RESOLVED that the Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, February 20, 2024 as presented under Exhibit A-1, is approved, and recommended to the Full Board for acceptance.

V. REVIEW AND TAKE ACTION

A. FY25 Compliance Workplan

MOTION: MOORE SECOND: GEARING

THEREFORE, BE IT RESOLVED that the FY25 Compliance Workplan as presented under Exhibit A-2, is approved, and recommended to the Full Board for acceptance.

B. Internal Audit FY2024 Q/Q3 Report

MOTION: GEARING SECOND: MOORE

THEREFORE, BE IT RESOLVED that the Internal Audit FY2024 Q/Q2 Report as presented under Exhibit A-3, is approved, and recommended to the Full Board for acceptance

VI. REVIEW AND COMMENT

A. Audit Committee will review the Compliance Department Report by Demetria Luckett.

VII. EXECUTIVE SESSION

There was no Executive Session during the Audit Committee Meeting.

VIII. ADJOURN-

MOTION: WOMACK SECOND: GEARING
With unanimous affirmative vote
BE IT RESOLVED The meeting was adjourned at 9:40 a.m.

_____

Veronica Franco, Board Liaison
J. Lykes, Chairperson,
Audit Committee
The* HARRIS CENTER *for
Mental Health and IDD

EXHIBIT A-2

Compliance Department

FY24 Q4 Audit Reports

Presented by: Demetria Luckett, Compliance Director
September 2024

Summary of Audits Completed

Reporting Period: June 2024-July 2024

Compliance completed a total of fifteen (15) reviews during this reporting period, June 1, 2024, through August 31, 2024.

Four (4) Focused Reviews

- Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI, Jr.) Focus Review
- Substance Use Recovery Services Detoxification (DETOX) Program Physician Coding and Documentation Review
- Psychiatric Emergency Services (PES) Revenue Management Billing and Claims Documentation Review
- Adult Mental Health (AMH) Revenue Management Billing and Claims Documentation Review

Eight 8 Operational Reviews

- Crisis Residential Unit (CRU) Operational Review
- Jail Diversion (JD) Operational Review
- PEERS for Hope House Operational Review
- Southeast Child and Adolescent Services (SECAS) Operational Review
- Southeast Community Service Center (SECSC) Operational Review
- Step Down State Hospital Transition Program (Step Down) Operational Review
- Crisis Stabilization Unit (CSU) Operational Review
- Psychiatric Emergency Services (PES) Operational Review

Three (3) Comprehensive Reviews

- Crisis Stabilization Unit (CSU) Comprehensive Review
- Substance Use Recovery Services (SURS) Comprehensive Review
- Jail Diversion (JD) Comprehensive Review

Texas Correctional Office on Offenders with Medical or Mental Impairment (TCOOMMI Jr.)

The HARRIS CENTER for Mental Health and IDD

Focus Review

Purpose: At the request of the program director for the TCOOMMI Jr program, Compliance conducted a focus review of service encounters completed by one (1) family partner to ensure progress note documentation was completed in accordance with Texas Administrative Code (TAC), Harris Center Policies and Procedures, and the MH Behavioral Health Procedure Operation Manual

The threshold score for this review is 95%.

The Family Partner documentation had an overall score of 86%.

The Family Partner progress note documentation did not meet standards in the following areas:

- 17% The services provided were not supported by documentation.
- 74% Incorrect procedure code used.
- 57% Progress notes were not completed within two (2) business days.
- 21% The services provided must reflect the Plan of Care (POC) recovery goals.
- 49% Multiple notes reflecting the same wording “cloning, cookie cutter/copying and pasting.

The Program was required to submit a Plan of Improvement (POI) for the areas that did not meet the threshold score of 95%.

Action Plan: Compliance will review the TCOOMMI Jr Family Partner service encounter documentation in the next one hundred eighty (180) days to ensure implementation of its POI.

Substance Use Recovery Services Detoxification (DETOX)

The HARRIS CENTER for Mental Health and IDD

Program Physician Coding & Documentation Focus Review

Purpose: Compliance audited the DETOX program to ensure appropriate coding & documentation practices while reviewing the following standards: Centers for Medicare and Medicaid Services (CMS) Regulations, Current Procedural Terminology (CPT) guidelines, American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines, Texas Administrative Codes (TAC), and Harris Center Policies and Procedures.

The threshold score for this review was 95%.

The Program had an overall Physician (provider) score of 98%.

The Program met or exceeded standards in the following areas:

- 100% No Evidence of Overlap in Appointment Time
- 100% No Evidence of Copy & Pasting / Cloning within Documentation
- 100% Evidence of Medically Appropriate History
- 100% Evidence of Medically Appropriate Examination
- 100% Appropriate codes for Face to Face / Telehealth (TH) on date of service
- 100% Appropriate consent received for services rendered by QMHP
- 100% Appropriate secondary services billed and documented from Assessment & Plan
- 100% Evidence for authorized and approved codes for secondary services

The Program did not meet standards in the following areas:

- 82% Appropriate medical decision-making codes for service of DETOX encounters reviewed.

Action Plan: Compliance will review provider documentation and coding in the next one hundred eighty (180) days to ensure the program has implemented its POI pertaining to accurate primary coding for DETOX services.

Psychiatric Emergency Services (PES)

The HARRIS CENTER for Mental Health and IDD

Revenue Management Billing & Claims Documentation Focus Review

Purpose: Compliance conducted a focused review to assist the Revenue Management Department asses billing & claims practices for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code, and Harris Center Policies and Procedures as they pertain to programs serving persons within (PES) Psychiatric Emergency services.

The threshold score for this review was 95%.

The Program had an overall Physician (provider) score of 100%.

The Program met or exceeded standards in the following areas:

- 100% Services provided correspond to verified CPT code
- 100% Services provided correspond to verified Modifier codes
- 100% Services provided correspond to verified Add-On codes
- 100% Claim contains appropriate demographics set as detailed in EMR
- 100% Appropriate Payor approved codes documented within claim
- 100% Appropriate billing provider details listed within claim
- 100% Appropriate billing Units documented
- 100% Services provided are not billed as Duplicate
- 100% Services provided are not billed as a Bundle
- 100% Appropriate and verified Copay amount for billed service
- 100% Appropriate and verified original charges on claim
- 100% Appropriate and verified Adjustments on claim
- 100% Appropriate and verified Reimbursement collected
- 100% Appropriate collections resolution, overpayment verification completed

Action Plan: Compliance will continue to conduct regular billing and claims audits and provide essential support to the Revenue Management team regarding their documentation of services, including review of documentation from a credentialed professional coder.

Adult Mental Health Services Program (AMH)

The HARRIS CENTER for Mental Health and IDD

Revenue Management Billing & Claims Documentation Focus Review

Purpose: Compliance conducted a focused review to assist the Revenue Management Department asses billing & claims practices for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code, and Harris Center Policies and Procedures as they pertain to programs serving persons within (AMH) Adult Mental Health services.

The threshold score for this review was 95%.

The Program had an overall Physician (provider) score of 97%.

The Program met or exceeded standards in the following areas:

- 100% Services provided correspond to verified Modifier codes
- 100% Services provided correspond to verified Add-On codes
- 100% Claim contains appropriate demographics set as detailed in EMR
- 100% Appropriate Payor approved codes documented within claim
- 100% Appropriate billing provider details listed within claim
- 100% Appropriate billing Units documented
- 100% Services provided are not billed as Duplicate
- 100% Services provided are not billed as a Bundle
- 100% Appropriate and verified Copay amount for billed service
- 100% Appropriate and verified original charges on claim
- 100% Appropriate and verified Adjustments on claim
- 100% Appropriate and verified Reimbursement collected
- 100% Appropriate collections resolution, overpayment verification completed

The Program did not meet standards in the following areas:

- 66% Services provided correspond to verified CPT code

Action Plan: Compliance will review Revenue Management Billing and Claims processes in the next one hundred eighty (180) days to ensure the program has implemented its POI. Compliance will continue to provide essential support to the Revenue Management team regarding medical billing and claims documentation.

Crisis Residential Unit (CRU)

Jail Diversion (JD)

PEERS for Hope House

Southeast Child and Adolescent Services (SECAS)

Southeast Community Service Center (SECSC)

Step Down State Hospital Transition Program (Step Down)

Crisis Stabilization Unit (CSU)

Psychiatric Emergency Services (PES)

The HARRIS CENTER for Mental Health and IDD

Operational Reviews

Purpose: Compliance conducted annual onsite Operational reviews to ensure The Harris Center for Mental Health and IDD (The Harris Center) Crisis Residential Unit (CRU), PEERS for Hope House, Southeast Child and Adolescent Services (SECAS), Southeast Community Service Center (SECSC), Crisis Stabilization Unit (CSU), and Psychiatric Emergency Services (PES) programs met regulatory guidelines, city ordinances, and State and Federal labor laws and promoted the best practices in the workplace.

The threshold score for this review is 100%.

The Program had an overall score of 100%.

The Program met standards in the following areas:

- 100% Accessibility
- 100% Appearance
- 100% Safety and Infectious waste
- 100% Patient/Consumer/Consumer Service
- 100% Confidentiality
- 100% Required Posting and Documentation
- 100% Environmental

The Program did not meet standards in the following areas:

- N/A

Compliance reviewed eight (8) facilities. The programs met all the criteria within seven (7) business days of the review

Action Plan: Compliance will conduct annual Operational Reviews during the 4th Qtr. of FY 2025.

Crisis Stabilization Unit (CSU)

Comprehensive Review

Purpose: The purpose of this review was to ensure that CSU client documentation, employee credentials, and operational guidelines comply with the rules and regulations of the Texas Administrative Code (TAC), the Health and Human Service Commission's Information Item V, Harris Center Policies and Procedures, and Harris Center training requirements.

The threshold score for this review is 95%.

The Program had an overall score of 81%.

The Program met or exceeded standards in the following areas:

- 100% Medical requirements
- 95% Environment requirements

The Program did not meet standards in the following areas:

- 77% Policy requirements
- 57% Personnel requirements
- 74% Client records requirements

Action Plan: CSU was required to submit a Plan of Improvement (POI). Compliance will conduct a follow-up review in 180 days to ensure the implementation of the POI.

Substance Use Recovery Services (SURS)

The HARRIS CENTER for Mental Health and IDD

Comprehensive Review

Purpose: This review was conducted to determine if the SURS program was compliant with the Texas Administrative Code; Substance Use Program Guide; Operational Guidelines; Texas Health and Human Service Commission (HHSC) Hiring Practices; Personnel Requirements and Documentation; Texas Health and Human Services Commission Training requirements; Staff Competencies and Requirements and Documentation of Service Provision.

The threshold score for this review is 95%.

The Program had an overall score of 94%.

The Program met and exceeded standards in the following areas:

- 100% Priority Population Wait and Interim Service
- 100% Treatment for Adult Program Review
- 100% Treatment for Adult Personnel
- 100% Environmental Review
- 100% Treatment for Female Program Review

The Program did not meet standards in the following areas:

- 93% Policies and Procedures
- 93% Treatment for Adult (male) Record Review
- 85% Treatment for Female Record Review
- 77% Treatment for Female Personnel Review
- 89% Documentation of Service Provision

Action Plan: Compliance will conduct a POI Follow up in 180 days

Jail Diversion (JD)

Comprehensive Review

Purpose: This review was conducted to ensure that the JD program's client documentation, employee credentials, and operational guidelines comply with the rules and regulations of the Health and Human Service Commission's Information Item V, Texas Administrative Code (TAC), Harris Center Policies and Procedures, and Harris Center training requirements.

The threshold score for this review is 95%.

The Program had an overall score of 91%.

The Program met or exceeded standards in the following areas:

- 100% Medical Requirements
- 100% Policy requirements
- 100% Environment requirements
- 97% Personnel requirements

The Program did not meet standards in the following areas:

- 60% Client records requirements

Action Plan: The JD program was required to submit a Plan of Improvement (POI). Compliance will conduct a follow-up review in 180 days to ensure the implementation of the POI.

External Reviews

41 External Reviews were monitored by Compliance within this reporting period

1. Superior Healthplan Medical Records Request 06/04/2024
2. Datavant Cigna Medical Records Request 06/04/2024
3. Datavant Cigna Medical Records Request 06/04/2024
4. Datavant Cigna Medical Records Request 06/05/2024
5. Episource Aetna Medical Records Request 06/05/2024
6. COTIVITI Aetna Risk Adjustment Records Request 06/13/2024
7. Datavant Wellpoint Medical Records Request 06/17/2024
8. Molina Healthcare Behavioral Health Medical Record Review 06/18/2024
9. Datavant Anthem Wellpoint Medicare Risk Adjustment Data Review 06/18/2024
10. Optum Rx Northwest Clinic Pharmacy Desktop Review 06/21/2024
11. Optum Rx Southeast Clinic Pharmacy Desktop Review 06/26/2024
12. Optum Rx Northwest Clinic Pharmacy Desktop Review 06/26/2024
13. Optum Rx Northwest Clinic Pharmacy Desktop Review 06/26/2024
14. Advantmed Wellcare HEDIS Review 06/28/2024
16. NQCA Credentialing Audit 07/01/2024
17. Datavant Aetna Medical Records request 07/01/2024
18. Datavant United Healthcare Medical records Request 07/01/2024
19. Datavant Medical Records Request 07/03/2024
20. Humana Medical Records Request 07/05/2024
21. Optum Rx Southeast Clinic Pharmacy Desktop Review 07/12/2024
22. Optum Rx Northeast Clinic Pharmacy Desktop Review 07/15/2024
23. Datavant Wellpoint Medical Records Request 07/15/2024
24. Datavant Wellpoint Medical Records Request 07/16/2024
25. Advantmed Blue Cross Blue Shield of Texas HEDIS Review 07/17/2024
26. Optum Rx Northeast Clinic Pharmacy Desktop Review 07/22/2024
27. Optum Rx Southeast Clinic Pharmacy Desktop Review 07/22/2024
28. Texas Health and Human Services Hillcroft Empowerment Center Complaint Investigation 07/22/2024
29. Datavant Wellpoint Medical Records Request 07/22/2024
30. Advantmed Blue Cross Blue Shield of Texas Medical Records Request 07/24/2024
31. Optum Rx Southeast Clinic Pharmacy Desktop
32. Datavant Cigna Medical Records Request 07/25/2024
33. Texas Health and Human Services Commission 2024 Mental Health Independent Peer Review 08/07/2024
34. Datavant Wellpoint Notice of Outstanding Medical Records Request 08/08/2024
35. Datavant Wellpoint Notice of Outstanding Medical Records Request 08/08/2024
36. Datavant Wellpoint Medical Records Request 08/16/2024
37. Reveller Aetna Medical Records Request 08/19/2024
38. Datavant Devoted Health Medical Records Request 08/22/2024
39. Datavant Cigna Medical Records Request 08/22/2024
40. Harris County Community Supervision and Corrections Department FY 2024 Service Review 08/28/2024
41. Reveller Aetna Medical Records Request 08/30/2024

Thank you.

EXHIBIT A-3

FY2025 Q1 Audits

Internal Audit Department

David W. Fojtik, CPA, MBA, CIA, CFE
October 15, 2024

FY2025 1st Quarter Reports

Agenda:

Projects to be presented:

- Reimbursable Services Contracts Audit
- Review of Lost/Stolen Fixed Assets (Laptops) Audit
- Status Report: OSAR FY2024 Harm Reduction Program
- Annual Report of Fiscal Year 2024 Activities

FY2025 1st Quarter Reports

Reimbursable Services Contracts Audit

No findings or observations to report.

FY2025 1st Quarter Reports

Review of Stolen/Lost Laptops Audit

Observation #1 – Internal Audit reviewed the Center's Incident Report system over the three-year period (September 1, 2022 – August 31, 2024), which noted twelve (12) reports citing laptop losses due to being stolen/lost/or not returned. We found that most of these stolen laptops were reported during the third or the fourth quarters (March – August) of the audited years.

Regarding Incident Reports, we found eight (8) of the "stolen/lost" laptops were not recoverable by the employee nor the assigned fixed asset designee (FAD), and four (4) Center laptops were not returned by terminated employees.

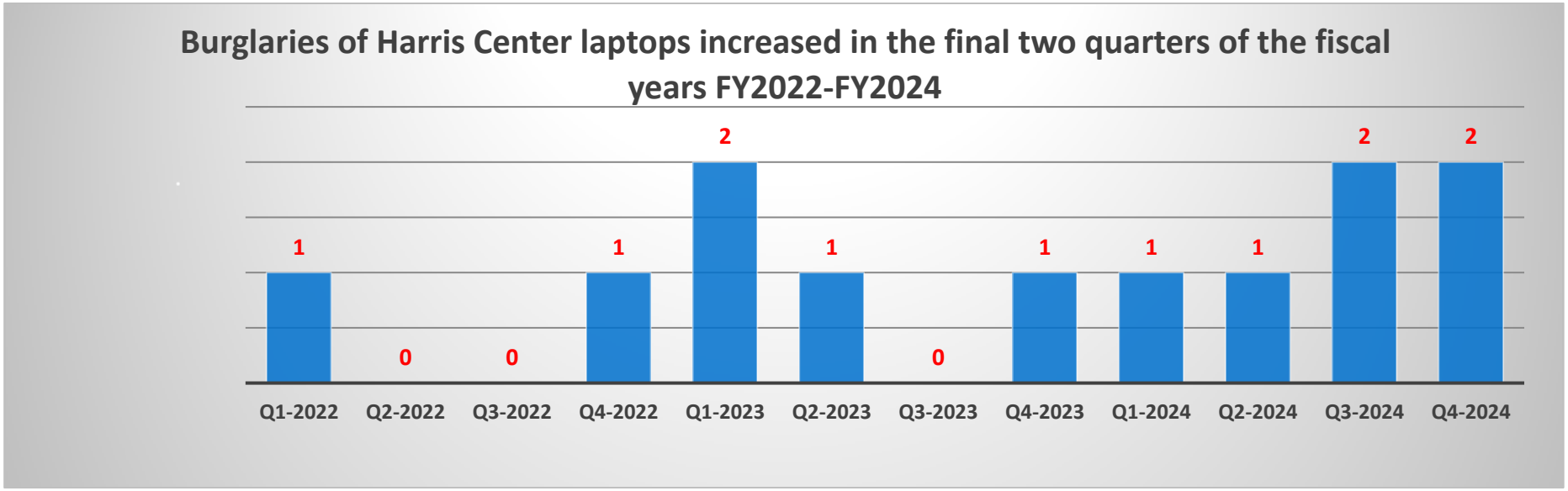
The Incident Report found the employees who reported the incidents had no updates on the missing laptops and no additional updates were provided from other employees.

FY2025 1st Quarter Reports

Review of Stolen/Lost Laptops Audit

Observation #1 (continued):

Exhibit I shows the number of laptops (12) lost/stolen/not returned between September, 2021 and August, 2024.



Source: Incident Reports, September 1, 2022 thru September 1, 2024

FY2025 1st Quarter Reports

Review of Stolen/Missing Laptops Audit

Finding #1 – As a result of the review of the Center's Incident Reports system over a three-year fiscal period (September 1, 2022 – August 31, 2024), we found that four (4) missing laptop incidents included loss of assigned laptops when employees terminated. Internal Audit contacted the managers of these units effected and there were no additional updates regarding the status of the Incident Reports, or resolutions in terms of employee payment information for laptops not surrendered.

Recommendation: Before a terminated employee's last payroll check is issued, all Harris Center property used by the employee must be accounted for. This step is paramount, because holding the employee's last payroll check until all laptops (or other fixed assets) are returned is the only leverage the Harris Center has in recovering or obtaining compensation for missing assets. The Harris Center handbook states that if property is not returned; the Agency may deduct the cost from their last payroll check. Also, if an employee has not returned equipment, a letter is sent to let them know they have a week to return said equipment or the Center will file a police report for criminal theft of government property.

Management Response (Director, Human Resources): *"This would need to be an IT/Risk Management policy. HR currently has a separation checklist for managers to utilize to ensure they collect all agency equipment, badges, parking decals, along with reminders to submit the Access Form to terminate the employee's server access, email accounts, and who to provide file access to within the department. In the event an employee doesn't surrender agency equipment, a request is made by the Manager to send a "demand" letter requesting the return of the agency equipment and coordinates with the IT Fixed Assets person and HR/Payroll regarding possible recoupment opportunities".*

FY2025 1st Quarter Reports

Review of Stolen/Missing Laptops Audit

Management Response (Director IT Enterprise Endpoint & Customer Service): *"The IT department's role primarily focuses on assisting with tracking the device and identifying the last individual who logged into the system to validate whether the terminated employee was indeed the last user. This is essential, as fixed asset records are sometimes inaccurate, with the user assigned not always reflecting the actual employee using the device".*

"From a technical perspective, IT has the capability to remotely disable or wipe data from the devices, provided the laptops are online and connected, enabling communication with the device. If a stable connection is maintained, IT can execute these actions to secure sensitive data and protect the organization's information effectively".

FY2025 1st Quarter Reports

Status Report: Harm Reduction Program

Observation #1 – In FY2024, the Harm Reduction Program reimbursed 1 OSAR Recipient and 1 OSAR Provider totaling $142,976.05. In FY2023, the prior HHSC COVID-19 Program grant had paid out $496,190.67 in claim reimbursement payments.

Claim#	Provider Name (FY2024 Program)	Received Date	Payment Date	Amount
2024-01	Santa Maria Hostel (Recipient)	1/15/2024	2/14/2024	$14,436.32
2024-02	Santa Maria Hostel (Recipient)	1/15/2024	2/14/2024	$18,569.52
2024-03	Santa Maria Hostel (Recipient)	2/29/2024	3/27/2024	$14,895.37
2024-04	Santa Maria Hostel (Recipient)	3/28/2024	4/17/2024	$15,564.02
2024-05	Santa Maria Hostel (Recipient)	4/10/2024	5/1/2024	$18,451.09
2024-06	Santa Maria Hostel (Recipient)	5/9/2024	5/15/2024	$14,177.83
2024-07	Santa Maria Hostel (Recipient)	6/7/2024	6/19/2024	$11,188.00
2024-08	Santa Maria Hostel (Recipient)	7/17/2024	7/24/2024	$16,787.01
2024-09	Santa Maria Hostel (Recipient)	8/19/2024	08/28/24	$13,876.65
2024-10	The Council On Recovery (Provider)	8/19/2024	08/28/24	$5,030.24
	FY2024 Harm Reduction Program reimbursements TOTAL: *Source: Internal Audit summary of FY2024 Harm Reduction Program*			**$142,976.05**

FY2025 1st Quarter Reports

Annual Report of Fiscal Year 2024 Activities

- Internal Audit completed a risk assessment of The Harris Center's key auditable entities while preparing a collection of future audit projects, as shown on the proposed Fiscal Year 2025 Audit Plan.
- Internal Audit completed five (5) Board-approved internal audit projects shown in Table I.
- Internal Audit completed six (6) special audit requests (SARs) or special management requests (SMRs), which are prioritized ad-hoc requests from management to evaluate special issues.
- Internal Audit completed four (4) follow-up audits based on prior year special audit requests (SARs) that showed some process irregularities and encouraged Internal Audit to revisit the auditable entity.

FY2025 1st Quarter Reports

Annual Report of Fiscal Year 2024 Activities

- In June 2023, Internal Audit entered into an agreement with FraudHotline (www.fraudhl.com) which can provide a confidential and anonymous site for employees, contractors and any others who report issues or behaviors that seem unusual or peculiar, and worthy of further investigation.
- In October 2023, Internal Audit asked the Communications Department to announce an International Fraud Awareness Week in November, 2023. The event is the annual outreach to educate the general public to recognize typical examples of fraud, waste and abuse. and provide an opportunity to show our employees how to report observations to Internal Audit on the FraudHotline for more investigation and analysis.
- In July 2024, Internal Audit successfully installed a continuous monitoring system dashboard in IDEA, which was custom developed by CaseWare, an award-winning data analytics item. The system finds anomalies in the business data from accounts payable activity to third-party vendors, and in-county travel reimbursement payments to employees, which may suggest that fraudulent activity has occurred.
- In June 2024, Internal Audit has worked with IT to upgrade the AutoAudit software platform to version 7.6, which includes the IssueTrack feature which improves issue communications to the business process owners. The feature enables quick responses and timely corrective actions to address financial and operational risks.

Questions

EXHIBIT A-4

The Harris Center for Mental Health and IDD (The Harris Center):
Compliance Department (Compliance) Audit Committee Report

Report Description: The aim of this report is to inform the Audit Committee of the reviews/audits conducted by, or in association with, Compliance for the review period: June 1, 2024, through August 31, 2024.

Presenter: Demetria Luckett, Compliance Director

Explanation of Reviews:
The following types of reviews were conducted by Compliance during the 4th Quarter (Qtr.) of Fiscal Year (FY) 2024:

Focus Review – A review concentrating on specific areas such as billing and procedural coding, individual information, confidentiality, service activities, etc. A focus review may be initiated by sources other than Compliance, including, but not limited to, directors, program managers, and administrative or direct care staff.

Twelve (12) focus reviews were conducted during the reporting period to ensure regulatory compliance in the following areas:

One (1) Family Partners Progress Note Review was conducted during the reporting period to ensure regulatory compliance:

- 07/03/2024 Texas Correctional Office on Offender with Medical or Mental Impairment (TCOOMMI, Jr)

Three (3) Billing and Coding Reviews were conducted in accordance with the Compliance Department's Audit Schedule:

- 05/18/2024 Substance Use Recovery Services Detoxification (DETOX) Program Coding
- 06/25/2024 Psychiatric Emergency Services (PES) Revenue Management Billing and Claims
- 06/25/2024 Adult Mental Health (AMH) Revenue Management Billing and Claims

Eight (8) Operational Reviews were conducted in accordance with the Compliance Department's Audit Schedule:

- 08/05/2024 Crisis Residential Unit (CRU)
- 08/05/2024 Jail Diversion (JD)
- 08/05/2024 PEERS for Hope House
- 08/05/2024 Southeast Child and Adolescent Services (SECAS)
- 08/05/2024 Southeast Community Service Center (SECSC)
- 08/05/2024 Step Down State Hospital Transition Program (Step Down)
- 08/06/2024 Crisis Stabilization Unit (CSU)
- 08/06/2024 Psychiatric Emergency Services (PES)

Comprehensive Review – A review of The Harris Center's adherence to regulatory guidelines related to Operations, Medical, Environment, Personnel Requirements, Clinical Record Review, and other areas as assigned. Records are selected randomly—the size of the programs and the frequency of entries are contributing factors to the number of records reviewed.

Three (3) Comprehensive Reviews were conducted during the review period to ensure the programs' compliance with Texas Administrative Codes, Agency Policy and Procedure, programmatic guidelines, and other statutes/regulations.

Three (3) Comprehensive Reviews were conducted in accordance with the Compliance Department's Audit Schedule:

- 05/21/2024 Crisis Stabilization Unit (CSU)
- 06/13/2024 Substance Use Recovery Services (SURS)
- 07/15/2024 Jail Diversion (JD)

Other Compliance Activities:

Training/Meeting: N/A

Other Responsibilities:
Epic Deficiency Tracking (Ongoing)
Managing The Harris Center's legacy incident reporting system
Maintenance of The Harris Center's policy and procedure process and platform (Ongoing)

Key Takeaways

1. Focus Review Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI, Jr.): At the request of the program director for the TCOOMMI Jr program, Compliance conducted a focus review of service encounters completed by one (1) family partner to ensure documentation was completed in accordance with the *Texas* Administrative Code (TEX. ADMIN. CODE) *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353; Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361; Medication Training and Support Services 26 TEX. ADMIN. CODE § 306.315; The Harris Center Policies and Procedures ACC.B.2 Plan of Care, HIM.EHR.B.5 Content of Patient/Individual Records, HIM.EHR.B.6 Correcting Documentation and Coding Errors,* and *HIM.EHR.B.13 Standardized Patient Record Form;* and the *MH Behavioral Health Procedure Operation Manual.*

   The family partner had an overall score of 86%. The program is required to submit a Plan of Improvement (POI) in the following areas: providing family partner services that are supported by documentation, using the appropriate procedure code, completing progress notes within two (2) business days, ensuring the services that are provided reflect the Plan of Care (POC) recovery goals, and avoid documenting "cookie cutter, cloning, copying and pasting" documentation.

Action: Compliance will review the TCOOMMI Jr Family Partner service encounter documentation in the next one hundred eighty (180) days to ensure implementation of its POI.

2. Focus Review Substance Use Recovery Services Detoxification (DETOX) Program Coding Review: A review of the DETOX Program's Physician Coding and Documentation was completed to ensure compliance with the following standards: *2023—2024 Centers for Medicare and Medicaid Services (CMS) Coding Regulations and Guidance*; *Current Procedural Terminology (CPT) guidelines; 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation Guidelines*; *Telemedicine and Telehealth Benefits and Limitations 1 TEX. ADMIN. CODE § 354.1432*; *Definitions 26 TEX. ADMIN. CODE § 510.2; Definitions 26 TEX. ADMIN. CODE § 306.45;* the *Health and Human Services Commission's Information Item V (pp. 2, 4,* and *31-33);* and *The Harris Center Policies and Procedures HIM.EHR.A.6 Correcting Documentation and Coding Errors, MED.B.6 Telehealth and Telemedicine Procedure, EM.P.4 Corporate Compliance Documentation and Claims Integrity Plan, GA.B.6 All Contracts,* and *LD.A.13 Code of Ethics Policy*.

   The overall score for the program was 98%. The program met or exceeded standards in the following areas: overlap in appointment time, copying and pasting/cloning within documentation, medically appropriate history, medically appropriate examination, appropriate codes for face-to-face/telehealth services on the date of service, consent for services rendered by a qualified mental health professional (QMHP), secondary services billed and documented from assessment and plan, and authorized and approved codes for secondary services.

   The program did not meet standards in the following area: appropriate medical decision-making codes for service. Audit findings revealed deficiencies pertaining to primary codes for follow-up client encounters. Provider(s) indicated Multiple Intake Assessment code (90792) for the same client within the same line of service.

   Action Plan: Compliance will review provider documentation and coding in the next one hundred eighty (180) days to ensure the program has implemented its POI pertaining to accurate primary coding for DETOX services, including reviewing documentation from a credentialed professional coder.

3. Focus Review Psychiatric Emergency Services (PES) Revenue Management Billing and Claims: A review of Revenue Management Billing & Claims practices was completed to ensure compliance with the following standards: *2023 – 2024 Centers for Medicare and Medicaid Services (CMS) Coding Regulations and Guidance; Current Procedural Terminology (CPT) guidelines; 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines; Outpatient Hospital Reimbursement 1 TEXAS ADMIN. CODE § 355.8061; Reimbursement to Licensed Professional Counselors, Licensed Clinical Social Workers, and Licensed Marriage and Family Therapists 1 TEXAS ADMIN. CODE § 355.8091; Reimbursement Methodology for Mental Health Case*

Management 1 TEXAS ADMIN. CODE § 355.743; Rehabilitative Services Reimbursement Methodology 1 TEXAS ADMIN. CODE § 355.781; *HHSC Information Item V, Page(s) 2, 4, 31-33;* and *The Harris Center Policies and Procedures EM.P.4 Mental Health Documentation Standards*, *ACC.A.13 State Service Contract Monitoring, FM.B.10 Writing Off Self Balances; FM.B.11 Charity Care Cases, LD.A.13 Code of Ethics Policy,* and *MED.B.6 Telehealth and Telemedicine Procedures*.

The Program had an overall Physician (Provider) score of 100%. Medical Billing & Claims documentation and practices met or exceeded expectations in the following areas: *(14 elements)* Services provided correspond to verified CPT code, Services provided correspond to verified Modifier codes, Services provided correspond to verified Add-On codes, Claim contains appropriate demographics set as detailed in the electronic medical record (EMR), Appropriate Payor approved codes documented within claim, Appropriate billing provider details listed within claim, Appropriate billing Units documented, Services provided are not billed as Duplicate, Services provided are not billed as a Bundle, Appropriate and verified Copay amount for billed service, Appropriate and verified original charges on claim, Appropriate and verified Adjustments on claim, Appropriate and verified Reimbursement collected, Appropriate collections resolution.

Action: Compliance will continue to conduct regular billing and claims audits and provide essential support to the Revenue Management team regarding their documentation of services, including review of documentation from a credentialed professional coder.

4. Focus Review Adult Mental Health (AMH) Revenue Management Billing and Claims: A review of Revenue Management Billing & Claims practices was completed to ensure compliance with the following standards: *2023 – 2024 Centers for Medicare and Medicaid Services (CMS) Coding Regulations and Guidance; Current Procedural Terminology (CPT) guidelines; 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines; Outpatient Hospital Reimbursement 1 TEXAS ADMIN. CODE § 355.8061; Reimbursement to Licensed Professional Counselors, Licensed Clinical Social Workers, and Licensed Marriage and Family Therapists 1 TEXAS ADMIN. CODE § 355.8091, Reimbursement Methodology for Mental Health Case Management 1 TEXAS ADMIN. CODE § 355.743, Rehabilitative Services Reimbursement Methodology 1 TEXAS ADMIN. CODE § 355.781; HHS Information Item V, Pages 2, 4,* and *31-33,* and *The Harris Center Policies and Procedures EM.P.4 Mental Health Documentation Standards*, *ACC.A.13 State Service Contract Monitoring, FM.B.10 Writing Off Self Balances; FM.B.11 Charity Care Cases, LD.A.13 Code of Ethics Policy,* and *MED.B.6 Telehealth and Telemedicine Procedures.*

The program had an overall Physician (Provider) score of 97%. Medical Billing & Claims documentation and practices met and exceeded expectations in the following areas: *(13 elements)* Services provided correspond to verified Modifier codes, Services provided correspond to verified Add-On codes, Claim contains appropriate demographics set as detailed in EMR, Appropriate Payor approved codes documented within claim, Appropriate billing provider details listed within claim, Appropriate billing Units documented, Services

provided are not billed as Duplicate, Services provided are not billed as a Bundle, Appropriate and verified Copay amount for billed service, Appropriate and verified original charges on claim, Appropriate and verified Adjustments on claim, Appropriate and verified Reimbursement collected, Appropriate collections resolution.

Medical Billing & Claims documentation and practices did not meet expectations in the following areas: *(1 element) S*ervices provided correspond to verified CPT codes. The findings pertain to the original bill amount for identified outpatient evaluation & management (E/M) codes. CPT codes attached to identified E/M encounters within EMR are inaccurate, and reconciliation between provider and biller is required.

Action Plan: Compliance will review Revenue Management Billing and Claims processes in the next one hundred eighty (180) days to ensure the program has implemented its POI.

5. Operational Review Crisis Residential Unit (CRU): A review was completed to ensure compliance with the following regulations: *Accessibility 42 United States Code (U.S.C.) Chapter 1; Appearance 42 U.S.C Chapter 1; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3), Compliance Plan FY24 LD.P.1.IV Seven Elements of The Harris Center's Compliance Plan Element 1: Written Policies and Procedures A. Standards of Behavior for The Harris Center Personnel 2. Compassion (iii)* and *(iv); Compliance Plan FY24 LD.P.1.V. The Harris Center's Compliance Program Effectiveness 1. Code of Conduct Principle 3; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3)); Maintenance, Preservation, and Availability of Records; Issuance of Regulations; Scope of Records; Periodic Inspections by Employer; Posting of Notices by Employer; Notification of Employee of Corrective Action 29 U.S.C. 657(c); Posting of notice; availability of the Act, regulations and applicable standards 29 Code of Federal Regulations (CFR) § 1903.2; Employer notice requirements 29 CFR § 825.300, Violations of the posting requirement 29 CFR § 825.402; Equal opportunity clause 1 CFR § 60-1.4; Equal opportunity clause 41 CFR § 60-741.5 (a)4; Equal opportunity clause 41 CFR § 60-300.5 (a)9; Posting of notices U.S.C. 29 § 525.14; Notice of protection U.S.C. 29 § 22.2003; Definitions 40 TEX. ADMIN. CODE § 815.1 (14); Emergency Preparedness Planning and Implementation 26 TEX. ADMIN. CODE § 558.256; Limitations on the Employment of 14- and 15-Year-Old Children 40 TEX. ADMIN. CODE § 817.21; Posting of notices 29 CFR § 516.4; Employer's Notice of Ombudsman Program and First Responder Liaison to Employees 28 TEX. ADMIN. CODE § 276.5 (b-c); Findings and purpose USC 42.126 § 12101;* and *Performance Contract Notebook FY22-23 1.A.6.j.(1)*.

   The program had an overall score of 100%. The program met standards in the following areas: Accessibility, Appearance, Safety and Infectious Waste, Patient/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. The program met all criteria within seven (7) business days.

   Action Plan: Compliance will conduct annual Operational Reviews during the 4th Qtr. of FY 2025.

6. Operational Review Jail Diversion (JD): A review was completed to ensure compliance with the following regulations: *Accessibility 42 U.S.C. Chapter 1; Appearance 42 U.S.C Chapter 1; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3), Compliance Plan FY24 LD.P.1.IV Seven Elements of The Harris Center's Compliance Plan Element 1: Written Policies and Procedures A. Standards of Behavior for The Harris Center Personnel 2. Compassion (iii)* and *(iv); Compliance Plan FY24 LD.P.1.V. The Harris Center's Compliance Program Effectiveness 1. Code of Conduct Principle 3; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3)); Maintenance, Preservation, and Availability of Records; Issuance of Regulations; Scope of Records; Periodic Inspections by Employer; Posting of Notices by Employer; Notification of Employee of Corrective Action 29 U.S.C. 657(c); Posting of notice; availability of the Act, regulations and applicable standards 29 CFR § 1903.2; Employer notice requirements 29 CFR § 825.300, Violations of the posting requirement 29 CFR § 825.402; Equal opportunity clause 1 CFR § 60-1.4; Equal opportunity clause 41 CFR § 60-741.5 (a)4; Equal opportunity clause 41 CFR § 60-300.5 (a)9; Posting of notices U.S.C. 29 § 525.14; Notice of protection U.S.C. 29 § 22.2003; Definitions 40 TEX. ADMIN. CODE § 815.1 (14); Emergency Preparedness Planning and Implementation 26 TEX. ADMIN. CODE § 558.256; Limitations on the Employment of 14- and 15-Year-Old Children 40 TEX. ADMIN. CODE § 817.21; Posting of notices 29 CFR § 516.4; Employer's Notice of Ombudsman Program and First Responder Liaison to Employees 28 TEX. ADMIN. CODE § 276.5 (b-c); Findings and purpose USC 42.126 § 12101;* and *Performance Contract Notebook FY22-23 1.A.6.j.(1)*. The program had an overall score of 100%. The program met standards in the following areas: Accessibility, Appearance, Safety and Infectious Waste, Patient/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. The program met all criteria within seven (7) business days.

   Action Plan: Compliance will conduct annual Operational Reviews during the 4th Qtr. of FY 2025.

7. Operational Review PEERS for Hope House: A review was completed to ensure compliance with the following regulations: *Accessibility 42 U.S.C. Chapter 1; Appearance 42 U.S.C Chapter 1; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3), Compliance Plan FY24 LD.P.1.IV Seven Elements of The Harris Center's Compliance Plan Element 1: Written Policies and Procedures A. Standards of Behavior for The Harris Center Personnel 2. Compassion (iii)* and *(iv); Compliance Plan FY24 LD.P.1.V. The Harris Center's Compliance Program Effectiveness 1. Code of Conduct Principle 3; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3)); Maintenance, Preservation, and Availability of Records; Issuance of Regulations; Scope of Records; Periodic Inspections by Employer; Posting of Notices by Employer; Notification of Employee of Corrective Action 29 U.S.C. 657(c); Posting of notice; availability of the Act, regulations and applicable standards 29 CFR § 1903.2; Employer notice requirements 29 CFR § 825.300, Violations of the posting requirement 29 CFR § 825.402; Equal opportunity clause 1 CFR § 60-1.4; Equal opportunity clause 41 CFR § 60-741.5 (a)4; Equal opportunity clause 41 CFR § 60-300.5 (a)9; Posting of notices U.S.C. 29 § 525.14; Notice of protection U.S.C. 29 § 22.2003;*

Definitions 40 TEX. ADMIN. CODE § 815.1 (14); Emergency Preparedness Planning and Implementation 26 TEX. ADMIN. CODE § 558.256; Limitations on the Employment of 14- and 15-Year-Old Children 40 TEX. ADMIN. CODE § 817.21; Posting of notices 29 CFR § 516.4; Employer's Notice of Ombudsman Program and First Responder Liaison to Employees 28 TEX. ADMIN. CODE § 276.5 (b-c); Findings and purpose USC 42.126 § 12101; and *Performance Contract Notebook FY22-23 1.A.6.j.(1)*. The program had an overall score of 100%. The program met standards in the following areas: Accessibility, Appearance, Safety and Infectious Waste, Patient/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. The program met all criteria within seven (7) business days.

Action Plan: Compliance will conduct annual Operational Reviews during the 4th Qtr. of FY 2025.

8. Operational Review Southeast Child and Adolescent Services (SECAS): A review was completed to ensure compliance with the following regulations: *Accessibility 42 U.S.C. Chapter 1; Appearance 42 U.S.C Chapter 1; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3), Compliance Plan FY24 LD.P.1.IV Seven Elements of The Harris Center's Compliance Plan Element 1: Written Policies and Procedures A. Standards of Behavior for The Harris Center Personnel 2. Compassion (iii)* and *(iv); Compliance Plan FY24 LD.P.1.V. The Harris Center's Compliance Program Effectiveness 1. Code of Conduct Principle 3; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3)); Maintenance, Preservation, and Availability of Records; Issuance of Regulations; Scope of Records; Periodic Inspections by Employer; Posting of Notices by Employer; Notification of Employee of Corrective Action 29 U.S.C. 657(c); Posting of notice; availability of the Act, regulations and applicable standards 29 CFR § 1903.2; Employer notice requirements 29 CFR § 825.300, Violations of the posting requirement 29 CFR § 825.402; Equal opportunity clause 1 CFR § 60-1.4; Equal opportunity clause 41 CFR § 60-741.5 (a)4; Equal opportunity clause 41 CFR § 60-300.5 (a)9; Posting of notices U.S.C. 29 § 525.14; Notice of protection U.S.C. 29 § 22.2003; Definitions 40 TEX. ADMIN. CODE § 815.1 (14); Emergency Preparedness Planning and Implementation 26 TEX. ADMIN. CODE § 558.256; Limitations on the Employment of 14- and 15-Year-Old Children 40 TEX. ADMIN. CODE § 817.21; Posting of notices 29 CFR § 516.4; Employer's Notice of Ombudsman Program and First Responder Liaison to Employees 28 TEX. ADMIN. CODE § 276.5 (b-c); Findings and purpose USC 42.126 § 12101;* and *Performance Contract Notebook FY22-23 1.A.6.j.(1)*.

   The program had an overall score of 100%. The program met standards in the following areas: Accessibility, Appearance, Safety and Infectious Waste, Patient/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. The program met all criteria within seven (7) business days.

   Action Plan: Compliance will conduct annual Operational Reviews during the 4th Qtr. of FY 2025.

9. Operational Review Southeast Community Service Center (SECSC): A review was completed to ensure compliance with the following regulations: *Accessibility 42 U.S.C. Chapter 1; Appearance 42 U.S.C Chapter 1; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3), Compliance Plan FY24 LD.P.1.IV Seven Elements of The Harris Center's Compliance Plan Element 1: Written Policies and Procedures A. Standards of Behavior for The Harris Center Personnel 2. Compassion (iii)* and *(iv); Compliance Plan FY24 LD.P.1.V. The Harris Center's Compliance Program Effectiveness 1. Code of Conduct Principle 3; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3)); Maintenance, Preservation, and Availability of Records; Issuance of Regulations; Scope of Records; Periodic Inspections by Employer; Posting of Notices by Employer; Notification of Employee of Corrective Action 29 U.S.C. 657(c); Posting of notice; availability of the Act, regulations and applicable standards 29 CFR § 1903.2; Employer notice requirements 29 CFR § 825.300, Violations of the posting requirement 29 CFR § 825.402; Equal opportunity clause 1 CFR § 60-1.4; Equal opportunity clause 41 CFR § 60-741.5 (a)4; Equal opportunity clause 41 CFR § 60-300.5 (a)9; Posting of notices U.S.C. 29 § 525.14; Notice of protection U.S.C. 29 § 22.2003; Definitions 40 TEX. ADMIN. CODE § 815.1 (14); Emergency Preparedness Planning and Implementation 26 TEX. ADMIN. CODE § 558.256; Limitations on the Employment of 14- and 15-Year-Old Children 40 TEX. ADMIN. CODE § 817.21; Posting of notices 29 CFR § 516.4; Employer's Notice of Ombudsman Program and First Responder Liaison to Employees 28 TEX. ADMIN. CODE § 276.5 (b-c); Findings and purpose USC 42.126 § 12101;* and *Performance Contract Notebook FY22-23 1.A.6.j.(1)*. The program had an overall score of 100%. The program met standards in the following areas: Accessibility, Appearance, Safety and Infectious Waste, Patient/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. The program met all criteria within seven (7) business days.

   Action Plan: Compliance will conduct annual Operational Reviews during the 4th Qtr. of FY 2025.

10. Operational Review Step Down State Hospital Transition (Step Down) Program: A review was completed to ensure compliance with the following regulations: *Accessibility 42 U.S.C. Chapter 1; Appearance 42 U.S.C Chapter 1; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3), Compliance Plan FY24 LD.P.1.IV Seven Elements of The Harris Center's Compliance Plan Element 1: Written Policies and Procedures A. Standards of Behavior for The Harris Center Personnel 2. Compassion (iii)* and *(iv); Compliance Plan FY24 LD.P.1.V. The Harris Center's Compliance Program Effectiveness 1. Code of Conduct Principle 3; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3)); Maintenance, Preservation, and Availability of Records; Issuance of Regulations; Scope of Records; Periodic Inspections by Employer; Posting of Notices by Employer; Notification of Employee of Corrective Action 29 U.S.C. 657(c); Posting of notice; availability of the Act, regulations and applicable standards 29 CFR § 1903.2; Employer notice requirements 29 CFR § 825.300, Violations of the posting requirement 29 CFR § 825.402; Equal opportunity clause 1 CFR § 60-1.4; Equal opportunity clause 41 CFR § 60-741.5 (a)4; Equal opportunity clause 41 CFR § 60-300.5 (a)9; Posting of notices U.S.C. 29 § 525.14; Notice of protection U.S.C. 29 § 22.2003; Definitions 40 TEX. ADMIN. CODE § 815.1 (14); Emergency*

Preparedness Planning and Implementation 26 TEX. ADMIN. CODE § 558.256; Limitations on the Employment of 14- and 15-Year-Old Children 40 TEX. ADMIN. CODE § 817.21; Posting of notices 29 CFR § 516.4; Employer's Notice of Ombudsman Program and First Responder Liaison to Employees 28 TEX. ADMIN. CODE § 276.5 (b-c); Findings and purpose USC 42.126 § 12101; and *Performance Contract Notebook FY22-23 1.A.6.j.(1)*. The program had an overall score of 100%. The program met standards in the following areas: Accessibility, Appearance, Safety and Infectious Waste, Patient/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. The program met all criteria within seven (7) business days.

Action Plan: Compliance will conduct annual Operational Reviews during the 4th Qtr. of FY 2025.

11. Operational Review Crisis Stabilization Unit (CSU): A review was completed to ensure compliance with the following regulations: *Accessibility 42 U.S.C. Chapter 1; Appearance 42 U.S.C Chapter 1; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3), Compliance Plan FY24 LD.P.1.IV Seven Elements of The Harris Center's Compliance Plan Element 1: Written Policies and Procedures A. Standards of Behavior for The Harris Center Personnel 2. Compassion (iii)* and *(iv); Compliance Plan FY24 LD.P.1.V. The Harris Center's Compliance Program Effectiveness 1. Code of Conduct Principle 3; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3)); Maintenance, Preservation, and Availability of Records; Issuance of Regulations; Scope of Records; Periodic Inspections by Employer; Posting of Notices by Employer; Notification of Employee of Corrective Action 29 U.S.C. 657(c); Posting of notice; availability of the Act, regulations and applicable standards 29 CFR § 1903.2; Employer notice requirements 29 CFR § 825.300, Violations of the posting requirement 29 CFR § 825.402; Equal opportunity clause 1 CFR § 60-1.4; Equal opportunity clause 41 CFR § 60-741.5 (a)4; Equal opportunity clause 41 CFR § 60-300.5 (a)9; Posting of notices U.S.C. 29 § 525.14; Notice of protection U.S.C. 29 § 22.2003; Definitions 40 TEX. ADMIN. CODE § 815.1 (14); Emergency Preparedness Planning and Implementation 26 TEX. ADMIN. CODE § 558.256; Limitations on the Employment of 14- and 15-Year-Old Children 40 TEX. ADMIN. CODE § 817.21; Posting of notices 29 CFR § 516.4; Employer's Notice of Ombudsman Program and First Responder Liaison to Employees 28 TEX. ADMIN. CODE § 276.5 (b-c); Findings and purpose USC 42.126 § 12101;* and *Performance Contract Notebook FY22-23 1.A.6.j.(1)*. The program had an overall score of 100%. The program met standards in the following areas: Accessibility, Appearance, Safety and Infectious Waste, Patient/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. The program met all criteria within seven (7) business days.

    Action Plan: Compliance will conduct annual Operational Reviews during the 4th Qtr. of FY 2025.

12. Operational Review Psychiatric Emergency Services (PES): A review was completed to ensure compliance with the following regulations: *Accessibility 42 U.S.C. Chapter 1; Appearance 42 U.S.C Chapter 1; Environment of Care and Safety 26 TEX. ADMIN. CODE §*

301.323 (a)(3), Compliance Plan FY24 LD.P.1.IV Seven Elements of The Harris Center's Compliance Plan Element 1: Written Policies and Procedures A. Standards of Behavior for The Harris Center Personnel 2. Compassion (iii) and *(iv); Compliance Plan FY24 LD.P.1.V. The Harris Center's Compliance Program Effectiveness 1. Code of Conduct Principle 3; Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323 (a)(3); Maintenance, Preservation, and Availability of Records; Issuance of Regulations; Scope of Records; Periodic Inspections by Employer; Posting of Notices by Employer; Notification of Employee of Corrective Action 29 U.S.C. 657(c); Posting of notice; availability of the Act, regulations and applicable standards 29 CFR § 1903.2; Employer notice requirements 29 CFR § 825.300, Violations of the posting requirement 29 CFR § 825.402; Equal opportunity clause 1 CFR § 60-1.4; Equal opportunity clause 41 CFR § 60-741.5 (a)4; Equal opportunity clause 41 CFR § 60-300.5 (a)9; Posting of notices U.S.C. 29 § 525.14; Notice of protection U.S.C. 29 § 22.2003; Definitions 40 TEX. ADMIN. CODE § 815.1 (14); Emergency Preparedness Planning and Implementation 26 TEX. ADMIN. CODE § 558.256; Limitations on the Employment of 14- and 15-Year-Old Children 40 TEX. ADMIN. CODE § 817.21; Posting of notices 29 CFR § 516.4; Employer's Notice of Ombudsman Program and First Responder Liaison to Employees 28 TEX. ADMIN. CODE § 276.5 (b-c); Findings and purpose USC 42.126 § 12101;* and *Performance Contract Notebook FY22-23 1.A.6.j.(1)*. The program had an overall score of 100%. The program met standards in the following areas: Accessibility, Appearance, Safety and Infectious Waste, Patient/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. The program met all criteria within seven (7) business days.

Action Plan: Compliance will conduct annual Operational Reviews during the 4th Qtr. of FY 2025.

13. Comprehensive Review Crisis Stabilization Unit (CSU): A review of the Crisis Stabilization Unit (CSU) was completed to ensure compliance with the following regulations and Harris Center Policies and Procedures: Texas Administrative Code (TEX. ADMIN. CODE) *Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 25 TEX. ADMIN. CODE § 404.161 (d)-(f); Patient's Bill of Rights, Teen's Bill of Rights, and Children's Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals 25 TEX. ADMIN. CODE § 404.162 (e)-(f); Communication of Rights to Individuals Receiving Mental Health Services 25 TEX. ADMIN. CODE § 404.163 (a)-(d); Rights Protection Officer at Department Facilities and Community Centers 25 TEX. ADMIN. CODE § 404.164 (b); Documentation of Informed Consent 25 TEX. ADMIN. CODE § 414.405; Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331 (a)(3)(A)-(B); Crisis Services 26 TEX. ADMIN. CODE § 301.351 (e); Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353 (a), (e),* and *(h); Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361 (a)-(b); Supervision 26 TEX. ADMIN. CODE § 301.363 (a)(1); MH Case Management Services Standards 26 TEX. ADMIN. CODE § 306.263 (b); Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275 (c); the Texas Health and Human Services Commission Information Item V Section VI Crisis Respite Services;* and *The Harris Center*

Policies and Procedures ACC.B.2 Plan of Care; ACC.B.8 Referral, Transfer, and Discharge; ACC.B.14 Declaration for Mental Health Treatment; HIM.EHR.B.5 Content of Patient/Individual Record; HIM.EHR.B.9 Patient/Individual Records Administration; MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention; RR.B.2 Assurance of Individual Rights; and *required employee training courses.*

The overall score for the program was 81%. The program met or exceeded standards in the following areas: medical requirements and environment requirements.

The program did not meet standards in the following areas: records review—discharge planning was not being completed; discharge planning activities were not documented; intake assessments, nursing assessments, treatment plans, progress notes, and crisis services did not include all required information; and medication consent documents were not completed appropriately; personnel requirements—staff were not trained or recertified in screening and assessment tasks; and policy requirements—operational guidelines did not contain all elements mandated by the Texas Administrative Code or the Health and Human Services Commission's Information Item V. The program was required to submit a POI for personnel requirements, policy requirements, and client record requirements.

Action Plan: Compliance will review the CSU Program in the next one hundred eighty (180) days to ensure the program has implemented its POI.

14. Comprehensive Review Substance Use Recovery Services (SURS): A review was completed to ensure compliance with the following regulations: *Responding to Emergencies 26 TEX. ADMIN. CODE § 564.707; Requirements Applicable to Detoxification Services 26 TEX. ADMIN. CODE § 564.905 (a)(8); Substance Use Program Guide 14 Quality Management Policies and Procedures; Substance Use Guide 8 Interim Services; Treatment for Adult (TRA); Statement of Work (SOW) V Levels of Care Ambulatory Withdrawal Management Services F.1-F2, TRA SOW III, Service Requirements Administrative Requirements A.8-11; TRA SOW IV Staff Competencies and Requirements 6-10, 13; Treatment for Female (TRF); Statement of Works (SOW) III Service Requirement; Additional Service Requirements F.4, F6, F.8-F.14, TRF SOW IV; Levels of Care/Service Types Outpatient Treatment Services A.1-A6, TRF SOW III Service Requirements Administrative Requirements A.1-A.9, A.11; TRF SOW IV Staff Competences and Requirements 12; TRF SOW III Service Requirements Administrative Requirements A.13, Hiring Practices 26 TEX. ADMIN. CODE § 564.601, Substance Use Program Guide 9 Personnel Requirements and Documentation 1,2 and 4; Training 26 TEX. ADMIN. CODE § 564.603 (d); Training 26 TEX. ADMIN. CODE § 564.603.4-7; TRF SOW IV Staff Competencies and Requirements 6-10, 14-15;* and *Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361.*

The Program had an overall score of 94%. The program met or exceeded standards in the following areas: Prior Population Wait List and Interim Services, Treatment for Adult Program Review, Treatment for Adult Personnel Review, Environmental Review, and Treatment for Female Program Review.

The program did not meet standards in the following areas: policies and procedures requirements, Treatment for Adult Records Review, Treatment for Female Record Review, and Documentation of Service Provision. The program was required to submit a Plan of Improvement (POI) for the following areas: Policy and Procedure requirements, Treatment Adult Record Review, Treatment for Female Record review, Treatment for Female Personnel Review, and Documentation of Service Provision.

Action Plan: Compliance will review the SURS Program in the next one hundred eighty (180) days to ensure the program has implemented its POI.

15. Comprehensive Review Jail Diversion (JD): A review of the Jail Diversion (JD) Program was completed to ensure compliance with the following regulations and Harris Center Policies and Procedures: *Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 25 TEX. ADMIN. CODE § 404.161 (d)-(f); Patient's Bill of Rights, Teen's Bill of Rights, and Children's Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals 25 TEX. ADMIN. CODE § 404.162 (e)-(f); Communication of Rights to Individuals Receiving Mental Health Services 25 TEX. ADMIN. CODE § 404.163 (a)-(d); Rights Protection Officer at Department Facilities and Community Centers 25 TEX. ADMIN. CODE § 404.164 (b); Documentation of Informed Consent 25 TEX. ADMIN. CODE § 414.405; Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331 (a)(3)(A)-(B); Crisis Services 26 TEX. ADMIN. CODE § 301.351 (e); Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353 (a), (e),* and *(h); Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361 (a)-(b); Supervision 26 TEX. ADMIN. CODE § 301.363 (a)(1); MH Case Management Services Standards 26 TEX. ADMIN. CODE § 306.263 (b); Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275 (c); the Texas Health and Human Services Commission Information Item V Section VI Crisis Respite Services;* and *The Harris Center Policies and Procedures ACC.B.2 Plan of Care; ACC.B.8 Referral, Transfer, and Discharge; ACC.B.14 Declaration for Mental Health Treatment; HIM.EHR.B.5 Content of Patient/Individual Record; HIM.EHR.B.9 Patient/Individual Records Administration; MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention; RR.B.2 Assurance of Individual Rights;* and *required employee training courses.* The program had an overall score of 91%.

The program met or exceeded standards in the following areas: medical requirements, policy requirements, environment requirements, and personnel requirements.

The program did not meet standards in the following areas: client records—treatment plans were not completed; case management services were not documented; some persons served were not offered a Declaration of Mental Health Treatment; all sections of the crisis assessment and admission assessment were not completed; progress note criteria were not fulfilled; discharge summaries were not completed; and some medication consent documents were not appropriately completed. The program was required to submit a Plan of Improvement (POI) for client record documentation.

Action Plan: Compliance will review the JD Program in the next one hundred eighty (180) days to ensure the program has implemented its POI.

The following is a list of the external reviews (i.e., Governing Bodies, Managed Care Organizations (MCO), etc.) completed during the review period with involvement or oversight from Compliance:

1. The Superior Healthplan on behalf of STAR Health for ECI (Early Childhood Intervention) Medicaid Medical Records Request. 6/4/2024 The request was submitted for one person, and the requested information was for the Individual Family Service Plan (IFSP) **Outcome:** Health and Information Management Release of Information (HIM ROI) submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

2. Datavant Cigna Medical Records Request 6/4/2024: Datavant, on behalf of Cigna, conducted a Risk Adjustment review. Datavant requested eleven (11) records of members' medical records for services rendered. The documentation requested for this chart review was the Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities. **Outcome:** HIM ROI sent the requested documentation, and a confirmation receipt was received upon completion. No further communication has been received.

3. Datavant Cigna Medical Records Request 6/4/2024: Datavant, on behalf of Cigna, conducted a Risk Adjustment review. Datavant requested eleven (11) records of members' medical records for services rendered. The documentation requested for this chart review was the Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities. **Outcome:** HIM ROI sent the requested documentation, and a confirmation receipt was received upon completion. No further communication has been received.

4. Datavant Cigna Medical Records Request 6/5/2024: Datavant, on behalf of Cigna, conducted a Risk Adjustment review. Datavant requested eleven (11) records of members' medical records for services rendered. The documentation requested for this chart review was the Demographic/Face Sheet, Physical, Occupational, and other Therapy; history &

Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities. **Outcome:** HIM ROI sent the requested documentation, and a confirmation receipt was received upon completion. No further communication has been received.

5. Episource: Aetna Medical Record Request 6/5/2024: Aetna performed a Medicare Risk Adjustment Review. The medical record for (1) individual was requested for services rendered. The documentation requested for this review was Demographic/Face Sheet, Progress Notes, Consult Notes, Hospital Records, History & Physical Reports, Pathology Reports, Diagnostics, Medication and Problem List, and Past Medical History where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon medical records completion. No further communication has been received.

6. COTIVITI: Aetna 6/13/2024: Risk Adjustment Records Request on behalf of Aetna. Cotiviti was hired to complete a Record Review of clients receiving services from the Harris Center. Cotiviti requested two (2) charts of specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech, and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon medical records completion. No further communication has been received.

7. Datavant Wellpoint Medical Records Request 6/17/2024: Datavant, on behalf of Wellpoint, conducted a Medicare Risk Adjustment Data review. Datavant requested nine (9) records of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

8. Molina Healthcare conducted a Behavioral Health Medical Record Review Project 6/18/2024. The requested documents were Demographic Sheet Copy of the Member's Health ID Plan card, Intake Assessment, ANAS/CANS with LOC included from CMBHS, Psychiatric Evaluation, Discharge Summary, History, Treatment Plan, All Doctor/Progress/TCM notes, Medication information, Labs and or any diagnostic results and

Referrals. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

9. Datavant Anthem Wellpoint 6/18/2024: Datavant conducted a Medicare Risk Adjustment Data review. Datavant requested two (2) charts of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

10. Optum Rx Northwest Clinic Pharmacy 06/21/2024: conducted a Desktop Audit EXL ID 120441. Supporting Documentation was submitted to attest to the claim being billed correctly for one prescription Invega Trinz INJ 546mg. The documentation was submitted for this review and was signed off by the Pharmacy Manager/Representative on 6/25/2024. **Outcome:** The requested documentation was submitted by the Pharmacy Manager/Representative. Documentation was accepted and the audit was closed.

11. Optum Rx Southeast Clinic Pharmacy 06/26/2024: conducted a Desktop Audit EXL ID 1203560. Supporting Documentation was submitted to attest to the claim being corrected from a one-day supply to a 28-day supply for one prescription of Invega Trinz INJ. The documentation was submitted for this review and was signed by the Pharmacy Manager/Representative on 6/26/2024. **Outcome:** The requested documentation was submitted by the Pharmacy Manager/Representative. The Day supply was corrected, and Documentation was accepted, and the audit was closed.

12. Optum Rx Northwest Clinic Pharmacy 06/26/2024: conducted a Desktop Audit EXL ID 1204419. Supporting Documentation was submitted to attest to the claim being billed correctly for one prescription Invega Trinz INJ 546mg. The documentation was submitted for this review and was signed off by the Pharmacy Manager/Representative on 6/26/2024. **Outcome:** The requested documentation was submitted by the Pharmacy Manager/Representative. Documentation was accepted and the audit was closed.

13. Optum Rx Northwest Clinic Pharmacy 06/26/2024: conducted a Desktop Audit EXL ID 1204419. Supporting Documentation was submitted to attest to the claim being billed correctly for one prescription Invega Trinz INJ 546mg. The documentation was submitted for this review and was signed off by the Pharmacy Manager/Representative on 6/26/2024. **Outcome:** The requested documentation was submitted by the Pharmacy Manager/Representative. Documentation was accepted and the audit was closed.

14. Advantmed Wellcare 6/28/2024, Wellcare was hired to conduct a HEDIS Review. The medical records of eighty (80) members were requested for services rendered. The documents requested included the Member Demographic Sheet: Name and Date of Birth, all Blood Pressure Readings from 1/1/2023 to 12/31/2023, Cervical Cancer Screening, Child Immunization status, Medication List, Colorectal Cancer Screening, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c), Developmental Screening (First three years of Life, second and third Years of Life), Eye Exam for People with Diabetes, Immunization for Adolescents, Lead Screening in children, Perinatal depression screening, Prenatal Screening for Smoking and Treatment Discussion during Prenatal visit, Prenatal, Prenatal and Postpartum Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Progress Notes, History and Physical, Consult/Specialist Notes or Letters, Operative Notes, Procedures Notes, Reports, Vital Signs and Lab result where applicable. **Outcome:** The requested documentation was submitted by HIM ROI, and a confirmation receipt was received upon completion. No further communication has been received.

15. Advantmed Wellcare 6/28/2024, Wellcare was hired to conduct a Healthcare Effectiveness Data and Information Set (HEDIS) Review. The medical records for seventy-eight (78) members were requested for services rendered. The documents requested include the Member Demographic Sheet: Name and Date of Birth, all Blood Pressure Readings from 1/1/2023 to 12/31/2023, Cervical Cancer Screening, Child Immunization status, Medication List, Colorectal Cancer Screening, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c), Developmental Screening (First three years of Life, second and third Years of Life), Eye Exam for People with Diabetes, Immunization for Adolescents, Lead Screening in children, Perinatal depression screening, Prenatal Screening for Smoking and Treatment Discussion during Prenatal visit, Prenatal, Prenatal and Postpartum Care, Weight Assessment and Counseling for Nutrition and Physical Activity Children/Adolescents Progress Notes, History and Physical, Consult/Specialist Notes or Letters, Operative Notes, Procedures Notes, Reports, Vital Signs and Lab result where applicable. **Outcome:** The requested documentation was submitted by HIM ROI, and a confirmation receipt was received upon completion. No further communication has been received.

16. Datavant Aetna Medical Records Request 7/1/2024: Datavant, on behalf of Aetna, conducted a Medicare Risk Adjustment Data review. Datavant requested one (1) record of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:**

HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

17. Datavant United Healthcare Medical Records Request 7/1/2024: Datavant, on behalf of Aetna, conducted a Medicare Risk Adjustment Data review. Datavant requested one (1) record of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

18. Datavant Medical Records Request 7/3/2024: Datavant conducted a Medicare Risk Adjustment Data review. Datavant requested fifty (50) records of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

19. Humana Medical Records Request 7/5/2024: Humana conducted a Medicare Risk Adjustment Data review and STAR measure Review. Humana requested six (6) records of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

20. Optum Rx Southeast Clinic Pharmacy 07/12/2024: conducted a Desktop Audit EXL ID 1209915. Supporting Documentation was submitted to attest to the claim being billed

correctly for one prescription Invega Trinz INJ 546mg. The documentation was submitted for this review and was signed off by the Pharmacy Manager/Representative on 7/12/2024. **Outcome:** The requested documentation was submitted by the Pharmacy Manager/Representative. Documentation was accepted and the audit was closed.

21. Optum Rx Northeast Clinic Pharmacy 07/15/2024: conducted a Desktop Audit EXL ID 1206958. Supporting Documentation was submitted to attest to the claim being corrected to a 90-day supply for one prescription of Invega Trinz INJ. The documentation was submitted for this review and was signed by the Pharmacy Manager/Representative on 7/16/2024. **Outcome:** The requested documentation was submitted by the Pharmacy Manager/Representative. The Day supply was corrected, Documentation was accepted, and the audit was closed.

22. Datavant Wellpoint Medical Records Request 7/15/2024: Datavant, on behalf of Wellpoint, conducted a Medicare Risk Adjustment Data review. Datavant requested eighty-two (82) records of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

23. Datavant Wellpoint Medical Records Request 7/16/2024: Datavant, on behalf of Wellpoint, conducted a Medicare Risk Adjustment Data review. Datavant requested forty-seven (47) records of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

24. Advantmed Blue Cross Blue Shield of Texas 7/17/2024, Advantmed was hired to conduct a HEDIS Review. The medical record for one (1) member was requested for services rendered. The documents requested include the Member Demographic Sheet: Name and Date of Birth, all Blood Pressure Readings from 1/1/2023 to 12/31/2023, Cervical Cancer

Screening, Child Immunization status, Medication List, Colorectal Cancer Screening, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c), Developmental Screening (First three years of Life, second and third Years of Life), Eye Exam for People with Diabetes, Immunization for Adolescents, Lead Screening in children, Perinatal depression screening, Prenatal Screening for Smoking and Treatment Discussion during Prenatal visit, Prenatal, Prenatal and Postpartum Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Progress Notes, History and Physical, Consult/Specialist Notes or Letters, Operative Notes, Procedures Notes, Reports, Vital Signs and Lab result where applicable. **Outcome:** The requested documentation was submitted by HIM ROI, and a confirmation receipt was received upon completion. No further communication has been received.

25. Optum Rx Northeast Clinic Pharmacy 07/22/2024: conducted a Desktop Audit EXL ID 1212163. Supporting Documentation was submitted to attest to the claim being billed correctly for one prescription Invega Trinz INJ 234mg. The documentation was submitted for this review and was signed off by the Pharmacy Manager/Representative on 7/22/2024. **Outcome:** The requested documentation was submitted by the Pharmacy Manager/Representative. Documentation was accepted, and the audit was closed.

26. Optum Rx Southeast Clinic Pharmacy 07/22/2024: conducted a Desktop Audit EXL ID 1211618. Supporting Documentation was submitted to attest to the claim being billed correctly for one prescription Invega Trinz INJ 819mg. The documentation was submitted for this review and was signed off by the Pharmacy Manager/Representative on 7/22/2024. **Outcome:** The requested documentation was submitted by the Pharmacy Manager/Representative. Documentation was accepted and the audit was closed.

27. Texas Health and Human Services Hillcroft Empowerment Center Complaint Investigation visit 7/22/2024. The entrance for the investigation was on 3/17/2024. **Outcome:** No violations cited. No further communication has been received.

28. Datavant Wellpoint Medical Records Request 7/22/2024: Datavant, on behalf of Wellpoint, conducted a Medicare Risk Adjustment Data review. Datavant requested two hundred ninety-four (294) records of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

29. Advantmed Blue Cross Blue Shield of Texas Medical Records Request 7/24/2024: Advantmed, on behalf of Blue Cross Blue Shield of Texas, conducted a Medicare Risk Adjustment Data review. Datavant requested eighty-two (82) records of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

30. Optum Rx Southeast Clinic Pharmacy 07/24/2024: conducted a Desktop Audit EXL ID 1215313. Supporting Documentation was submitted to attest to the claim being billed correctly for one prescription Invega Trinz INJ 819mg. The documentation was submitted for this review and was signed off by the Pharmacy Manager/Representative on 7/22/2024. **Outcome:** The requested documentation was submitted by the Pharmacy Manager/Representative. Documentation was accepted and the audit was closed.

31. Datavant Cigna Medical Records Request 7/25/2024: Datavant, on behalf of Wellpoint, conducted a Medicare Risk Adjustment Data review. Datavant requested forty-seven (47) records of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

32. The Health and Human Services Commission (HHSC) 8/07/2024, The Behavioral Health Services Quality Management Unit (QM), completed the fiscal year 2024 Mental Health Independent Peer Review in accordance with the Mental Health Block Grant section 1943. The grant requires at least five percent of providers receiving block grant funding to participate in the peer review to assess the quality, appropriateness, and efficacy of services to improve services continuously. The Preadmission Screening Resident Review Mental Impairment (PASRR MI) was scored in the following areas: Clinical Record Review, PASRR process for service initiation, PASRR Renewal and Revision of Person-Centered Recovery Plan, PASRR service delivery, and PASRR documentation. **Outcome**: There has

not been any further information provided by the reviewer regarding an overall score at this time.

33. Datavant Wellpoint Notice of Outstanding Medical Records Request 8/09/2024: Datavant, on behalf of Wellpoint, conducted a Medicare Risk Adjustment Data review. Datavant requested two (2) records of members' medical records for services rendered that were outstanding. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested outstanding documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

34. Datavant Wellpoint Notice of Outstanding Medical Records Request 8/09/2024: Datavant, on behalf of Wellpoint, conducted a Medicare Risk Adjustment Data review. Datavant requested three (3) records of members' medical records for services rendered that were outstanding. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested outstanding documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

35. Datavant Wellpoint Medical Records Request 8/16/2024: Datavant, on behalf of Wellpoint, conducted a Medicare Risk Adjustment Data review. Datavant requested four (4) records of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

36. Reveller Aetna Medical Records Request 8/19/2024: Reveller, on behalf of Aetna conducted a Medicare Risk Adjustment Data review. Reveller requested three (3) members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

37. Datavant Devoted Health Medical Records Request 8/22/2024: Datavant, on behalf of Devoted Health, conducted a Medicare Risk Adjustment Data review. Datavant requested two (2) records of members' medical records for services rendered. The documentation requested for this chart review was a Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology. Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

38. Datavant Cigna Medical Records Request 8/22/2024: Datavant, on behalf of Cigna, conducted a Medicare Risk Adjustment Data review. Datavant requested two (2) records of members' medical records for services rendered. The documentation requested for this chart review was a Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology. Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

39. Harris County Community Supervision and Corrections Department 8/28/2024 Audit Results from the Harris County Quality Improvement/ Quality Assurance Unit. The Harris Center FY 2024 Service Review. Twenty-five (25) client records were reviewed. **Outcome:** The following objectives were not met during the review: Each client exiting treatment will have a discharge plan completed and forwarded to the Department; all counselors' caseloads

limited to twenty (20) clients or less; complete nursing assessment conducted within ninety-six (96) hours of admission; comprehensive offender assessment completed before placement or within ten (10) business days of admission; direct care staff on-site during all hours of operation. No further communication has been received.

40. Reveller Aetna Medical Records Request 8/30/2024: Reveller, on behalf of Aetna conducted a Medicare Risk Adjustment Data review. Reveller requested three (3) records of members' medical records for services rendered. The documentation requested for this chart review was Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facility where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

The Harris Center for Mental Health and IDD:
The Compliance Department
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Executive Summary Cover Sheet
Mental Health (MH) Forensic Division
Texas Correctional Office on Offender with Medical or Mental Impairments (TCOOMMI Jr)
Focus Review
Review Date: July 3, 2024, to July 15, 2024

I. Audit Type:
Focus Review.

II. Purpose:
At the request of the program director for TCOOMMI Jr, Compliance conducted a focus review of a family partner encounter data services to ensure documentation was completed in accordance with the Texas Administrative Code (TAC) *Title 26 Part 1 Ch 301 and 306 Rule §301.353, §301.361, §306.315, and Agency Policy and Procedures (P&P) - ACC.B.2* and *HIM.EHR. B.5, B.6, B.13 and the MH Behavioral Health Procedure Operation Manual.*

III. Audit Method:
Active records were randomly selected from the *Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 3rd and 4th Qtr. of FY 2024 (May 1, 2024 - June 30, 2024). Compliance conducted a desk review, sampling twenty-seven (27) records using the service documentation Review Tool. Detailed data for this review is presented below.

IV. Audit Findings and History:

Overall Program Score: 86%
Detailed finding(s) are presented below.
The program scored 100% in the following areas: The progress notes were in the EHR, no duplicate or overlapping services were billed, the times matched the billed units, each person served was eligible for services, The dates of services were documented, the begin time and end time of the service was documented. The signature and title of the person who provided the service were documented. The location time was accounted for in the note, the Services listed in the record match what is entered Epic, and All medication training and supported services were documented, The identifying information to whom the service was provided was documented, The progress note were written to promote recovery, and the correct name, case number, and gender were documented.

Listed are the areas where the program failed below the 95% threshold: The services provided were not supported by documentation 17%, the Incorrect procedure code was used 74%, Progress notes were not completed within two (2) business days 57%, the services provided did not reflect the Plan of care (POC) recovery goals 21%, and Multiple notes reflected the same wording, “cloning, cookie cutter/copying and pasting” 49%.

History

No previous review of this type has been completed.

V. Recommendations:
Compliance recommends that the TCOOMMI Jr. program review the findings and continue to assess its family partner processes to ensure service documentation is in accordance with TAC and Agency P&P. Due to an overall score of 86%, the program will be required to submit a Plan of Improvement (POI). A management response signed by the Vice President of the Forensic Division and Program Director/Manager must sign and return this report along with the POI to Compliance within seven (7) business days.

Compliance Department (Compliance) Review Report:
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH) Forensic Division
Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI Jr.)
Focus Review

Compliance Auditor(s): Coneka Caleb and Marvin Williams

Review Dates: July 3-15, 2024

Purpose

At the request of the program director for TCOOMMI Jr, Compliance conducted a focus review of a family partner encounter data services to ensure documentation was completed in accordance with the Texas Administrative Code (TAC) *Title 26 Part 1 Ch 301 and 306 Rule §301.353, §301.361, §306.315, and Agency Policy and Procedures (P&P) - ACC.B.2* and *HIM.EHR. B.5, B.6, B.13 and the MH Behavioral Health Procedure Operation Manual.*

Method

Active records were randomly selected from the *Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 3rd and 4th Qtr. of FY 2024 (May 1, 2024 - June 30, 2024). Compliance conducted a desk review, sampling twenty-seven (27) records using the service documentation Review Tool. Detailed data for this review is presented below.

Findings

Overall program Score: 86%
Detailed findings are presented below.

Strengths:

- The progress notes were in the EHR. *Agency P&P HIM.EHR. B.5* **100%**
- No duplicate or overlapping services were billed. *Agency P&P HIM.EHR. B.13* **100%**
- No persons served resided in an excluded location that would have made them ineligible for Medicaid reimbursement. *§301.361(a)(5)* **100%**
- The times matched the billed units. *§301.361(a)(5)* **100%**
- Each person served was eligible for services. *§301.353 (d) (1) (A)* **100%**
- The dates of service were documented. *§301.361(a)(3)* **100%**
- The begin time and end time of the service was documented. *§301.361(a)(4)* **100%**
- The signature and title of the person who provided the service was documented. *§301.361(a)(13)* **100%**
- The location where the service was provided. *§301.361(a)(5)* **100%**
- The time was accounted for in the note. *Agency P&P HIM.EHR. B.5* **100%**
- Services listed in the record match what is entered into Epic. *§301.361(c)* **100%**
- All medication training and support (MTS) services were documented. *§306.315(a) (1-7)* **100%**

- The identifying information to whom the service was provided was documented. *§301.361(a) (1)* **100%**
- The progress notes were written to promote recovery. *Agency P&P HIM.EHR. B.5* **100%**
- Correct name, case number and gender were documented. *§301.361 (a) (1)* **100%**

Areas of Improvement:

- The services provided were not supported by documentation. *§301.361 (a) (10,12)* **17%**
- Incorrect procedure code used. *Agency P&P HIM.EHR. B.6* **74%**
- Progress notes were not completed within two (2) business days. *§301.361(b)* **57%**
- The services provided must reflect the Plan of Care (POC) recovery goals. *§301.353(d) (C)* **21%**
- Multiple notes reflecting the same wording "cloning, cookie cutter / copying and pasting" *MH Behavioral Health Procedure Operation Manual* **49%**

Observations

There are no observations to be noted for this review.

History

No previous review of this type has been completed.

Recommendations

Compliance recommends that the TCOOMMI Jr. program review the findings and continue to assess its family partner processes to ensure service documentation is in accordance with TAC and Agency P&P. Due to an overall score of 86%, the program will be required to submit a Plan of Improvement (POI). A management response signed by the Vice President of the Forensic Division and Program Director/Manager must sign and return this report along with the POI to Compliance within seven (7) business days by close of business, August 14, 2024.

Management Response:

TCOOMMI management has reviewed the findings and find them to be accurate. To improve in the areas documented above, management will continue assess its family partner processes to ensure compliance with TAC and Agency P&P. TCOOMMI management will work closely with the Family Partner supervisor to ensure that the Family Partner is trained properly on documentation procedures and expectations. This will aid in ensuring that services are supported in documentation, correct procedure codes are used, progress notes are submitted within two (2) business days, and to prevent submission of cloned notes. For the first 90 days, the Assistant Program Director will review and cosign notes daily to ensure understanding and compliance. Cases will be assigned to the Family Partner at enrollment. All goals and interventions will be included in the initial case plan. Goals and interventions will be updated as needed.

Signature Page

X Monalisa Jiles 8/30/24

Vice President of MH Forensic Division

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Jasper York, LPC
Program Director/Manager

X Demetria Luckett

Compliance Director

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary
Substance Use Recovery Services Detoxification Program (DETOX) Focused Review
Review Dates: 05/08/2024 to 06/13/2024

I. **Audit Type:**
Focused Review

II. **Purpose:**
The purpose of this review was to assist the DETOX Program, Comprehensive Psychiatric Emergency Program (CPEP) Division in assessing Physician Documentation for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (TAC), HHS Information Item V, and Agency Policy and Procedures (P&P) concerning mental health documentation standards. This review is a follow-up to an externally contracted review regarding Physician Documentation.

III. **Audit Method:**
Compliance ran the AFF HC Encounter Data OP Services Details Report in the Electronic Health Record (EHR) system to identify an appropriate sample size for persons served during the 2nd Qtr. of FY 2024 (02/01/2024 – 02/29/2024). Compliance reviewed client encounters containing physician documentation for service codes 99702, 99212, 99213, 99214 and 99215. Sample size was obtained on 05/08/2024. This desk review was conducted using the Coding Audit Review Tool. Detailed data for the services reviewed are presented in the findings section below.

IV. **Audit Findings and History:**
Of the records reviewed for DETOX Program, CPEP Division, the program met and exceeded standards for 8 of the 9 elements reviewed with an overall Score of 98%. Audit findings revealed deficiencies in appropriate primary codes for follow-up client encounters. Provider(s) indicated Multiple Intake Assessment code (90792) for the same client within the same line of service.

V. **Recommendations:**
It is recommended that the Vice President (VP) of Comprehensive Psychiatric Emergency Services review the findings and collaborate with the appropriate personnel to assess and ensure physician services are documented in accordance with Information Item V, TAC, CPT, CMS, E/M guidelines and Agency P&P. Compliance will review provider documentation and coding in the next one hundred eighty (180) days to ensure the program has implemented its POI pertaining to accurate primary coding for DETOX services, including reviewing documentation from a credentialed professional coder. The VP of Mental Health Medical Services must return a signed copy acknowledging receipt of this report to Compliance within three (3) business days.

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary
Revenue Management (PES Program) Focused Billing & Claims Review
Review Dates: 06/25/2024 to 08/22/2024

I. **Audit Type:**
Focused Review

II. **Purpose:**
The purpose of this review was to assist the Revenue Management Department asses billing & claims practices for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (TAC §355.8061, §355.8091, §355.743, §355.781) and Agency Policy and Procedures (P&P) *(EM.P.4, ACC.A.13, FM.B.10, FM.B.11, MED.B.6, LD.A.13)* as it pertains to programs serving persons within (PES) Psychiatric Emergency services.

III. **Audit Method:**
Compliance ran the *Compliance PB Transaction Repor*t in the Electronic Health Record (EHR) system to identify an appropriate sample size for persons served during the 2nd Qtr. of FY 2024 (02/01/2024 – 02/29/2024). Compliance reviewed client encounters containing physician documentation for service codes 99702, 99212, 99213, 99214 and 99215. Sample size was obtained on 08/06/2024. This desk review was conducted using the *Compliance Billing Audit Review* Tool. Detailed data for the services reviewed are presented in the findings section below.

IV. **Audit Findings and History:**
Of the records and transaction details reviewed for the PES Program, the program met and exceeded standards for 14 of the 14 elements reviewed with an overall Score of 100%.

V. **Recommendations:**
It is recommended that the Vice President (VP) of Revenue Cycle and Grants review the findings and collaborate with the appropriate personnel to assess and ensure physician and other QMHP services are billed, and claims are filed and collected in a timely and accurate manner in accordance with Information Item V, TAC, CPT, CMS, E/M guidelines and Agency P&P. Current Medical Billing and Claims audit findings satisfy the minimum threshold score and as such, no Plan of Improvement is necessary. Compliance will continue to provide essential support to the Revenue Management team regarding medical billing and claims documentation, including review of documentation from a credentialed professional coder. The VP of Revenue Cycle and Grants must return a signed copy acknowledging receipt of this report to Compliance within three (3) business days.

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Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Revenue Management Division
Psychiatric Emergency Services (PES) Program
Medical Billing & Claims Review

Compliance Auditor(s): Prakash Thomas

Compliance Review: 06/25/2024 to 08/22/2024

Purpose

The purpose of this review was to assist the Revenue Management Division asses billing & claims practices for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 AMA Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (TAC §355.8061, §355.8091, §355.743, §355.781) and Agency Policy and Procedures (P&P) *(EM.P.4, ACC.A.13, FM.B.10, FM.B.11, MED.B.6, LD.A.13)* as it pertains to programs serving persons within Mental Health facilities.

Method

Active records were randomly selected by generating the *Compliance PB Transaction Report* in the EPIC (EHR) system for persons served during the 2nd Qtr. of FY 2024 (February 1, 2024 – February 29, 2024). Compliance reviewed forty-five (45) client encounters containing qualified mental health care provider documentation for intake codes, crisis service codes, and E/M service codes 99702, 99212, 99213, 99214, 99215, and H2011. Above mentioned sample size was obtained on 08/06/2024. This desk review was conducted using the *Compliance Billing Audit Review Tool.*

Findings

Overall Billing Audit Score (PES Program) – 100%

Medical Billing & Claims documentation and practices met and exceeded expectations in the following areas:

- Servies provided correspond to verified CPT code - 100%
- Services provided correspond to verified Modifier codes - 100%
- Services provided correspond to verified Add-On codes - 100%
- Claim contains appropriate demographics set as detailed in EMR - 100%
- Appropriate Payor approved codes documented within claim - 100%
- Appropriate billing provider details listed within claim - 100%
- Appropriate billing Units documented - 100%

- Services provided are not billed as Duplicate - 100%
- Services provided are not billed as a Bundle - 100%
- Appropriate and verified Copay amount for billed service - 100%
- Appropriate and verified original charges on claim - 100%
- Appropriate and verified Adjustments on claim - 100%
- Appropriate and verified Reimbursement collected - 100%
- Appropriate collections resolution, overpayment verification completed - 100%

Recommendations

It is recommended that the Vice President (VP) of Revenue Cycle and Grants review the findings and collaborate with the appropriate personnel to assess and ensure physician and other QMHP services are billed, and claims are filed and collected in a timely and accurate manner in accordance with Information Item V, TAC, CPT, CMS, E/M guidelines and Agency P&P. Current Medical Billing and Claims audit findings satisfy the minimum threshold score and as such, no Plan of Improvement is necessary. Compliance will continue to provide essential support to the Revenue Management team regarding their documentation of services, including review of documentation from a credentialed professional coder. The VP of Revenue Cycle and Grants must return a signed copy acknowledging receipt of this report to Compliance within three (3) business days.

Management Response:

The Harris Center Staff are trained on the use of CPT codes upon employment with the agency and receive annual training for any coding changes implemented by CMS. The agency is actively recruiting medical coders who will validate 100% of the claims processed daily to ensure the CPT selected is consistent with the clinical documentation.

X Rachel M Beesley

VP of Revenue Cycle

X

Program Director/Manager

X Demetria Luckett

Compliance Director/Manager

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary
Revenue Management (AMH Program) Focused Billing & Claims Review
Review Dates: 06/25/2024 to 08/22/2024

I. **Audit Type:**
Focused Review

II. **Purpose:**
The purpose of this review was to assist the Revenue Management Department asses billing & claims practices for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (TAC §355.8061, §355.8091, §355.743, §355.781) and Agency Policy and Procedures (P&P) *(EM.P.4, ACC.A.13, FM.B.10, FM.B.11, MED.B.6, LD.A.13)* as it pertains to programs serving persons within (AMH) Adult Mental Health services.

III. **Audit Method:**
Compliance ran the AFF HC Encounter Data OP Services Details Report in the Electronic Health Record (EHR) system to identify an appropriate sample size for persons served during the 2nd Qtr. of FY (Fiscal Year) 2024 (01/01/2024 – 01/31/2024). Compliance reviewed client encounters containing physician documentation for service codes 99702, 99212, 99213, 99214 and 99215. Sample size was obtained on 08/06/2024. This desk review was conducted using the *Compliance Billing Audit Review* Tool. Detailed data for the services reviewed are presented in the findings section below.

IV. **Audit Findings and History:**
Of the records and transaction details reviewed for the AMH Program, the program met and exceeded standards for 13 of the 14 elements reviewed with an overall Score of 97%. Audit findings revealed deficiencies pertaining to original bill amount for identified outpatient E/M (evaluation & management) codes. CPT codes attached to identified E/M encounters within EMR are inaccurate and reconciliation between provider and biller is required.

V. **Recommendations:**
Key program/division stakeholders are required to present a Plan of Improvement (POI) during subsequent audits. Compliance will work with division leaders/directors and review Agency P&P in the next one hundred (180) days to ensure the program has implemented its POI. Compliance will continue to provide essential support to the Revenue Management team regarding medical billing and claims documentation, including review of documentation from a credentialed professional coder. The VP (Vice President) of Revenue Cycle and Grants must return a signed copy acknowledging receipt of this report to Compliance within three (3) business days.

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Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Revenue Management Division
Adult Mental Health Services (AMH) Program
Medical Billing & Claims Review

Compliance Auditor(s): Prakash Thomas

Compliance Review: 06/25/2024 to 08/22/2024

Purpose

The purpose of this review was to assist the Revenue Management Division asses billing & claims practices for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 AMA Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (TAC §355.8061, §355.8091, §355.743, §355.781) and Agency Policy and Procedures (P&P) *(EM.P.4, ACC.A.13, FM.B.10, FM.B.11, MED.B.6, LD.A.13)* as it pertains to programs serving persons within Mental Health facilities.

Method

Active records were randomly selected by generating the *Compliance PB Transaction Report* in the EPIC (EHR) system for persons served during the 2nd Qtr. of FY 2024 (January 1, 2024 – January 31, 2024). Compliance reviewed thirty-five (35) client encounters containing qualified mental health care provider documentation for intake codes, crisis service codes, and E/M service codes 99702, 99212, 99213, 99214, 99215, and H2011. Above mentioned sample size was obtained on 08/06/2024. This desk review was conducted using the *Compliance Billing Audit Review Tool.*

Findings

Overall Billing Audit Score (AMH Program) – 97%

Medical Billing & Claims documentation and practices met and exceeded expectations in the following areas:

- Services provided correspond to verified Modifier codes - 100%
- Services provided correspond to verified Add-On codes - 100%
- Claim contains appropriate demographics set as detailed in EMR - 100%
- Appropriate Payor approved codes documented within claim - 100%
- Appropriate billing provider details listed within claim - 100%
- Appropriate billing Units documented - 100%

- Services provided are not billed as Duplicate - 100%
- Services provided are not billed as a Bundle - 100%
- Appropriate and verified Copay amount for billed service - 100%
- Appropriate and verified original charges on claim - 100%
- Appropriate and verified Adjustments on claim - 100%
- Appropriate and verified Reimbursement collected - 100%
- Appropriate collections resolution, overpayment verification completed - 100%

Medical Billing & Claims documentation and practices did not meet expectations in the following area:

- Services provided correspond to verified CPT code - 66%

  Findings pertain to original bill amount for identified outpatient E/M (evaluation & management) codes. CPT codes attached to identified E/M encounters within EMR are inaccurate and reconciliation between provider and biller is required.

Recommendations

It is recommended that the Vice President (VP) of Revenue Cycle and Grants review the findings and collaborate with the appropriate personnel to assess and ensure physician and other QMHP services are billed, and claims are filed and collected in a timely and accurate manner in accordance with Information Item V, TAC, CPT, CMS, E/M guidelines and Agency P&P. Key program/division stakeholders are required to present a Plan of Improvement (POI) and Compliance will work with division leaders/directors to review medical billing and claims in the next one hundred (180) days to ensure the program has implemented its POI. Compliance will continue to provide essential support to the Revenue Management team regarding their documentation of services, including review of documentation from a credentialed professional coder. The VP of Revenue Cycle and Grants must return a signed copy acknowledging receipt of this report to Compliance within three (3) business days.

Management Response:

The Harris Center Staff are trained on the use of CPT codes upon employment with the agency and receive annual training for any coding changes implemented by CMS. The agency is actively recruiting medical coders who will validate 100% of the claims processed daily to ensure the CPT selected is consistent with the clinical documentation.

X Rachel M Beesley

VP of Revenue Cycle

X

Program Director/Manager

X Demetria Luckett

Compliance Director/Manager

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Crisis Residential Unit (CRU) Operational Review
Review Date: August 5, 2024

I. Audit Type:
Operational Review

II. Purpose:
Compliance conducted annual onsite operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) Crisis Residential Unit (CRU) to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

III. **Audit Method:**
The Compliance Department (Compliance) conducted the annual onsite operational review of the CRU Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed were Accessibility, Appearance, Safety, Infectious Waste, Patient/Consumer/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. Detailed information for the Operational Review was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Share Folder (SharePoint)

IV. Audit Findings and History:
The program met all the criteria within seven days (7) of the review. The Compliance Department previously performed an operational review of CRU during the 4th Qtr. FY 2023.

V. Recommendations:
The program manager or designees should remain informed of their program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division signed and returned the report to the Compliance Department by September 11, 2024, acknowledging receipt and review of the information presented.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Operational Review Report:
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP)
Crisis Residential Unit (CRU)
Operational Review

Compliance Auditor(s): Christopher Beard and Prakash Thomas

Review Date: August 5, 2024

Purpose

Compliance conducted the annual onsite operational review to assess The Harris Center for Mental Health and IDD (The Harris Center) Crisis Residential Unit Caroline and Southmore locations to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes best practices in the workplace.

Method

Compliance conducted the annual operational review of the CRUs during the 4th Qtr. of FY 2024. The program manager was provided an entrance email and a copy of the operational review tool and was notified of the date and time of the review, as well as the compliance auditors' names and contact information. The program was provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are identified below:

- Accessibility
- Appearance
- Safety and Infectious Waste
- Patient/Consumer/Consumer Service
- Confidentiality
- Required Postings and Documentation
- Environmental

After the review, detailed information for the Operational Review was presented to the program manager and posted in the appropriate program subfolders of the Compliance Shared Folder (SharePoint).

Findings

The program met all the criteria within seven days (7) of the review.

History

Compliance previously conducted an operational review during the 4th Qtr. FY 2023.

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Recommendations

The program manager or designee should remain informed of the program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division must sign this report and return it to the Compliance Department by September 11, 2024, acknowledging receipt and review of the information presented in this report.

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Signature Page

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Vice President of CPEP Division

X Demetria Luckett

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Jail Diversion Program Operational Review
Review Date: August 5, 2024

I. **Audit Type:**
Operational Review

II. **Purpose:**
Compliance conducted annual onsite operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center Step Down Program to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

III. **Audit Method:**
The Compliance Department (Compliance) conducted the annual onsite operational review of the Jail Diversion Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed were Accessibility, Appearance, Safety, Infectious Waste, Patient/Consumer/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. Detailed information for the Operational Review was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Share Folder (SharePoint)

IV. **Audit Findings and History:**
Overall Program Score: 100%
The program met all the criteria within seven days (7) of the review. The Compliance Department had not previously performed an operational review of the Jail Diversion program.

V. **Recommendations:**
The program manager or designee should remain informed of the program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division must sign this report and return it to the Compliance Department, acknowledging receipt and review of the information presented in this report.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Operational Review Report:
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP)
Jail Diversion Program
Operational Review

Compliance Auditor(s): Christopher Webb

Review Date: August 5, 2024, to August 5, 2024

Purpose

Compliance conducted annual onsite Operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) Jail Diversion Program to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

Method

The Compliance Department (Compliance) conducted the annual onsite operational review of the Jail Diversion Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are identified below:

- Accessibility
- Appearance
- Safety and Infectious Waste
- Patient/Consumer/Consumer Service
- Confidentiality
- Required Postings and Documentation
- Environmental

Detailed information for the Operational Reviews was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Shared Folder (SharePoint).

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Findings

The) program met all the criteria within seven days (7) of the review.

History

The Compliance Department previously performed an operational review of the Jail Diversion Program.

Recommendations

The program manager or designees should be informed of their specific program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division must sign this report and return it to the Compliance Department by August 27, 2024, acknowledging receipt and review of the information presented in this report.

The HARRIS CENTER for Mental Health and IDD

Signature Page

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Vice President of CPEP Division

X Demetria Luckett

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Psychiatric Emergency Services (PES) Operational Review
Review Date: August 6, 2024

I. Audit Type:
Operational Review

II. Purpose:
Compliance conducted annual onsite operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) Psychiatric Emergency Services (PES) to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

III. **Audit Method:**
The Compliance Department (Compliance) conducted the annual onsite operational review of the PES Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed were Accessibility, Appearance, Safety, Infectious Waste, Patient/Consumer/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. Detailed information for the Operational Review was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Share Folder (SharePoint)

IV. Audit Findings and History:
The program met all the criteria within seven days (7) of the review. The Compliance Department previously performed an operational review of PES during the 4th Qtr. FY 2023.

V. Recommendations:
The program manager or designee should remain informed of their program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division must sign this report and return it to the Compliance Department by August 27, 2024, acknowledging receipt and review of the information presented in this report.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Operational Review Report:
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP)
Peers Hope House Crisis Respite
Operational Review

Compliance Auditor(s): Emmanuel Golakai & Sharenea Mosley

Review Date: August 5, 2024, to August 5, 2024

Purpose

Compliance conducted annual onsite Operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) Peers for Hope House Crisis Respite to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

Method

The Compliance Department (Compliance) conducted the annual onsite operational review of the Peers for Hope House Crisis Respite Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are identified below:

- Accessibility
- Appearance
- Safety and Infectious Waste
- Patient/Consumer/Consumer Service
- Confidentiality
- Required Postings and Documentation
- Environmental

Detailed information for the Operational Reviews was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Shared Folder (SharePoint).

Findings

The) program met all the criteria within seven days (7) of the review.

History

The Compliance Department previously performed an operational review of Peers for Hope House on 2/20/2019.

Recommendations

The program manager or designees should be informed of their specific program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division must sign this report and return it to the Compliance Department by August 27, 2024, acknowledging receipt and review of the information presented in this report.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Evelyn Locklin 9/5/2024
10B4D93793CD4DA...

Vice President of CPEP Division

X

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Executive Summary Cover Sheet
Mental Health (MH) Division
Southeast Child and Adolescent Services (SECAS)
Operational Review
Review Date: August 5, 2024

I. Audit Type:
Operational Review

II. Purpose:
Compliance conducted annual onsite Operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) Southeast Child and Adolescent Services (SECAS) to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

III. Audit Method:
The Compliance Department (Compliance) conducted the annual onsite operational review of the Southeast Child and Adolescent Services (SECAS) Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are Accessibility, Appearance, Safety/Infectious waste, Consumer Services, Confidentiality, and Postings.

IV. Audit Findings and History:
Overall Program Score: 100%
Detailed finding(s) is presented below.
The program met all operational requirements.

History

The Compliance Department previously performed no operational reviews.

V. Recommendations:
The program manager or designee should be informed of their specific program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the MH Division must sign this report and return it to the Compliance Department within seven (7) business days, acknowledging receipt and review of the information presented in this report.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Operational Review Report: 4th Quarter (Qtr.) of Fiscal Year (FY) 2024 Mental Health (MH) Southeast Child and Adolescent Services (SECAS) Operational Review

Compliance Auditor(s): Marvin Williams

Review Date: August 5, 2024, to August 5, 2024

Purpose

Compliance conducted annual onsite Operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) Southeast Child and Adolescent Services (SECAS) to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

Method

The Compliance Department (Compliance) conducted the annual onsite operational review of the Southeast Child and Adolescent Services (SECAS) Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are identified below:

- Accessibility
- Appearance
- Safety and Infectious Waste
- Patient/Consumer/Consumer Service
- Confidentiality
- Required Postings and Documentation

Detailed information for the Operational Reviews was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Shared Folder (SharePoint).

The HARRIS CENTER for Mental Health and IDD

Findings

The program met all the criteria within seven days (7) of the review.

History

The Compliance Department previously performed no operational reviews.

Recommendations

The program manager or designees should be informed of their specific program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the MH Division must sign this report and return it to the Compliance Department by September 3, 2024, acknowledging receipt and review of the information presented in this report.

Signature Page

X Signed by: Lance Britt BAB06A90B5FE4AC...

Vice President of MH Division

X Signed by: demetria luckett B4ED8213E5ED41A...

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Executive Summary Cover Sheet
Adult Mental Health (AMH) Division
Southeast Community Service Center (SECSC)
Operational Review
Review Date: August 5, 2024

I. Audit Type:
Operational Review

II. Purpose:
Compliance conducted annual onsite Operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) Southeast Community Service Center (SECSC) to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

III. Audit Method:
The Compliance Department (Compliance) conducted the annual onsite operational review of the Southeast Community Service Center (SECSC) Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are Accessibility, Appearance, Safety/Infectious waste, Consumer Services, Confidentiality, and Postings.

IV. Audit Findings and History:
Overall Program Score: 100%
Detailed finding(s) is presented below.
The program met all operational requirements.

History

The Compliance Department previously performed no operational reviews.

V. Recommendations:
The program manager or designee should be informed of their specific program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the MH Division must sign this report and return it to the Compliance Department within seven (7) business days, acknowledging receipt and review of the information presented in this report.

HARRIS CENTER
Mental Health and IDD

Compliance Department (Compliance) Operational Review Report:
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH)
Southeast Community Service Center (SECSC)
Operational Review

Compliance Auditor(s): Marvin Williams

Review Date: August 5, 2024, to August 5, 2024

Purpose

Compliance conducted annual onsite Operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) Southeast Community Service Center (SECSC) to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

Method

The Compliance Department (Compliance) conducted the annual onsite operational review of the Southeast Community Service Center (SECSC) Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are identified below:

- Accessibility
- Appearance
- Safety and Infectious Waste
- Patient/Consumer/Consumer Service
- Confidentiality
- Required Postings and Documentation

Detailed information for the Operational Reviews was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Shared Folder (SharePoint).

HARRIS CENTER
Mental Health and IDD

Findings

The program met all the criteria within seven days (7) of the review.

History

The Compliance Department previously performed no operational reviews.

Recommendations

The program manager or designees should be informed of their specific program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the MH Division must sign this report and return it to the Compliance Department by September 3, 2024, acknowledging receipt and review of the information presented in this report.

HARRIS CENTER
Mental Health and IDD

Signature Page

X Lance Britt

Vice President of MH Division

Brut Danton 9/10/24
PRACTICE MANAGER

X Demetria Luckett

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Step-Down Program Operational Review
Review Date: August 5, 2024

I. **Audit Type:**
Operational Review

II. **Purpose:**
Compliance conducted annual onsite operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) Step Down Program to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

III. **Audit Method:**
The Compliance Department (Compliance) conducted the annual onsite operational review of the Step-Down Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed were Accessibility, Appearance, Safety, Infectious Waste, Patient/Consumer/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. Detailed information for the Operational Review was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Share Folder (SharePoint)

IV. **Audit Findings and History:**
Overall Program Score: 100%
The program met all the criteria within seven days (7) of the review. The Compliance Department had not previously performed an operational review of the Step-Down program.

V. **Recommendations:**
The program manager or designee should remain informed of the program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division must sign this report and return it to the Compliance Department, acknowledging receipt and review of the information presented in this report.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Operational Review Report:
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP)
Step-Down Program
Operational Review

Compliance Auditor(s): Christopher Webb

Review Date: August 5, 2024, to August 5, 2024

Purpose

Compliance conducted annual onsite Operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) Step-Down Program to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

Method

The Compliance Department (Compliance) conducted the annual onsite operational review of the Step-Down Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are identified below:

- Accessibility
- Appearance
- Safety and Infectious Waste
- Patient/Consumer/Consumer Service
- Confidentiality
- Required Postings and Documentation
- Environmental

Detailed information for the Operational Reviews was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Shared Folder (SharePoint).

The HARRIS CENTER for Mental Health and IDD

Findings

The) program met all the criteria within seven days (7) of the review.

History

No previously performed operational review for this program.

Recommendations

The program manager or designees should be informed of their specific program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division must sign this report and return it to the Compliance Department by August 27, 2024, acknowledging receipt and review of the information presented in this report.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X _____

Vice President of CPEP Division

X Demetria Luckett

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Crisis Stabilization Unit (CSU) Operational Review
Review Date: August 6, 2024

I. Audit Type:
Operational Review

II. Purpose:
Compliance conducted annual onsite operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) Crisis Stabilization Unit (CSU) to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

III. **Audit Method:**
The Compliance Department (Compliance) conducted the annual onsite operational review of the CSU Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed were Accessibility, Appearance, Safety, Infectious Waste, Patient/Consumer/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. Detailed information for the Operational Review was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Share Folder (SharePoint)

IV. Audit Findings and History:
The program met all the criteria within seven days (7) of the review. The Compliance Department previously performed an operational review of CSU during the 4th Qtr. FY 2023.

V. Recommendations:
The program manager or designees should remain informed of their program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division signed and returned the report to the Compliance Department by September 11, 2024, acknowledging receipt and review of the information presented.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Operational Review Report:
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP)
Crisis Stabilization Unit (CSU)
Operational Review

Compliance Auditor(s): Christopher Beard, Prakash Thomas, and Olivia Mosley

Review Date: August 6, 2024

Purpose

Compliance conducted the annual onsite operational review to assess The Harris Center for Mental Health and IDD (The Harris Center) Crisis Stabilization Unit to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes best practices in the workplace.

Method

Compliance conducted the annual operational review of the CSU during the 4th Qtr. of FY 2024. The program manager was provided an entrance email and a copy of the operational review tool and was notified of the date and time of the review, as well as the compliance auditors' names and contact information. The program was provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are identified below:

- Accessibility
- Appearance
- Safety and Infectious Waste
- Patient/Consumer/Consumer Service
- Confidentiality
- Required Postings and Documentation
- Environmental

After the review, detailed information for the Operational Review was presented to the program manager and posted in the appropriate program subfolders of the Compliance Shared Folder (SharePoint).

Findings

The program met all the criteria within seven days (7) of the review.

History

Compliance previously conducted an operational review during the 4th Qtr. FY 2023.

The HARRIS CENTER for Mental Health and IDD

Recommendations

The program manager or designee should remain informed of the program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division must sign this report and return it to the Compliance Department by September 11, 2024, acknowledging receipt and review of the information presented in this report.

The HARRIS CENTER for Mental Health and IDD

Signature Page

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Vice President of CPEP Division

X Demetria Luckett

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Psychiatric Emergency Services (PES) Operational Review
Review Date: August 6, 2024

I. Audit Type:
Operational Review

II. Purpose:
Compliance conducted annual onsite operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) Psychiatric Emergency Services (PES) to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practices in the workplace.

III. **Audit Method:**
The Compliance Department (Compliance) conducted the annual onsite operational review of the PES Program during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2024. The Program Manager was provided an entrance email, copies of the operational review tools, and notified of the date and time of the review and the compliance auditors' names and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed were Accessibility, Appearance, Safety, Infectious Waste, Patient/Consumer/Consumer Service, Confidentiality, Required Postings and Documentation, and Environmental. Detailed information for the Operational Review was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Share Folder (SharePoint)

IV. Audit Findings and History:
The program met all the criteria within seven days (7) of the review. The Compliance Department previously performed an operational review of PES during the 4th Qtr. FY 2023.

V. Recommendations:
The program manager or designees should remain informed of their program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division signed and returned the report to the Compliance Department by September 11, 2024, acknowledging receipt and review of the information presented.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Operational Review Report:
4th Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP)
Psychiatric Emergency Services (PES) Program
Operational Review

Compliance Auditor(s): Christopher Beard, Prakash Thomas, and Olivia Mosley

Review Date: August 6, 2024

Purpose

Compliance conducted the annual onsite operational review to assess The Harris Center for Mental Health and IDD (The Harris Center) Psychiatric Emergency Services (PES) Program to ensure the program meets regulatory guidelines, city ordinances, and State and Federal labor laws and promotes best practices in the workplace.

Method

Compliance conducted the annual operational review of the PES Program during the 4th Qtr. of FY 2024. The program manager was provided an entrance email and a copy of the operational review tool and was notified of the date and time of the review, as well as the compliance auditors' names and contact information. The program was provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are identified below:

- Accessibility
- Appearance
- Safety and Infectious Waste
- Patient/Consumer/Consumer Service
- Confidentiality
- Required Postings and Documentation
- Environmental

After the review, detailed information for the Operational Review was presented to the program manager and posted in the appropriate program subfolders of the Compliance Shared Folder (SharePoint).

Findings

The program met all the criteria within seven days (7) of the review.

History

Compliance previously conducted an operational review during the 4th Qtr. FY 2023.

The HARRIS CENTER for Mental Health and IDD

Recommendations

The program manager or designee should remain informed of the program's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division must sign this report and return it to the Compliance Department by September 11, 2024, acknowledging receipt and review of the information presented in this report.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Kim Kg

Vice President of CPEP Division

X Demetria Luckett

Compliance Director

The Harris Center for Mental Health and IDD
Transforming Lives

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Crisis Stabilization Unit (CSU) Comprehensive Review
Review Dates: May 21, 2024-June 21, 2024

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if client and staff records, service provision to persons served, and policies and procedures complied with the Texas Administrative Code (TEX. ADMIN. CODE) *Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 25 TEX. ADMIN. CODE §§ 404.161 (d)-(f); Patient's Bill of Rights, Teen's Bill of Rights, and Children's Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals 25 TEX. ADMIN. CODE §§ 404.162 (e)-(f); Communication of Rights to Individuals Receiving Mental Health Services 25 TEX. ADMIN. CODE §§ 404.163 (a)-(d); Rights Protection Officer at Department Facilities and Community Centers 25 TEX. ADMIN. CODE § 404.164 (b); Staff Training in Rights of Persons Receiving Mental Health Services 25 TEX. ADMIN. CODE § 404.165; Documentation of Informed Consent 25 TEX. ADMIN. CODE § 414.405; Monitoring Compliance with Policies and Procedures 25 TEX. ADMIN. CODE § 414.413; General Requirements for Use of Restraint and Seclusion 25 TEX. ADMIN. CODE §§ 415.254 (c)-(d); Staff Member Training 25 TEX. ADMIN. CODE §§ 415.257 (c)(5)-(d)(3)* and *(i); Documenting, Reporting, and Analyzing Restraint and Seclusion 25 TEX. ADMIN. CODE § 415.272 (a); Competency and Credentialing 26 TEX. ADMIN. CODE §§ 301.331 (a)(3)(A)-(B); Crisis Services 26 TEX. ADMIN. CODE §301.351 (e) Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353 (e); Supervision 26 TEX. ADMIN. CODE § 301.363 (a)(1); MH Case Management Services Standards 26 TEX. ADMIN. CODE § 306.263 (b); Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275 (c); General Provisions 26 TEX. ADMIN. CODE § 306.47; Admission Criteria 26 TEX. ADMIN. CODE § 306.51; Pre-admission Screening and Assessment 26 TEX. ADMIN. CODE §§ 306.53 (a)(3)-(e); Voluntary Admission Criteria and Intake Process 26 TEX. ADMIN. CODE §§ 306.55 (c)* and *(d)(3)-(5); Crisis Stabilization Unit Medical Services 26 TEX. ADMIN. CODE §§ 306.61 (d)-(f)* and *(h); Crisis Stabilization Unit Nursing Services 26 TEX. ADMIN. CODE §§ 306.63 (b)-(d); Crisis Stabilization Services and Recovery or Treatment Planning 26 TEX. ADMIN. CODE §§ 306.65 (b)* and *(d)-(f);Discharge Planning 26 TEX. ADMIN. CODE §§ 306.71 (a)-(b)* and *(e); Discharge Notices 26 TEX. ADMIN. CODE § 306.73 (c); Medical Record 26 TEX. ADMIN. CODE § 306.81; Staff Training 26 TEX. ADMIN. CODE §§ 306.83 (f)-(i)* and *(l); Minimum Staffing Requirements 26 TEX. ADMIN. CODE §§ 306.85 (b)-(c); Protection of an Individual Receiving Crisis Stabilization Unit Services 26 TEX. ADMIN. CODE § 306.87 (b); Crisis Stabilization Unit Response to an Emergency Medical Condition 26 TEX. ADMIN. CODE §§ 306.89 (a)(2)-(b)* and *(e)-(g); Fire Prevention and Safety Requirements 26 TEX. ADMIN. CODE §§ 510.101 (d)* and *(f)-(g); General Safety § 510.102 (b); Facility Functions and Services §§ 510.41 (d), (d)(1), (d)(1)(A), (d)(1)(C), (d)(3), (f)(1)-(f)(6)(A),* and *(f)(6)(D); Discrimination or Retaliation Standards 26 TEX. ADMIN. CODE § 510.42 (a); Abuse and Neglect Issues 26 TEX. ADMIN. CODE § 510.46 (c)(2);* and *The Harris Center Policies and Procedures ACC.B.2 Plan of Care; ACC.B.8 Referral, Transfer, and Discharge; HIM.EHR.B.5 Content of Patient/Individual Record; HIM.EHR.9 Patient/Individual Records Administration; MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention; RR.B.2 Assurance of Individual Rights;* and *required employee training courses.*

III. Audit Method:
An active client roster and employee roster were requested from and provided by program leadership. Twenty (20) clients and three (3) employees were selected by utilizing an Excel formula to generate a random number list. Client records from the 2nd Qtr. FY 2024 (December 1, 2023-February 29, 2024), were reviewed. The review utilized an audit tool developed by Compliance.

IV. Audit Findings/History:
Compliance noted the program's operational guidelines did not contain all elements mandated by TEX. ADMIN. CODE or Item V; staff were not trained or recertified in screening and assessment tasks; discharge planning was not being completed; discharge planning activities were not documented; intake assessments, nursing assessments, treatment plans, progress notes, and crisis services did not include all required information; and medication consent documents were not completed appropriately. Compliance has not previously audited the CSU Program.

V. Recommendations:
The Program should continue to review client documentation (e.g., progress notes, treatment plans, admission documentation, and discharge documentation), employee records (i.e., annual training requirements), and program documentation (i.e., operational guidelines) for compliance with regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this report.

The HARRIS CENTER
Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP) Division
Crisis Stabilization Unit (CSU) Program Comprehensive Review

Compliance Auditor(s): Christopher Beard

Review Dates: May 21, 2024-June 21, 2024

Purpose

This review was conducted to determine if the CSU Program was compliant with the Texas Administrative Code (TAC) *Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 25 TAC §§ 404.161 (d)-(f); Patient's Bill of Rights, Teen's Bill of Rights, and Children's Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals 25 TAC §§ 404.162 (e)-(f); Communication of Rights to Individuals Receiving Mental Health Services 25 TAC §§ 404.163 (a)-(d); Rights Protection Officer at Department Facilities and Community Centers 25 TAC § 404.164 (b); Staff Training in Rights of Persons Receiving Mental Health Services 25 TAC § 404.165; Documentation of Informed Consent 25 TAC § 414.405; Monitoring Compliance with Policies and Procedures 25 TAC § 414.413; General Requirements for Use of Restraint and Seclusion 25 TAC §§ 415.254 (c)-(d); Staff Member Training 25 TAC §§ 415.257 (c)(5)-(d)(3)* and *(i); Documenting, Reporting, and Analyzing Restraint and Seclusion 25 TAC § 415.272 (a); Competency and Credentialing 26 TAC §§ 301.331 (a)(3)(A)-(B); Crisis Services 26 TAC §301.351 (e) Provider Responsibilities for Treatment Planning and Service Authorization 26 TAC § 301.353 (e); Supervision 26 TAC § 301.363 (a)(1); MH Case Management Services Standards 26 TAC § 306.263 (b); Documenting MH Case Management Services 26 TAC § 306.275 (c); General Provisions 26 TAC § 306.47; Admission Criteria 26 TAC § 306.51; Pre-admission Screening and Assessment 26 TAC §§ 306.53 (a)(3)-(e); Voluntary Admission Criteria and Intake Process 26 TAC §§ 306.55 (c)* and *(d)(3)-(5); Crisis Stabilization Unit Medical Services 26 TAC §§ 306.61 (d)-(f)* and *(h); Crisis Stabilization Unit Nursing Services 26 TAC §§ 306.63 (b)-(d); Crisis Stabilization Services and Recovery or Treatment Planning 26 TAC §§ 306.65 (b)* and *(d)-(f);Discharge Planning 26 TAC §§ 306.71 (a)-(b)* and *(e); Discharge Notices 26 TAC § 306.73 (c); Medical Record 26 TAC § 306.81; Staff Training 26 TAC §§ 306.83 (f)-(i)* and *(l); Minimum Staffing Requirements 26 TAC §§ 306.85 (b)-(c); Protection of an Individual Receiving Crisis Stabilization Unit Services 26 TAC § 306.87 (b); Crisis Stabilization Unit Response to an Emergency Medical Condition 26 TAC §§ 306.89 (a)(2)-(b)* and *(e)-(g); Fire Prevention and Safety Requirements 26 TAC §§ 510.101 (d)* and *(f)-(g); General Safety § 510.102 (b); Facility Functions and Services §§ 510.41 (d), (d)(1), (d)(1)(A), (d)(1)(C), (d)(3), (f)(1)-(f)(6)(A),* and *(f)(6)(D); Discrimination or Retaliation Standards 26 TAC § 510.42 (a); Abuse and Neglect Issues 26 TAC § 510.46 (c)(2);* and *The Harris Center Policies and Procedures ACC.B.2 Plan of Care; ACC.B.8 Referral, Transfer, and Discharge; HIM.EHR.B.5 Content of Patient/Individual Record; HIM.EHR.9 Patient/Individual Records Administration; MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention; RR.B.2 Assurance of Individual Rights;* and *required employee training courses.*

HARRIS CENTER
Mental Health and IDD

Methods

A client roster that included persons served during the 2nd Qtr. FY 2024 (December 1, 2023-February 29, 2024) and an employee roster was requested from and provided by program leadership. Twenty (20) client records were selected by using an Excel formula to generate a random number list. Three (3) employee records were reviewed. The review utilized an audit tool developed by Compliance. It consisted of five (5) components: policy and procedure requirements (policy), environment requirements (environment), medical requirements (medical), personnel requirements (personnel), and client record requirements (client records).

Findings

Overall Score: 81%
Detailed findings are presented below:

Strengths:

• Medical requirements (*TAC §§ 306.61, 63,* and *89*; and *TAC § 510.41*)	**100%**
• Environment requirements (*TAC §§ 306.85* and *87*; *TAC § 404.164*; and *TAC § 510.41, 42, 46,* and *101*)	**95%**

Areas of Improvement:

• Policy requirements (*TAC §§ 306.47, 51, 53, 85,* and *89*; *TAC §§ 404.161* and *162*; *TAC § 414.413*; *TAC §§ 415.254* and *272*; *TAC §§ 510.41, 101,* and *102;* and *RR.B.2*)	**77%**
• Personnel requirements (*TAC §§ 301.331* and *363; TAC § 306.83; TAC § 404.165; TAC § 415.257*; *MED.MH.B.1;* and *Agency training requirements*)	**57%**
• Client Records (*TAC §§ 301.351* and *353; TAC §§ 306.53, 55, 61, 63, 65, 71, 73, 81, 263* and *275; TAC §§ 404.161, 162,* and *163; TAC § 414.405; HIM.EHR.B.5; ACC.B.8; HIM.EHR.B.9; ACC.B.2;* and *RR.B.2)*	**74%**

Observations

- Case management services were not documented during the review period.

History

Compliance has not previously audited the CSU Program.

Recommendations

The Program should continue to review client documentation (e.g., progress notes, treatment plans, admission documentation, and discharge documentation), employee records (i.e., annual training requirements), and program documentation (i.e., operational guidelines) for compliance with regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice

HARRIS CENTER for Mental Health and IDD

President of the CPEP Division and the CSU Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days (July 26, 2024).

Management Response

Staff (social services, nursing, and MDs) will be informed on findings of comprehensive review. Staff will be educated on expectations and required to complete any expired trainings within the next 90 days. Trainings can be tracked in SABA and with training department as applicable. Findings regarding updating and implanting written policies will be completed by PD within the next 90 days.

The HARRIS CENTER
Mental Health and IDD

Signature Page

X

Vice President of CPEP Division

X Rachel Richards

Program Director/Manager

X Demetria Luckett

Director of Compliance

, The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Substance Use Recovery Services Comprehensive Review
Review Date: June 13, 2024, to July 27, 2024

I. Audit Type:
Comprehensive Review

II. Purpose:
This review was conducted to determine if the Substance Use Recovery Services Program was compliant with the Responding to Emergencies *26 TAC §564.707, Requirements Applicable to Detoxification Services 26 TAC §564.905(a)(8), Substance Use Program Guide 14 Quality Management Policies and Procedures, Substance Use Guide 8 Interim Services, Treatment for Adult (TRA), Statement of Work (SOW) V Levels of Care Ambulatory Withdrawal Management Services F.1-F2, TRA SOW III, Service Requirements Administrative Requirements A.8-11, TRA SOW IV Staff Competencies and Requirements 6-10, 13, Treatment for Female (TRF) Statement of Works (SOW) III Service Requirements, Additional Service Requirements F.4, F6, F.8-F.14, TRF SOW IV Levels of Care/Service Types Outpatient Treatment Services A.1-A6, TRF SOW III Service Requirements Administrative Requirements A.1-A.9, A.11, TRF SOW IV Staff Competences and Requirements 12,TRF SOW III Service Requirements Administrative Requirements A.13, Hiring Practices 26 TAC §564.601, Substance Use Program Guide 9 Personnel Requirements and Documentation 1,2 and 4, Training 26 TAC §564.603 (d) Training 26 TAC §564.603.4-7,TRF SOW IV Staff Competencies and Requirements 6-10, 14-15 and Documentation of Service Provision 26 TAC §301.361.*

III. **Audit Method:**
A client roster that included persons served during the 3rd Qtr. FY 2024 (March 1, 2024-May 31, 2024) and an employee roster was requested from and provided by program leadership. Twenty (20) clients were randomly selected, forty-two (42) progress notes were reviewed, and seven (7) employee training records, License Verification, and credentials were provided to Compliance by the Human Resources (HR) Department. The review utilized an audit tool developed by the Health and Human Service Commission (HHSC) and consisted of twelve (12) components: CAP Summary, Policy and Procedure, Prior Population Wait List, TRA Record Review, TRA Program Review, TRA Personnel, TRF Record Review, TRF Program Review, TRF Personnel, Environmental, Progress Note and Documentation of Service Provision.

IV. Audit Findings and History:
The overall score is 94%. The program's strengths were Prior Population, Waitlist and Interim Services, Treatment for Adults (TRA), Treatment for Adult Personnel, Environmental, and Treatment for Females (TRF). The Program scored 100% in all of these areas. The areas of improvement included Policy and procedures 93%, Treatment for Adult records 93%, Treatment for Female Records 85%, Treatment for Female Personnel 77%, and documentation of Service Provision 89%. During the environmental walkthrough, the Program Director aided the Auditor when needed at each of the Program's four location. The Program Manual was neatly organized and user-friendly. Texas Health and Human Services Commission Inspectors reviewed the program sites, outpatient clients, client records, employee files, program policies, and procedures from August 9, 2024, to August 11, 2023.

V. Recommendations:
The Program should continue to maintain an updated manual that includes policies and procedures required by HHSC, ensure Screening is done face to face with clients, provide evidence-based education, ensure client records reflect that the program provides trauma-informed services, overdose prevention, document one hour of a group or individual counseling services for every six hours of educational services, training, and credentials are updated as required by contract and progress notes comply with Texas Administrative Code and SURS contract, A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the MH Division and the SURS Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days

HARRIS CENTER
Mental Health and IDD

Compliance Department (Compliance) Review Report
4th (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH)) Division
Substance Use Recovery Services (SURS) Comprehensive Review

Compliance Auditor(s): Emmanuel Golakai

Review Dates: June 13, 2024-July27, 2024

Purpose

This review was conducted to determine if the Substance Use Recovery Services Program was compliant with the Responding to Emergencies *26 TAC §564.707, Requirements Applicable to Detoxification Services 26 TAC §564.905(a)(8), Substance Use Program Guide 14 Quality Management Policies and Procedures, Substance Use Guide 8 Interim Services, Treatment for Adult (TRA), Statement of Work (SOW) V Levels of Care Ambulatory Withdrawal Management Services F.1-F2, TRA SOW III, Service Requirements Administrative Requirements A.8-11, TRA SOW IV Staff Competencies and Requirements 6-10, 13, Treatment for Female (TRF) Statement of Works (SOW) III Service Requirements, Additional Service Requirements F.4, F6, F.8-F.14, TRF SOW IV Levels of Care/Service Types Outpatient Treatment Services A.1-A6, TRF SOW III Service Requirements Administrative Requirements A.1-A.9, A.11, TRF SOW IV Staff Competences and Requirements 12,TRF SOW III Service Requirements Administrative Requirements A.13, Hiring Practices 26 TAC §564.601, Substance Use Program Guide 9 Personnel Requirements and Documentation 1,2 and 4, Training 26 TAC §564.603 (d) Training 26 TAC §564.603.4-7,TRF SOW IV Staff Competencies and Requirements 6-10, 14-15 and Documentation of Service Provision 26 TAC §301.361.*

Methods

A client roster that included persons served during the 3rd Qtr. FY 2024 (March 1, 2024-May 31, 2024) and an employee roster was requested from and provided by program leadership. Twenty (20) clients were randomly selected, forty-two (42) progress notes were reviewed, and seven (7) employee training records, License Verification, and credentials were provided to Compliance by the Human Resources (HR) Department. The review utilized an audit tool developed by the Health and Human Service Commission (HHSC) and consisted of twelve (12) components: CAP Summary, Policy and Procedure, Prior Population Wait List, TRA Record Review, TRA Program Review, TRA Personnel, TRF Record Review, TRF Program Review, TRF Personnel, Environmental, Progress Note and Documentation of Service Provision.

Findings

Overall Score:94 %
Detailed findings are presented below:

Strengths:

• Prior Population, Wait List, and Intern Services ***(Substance Use Program Guide 8 Interim Services***	100%
• Treatment for Adult Program Review (***TRA SOW III Service Requirements & Administrative Requirements A.1-11, D7-10***)	100%
• Treatment for Adult Personnel ***(TRA SOW IV Staff Competencies and Requirements 6-13)***	100%
• Environmental ***(26 TAC 564.1001-10, TRA, TRA 2022 SOW Section V)***	100%
• Treatment for Female Program Review **(TRF SOW III Service Requirements Administrative Requirements (A.2, A.4(A.2) (A.5) (A.6)(A.7)(A.8)(A.11)(A.12)(A.13), TRF SOW III)**	100%

Areas of Improvement:

• Policy and Procedures ***1TAC392.511, 26TAC564.502(504) (507), ,26 TAC 564.509 (a-b) (c-f), 26TAC 564.510, 26 TAC 564.701(a), 26 TAC 702 (a-b) (703) (704) (707), 26 TAC 564.905(a)(8), Substance Use Program Guide 14***	93%
• Treatment for Adult Record Review (***TRA SOW III Service Requirements, Screening and Assessment C.1-12) (D.1-3, TRA SOW Section V(D6), TRA SOW V (F.2), 26 TAC 564. 902. g***	93%
• Treatment for Female Record Review ***(FRF SOW III Service Requirements, Screening and Assessment C.1), TRF SOW II Target Population Treatment for Female (TRF)A, TRFSOW II Target Population Treatment for Women and children B, TAC 26 564.910(h), TRF SOW II Service Requirements Screening and Assessment (c.2) (3) (F.4) (6)(7) (d.1)***	85%
• Treatment for Female Personnel Review ***(26 TAC 564.601) (603) (d) (603.7), Substance Use Program Guide 9 Personnel Requirements and Documentation 1,24,5, TRF SOW IV Staff Competencies and Requirements 2-3,6-7,8-9,10,14,15***	77%
• Documentation of Service Provision ***26 TAC 301.361***	89%

Observations

- During the environmental Walkthrough, the Program Director aided when needed at each of the program's four locations. The Program manual was nearly organized and user-friendly.

History

Texas Health and Human Services Commission (HHSC) Inspectors reviewed the Substance Use Disorder program sites from August 9, 2023, to August 11, 2023. The outpatient clients, client

records, employee files, program policies and procedures, and physical site inspections were reviewed to determine the compliance status. The program was out of compliance with the following: the display of licensure certificates in the outpatient locations; the facilities had incomplete ADA self-inspections; the facilities did not have the bill of rights posted; pre-employment drug tests were missing from employee records, and there was no orientation training in employee records. The programs did not use the screening process appropriate for the target population to determine eligibility, and there were no authorizations or consent forms for treatment during admission. A discharge plan was not developed for several clients. The program provided services by electronic means, and there was no documentation. The program was required to submit a written response within twenty (20) business days by 11/10/2023.

Recommendations

- The Program should continue to maintain an updated manual that includes policies and procedures required by HHSC, ensure Screening is done face to face with clients, provide evidence-based education, ensure client records reflect that the program provides trauma-informed services, overdose prevention, document one-hour of a group or individual counseling services for every six hours of educational services, training, and credentials are updated as required by contract and progress notes comply with Texas Administrative Code and SURS contract, A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the MH Division and the SURS Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days (August 23, 2024).

Management Response

The HARRIS CENTER for Mental Health and IDD

Signature Page

Recoverable Signature

X

Vice President of HM Division
Signed by: Lance Britt

X

Program Director/Manager

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Jail Diversion (JD) Comprehensive Review
Review Dates: July 15, 2024-July 22, 2024

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if client and staff records, service provision to persons served, and policies and procedures complied with the Texas Administrative Code (TEX. ADMIN. CODE) *Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 25 TEX. ADMIN. CODE §§ 404.161 (d)-(f); Patient's Bill of Rights, Teen's Bill of Rights, and Children's Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals 25 TEX. ADMIN. CODE §§ 404.162 (e)-(f); Communication of Rights to Individuals Receiving Mental Health Services 25 TEX. ADMIN. CODE §§ 404.163 (a)-(d); Rights Protection Officer at Department Facilities and Community Centers 25 TEX. ADMIN. CODE § 404.164 (b); Documentation of Informed Consent 25 TEX. ADMIN. CODE § 414.405; Competency and Credentialing 26 TEX. ADMIN. CODE §§ 301.331 (a)(3)(A)-(B); Crisis Services 26 TEX. ADMIN. CODE §301.351 (e); Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353 (a), (e),* and *(h); Documentation of Service Provision 26 TEX. ADMIN. CODE §§ 301.361 (a)-(b); Supervision 26 TEX. ADMIN. CODE § 301.363 (a)(1); MH Case Management Services Standards 26 TEX. ADMIN. CODE § 306.263 (b); Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275 (c); the Texas Health and Human Services Commission Information Item V Section VI Crisis Respite Services;* and *The Harris Center Policies and Procedures ACC.B.2 Plan of Care; ACC.B.8 Referral, Transfer, and Discharge; ACC.B.14 Declaration for Mental Health Treatment; HIM.EHR.B.5 Content of Patient/Individual Record; HIM.EHR.B.9 Patient/Individual Records Administration; MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention; RR.B.2 Assurance of Individual Rights;* and *required employee training courses.*

III. Audit Method:
An active client roster and an employee roster were requested from and provided by program leadership. Twenty (20) clients and five (5) employees were selected by utilizing an Excel formula to generate a random number list. Client records from the 3rd Qtr. FY 2024 (March 1, 2024-May 31, 2024), were reviewed. The review utilized an audit tool developed by Compliance.

IV. Audit Findings/History:
Compliance noted the program was not conducting monthly supervision meetings with employees; was not completing treatment plans or case management; was not offering persons served a Declaration of Mental Health Treatment; was not completing all sections of the crisis assessment or admission assessment; was not fulfilling requirements of progress note criteria; was not completing discharge summaries; and were not appropriately completing medication consent documents. Compliance has not previously audited the JD Program.

V. Recommendations:
The Program should continue to review client documentation (e.g., progress notes, treatment plans, admission documentation, and discharge documentation) and program documentation (i.e., operational guidelines) for compliance with regulatory standards. Program leadership should ensure the appropriate staff complete treatment plans as soon as possible after admission to ensure case management is provided to persons served by the program. A Plan of Improvement (POI) is required to address the deficiencies noted during this review.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
4th (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP) Division
Jail Diversion (JD) Program Comprehensive Review

Compliance Auditor(s): Christopher Beard

Review Dates: July 15, 2024-July 22, 2024

Purpose

This review was conducted to determine if the JD Program was compliant with the Texas Administrative Code (TAC) *Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 25 TAC §§ 404.161 (d)-(f); Patient's Bill of Rights, Teen's Bill of Rights, and Children's Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals 25 TAC §§ 404.162 (e)-(f); Communication of Rights to Individuals Receiving Mental Health Services 25 TAC §§ 404.163 (a)-(d); Rights Protection Officer at Department Facilities and Community Centers 25 TAC § 404.164 (b); Documentation of Informed Consent 25 TAC § 414.405; Competency and Credentialing 26 TAC §§ 301.331 (a)(3)(A)-(B); Crisis Services 26 TAC §301.351 (e); Provider Responsibilities for Treatment Planning and Service Authorization 26 TAC § 301.353 (a), (e),* and *(h); Documentation of Service Provision 26 TAC §§ 301.361 (a)-(b); Supervision 26 TAC § 301.363 (a)(1); MH Case Management Services Standards 26 TAC § 306.263 (b); Documenting MH Case Management Services 26 TAC § 306.275 (c); the Texas Health and Human Services Commission Information Item V Section VI Crisis Respite Services;* and *The Harris Center Policies and Procedures ACC.B.2 Plan of Care; ACC.B.8 Referral, Transfer, and Discharge; ACC.B.14 Declaration for Mental Health Treatment; HIM.EHR.B.5 Content of Patient/Individual Record; HIM.EHR.B.9 Patient/Individual Records Administration; MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention; RR.B.2 Assurance of Individual Rights;* and *required employee training courses.*

Methods

A client roster for persons served during the 3rd Qtr. FY 2024 (March 1, 2024-May 31, 2024) and an employee roster was requested from and provided by program leadership. Twenty (20) client records and five (5) employee records were selected using an Excel formula to generate a random number list. The review utilized an audit tool developed by Compliance. It consisted of five (5) components: policy and procedure requirements (policy), environment requirements (environment), medical requirements (medical), personnel requirements (personnel), and client record requirements (client records).

Findings

Overall Score: 91%
Detailed findings are presented below:

The HARRIS CENTER for Mental Health and IDD

Strengths:

- Medical requirements (*Item V: VI*) **100%**
- Policy requirements (*Item V: VI* and *TAC §§ 404.161 (d)* and *(f)*) **100%**
- Environment requirements (*Item V: VI;* and *TAC § 404.162 (f)* and *164 (b)*) **100%**
- Personnel requirements (*TAC §§ 301.331* and *363; HR.B.35; MED.MH.B.1;* and *MED.NUR.B.10*) **97%**

Areas of Improvement:

- Client Records (*Item V:VI; TAC §§ 301.351, 353,* and *361; TAC §§ 306.263* and *275; TAC §§ 404.161, 162,* and *163; TAC § 414.405; HIM.EHR.B.5; ACC.B.8; ACC.B.14; HIM.EHR.B.9; ACC.B.2;* and *RR.B.2)* **60%**

Observations

- The exclusionary criteria listed in the program's Operational Guidelines indicate persons served experiencing a mental health crisis are ineligible for admission.
- Case management services were not documented during the review period.
- Treatment plans are not completed by JD staff.

History

Compliance has not previously audited the JD Program.

Recommendations

The Program should continue to review client documentation (e.g., progress notes, treatment plans, admission documentation, and discharge documentation) and program documentation (i.e., operational guidelines) for compliance with regulatory standards. Program leadership should ensure that JD Aftercare staff completes treatment plans as soon as possible after admission to ensure case management is provided to persons served by the program. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the CPEP Division and the JD Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days (August 19, 2024).

The HARRIS CENTER for Mental Health and IDD

Signature Page

X _____

Vice President of CPEP Division

X _____

Program Director/Manager

X Demetria Luckett

Director of Compliance

The HARRIS CENTER for Mental Health and IDD

Management Response

Program Director has reviewed the findings of review. The Program will implement plans to ensure that negative findings are corrected. This will be evident by increasing staff training on documentation in EHR for assessments and progress notes. Staff will also ensure consumers receive all documentation on their rights as evident by increased documentation in HER. This plan will be shared with leadership in Jail Diversion to begin training immediately.

superior healthplan.

Centene Company of Texas, LP

5900 E. Ben White Blvd.
Austin, TX 78741
1-800-218-7508
www.SuperiorHealthPlan.com

Fax Transmittal

To: MEDICAL RECORDS

Fax: 713-970-3817

Company: THE HARRIS CENTER FOR MENTAL HEALTH

Date: June 3, 2024

Subject:

Comments:

From: LUZ M. GARCIA

Fax: 877-690-9328

JUN 04 2024

RECEIVED

A special license for Utilization Review Agents (URA) is issued through the Texas Department of Insurance (TDI) and is necessary to perform medical reviews. Centene Company of Texas, LP is a Licensed URA (#4167), contracted with Superior HealthPlan to perform utilization review.

PRIOR AUTHORIZATION IS A CONDITION FOR REIMBURSEMENT; IT IS NOT A GUARANTEE OF PAYMENT

06/04/2024

superior healthplan
5900 E. Ben White Blvd.
Austin, TX 78741

The Harris Center For Mental Health And IDD
ECI MHMR Authority Of Harris County
6125 Hillcroft
Houston, TX 77081
Referral Number - (713) 970-7000
Fax Number - (713) 970-3817

Medicaid Medical Records Request

Your prompt response is important.

Dear Provider,

Please consider this a request for release of medical information. STAR Health is a Medicaid plan. Per your obligations in the provider agreement, please submit the requested records to the representative of the health plan listed below.

Luz M. Garcia
Program Coordinator
866-615-9399 ext 42505
STAR Health
Fax: 877-690-9328

Member Name	DOB
[redacted]	[redacted]

- ☐ *Admission history and physical*
- ☐ *Clinic records*
- ☐ *Clinical/graphic chart*
- ☐ *Colonoscopy report*
- ☐ *Consultation reports*
- ☐ *Delivery forms*
- ☐ *Discharge/transfer summary*
- ☐ *Doctors' orders*
- ☐ *Emergency room report*
- ☐ *HgbA1C*
- X ***Individual Family Service Plan (IFSP)***
- ☐ *Lab reports*
- ☐ *LDL (Lipid Panel)*
- ☐ *Mammograms*
- ☐ *MD progress notes*
- ☐ *Medication list*
- ☐ *Nurses' notes*
- ☐ *Operative reports*
- ☐ *Pap test*
- ☐ *Prenatal care records*
- ☐ *Vitals*
- ☐ *X-ray/diagnostic reports*

Other: ***Most recent IFSP and Outcome & Goals***

Thank you,

Luz M. Garcia

1-866-615-9399 Ext 42505

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	MEDICAL RECORDS	Date:	6/3/2024
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7326

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to any/all Datavant requests in a single digital queue with Request Manager
https://idsb-portal.datavant.com/onboarding/setup
OR securely respond to this single request at www.cioxlink.com using these credentials:

- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to 972-729-6174

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Datavant
2222 W. Dunlap Ave
Phoenix, AZ 85021

JUN 04 2024

RECEIVED

Datavant can help you **remove the burden of fulfilling record requests** through:
> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records
> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

**** INSTRUCTIONS FOR FACILITIES ****

March 15, 2024

Dear Facility:

Cigna Healthcare is in the process of conducting medical record diagnostic coding reviews as part of its Medicare Advantage risk adjustment process and as part of its commitment to quality patient care and provider support. As you may know, risk adjustment is the methodology used by the Centers for Medicare and Medicaid Services (CMS) to determine payments to Medicare Advantage health plans. This methodology is dependent on accurate and complete diagnosis coding. Reviewing medical chart documentation assists Cigna Healthcare in meeting these requirements.

Our goal is to make this process as unobtrusive as possible. To support this goal, Cigna Heathcare has enlisted the services of **Datavant Health, formerly CIOX Health,** to retrieve medical records. You will be contacted by Datavant Health to make arrangements convenient for your facility. We will also work with you to minimize disruptions in patient care activities.

Next steps:

- Please anticipate receiving a call from Datavant Health to schedule the chart retrieval.
- For each medical record, the following information is needed for dates of service from **January 1, 2023 to Current**:

  - Admitting Documents
  - History & Physical
  - Consult Notes
  - Progress Notes
  - Discharge Summary
  - Medication List
  - Demographic Sheet
  - Signature Log

Cigna Healthcare has executed a confidentiality agreement with Datavant Health and their employees, so that any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding confidentiality and HIPAA requirements. Should you have any questions regarding this project, please contact the Datavant Health Provider Support Center at 1-877-445-9293.

Cigna Healthcare is conducting this chart review to ensure compliance with CMS guidelines for the submission of accurate information about your patients. Your participation is extremely valuable and necessary.

Thank you for your cooperation with this important activity.

**** INSTRUCTIONS FOR PROVIDER OFFICES ****

March 15, 2024

Dear Provider:

Cigna Healthcare is in the process of conducting medical record diagnostic coding reviews as part of its Medicare Advantage risk adjustment process and as part of its commitment to quality patient care and provider support. As you may know, risk adjustment is the methodology used by the Centers for Medicare and Medicaid Services (CMS) to determine payments to Medicare Advantage health plans. This methodology is dependent on accurate and complete diagnosis coding. Reviewing medical chart documentation assists Cigna Healthcare in meeting these requirements.

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Next steps:

- Please anticipate receiving a call from Datavant Health to schedule the chart retrieval
- For each medical record, the following information is needed for dates of service from **January 1, 2023 through Current**:
    - History & Physical
    - Consultation Notes
    - Progress Notes
    - Medication List
    - Enhanced Encounter/360/HMR documents
    - Demographic Sheet
    - Search all EHR **and** Paper Chart formats for date range

Cigna Healthcare has executed a confidentiality agreement with Datavant Health and their employees, so that any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding confidentiality and HIPAA requirements. Should you have any questions regarding this project, please contact the Datavant Health Support Center at 1-877-445-9293.

Cigna Healthcare is conducting this chart review to ensure compliance with CMS guidelines for the submission of accurate information about your patients. Your participation is extremely valuable and necessary.

Thank you for your cooperation with this important activity.

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	MEDICAL RECORDS	Date:	6/3/2024
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7326

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
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To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to any/all Datavant requests in a single digital queue with Request Manager
https://idsb-portal.datavant.com/onboarding/setup
OR securely respond to this single request at www.cioxlink.com using these credentials:

- Username: C48811672
- Password: fE*ef7bb

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
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5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Datavant
2222 W. Dunlap Ave
Phoenix, AZ 85021

JUN 04 2024

RECEIVED

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> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

cigna healthcare

**** INSTRUCTIONS FOR FACILITIES ****

March 15, 2024

Dear Facility:

Cigna Healthcare is in the process of conducting medical record diagnostic coding reviews as part of its Medicare Advantage risk adjustment process and as part of its commitment to quality patient care and provider support. As you may know, risk adjustment is the methodology used by the Centers for Medicare and Medicaid Services (CMS) to determine payments to Medicare Advantage health plans. This methodology is dependent on accurate and complete diagnosis coding. Reviewing medical chart documentation assists Cigna Healthcare in meeting these requirements.

Our goal is to make this process as unobtrusive as possible. To support this goal, Cigna Heathcare has enlisted the services of **Datavant Health, formerly CIOX Health,** to retrieve medical records. You will be contacted by Datavant Health to make arrangements convenient for your facility. We will also work with you to minimize disruptions in patient care activities.

Next steps:

- Please anticipate receiving a call from Datavant Health to schedule the chart retrieval.
- For each medical record, the following information is needed for dates of service from **January 1, 2023 to Current**:

  - Admitting Documents
  - History & Physical
  - Consult Notes
  - Progress Notes
  - Discharge Summary
  - Medication List
  - Demographic Sheet
  - Signature Log

Cigna Healthcare has executed a confidentiality agreement with Datavant Health and their employees, so that any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding confidentiality and HIPAA requirements. Should you have any questions regarding this project, please contact the Datavant Health Provider Support Center at 1-877-445-9293.

Cigna Healthcare is conducting this chart review to ensure compliance with CMS guidelines for the submission of accurate information about your patients. Your participation is extremely valuable and necessary.

Thank you for your cooperation with this important activity.

**** INSTRUCTIONS FOR PROVIDER OFFICES ****

March 15, 2024

Dear Provider:

Cigna Healthcare is in the process of conducting medical record diagnostic coding reviews as part of its Medicare Advantage risk adjustment process and as part of its commitment to quality patient care and provider support. As you may know, risk adjustment is the methodology used by the Centers for Medicare and Medicaid Services (CMS) to determine payments to Medicare Advantage health plans. This methodology is dependent on accurate and complete diagnosis coding. Reviewing medical chart documentation assists Cigna Healthcare in meeting these requirements.

Our goal is to make this process as unobtrusive as possible. To support this goal, Cigna Healthcare has enlisted the services of **Datavant Health, formerly CIOX Health,** to retrieve medical records. You will be contacted by Datavant Health to make arrangements convenient for your practice. We will also work with you to minimize disruptions in patient care activities.

Next steps:

- Please anticipate receiving a call from Datavant Health to schedule the chart retrieval
- For each medical record, the following information is needed for dates of service from **January 1, 2023 through Current**:
    - History & Physical
    - Consultation Notes
    - Progress Notes
    - Medication List
    - Enhanced Encounter/360/HMR documents
    - Demographic Sheet
    - Search all EHR **and** Paper Chart formats for date range

Cigna Healthcare has executed a confidentiality agreement with Datavant Health and their employees, so that any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding confidentiality and HIPAA requirements. Should you have any questions regarding this project, please contact the Datavant Health Support Center at 1-877-445-9293.

Cigna Healthcare is conducting this chart review to ensure compliance with CMS guidelines for the submission of accurate information about your patients. Your participation is extremely valuable and necessary.

Thank you for your cooperation with this important activity.

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	6/4/2024
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7330

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to any/all Datavant requests in a single digital queue with Request Manager https://idsb-portal.datavant.com/onboarding/setup
OR securely respond to this single request at www.cioxlink.com using these credentials:

- Username: [redacted]
- Password [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to 972-729-6174

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Datavant
2222 W. Dunlap Ave
Phoenix, AZ 85021

JUN 05 2024

RECEIVED

Datavant can help you **remove the burden of fulfilling record requests** through:
> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records
> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

cigna healthcare

**** INSTRUCTIONS FOR FACILITIES ****

March 15, 2024

Dear Facility:

Cigna Healthcare is in the process of conducting medical record diagnostic coding reviews as part of its Medicare Advantage risk adjustment process and as part of its commitment to quality patient care and provider support. As you may know, risk adjustment is the methodology used by the Centers for Medicare and Medicaid Services (CMS) to determine payments to Medicare Advantage health plans. This methodology is dependent on accurate and complete diagnosis coding. Reviewing medical chart documentation assists Cigna Healthcare in meeting these requirements.

Our goal is to make this process as unobtrusive as possible. To support this goal, Cigna Heathcare has enlisted the services of **Datavant Health, formerly CIOX Health,** to retrieve medical records. You will be contacted by Datavant Health to make arrangements convenient for your facility. We will also work with you to minimize disruptions in patient care activities.

Next steps:

- Please anticipate receiving a call from Datavant Health to schedule the chart retrieval.
- For each medical record, the following information is needed for dates of service from **January 1, 2023 to Current**:

  - Admitting Documents
  - History & Physical
  - Consult Notes
  - Progress Notes
  - Discharge Summary
  - Medication List
  - Demographic Sheet
  - Signature Log

Cigna Healthcare has executed a confidentiality agreement with Datavant Health and their employees, so that any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding confidentiality and HIPAA requirements. Should you have any questions regarding this project, please contact the Datavant Health Provider Support Center at 1-877-445-9293.

Cigna Healthcare is conducting this chart review to ensure compliance with CMS guidelines for the submission of accurate information about your patients. Your participation is extremely valuable and necessary.

Thank you for your cooperation with this important activity.

**** INSTRUCTIONS FOR PROVIDER OFFICES ****

March 15, 2024

Dear Provider:

Cigna Healthcare is in the process of conducting medical record diagnostic coding reviews as part of its Medicare Advantage risk adjustment process and as part of its commitment to quality patient care and provider support. As you may know, risk adjustment is the methodology used by the Centers for Medicare and Medicaid Services (CMS) to determine payments to Medicare Advantage health plans. This methodology is dependent on accurate and complete diagnosis coding. Reviewing medical chart documentation assists Cigna Healthcare in meeting these requirements.

Our goal is to make this process as unobtrusive as possible. To support this goal, Cigna Healthcare has enlisted the services of **Datavant Health, formerly CIOX Health,** to retrieve medical records. You will be contacted by Datavant Health to make arrangements convenient for your practice. We will also work with you to minimize disruptions in patient care activities.

Next steps:

- Please anticipate receiving a call from Datavant Health to schedule the chart retrieval
- For each medical record, the following information is needed for dates of service from **January 1, 2023 through Current**:
    - History & Physical
    - Consultation Notes
    - Progress Notes
    - Medication List
    - Enhanced Encounter/360/HMR documents
    - Demographic Sheet
    - Search all EHR **and** Paper Chart formats for date range

Cigna Healthcare has executed a confidentiality agreement with Datavant Health and their employees, so that any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding confidentiality and HIPAA requirements. Should you have any questions regarding this project, please contact the Datavant Health Support Center at 1-877-445-9293.

Cigna Healthcare is conducting this chart review to ensure compliance with CMS guidelines for the submission of accurate information about your patients. Your participation is extremely valuable and necessary.

Thank you for your cooperation with this important activity.

aetna

episource

Epi Reference ID: L-[redacted]

Episource, LLC on behalf of Aetna
Address: 500 W. 190th Street, 4th Floor Suite 400, Gardena, CA 90248.
Phone: 1-209-299-3563 or 1-860-316-2982
Fax: 1-888-300-0970 or 1-800-893-7048
Email: aetnachartretrieval@episource.com (for questions regarding chart retrieval)
Email (Chart Submission): docmgt@episource.com (To protect ePHI, please use encrypted email)

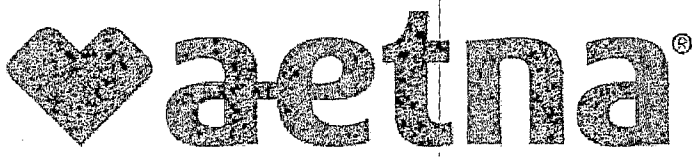
Medical Records Request
Medicare Risk Adjustment Review

Attention To: **Medical Records**
Phone: (713) 970-7330
Fax: (713) 970-3817
Request Date: 06/05/2024
Epi Reference ID: [redacted]

Requested patient list, dates of service, and submission options attached.
Please contact Episource within 7 days of receiving this request:
1-209-299-3563 or 1-860-316-2982
Email: aetnachartretrieval@episource.com

JUN 05 2024

RECEIVED



6/12/2024

Attention To: MEDICAL RECORDS
Harris Center for Mental Health & IDD
9401 SOUTHWEST FWY

HOUSTON, TX 77074

Phone: 17139707000
Fax: 17139703817

Dear Physician or Office Administrator:

Request for medical records

As a Medicare Advantage (MA) organization, we are required to submit risk adjustment data to the Centers for Medicare & Medicaid Services (CMS). We're beginning our annual Medicare risk adjustment data review of medical records to ensure we submit complete risk adjustment data to CMS. We are asking for your help with this data collection. This review is a medical record review and not a claims payment audit.

Cotiviti will contact you regarding data collection.
We're working with Cotiviti on this initiative. Since Aetna is an MA organization, you do not need patient authorization information releases to provide medical records to us for this review.

Here's an overview of the medical records requested. If applicable, we're requesting records for all dates of service **01/01/23-present** for Aetna MA members:

- History and physical exam: session, visit and progress notes
- Progress notes
- Physician orders
- Operative and pathology reports
- Face sheet
- Consultation reports
- Diagnostic test reports
- Discharge summaries

Please return using one of the five return methods listed on the following Medical Record Member List along with a copy of the requested documentation for the referenced member(s).

Our agreement with Cotiviti complies with HIPAA privacy regulations

Cotiviti works with us in a role that is defined and covered by the Health Insurance Portability and Accountability Act (HIPAA). As a "business associate" of Aetna under HIPAA, Cotiviti is authorized to conduct this review. Cotiviti will maintain the confidentiality of any protected health information (PHI) they receive from you on our behalf, in accordance with HIPAA and other applicable confidentiality and privacy laws.

Please respond within 14 days of receipt of this request.

We very much appreciate your assistance with this data collection. If you have questions about this request, call Cotiviti. You can reach them at **877-489-8437**, Monday through Friday, from 6:30 a.m. to 5:30 p.m. MT.

Sincerely,

Robin Collins

Robin Collins
Executive Director,
Healthcare Quality

JUN 13 2024

RECEIVED

aetna®

MEDICAL RECORDS MEMBER LIST (CONFIDENTIAL)

6/12/2024

Site Information

Site ID:	[redacted]
Site Name:	Harris Center for Mental Health & IDD
Site Address:	9401 SOUTHWEST FWY HOUSTON, TX 77074
Site Phone:	17139707000

Action Requested:
Please provide the following medical record documentation to our vendor, Cotiviti.

- History and physical exam: session, visit and progress notes
- Progress notes
- Physician orders
- Operative and pathology reports
- Face sheet
- Consultation reports
- Diagnostic test reports
- Discharge summaries

Please return this Medical Record Member List and a copy of the requested documentation for the member(s) listed on the form below. Each member on the list is assigned to a line of business (Duals, DSNP, MRA, Allina). We ask that you prioritize the return of the DSNP and Duals records first if applicable. If the record is not available, check the No Patient/No Record box.

PLEASE DO NOT SEND THIS REQUEST TO ANY PRINTING/COPY SERVICES

Records can be sent by:

1. Uploading the record image to Cotiviti's secure portal at www.submitrecords.com/aetna, enter your Client Identifier: **aetmrarecs62** and select the files to be uploaded.
2. Secure fax to 888-417-4547; or
3. US Postal Service
   C/O Cotiviti-1000
   10701 S Riverfront Pkwy
   Box 12000
   South Jordan, Utah 84095
4. Remote EMR Downloading
   • Please call **801-506-1998** for remote EMR set up or any questions regarding remote EMR retrieval services
5. Onsite Scanning Technician
   • Please call **385-557-5694** to set up Onsite Scanning Services or for any questions regarding Onsite Scanning.

If you have any questions regarding this medical record request, please contact Cotiviti directly at 877-489-8437.

Site ID: 1870102

Member Name	Date of Birth	Effective Dates	Request ID	Line of Business	No Patient/ No Record
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted] Present	[redacted]	[redacted]	☐

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	6/17/2024
Fax Number:	(713) 970-7007	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to any/all Datavant requests in a single digital queue with Request Manager
https://idsb-portal.datavant.com/onboarding/setup
OR securely respond to this single request at www.cioxlink.com using these credentials:

- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to 1-972-957-2143

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Datavant
2222 W. Dunlap Ave
Phoenix, AZ 85021

Datavant can help you **remove the burden of fulfilling record requests** through:
> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records
> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

Wellpoint

[redacted] Arizona • Iowa • New Jersey • Tennessee • Texas • Washington | Medicare Advantage

May 2024

Subject:Time-sensitive request for medical records for Medicare risk adjustment data

Dear Provider:

Wellpoint is committed to improving the quality of care provided to our members and is required by CMS to submit complete and accurate diagnostic data regarding our members enrolled in certain Medicare-covered health plans. Accordingly, Wellpoint requests your cooperation to facilitate a medical record review of January 1, 2023 – Present for a certain number of your patients enrolled in such plans.

We have engaged Datavant, formerly Ciox Health, to conduct retrieval of records for the medical chart review. A Datavant representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from January 1, 2023 – Present.

Please include all medical record documentation available for this chart review, including:

- Progress notes.
- History and physical.
- Consult/specialist notes or letters.
- Operative and pathology notes.
- Procedure notes/reports.
- Physical, speech, and/or occupational therapist reports.
- Emergency department records.
- Discharge summary.

Notes should include member name, date of visit, and provider signature with credentials.

If there are no encounter notes for the member, please indicate CNA (chart not available) by the chart ID along with comments explaining why the chart is not available.

If available, also include:

- *Health Maintenance Form.*

Behavioral Health
Medical Record Review Project

Molina Healthcare of TX
Attention: BH CM Department
445 Executive Center #100
El Paso, TX 79902
TX_BHRecords@MolinaHealthCare.Com

To:	The Harris Center for Mental Health and IDD	**From:**	[redacted] BH Clinical Auditor
Attention:	Medical Records & [redacted]	**Date:**	06/18/2024
Phone:	713-970-7339	**Phone:**	281-698-5025
Fax:	713-970-3817	**Deadline:**	07/01/2024

RE: The Harris Center for Mental Health and IDD Medical Record Request BH Audit Q2_2024

We value our relationship with you, and we appreciate the quality care you provide to Molina members. Molina Healthcare of Texas. (MHT) is a company that is contracted by the Health and Human Services Commission (HHSC) to administer the Medicaid Program to eligible enrollees. MHT periodically conducts utilization review retrospective audits of behavioral health services rendered for quality of care, medical necessity, follow-up to quality investigation and cost evaluation purposes. Having agreed to accept the terms for Medicaid/Medicare Program participation, providers/facilities are required to provide treatment records that are requested to satisfy performance oversight requirements. The Health Insurance Portability and Accountability (HIPAA) regulation CFR 164.506(c)(4) permits a covered entity, such as a physician practice, to disclose protected health information (PHI) to another covered entity, such as a health plan, without obtaining **authorization** or consent for the purpose of facilitating health care operations.

Please take a moment to review the following:

- Medical record information is required for patients on the attached list.
- The entire medical record may be required. Copy instructions attached.
- Return the attached "Return Records Cover Sheet" with all documents so your office can be easily identified.
- Indicate on the patient list, the reason for any records that you are unable to locate.
- If a member on the list is not your patient, or has not been seen at this location, please check appropriate box and return.
- Return all records by the deadline listed above.
- Call the specialist on this request if you have any questions or concerns regarding this request.

Record Return Methods:

- Secure Email or SFTP: Send Records quickly and securely using the following email or call for more information on SFTP portal accounts: TX_BHRecords@MolinaHealthCare.com

Thank you.

Abraham Minjarez, MBA, MA, LPC
Behavioral Health Clinical Auditor
281-698-5025
abraham.minjarez@molinahealthcare.com

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Record	Date:	6/14/2024
Fax Number:	(713) 970-4749	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to any/all Datavant requests in a single digital queue with Request Manager https://idsb-portal.datavant.com/onboarding/setup
OR securely respond to this single request at www.cioxlink.com using these credentials:

- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to 1-972-957-2143

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Datavant
2222 W. Dunlap Ave
Phoenix, AZ 85021

JUN 18 2024

RECEIVED

Datavant can help you **remove the burden of fulfilling record requests** through:
> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records
> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

Anthem

Anthem Blue Cross | Medicare Advantage | California • New York

May 2024

Subject:Time-sensitive request for medical records for Medicare risk adjustment data

Dear Provider:

Anthem is committed to improving the quality of care provided to our members and is required by CMS to submit complete and accurate diagnostic data regarding our members enrolled in certain Medicare-covered health plans. Accordingly, Anthem requests your cooperation to facilitate a medical record review of January 1, 2023 – Present for a certain number of your patients enrolled in such plans.

We have engaged Datavant, formerly Ciox Health, to conduct retrieval of records for the medical chart review. A Datavant representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from January 1, 2023 – Present.

Please include all medical record documentation available for this chart review, including:

- Progress notes.
- History and physical.
- Consult/specialist notes or letters.
- Operative and pathology notes.
- Procedure notes/reports.
- Physical, speech, and/or occupational therapist reports.
- Emergency department records.
- Discharge summary.

Notes should include member name, date of visit, and provider signature with credentials.

If there are no encounter notes for the member, please indicate CNA (chart not available) by the chart ID along with comments explaining why the chart is not available.

If available, also include:

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 7 BUSINESS DAYS.

FROM: [redacted] (Sender's Name)

TO: EXL Service
Secure Fax: 844-505-8246
Encrypted Email: Optum.RxPVR@exlservice.com

# of Pages: 4 (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY
NABP #: 4586927
Date: June 21, 2024

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
1201765	[redacted]		06/18/2024	INVEGA TRINZ INJ 546MG	RETURNED TO STOCK DISCONTINUED BY MD

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
4. **Include this Records Transmittal Page with document submission.**

[✓] I ATTEST TO THE CLAIM(S) BEING BILLED CORRECTLY.

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED INCORRECTLY AND REVERSED (ORx will verify and reverse as appropriate).

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO _____
(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

[redacted] 6-21-24

Pharmacy Manager / Representative Signature Date

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 7 BUSINESS DAYS.

FROM: Southeast Pharmacy (Sender's Name) **TO: EXL Service**

Secure Fax: 844-505-8246
Encrypted Email: Optum.RxPVR@exlservice.com

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: June 26, 2024

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
1203560	[redacted]	[redacted]	06/21/2024	INVEGA SUST INJ 234/1.5	

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
4. **Include this Records Transmittal Page with document submission.**

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED CORRECTLY.

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED INCORRECTLY AND REVERSED (ORx will verify and reverse as appropriate).

[X] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO Corrected day supply for # 1 day to # 28 days. Patient receives injection every 28 days.
(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

[redacted] 6/26/24

Pharmacy Manager / Representative Signature Date

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 7 BUSINESS DAYS.

FROM: Monica Butler (Sender's Name)

TO: EXL Service
Secure Fax: 844-505-8246
Encrypted Email: Optum.RxPVR@exlservice.com

# of Pages: 5 (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY
NABP #: [redacted]
Date: June 26, 2024

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
1204419	[redacted]	[redacted]	06/21/2024	INVEGA TRINZ INJ 546MG	

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
4. **Include this Records Transmittal Page with document submission.**

[✓] I ATTEST TO THE CLAIM(S) BEING BILLED CORRECTLY.

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED INCORRECTLY AND REVERSED (ORx will verify and reverse as appropriate).

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO_____
(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

[redacted] 6-26-24

Pharmacy Manager / Representative Signature Date

Optum Rx®

EXL

NABP #: 4586927

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 7 BUSINESS DAYS.

FROM: MONICA BUTLER (Sender's Name)

TO: EXL Service
Secure Fax: 844-505-8246
Encrypted Email: Optum.RxPVR@exlservice.com

# of Pages: 5 (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY
NABP #: 4586927
Date: June 26, 2024

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]			06/21/2024	INVEGA TRINZ INJ 546MG	

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
4. **Include this Records Transmittal Page with document submission.**

[✓] I ATTEST TO THE CLAIM(S) BEING BILLED CORRECTLY.

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED INCORRECTLY AND REVERSED (ORx will verify and reverse as appropriate).

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO _____
(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT MONICA BUTLER

Monica Butler 6-26-24

Pharmacy Manager / Representative Signature Date

Advantmed

REQUEST FOR MEDICAL RECORDS

Request Send Date: June 27, 2024

Provider ID: [redacted]

ATTENTION TO: Medical Records

TO: [redacted]	FROM: ADVANTMED
9401 Southwest Freeway, Houston, TX 77074	17981 Sky Park Circle, Building 39/Suite B & C, Irvine, CA 92614
(713)970-7000	(800)698-1690
(713)970-3817	(800)340-7804
	Providersupport@advantmed.com
	https://www.advantmed.com/

Dear Physician or Office Administrator:

Wellcare has partnered with Advantmed to collect medical records for Risk Adjustment Data Collection & Reporting.

REQUESTOR: Wellcare

DUE DATE: July 11, 2024

Advantmed offers multiple methods to submit records in response to this request. Please consider uploading records through our **"SECURE UPLOAD PORTAL"** to expedite the process.

Please use link for sharing your feedback: 'https://secure1.advantmed.com/ClientPortals/SurveyForm'

Most Convenient and Secure Method:
To upload records securely visit https://www.advantmed.com/uploadrecords
OR email records to our secure server at **records@advantmed.com**

To begin set up for remote EMR download by Advantmed's trained Medical Record Technicians, email necessary forms to RemoteAccess@advantmed.com. Please provide a point of contact and number for further communication.

To fax records toll free, use our secure fax lines:
(800)340-7804 (Main Fax Line)
(949)222-0185 (Alternate Fax Line)

To mail records, please send to:
17981 Sky Park Circle, Building 39/Suite B & C, Irvine, CA 92614

To schedule an onsite appointment, please contact us at (800)698-1690

JUN 28 2024

RECEIVED

RECORDS REQUEST

Dear Provider,

Wellcare is committed to improving the quality of care provided to our members. We are required by the Centers for Medicare & Medicaid Services (CMS) to submit complete diagnostic data regarding our members enrolled in Wellcare. Accordingly, Wellcare requests your cooperation to facilitate a medical record review of 2023 dates of service for a certain number of your patients enrolled in such plans.

We have engaged Advantmed to conduct the medical chart review. Advantmed representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from January 1, 2023, to present.

What does this mean to you?

In order to limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as compiling information for Healthcare Effectiveness Data and Information Set (HEDIS®) measures and assisting in CMS risk adjustment data validation audits.

Your assistance in helping Advantmed with this retrieval is greatly appreciated.

Please note the items listed below are the components requested, if applicable, for all dates of service from January 1, 2023, to present:

- Patient Demographic Sheet.
- History & physical records, progress notes and consultations.
- Discharge record, consult and pathology summaries, and reports.
- Surgical procedures and operating summaries.
- Subjective and objective assessments, and plan notes.
- Diagnostic testing, including but not limited to cardiovascular diagnostic testing reports (EKG, stress test, Holter monitors, Doppler studies), interventional radiology (MRA, catheter angiography, etc.), neurology (EEG, EMG, nerve conduction studies, sleep studies).
- Emergency and Urgent Care records.
- Consultation reports.
- Specialist Notes.
- Procedure notes/reports.
- Valid signature with credentials.

Advantmed

REQUEST FOR MEDICAL RECORDS

Request Send Date: June 28, 2024

Provider ID: [redacted]

ATTENTION TO: Medical Records

TO: [redacted]	FROM: ADVANTMED
9401 Southwest Freeway, Houston, TX 77074	17981 Sky Park Circle, Building 39/Suite B & C, Irvine, CA 92614
(713)970-7000	(800)698-1690
(713)970-3817	(800)340-7804
	Providersupport@advantmed.com
	https://www.advantmed.com/

Dear Physician or Office Administrator:

Wellcare has partnered with Advantmed to collect medical records for Risk Adjustment Data Collection & Reporting.

REQUESTOR: Wellcare

DUE DATE: July 12, 2024

Advantmed offers multiple methods to submit records in response to this request. Please consider uploading records through our "**SECURE UPLOAD PORTAL**" to expedite the process.

Please use link for sharing your feedback: 'https://secure1.advantmed.com/ClientPortals/SurveyForm'

Most Convenient and Secure Method:
To upload records securely visit https://www.advantmed.com/uploadrecords
OR email records to our secure server at **records@advantmed.com**

To begin set up for remote EMR download by Advantmed's trained Medical Record Technicians, email necessary forms to RemoteAccess@advantmed.com. Please provide a point of contact and number for further communication.

To fax records toll free, use our secure fax lines:
(800)340-7804 (Main Fax Line)
(949)222-0185 (Alternate Fax Line)

To mail records, please send to:
17981 Sky Park Circle, Building 39/Suite B & C, Irvine, CA 92614

JUL 01 2024

RECEIVED

To schedule an onsite appointment, please contact us at (800)698-1690

RECORDS REQUEST

Dear Provider,

Wellcare is committed to improving the quality of care provided to our members. We are required by the Centers for Medicare & Medicaid Services (CMS) to submit complete diagnostic data regarding our members enrolled in Wellcare. Accordingly, Wellcare requests your cooperation to facilitate a medical record review of 2023 dates of service for a certain number of your patients enrolled in such plans.

We have engaged Advantmed to conduct the medical chart review. Advantmed representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from January 1, 2023, to present.

What does this mean to you?

In order to limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as compiling information for Healthcare Effectiveness Data and Information Set (HEDIS®) measures and assisting in CMS risk adjustment data validation audits.

Your assistance in helping Advantmed with this retrieval is greatly appreciated.

Please note the items listed below are the components requested, if applicable, for all dates of service from January 1, 2023, to present:

- Patient Demographic Sheet.
- History & physical records, progress notes and consultations.
- Discharge record, consult and pathology summaries, and reports.
- Surgical procedures and operating summaries.
- Subjective and objective assessments, and plan notes.
- Diagnostic testing, including but not limited to cardiovascular diagnostic testing reports (EKG, stress test, Holter monitors, Doppler studies), interventional radiology (MRA, catheter angiography, etc.), neurology (EEG, EMG, nerve conduction studies, sleep studies).
- Emergency and Urgent Care records.
- Consultation reports.
- Specialist Notes.
- Procedure notes/reports.
- Valid signature with credentials.

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

[redacted]

[redacted]	[redacted]	Date:	6/28/2024
[redacted]	[redacted] 970-3817	Phone Number:	(713) 970-7335

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to any/all Datavant requests in a single digital queue with Request Manager https://idsb-portal.datavant.com/onboarding/setup
OR securely respond to this single request at www.cioxlink.com using these credentials:

- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to 1-972-957-2169

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Datavant
2222 W. Dunlap Ave
Phoenix, AZ 85021

JUL 01 2024

RECEIVED

Datavant can help you **remove the burden of fulfilling record requests** through:
> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records
> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

151 Farmington Avenue
Hartford, CT 06156

Robin Collins
Executive Director, Healthcare Quality

Dear Physician or Office Administrator:

Request for medical records

As a Medicare Advantage (MA) organization, we are required to submit risk adjustment data to the Centers for Medicare & Medicaid Services (CMS). We're beginning our annual Medicare risk adjustment data review of medical records to ensure we submit complete risk adjustment data to CMS. We are asking for your help with this data collection. This review is a medical record review and not a claims payment audit.

Datavant will contact you regarding data collection

We're working with Datavant on this initiative. Since Aetna is an MA organization, you do not need patient authorization information releases to provide medical records to us for this review.

We also ask that you provide a full and complete copy of the medical records for Aetna MA plan patients on the enclosed list for dates of service from January 1, 2023, to present.

You can provide the medical records to Datavant by either:

- Securely faxing to **1-972-957-2169.**
- Calling **1-877-445-9293** to have a scanner technician visit your office.
- Mailing the records directly to Datavant. Please mark the envelope "Confidential" and send to:

  Datavant (Attention Chart Retrieval)
  2222 W. Dunlap Avenue
  Phoenix, AZ 85021

Our agreement with Datavant complies with HIPAA privacy regulations

Datavant works with us in a role that is defined and covered by the Health Insurance Portability and Accountability Act (HIPAA). As a "business associate" of Aetna under HIPAA, Datavant is authorized to conduct this review. Datavant will maintain the confidentiality of any protected health information (PHI) they receive from you on our behalf, in accordance with HIPAA and other applicable confidentiality and privacy laws.

datavant
[redacted]erly named Cox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	MEDICAL RECORDS	Date:	6/28/2024
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7335

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to any/all Datavant requests in a single digital queue with Request Manager https://idsb-portal.datavant.com/onboarding/setup
OR securely respond to this single request at www.cioxlink.com using these credentials:

- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to 1-972-957-2143

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Datavant
2222 W. Dunlap Ave
Phoenix, AZ 85021

JUL 01 2024

RECEIVED

Datavant can help you **remove the burden of fulfilling record requests** through:
> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records
> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

UnitedHealthcare®
Community Plan

May 2024

Medical record review — Medicaid risk adjustment

Dear Practice or Facility Administrator:

Re: Time sensitive request for medical records for Medicaid risk adjustment data

UnitedHealthcare Community Plan is committed to improving the quality of care provided to our members and is required by the Texas Health and Human Services Commission (HHSC) to submit complete diagnostic data regarding our members enrolled in certain Medicaid Managed Care covered health plans. Accordingly, UnitedHealthcare Community Plan requests your cooperation to facilitate a medical record review of 2023 & 2024 dates of service for a certain number of your patients enrolled in such plans.

We have engaged Optum and Datavant (formerly CiOX Health (CiOX) to conduct the medical chart review. A Datavant representative will work with you to provide retrieval options and a pull list of the requested members' medical records for services rendered from **September 1, 2023 to August 31, 2024.**

Notes should include member name, date of visit, and provider signature with credentials.

Please include all of the following medical record documentation available for this chart review:

- Progress notes
- History and physical
- Consult/Specialist notes or letters
- Operative and pathology notes
- Procedure notes/reports
- Physical, speech and/or occupational therapist reports
- Emergency department records
- Discharge summary

Only if there are no encounter notes for the member, please indicate CNA (Chart Not Available) by the Chart ID along with comments explaining why the chart is not available.

If also available include:

- Health maintenance form
- Demographics sheet (include documentation for name changes, DOB discrepancies)
- Signature log (complete and return if progress notes contain handwritten signatures or credentials of provider are not contained in patient information being sent)

Note: Pursuant to UnitedHealthcare Community Plan requirements, providers' signatures and qualifications are required to validate each medical record.

To limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as compiling information for Healthcare Effectiveness Data & Information Set (HEDIS®) measures and assisting in CMS risk adjustment data validation audits.

Questions?
Thank you in advance for your assistance. If you have questions related to the scheduling of this review, please call Datavant at 1-877- 445-9293 between 7a.m. to 8 p.m. CT, Monday through Friday, or email at chartreview@datavant.com.

Sincerely,

Risk Adjustment Retrieval
uhc_chartreview@uhc.com
1-866-315-2318

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records attn	Date:	7/2/2024
Fax Number:	(713) 970-6021	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to any/all Datavant requests in a single digital queue with Request Manager
https://idsb-portal.datavant.com/onboarding/setup
OR securely respond to this single request at www.cioxlink.com using these credentials:

- Username: C49296800
- Password: Aa^7994c

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to 1-972-957-2143

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Datavant
2222 W. Dunlap Ave
Phoenix, AZ 85021

JUL 08 2024
RECEIVED

Humana®

9401 SOUTHWEST FWY
HOUSTON, TX 770742007

Fax

TO:	THE HARRIS CENTER FOR MENTAL HEALTH AND IDD	FROM:	Humana
PHONE:	17139707263	PAGES:	13
FAX:	17139703817	DATE:	7/3/2024
RE:	Medical Records Retrieval	SITE ID/ REFERENCE NUMBER:	62482

JUL 05 2024

RECEIVED

404105ALL0224-A

Humana®

7/3/2024

THE HARRIS CENTER FOR MENTAL HEALTH AND IDD
9401 SOUTHWEST FWY

HOUSTON, TX 770742007

RE: Please submit requested medical record(s) for your Humana-covered patient(s)

Dear physician or office administrator:

Humana reviews medical records for our members in an effort to report complete and accurate diagnosis coding to the Centers for Medicare & Medicaid Services (CMS) for our Medicare Advantage members and to the U.S. Department of Health and Human Services for our commercial members.

Please return the medical record(s) for the time period(s) requested, with the enclosed patient information form, for the patient(s) listed. Return in one of the following ways:

- Upload records to the secure provider upload portal at www.submitrecords.com/humana (instructions enclosed).
- Send via secure fax to **800-205-5840**.
- Send via mail using the enclosed self-addressed, prepaid trackable postage label(s). A new prepaid label is being used. Please discard old labels.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule states in the Safeguards Principle that individually identifiable health information should be protected with reasonable administrative, technical and physical safeguards to ensure its confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure. **Please submit all electronic and hard-copy medical records via a HIPAA-compliant method.**

Please ensure each record includes the section with the physician's or healthcare provider's signature. Do not submit original medical records. Please include the following:

If a physician record (including telehealth visits):		
Discharge summary	Consult notes	Demographics sheet
	Diagnostic testing reporting (commercial patients only)	Dialysis (commercial patients only)
History and physical	Infusion testing and reporting (commercial patients only)	Operative reports
Physician or healthcare provider signature and credentials (electronic or handwritten)	Problem list	Progress notes
Signature log*	SOAP notes (subjective, objective, assessment, plan)	Telehealth visits progress notes

If a hospital record (including telehealth visits):		
Admit notes (commercial patients only)	Demographics sheet	Coding summary (if not on face sheet)
Consult notes		Diagnostic testing reports
Discharge summary	Emergency department records	Face sheet
History and physical	Infusion testing and reporting (commercial patients only)	Lab results/pathology reports
Operative reports	Physician orders	Physician or healthcare provider signature and credentials (electronic or handwritten)
Problem list	Progress notes	Signature log*
SOAP notes (subjective, objective, assessment, plan)	Telehealth visits progress notes	

***Note:** Signature logs are not accepted in place of the physician's or healthcare provider's electronic or handwritten signature. Signature logs are used to identify a provider's name if the signature is illegible.

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 7 BUSINESS DAYS.

FROM: Southeast Pharmacy (Sender's Name) **TO: EXL Service**

Secure Fax: 844-505-8246
Encrypted Email: Optum.RxPVR@exlservice.com

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: July 12, 2024

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
1209915	[redacted]	[redacted]	07/09/2024	INVEGA TRINZ INJ 546MG	

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
4. **Include this Records Transmittal Page with document submission.**

[X] I ATTEST TO THE CLAIM(S) BEING BILLED CORRECTLY.

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED INCORRECTLY AND REVERSED (ORx will verify and reverse as appropriate).

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO _____
(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

Pharmacy Manager / Representative Signature

7/12/24
Date

Optum Rx EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 7 BUSINESS DAYS.

FROM: [redacted] (Sender's Name)

TO: EXL Service
Secure Fax: 844-505-8246
Encrypted Email: Optum.RxPVR@exlservice.com

# of Pages: 5 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY
NABP #: 5911614
Date: July 5, 2024

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
1206958	[redacted]	[redacted]	07/01/2024	INVEGA TRINZ INJ 410MG	

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
4. **Include this Records Transmittal Page with document submission.**

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED CORRECTLY.

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED INCORRECTLY AND REVERSED (ORx will verify and reverse as appropriate)

[X] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO 90 day supply
(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

[redacted] 7-15-24

Pharmacy Manager / Representative Signature Date

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	7/12/2024
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7326

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to any/all Datavant requests in a single digital queue with Request Manager
https://idsb-portal.datavant.com/onboarding/setup
OR securely respond to this single request at www.cioxlink.com using these credentials:

- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to 1-972-957-2143

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Datavant
2222 W. Dunlap Ave
Phoenix, AZ 85021

JUL 15 2024

RECEIVED

Datavant can help you **remove the burden of fulfilling record requests** through:
> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records
> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Ariel A	Date:	7/15/2024
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to any/all Datavant requests in a single digital queue with Request Manager https://idsb-portal.datavant.com/onboarding/setup
OR securely respond to this single request at www.cioxlink.com using these credentials:

- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to 1-972-957-2143

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Datavant
2222 W. Dunlap Ave
Phoenix, AZ 85021

JUL 16 2024

RECEIVED

Datavant can help you **remove the burden of fulfilling record requests** through:
> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records
> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

To learn more about one of these **NO COST** retrieval options, visit www.datavant.com/campaign/betterway

BlueCross BlueShield of Texas

Advantmed

URGENT MEDICAL RECORD REQUEST

1st MR Request Sent Date: July 16, 2024

Provider ID: [redacted]

TO: Dr. Fatima Nida		FROM: ADVANTMED	
Attention To:	Medical Records	Address:	17981 Sky Park Circle, Building 39/Suite B & C
Address:	9401 Southwest Freeway,	City, State Zip:	Irvine, CA 92614
City, State Zip:	Houston, TX 77074	Phone:	(800)698-1690
Phone:	(713)970-7000	Fax:	(800)340-7804
Fax:	(713)970-3817	Email:	Providersupport@advantmed.com
		Website:	https://www.advantmed.com

DUE DATE: July 23, 2024

Dear Physician Or Office Administrator

Blue Cross and Blue Shield of Texas has partnered with Advantmed to collect and review medical records for HEDIS® Reporting.

Advantmed offers multiple methods to submit records in response to this request. Please consider uploading records through our "SECURE UPLOAD PORTAL" to expedite the process.

Upload
Most Convenient and Secure Method:
To upload records securely visit
https://www.advantmed.com/uploadrecords

Fax
To fax records toll free, use our secure fax lines:
(800)340-7804 (Main Fax Line)
(949)222-0185 (Alternate Fax Line)

Email
To email records to our secure server:
records@advantmed.com

Mail
To mail records, please send to:
17981 Sky Park Circle, Building 39/Suite B & C,
Irvine, CA 92614

Please use link for sharing your feedback: 'https://secure1.advantmed.com/ClientPortals/SurveyForm'

JUL 17 2024

RECEIVED

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 7 BUSINESS DAYS.

FROM: Northeast Pharmacy (Sender's Name)

TO: EXL Service
Secure Fax: 844-505-8246
Encrypted Email: Optum.RxPVR@exlservice.com

# of Pages: 6 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY
NABP #: 5911614
Date: July 18, 2024

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
1212163	[redacted]	[redacted]	07/15/2024	INVEGA TRINZ INJ 819MG	90 day correct

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
4. **Include this Records Transmittal Page with document submission.**

[X] I ATTEST TO THE CLAIM(S) BEING BILLED CORRECTLY.

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED INCORRECTLY AND REVERSED (ORx will verify and reverse as appropriate).

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO _____
(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

[redacted] 7/22/24

Pharmacy Manager / Representative Signature Date

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 7 BUSINESS DAYS.

FROM: Southeast Pharmacy (Sender's Name) **TO: EXL Service**

Secure Fax: 844-505-8246
Encrypted Email: Optum.RxPVR@exlservice.com

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: July 16, 2024

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
1211618	[redacted]	[redacted]	07/11/2024	INVEGA SUST INJ 234/1.5	

Please Remember to: * Patient starting Sustenna. Verified with provider they will get 234mg and then 156 mg on day 8.

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
4. **Include this Records Transmittal Page with document submission.**

[X] I ATTEST TO THE CLAIM(S) BEING BILLED CORRECTLY.

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED INCORRECTLY AND REVERSED (ORx will verify and reverse as appropriate).

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO _____
(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

[redacted] 7/16/24

Pharmacy Manager / Representative Signature Date

SCIO0780202019A0001211618000117922B

PRINTED: 07/22/2024
FORM APPROVED

Texas Health and Human Services Commission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: _____ B. WING _____	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCROFT EMPOWERMENT CENTER	**6125 HILLCROFT AVE HOUSTON, TX 77081**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
5 000	Initial Comments The complaint investigation was completed on 7/22/24. The Census was 36. Facility entrance was on 3/17/2024 for a complaint investigation for intake #517916, 517960, 518623. No Violations Cited.	5 000		

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	7/22/2024
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7326

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

To learn how to reduce the phone calls and faxes from Datavant and eliminate the burden of medical record retrieval in the future, visit www.datavant.com/campaign/betterway

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to any/all Datavant requests in a single digital queue with Request Manager https://idsb-portal.datavant.com/onboarding/setup
OR securely respond to this single request at www.cioxlink.com using these credentials:

- Username: [redacted]
- Password: [redacted]

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates.
Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant.
Contact

4.Fax:
Send secure faxes to 1-972-957-2143

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Datavant
2222 W. Dunlap Ave
Phoenix, AZ 85021

JUL 22 2024

RECEIVED

Datavant can help you **remove the burden of fulfilling record requests** through:
> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records
> **Release of Information Services:** Free up staff time with centralized and outsourced chart retrievals

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BlueCross BlueShield of Texas

Advantmed

MEDICARE MEDICAL RECORD REQUEST

1st MR Request Sent Date: July 23, 2024

Provider ID: [redacted]

TO: [redacted]	
Attention To:	Medical Records
Address:	7011 Southwest Freeway,
City, State Zip:	Houston, TX 77074
Phone:	(713)970-7000
Fax:	(713)970-3817

FROM: ADVANTMED	
Address:	17981 Sky Park Circle, Building 39/Suite B & C
City, State Zip:	Irvine, CA 92614
Phone:	(800)698-1690
Fax:	(800)340-7804
Email:	Providersupport@advantmed.com
Website:	https://www.advantmed.com

DUE DATE: July 30, 2024

Dear Physician Or Office Administrator

Blue Cross and Blue Shield of Texas has partnered with Advantmed to collect and review medical records Risk Adjustment Data Collection & Reporting.

Advantmed offers multiple methods to submit records in response to this request. Please consider uploading records through our "SECURE UPLOAD PORTAL" to expedite the process.

Upload
Most Convenient and Secure Method:
To upload records securely visit
https://www.advantmed.com/uploadrecords

Fax
To fax records toll free, use our secure fax lines:
(800)340-7804 (Main Fax Line)
(949)222-0185 (Alternate Fax Line)

Email
To email records to our secure server:
records@advantmed.com

Mail
To mail records, please send to:
17981 Sky Park Circle, Building 39/Suite B & C,
Irvine, CA 92614

Please use link for sharing your feedback: 'https://secure1.advantmed.com/ClientPortals/SurveyForm'

JUL 24 2024

RECEIVED

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 7 BUSINESS DAYS.

FROM: Southeast Pharmacy (Sender's Name) **TO: EXL Service**

Secure Fax: 844-505-8246
Encrypted Email: Optum.RxPVR@exlservice.com

# of Pages:_____ (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: July 24, 2024

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
1215313	[redacted]	[redacted]	07/19/2024	INVEGA TRINZ INJ 819MG	

Please Remember to:

1. **Add Comments above, if needed.**
2. **Check the appropriate box below, as applicable.**
3. **Submit a copy (front and back) of the prescription listed and any additional supporting documentation (e.g., electronically stored prescription clarifications).**
4. **Include this Records Transmittal Page with document submission.**

[X] I ATTEST TO THE CLAIM(S) BEING BILLED CORRECTLY.

[ ] I ATTEST TO THE CLAIM(S) BEING BILLED INCORRECTLY AND REVERSED (ORx will verify and reverse as appropriate).

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO_____
(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

[redacted] 7/25/24

Pharmacy Manager / Representative Signature Date

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	medical records	Date:	7/24/2024
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7330

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

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OR securely respond to this single request at www.cioxlink.com using these credentials:

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- Password: [redacted]

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Contact

4.Fax:
Send secure faxes to 972-729-6174

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Datavant
2222 W. Dunlap Ave
Phoenix, AZ 85021

JUL 25 2024

RECEIVED

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Show All | Refresh | Spell | Hide Guidance | Unhide

Review Period		
03.21.2024	Thru	07.05.2024

Reviewer Contact Information		Monitoring Review of	
Name/Title:	Jaleesa Tilley-Weeks & Jandale Wallace; Program Specialist V	Contractor:	ACCESS, Burke Center, Central Plains Center, Gulf Coast Center, The Harris Center for Mental Health and IDD, and Lakes Regional MHMR
Monitoring Entity:	HHSC BHS QM MH	Location:	N/A
Phone/Email:	jaleesa.tilley@hhs.texas.gov, jandale.wallace01@hhs.texas.gov	Monitoring Period:	FY23 (Entire Year)

Row	Citation	Statement	Score	Row Comments	Person Responsible		
					Title	First Name	Surname
	Clinical Record Review						
	PASRR MI						
	PASRR						
17	303.912 (4)	(4) documentation of all meetings, including the required 30, 60, and 90 day follow-up meetings held after the initial IDT meeting for a resident with MI who refuses MI specialized services;	46.15%	PASRR MI refusal record did not include documentation of 30, 60, 90 day follow-ups			
	PASRR Process for Service Initiation						
21	303.905 (c)(1)(2)	(c) Within 20 business days after the IDT meeting, if the resident with MI or LAR agrees, the LMHA or LBHA must: (1) complete the uniform assessment; (2) develop the PCRP;	50.00%	PCRP and Uniform Assessment were not completed within 20 business days of the IDT meeting			
22	303.905 (c)(3)	(c)(3) for a resident with MI only, convene a meeting to discuss the results of the uniform assessment and PCRP, and to determine the MI specialized services the resident with MI will receive.	20.00%	a meeting did not occur to discuss the results of the PCRP and Uniform Assessment			
23	303.905 (d) (1-4)	(d) Attendees at the meeting convened in accordance with subsection (c)(3) of this section must include: (1) the QMHP-CS who completed the uniform assessment and PCRP; (2) the resident with MI; (3) the resident with MI's LAR, if any; and (4) a NF staff person familiar with the resident with MI's needs.	50.00%	PASRR MI update meeting did not include the required participants			
	PASRR Renewal and Revision of Person-Centered Recovery Plan						
26	§303.907 (a)(1)(2)	(a) At least quarterly, the QMHP-CS must convene an MI quarterly meeting to: (1) review the PCRP to determine whether the MI specialized services previously identified remain relevant; and (2) determine whether the current uniform assessment accurately reflects the resident with MI's need for MI specialized services in the identified frequency, amount, and duration, or if an updated uniform assessment is required.	50.00%	PASRR MI record did not include documentation of quarterly meetings			
27	§303.906	The QMHP-CS, in conjunction with the MI specialized services team, develops, reviews at least quarterly, and revises as needed the PCRP for each resident with MI in accordance with §301.353(e)-(g) of this title (relating to Provider Responsibilities for Treatment Planning and Service Authorization).	66.67%	PASRR MI record did not include quarterly meetings with MI specialized services team			

31	303.907(e)	(e) Within ten calendar days after the PCRP is updated or renewed, the QMHP-CS must send each member of the MI specialized services team a copy of the revised PCRP.	50.00%	PASRR MI specialized services team did not receive copies of the revised PCRP			
	PASRR Service Delivery						
33	303.908 (a)	(a) The LMHA or LBHA must begin delivering all MI specialized services in accordance with the PCRP within five business days after the MI specialized services team meeting	60.00%	PASRR MI service delivery did not occur within 5 business days of the team meeting			
	PASRR Documentation						
37	303.912 (3)(B)	An LMHA or LBHA must maintain the following documentation in the resident with MI's record: (3) documentation related to monitoring MI specialized services, including: (B) progress or lack of progress toward achieving goals and outcomes identified in the PCRP;	40.00%	PASRR MI record did not include documentation of progress or lack of progress toward achieving goals and outcomes			

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Notice of an Outstanding Medical Record Request

Outreach ID: [redacted]

This is a reminder regarding a previoulsy submitted Medical Records Request.

If you have not submitted these medical records, your immediate response is required.

Please find details of this outstanding request in the following pages.

For questions or assistance regarding this notice, please contact our Provider Support team at 1-877-445-9293, or via email at chartreview@datavant.com

To fulfill this request for medical records, please use one of the following options:

- To return records online, visit our secure, easy to use drag & drop provider portal at www.cioxlink.com
- To return records via secure fax, please use the Fax Number contained in the attached request for records, or our main fax numbers: **1-972-729-6194** or **1-972-865-7844**.
- To return records through the mail, please mark "Confidential" on the envelope and address to:
  Datavant
  2222 W. Dunlap Ave
  Phoenix, AZ 85021
- Need assistance in processing this chart request? Datavant can help. Schedule on-site retrieval with a complimentary Datavant Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Datavant by contacting 1-877-445-9293.

We value your Partnership and appreciate your attention to this time sensitive matter.

Want to reduce phone calls and faxes from Datavantand eliminate the burden of medical record retrieval? Email auditrelief@datavant.com

AUG 09 2024

RECEIVED

datavant
Formerly named Ciox Health

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datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

AUG 16 2024

Chart Review Request

RECEIVED

To:	medical records	Date:	8/15/2024
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

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- Password: [redacted]

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reveleer

Today's Date: 08/13/2[illegible]
Due Date: 08/22/202[illegible]

To	ATTN-Medical Records	**From**	Reveleer
Provider Name	The Harris Center For Mental Health And Idd	**Requester**	PSR - [redacted]
Provider Fax	(713) 970-3315	**Provider Phone**	

REQUEST FOR MEDICAL RECORDS

Department of *Health and Human Services & Centers for Medicare and Medicaid Services* Risk Adjustment Data Validation – Initial Validation Audit (HRADV-IVA)

January 1, 2023, through December 31, 2023

Reveleer is contacting you to request medical record documentation as listed below as soon as possible. To give you adequate time to prepare the necessary information, Reveleer is providing you with retrieval details and a specific list of plan members that are part of this review.

Aetna is requesting your cooperation by providing specific patient medical records from your office to facilitate the medical record review. As you may know, Risk Adjustment is the payment methodology used by (CMS) Centers for Medicare and Medicaid Services for Affordable Care Act (ACA) members based on the patient health status. To assess your medical record documentation of the patient health conditions, it is necessary to perform ongoing chart reviews to evaluate the accuracy and completeness of your medical record documentation.

Reveleer has entered into a Business Associate Agreement with Aetna and, as such, is bound by applicable federal and state privacy and confidentiality requirements in conducting this activity on Aetna's behalf. Any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding the confidentiality of patient records, including current HIPAA requirements.

Reveleer requests documentation for dates of service within **January 1, 2023, through December 31, 2023.**

Please refer to the Member Pull list for specific dates of service and the IVA Documentation Check List. Please note- To avoid follow up calls to your office, please ensure the attached attestation form is completed.

Thank you for your participation. Please send your records using one of the following options:

1. **Provider Gateway** – A portal with unique pin to upload charts securely to Reveleer Platform https://platform.reveleer.com/providergateway

o Pin located on Member Pull List page (see attached)

2. **Remote Download** – For secure access EMR set up; email us at **EMR@Reveleer.com**

AUG 19 2024

RECEIVED

datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	medical records/debra	Date:	8/16/2024
Fax Number:	(713) 970-6021	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@datavant.com with any questions.

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Phoenix, AZ 85021

AUG 22 2024

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datavant
Formerly named Ciox Health

Outreach ID: [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	8/16/2024
Fax Number:	(713) 970-6021	Phone Number:	(713) 970-7000

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Send secure faxes to 972-729-6174

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Harris County Community Supervision and Corrections Department

Teresa May, Ph.D.
Director

Trina Willis
Assistant Director

Harris County CSCD
Quality Improvement/Quality Assurance Unit
49 San Jacinto Houston, Texas 77002

The Harris Center FY 2024 Services Review

Date of Monitoring Activity: 05/09/24
Period Covered: 10/01/23 to 12/31/23.

Objectives

The review objectives were established prior to the review based on applicable laws, standards, contract agreement and departmental policies. The objectives define the scope of this review and are listed in detail throughout the report. The objectives focus on the following areas:

Objective 1: Develop an individualized treatment plan that addresses the needs of each individual served.

Measures: One hundred percent (100%) of individuals served will have a written individual treatment plan identifying objectives to be completed. It is expected that at least ninety-five (95%) of all individuals served will have an individual treatment plan identifying objectives to be completed with ten (10) working days of enrollment in the program.

Outcome:
Objective 1 met.

Comment:
All clients had a treatment plan present. Client Erin Garcia's treatment plan was completed 24 business days after admission. The remaining 24 client treatment plans were completed within 10 business days.

Objective 2: Client's progress on individualized treatment plans will be documented.

Measures: One hundred percent (100%) of individuals served will have chronological recordings in their case files documenting the client's level of participation and compliance with treatment goals and objectives, it is expected that at least ninety-five percent (95%) of individuals served will have chronological recordings in their case files on a weekly basis documenting the client's level of participation and compliance with treatment goals and objectives

Outcome:
Objective 2 met.

Comment:
Client Semion McGee was missing his December 18-22 weekly progress report. The remaining 24 clients all had their weekly reports present.

Objective 3: Each client exiting treatment will have a discharge plan completed and forwarded to the DEPARTMENT.

Measures: One hundred percent (100%) of the clients exiting treatment shall have a discharge plan prepared and forwarded to the DEPARTMENT. It is expected that at lease ninety-five (95%) of the clients exiting treatment shall have a discharge plan prepared and forwarded to the Department within three (3) working of the client's discharge.

Outcome:
Objective not met.

Comment:
Client Zarek Williams did not have a Discharge Plan present. It was however mentioned the discharge plan was discussed with the client in the CSS Chronos on 02/05/24.

Recommendation:
Assure all clients have a Discharge Plan present in their file for verification purposes.

Objective 4: A monthly summary of progress in the treatment program shall be located in the client's chart

Measures: One hundred percent (100%) of the files of individuals served will contain a type/computer generated monthly progress report. These progress reports shall detail the levels of treatment compliance and progress as established in their individual treatment plans during the previous month. Ninety-five percent (95%) of the files must reflect that a copy of the said report was sent to the Department by the 5th day the of the following month.

Outcome:
Objective 4 met.

Additional Observations:

1. Are direct care staff on site during all hours of operation?

YES ☐ NO ☒

Comment:
I was unable to verify. I was not provided a staff work schedule.

Recommendation:
Provide staff work schedules as records to verify direct care staff are on site during all hours of operation or provide written documentation or justification of why this was not provided.

2. From reviewing the attendance records maintained by Vendor, are the size of the groups for cognitive-based and process groups limited to sixteen (16) clients or less?

YES ☐ NO ☒

Comment:
I was unable to verify. I was not provided attendance records.

Recommendation: Provide attendance records to verify the cognitive based groups are limited to 16 clients or provide written documentation or justification of why this was not provided.

3. Are all counselors' caseloads limited to twenty (20) clients or less?

YES ☐ NO ☒

Comment:
I was unable to verify. Staff indicated in an email the caseload size was 15, however, I was not provided with supporting documentation.

Recommendation:
Provide documentation that verifies and supports caseload sizes or provide written documentation or justification of why this was not provided.

4. Is a complete nursing assessment conducted within ninety-six (96) hours of admission?

YES ☐ NO ☒

Comment:
Thirteen of the twenty-five clients did not have a nursing assessments present.

Recommendation:
Assure all clients have a complete nursing assessment conducted within 96 hours of admission.

5. Is a comprehensive offender assessment completed prior to placement or within ten (10) business days of admission?

YES ☐ NO ☒

Comment:
Sixteen of the twenty-five clients did not have Admission Assessments present, and twelve clients did not have an evaluation present. However, all clients had a TRAS completed prior to admission.

Recommendation:
Assure all clients have a comprehensive offender assessment completed prior to placement or within ten business days of admission.

Also, please inform the Auditor if the TRAS is now used in lieu of the admission assessment or the evaluation. All clients had a TRAS completed with/in 10 days of admission.

reveleer

AUG 30 2024

RECEIVED

Today's Date: 08/29/2024
Due Date: 08/30/2024

To	Attn: Medical Record- IVA Review	**From**	Reveleer
Provider Name	The Harris Center Southwest Community Service Center	**Requester**	PSR - [redacted]
Provider Fax	(713) 970-4373	**Provider Phone**	(855) 454-6182

REQUEST FOR MEDICAL RECORDS

Department of *Health and Human Services & Centers for Medicare and Medicaid Services* Risk Adjustment Data Validation – Initial Validation Audit (HRADV-IVA)

January 1, 2023, through December 31, 2023

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o Pin located on Member Pull List page (see attached)

2. **Remote Download –** For secure access EMR set up; email us at **EMR@Reveleer.com**

EXHIBIT A-5

Executive Summary

REIMBURSABLE SERVICES CONTRACTS AUDIT
(RSC0125)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

No findings to report.

Reimbursable Services Contracts Audit

(RSC0125)

INTERNAL AUDIT REPORT

October 15, 2024

David W. Fojtik, CPA, MBA, CIA, CFE

Director, Internal Audit

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CURRENT PROCESS

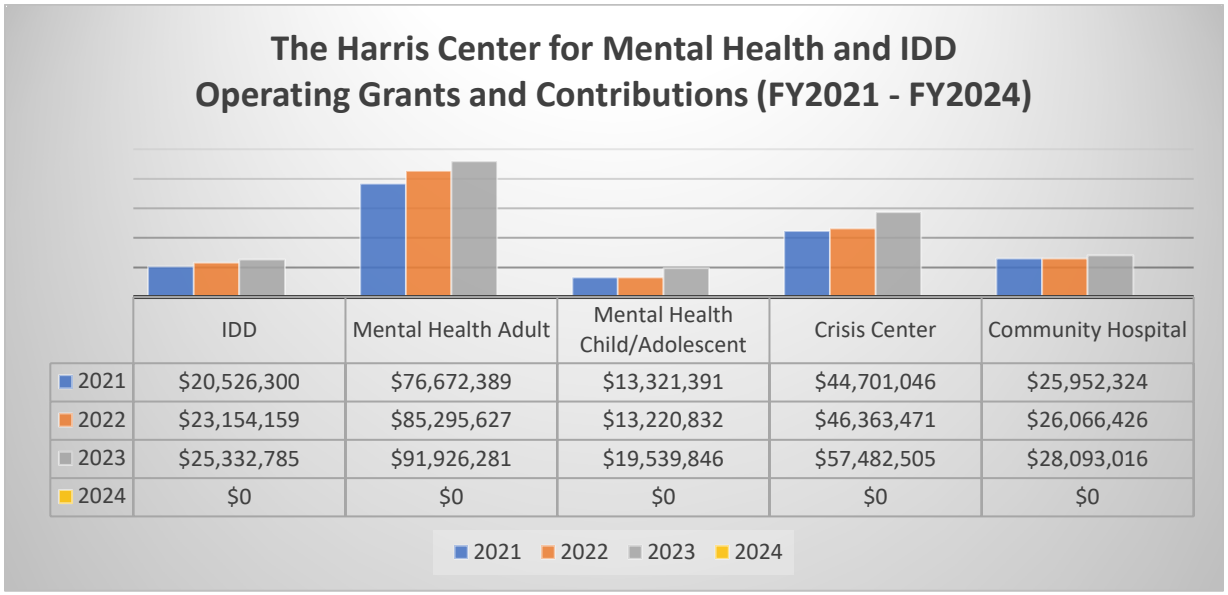
The Harris Center receives funding from 137 different sources including federal program funds that are "passed through" and therefore administered by the state agency associated with those contracts. The *Annual Comprehensive Financial Report (ACFR)* reporting that lists all the grant contracts in their report. In the current year, there are 83 reimbursable contracts which require active billing activity.

The goal for this audit is to affirm that appropriate billing activity is performed for the activity period, prepared by the stated deadline date, and reimbursable services charges are adequately supported by subordinate documentation (payroll records, cell phone reports of call activity, daily parking fees, etc.). In a prior reimbursable services audit, we found the details were compiled manually but the review showed that the most frequent issues were about "timing" issues. The remedy for "missed" charges was to add the charge to a future invoice, and the process accommodated that solution very well.

Financial Services sent us their list of reimbursable contracts that summarize the Center's key activities and year-end balances. The contracts are identified by their reporting frequency and deadlines, such as monthly, or quarterly, or by specific deadline dates. The current process is performed by six (6) active staffers in Financial Services versus one or two individuals who performed similar workloads in the past. The staff are well-versed in the mechanics of delivering the reimbursable billing activity in a timely way. There was a period when a previous staffer left the position, and the process went unfulfilled for several weeks, but in early 2024 the Controller reported the process resumed its full potential since that time.

The Harris Center's *Annual Comprehensive Financial Report* (ACFR), as of August 31, 2023 showed that revenue growth for operating grants and contributions increased in all ACFR specified service divisions (IDD, Mental Health Adult, Mental Health Child/Adolescent, Crisis center, and Community Hospital).

The grant program revenues represent reimbursable services contracts revenues, which include accruals and intergovernmental transfer (IGT) payments from federal, state and local governments. (Note: The comparable FY2024 data were not available as of October 1, 2024, but they continued to increase.)



	IDD	Mental Health Adult	Mental Health Child/Adolescent	Crisis Center	Community Hospital
2021	$20,526,300	$76,672,389	$13,321,391	$44,701,046	$25,952,324
2022	$23,154,159	$85,295,627	$13,220,832	$46,363,471	$26,066,426
2023	$25,332,785	$91,926,281	$19,539,846	$57,482,505	$28,093,016
2024	$0	$0	$0	$0	$0

Source: Annual Comprehensive Financial Report, The Harris Center for Mental Health, August 31, 2024

Internal Audit's sampling of reimbursable contracts

Financial Services stated there are 81 federal, state and local reimbursable contracts worth $68.5 million (as of the end of June, 2024), and our sample reviewed $38.7 million, or 56.4% of total contracts value.

Contract with	Contract Name	Assigned	Board Report	Unit
Baylor College of Medicine/ Texas Higher Education Board (THECB)	**Baylor State of Texas Child Mental Healthcare Cons TCMHCC (PWE1)**	**Javen**	**State Contracts and Grants**	**2405**
City of Houston	**CCHP 2.1**	**Trushar**	**Federal Contracts and Grants**	**9244**
Harris County	**CCHP 2.1**	**Trushar**	**Federal Contracts and Grants**	**9245**
City of Houston	**Chronic Consumer Stabilization Initiative (CCSI)**	**Javen**	**Harris County and Local**	**9229**
City of Houston Police Dept.	Clinician Officer Remote Eval (CORE)	**Edith**	Federal Contracts and Grants	9269
Various Community MH Center (7)	Crisis Intervention Helpline Srvcs	**Hayden**	Harris County and Local	7001
Harris County	Dual Diagnosis Residential Program Community Supervision& Corrections (Atasc.) DDRP CSCD	**Edith**	Harris County and Local	6401
HHSC	Early Childhood Intervention (ECI)	**Javen**	Federal Contracts and Grants	3360
HHSC	EMPLOYMENT NAVIGATOR PILOT	**Javen**	State Contracts and Grants	3501
HHSC/DADS	Enhanced Community Coordination (ECC)	**Hayden**	State General Revenue	3421
HHSC	Healthy Community Collaborative (HCC)	**Rachel**	State Contracts and Grants	9268
HHSC	Healthy Community Collaborative (HCC)	**Trushar**	State Contracts and Grants	9261
HHSC	HR133 Housing and Homelessness (A02)	**Hayden**	Federal Contracts and Grants	9267, 9501, 9504, 9505
HHSC	Independ. Living @ Dennis St (HCC)	**Trushar**	State Contracts and Grants	9243
Harris County Judge's Office	Jail Diversion Program	**Dawn**	Harris County and Local	9401, 9403, 9404, 9406
HHSC	**Jail-Based Competency Restoration (JBCR)**	**Dawn**	**State Contracts and Grants**	**6208**
Harris County Sheriff Dept.	**Jail-Based Competency Restoration Expansion (JBCR-E)**	**Closed Out**	**Federal Contracts and Grants**	**6207**
HHSC	Lifeline	**Javen**	Harris County and Local	7001
UT Health San Antonio	Medication Assisted Treatment Alco Substance Use Disorder (MAT AUD)	**Dawn**	Federal Contracts and Grants	9363
HHSC/DSHS	PATH	**Dawn**	Federal Contracts and Grants	2250
City of Houston	ReCenter	**Hayden**	Harris County and Local	9273
Harris County	RISE 24-1351	**Dawn**	Federal Contracts and Grants	9273
HHSC/DSHS	SA/OSR	**Dawn**	Federal contracts and Grants	2234, 2244
Texas Correctional Office on Offenders with Medical or Mental Impairments	TCOOMMI-Adult Services	**Becky**	State Contracts and Grants	6301, 6302, 6306, 6307, 6309, 6310, 6312, 6313
Texas Correctional Ofc on Offenders with Medical or Mental Impairments	TCOOMMI-Juvenile Services	**Becky**	State Contracts and Grants	6801
Harris County Juvenile Probation Dept. (HCJPD)	TRIAD Forensics Unit	**Edith**	Harris County and Local	6701
HHSC	Vocational Apprenticeship (VAP)	**Edith**	State Contracts and Grants	3412
Harris County	Youth Diversion Center (YDC)	**Edith**	Federal Contracts and Grants	6500

Source: FY24 Grant Financial Reporting Requirements Tracking (R. Beasley), Financial Services, August 2024

SCOPE AND OBJECTIVES

Audit Scope: This audit reviews The Harris Center's activities to fulfill reimbursable service contracts to focus on the Financial Services processing and engagement from The Harris Center's reimbursable services contract owners providing those services performed by The Harris Center's organizations.

Audit Objectives: The report is based on determining contract performance qualities that may:

1. Improve the Financial Services process so that their staffing resources are applied where needed.
2. Provide possible improvements in adding reporting transparency to the grant program managers and enable greater accessibility of grant reporting results for the Center's senior management.
3. Measure methods used for motivating contract owners to assist Financial Services in the process and highlight opportunities to advance the process to ensure more timely reimbursement.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes may include the following:

1. Management may not be willing to evaluate the reimbursable billing process due to limited staff or headcount allocations, or other resource limitations.
2. Management may not be able to adequately evaluate the billing process to effectively bring about process improvements.
3. Management may find that they require significant system development to overhaul the process.

FIELD WORK

Field Work: Internal Audit has performed the reimbursable services billing process audit in the past. The methodology has changed since Financial Services modified the staff assignment process. The field work for this current audit is subject to change, but this audit seeks to:

1. Obtain the list of the reimbursable services billing contracts in the Financial Services organization.
2. Review the universe of contracts and use a random sample of 28 invoices from 28 different grants to gain a broad sampling of invoicing activity.
    - Alternatively, stratify the sample so that the analysis includes coverage that would represent a balance of federal, state and local grants, or.
    - Generate a proposed list of grants of highest value and discuss with an independent source such as a Chief who can identify any known challenges to a given grant contract invoicing.
    - Use **\\mhmrdfs02\shares\Grant Billing** - H. Hernandez, Director Grant Administration, August 14, 2024
3. Identify the Financial Services contacts who perform the billing activity and interview them for their assessment of the current process and probe for possible improvements in the workflow.
4. interview the grant contract program managers and other process owners, and discuss their satisfaction levels with the current process, and probe for any potential process improvements.
5. Reconcile billing invoice amounts as reported in the PowerBI online trending reports.
6. Analyze any reporting bias that can overstate / understate the Harris Center's financial reporting and discuss ways to address reporting bias in the future invoicing activity with process owners.

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

No findings to report.

CONCLUSION

The reimbursable services contract process requires compilation of business unit operational expense data in order to provide periodic invoicing for compensating The Harris Center for contractual services. The reimbursable services contracts include federal programs, state grants and local grants from the City of Houston as well as from Harris County. The reimbursable services represent grants requiring active invoicing performed primarily by the grant administrators who represent Financial Services staffers.

The invoicing activity requires the acquisition of documented staff costs, such as salary and fringe data, any related IT and supply costs, computer usage fees, approved purchases for the unit's operations, and reconciliation with the general ledger. Many federal grants are administered by the state-level agencies, such as the Texas Department of Health and Human Services (HHSC). Contract requirements vary by program, and in some cases, some salary or fringe costs may be limited or excluded per the contract.

Internal Audit performed the last reimbursables services contract audit several years ago with analysis focused on five contracts successive monthly billings. In the current audit, we tested 28 programs for in invoicing quality (e.g., comparing results documented in reconciliation and system-generated reports to invoiced amounts), and for consistency (e.g., to assure that invoices contain comparable billable items in successive months), and that invoices clearly identify the provided service period.

The Financial Services team shared their online folders containing signed invoices, reconciliation work, accounts receivable histories, and in some cases the original contracts showing specific requirements. Internal Audit found clear reconciliation documentation and found that their grant files included many of the grant program manager's communications, which showed strong communication with the units.

Financial Services has been actively making improvements in their process in the past year and they have hired several new grant administrators during FY2024. Internal Audit interviewed several grant administrators and we found them to be a knowledgeable group producing an impressive work product.

Respectfully submitted,

David W. Fojtik

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Director of Internal Audit
The Harris Center for Mental Health and IDD

Kirk D. Hickey

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Staff Internal Auditor
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Executive Summary

REVIEW OF LOST/STOLEN LAPTOPS AUDIT (FUFAINV0125)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Finding #1 – Internal Audit reviewed the Center's Incident Reports system over a three-year period and we found four (4) incidents that included loss of their assigned laptop when that employees was terminated. Internal Audit contacted the managers of these units to determine if there was an update for the Incident Report, or an issue resolution in terms of employee payment for the unit, or recovery of the unit whenever it was not surrendered.

9401 Southwest Fwy Houston TX 77074	**Crisis Line**	**4/6/2022**	Employee quit unexpectedly and did not return her laptop. Many attempts were made to retrieve the laptop. Police report was made.
Off-Site	**AMH - NW Clinic**	**7/25/2022**	Employee was terminated on 7/25/22 from government agency, The Harris Center. The agency has attempted to acquire equipment. Agency sent 2 certified letters that were signed for but not responded to. Letters were sent 7/25/22 and 8/3/22. Agency also sent a driver to the home of employee on 8/2/22 and no one answered door.
3737 Dacoma St, Houston, TX 77092	**AMH - NW AOT Program**	**7/6/2023**	Employee resigned from the agency on 7/6/2023, but has not returned any of her agency equipment including: laptop, phone, key to NW building, badge. HR reached out to her and requested equipment returned and she agreed to return it, but never came to do so. Agency legal counsel sent a letter on 7/21/23 requesting return of these items.
9401 Southwest Fwy Houston TX 77074	**Crisis Line**	**2/23/2023**	Employee was terminated as a Crisis Line counselor because she abandoned her position after her maternity. She failed to return her laptop to the agency. Manager called, texted, emailed her with no response. Legal sent a certified letter to her residence in El Paso, Texas asking for the return of the laptop, however the certified letter was returned. A police report was filed with the El Paso Police.

Source: RLDatix Incident Report pulled for "Lost/Stolen Property," for FY2022 to FY2024

Recommendation: Before a terminated employee's last payroll check is issued, all Harris Center property used by the employee must be accounted for. This step is paramount, because holding the employee's last payroll check until all laptops (or other fixed assets) are returned is the only leverage the Harris Center has in recovering or obtaining compensation for missing assets. The Harris Center handbook states that if property is not returned, the Agency may deduct the cost from their last payroll check. Also, if an employee has not returned equipment, a letter is sent to let them know they have a week to return said equipment or the Center will file a police report for criminal theft of government property.

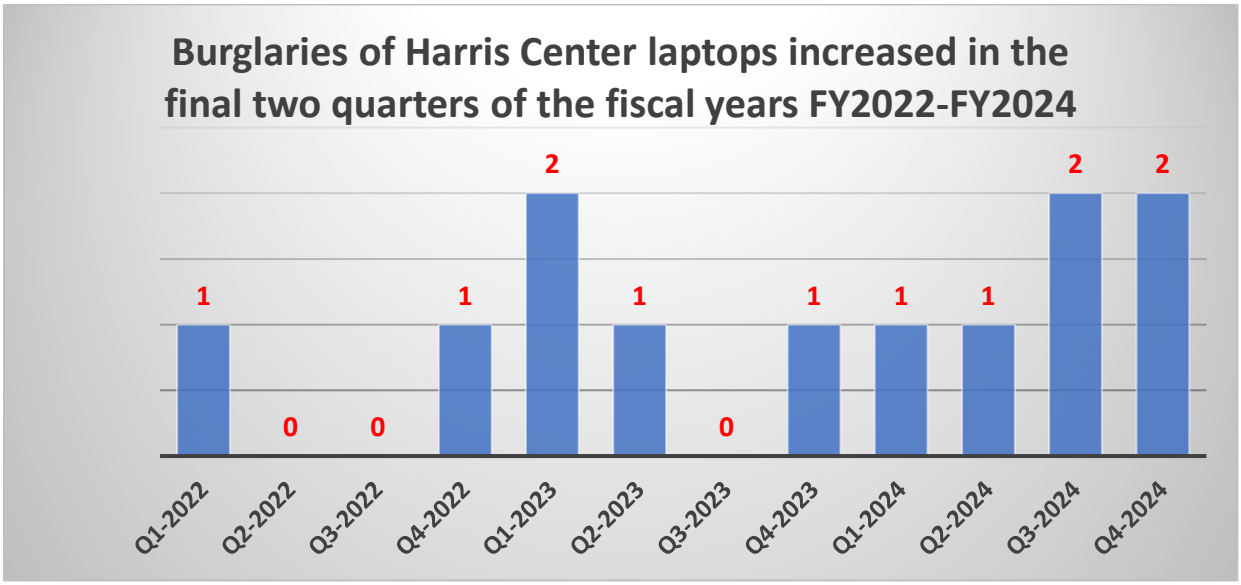
Management Response (Director, Human Resources): "*This would need to be an IT/Risk Management policy. HR currently has a separation checklist for managers to utilize to ensure they collect all agency equipment, badges, parking decals, along with reminders to submit the Access Form to terminate the employee's server access, email accounts, and who to provide file access to within the department (e.g. manager, new employee assuming the role). In the event an employee doesn't surrender agency equipment, a request is made by the Operations Leader to send a "demand" letter requesting the return of the agency equipment and coordinates with the IT Fixed Assets person and HR/Payroll regarding possible recoupment opportunities."*

Management Response (Chief Administrative Officer):

Observation #1 – Internal Audit reviewed the Center's Incident Report system over the three-year period (September 1, 2022 – August 31, 2024), which noted twelve (12) incident reports citing laptop losses due to items being stolen/lost/or not returned. We found that most of these stolen laptops were reported during the third or the fourth quarters (March – August) of the audited years.

Exhibit I shows number of stolen laptops by burglary between September, 2022 and September, 2024.

Exhibit I – Stolen and lost laptops reported as burglaries by employees



Source: RLDatix Incident Report pulled for "Lost/Stolen Property," for FY2022 to FY2024

Internal Audit also found eight (8) additional reports of "stolen and lost" laptops, which were not recoverable by the employee nor the fixed asset designee (FAD) responsible for the unit's inventory.

Management Response Not Required.

Review of Lost/Stolen Laptops Audit

(FAINV0125)

INTERNAL AUDIT REPORT

October 15, 2024

David W. Fojtik, CPA, CIA, MBA, CFE

Director, Internal Audit

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SCOPE AND OBJECTIVES

Audit Scope: This audit is a review of reported instances of stolen and lost fixed assets, specifically stolen and missing laptop computers. We will examine The Harris Center's policies and procedures for adequacy and recommend changes as needed.

Audit Objectives: An internal review of misappropriated fixed assets project has been approved by the Board to be included in Internal Audit's FY2025 Audit Plan, and our audit objectives are to:

1. Review the internal controls used to account for physical location and custody of fixed assets;
2. Report on any fixed assets that are misplaced, misused or misappropriated (stolen or disposed);
3. Determine ways to reduce situations in which fixed assets are being reported as misappropriated by recommending new reviews and enforcing employee accountability for custody of fixed assets.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes, including the following:

1. The Center's management does not act on findings from a misappropriated fixed assets audit report or enforce rules of employee accountability over assigned fixed assets including portable personal computers and laptops per the Center's policies and procedures.
2. The Center's management does not improve the record-keeping process used by the fixed asset designees (FADs) to assure more timely and accurate information to fortify the process integrity.
3. The Center's management cannot identify process priorities or fixed asset tracking item controls in the Center's current policy and procedures.

FIELD WORK

Field Work: A high-level summary of audit work is needed to address the audit objectives listed above:

1. Review the Center's fixed asset policies and procedures on record-keeping of fixed assets.
2. Plan a meeting with the Fixed Asset Examiner (FAE) who coordinates fixed asset process with the Fixed Asset Designees (FADs) who document moves or changes in the fixed asset tracking process.
3. Develop a questionnaire for the FADs to identify current challenges and pitfalls, identify process improvements, and discuss additional improvements for the fixed assets management process.
4. Review results of the questionnaire to track categorical outcomes: disposal due to obsolescence or due to physical loss of portable fixed assets including laptops, computers, printers and scanners.
5. Obtain a list of employees who reported the loss of fixed assets inventory due to misappropriation over the past three fiscal years (2022-2024) to identify higher risk behaviors or other factors that can lead to successive fixed asset misappropriation or recurring challenges in employee's custody.
6. Review Incident Reports involving lost or stolen fixed assets with the Fixed Asset Examiner (FAE) to determine what strategies can improve safeguarding of fixed assets and improve record-keeping.

CURRENT PROCESS

Internal Audit has performed annual fixed asset and inventory control audits over the past few years. We have sampled various fixed assets in their physical location and compared the items to the reports. Internal Audit collaborated with the Fixed Asset Examiner (FAE) on current issues of equipment status of alleged or potential misappropriations with members of the Center's staff. The Internal Audit process independently reviewed the fixed asset reports to assure currency and accuracy of the current database.

According to **FM.B.19 Property Inventory** policy, capital assets are $5,000 or more in value) while the controlled asset has a "value less than the capitalization threshold established for that asset type with a high-risk nature, that is, equipment with a historical cost between $500 and $4,999.99 and classified as: desktop computer; laptop computer; smartphone; tablet and other hand held devices; data projectors; TV's and video players/records, sound system and other audit equipment; camera-portable-digital SLR."

The **FM.A.3 Asset Tracking and Depreciation** policy states that "it is the policy of The Harris Center for Mental Health and IDD to conform with the Government Accounting Standards Board and report Center Property Plant and Equipment through the Comprehensive Annual Financial Report." [1] [2]

In the prior year reports, Internal Audit reviewed the police reports of laptop thefts. All thefts are recorded in the Incident Report (IR) platform and break-in details are also reported in the police reports. However, the actual recovery of fixed assets is problematic as the misappropriated or otherwise stolen items are likely damaged or disassembled if discovered and found after the event.

The Harris Center has a liability related to the loss of client data such as ePHI, which is worth many times more than the financial value of a pre-owned computer. The Harris Center carries an insurance coverage policy against these losses, and the policy details should be reviewed with Enterprise Risk Management for specific coverage details or any special provisions required.

The process challenges arise when transfer paperwork is not properly obtained or not reviewed by the fixed asset designees (FAD) or their approving managers. Whenever any of the items are not effectively tracked, they may "go astray," but our experience has been that the FADs locate these wayward items. However, the effort to track items down may require a substantial part of their workday and has a cost.

Internal Audit's concern is the inventory and record-keeping process over the fixed assets as the asset records in the corporate radar and other adjunct systems represent the key control to the inventory. Internal Audit relies on the accuracy of PowerBI fixed asset reports as an inventory control resource, and we have used these reports over the years to show anomalies that point out irregularities to investigate.

A related conversation in this review concerns fraud potential from employees to become involved in a situation in which they possibly know the perpetrator of the fixed asset's misappropriation, or could be involved to benefit from it in one way or another. When we review the names of the employees who are named in the incidents we may find situations that may have occurred in multiple years.

[1] Viewing FM.B.19 Property Inventory (policystat.com)

[2] Viewing FM.A.3 Asset Tracking and Depreciation (policystat.com)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

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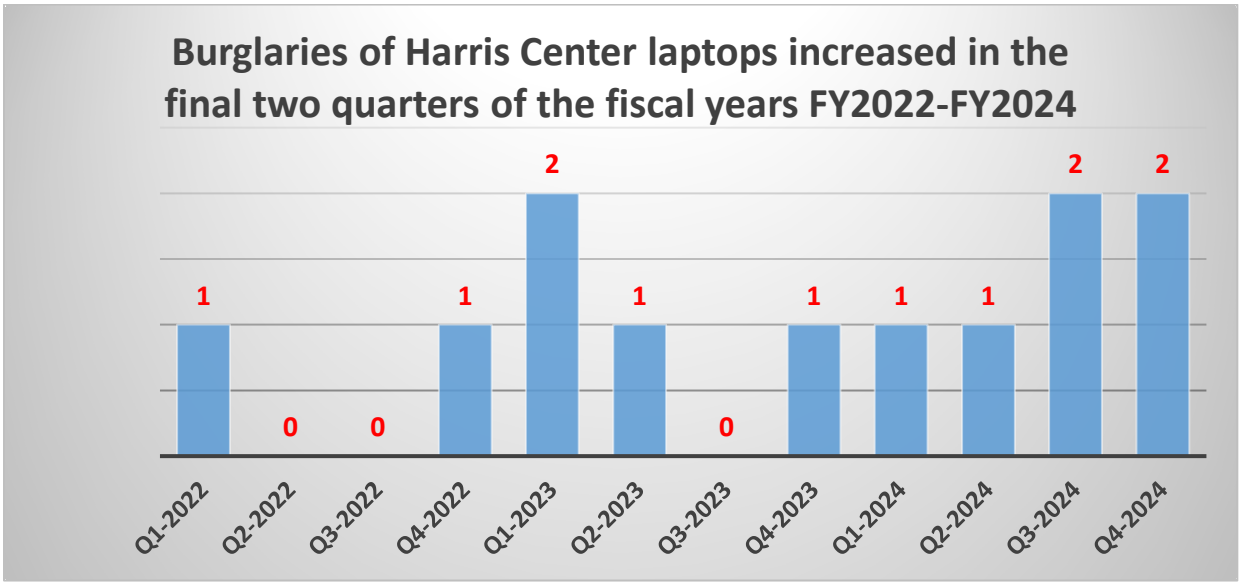

Source: RLDatix Incident Report pulled for "Lost/Stolen Property," for FY2022 to FY2024

Internal Audit also found eight (8) additional reports of "stolen and lost" laptops, which were not recoverable by the employee nor the fixed asset designee (FAD) responsible for the unit's inventory.

Management Response Not Required.

CONCLUSION

Internal Audit's focus has been generally on the business controls used in this record-keeping process.

This report concerned the frequency of misappropriations that are being reported at The Harris Center for fixed asset items such as Center laptops, as well as personal items such as employee purses and keys.

Internal Audit used the Center's Incident Report database, and we saw considerable amounts of activity. The RLDatix allowed us to evaluate and sort the types of misappropriation cases, which makes auditing the reports very efficient. From the reports, we found that reports identified as "Lost/Stolen" generally were burglarized from an employee's vehicle or home, or lost for any number of reasons.

We concentrated on instances in which laptops are misappropriated via burglary of a vehicle or a home. Using the RLDatix system we could filter selection for "laptops" and from a three-year reporting period we found 21 reports involving "laptop" losses, including 9 burglaries, 8 lost laptops, and 4 laptops that appear to be unreturned from terminated employees. The burglaries were reviewed to detect any recurring instances by the same employees which may suggest that some fraudulent activity occurred.

Internal Audit works closely with the Fixed Asset Examiner to assure that the Fixed Assets team can continue to track items and their physical location effectively in the Harris Center's various locations.

Respectfully submitted,

David W. Fojtik

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The Harris Center for Mental Health and IDD

Kirk D. Hickey

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Staff Internal Auditor
The Harris Center for Mental Health and IDD

Executive Summary

STATUS REPORT: FY2024 HARM REDUCTION PROGRAM (SRHRP0124)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – In FY2024, the Harm Reduction Program reimbursed 1 OSAR provider and 1 OSAR recipient totaling $142,976.05. In FY2023, the prior HHSC COVID-19 Program grant had paid out $496,190.67 in claim reimbursement payments.

Exhibit I – Summary of FY024 Harm Reduction Program reimbursements to HHSC Region 6 providers

Claim#	Provider Name (FY2024 Program)	Received Date	Payment Date	Amount
2024-01	Santa Maria Hostel Inv. #19658	1/15/2024	2/14/2024	**$14,436.32**
2024-02	Santa Maria Hostel Inv. #19662	1/15/2024	2/14/2024	**$18,569.52**
2024-03	Santa Maria Hostel Inv. #19693	2/29/2024	3/27/2024	**$14,895.37**
2024-04	Santa Maria Hostel Inv. #19717	3/28/2024	4/17/2024	**$15,564.02**
2024-05	Santa Maria Hostel Inv. #19728	4/10/2024	5/1/2024	**$18,451.09**
2024-06	Santa Maria Hostel Inv. #19759	5/9/2024	5/15/2024	**$14,177.83**
2024-07	Santa Maria Hostel Inv. #19791	6/7/2024	6/19/2024	**$11,188.00**
2024-08	Santa Maria Hostel Inv. #19817	7/17/2024	7/24/2024	**$16,787.01**
2024-09	Santa Maria Hostel Inv. #	8/19/2024	08/28/24	**$13,876.65**
2024-10	The Council On Recovery Inv. #	8/19/2024	08/28/24	**5,030.24**
	FY2024 Harm Reduction Program (OSAR Covid-19 Grant Program) TOTAL:			**$$142,976.05**

Source: Internal Audit records, OSAR Program Administration (Internal Audit), from September 1, 2023 through August 31, 2024

Management Response #1 (Director of Special Mental Health Projects):

Status Report: 2024 Harm Reduction Program (SRHRP0124)

INTERNAL AUDIT REPORT

October 15, 2024

David W. Fojtik, MBA, CPA, CIA, CFE

Director, Internal Audit

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CURRENT PROCESS

This status report on the FY2024 Harm Reduction Program for OSAR Providers is a grant program that succeeded the FY2022 and FY2023 COVID-19 OSAR reimbursement programs, which were administered by the Texas Department of Health and Human Services Commission (HHSC) agency.

The program is designated for OSAR (Outreach, Screening, Assessment, and Referral) providers in the agency's Region 6 of Texas which includes: Harris, Liberty, Montgomery, Walker, Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Matagorda, Waller, and Wharton counties. The Gulf Coast Center, which is based in Texas City, has also provided like services in many of these counties. [1]

The Harm Reduction Program was introduced at The Harris Center as a new grant in September 2022, which was led by the Mental Health Division's Director of Special Mental Health Projects. The FY2024 program reimbursed OSAR providers for a variety of client-facing services, purchases of PPE and basic health supplies, COVID testing kits, health kits and more, as provided to clients in the Region 6 area.

The Council On Recovery's Senior Director of Program Operations has provided guidance on interpreting allowable reimbursements for providers, based on the Harm Reduction Program's grant requirements which include a list of Allowable Items.

The Internal Audit staff receives incoming requests for reimbursement primarily come one provider who seeks to reimbursement for medical and healthcare kits, PPE purchases, and for client transportation on Metro passes and taxis. The review and approval process uses two additional reviewers of the team, including the Director of Special Mental Health Projects, Director of Internal Audit, and Senior Director of Program Operations at The Council on Recovery (TCOR). The fully approved reimbursement is issued for payment generally once a month, and in past months has required four to five hours of evaluation.

The Harm Reduction Program team reviewed submitted requests compared these requested amounts on the summary form against amounts on online sales documentation or on actual cash register tapes. The Staff Internal Auditor served as the workflow administrator and the main contact for the Region 6 providers. The Staff Internal Auditor tests submissions for fraud, waste and abuse, and regularly checks for duplicate items and disallows items specifically restricted from the Harm Reduction Program rules.

Internal Audit enhanced our knowledge of the review process by calling one or more of the contacts at the Texas Department of Health and Human Services (HHSC) who have provided expertise in the program, which helps make the correct call on approving submitted reimbursement items. Over time, the contacts and the OSAR review team members met by conference call to assure we were 'on track'.

The FY2024 Harm Reduction Program will end on August 31, 2024, but HHSC has launched the new FY2025 Harm Reduction Program, with a larger budget of $200k annually, and ends August 31, 2025.

[1] https://www.hhs.texas.gov/services/mental-health-substance-use/mental-health-substance-use-resources/outreach-screening-assessment-referral

SCOPE AND OBJECTIVES

Audit Scope: The Director of Internal Audit approved joining the team to review and approve requests from OSAR providers located in the Texas Department of Health and Human Services (HHSC) Region 6, which includes OSAR providers based in Harris County and ten (10) surrounding counties in Texas.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes, including the following:

1. The review team does not adequately identify reimbursement requests that are not eligible for reimbursements in accordance with the HHSC's Harm Reduction program grant documentation.
2. The review team submits completed financial reimbursements to the Financial Services teams for items previously reimbursed by other agencies or other governmental reimbursement programs.

FIELD WORK

Field Work: A high-level summary of audit work is needed to address the objectives listed above:

1. Identify the OSAR provider list from the Texas Department of Health and Human Services (HHSC), and determine the primary contacts for each of these organizations.
2. Contact the Harris Center's Controller and explain that providers submit reimbursement requests over time but not with any regularity, unless it is specified as such by the provider.
3. Ensure that the Harris Center's Controller's office has provided the latest version of the W-9 form, and the Harris Center's ACH authorization form for the provider to complete.
4. Send an introduction and announce the availability of the grant reimbursement program and send them basic documents to be used in the providers' submissions: the reimbursement form (excel), the program documentation from HHSC, and W-9 form, and the Center's ACH authorization form.
5. Review reimbursement requests daily and inform the provider when the submitted reimbursement materials are to be initially reviewed.
6. Reconcile the Reimbursement Form amounts to all submitted documentation that were provided as supports. Add Notes to the documentation to assist team reviewers about the Form inspection.
7. As needed, reach out to the Texas Department of Health and Human Services contacts to evaluate any concerns or questions about item eligibility or about inquiries from out of area OSAR providers who may contact us about joining the reimbursement process we have established. (To date, we have not found OSAR providers contacting us to seek reimbursement payments for this grant.)
8. Request written approval from the team members and seek one or more acknowledged approvals before forwarding request to Controller's office for their review.
9. Verify on Aptean Ross Browser that payments were processed in a timely manner (within 10 days), otherwise send an inquiry to the Controller's office about the status of the reimbursement. Verify that all payment requests are read at the Controller's email and payments fulfilled as documented on Ross Browser. (Note: A payment may be bundled with other payments to the OSAR provider, so total payment may appear to be greater than the COVID-19 reimbursement payment amount.)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – In FY2024, the Harm Reduction Program reimbursed 1 OSAR provider and 1 OSAR recipient totaling $142,976.05. In FY2023, the prior HHSC COVID-19 Program grant had paid out $496,190.67 in claim reimbursement payments.

Exhibit I – Summary of FY024 Harm Reduction Program reimbursements to HHSC Region 6 providers

Claim#	Provider Name (FY2024 Program)	Received Date	Payment Date	Amount
2024-01	Santa Maria Hostel Inv. #19658	1/15/2024	2/14/2024	**$14,436.32**
2024-02	Santa Maria Hostel Inv. #19662	1/15/2024	2/14/2024	**$18,569.52**
2024-03	Santa Maria Hostel Inv. #19693	2/29/2024	3/27/2024	**$14,895.37**
2024-04	Santa Maria Hostel Inv. #19717	3/28/2024	4/17/2024	**$15,564.02**
2024-05	Santa Maria Hostel Inv. #19728	4/10/2024	5/1/2024	**$18,451.09**
2024-06	Santa Maria Hostel Inv. #19759	5/9/2024	5/15/2024	**$14,177.83**
2024-07	Santa Maria Hostel Inv. #19791	6/7/2024	6/19/2024	**$11,188.00**
2024-08	Santa Maria Hostel Inv. #19817	7/17/2024	7/24/2024	**$16,787.01**
2024-09	Santa Maria Hostel Inv. #	8/19/2024	08/28/24	**$13,876.65**
2024-10	The Council On Recovery Inv. #	8/19/2024	08/28/24	**5,030.24**
	FY2024 Harm Reduction Program (OSAR Covid-19 Grant Program) TOTAL:			**$$142,976.05**

Source: Internal Audit records, OSAR Program Administration (Internal Audit), from September 1, 2023 through August 31, 2024

Management Response #1 (Director of Special Mental Health Projects): No response received.

CONCLUSION

The Harris Center for Mental Health and IDD was designated as the administrator of the Harm Reduction Program grant which was issued by the Texas Department of Health and Human Services (HHSC).

The Harm Reduction Program reimbursements are supported by the Director of Mental Health Projects, who introduced it to us with the local OSAR program contact (e.g., The Council on Recovery in Houston). The grant was created to provide reimbursement funds to OSAR providers who incurred incremental such as for personal protective equipment (PPE) purchases, client transportation, and infection control measures to mitigate the spread of COVID-19 by adapting client housing, etc.

The Harris Center as well as the Gulf Coast Center in Texas City were responsible for supporting the HHSC Region 6 OSAR providers. We have identified 24 OSAR providers in HHSC Region 6 (Harris County). Over the course of several years, we have worked with six (6) OSAR providers, and in FY2024 we worked with fewer reimbursement requests from two (2) local Region 6 OSAR providers.

The review team consists of Internal Audit staffers, the Director of Special Mental Health Projects and Executive Director of Special Projects from The Council On Recovery (TCOR), the local OSAR provider. Internal Audit performs mostly arithmetic checks and eligibility checks and found no unsubstantiated claims and worked effectively with OSAR providers who were compliant with the grant's rules.

At a recent meeting with HHSC, the grant administration contacts announced an expanded budget of grant to $200k for the FY2025 grant starting September 1, 2024.

Respectfully submitted,

David W. Fojtik

David W. Fojtik, MBA, CPA, CFE, CIA
Director of Internal Audit
The Harris Center for Mental Health and IDD

Kirk D. Hickey

Kirk D. Hickey, MBA, MIM, CFE
Staff Internal Auditor
The Harris Center for Mental Health and IDD

ANNUAL REPORT ON FISCAL YEAR 2024 INTERNAL AUDIT ACTIVITIES INCLUDING

APPENDIX 1 – FY 2024 ISSUE TRACKING MATRIX

APPENDIX 2 – FY 2025 AUDIT PLAN

David W. Fojtik, CPA, CIA, CFE
Internal Audit Director

Kirk D. Hickey, CFE
Staff Internal Auditor

October 15, 2024

9401 Southwest Freeway
Houston, Texas 77074

Annual Report on Fiscal Year 2024

Purpose of the Annual Report: To provide information on the benefits and effectiveness of the internal audit function.

Table of Contents

I. Message from the Director of Internal Audit

I am pleased to submit the Internal Audit Annual Report for the fiscal year ended August 31, 2024. This report itemizes the services provided and other activities performed by the Harris Center Office of Internal Audit and fulfills the Texas Internal Auditing Act (the Act) requirements set out in Texas Government Code, Section 2102.009.

Included in this report are Internal Audit's Key Wins and Accomplishments for Fiscal Year 2024, the results of five (5) Board approved audit plan, explanations for any deviations from the audit plan, and results of six (5) Special Management Requests, and four (4) Follow-up Audits that were completed during the fiscal year. The results of these reports have been communicated to the Board of Trustees through the Audit Committee.

I believe the work of the Office of Internal Audit contributed to making The Harris Center's operations more efficient and effective by providing positive contributions to risk management efforts, control systems, and governance processes.

The Harris Center's Internal Department in FY2024 incorporated myriad creative solutions in orchestrating new efficiencies — as well as new methods — in evidence gathering. We have experienced and benefitted from the Center's willingness to build cloud-based platforms that are designed to not only facilitate remote collaboration but automate workflows and we were successful in streamlining and facilitating the actions of multiple stakeholders to reach common, intersecting goals.

Internal Audit always strives to uphold the goal that the Board and management can rely on the collective competencies of the internal audit staff to think critically and to address high priority risks. We will continue to utilize data analytics in routine audits which are quick and discrete wins typically found in complex core business processes, such as accounts payable, travel, payroll, general ledger, and in IT.

At this time, we are pleased to present the following recap of audit activities in Fiscal Year 2024. We thank you for your continued support of the Internal Audit Department.

David W. Fojtik

September 27, 2024

II. The Internal Audit Department's Mission and Responsibilities

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Mission Statement

Internal Auditing is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

— The Institute of Internal Auditors (IIA) Standards for the Professional Practice of Internal Audit

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Internal Audit's goals are to assist the Center accomplish its objectives by bringing a systematic, disciplined approach in evaluating and improving the effectiveness of risk assessment and risk management models. Internal Audit works to ensure that The Harris Center's business risks are being mitigated or accepted, or easily transferred or managed within an acceptable degree.

The Internal Audit Department's charge is derived by The Harris Center's Board of Trustees' ("the Board") need to perform various independent reviews of key business processes and auditable entities at the Center. The Director of Internal Audit is appointed to provide the unique consultative role that can truly provide an objective functional responsibility to the Board and the Audit Committee members, and at the same time he can maintain the administrative responsibility to the Chief Executive Officer.

The Internal Audit Department's primary responsibilities include:

1) Establishing an annual risk assessment of the Center's business units (auditable entities).
2) Performing reviews of auditable entities to evaluate their internal controls and management's compliance to such controls.
3) Recommending best practices, where possible, and soliciting meaningful corrective action plans.
4) Monitoring the Center's operations for observations of waste, abuse, and fraud in Center offices.

5) Challenging the Center's business units' management teams to integrate process improvements into their workflow whenever and wherever feasible.
6) Dialoguing issues with members of the Center's senior management and Chief Executive Officer, and as needed, additionally with the members of the Board of Trustees.
7) Presenting the results of Board-approved audit reports to the Audit Committee during the year.
8) Educating the Center's management and staff on changes in federal, state, and local regulations.
9) Promoting management's training of their employees for performing their job duties efficiently, and to strive for employee compliance in their job functions.
10) Maintaining the anonymous hotline for employee and consumer reports of waste and fraud with an external fraud hotline service called Fraud Hotline (www.fraudhl.com), which allows employees to self-report fraud, waste, or abuse, and relay their own ideas for process improvement.

The Internal Audit Department mission is to enhance and protect THC's organizational value and its reputation by providing risk-based business process assessments (BPAs) that identify new opportunities for growth as well as provide various objective assurance services, auditing skills, and investigative services.

Internal Audit has worked with external auditor firms, business consultants, industrial psychologists, and other healthcare professionals to evaluate complex healthcare business issues.

III. Internal Audit Department Services

The Internal Audit Department is responsible for continuously assessing the Center's tolerance for risk by developing audit objectives, priorities and procedures that balance risk with effective internal controls.

While Center management is solely responsible for adherence to internal controls, the Internal Audit Department is (within the audit scope) solely responsible for evaluating the adequacy and effectiveness of these controls.

Internal control comprises methods and procedures are adapted to:

* Safeguard physical and digital assets and promote operational efficiency.
* Check accuracy and reliability of financial and other operational data.
* Encourage adherence to the Center's established policies and procedures.
* Discourage waste, abuse, and misuse of the Center's resources by soliciting employee tips on a toll-free number or by the fraud website.
* Review clinical and business office operations to ascertain consistency with the Center's goals.

It is the responsibility of the Internal Auditor to give an opinion, at least once annually, on the adequacy and effectiveness of financial and other internal controls used in the key business processes at the Center. This opinion is based on the adequacy of controls noted from a selection of risk-based system audits and other advice work on control systems. such as the results of investigative inquiries, fieldwork of performing internal process reviews, and the evaluation of audit reports produced by external sources that can enhance the Internal Auditor's opinion of the particular findings during internal audit.

Internal Audit worked to support The Harris Center's achievement of its mission by strengthening internal controls, applying proven scientific management principles, aligning Agency and departmental resources, and through ongoing fraud deterrence and prevention. Internal Audit continued to refine the audit approach and methodologies in order to build stronger levels of proficiency and increase the understanding of the Harris Center's culture and build long-term and trusting relationships with the Board of Directors.

The Internal Audit Department's mission provided an unbiased and independent assurance of business processes and consulting services that add value by improving the organization's business operations.

Internal Audit helped the units accomplish its goals by using a systematic, disciplined fraud risk assessment approach to improve the effectiveness of risk management, control, using three primary objectives:

* Mitigating or even avoiding potential losses.
* Increasing process efficiency and effectiveness; and
* Ensuring resources are applied toward accomplishing the Center's vision, mission, and goals.

Internal Audit has performed five (5) types of audit and consultative services throughout the year:

Traditional Audits: Internal Audit reviewed management, financial, and operating controls to appraise the soundness and adequacy of the controls and advise management whether the internal control systems provide reasonable assurance regarding the achievement of objectives; that established plans, policies and procedures are complied with; and assure The Harris Center's assets are being properly accounted for and are being safeguarded from loss. Internal audits regularly result in recommendations to management to use in improving operating efficiency.

Advisory Services: Internal Audit undertook management requested reviews of current operating practices and our prevailing policies and procedures and identified changes in the system of internal controls occurring with system development and implementation, financial and operational processes, or process improvement.

Fraud Assessments and Investigations: Internal Audit investigated allegations of fraud, waste, conflicts of interest, or improper governmental activities which determined if the conditions were to be confirmed as material in magnitude or have great likelihood to pose future business risks to the Center or substantiated for a future review.

External Audit Coordination: Internal Audit has been the external auditors' liaison to The Harris Center. Internal Audit coordinated projects and contracts, performed key communications and data exchanges during the performance of business process and operational audits, process reviews and provide singular contact for any future investigations between the Center and all external audit agencies, including public accounting firms.

Data Analytic Services: Internal Audit has usually performed a variety of traditional audits and maintains its responsibilities over audit project performance, advisory services, fraud assessments and investigations. However, the audit professional training seminars widely support integration of more data analysis and other online tools in order to review complete sets of business data versus traditional sampling tools. Internal Audit will continue to use IDEA CaseWare, a data analytical software package that has desktop auditing tools to view large volumes of business data.

The IDEA CaseWare platform provides a continuous monitoring processing in our the business data in order to identify data anomalies and identified irregularities which pinpoint a "guardrail" failure or fraudulent activity. Internal Audit implemented this platform on our key business data to assure adequate and comprehensive review of these data, by using analytics to test for duplicate invoices, which may indicate fraud, or at least dubious integrity or poor accounting methods used by a vendor's accounting department.

Continuous monitoring processing is superior to sampling methods because it is capable of reviewing complete data sets. During FY2024, Internal Audit led the project to install the IDEA continuous monitoring modules designed by award-winning firm Audimation CaseWare. It was completed in FY 2024.

IV. Departmental Statement of Goals and Goal Assessment Results

Goal #1: Conducted scheduled and unscheduled audits to provide management with appraisals of the Center's compliance with policies and procedures as well as local, state, and federal laws, and regulations.

Assessment for Goal #1: Developed an annual audit plan that was approved by the Center's Audit Committee. Performed active testing and reviews of the projects approved by the Audit Committee. Identified key controls used to ensure compliance, identified internal control weaknesses, and made constructive recommendations to management.

Goal #2: Insured compliance with those requirements mandated by government standards as defined by the Institute of Internal Auditors (IIA), the Governmental Accounting Standards Board (GASB), and the Association of Certified Fraud Examiners (ACFE).

Assessment for Goal #2: Scheduled and unscheduled audits were performed in compliance with applicable governmental auditing standards as outlined in the 2014 published guidelines, as provided by the Comptroller General of the United States.

The Internal Audit staff also completed annual trainings, maintained professional memberships and certifications to remain on the forefront of new governmental auditing standards and emerging trends and issues such as ransomware and business email compromise.

V. FY2024 Key Activities and Accomplishments

FY2024 Key Activities

- Internal Audit completed a risk assessment of The Harris Center's key auditable entities while preparing the collection of future audit projects, as shown on the Internal Audit proposed Fiscal Year 2025 Audit Plan.
- Internal Audit completed five (5) Board-approved internal audit projects listed in the order shown in Table I. Note that audit projects with the higher calculated risk ratings had been prioritized for an earlier review in the department's Audit Plan schedule than other Board-approved projects.
- Internal Audit completed six (6) special audit requests (SARs) or special management requests (SMRs), which are prioritized ad-hoc requests from management to evaluate special issues that occur from time to time.
- Internal Audit completed four (4) follow-up (FUs) audits based on any of the prior year special audit requests from several topics that showed some irregularities and encouraged Internal Audit to revisit the auditable entity.
- In June 2023, Internal Audit had entered an agreement with FraudHotline (www.fraudhl.com) which can provide a confidential and anonymous site for employees, contractors and any others who report issues or behaviors that seem unusual or peculiar, and worthy of further investigation.
- In October 2023, Internal Audit asked the Communications Department to announce an International Fraud Awareness Week in November, 2023. The event is the annual outreach to educate the fraud examiner community and general public to recognize typical examples of fraud, waste and abuse and provide an opportunity show employees how to report observations to Internal Audit on the FraudHotline to seek more investigation and analysis.
- In June 2024, Internal Audit successfully installed a continuous monitoring system dashboard in IDEA, which was custom developed by CaseWare, an award-winning data analytics item. The system finds anomalies in business data generated from accounts payable activity to third-party vendors, or for testing for anomalies found with in-county travel reimbursement reporting.
- In June 2024, Internal Audit worked with IT to complete an upgrade of the AutoAudit software platform to version 7.6, which includes IssueTrack, a means to improve issues communications to the business process owners. This can enable quicker responses and more timely corrective actions from management to address any identified risks and their implications.

FY2024 Key (Wins) Accomplishments

- ✓ Employee License Update – Internal Audit continued our review of monthly employee license renewals by reviewing the Human Resources Department's monthly report showing renewal activity. Last year and in prior years, there seemed to be dozens of employees with licenses that appeared to be expired; in actuality they may have not had the ability to effectively report their renewal activity. However, the efforts provided by Internal Audit and renewed interest in assistance from Human Resources seems to have reduced the number of expired licenses down to zero.
- ✓ Employee Mileage Update – Internal Audit evaluated the composition of employee trip reporting and found about 12% of trips from home to client residential addresses may include normal commute mileage, which is not reimbursable according to IRS travel guidelines. Additionally we found a trip mileage from client home addresses to an employee's home includes miles that are considered by the IRS to be normal commute mileage. Our review of origins and destinations found that employees reported multiple trips to the client locations and some made additional trips to home during the day, which technically per IRS rules are not reimbursable.
- ✓ The FY2024 OSAR Harm Reduction Program replaced the prior OSAR Provider Reimbursement Grant for COVID-19 reimbursement program. Internal Audit staff reviewed OSAR providers' reimbursements for PPE and client transportation, and we worked closely with The Harris Center's Director of Mental Health Projects on the standardized review process. The rules for reimbursement payments of allowable goods and services is outlined by the Texas Department of Health and Human Services (HHSC) Harm Reduction Program. We worked with The Council on Recovery to broaden provider interest in program participation in HHSC Region 6, which includes Harris County and some twelve (12) surrounding counties.
- ✓ Internal Audit completed the direction of the installation of the AutoAudit software system which provides an independent repository of audit reports and related administrative controls. Internal Audit originally purchased the platform for managing and storage of published audit reports since 2014.
- ✓ Internal Audit successfully project-managed installation of a continuous monitoring module of business data for accounts payable and in-county travel reporting, where occasional data anomalies may be found. The Information Technology Department implemented this new module timely, and Internal Audit could access the CaseWare dashboard in June 2024.

VI. Audit Projects Completed by the Internal Audit Department in Fiscal Year 2024

Most audit project work begins with an assessment of the business risk followed by review of systems and identification of known weaknesses, such as inadequate separation of duties, or failure to follow established procedures. Testing of compliance by a sampling of transactions confirms that the controls performed during typical operations. If necessary, a larger substantive sample is tested to evaluate the extent of any error or loss.

The Harris Center's departmental management teams are responsible for establishing and maintaining a system of internal controls to comply with Center-approved policies and procedures. The objectives of an internal control system provide management with reasonable, but not absolute, assurance that agency assets are safeguarded against loss from unauthorized use or theft, or that transactions are executed in accordance with management's authorization and recorded properly. Policy and procedure add specific requirements to elevate the awareness of possible weaknesses that they should be aware of.

Due to inherent limitations in any system of internal accounting controls, data errors or other irregularities can occur and are not detected in a timely manner. The projection of system evaluations in future periods is subject to the risk that procedures may become inadequate because of changes in conditions, or because a degree of staff compliance with the procedures starts to deteriorate over time.

The scope of work completed for Internal Audit's Fiscal Year 2024 Audit Plan did not claim to constitute an exhaustive evaluation of all the overall internal control structure of all business units within the Center. These examinations were designed to test management's compliance with approved policy and procedures.

In the Fiscal Year 2024 timeframe it was determined that overall departmental compliance with these established criteria to govern the Center's activities were "adequate" overall.

Internal Audit tracked all findings and observations throughout the year in a follow-up matrix, noting the specific weaknesses discussed with management. Internal Audit pursued a timeframe with management or other auditees to add corrective actions that address the weaknesses or mitigate risks by adding new reporting or by taking other actions to fulfill the process. The finalized issue results are reported and discussed with the Audit Committee members.

Table 1 lists five (5) Board-approved audits completed in Fiscal Year 2024 listed here in the order of their presentation to the Audit Committee members. Please note that some projects began in sequence but they might change order due to system upgrade or other factor that can affect an entity's performance, or other factors which can affect the vulnerability of that workflow.

Table 1

Audit Title:	Report Seq#	FY2024 Audit Number	Date presented to Board
Check/EFT/ACH Signature Levels Review	1	CSEFTACH0124	02/20/2024
Security Services Audit	2	SECSVCS0124	02/20/2024
Bank/Treasury/Investment Controls Audit	3	BANKTRS0124	06/18/2024
Accounts Receivable and Fee Collections	4	ARFC0124	06/18/2024
Bank Reconciliation Audit	5	BANKREC0124	06/18/2024

Source: Internal Audit Department, October 2024

Table 2 lists six (6) Special Audit Request audits requested by management and as they were completed in Fiscal Year 2024 to assure operational controls and compliance with the departments' basic controls, as well as departmental compliance with the specific contract performance requirements.

Table 2

Audit Title:	Report Seq#	FY2024 Audit Number	Date presented to Board
SMR: Accounting Controls Audit	1	SMRCTRLS0124	02/20/2024
SMR: Payment Fraud Investigation	2	SMRPAYMT0124	03/18/2024
SAR: Facilities Services Audit	3	SARFACSRV0124	06/18/2024
SAR: Petty Cash and Change Funds Audit	4	SARPCF0124	06/18/2024
SMR: Cybersecurity Audit	5	SMRCYBER0124	06/18/2024
SMR: Recenter Payroll Testing	6	SMRRECNT0124	08/31/2024

Source: Internal Audit Department, October 2024

Table 3 lists four (4) Follow-Up audits that tracked management's progress on findings and observations that were found in the Special Audit Requests as completed during the past one or two fiscal years.

Table 3

Audit Title:	Report Seq#	FY2024 Audit Number	Date presented to Board
FU: Employee Licenses (SAR FY2023)	1	FUEMPLIC0124	02/20/2024
FU: Travel Reimbursement (SAR FY2023)	2	FUTRAVREIM0124	06/18/2024
FU: Fleet Management Audit (SAR FY2023)	3	FUFM0124	06/18/2024
FU: Fixed Assets/Inv. Control (SAR FY2023)	4	FUFAINV0124	06/18/2024

Source: Internal Audit Department, October 2024

VII. Analysis of Findings and Observations

Internal Audit performs audits by examining business processes and procedures, compliance to policy and procedures, and observations of the workflows. In the event that we observe non-compliant outcomes, we identify the outcome as a "Finding," which may be enhanced with a Recommendation statement to add clarity or avoid a missed outcome. The Recommendation clarifies the corrective action and suggests how management can fix it.

An audit report finding needs to be resolved in a timely manner by seeking a response from the auditee or management. The Finding is normally addressed with a Management Response, to allow the auditee or management to indicate their specific actions to correct the issue. Internal Audit expects management to voice plans for the correction action but not assume it is addressed unless it verified by both Internal Audit and Management as a valid Finding.

An audit report's Observation is similar to a Finding, but it does not indicate that it requires corrective action to "correct" the inadequate process outcome. Internal Audit may add a Recommendation to enhance clarity of the detailed Finding or Observation.

Internal Audit seeks a management response to vet the finding or observation, but Internal Audit will not consider it necessary for management to fulfill the corrective action or issue. Instead, Internal Audit recommends resolving the issue to its desired outcome in accordance with the process owners' standards, the applicable legal requirements, and the Center's policies and procedures.

Table 4 summarizes the findings and observations reported in projects completed during Fiscal Year 2024.

Table 4

	Number of Audit Recommendations
Findings/Observations	16
Total Observations by Internal Audit	13
Total Findings by Internal Audit	03
Total Findings Addressed by Management -	16

Source: Internal Audit Department, August 2024

VIII. Standard Allocation of Effort by all Positions and Staff Productivity

Internal Audit recommendations provide insight into the combined effectiveness of The Harris Center's performance to its business plan and to adhere to the Center's current policy and procedures.

Internal Audit provides reviews for improvements in performance, fairness, objectivity, consistency, and in management decision-making.

There are also critical long-term benefits of a strong measurement review system which can simply justify the recommended requests, create enduring focus and justify fund reallocation. Most importantly, performance measures are a leading indicator of long-term compliance conditions and, consequently, represent a long-term planning asset when conducting reviews such as:

- Learn from best-practice measurement systems,
- Forecast the costs and benefits of measurement systems,
- Identify measures important to the head of the unit,
- Categorize types of measures, weigh tangible and intangible measures,
- Align measures throughout the organization that is audited,
- Link measures to strategic Center goals,
- Identify roadblocks to measure development,
- Gain employees' buy-in to the measurement system recommendations,
- Automate processes and procedures,
- Measure effectiveness of shared service and cross-functional processes,
- Monitor and manage using key measures and ensure the consistency and integrity of measures,
- Prepare for changes in strategy or operations,
- Translate measured results into further action,
- Compare output to outcome and determine the frequency of gathering data and reporting.

Internal Audit accomplishes tasks using a 'budgeted hours' approach, in other words, any activity undertaken is measured in hours and effort by positions. For Fiscal Year 2024, Internal Audit delivered 54 total hours above budgeted (2,744 actual vs. 2,690 budgeted) accomplished through off-hours. Based upon the prior fiscal year when we were 85 net hours over budget, in FY2024 we endeavored to work smarter and faster using such tools as data analytic audit programs to improve productivity.

Table 5 shows the annual standard allocation of effort by two Internal Audit positions for Fiscal Year 2024 audits.

Table 5

Standard Allocation of Effort by all Positions in Internal Audit in FY2024

	Priority Budgeted Hours	Actual Hours Utilized	Over <Under> Total Budgeted Hours
Regular Hours Available	4,160	4,214	54
PTO	(150)	200	50
Training	(80)	64	-16
Travel	(40)	20	-20
Administration	(150)	220	70
Approved Audits	(1,680)	1,500	(180)
Follow Up / Special Audit Requests	(430)	600	170
Participation with Outside Auditors	(40)	40	0
Consulting Activity Projects	(120)	100	(20)
Hours Required:	**(2,690)**	**2,744**	**54 ***

**** Accomplished through off-hours***

Net Hours Over <under> Budget ***54***

IX. Internal Audit Professional Development

The Department's leadership is committed to achieving an outstanding level of professional competency which is enumerated through professional certification, improved with continuing education, sustained by supporting local audit organizations and demonstrated through the Department's audit product.

Internal Audit staff has completed annual training requirements as Certified Professional Education units (CPE) and Certified Education Units (CEU) and maintained memberships and credentials.

Additional hours were committed to installing new versions of AutoAudit and in the IDEA CaseWare continuous monitoring module to perform analytical work to track fraud and waste by examination of anomalies in business data.

All the courses listed were on-line and completed after business hours.

David W. Fojtik, CPA - Annual Training	**Hours**
➢ Texas State Auditor's Office Annual Conference	16
➢ Auditing Developments	16
➢ Institute of Internal Auditors Annual Conference	8
➢ Ethics Training for Texas CPAs	4
	44

Kirk D. Hickey, CFE – Annual Training	**Hours**
➢ Challenges of Provider-Patient Communications	1
➢ Adv. Leadership: Interpersonal, Behavior, Communications	4
➢ The Role of Internal Controls in Fight against Fraud	2
➢ Personal Skepticism and Combatting Lies	2
➢ 2024 Mid-Year Business Ethics Review	2
➢ Why We Take the Road to the Ethical Dark Side	1
➢ Members Appreciation (Houston Chapter ACFE)	1
➢ Fraud Prevention, Detection and Response	8
➢ Cybersecurity Threats to Healthcare Industry in FY2024	1
➢ Ransomware, Business Email Compromise (BEC) virtual	1
➢ The Roles of Forensic Social Work in Caring for …	1
	20

X. Internal Audit Staff Professional Certifications and Memberships

Professional Memberships*

David W. Fojtik

- Texas Society of Certified Public Accountants, Houston (TSCPA)
- Houston Chapter, The Institute of Internal Auditors (IIA)
- Association of Healthcare Internal Auditors (AHIA)
- Association of Certified Fraud Examiners (ACFE)

Kirk D. Hickey

- Association of Certified Fraud Examiners (ACFE)

Professional Certifications*

David W. Fojtik

- Certified Public Accountant – CPA
- Certified Internal Auditor – CIA
- Certified Fraud Examiner – CFE

Kirk D. Hickey

- Certified Fraud Examiner – CFE

**All national and local membership dues and certification fees are paid by the Internal Audit staff.*

The maintenance of each certification requires a minimum of 20 to 40 hours of formal continuing education hours each year, which is obtained by attending conferences, viewing webinars, and other self-study events.

Membership in these organizations provide excellent opportunities in learning new auditing and fraud detection techniques and afford valuable networking opportunities with other healthcare professionals.

The Internal Audit staff are also expected to continuously stay abreast of professional publications on a variety of risk and healthcare topics.

XI. Appendix 1 – FY 2024 Issue Tracking Matrix

<table>
<tr><th>Audit Report Topic</th><th>Findings or Observations // Management Response</th></tr>
<tr><td>1. Check/ETF/ACH Signature Level Review
CXETFACH0124
Report Date: 01-16-24

COMPLETED</td><td>Observation #1 – Internal Audit reviewed the larger contracts in order to find sample transactions which show the check signing approver titles and dates on checks and on electronic funds transfer payments. We found the first approver signed on the same day or next day, and second approver signed on the same day or next day. We found that the multiple signature levels complied with FM.A.13 Check Signing policy requirements.

Summary of Sampled Contracts Payments paid with Checks or EFT Payments in FY2023
<table>
<tr><th>Payee Name</th><th>Invoice Date</th><th>Payment Date</th><th>Invoiced Amt.</th><th>Payment Info.</th><th>Signature 1 Info.</th><th>Signature 2 Info.</th></tr>
<tr><td>FREEITDATA</td><td>4/11/2023</td><td>05/31/2023</td><td>$330,789.04</td><td>CHECK 513334</td><td>CFO on 06/01/23</td><td>CEO on 06/02/23</td></tr>
<tr><td>ODONNELL</td><td>2/15/2023</td><td>03/22/2023</td><td>$775,731.05</td><td>CHECK 512730</td><td>CONTLR 03/22/23</td><td>CEO on 03/23/23</td></tr>
<tr><td>EASTERSEALS</td><td>8/16/2023</td><td>08/23/2023</td><td>$114,754.50</td><td>EFT 104310</td><td>CFO on 08/24/23</td><td>CEO on 08/24/23</td></tr>
<tr><td>TEXASWESTOAK</td><td>9/14/2023</td><td>09/20/2023</td><td>$251,250.00</td><td>EFT 104331</td><td>CFO on 09/21/23</td><td>CEO on 09/21/23</td></tr>
<tr><td>UNIVERS.OFHO</td><td>2/22/2023</td><td>03/01/2023</td><td>$114,015.00</td><td>EFT 104203</td><td>CONTLR 03/01/23</td><td>CEO on 03/02/23</td></tr>
<tr><td>REYDELAREZA</td><td>5/08/2023</td><td>05/10/2023</td><td>$109,518.44</td><td>CHECK 513163</td><td>CONTLR 05/10/23</td><td>CEO on 05/10/23</td></tr>
<tr><td>ARAMARKCORR</td><td>11/01/2022</td><td>01/11/2023</td><td>$97,459.32</td><td>CHECK 512039</td><td>CONTLR 01/11/23</td><td>CEO on 01/11/23</td></tr>
<tr><td>HARRISHEALTH</td><td>9/01/2022</td><td>10/26/2022</td><td>$39,076.29</td><td>CHECK 511371</td><td>CONTLR 10/26/23</td><td>CEO on 10/31/23</td></tr>
<tr><td>PDGARCHITECT</td><td>1/18/2023</td><td>02/8/2023</td><td>$90,150.00</td><td>CHECK 512325</td><td>CONTLR 02/08/23</td><td>CEO on 02/10/23</td></tr>
<tr><td>LANGRANDANDC</td><td>2/06/2023</td><td>07/5/2023</td><td>$53,713.84</td><td>CHECK 513597</td><td>CFO on 07/06/23</td><td>CEO on 07/06/23</td></tr>
<tr><td>ARCHSTAFFING</td><td>2/26/2023</td><td>03/29/2023</td><td>$30,209.19</td><td>EFT 104216</td><td>CONTLR 03/29/23</td><td>CEO on 03/30/23</td></tr>
<tr><td>RAINBOWHEALT</td><td>8/09/2023</td><td>8/30/2023</td><td>$60,833.00</td><td>CHECK 514079</td><td>CFO on 08/31/23</td><td>CEO on 09/01/23</td></tr>
<tr><td>ULTRAMEDICAL</td><td>2/23/2023</td><td>05/10/2023</td><td>$216,841.21</td><td>EFT 104242</td><td>CONTLR 05/10/23</td><td>CEO on 05/10/23</td></tr>
<tr><td>TEXASBUSSALE</td><td>04/06/3023</td><td>04/26/2023</td><td>$125,294.50</td><td>CHECK 513038</td><td>CONTLR 04/26/23</td><td>CEO on 04/28/23</td></tr>
<tr><td>TEXASBUSSALE</td><td>06/09/2023</td><td>06/14/2023</td><td>$125,294.50</td><td>CHECK 513441</td><td>CFO on 06/15/23</td><td>CEO on 06/16/23</td></tr>
</table>
Source: Financial Services, Purchase Order Review Report, October, 2023
The total value of the payments was $2,534,929.88, and Accounts Payable obtained appropriate signing authority based on the levels defined in FM.A.13 Check Signing policy.

Management Response not required.</td></tr>
<tr><td>2. Bank, Treasury and Investments Audit
BANKTRS0124
Report Date: 04-16-24

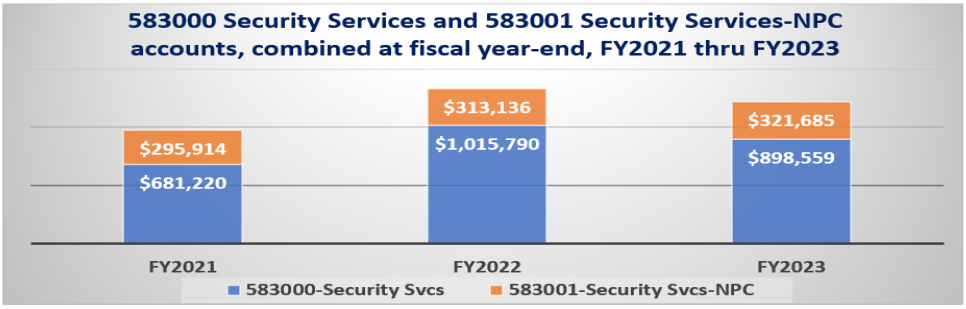
COMPLETED</td><td>Observation #1 – Internal Audit found that the FM.A.17 Investment Policy contained clear language about training requirements for newly-appointed investment officers who need to attend training of at least ten (10) hours within the twelve months after the investment officer assumed the officer’s duties.
This inquiry was to ascertain that this specific training was obtained the officer retains training records to show that the PFIA investment training coursework was completed, and that this information was submitted to the external auditors while preparing the Annual Comprehensive Financial Review (ACFR).

Management Response not required.</td></tr>
</table>

3. Security Services Audit
SECSVCS0124
Report Date: 01-16-24

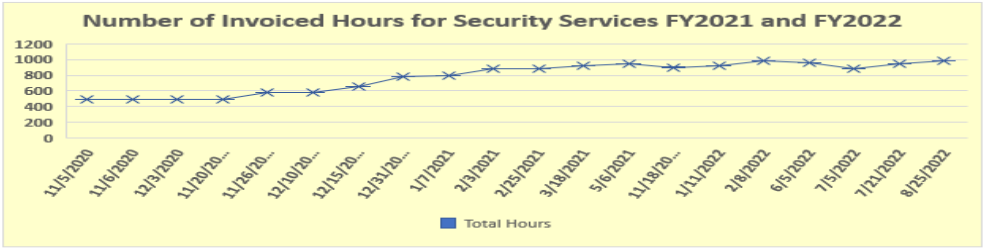
COMPLETED

Comment #1 – Internal Audit found 583000 Security Services account actuals increased by 49.1% in FY2022 compared to FY 2021, then decreased by 11.5% in FY2023 compared to FY 2022. The causation of the dollar increase in FY 2022 was due to a number of factors such as the opening of a new Center location (6160), increase in contracted labor services, and delayed invoicing and payments in FY2022. Also, the new personnel costs were added in FY2022 and FY2023. We also found 583001 Security Services-NPC account actuals increased by 5.8% in FY2022 and by 2.7% in FY2023. Security services at NPC are provided by Harris Health but billed to the Harris Center's 583001 Security Services-NPC account.

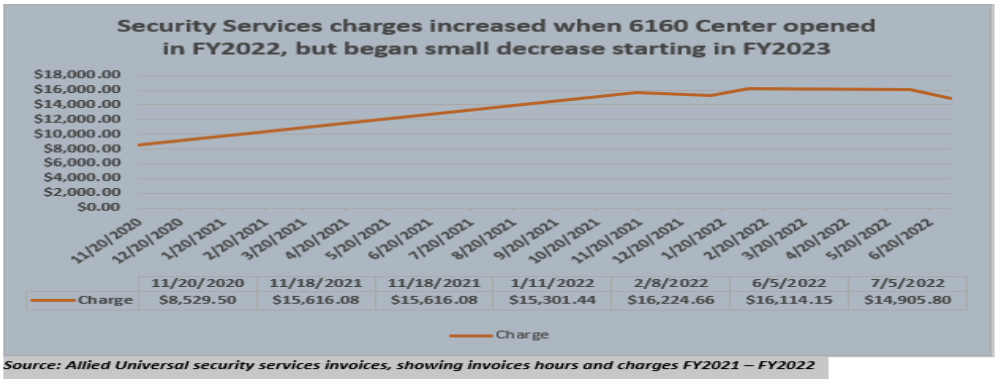


Source: Financial Services, online trending report, November 20, 2023

Comment #2 – Internal Audit found 583000 Security Services invoiced hours and charges increased when the 6160 location opened in early 2021. Internal Audit found invoices from Allied Universal showing invoiced hours averaging 549 hours until early 2021, and invoices averaging 907 hours in FY2022. Many of increased hours are associated with 6160 location.



Source: Allied Universal security services invoices, showing invoices hours and charges FY2021 – FY2022



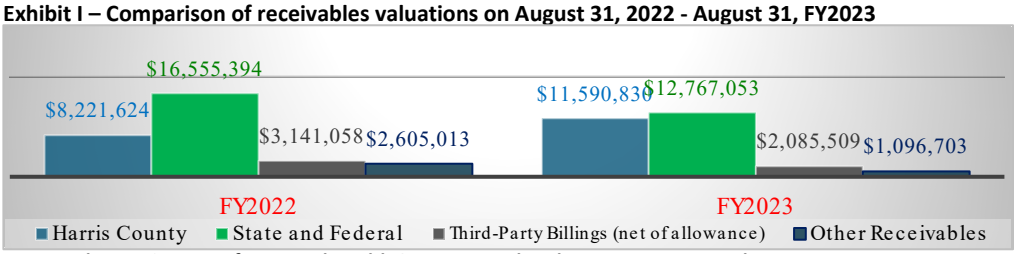
Source: Allied Universal security services invoices, showing invoices hours and charges FY2021 – FY2022

Management Response (Director of Security) –

"1 - Harris Health (583001) NPC has increased the salary of their Security Officers each of these years. Their salaries increased from $24.91/hr. in FY2021 to $25.59 in FY2022 and $26.18 in FY2023."

"2 - As far as Center-wide Security Services (583000) I'm still waiting for reports from Budget to get more specific; however, what I can tell you is additional personnel costs were added to the budget in FY2022 as a new item. In addition, the Allied contract had an hourly wage increase as well."

"3- There was an increase in the Allied Security Contract personnel hourly rate, we added new officers for the Youth Diversion Center."

4. Special Management Request: Fraud Payment Investigation **SMRPMT0124** **Report Date: 01-16-24** **COMPLETED**	**Finding #1 –** Internal Audit observed that the current Financial Services procedure for changing/updating a vendor's banking account information does not include a verification process to independently verify that the change is agreeable with the account holder, which is essential if other internal controls are not being followed. The $18,400 has not been recovered by the police and the amount was below the insurance deductible. **Recommendation:** Internal Audit recommends current procedures for changing/updating a vendor's banking account information be strengthened to include placing an outbound call to vendors/account owners to verify that banking information has been requested to be changed by the vendor. **UPDATE - Payment was made to the contractor on December 13, 2023 to make them whole. Management is now verbally checking all banking information changes with vendors to verify that requested bank changes are authentic. Also, the Purchasing Department is currently performing due diligence in drafting new Policies and Procedures to address future changes to vendor banking information.** **Management Response (Financial Services – CFO):** **"1 - Financial Services ONLY accept vendor changes from the vendor directly – these should not involve any of our employees. The accounts payable team should have NO involvement in changes, which the system prohibits but I think they have been the conduit of changes (vendor gives AP changes and then AP forwards to Financial Services)".** **"2 – Ross security files that log all vendor changes be reviewed. Daily is too extensive – but I think someone can be reviewing the security logs. Internal Audit is one recommendation."**
5. Accounts Receivable and Fee Collections Audit **ARCF0124** **Report Date: 06-18-24** **COMPLETED**	**Observation #1 –** Internal Audit compared Accounts Receivables recorded at year-end in the *Annual Comprehensive Financial Report (ACFR)* FY2022 and FY2023. We noted four trends: Harris County receivables were $8.2 million, then increased to $11.6 million at the year-end of FY2023. This agrees with the online trending report that showed Harris County revenues increased $2.8 million. State and Federal program receivables were $16.6 million in FY2022, which then declined to $12.8 million in FY2023, as noted in Note 4 - Accounts Receivable (ACFR, page 46). The online trending report showed that new State and Federal grant program revenue programs began their actviities, including the Direct Payment Program (DPP) and Federal Charity Care Pool (CCP) programs in FY2023. The Center's third-party billings (net of allowance) shows receivables based on net "collectible" receivables from patients, insurance companies and other payors. These net receivables were $3.1 million in FY2022, which then decreased to $2.1 million in FY2023. The estimates represent the remainder of all "collectible" revenues based on a margin established by financial services. The Other Receivables balance posted $2.6 million in FY2022, then fell to $1.1 million in FY2023. The Other Receivables account includes items such as interest receivables, salary receivables, tax refunds, as noted in Note 4 - Accounts Receivable (ACFR, page 46). Internal Audit found that total accounts receivables posted $30.5 million at fiscal year-end FY2022, and $27.5 million at fiscal year-end FY2023, as noted in Note 4 – Accounts Receivable (ACFE, page 46). This $3.0 million decline reflects introduction of new grant programs (which increased revenues $23 million), plus any changes in the payor mix. The total receivables reflects changes in the Center's business model, not necessarily the employee productivity nor the quality or composition of billed services. **Exhibit I – Comparison of receivables valuations on August 31, 2022 - August 31, FY2023**  ***Source: The Harris Center for Mental Health & IDD, ACFR dated August 31, 2023 and 2022***

6. Bank Reconciliation Audit **BANKREC0124** **Report Date: 07-16-24** **COMPLETED**	**Observation #1 –** Internal Audit met with the Financial Services accountant for a demonstration of the Center's primary bank account reconciliation process on the JPM-Chase account, which is the Center's primary bank account. The process required downloading the general ledger data from Ross financial system. Next the report comparing balances to show that accounts receivables were process successfully and that accounts payable transactions were completed. The reconciliation process is used to identify non sufficient funds (NSF) checks that did not process as payments, and examination of unreconciled checks which indicate that they have not yet been cashed. The basic use of bank reconciliations is to identify the amount of cash on hand for handling the Center's cash needs. The accountant also discussed the methods that the department uses to reconcile ACH and electronic funds transfers that did not process as planned and spoke about the occasional ACH reversals process and checking escheat accounts. The accountant who demonstrated this reconciliation has worked in a similar position in the past and has firm expertise in explaining Center's monthly reconciliation process. We found no issues with the methods used to conduct the current bank reconciliation process which is performed by Financial Services in a timely manner to gauge the Center's cash needs. **Management Response not required.**
7. Special Management Request: Accounting Controls Audit **SMRCTRLS124** **Report Date: 01-16-24** **COMPLETED**	**Observation #1 –** Internal Audit found a policy called **BUS-F/B:18 Cash Receipts and Bank Deposits** with a new Board Approval Date of 10/28/2020. The policy was signed later by Wayne Young on 10/29/2020. The Policy section appears vaguely worded to direct the Clinical offices to create "proper and adequate" controls for processing consumer payments timely and for providing reports timely to Financial Services. **Recommendation:** Internal Audit believes the policy should cite specific procedural requirements for posting consumer payments, for providing financial custody and tracking of payments, and for generating timely reports to advise Financial Services of all completed consumer fee collections. (See Appendix B) **Management Response not required.**
8. Special Audit Request: Facilities Services Audit **SARFACSRV0124** **Report Date: 07-16-24** **COMPLETED**	**Finding #1 –** Internal Audit performed an analysis of the contract for The Brandt Companies, a firm specializing in large scale HVAC building renovations. In 2022, The Harris Center entered into a contract in August, 2021 to install a climate control system at the Center's 6160 South Loop East location. The Director of Facilities Services provided an overview of the vendor's contract. The Brandt Companies issued invoices monthly and beginning in February, 2022, they added change orders for mechanical and electrical work that were not authorized by the Harris Center's project team. Over time, more change orders were added to invoices with adequate notations but no signed authorizations were provided to the Brandt Companies to agree to the charges. The climate control contract included a contingency fee for cost overruns. However, the total amount of change orders exceeded the project's contingency, so change order details should be communicated to the Facilities Services as they were discovered. The vendor added change order charges to the invoices even though they did not obtain client-authorized change order agreements. Internal Audit noted that the vendor's sum of change orders was $530,272.40, but Internal Audit's calculated sums of these same change orders was $514,989.33 representing a difference of $15,283.08. Internal Audit reviewed the project invoicing near or at the end of project completion, at which time the contract went into litigation for alleged non-payment. **Recommendation:** Internal Audit recommends management should identify all project-type contracts when used in construction or similar project management initiative to add a secondary review team for the review and approval of vendor payments. This partnering approver will be able to address ambiguity in the vendor invoicing, interrogate vendor representatives and have authority to assist in approving any additional changes on vendor invoices, or for charges deemed related to project change orders. **Management Response #1 (Legal Counsel):** The Harris Center reached a settlement with Brandt.

9. Special Audit Request: Petty Cash and Change Funds Audit
SARPCF0124
Report Date: 07-16-24

COMPLETED

Observation #1 – Internal Audit performed unannounced petty cash audits at the following locations and found the counted contents of currency agreed with the designated target cash balance that were listed in the Petty Cash Custodian Listing, Recreational Funds and Fee Collections Static Funds report.

Internal Audit has audited the petty cash function for over ten years, and noticed that the petty cash balances have decreased, and many petty cash custodians do not reconcile the petty cash funds due to fewer transactions that require petty cash. Also, increased online purchases have been adopted in Center operations, and such purchases do not use cash. Internal Audit examined 9 of the current 17 petty cash and change funds, which totaled $4,150.00. The current petty cash and change funds account is $5,350.00. By comparison, our review of the 2019 report showed 24 petty cash and change funds in operation, and their currency valuation was $9,350.00. Internal Audit learned that the petty cash funds for MCOT Expansion unit and Pasadena Cottages closed.

Current list of current petty cash and change fund locations located at The Harris Center

DIVISION	UNIT	UNIT NAME	LOCATION	TARGET
Administration	1122	DSHS FF; HCS Support	9401 Southwest Fwy.	$2,000.00
Administration	2212	Northwest CSC Fee Coll'n	3737 Dacoma Street	$250.00
Adult MH	2213	Northeast Clinic	7200 North Loop East	$50.00
Adult MH	2214	Southeast Fee Collection	5901 Long Drive	$50.00
Admin.	2215	Southwest CSC Fee Coll'n	9401 Southwest Fwy.	$100.00
CPEP	2250	PATH	2627 Caroline Street	$250.00
IDD	3390	Westbury House	6125 Hillcroft Street	$400.00
Admin.	3636	Coffee House	3737 Dacoma Street	$50.00
Adult Forensic	9403	Jail Diversion Center	6160 South Loop East	$1,000.00
			Total All Cash and Change Funds:	**$4,150.00**

Source: Accounts Payable report, October 2023 **** W/P = documented Petty Cash work paper***

Management Response #1 (Accounts Payable):

10. Special Management Request: Cybersecurity Audit
SMRCYBER0124
Report Date: 07-16-24

COMPLETED

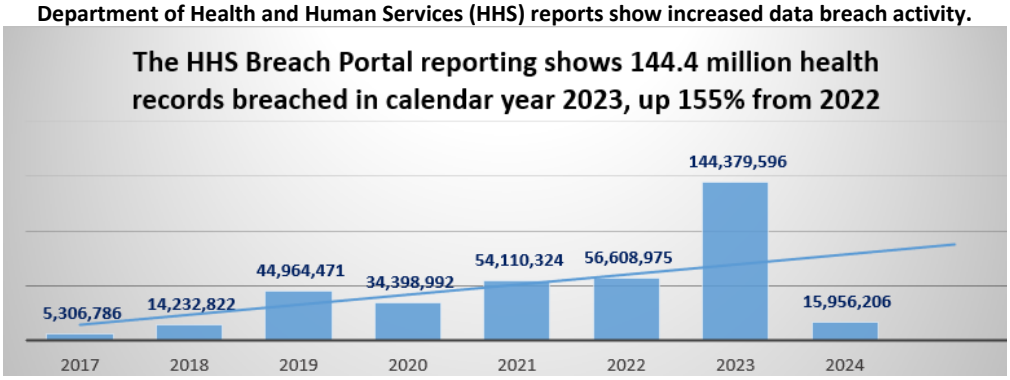
Observation #1 – Internal Audit met with the Center's Information Security Officer (ISO) to discuss the Center's stabilization following a cybersecurity attack on November 7, 2023.

1) We learned that at the time a previously unidentified "bad actor" emerged and made their entry through the Center's Citrix Netscaler system, then pursued a systematic encryption of our data files, to make them unavailable to the Center's users. The attack was not a denial of service but instead was a ransomware attack propagated by BlackSuits, an organization known by other different names. During the initial attack, they quoted their ransom demands.

2) The Information Security Officer reported that granting system access quickly was essential to restoring the Center's operations and Information Technology consultants were brought in to assist. The Harris Center's response to this incident was enhanced significantly with the purchase of Crowdstrike Endpoint Managed Detection and Response platform, which provides greater monitoring than was provided in previous threat detection systems employed at the Center. The ISO's objective was to "reduce our attack surface" without shutting down service to end-users, which could have halted services in the Center's offices.

3) The attack encrypted thousands of patient records with varying amounts of sensitive information and the ISO stated that the volume necessitated notifying patients and/or patient families of this type of data breach, which is specified clearly in HIPAA regulations. Information Technology teams were able to restore service by changing the internet access swiftly. As an additional precaution, Information Technology organized a plan for reimaging the Center's laptop computers to assure additional protection to the end-users going forward.

Summary - No ransom was paid and the Center's operations continued with minor delays after the breach occurred.

	Observation #2 – Internal Audit attended a Clearwater Security debrief which reported that the HHS Breach Portal reported 144.4 million medical records were reported as breached in calendar year 2023 compared to 56.6 million records in calendar year 2022, representing a 155.0% increase in quantity. **Department of Health and Human Services (HHS) reports show increased data breach activity.**  ***Source: HHS Breach Portal (data pulled March 3, 2024), Clearwater Security presentation, April 8, 2024*** **Management Response not required.**
11. Special Management Request: Recenter Payroll Testing SMRRECNT0124 Report Date: 07-16-24 **COMPLETED**	**Observation #1 –** Internal Audit reviewed the financial documents supporting the payroll and accounts payables activity at the Recenter since April, 2024. The documents include the monthly bank statements and detailed payroll processing records, and numerous invoices for ongoing services including AT&T, the City of Houston for water usage, insurance policies, workers' compensation coverage, and maintenance issues. Most of the activity shown in the bank statements appears to be for Walmart and other stores, and the direct deposit activity for payroll. We found several anomalies in the review. One invoice in the supporting documentation appeared to be $10 less than the amount provided in the reimbursement from The Harris Center to the Recenter, so it is a slight overpayment. The payroll calculations were reviewed for accuracy and were detailed enough to ensure verification to the penny. We noted that the number of individuals on the payroll had diminished with each pay period. Roughly half of the individuals receive payment by direct deposit as processed by a QuickBooks user. The federal income taxes are calculated and paid timely, as are employee deductions for laundry, etc. What was also significant was to see the vendor notices regarding shutoff, notably a significant notice from AT&T. in our usual reviews, this kind of notification is not discovered, and it appears that many of the vendors have provided service despite the collections status. One other observation was seeing the frequency of debit transactions on the monthly bank statements which are noted simply as "loan" or "loan payment," but the debits appeared in different ways on the statement, and likely represent different loan sources. The identity of those sources was not revealed nor made obvious in the supplied financial records. Our review primarily focused on testing the accuracy of payroll processing and that process appeared to be well executed each pay period. One recommendation to improve the transitional documentation process is to secure approval dates in addition to the approver names. This would be more in line with expected accounts payable activity as normally observed at The Harris Center.

12. Follow-Up: Employee Licenses Review FUEMPLIC0124 Report Date: 07-16-24 **COMPLETED**	**Comment #1 –** Internal Audit found one employee with an alleged expired license as of December 14, 2023, the date of the HRIS (Human Resource) Report. The employee explained she had submitted her license renewal in October, 2023, however, the license renewal was not updated on the HRIS license report. By contrast, there were four (4) employees erroneously listed on the November 2022 report. The Human Resource Department has done a great job in expediting confirmation of license renewals and by doing so has made the HRIS Report more accurate and functional. For clarity, no personnel have worked at The Harris Center without an active license.
13. Follow-Up: Travel Reimbursements Audit FUTRAVREIM0124 Report Date: 07-16-24 **COMPLETED**	**Observation #1** – Travel reports reviewed between September 1, 2023 and March 7, 2024. 1) The six-month reimbursements totaled 1,145,215 miles compared to 1,276,975 miles reported in a prior six-month period from September 1, 2022 through February 28, 2023. 2) We determined that 95.7% of the First Trip segment miles started from the employee's assigned Harris Center location and 88.2% of Last Trip segment miles ended at their assigned Harris Center location. 3) Internal Audit noted that the current Center's travel policies rely on IRS business travel guidelines which require employees to compute mileage by subtracting "normal commute miles" to their assigned Center location. Currently, 4.3% of reimbursed travel reimbursements included normal commute miles on the first trip of the day and 11.2% of last trip reimbursements ended at residential locations. 4) Employees reported 583,199 miles for the 4 months (September 1, 2023 through December 31, 2023), and were paid $394,707.75 in total employee mileage reimbursements (IRS rate = $0.655 per mile in 2023). Employees reported 562,016 miles for the 2 months (January 1, 2024 through March 7, 2024), and were paid $380,371.21 in total employee mileage reimbursements (IRS rate = $0.670 per mile, as updated as of January 1, 2024). The Harris Center paid out $775,079 in reimbursement payments during this six-month period. 5) We found that 635 employees submitted in-county mileage reports from September 1, 2023 through March 7, 2024. Internal Audit found 25 of these employees drove 6,000 or more miles over this six-month time period or about 4% of all employees who drove their own vehicles and submitted mileage claims.
14. Follow-Up: Fleet Management Audit FUFM0124 Report Date: 07-16-24 **COMPLETED**	**Observation #1** – The audit disclosed: 1) As of February 29, 2024, there were 21 agency-owned vehicles in inventory. 2) The average vehicle age of the remaining vehicles was 3.38 years. 3) The cost for operating 21 agency-owned vehicles February 29, 2024 was $188,265. 4) Enterprise Leasing invoices from 09/01/2023 - 02/29/2024 was $335,285 for 119 cars. 5) As of 02/29/2024, total fleet vehicle cost (Leased and Owned) totaled $523,550. **Management Response #1 (Director of Transportation):** *"Entering into the contract with Enterprise just as the nation faced the COVID crisis presented some very real challenges with the nation shutting down for several months and that coupled with the semi-conductor shortage drove the fleet replacement time from months to years. With the conditions improving in FY 2024, we expect the fleet replacement to be completed late FY 2024 to early FY 2025. Once the fleet is replaced with only the rental fleet, I expect to see a drop in operating cost across the board; maintenance, fuel cost, etc. The enterprise management team has been very good in helping navigate this crisis and has kept the transportation team informed and engaged in the replacement process and options available to the Center. Internally we are working on purchasing internal software to assist in managing the fleet for our end, this should result in reduced cost fleet wide. Once the fleet is replaced it is my recommendation an audit be conducted on vehicle use by program to determine if the actual car count could be reduced which would also result in reduced yearly expenditures."* ***Internal Audit Response*** we will perform a review of the leased vehicles.

15. Follow-Up: Fixed Assets and Inventory Control Audit FUFAINV0124 Report Date: 07-16-24 **COMPLETED**	**Finding #1 -** Internal Audit generated the Fixed Assets Inquiry online report, dated 01/31/2024, and found 73 fixed assets, such as personal computers, scanners, cameras, and installed medical equipment that were still assigned to former and terminated employees. Recommendation: Internal Audit recommends that the records containing names of former employees should be reassigned to show "general use" status if assets are not redeployed to another employee. **UPDATES** **As of 06/04/2024, the Fixed Asset team ensured that all corrective activity had occurred to address this issue, and in Internal Audit's follow-up review found no laptops or other fixed assets assigned to former employees. This was accomplished by ongoing intensified emails sent by the FA team to the Fixed Asset Designees (FADs) to provide the required paperwork. Also, the FADs' supervisors and Internal Audit were added to these emails.** **Note to Finding:** The Fixed Asset Team is doing what it is empowered, by the agency, to do to keep the Fixed Asset inventory up to date. The Fixed Asset Team cannot make any updates to devices (location and employee assignment) without the proper paperwork, which is required by agency policy to authorize any updates. **Staff Comments** – Internal Audit spoke with a number of fixed assets designees (FADs) who maintain the fixed assets inventory process. Here is a short list of additional comments from our conversations: 1. *Challenges include work environments where employees may trade or borrow laptops without the FAD's knowledge. but that type of exchange would occur after hours or weekends without the FAD's knowledge.* 2. *Another challenge is assigning a fixed location for equipment items when room numbers are updated during construction, or the equipment is a laptop used in the employee's home.* 3. *Whenever terminated employees leave employment, there is no automated process to identify the records that are no longer correct and require and amendment to show that or this laptop should be reassigned to "general use" or to "disposal" if it is no longer functional, or should be reassigned to another current employee in the business unit.* 4. *Fixed Asset Tags are placed in tough-to-read locations (back side, underneath side) of the equipment, which sometimes requires disassembling computer components to find Tag #.* 5. *There appears to be no tie-in to the Center's budgeting process or with the Ross financial system.* ***Management Response #1* (Fixed Asset Examiner):** ✓ *"Remove all ASSIGNED GENERAL USE designations as an employee assignment. Replace with either your (FAD) name or the unit manager's name.* ✓ *Remove all former employees and old unit staff data and replace it with the new staff names. If the position is vacant for now, replace that data with either your name or unit manager's name.* ✓ *Update locations if devices are moved or the Program relocates.}*

Compiled July 30, 2024
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XII. Appendix 2 – FY 2025 Audit Plan

Approval is requested for the listed project areas to be audited in Fiscal Year 2025. At any time, however, a special request/project may warrant adjustments in the schedule. The list below does not represent any order because the sequence of the audits depends primarily upon availability of the Center's schedules for internal or external staff contacts.

1) **Reimbursable Services Contracts Review – (100 Hours Scheduled)**
2) **Review of Misappropriated Fixed Assets (100 Hours Scheduled)**
3) **Payroll Audit – (100 Hours Scheduled)**
4) **RM Third-Party Billings and Refunds Audit – (100 Hours Scheduled)**
5) **PC Software License Compliance Audit – (100 Hours Scheduled)**
6) **Cybersecurity Audit – (100 Hours Scheduled)**
7) **Conflict of Interest – (100 Hours Scheduled)**
8) **Overtime Usage and Premium Holidays – (100 Hours Scheduled)**
9) **Follow-Up Audit: Fleet Management Audit – (100 Hours Scheduled)**

Plus:

1) **Audit Follow Up/Special Audit Requests** – (400 Hours Scheduled)
2) **Consulting Activities** – (70 Hours Scheduled)
3) **Provide Assistance to External Auditors** – (70 Hours Scheduled)

Total Direct Audit Hours	*1,440 Hours*
Indirect Hours (PTO, Training, Scheduling, Administration.)	*630 Hours*

There are 1,440 audit hours scheduled for Fiscal Year 2025, with an emphasis on revenue streams, license compliance, conflict of interest, payroll and administrative review. This includes committing a majority of project hours to the topics selected by the Risk Management tool plus two topics selected by the senior management and recommended topics from the members of the Board of Dircctors.

The Fiscal Year 2025 Annual Audit Plan consists of a variety of auditable entities. In practice, Internal Audit works on two or three audit projects concurrently since the fieldwork on any one audit project can be lengthy. Sometimes the progress of an audit is slowed because of the meetings with the auditee hard slow to obtain, so other auditees may be contacted to gain more specialized insight.

The Internal Audit Department audit projects can be charted for general planning purposes to show our commitment to seven (7) audits identified by our internal risk assessment model and with solicited input from the Board of Directors and Senior Management. These additional proposed projects are subject to the Board of Trustees' review and approval, before presenting a finalized Audit Plan. In addition, we expect at least three (3) Special Audit Requests to be identified throughout the year, and sometimes presented follow-up status audits that show improved conditions in the prior year's special audit request's audit report. In less common situation, Internal Audit has received executive requests to evaluate a situation which is treated as a Special Management Request (SMR), which merits direct conversations with members of Senior Management and possibly a member of the Board of Directors.

Internal Audit has performed consulting services on a topic that typically is not under audit evaluation but has need for due diligence. Senior Management or a member of the Board of Directors may ask for a consulting project to be performed. The other area is providing assistance to External Auditors, which provides guidance to external auditor firm staff who may seek access to non-routine tools.