

Public Comment Master Log including SP1, SP1, SP3, SP4 CAS & LPND							
Date of Response	Name	Clinic/Company	Service Package or LPND	Contact Address/Telephone	Email	Concerns/Comments	MHMRA response to comments
6/1/2009	Jean R Joseph-Vanderpool, MD	Atlantis Health Services	SP 1		<a href="mailto:jvanderpool@atlantishhealth.org">jvanderpool@atlantishhealth.org</a>	1.It seems like the rates are for Medicaid consumers, what will be the rate for GR patients. 2. What happens when a provider is treating an SP1 patient and the clinical presentation suggests a higher level of care, will the patient be changed back to the internal provider?	Respondent plans to attend Committee for Public Comment Forum for further discussion. GR patients are currently at Medicaid rates. When the clinical presentation changes, ideally the pt will stay with current provider if contracted for that service level and if not the case manager will assist in transitioning the pt to another level of care.
6/2/2009	Manasi Pawar	Euclid Infotech	SP 1	401, Dimple Arcade, Thakur Complex Kadivali (E), Mumbai 400 101/Phone: 0091-22-66023817 Fax: 0091-22-2854 1637	tenderingauthority400@gmail.com	Request for information.	Forwarded draft RFA by email as requested
6/2/2009	Desiree Morgan, RN, MS	UT/HCP	SP 1		Desiree.Morgan@ut.h.tmc.edu	<p>1. Contracted Rate: The MHMRA contracted rate is currently the Medicaid rate with a deduction of 5% if MHMRA submits the billing to the State. This rate is not sufficient to cover all of the additional visit requirements under the MHMRA contract which are not requirements for Medicaid</p> <p>2. Additional MHMRA Contract Requirements Compared to Medicaid.</p> <p>A. Completion of medication algorithm, Lab algorithm, TIMA scales, AIMS scales. These algorithm and scales are time consuming and are not being clinically utilized by clinicians. Information documented in the clinical record is what provides the information and continuity for ongoing clinical care.</p> <p>B. Requirement that patients sign a hard copy of their master treatment plan every 90 days, and receive a copy of the plan. Accepted Medicaid practice is to document in the clinical record that the patient's treatment plan was addressed and the patient's response. Particularly for programs with automated records, it is not good utilization to have to print copies of treatment plans for patient signatures, and in addition routinely provide copies to the patients.</p> <p>C. Requirement to call patients who no-show for appointments at least two different times, and place documentation in chart, even when appointment reminders are routinely provided to patients. This process is time consuming, and it does not appear that the information is used in any way to improve care, e.g. tracking and addressing reasons why patients miss appointments.</p> <p>D. Staff training requirements for the MHMRA contract are greater than the requirements for Medicaid, JCAHO and other regulatory agencies</p> <p>E. MHMRA contract requires TRAG to be completed every 90 days, in order to determine level of care. The tracking and scheduling of TRAGS adds to the time commitments of providers. TRAGS are conducted by bachelor's level practitioners, to determine an appropriate level of care.</p> <p>A more clinical centered alternative would be to have the physician or NP providing clinical care make recommendations regarding level of care based on clinical evidence on an as needed basis.</p> <p>F. Capacity issues make care difficult for providers, particularly when patients in SP1 service packages have been identified as needing SP3 services but lack of MHMRA capacity for SP3 services prevents quick access to those services. Sometimes patients are re-hospitalized, incarcerated or have other negative outcomes while they wait to be transferred to a higher service package.</p> <p>G. Patients who are assessed under the contract, and do not have a priority population diagnosis have</p>	<p>1. MHMRA recognizes this challenge and is working with DSHS in an effort to address but based on current funding and the number of consumers MHMRA is required to serve within that funding, these rates are the best the Agency can offer at this time. MHMRA is working with DSHS to try and reduce requirements if able; however, this reflects current contract requirements per DSHS.2.A. This is a DSHS/TAC requirement not under the control of the local mental health authority to change. This feedback will be sent to DSHS for consideration. B. This is a DSHS/TAC requirement not under the control of the local mental health authority to change. This feedback will be sent to DSHS for consideration. C. This is a DSHS/TAC requirement not under the control of the local mental health authority to change. This feedback will be sent to DSHS for consideration. D. The information is used to ensure engagement efforts have occurred prior to closer. D. This is a DSHS/TAC requirement not under the control of the local mental health authority to change. This feedback will be sent to DSHS for consideration. MHMRA has streamlined many of the trainings in an on-line format to accommodate provider needs and minimize time away from clinical sites. E. The TRAG requirement is a DSHS contract requirement and the LMHA has no authority to change this in our RFA without DSHS approval. These concerns will however be routed to DSHS for consideration. Clarification: The TRAG does not determine level of care (LOC); it is a guide for the clinician, who then determines the LOC in conjunction with the treatment team. The contract does not regulate that the TRAG is done by a QMHP/BA level staff, that is the minimum staff level to perform this function and if providers feel the MD or NP (whom are also QMHP's) should complete this then that is allowable as long as TRAG trained first. F. MHMRA is currently on waitlist for many levels of care due to limited resources for the number of consumers we are required to serve. However, Case Management (CM) services can assist in identifying consumers who need prioritization on the WL due to decompensation and/or risk factors. The provider needs to flag cases of concern and the Agency will coordinate a case review. MHMRA will pass this concern regarding capacity onto DSHS as well. G. Patients with non-priority diagnosis who still meet the acuity need for MHMRA services may be able to remain in MHMRA based on acuity levels upon Authority review. Providers need to flag these cases for review to the Authority. The LMHA will complete a clinical review on these referrals with subsequent recommendations. In addition, patients not meeting the over-ride acuity requirements yet needing assistance with transitioning to other providers can also be referred to CM for such service assistance if the provider is unable to identify other possible service providers. The LMHA will work in conjunction with the treatment team in identifying other options for referral as needed.</p>

6/8/2009	Ann Thorson	Former Harris County resident and Tri-county client	SP 1		<a href="mailto:omega679900@yahoo.com">omega679900@yahoo.com</a>	Expressed appreciation for MHMRA and stated she is pleased with what she read.	Thank you for your feedback.
6/9/2009	Leslie E Milliken	State DSHS	SP 1		Leslie.Milliken@dshs.state.tx.us	Here are a few comments on the draft RFA for consideration in your 14 day comment period. Thanks to all for your hard work. 1. Transition goals for consumers – I could not locate the LMHA's expectations or goals for transitioning consumers to the external provider 2. Transition goals for LMHA employees, if applicable – Was unable to locate a discussion of this item. Is it not applicable? 3. Could not locate any mention of asking external providers to address challenges to providing services in your area. 4. Contract term and the date and time proposals must be received were not found. 5. A Statement that the applicant agrees to provide specified MH services at the rate of payment described in the RFA could not be located. 6. There was a very thorough on site review plan. 7. In Part II, from p. 30 on, all documents relate to "Provider Application". These documents follow the "Facility Documents". This was somewhat confusing.	Thanks. 1) added to exhibit H. 2) n/a. 3) will add to future public comment RFA notice for feedback. 4) open enrollment-not RFP. 5) Attachment a already listed. 6) thanks. 7) Added to applications.
9/2/2009	Latasha Lewis	Private Practice	SP 2	713-383-1755; 504-669-3653		Requesting information about whether an unlicensed master's level person can provide SP-2 services, and commented that our documents suggest someone who is 'in the process' of licensure can make application.	Ms. Lewis was informed by phone that only licensed clinicians can provide services, and that any misleading information in our documents would be corrected.
9/2/2009	Rose Jackson	Private Practice	SP 2	713-413-2552		Question about whether "LMSW-AP" can be credentialed as ALPHA and make application as CBT Provider.	Per Bob Stakem an LMSW-AP does not qualify as an LPHA. Ms. Jackson informed by telephone.
9/3/2009	Lee Barnes	Health Source	SP 2	281-706-8384	gave me incorrect one	Referral from Bd Member Mr Womack. Home health agency looking to contract with us--explained what we are currently out for counseling and doctor services.	Cami per Rose Invited to NDAC meeting and schedule private meeting 9-10-09 10am. They currently do administrative contracting and home health services. Tried to email website link-got error message-will call back.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			The application does not but should stand on its own i.e., the reader must refer to TAC, Health and Safety Code and DSHS RDM website to decipher language and standards that must be met in order to be considered an eligible provider. This will require too much time by providers who have not previously contracted within the MHMR system. It will require too much time from those of us who already provide services under the RDM packages.	The additional requirements are too large to include in these documents, MHMRA acknowledges the time requirement for providers to review these but they stand this way within the DSHS contract as well and are subject to change so it is prudent to reference versus cite details. <b>MHMRA will work with DSHS to determine if another approach is feasible at a statewide level.</b>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Open enrollment is an improvement over the RFP process however, the amount of information requested and time required to be a provider in your network is unreasonable. All other managed care entities require a standardized credentialing application, resume, license, liability insurance, certificates and Medicaid/Medicare numbers for open enrollment.	MHMRA agrees, prior to LPND- we required a provider application and proof of malpractice insurance, and a site review for contracts, however these new stipulations are required in the LPND TAC 412.766. The only area defined by Harris County was how Financial viability and Quality mgmt is defined.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			There appears to be extraneous information in this application. This information is irrelevant to the service package being proposed and leads to reader confusion and waste. For example: this document/application appears to be open enrollment for Service Package 3, an adult service, yet child/adolescent language and standards are found within the body of the application and has no bearing on delivery of SP-3. Further other adult packages e.g., SP-4 are described for no apparent reason.	As our expectation is that providers contract for various levels of care in order to preserve pt continuity, it did not make sense to have various contracts in place for each level of care leading a provider and the Authority to manage several contract terms, hence our contract and RFA's are standard and inclusive of all requirements, what is streamlined for the specific package is Attachment A (rates), B (credential requirements), and D (training). As many of our interested providers were interested in all care levels inclusive of CAS/AMH populations it was felt this was the most prudent approach for all involved. As the MHMRA's also did not receive any additional funds for LPND, it is also a staff efficiency within our own system to not have 14 different versions created. Again, we understand that this takes more provider time but we also think providers understanding the whole DSHS contract versus just a subset is of value to the contractor, the pt, and the system as a whole.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			The document indicates "up to 20%" of 1215 consumers or approximately 243 consumers could be referred to the network providers. Given there is no way to predict you will refer anyone and given the application states there is no guarantee of referrals, this is a very unattractive application to spend time on due to the amount of information you are requesting.	The MHMRA referral is not the question- choice of external providers will be offered to all pts who are in the packages procured, the 20% cap is a fiscal balance for the MHMRA. Again, as there were no new dollars for this initiative the MHMRA's need to gradually reduce their internal costs as external costs expand and a cap is one means of doing so. As mentioned there is no provider guarantee of patient choice (not provider referral- that is guaranteed)- even if we expanded the cap to 40%, there remains no guarantee in a business that is driven by patient choice. We are open to discussing what is viable for providers. Feedback in our FY 08 planning was that this was a feasible percentage. <b>We can re-examine this in the FY 2010 planning.</b>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Page 2, #3 lists Child and Adolescent MH Priority Population. This appears to be irrelevant to SP-3 and is confusing.	We will see what type of resources it will take to <b>pull child and adult service references apart</b> . If feasible within our resources it will be separated. May not occur in the short 2 week window we have before final posting but ideally for future posts if resources permit.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A-SP3: Rates are below Medicaid and it will be challenging to find "viable and stable" providers for anything less than Medicaid rates, especially MDs.	Rates are at Medicaid rates UNLESS, provider chooses to have the MHMRA enter their data for submission to the state, if this is chosen by the provider than a 5% charge for that data entry service is charged. <b>MHMRA will clarify the wording that this is a data entry fee which is optional to provider.</b>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A, page 2: You are proposing a 5% administrative fee. This is unheard of with other managed care entities.	This is not an administrative fee but a charge for data entry for state submission should a provider chose not to utilize our system directly. This is a provider option. (see further explanation above)

2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 3: Service Definitions seem to float, unrelated to the flow of the application, I think without explanation, and creates more confusion.	This is required per TAC for contracting that service definitions are attached. We could skinny it down to just those for that particular RFP but we tried to resolve the volume by citing the page number on the first page of Attach A since we did not have edit access to the larger contract document. <a href="#">MHMRA will look into means to cut just those relevant sections out for each contract to minimize data overload.</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 13: #5 a) Service Determination: If the service determination is made "jointly" between the provider and the consumer, how does the provider maintain fidelity to the RDM model and how will the lack of consistency impact service outcomes?	This is language straight from the DSHS contract, not local language. However, RDM fidelity is that the pt is assessed and based on that assessment the provider and consumer have a discussion about the patients assessed needs, RDM recommendations, and their willingness to engage in those service levels. Pts have the right to refuse certain or all services and providers also have the clinical discretion to recommend outside of the TRAG calculations if clinically indicated. The assessment is a guide/recommendation ultimately it is the provider who determines medical necessity is met or not
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 13: #5 a) Service Determination; If the clinical assessment recommends specific services in the package and the consumer declines, what is the process for resolution and clinical liability? As a provider of behavioral health I would need to adhere to my assessment and recommendations, if the client declined recommended services and I provided less than the assessment called for, I am concerned it creates liability and there is an ethical issue running through this issue as well.	Consumer choice is imperative here in the non-crisis packages. The provider needs to educate and continue efforts to engage the pt in the appropriate level of care but patient choice is foremost with non-crisis care. If the pt will only accept a lower level of care than those lower services at minimum need to be provided while the provider attempts to engage at the higher service levels. (this is an excerpt straight out of the DSHS contract- not local language)
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 14: Please clarify for the reader CARE. It is not explained in your service definitions or in the application. This may be an added cost to providing services, already below Medicaid rates.	CARE is the DSHS system which MHMRA must submit encounter data into. WebCARE is the system which TRAG's (assessments) are entered into. Both are DSHS systems and requirements. WebCare is a provider requirement and CARE data can be entered in the local system by the provider or by the Authority (for the 5% data entry fee). <a href="#">Will add these clarifications to the contract definitions</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 14, #8 UA Requirements, c) staff must have documented training in the use of instruments (TRAG, TIMA, Community Data) yet no explanation of where to get the training, time involved, etc. Likely another cost to the provider just to be in network.	This training is currently provided by MHMRA of Harris County at cost to the Authority (not the provider) and details are included in attachment D. <a href="#">This is a DSHS requirement not a local one.</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 14, #9 Assessment in CARE: No explanation of WebCARE and no timeframes clarified.	This is an excerpt from the DSHS contract. Webcare is the DSHS UM system. Assessments are required at least every 90 days and are generally incorporated into consumer services. <a href="#">Will define as noted 2 comments above</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 14, C Service Requirements, C2- Implement a "PFEP". No definition available in this document. Please define.	Again this is straight from the DSHS contract. PFEP= is patient and family education and is defined in the mentioned link. <a href="#">Will consider removing this whole section</a> to minimize the document and related confusions- providers are trained on this during the initial training sessions.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 14, C3a-"Develop a service delivery system in accordance with the most current version of DSHS's UM Guidelines, Adult Trag and Fidelity instruments" This needs to be defined and I am not sure if IRS allows an agency to dictate a specific "service delivery system" to an independent contractor otherwise it may classify the work as "employee" v. independent contractor. Increases cost to the provider.	<a href="#">How</a> to deliver services is not defined in these references but components which must be addressed in the model are. Again, this is an excerpt straight from the DSHS contract. <a href="#">This is a DSHS requirement.</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 15, C3c- it appears you want the external provider to assess the individual to ensure they meet priority population however, shouldn't this be done by the Authority to ensure the consumer referred is priority population and is wanting his/her services from an external provider? There does not appear to be a rate set up for providing a "full assessment" for the consumer by the network provider. In the event the consumer does not qualify for services the provider would not be paid. Added cost to the provider.	The initial assessment is always done by the Authority but RDM requires on-going assessments and MHMRA of Harris County has determined the provider is the best to accurately assess the pt due to the on-going relationship. The Authority will track and trend these assessments. As for pt choice, yes that is offered by the Authority initially and then every 90 days by the provider- inclusive in the provider 90 day review is a handout for the pt to contact the Authority directly if wishing to change providers at any time. There is a rate for the intake assessment by provider. The Authority does initial qualification, if at a subsequent update the provider finds them not eligible, interim services are covered as pt transitions to another care provider for pt continuity purposes.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 15, C3d(1)-If the client refuses services at the assessed LOC and wants services at a different level of care, but the provider is not contracted to delivered that LOC, what is the resolution, besides just placing them on a "wait list"?	Once in care pts are not waitlisted, they are referred to the Authority Case Manager for transfer to another provider, ideally we want providers to have the various care levels to prevent this- but the Authority will assist the pt in moving between providers if necessary. The initial provider of care will continue as the assigned provider until such a move can occur
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 15: please define "Medicaid eligible", assuming it means they have Medicaid benefits why would they need to be served through MHMR and with RDM. Aren't Medicaid clients already given choice and they have their own benefit plan? Many of the services in RDM are not allowable benefits for the MEDICAID member and these services would be denied. More cost to the provider.	Medicaid pts are given choice and have their own benefit plan with the exception of Rehab and case mgmt which are entitlement services. These services are only provided through MHMRA's, hence if a pt needs meds or therapy, yes they can be referred out, however if they are entitled to rehab/case mgmt they must be served through the MHMRA. Hence if not needing entitlement services the external provider could see these pts as private business (not under MHMRA contract) and if they do require these exclusive service levels then it would be under-arrangement with the MHMRA.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 15, C3f- this is potentially in conflict with IRS definition of an independent contractor i.e., only an employee can be instructed that specifically i.e., mandating CBT.	<a href="#">This is a DSHS requirement not MHMRA.</a> The independent contractor issue has been previously sent to DSHS for review, MHMRA does not have the ability to change this stipulation without DSHS approval.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 15, C3h-another potential conflict with IRS i.e., requiring training of independent contractors i.e., "train the trainer" training. This is added cost as well for the private providers.	Currently this is provided free to employees and external providers and paid for under Authority dollars, however, in light of the discussions around these IRS rules, pending legal advisement, training may need to be at cost to the Provider. <a href="#">MHMRA is pending input from DSHS.</a> Trainings are required prior to doing DSHS business and is mandated by DSHS.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 15, C3i- more training mandates and added cost for the provider.	see above response. Trainings are required prior to doing DSHS business and is mandated by DSHS. <a href="#">This is direct from the DSHS contract</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 16, C6d- This appears to be in conflict with Medicaid guidelines for attempting to collect the deductible/co-pay. It can not be waived.	Community Mental Health Centers are required to follow the TAC- Charges for Community Based Services Rule- 412 subchapter C. <a href="#">Again this is direct from DSHS contract</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3			Exhibit A page 16, C6- please explain how, if "non-contract" funds pay for services how the consumer would still fall under the RDM? If payment for services is received from any other source that covers the entire cost, the Local Authority can not mandate how the consumer is treated and would fall outside their domain.	This stipulates that General Revenue funds are truly funds of last resort. Example: You have a Medicaid pt in a Managed Medicaid plan- as the provider you must bill the MD services, therapy services etc, to that payor and only the rehab and case mgmt to the Authority, as there is another payer for some of the services. Because some of the <a href="#">services are paid for under GR. RDM is mandated.</a>

2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		Exhibit A page 17: Recoupment. This will not be attractive to providers simply due to the subjective nature of the measures regardless of the system used to measure outcomes. There are too many variables. <b>Another potential cost to providers</b>	This is directly from the DSHS contract and all MHMRA's are held to these same standards. <a href="#">Will pass this feedback onto DSHS.</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Further and more importantly if you refer only 243 consumers to the external network and a provider gets only a few referrals the percentages listed will certainly result in recoupment of funds i.e., if provider A gets only 2 consumers and one does not make targets it is an automatic 22% recoupment on the first measure. The provider is now gambling on volume to even out the percentages and the recoupment that is set up will definitely result in an unstable provider network. This is a significant issue. We want good outcomes and should be paid for good outcomes. The SMI population will offer major challenges to any provider. <b>Another cost to providers</b>	This again is straight from the DSHS contract (not a local rule)- however, the recoupment does not occur unless the Center as a whole (internal and external counted together) fall below this rule. MHMRA will be penalized by DSHS and will pass this penalty onto any providers who fell below standard. The Center will work with providers as they bring up their numbers and as long as diligent efforts are documented to try and provide patient care. <a href="#">Will pass feedback onto DSHS.</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Exhibit A page 20, D1 speaks to both "adults and children". This application (open enrollment) is only for adults.	This just flags that the requirement is the same for adults and child providers so that if providing both levels of care it is understood. This is a direct pull from the DSHS Adult services attachment not a local draft. <a href="#">Will pass feedback onto DSHS</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Exhibit B page 2of4: Job Description listed are not job functions. They appear to be "assurances". Further, a job description for an independent contractor is a clear conflict with IRS definition of "independent contractor".	<a href="#">Will change wording to "credentialing requirements"</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Exhibit B page 2of4, B. 1.b):please spell out "ABMS"	<a href="#">Will spell out</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Exhibit C page 4 of 11, Quality Management Initiatives 2.a. "20 minutes" to be face to face is not possible and would be dangerous attempt. Do you mean the police or ambulance should be at the scene of an emergent situation in 20 minutes? This is still a stretch and exceeds all other standards we encounter. <b>Definitely would add cost for a provider to be staffed to make this timeframe.</b>	This is direct from the DSHS contract language and is a contract requirement. This is usually met by the entity providing crisis response for that service area, in Harris County this is met via our MCOT, CTI, and CIT teams and private providers would have the same access to these teams. <a href="#">Will pass feedback onto DSHS</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Exhibit C page 7 of 11 #8. Providers filling out PAP will add more cost to providers.	Providers have a choice of filling out the PAP applications or utilizing our PAP staff at the clinic pharmacies to do so. This is a local requirement as currently this brings in over \$8 mil in revenue which can go back into pt care and is critical in maintaining our operations with limited funding. The only requirement of the provider is signatures.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Exhibit C page 7 of 11 #10. Please clarify what "potentially responsible" means and "potentially be a penalty"? "Potentially", more cost to providers.	The TRAG assessment is required for service payment- it is your authorization and without it claims will not be paid. There are some exceptions to this which is why the language is vague. This is all covered in detail in provider training.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Exhibit C page 7 of 11 Reimbursement Criteria, 1c. Submission of claim forms to the Local Authority "2 business days after the month services were rendered exceed Medicaid standards and all other health plan payors standards. They allow 90 days.	Correct, however, the DSHS contract requires all of our data to be submitted in order to count in our contract and they close the month- the local authority has until the 5th day of the new month to ensure all data is submitted to DSHS. If scrubbing external provider data we need 3 days to ensure external data is in the system for the submission to occur to DSHS timely. Again, this is a dshs requirement on data. <a href="#">Will refer your concern to DSHS for review</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		So setting up a process to ensure this with such a low probability of referrals will add cost to the providers and will not attract more providers.	Local Authorities are held to the DSHS contract which requires this data submission timely. <a href="#">Will refer your concern to DSHS for review</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		Being denied due to timely filing and also holding providers to the percentages on outcomes will result is providers paying the Local Authority not a recoup but paying dollars from their own account i.e., unearned dollars. This scenario actually places the provider at risk of paying MHMR for the referral and clearly would result in providers leaving your network.	We do a readiness review to ensure timely data submission is in place before providers are placed on our referral list as well as put many supports in place as providers take on their first cases to ensure providers success. The Authority has also invested dollars in the provider at this point and is equally invested in its success. The Internal providers have opened their doors for modeling is systems as well as the NM staff coming onsite to assist in systems set up to ensure success. These requirements are DSHS requirements which the internal providers are held to as well. <a href="#">Will refer concerns to DSHS.</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- In the event the Local Authority does not pay timely on a clean claim on time (you say 30 days in your application description and 45 days in your contract) will you pay the 18% annual penalty to providers as other payors do?	<a href="#">Will correct to both read within 30 days. Will take the penalty request to the LPND committee for determination.</a> MHMRA has not had any late claims paid to date and hence has not encountered this request.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Exhibit C page 7 of 11: Reimbursement Criteria 1.d: you indicate here that payment will be made within 30 days of receipt of claims for an approved invoice, yet your contract indicates 45 days. This exceeds Medicaid deadlines i.e., 95% paid within 30 days. This will delay payment and create unstable network of providers. <b>Adds cost to providers.</b>	As stated above this will be corrected for both to read "within 30 days". Typically MHMRA pays within 1 week and payment delays are not an issue.
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Exhibit C page 9 of 11 #5 a. "current diagnosis by a physician". This exceeds standards i.e., a fully licensed LPC or LCSW may diagnose. <b>This will add cost for providers.</b>	<a href="#">Good point- will amend to read "current diagnosis by an LPHA".....</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Exhibit C page 9 of 11 #5 and #6. These specifically mandated requirements for documentation may conflict with IRS independent contractor guidelines.	DSHS required provisions. <a href="#">Will refer to DSHS.</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Exhibit D page 1 of 2 and 2 of 2. All mandatory training adds to over 60 hours of required training with no guarantee of referrals. This is also a potential IRS conflict for independent contractors to be required to receive mandatory training. This amount of training will not attract network providers at the rates you are offering. <b>It will add more cost to providers.</b>	As stated previously, these are DSHS required trainings and services cannot be provided until these are completed. These are the same requirements as internal providers are held to under DSHS contract. <a href="#">Will refer to DSHS.</a>
2/3/2010	Providence (R.Wallace)	Private Provider	SP 3		- Finally, can you report that the Harris County MHMRA has attempted to consolidate administrative functions for the purpose of making more dollars available to service delivery per TAC Title 25 Part 1 Chapter 412, subchapter P, rule 412.756 i.e., "strategies to maximize dollars available to provide services. The LMHA shall maximize dollars available to provide services by minimizing overhead and administrative costs and achieving purchasing efficiencies. Strategies that an LMHA shall consider in achieving this objective include joint efforts with other local authorities on planning, administrative, purchasing and procurement, other authority functions and service delivery activities."	Please refer to our Local Network plan from FY 08 which addresses this TAC requirement. We have taken on contracts from other entities to generate revenue, we have acquired credentialing delegation agreements which reduce overhead costs, we add over \$8mil in PAP funding which offsets service costs greatly, we generate over 90 app's/mo for SSI/SSDI benefits which reduces our GR costs and helps bring in other payer sources, to name a few examples. We will be addressing this again in our FY 2010 plan and encourage Providences participation in those meetings/reviews.
2/6/2010	Telecare (David Pan)	Private Provider	SP 3		My general reaction to the MHMRA of Harris County offering for open enrollment applications of providers for adult RDM service package 3 is that the offering is confusing and contains extraneous information that obscures the intent of the offering. The offering also appears to violate the spirit of the provider of last resort provision of HB 2292.	<a href="#">Please clarify how it violates provider of last resort HB 2292 so that we can better respond.</a>
2/6/2010	Telecare (David Pan)	Private Provider	SP 3		The offering is confusing in that the proposal is fifty pages long and contains information that is only tangentially relevant to a provider interested in providing SP 3 services. I have several reactions to the supporting documents offered by MHMRA of Harris County for this proposal:	Comment only- details below

2/6/2010	Telecare (David Pan)	Private Provider	SP 3			The proposal is a call for provider applications to become network providers for SP 3 services yet the fifty pages contain information on every aspect of the entire RDM model. Any potential provider unfamiliar with the DSHS RDM model would be completely confused by the extraneous information contained within the fifty page proposal document.	It is Harris Counties belief that any provider who is successful in RDM and DSHS services must have some level of familiarity with the entire contract and its provisions 1) it is our hope that they provide a service array at many levels for continuity or our patients 2) Even if only taking one service package, Patients ebb and flow between many packages and it is imperative that providers understand the other service levels so as to best triage patients to the appropriate level of care. 3) with our ideal that one provider has multiple service levels, it is resource intensive on both sides to create many versions of this RFA versus 1 streamlined form. Finally, SP-3 providers are required to also be sp-1 providers hence the need to understand the full contract.
2/6/2010	Telecare (David Pan)	Private Provider	SP 3			The proposal is for adult RDM SP 3 service yet references to services for children and adolescents are found throughout the document.	see above response- Harris county could <a href="#">consider 1 child and 1 adult versions</a> if deemed beneficial since there is less cross over between providers at these levels. Will determine if feasible within current resources.
2/6/2010	Telecare (David Pan)	Private Provider	SP 3			The proposal makes references to many other web sites that a potential applicant would have to access in order to fully understand what is being offered. The multiple references and web sites that must be accessed to respond to this proposal are daunting to any provider not intimately familiar with the RDM system.	We would be open to other suggestions in how to best ensure providers have all the information needed to make informed decisions and to understand the rules and regulations for this contract. We have requested DSHS create a state wide provider training on the contract stipulations which may help with this concern.
2/6/2010	Telecare (David Pan)	Private Provider	SP 3			The proposal references many requirements of the applicant with no explanation of what these requirements entail. For example, the proposal makes reference to the Texas DSHS CARE system and WebCARE with no explanation of what these are or how to learn about them. Another example is the training requirements that the provider or the staff of the provider would have to obtain and keep current; <del>there is no explanation as to the who, what, where and how of this training.</del>	<a href="#">We can elaborate on these areas. As referenced above</a>
2/6/2010	Telecare (David Pan)	Private Provider	SP 3			The offering appears to violate the intent of the provider of last resort provision that has been established and clarified since it became law with the Governor's signature of HB 2292 nearly seven years ago.	<b>Please provide details on how this has been violated as that is not Harris counties intent, on the contrary we believe we have attempted to contract out a vast amount of services.</b>
2/6/2010	Telecare (David Pan)	Private Provider	SP 3			The proposal is offering only 20% of the 1215 consumers who qualify for SP 3 benefits to choose from providers who submit an application and meet all of the requirements of the process. This does not seem to meet the requirements of the provider of last resort provision of the LPND plans. Why are all consumers not given the choice of making a selection of a provider from a network of providers? How can this be consumer choice when only 20% of the adult consumers who qualify for SP 3 services can choose a provider other than the local authority? Why are the other 80% of the adult consumers who qualify for SP 3 benefits not given a choice of providers from a network of providers?	As described in our Local plan for FY 08 LPND, (please see website if interested in reading details of the plan @ <a href="http://www.mhmraharris.org">www.mhmraharris.org</a> ), we are procuring 20% in yrs 1-2 and will continue to expand that by 20 % in yrs 3-4 and so on until fully procured assuming there are providers willing/able to take on this service provision. As there is no funding for network development, MHMRA's are in a bind of paying for existing providers while bringing up new ones and cannot begin to cut costs internally until new service are operational, hence it must be a gradual approach or the LMHA would run out of funds ( <del>funds are capped</del> ).
2/6/2010	Telecare (David Pan)	Private Provider	SP 3			The proposal is asking providers to submit detailed applications that will take many hours to complete with no assurances that they will be offered referrals once they are in the network of providers. There is no explanation as to how consumers will be informed about private providers. There is no explanation of how 20% of the consumers will choose a provider other than the local authority internal provider.	Since the law stipulated this as consumer choice, there is no way for MHMRA to guarantee a pt volume to any provider. Managed Care companies make no guarantees either so this is not unique to the LMHA's. For a description of how provider choice will happen please see our FY 08 LPND plan posted at <a href="http://www.mhmraharris.org">www.mhmraharris.org</a>
2/6/2010	Telecare (David Pan)	Private Provider	SP 3			The proposal appears to place 100% of the risk on the provider who makes application to become a network provider and no risk on the local authority. For example, the proposal speaks to "Medicaid Eligible" but there is no explanation that the consumer who is currently receiving Medicaid benefits could be QMB or MQMB. If the consumer has QMB Medicaid benefits, they would be ineligible for Medicaid Rehab services. The proposal places the risk for determining not only Medicaid eligibility but also the type of Medicaid eligibility entirely on the provider. Another example is the requirement that the provider determine the consumers' priority population eligibility. The risk for this appears to be entirely on the provider. Both of these eligibility determinations are authority functions; the provider should not be at risk for providing services to individuals who may or may not be eligible for the services. The local authority should determine a consumers' eligibility, insuring that they meet the criteria for the benefit package before <del>allowing them to choose a provider.</del>	The initial determination of eligibility is on the Authority however on-going confirmation of pts benefits rests with the provider of service as it does in the managed care sector). There is no risk to the provider unless benefits are not confirmed prior to each service visit.
2/6/2010	Telecare (David Pan)	Private Provider	SP 3			It appears that the reimbursement rates contained in the proposal are 95% of the full Medicaid rates of reimbursement. Medicaid reimbursement rates are already much lower than the usual and customary rates paid for similar services in the general healthcare market. Reimbursement rates that are less than Medicaid rates of reimbursement will not draw many interested providers.	This will be better clarified in the materials. The rates are 100% of Medicaid <del>IF</del> the provider does their own data entry into our database for importing to the State data system. However, if the provider chooses to have the authority data enter their services for up streaming to the state, then the Authority takes off 5% for data entry services.
2/6/2010	Telecare (David Pan)	Private Provider	SP 3			I would like to summarize my comments by stating that the requirements contained within this proposal are not very attractive to an external provider who would have to devote monetary and time resources to responding with no clear indication that any referrals would come to the provider. Unlike the local authorities, private providers do not get prospective payments of general revenue. Private providers must capitalize their business up front and then earn every dime of revenue from the services provided to consumers. In addition, the services provided are subject to many denials and the revenue earned is paid retroactively, often six weeks to two months after the service has been provided.	MHMRA of Harris County Guarantees claims payment within 30 days and typically has a 1 week turn around. We understand there is start up costs and risks in any new business venture and that risk and start up costs are shared by the Local Authority as well (with no new funds to cover expanded business). We hear this concerns and would welcome any suggestions in how to minimize this risk. As stated previously, we cannot guarantee a pt referral as it is pt choice driven, however we will do due diligence in identifying pts and ensuring outreach opportunities for new providers.

6/11/2010	DePelchin Children's Center	Private Provider	SP 4 CAS		<p>The comments in this memorandum are in response to the Public Notice of the MHMRA of Harris County seeking comments to its DRAFT Open Enrollment process to expand its network of service providers for children's mental health. MHMRA seeks comments on perceived challenges and general feedback. DePelchin Children's Center is an accredited provider of children's mental health services with a long history of serving all sectors of the population. Under the proposed terms, the added duties and paperwork increase the cost of providing services. This increased cost combined with current Medicaid rates make it impossible for DePelchin to pursue a contract, as we can serve Medicaid clients directly at a lower cost.</p> <p>Barrier: General: There is a shortage of mental health professionals who will treat children and adolescents, and a critical shortage of psychiatrists who will do so. Unless it is made convenient, few providers will take more than a handful of patients under the proposed contract, if any at all. Recent reports on mental illness estimate that Harris County has an estimated 186,000 children with mental illnesses, and 83,525 of those children have a severe mental illness. There are only 134 child psychiatrists to serve them.</p> <p>Barrier: Compensation. The proposed rate of Medicaid MINUS 5% is a major barrier. The current Medicaid rate covers only about 50% of DePelchin's costs to provide services. There is already a shortage of providers that accept Medicaid rates to serve children and adolescents, especially psychiatrists. At this reimbursement rate, few psychiatrists will take any patients, and those who do will be taking them as quasi pro bono patients. It is not unusual for some psychiatrists to serve their pro bono patients for free or a small cost rather than coping with the paperwork of Medicaid. This proposal appears to create even more paperwork than Medicaid, so the psychiatrists are not likely to contract. Further complicating this is that this population of patients usually has more complex needs than most patients. Families of severely emotionally disturbed children often need case management support and these services are not reimbursed by Medicaid.</p> <p>Not paying for "no-shows" is also a significant problem. Medicaid patients have a higher no-show rate than private pay clients. Since mental health professionals' product is their wisdom, knowledge, and time, this lost time cannot be recouped and becomes a direct cost of serving this population.</p>	MHMRA appreciates these comments and will share these with DSHS as the rates, documentation, and contract terms are direct from the DSHS requirements of the Local MHMR's. Further clarifications: Data submission is driven by DSHS requirements as is documentation. Rates are driven by total dshs funding and caseload requirements. MHMRA will on an on-going basis re-assess rates to see if it is fiscally feasible to pay above Medicaid rates, at this time it is not. Case management cannot be contracted out under current law. Sole discretion of changing the rate is not dependent on MHMRA at this time but is reflective of changes in Medicaid reimbursement, No shows are not reimbursed by DSHS. Time frames for requested appts to actual appt is a DSHS requirement.
6/30/2010			LPND Community Forum		What has MHMRA done to publish the procurements?	MHMRA has distributed procurement/network updates to an open stakeholder distribution list (over 160+ participants) as well as listed procurements in local dist/professional papers, NAMI, posted on Business Daily website and local MHMRA website, as well as shared with local Consumer Advisory groups.
6/30/2010			LPND Community Forum		Can we have a consumer rating system of Providers for the consumers to review?	MHMRA agrees consumer input is important. Initially we will have a provider matrix for all to see which equally compares providers for things like locations, hours, languages, transportation, etc. We will also release consumer satisfaction results for each once available. MHMRA will host provider fairs for consumers to meet providers as well as offer providers the option of posting virtual fair videos onto the agency website explaining their services for consumers to view
6/30/2010			LPND Community Forum		How are you marketing to Providers? Have you included family practice physicians,	No changes needed- Question/clarification only. MHMRA is sending information out across a 160+ community network for distribution as well as targeting trade associations for each specific package level. We have targeted the Houston Medical Society as a way to reach physicians. Will look at utilizing Medicaid provider lists to identify PCP's who may be interested in step down/transition care based on this recommendation
6/30/2010			LPND Community Forum		Have you approached UT systems for contracts?	No changes needed- Question/clarification only. UT-HCPC is currently under contract but has decided to term the contract effective Aug 31, 2010. Other areas of UT have not been explored; specific comment was around new expanding UT programs and psychiatrist/resident availability. MHMRA will explore if there is any interest by UT in further contract discussions.
6/30/2010			LPND Community Forum		We need an expansion of CIRT beyond City limits as well as an expansion to children/adolescents as a preventative measure for community integration. There is a benefit to consumer and family interventions in the home (like MCOT) – need this expansion in Houston	No changes needed- Question/clarification only. MHMRA agrees in the benefit of such an expansion, however, in order to expand; MHMRA would need additional funding and agreement with law enforcement for such collaboration. With current funding limitations, this is not feasible, but MHMRA will consider such expansion in the future if resources allow
6/30/2010			LPND Community Forum		Has MHMRA explored grants to support the CAS Assessment Center? If this program can come to fruition, there would be a large community benefit.	No changes needed- Question/clarification only. At this time this is not an initiative which MHMRA is taking the lead on.
6/30/2010			LPND Community Forum		Is there a means to increase provider reimbursement above Medicaid?	No changes needed- Question/clarification only. MHMRA has looked into this multiple times and advocated for increases in reimbursement rates at the State level. At this time, MHMRA cannot supplement Medicaid rates. MHMRA will continue to explore alternative means to making the contract feasible for providers.
6/30/2010			LPND Community Forum		Has there been outreach targeted to Nurse Practitioners? This may increase the provider pool and the success of procurement. - Recommend approaching the TX Nursing Association (TNA) - and querying how to reach those in Psych specialty areas.	No changes needed- Question/clarification only. MHMRA will explore whether the TNA has a means for communication with this sub-specialty and if posting notices can be done through their organization.
6/30/2010			LPND Community Forum		Have you considered pharmacy options- mail order?	No changes needed- Question/clarification only. Yes, MHMRA has looked at many pharmacy options in order to ensure consumer needs are met. MHMRA has a fax and fill as well as a per member per month (PMPM) management model available to providers who are interested in adding this service to their provider location
6/30/2010			LPND Community Forum		Challenge of past 2008 plan was requiring providers to contract for sp-1 before sp-3 and it was not a cost beneficial model to the providers.	No changes needed- Question/clarification only. This has been addressed in the FY2010 Local Plan- which now allows for providers with DSHS experience to submit past performance audits to verify contract compliance as a means to potentially waive this requirement and allow for immediate release of higher sp-3 service packages with a cap until local audits are passed.
6/30/2010			LPND Community Forum		How will parity and healthcare reform effect this plan?	No changes needed- Question/clarification only. Since details on the implementation of both of these initiatives have not yet released, it is hard to speculate the impact, though there will likely be significant change in the community mental health systems. MHMRA will continue to monitor these changes as details develop and will adjust plans as needed with stakeholder notification and input.

1/27/2010			SP 3 & LPND Community Forum			What can we do to help get the state change some of the requirements to get providers?	Public comments are sent to the state with our plan.
1/27/2010			SP 3 & LPND Community Forum			What is the advantage to putting all service packages out at one time?	We did not have all of our contracts ready for release at the same time. Also, we do not have enough staff to get it done.
4/9/2010			LPND Community Forum			Have you thought about doing a Per member per month?	We did consider this a couple of years ago early in our discussions however; we found that lower quality and lower level of service trends seem to be provided. A fee for service pushes the provider to be held accountable to provide level of care the consumers are needing. We found better outcomes...at this point we are doing fee for service.
4/9/2010	Carolyn Ham	NAMI	LPND Community Forum			Disappointed that people did not show up for this meeting. Feel like the whole community should be here if they want to understand what MHMRA of Harris County has to do to provide services. We explain to families all of the time so that they can understand the states' expectation.	It's a huge challenge and MHMRA does a fantastic job in explaining the whole process in terms that ordinary people will understand. A couple of years ago, the state opened up some comment lines for internal and external providers. Some of the external providers were not happy with what's going on with the state. State could hear that we are not the only ones complaining about state requirements. We will get there. Patients have become empowered through this process. We will see a lot more empowered patients here in Harris County. The reason for the meeting no show...people appear to be tired of hearing about this and my feel it's never going to happen. We will ask our Consumer Advisory Committee for support. We do consumer survey in the clinic now. We may need to have uniform consumer surveys. All the patients of MHMRA are subject to be chosen for state satisfaction survey annually both internal and external. We need to make sure we are using the same form. We can put a box in all external lobbies for consumer feedback. The state is not providing enough funding for services which is usually the main problem.
9/9/2009			SP 2 Community Forum			Have we had any large providers that have expressed interest that could take over the entire operation?	The law will not allow one provider to come in to take over. If that provider fails or has quality issues or goes under, we have no options where to put those patients. We will remain a provider if there is only one provider; it must be 2 or more providers. Those providers must have financial responsibility and have demonstrated competency with a contract before we back ourselves out. It will take us approximately 8-10 years to procure our services. It could move faster or slower depending on circumstances. Five expressed interest; 1 has submitted an application and 1 withdrawn. Currently we have 3 respondents we're working with to be credentialed.
9/9/2009			SP 2 Community Forum			The Consumer Advisor Council members of MHMRA has been speaking with consumers at the clinics on a one to one basis to prepare them about the transition and see how they feel about external providers possibly being available to provide services. The council is receiving a lot of feedback.	We hope to have some providers available in the next 60 days. We will also put some information in the lobbies of our clinic as soon as we have providers ready.