EXHIBIT C

Agency Guidelines

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

Mental Health Provider Network Operational Procedures

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

Introduction

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County, as the Local Authority, is a contractor of the Texas Department of State Health Services (DSHS) established to plan, coordinate, develop policy, develop and allocate resources, supervise, and ensure the provision of community based mental health and mental retardation services for the residents of Harris County, Texas. As the local mental health authority, MHMRA may obtain clarification and confirmation of information submitted by the provider during the application process and ensure those applicants will demonstrate compliance to all guidelines specified in the FY2012 DSHS Performance Contract at http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm and http://www.dshs.state.tx.us/mhcontracts/renewal.shtm.

Pursuant to Texas Administrative Code §412.60, MHMRA of Harris County has the authority to assemble a network of service providers to provide the following services to the designated population of persons with mental illness who reside in Harris County. The funds allocated by DSHS are referred to as General Revenue (GR)-funds.

I. SERVICES SOUGHT

See Request for Proposal. For a description of services, see http://www.dshs.state.tx.us/mhcommunity/LPND/definitions.shtm.

Priority and Target Population

1. Adult Mental Health (MH) Priority Population - Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.

2. Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, or severe major depression with GAF under 50.

3. Child and Adolescent Mental Health Priority Population - children ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, mental retardation, autism or pervasive developmental disorder) who exhibit serious emotional, behavioral or mental disorders and who:
   a. have a serious functional impairment; or
   b. are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
   c. are enrolled in a school system's special education program because of a serious emotional disturbance.

II. MINIMUM REQUIREMENTS

At minimum, Applicants must be qualified providers. Thus they must:

1. Meet the minimum qualifications of the DSHS performance contract http://www.dshs.state.tx.us/mentalhealth.shtm and local plan http://www.mhmraharris.org/epn.asp;

2. Demonstrate one's ability to provide services in compliance with DSHS contract requirements;

3. Be able to provide services in the language as dictated by the person receiving services and/or utilization of translator by prior approval of the Authority;

4. Engage and involve consumers, legally authorized representatives, and families in the policy and practice levels within the applicant's organization or individual practice; and

Notwithstanding the above, Applicants must be eligible/registered to do business in Texas. In any situation where a consortium of providers is applying, a single entity responsible for services must be identified and the financial agent must be an organization with a demonstrated ability to manage funds. See other applicant credentialing requirements in Exhibit B.

III. RESPONSIBILITIES

Local Authority Responsibilities
The Local Authority will be responsible for service coordination/case management and facilitating an individual's selection of service providers, authorizing services, reviewing claims and paying for appropriate, authorized services rendered by the service providers in its Network. The Local Authority is also responsible for utilization management and quality assurance. The Local Authority ensures that contracted services addressing the needs of the Priority Population are provided as required by DSHS, comply with the rules and standards adopted under Section 534.052 of the Texas Health and Safety Code, and Chapter 412, Subchapter G of the Texas Administrative Code. The Local Authority does not guarantee any referral volume to any service provider within its Network of Providers. To review the Local Authorities FY12 Service Targets and Capacity go to http://www.dshs.state.tx.us/mhcommunity/LPND/LMHAs/harris-county.shtm.

Service Provider Responsibilities
The service provider will be responsible for maintaining all original documentation reflecting service provision regarding treatment and/or services rendered to the Local Authority's individuals with mental illness, and allow the Local Authority access to such records upon request. The service provider is required to comply with all state and federal laws regarding the confidentiality of consumers' records and nondiscrimination. The service provider will actively assist in the disbursement of consumer and advocate satisfaction surveys. The service provider will obtain prior authorization, provide acceptable levels of care, and maintain acceptable levels of liability insurance, and appropriate licenses and accreditations. If the service provider is not a Medicaid or Medicare provider, the contractor will apply to become a Medicaid or Medicare provider if providing Medicaid/Medicare billable type services. The service provider will maintain status as a Medicaid provider in order to minimize service disruption for consumers obtaining Medicaid benefits. The service provider also agrees that its name may be used, along with a description of its facilities, care, and services in any information distributed by the Local Authority listing its service providers. The service provider must comply with the rules and standards adopted under Section 534.052 of the Texas Health and Safety Code and applicable local, state, and federal laws, rules and regulations.

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

Re-credentialing

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

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

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

Site Review Criteria:

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

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

Record Systems Review

(Compliance with payer requirements and federal billing guidelines)

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

Operational Standards Review

1. Information is posted in relation to complaints, appeals and duty to report processes
2. Confidentiality policies, consumer rights and privacy notices are provided to consumers
3. Access and Availability Audits
4. After Hours Availability Audits
5. Satisfaction Surveys - DSHS conducts annual consumer satisfaction surveys as a mechanism to obtain feedback and quality of care concerns regarding network providers. MHMRA may also conduct periodic patient satisfaction surveys.

Sanctions imposed by Local Authority

Failure to comply with MHMRA's procedures or with general obligations under the Agency may result in the following actions:

1. Case Managers and/or the Network Management Coordinator will document provider non-compliance and will refer the investigation of the complaint to the Quality Management Department.

2. The Quality Management representative will address the issue directly with the provider via a phone call, letter or visit.

3. Providers are responsible for completing a plan of improvement on all items that are out of compliance; failure to do so will be reviewed by the Agency and may be subject to contract termination and/or:
    a) Temporary suspension of network privileges
    b) Termination of network privileges
    c) Recoupment of funds

IV. Quality Requirements & Procedures

Quality of Care
MHMRA has comprehensive Utilization Management and Quality Management Programs that monitor and evaluate the care and services provided to consumers. Any issue that is a source of concern in regards to the services that could impact a consumer's treatment is reviewed as a quality of care concern.

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

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

3. Treatment Record Audits and Data Submission Compliance - MHMRA conducts treatment record documentation audits at least annually to check provider's treatment records for compliance with the described standards. The providers will receive notification of the audit at least 30 days prior to the audit beginning. Providers will be asked to make available blinded records submitted by Quality Management, which will be audited based on the criteria listed below. Once the audit is complete, the scores will be communicated to the provider. If the provider does not meet compliance, an action plan will be implemented and another audit scheduled. MHMRA has set a performance goal of at least 95% compliance. Criteria to be evaluated include the following:
    - Consumer Name or ID number on all pages
    - Biographical/personal data such as address, employer info, school info, age, marital status, phone number, emergency contacts, legal status, consents and guardianship information is noted
    - Provider's credentials and signature on each entry
    - All entries are dated
    - Record is legible
    - Presenting problem/chief complaint is listed including psychological and social conditions affecting client's medical/mental health status
    - Medical treatment history is documented such as significant illnesses, surgeries, pregnancies and/or accidents
    - History of and/or cigarette, current alcohol or substance abuse is documented for patients 12 years of age and older
    - Assessment and intervention with children, adolescents and families

- Clinical specialties directly related to the services to be performed
- Age appropriate clinical assessment including the uniform assessment
- Age appropriate engagement techniques (e.g., motivational interviewing)
- Age appropriate rehabilitative approaches
- Use of telemedicine equipment if applicable
- Utilization management guidelines
- Appropriate interactions with an individual who has a physical disability such as a hearing or visual impairment
- Psychiatric history is documented including previous dates, provider, facilities, interventions, family information, and for children/adolescents: prenatal, perinatal, and full developmental history
- Special status situations (SI, HI), severe deterioration and elopement potential are documented including referrals to appropriate providers/facilities and/or revised compliance with written protocols
- Each record indicates medications, dosages of each, dates of initial prescriptions/refills, relevant labs if appropriate and medication consents
- Allergies and adverse reactions are clearly documented including no known allergies to drugs or other substances
- Proficiency in specimen collection
- DSM IV five axis diagnosis is consistent with symptoms, history and other assessment data
- Developing and implementing an individualized treatment plan
- Treatment plans/actions are based on medical necessity and consistent with diagnosis(is) and have measurable objectives and timeframes as well as the understanding of the patient of the treatment goals which s/he has helped to set
- Consumer's mental status exams are documented
- Progress notes reflect treatment goals and consumers strengths and limitations
- Proper documentation of services provided
- Referrals are recommended when indicated reflecting coordination and continuity of care between PCP/other providers
- Prevention and educative services are documented
- Peer-provider or consumer-operated service model
- PCP/Pediatrician coordination is documented and proper release of information is in place
- Records are kept in a secure, confidential and organized manner. Records are retrievable. Records are maintained for a period of at least six (6) years.
- Discharge plans and/or follow up plans are noted
- Planning and training for responding to severe weather, disasters, and bioterrorism

4. Satisfaction Surveys - MHMRA conducts provider satisfaction surveys as a mechanism to obtain feedback and suggestions for improvement from providers. Surveys will be mailed to providers on a yearly basis, and will assess satisfaction with the agency in the areas:
   a) Outpatient consumer referral process
   b) Phone wait time
   c) Utilization management process
   d) Care manager availability, support and consultation
   e) Staff's professional behavior and courtesy
   f) Provider status turn-around time
   g) Overall service

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

by MHMRA. Additionally, MHMRA staff may attend quality reviews conducted by the provider.

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

Outcomes Measurement

Personal responsibility or health outcomes and consumer-provider partnership in treatment decisions are primary tools of successful treatment. Clinical progress in each level of care will be assessed on an ongoing basis per defined measures in Request for proposal and DSHS contract.

Network Requirements depending on services contracted:

1. Training (See Exhibit D) - Contract training will be provided to new providers within 30 days of approval for the network and prior to service delivery. Annual updates will be scheduled and active network providers will be notified for participation/attendance. Additional training may be deemed necessary based on changes that occur in procedures or regulations. Providers will be notified of any ad hoc training sessions that may occur. Providers are responsible for tracking the due dates of all their trainings.
2. Documentation Requirements- Contractor shall follow documentation procedures as delegated by the Agency. See Provider training materials for format and timeframe requirements. All documentation shall be on Agency approved forms and shall be submitted to the Agency within 48 hours of completion for data entry into the system to ensure payment. All documentation is subject to review by the Agency upon request.
3. Formulary- Providers must follow the Agency formulary and prescribing guidelines as set forth by the Agency. Exceptions to these guidelines require prior written approval by the MHMRA-Medical Director for Mental Health Services.
4. Notification of Change: Provider must provide written notification of change within 10 days of the occurrence for the following:
   a) Change of Address
   b) Change of Phone Numbers
   c) Change of Appointment Availability for New Consumers
   d) Any other material changes that affect access and availability to consumers
5. Lab work. Provider will use MHMRA's lab work contractor unless able to provide service at same rate.
6. Nursing services. Provider will schedule EKGs and injections with MHMRA nurses at one of our clinic locations unless able to provide service at same rate. Provider must follow agency guidelines.
7. Pharmacy. Provider will use one of MHMRA's pharmacies at any of the 4 clinic locations or assigned clinic location unless able to provide service at same rate or unless client has a private insurance plan and can use any approved pharmacy. Pharmacy must be aware of client's return appointment and TRAG assessment dates at time of script refill.
8. PAP. Prescription Assistance Program for medication. Provider will assist in completing applications within designated timeframes.
9. Requirements. Provider will be knowledgeable and compliant with DSHS timelines for due dates of client materials (i.e.-TRAG due by 90th day).
10. Providers contracting with MHMRA will be responsible for the completion of the TRAG assessment within deadlines prescribed by the DSHS contract (currently every 90 days) and potentially responsible for timely data entry into DSHS Webcare electronic system. If either of these is not met, there will potentially be a penalty or lack of payment for services.
11. No shows. Providers will adhere to a good faith effort in trying to reschedule clients with missed

appointments and document such attempts in clinical chart. MHMRA will not pay for no show appointments. A Discharge Summary for clients no longer receiving care will be required.

12. MAP. Providers will be knowledgeable about client's monthly ability to pay for services which MHMRA assesses yearly (or in event of change) at financial review and collects from client directly. The financial review is required to be renewed yearly and providers need to be aware of these deadlines for claim submissions.
13. Client choice. Provider will offer clients a choice of providers within our network at every treatment plan review or every 90th day. A client's signature acknowledging their decision needs to be recorded.
14. Meetings. Providers will attend regularly scheduled Provider meetings for operational guidelines updated when required.
15. Providers will grant electronic access to medical records for MHMRA Authority staff and if unable, paper copies may be required to be provided to MHMRA Authority prior to claims processing to ensure compliance with contract requirements.

Reimbursement Criteria

1. Billing

a) MHMRA is responsible for processing claims for consumers who receive authorized services from a provider. All non-emergency services must be pre-authorized. All emergency services must be authorized within 24 hours or 1 business day of service initiation.

b) The payment amount will be based on a CMS-1500 /UB-92 Claim Form or on an Agency pre-approved Invoice, which shall reflect the services, provided by the Contractor, and is approved by the Agency employee(s) authorized to approve billing(s) as set forth in the Agreement.

c) Claim forms for services must be received no later than the 2nd business day after the month in which services were rendered depending on contract arrangement. Claim forms for services received later than the 2nd business day on which the prior month services were rendered will be denied due to untimely filing.

d) Payment shall be made within 30 days of receipt of the Claim form or approved Invoice. Payment may be delayed, adjusted or withheld, where a deficiency is noted in goods, services, or invoices received. MHMRA retains the right to offset payments for future claims paid where a deficiency is noted after payment has been processed. Payments will not be further paid if data is being upstream claimed to another payor until MHMRA receives payment from such payor.

e) Claim Appeals shall be submitted within 30 days from the initial EOB date to the following mailing address:

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

f) Consumers cannot be billed for services that are not covered by the Benefit Plan. A provider may not require a down payment prior to providing allowable services to eligible consumers.

g) A provider who furnishes services not covered by Benefits, including those services which have been determined as not medically necessary, must obtain the consumer's signature acknowledging that the consumer understands their responsibility for payment of uncovered services.

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

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

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

2. Payments

a) Coordination of Benefits: Contractor will collect information concerning duplicate coverage at the time of treatment and will provide such information to the Agency in administering the coordination of benefits within 7 days of receipt of such information.
b) Warranty: By submitting a claim, Contractor warrants and represents that the services for which the claim is made were provided to the Consumer. The Agency shall have the right to review Contractor's records, upon reasonable notice and during business hours, to verify that such services were rendered.

3. Modification of Existing Fee Schedule

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

4. Notices to Agency

Contractor shall notify the Agency within 10 business days of any events effecting licensure such as suspension, revocation, threatened loss or any way in which the Contractor would be limited in providing Covered Services. Any loss of Contractor's Professional Liability Insurance or material change in the policy must also be reported to the Agency within 10 business days of notification of this event.

a) No Discrimination: Contractor agrees to render Covered Services to Consumers in the same manner and in accordance with the same standards and with the same time availability as it offers to non-Consumers and consistent with existing medical, ethical, and legal requirements for providing continuity of care to any patient.
b) Covered Services: Contractor represents and warrants to the Agency that Covered Services shall be provided to all Consumers in an appropriate, timely, and cost effective manner. Further, Contractor represents and warrants to the Agency that Contractor shall furnish such services according to the generally accepted medical and mental health practices and applicable laws and regulations.

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

a) Current diagnosis by a Physician or LPHA -data entered into electronic system or provided to Authority
b) Uniform Assessment – RDM (UA-RDM) completed by a QMHP

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

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

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

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

V. Appeal Procedure for Denial of Access to Network:

1. Function and Timeline

    a) The Credentialing Committee of MHMRA may make a negative decision based on (but not limited to) one of the following :
        i) State license encumbered or not current
        ii) Malpractice insurance is not in effect

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

2. Provider Denial of Credentials

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

3. Provider Appeals

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

VI. PRINCIPLES AND PRACTICES OF CONTRACTING WITH THE COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAMS DIVISION

Introduction
The CPEP Division of MHMRA of Harris County provides services to a number of eligible consumers in Harris County. To be eligible for the co-occurring disorders program, a consumer must:

1. Have a diagnosis of major depressive disorder, bipolar disorder or schizophrenia, schizoaffective disorder or schizophreniform;
2. Have a diagnosed substance abuse disorder;
3. Be a current resident of Harris County;
4. Adult (over age 18) and voluntary;

5. Have a capacity to make a decision to enter into voluntary treatment;
6. Have a history of two or more admissions to a psychiatric hospital within the past six months and/or a history of substance abuse rehabilitation admissions or recommendations for substance abuse rehabilitation or Harris County Incarceration within the last 6 months;
7. not in need of acute care interventions;
8. Documented history of substance abuse/dependence which impacts MH treatment adherence;
9. Willingness to engage and participate in group and individual treatment modalities;
10. Patient is unable to be appropriately treated in a less intensive treatment setting (demonstrated failure in traditional outpatient services);
11. Patient able to comply with residential rules and regulations;
12. Medically stable and not in acute withdrawal;
13. Not bed confined or having medical complications which would significantly hinder participation in residential treatment; and a
14. Capacity to benefit from rehabilitation interventions (i.e. no significant cognitive impairments and/or limitations such as moderate/profound MR, brain injury, etc)

Within the limits of funding and other contract requirements, consumers will choose which services they receive from MHMRA and its Contract Providers. The underlying goal of all programs operated, or funded, by MHMRA of Harris County is to assist persons with mental health and substance abuse issues to develop the skills and access the community supports and resources necessary to learn, work, and live with dignity as contributing members of the community. The CPEP Division will not fund services which segregate consumers from the general treatment community, or do not work toward integrating consumers with mental illness into the community.

General Contract Information

The CPEP Division maintains an open enrollment process for all contract providers who meet the requirements of the contract and places no artificial limits on the number of providers within the Co-occurring Disorders Treatment Provider Network. Because of this, there are several facts that contract providers should be aware of:

- Having a valid contract with MHMRA does not guarantee that any particular provider will receive referrals for services. Referrals are based solely on consumer choice of available programs.
- The contracting process with MHMRA can be quite lengthy, requiring review by several Departments in the Agency and final approval by the Board of Directors. MHMRA staff may not authorize payments under any contract that has not been approved by the MHMRA Board.

Consumer Choice

MHMRA uses the concept of consumer choice to assure that consumers are afforded the same choices that every other member of the community have as their right. There are three areas regarding the choices presented to consumers that require further explanation here. Violation of these principles will result in MHMRA removing a provider from the list of agencies given to consumers when choosing services and service providers.

- No solicitation of consumers (or their families) currently being served by another provider is permitted. Such behavior is considered inappropriate and unethical.
- No action will be taken to change the services for which a consumer is authorized unless that consumer has informed his/her Case Manager that he/she wants to make a change in services.
- Providers may not initiate changes in any consumer's service provider. Changes may only come from the consumer and must be authorized by the Case Manager.