



NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

BOARD OF DIRECTORS MEETING

**October 8, 2025
12:00 PM**

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

Board of Directors Meeting

A Videoconference Meeting (Pursuant to Tex. Gov't Code § 551.127) will be held on

Wednesday, October 8, 2025 @ 12:00 PM

Presiding Officer will be present at meeting Location: 8111 LBJ Frwy., Suite 900; Dallas, TX 75251

General Public May Join Webinar Meeting

<https://ntbha-org.zoom.us/j/83600108411?pwd=CzfhSdL6ovqc7RAlaNGwAVcdnQQqxd.1>

Passcode: 123411

Due to limited accommodations, the general public is encouraged to join the meeting via Zoom using information above.

A G E N D A

The NTBHA Board of Directors will meet in a regularly scheduled and posted open meeting to consider, discuss and possibly take action on:

**denotes item which requires a vote*

Item #	Agenda Item		Attachment
1.	Call to Order and Declaration of Quorum	Commissioner Dr. Elba Garcia, Chair	
2.	Secretary's Report <i>*Present Minutes for approval: September 2025</i>	Judge Cody Beauchamp, Secretary	X
3.	Finance Committee Report <i>*Financial Reports for approval: August 2025</i>	Ryan Brown, Treasurer	X
4.	Public Commentary - Limited to 2 minutes – only those who are registered		
	Consent Agenda Items		
5.	Provider Meeting Update	Matt Roberts	X
6.	PLAG - Psychiatrists Leadership & Advocacy Group Update	John Bennett, M.D.	X
7.	PNAC - Planning & Network Advisory Committee Update	Walter Taylor, PhD	
8.	Legislative Update	Janie Metzinger	X
	Agenda Item		
9.	Presentation: <i>Bridging the Gap Foundation Impact Report</i>	Patric LeBlanc, President & CEO of <i>Bridging the Gap Foundation</i>	
10.	Chief Executive Officer's Overview and Analysis	Carol Lucky	X

11.	*Resolution 476-2025 Ratify HHSC Contract for Local Mental Health Authority Performance Agreement Grant Program (LMHA) for FY2026 – FY2027	Carol Lucky	X
12.	*Resolution 477-2025 Approve Inpatient Psychiatric Hospital Contract Renewals for FY2026 and FY2027	Carol Lucky	X
13.	*Resolution 478-2025 Approve Substance Use Disorder Provider Contract Renewals for FY2026 and FY2027	Carol Lucky	X
14.	*Resolution 479-2025 Approve Mental Health Provider Contract Renewals for FY2026 and FY2027	Carol Lucky	X
15.	*Resolution 480-2025 Approve Harris County Crisis Hotline Interlocal Agreement (<i>Renewal</i>) for FY2026 and FY2027	Carol Lucky	X
16.	*Resolution 481-2025 Approve Clinical Pathology Laboratories (<i>CPL</i>) Contract Renewal for FY2026 and FY2027	Carol Lucky	X
17.	*Resolution 482-2025 Ratify Be Well Texas Contract for Medications for Opioid Use Disorder (MOUD) Treatment Services Agreement for FY2026	Carol Lucky	X
18.	*Resolution 483-2025 Ratify Be Well Texas Contract for Office-Based Treatment (OBT) Services Agreement for FY2026	Carol Lucky	X
19.	Executive Session <i>The Board may go into Executive Session pursuant to Chapter 551, Subchapter D, Texas Govt. Codes as shown below:</i>		
20.	Discussion and possible vote in open session on matters considered in Executive Session	Commissioner Dr. Elba Garcia, Chair	
21.	Next Regular Board of Directors Meeting: November 12, 2025	Commissioner Dr. Elba Garcia, Chair	
22.	Adjourn	Commissioner Dr. Elba Garcia, Chair	

***Action Items - Discussions and possible approval**

If during the course of the meeting covered by this notice the Board of Directors should determine that a closed or executive meeting or session of the Board of Directors is required, then such closed or executive meeting or session is authorized by the Texas Open Meetings Act, Texas Government Code, Section 551.001 et seq., including but not limited to the following sections and purposes:

Tex. Gov't Code § 551.071 – Consultation with attorney to seek advice on legal matters.

Tex. Gov't Code § 551.072 – Discussion of purchase, exchange, lease, or value of real property.

Tex. Gov't Code § 551.073 – Deliberations regarding gifts and donations.

Tex. Gov't Code § 551.074 – Deliberations regarding the appointment, employment, evaluation, reassignment, duties, discipline, or dismissal of a public officer or employee.

Tex. Gov't Code § 551.076 – Deliberations regarding security devices or security audits.

Tex. Gov't Code § 551.087 – Deliberations regarding Economic Development negotiations.



NTBHA Provider Network Meeting
September 26, 2025
10am
Teleconference: Microsoft Teams

*Agenda is subject to change

****read.ai meeting notes, or iabot technology: These technology features are NOT allowed in this meeting.**

Agenda Item	Presenter	Agenda Talking Points
Welcome & Introductions	Alvin Mott	Greetings
General Updates	Alvin Mott	➤ Operational Changes notify NTBHA at provider.relations@ntbha.org or call Alvin Mott at 469-530-0246 ➤ NTBHA Provider Manual ○ https://ntbha.org/providers/manuals-forms/ ○ Or request a pdf copy – email amott@ntbha.org ➤ FY26 CMHP and SUD contracts ○ 60 to 90 day extension for those contracts that have not been terminated ➤ Provider contact updates ○ NTBHA Provider Key Personnel – Contact List. Submit to provider.relations@ntbha.org no later than October 1, 2025 by 4pm. ○ Info from above will be used for Provider Directory / OSAR Resource Directory ➤ Deliverables: ○ NTBHA CMBHS Security Attestation Form (your NTBHA provider locations) ○ NTBHA Form K: CMBHS Security Administrator Attestation (MH User Administrator – Primary and Secondary)
Presentations	Jessica Martinez	➤ TBA
SUD Updates	Alvin Mott	➤ FY25 Claims ○ Timelines: ▪ Last day to submit SUD Claims 9/30/25 by noon. ▪ Please work on any corrections ASAP ➤ FY26 claims: Submissions started ➤ MOUD (formerly MAT): New CMBHS locations ○ Created ○ Activated – email cmbhstrainingteam@hhs.texas.gov ○ Inform Alvin at amott@ntbha.org that location is active.
Outpatient, Utilization and Evaluation Updates	Robert Johnson	➤ Quick Reminders CMHPs: ○ TA-Documentation of Services-Due by 10-6-25. Requesting a Recovery Plan and two progress notes associated with that plan. The two notes can be from Skills training or Psychosocial. ○ Recovery Plan-please review the Strengths, Barriers and other sections that the content of that section is a listing of ANSA or CANS scores. Content verbiage needs to be in each section-meaning a description. NTBHA is currently engaged in TA with all providers to ensure TAC is met. Recovery Plans reviewed after 11-1-25 will be sent back to the Provider if the content does not reflect the section heading. ○ There is an increase in deviation requests that are not being authed at first submission. The main issues are twofold: a) deviation comments/QIDS do not match the ANSA/CANS scores. B) there is minimal information provided-Ex-please auth, Ex-Requested, Ex-would like this service, Ex-Need ○ Please contact me when the UA has been corrected. rjohnson@ntbha.org ○ Any UA submitted after the 15th of the month will show up in Served Not Assessed Performance Contract Measure and not count. ○ Please return the RX/SNA/Medicaid/Error report each month.
Compliance / Quality Management	QM	➤ Review Reminders ➤ QM New Complaint Form for MH providers
Announcements	Alvin Mott	➤ Please review the attachments to agenda ➤ Next Meeting

Questions From Providers	Open	
Providers: NTBHA would like to highlight the good work you all are doing in the community. This is your opportunity to brag to the NTBHA board about the good work you are doing in the community. Please send your submission to Provider.Relations@NTBHA.org by COB on the Monday following each provider meeting.		
The Next Meeting: October 31, 2025, at 10am **Meeting notes are included in NTBHA Board Meeting Documents. You can access NTBHA Board Meeting Documents at: https://ntbha.org/meetings/board-of-directors/		

Announcements / Resources

If any provider would like to announce any trainings or events please send information to amott@ntbha.org

Region 10 Interagency Brown Bag event: October 23rd from 9am -12pm.

To sign up use link: <https://forms.gle/s8fKAzMEdfr2DkTS6>

Contact: Amy Reeves at amy.reeves@region10.org

What is this event:

Each year, Region 10 Education Service Centers host an Interagency Brown Bag Event. This event is designed for agencies to quickly (maybe 2 minutes) share about their organization with other agencies and educators throughout Region 10.



**MENTAL HEALTH
RESOURCES DAY**
MAKING COMMUNITIES HEALTHIER



Saturday,
October 25, 2025
10 AM - 3 PM



2345 Reagan St.
Dallas, TX
75219

Please join us on Saturday, October 25, 2025 from 10 AM to 3 PM for our first annual MENTAL HEALTH RESOURCES DAY – DFW!

MENTAL HEALTH RESOURCES DAY is a mental health fair with vendors and speakers presented by Creative Mental Wellness and Phoenix House Texas. The event gives community members the opportunity to learn more about the resources exist in the DFW area while also providing organizations and people who work in the mental health field the opportunity to connect and collaborate. The event will feature a presentation by Phoenix House Texas' CEO, Drew Dutton, MEd, MBA, MAPP, LPC-S, LCDC, ACPS, on Positive Psychology and Well-Being (2 CE hours) as well as a panel discussion.

The event is free to attend! Please RSVP to let us know you're coming by [submitting this registration form](#).



Celebrate the season with us at this beloved community event! Enjoy a fun-filled day featuring **games, face painting, arts & crafts**, and more.

Feel free to **come in costume** and join the festive spirit, we can't wait to see your creativity shine!

Bring your friends and family—it's going to be a blast!

Date: Saturday, November 1

Time: 2:30 pm – 4:30 pm

Location: 4701 Samuell Boulevard, Dallas, TX 75228



Lone Star Awards & General Member Meeting

Please save the dates for this year's Lone Star Awards Luncheon and General Member Meeting being held at Homeward Bound in Dallas on November 5 & 6, 2025.

Registration will be opening soon.

Registration Link for the Association of Substance Abuse Programs (ASAP):

https://dr49r9bab.cc.rs6.net/tn.jsp?f=001V5rreq7bjOaQ67j0hlZQQmU3XXsBvcOsC5KLaY2Mevj4EpWdBOZSj5FyFDliZr8t-lSsRJ4QUhmt_wRnlewt-C1rvpNgL4SsfwbntzKqMd84Z5zN9P_Rz1q9iemiB66oq8umY_dGf3lrTIlvzh4V4ZZHDKkSnZJUrhYNh1F39BfyRy9-TqIKXEcCJRYZBOLwMScv7qBmgW-XBEZbDG1NfWrDnftZ1rVo7Ch8m5pWWj58NL1lIKyJG2sf56L3bPVQO2KyIYbNO0xjwmSzck-V1ddA3Qja8TUEHoQnzo_XfHh77_ilx-bAzw-KVuRrbHmg_07uBWcbgXcn7m3wi0Q==&c=Duo1UimewQ235FvN7KAxxlralYYb3d-zUogFF4qU63va306mgZSFIA==&ch=yIzIUJyJ8lCujLjzRFRqMGsuNFi8AKh1VpU6EEpleyS-YF4D6DXw4g==

AMHP Conference 2025

The AMHP Conference 2025 is a comprehensive event for mental health professionals, taking place in Carrollton, TX. It features a range of speakers and topics relevant to the field.

October 9–10, 2025

Association for Mental Health Professionals

Carrollton, Texas

[More Details](#)

<https://associationformentalhealthprofessionals.org/amhp-conference-2025/#!event-register/2025/10/9/2025-amhp-annual-conference>

2025 NAMI Texas Annual Conference

The 2025 NAMI Texas Annual Conference & Awards Celebration will be held in Austin, TX, bringing together individuals with mental illness, family members, and professionals to discuss the latest in mental health.

October 30 to November 1, 2025

NAMI Texas

Austin, Texas

[More Details](#)

<https://namitexas.org/event/2025-nami-texas-annual-conference/>

North Texas Mental Health Symposium

The North Texas Mental Health Symposium is set to take place in Plano, TX, focusing on key areas such as youth mental health and first responders. It aims to provide practical solutions and resources for professionals in the mental health field.

November 20, 2025

None

Plano, Texas

[More Details](#)

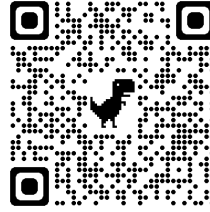
<https://mhsymposium.com/index.html>



Below you will find a list of our upcoming MHFA/YMHFA Classes. Please feel free to share with staff and community members, these classes are free for Texas Residents. If you are interested in hosting a class for your organization, feel free to contact Amy Sanders directly.

Amy Sanders

Manager of MHFA Education and Outreach
North Texas Behavioral Health Authority
8111 LBJ Frwy | Suite 900 | Dallas, TX
Direct 469-530-0574
Cell 469-595-1211
mhfa@ntbha.org



Want to Take a MHFA Class?

Community Presentations Available



OSAR is available to give free community presentations on a variety of substance related topics such as:

- Fentanyl Awareness & Trends
- How To Administer Narcan
- Marijuana and Vaping
- Alcohol Awareness and the Body
- OSAR 101
- Kratom Awareness
- Marijuana Awareness
- Addiction and The Elderly
- Methamphetamine Awareness
- Co-Occurring Disorders
- Tobacco Awareness

If interested in a training for a group or agency, please contact Janet Buchanan at jbuchanan@ntbha.org or call 469-290-2101



Quality Management Reminders to all Providers

MH Providers: It is a requirement to complete financial assessments in PIGEON for all individuals in MH services, regardless of having Medicaid or other funding source.

Recovery Plans should be created & in effect before providing routine care services.

When you receive emails from QM, please acknowledge receipt of them.

SUD Providers: please make follow up calls for missed groups/sessions/appts.

. In-person signatures are required on financial eligibility, consents, recovery plans and reviews, discharge plans.

. We want to emphasize the importance of your documentation being timely and detailed for all provided services this includes all clinical documentation, progress notes, recovery planning, safety planning, appropriate discharge planning, documentation for outreach/missed appointments calls/call attempts

. Ensure accurate coding by properly justifying billed services to mitigate liability and prevent potential repayment of funds

. Review Treatment Plans prior to requesting authorization for continuation of services.

. A correlating progress note must be documented when completing an ANSA/CANS assessment, whether conducted face-to-face or via telehealth. If a deviation is being requested, this progress note must include in detail the discussion you have with the individual and/or LAR, that explains the reason for deviation, and the information provided for them to be informed and aware of the services they are declining if deviating by choice to a lower level of care.

. When OSAR sends you a referral for SUD and/or MH services, please respond to their emails acknowledging that it has been received so they know you are contacting the individuals.

. MH Providers: When you receive email communication from NTBHA concerning correcting authorizations (ANSA/CANS) and related clinical information requests, please respond to the identified NTBHA staff within 3 business days when issues have been corrected. We are identifying staff with ongoing concerns and moving forward we may request corrective actions if we do not see improvements. We highly recommend that you meet one on one with these staff to address the ongoing documentation concerns/errors.

. MH Providers: When you receive email communication from NTBHA concerning the RX/SNA/Medicaid/Error Report, please respond to the identified NTBHA staff within 10 calendar days of the email with all corrections.

. When you receive emails from QM, please acknowledge receipt of them.

. When records are requested from QM, please ensure they are complete records. This will prevent back and forth communication regarding records and/or follow-up questions if information is missing and we are trying to get the full picture.

. Please type all incident reports so we can easily read them. If you do not have the fillable version from us, let us know so we can send it to you.

. A reminder that death report forms, death incident reports & preliminary death reviews should be submitted to NTBHA QM within 24 business hours of your agency being informed of the death. Administrative and Clinical death reviews should be submitted to NTBHA QM as soon as completed.

. Please make sure that all submitted documents are legible, signed and dated as required.



· MH Providers: if you provide ACT services but are at capacity, please ensure you are referring individuals who score into ACT, to another provider who can serve them at this LOC.

· MH Providers: please ensure that individuals who are returning after a MH or SUD hospitalization are being reassessed to determine if a higher level of care is needed. You do not have to wait to do this. If you are getting a new individual after they have been hospitalized, please ensure that their ANSA is being scored correctly to determine if a higher level of care is needed based on the recent crisis.

· NTBHA QM conducts mystery calls on a rotating basis each quarter with an emphasis on access to care.

1. Voicemail messages for individuals seeking services should be called back within 2 business days.

2. Each caller should be assessed for SI/HI or other crisis and then connected immediately to services if they indicate needing urgent/emergent care. You may utilize the NTBHA 24/7 Crisis line and the NTBHA Care Coordinators, if needed.

3. Inform callers of the NTBHA program and ensure it is presented accurately & inform them of what documents they need to bring with them to first appt. A friendly reminder not to refer to NTBHA as insurance.

· Please keep up with all your staff's required training and continue consistent supervision of your staff and reviewing if they have completed trainings and the quality of their documentation. We understand everyone is busy, but we want to emphasize consistent supervision always helps staff feel educated and supported and helps continuous quality improvement.

· We thank all our providers for turning in all your monthly reports, incidents, and death reviews timely to us. As you all know we have deadlines at our end, and we appreciate your diligence.

**We thank you all for all your hard work. If you all have any questions, please feel free to email
QM@NTBHA.ORG**

ANSA/CANS/SARS Expectations

- ANSA/CANS be uploaded to CMBHS within 14 calendar days of date of service.
- Observation emails responses within 3 business days
- SAR must be submitted within 3 business days of the begin service date. Request submitted outside of the 3 business days of completion must be accompanied with written justification for delay of submission and will be considered by the NTBHA QM/UM Department and authorized accordingly

If you have any questions, feel free to contact:

Robert Johnson, Director of Outpatient, Utilization and Evaluation
Rjohnson@ntbha.org

SUD Service Authorization Request (SAR)

Service Authorization Requests (SAR) are submitted by the provider once the individual's Financial, Residential, and Diagnosis Eligibility has been verified to determine the service package to be provided.

Service Packages	Typical Amount Requested	MAX Amount in CMBHS
Residential Detoxification	5 units	NA
Ambulatory Detox	5 units	NA
Adult Intensive Residential	28 units	180 units
Adult Outpatient	100 units	180 units
OST/OTS	365 units	NA
OBOT	365 units	NA
Youth Intensive Residential	60 units	180 units
Youth Outpatient	100 units	180 units
Adult W&C, Intensive Residential	45 units	180 units
Adult SF Intensive Residential	45 units	180 units
Adult SF Outpatient	100 units	NA
COPSD	90 units	NA

Units = Days

Service packages can be authorized up to the allowable Service Package Amount or the SAR as long as an appropriate narrative is provided for the Authorizer to approve.

Clinicians should take the information gathered through screening and assessment to document the individual's need for service that address the DSM criteria. The narrative should include:

1. Basis for the DSM SUD Diagnosis: Description of how the client meets diagnosis criteria
2. Impairments related to the SUD: Description of life areas most severely affected by the substance use
3. Corresponding level of care: what is indicated based on diagnosis and severity of impairments that will meet the individual's needs

**SYMPTOMS OF SUD
+ BEHAVIOR
+ IMPAIRMENT**

SAR

Recommended Format for SAR Submission:

"(Name) meets criteria for (DSM-5 SUD diagnosis) as evidenced by _____. Severity is (mild, moderate, severe) and meets (number of DSM-5 criteria for SUD diagnosis) of the criteria. Currently, (Name), endorses the following symptoms (criteria). (Name) has had a pattern of problematic use over/within the last (duration of use) as evidenced by _____.

(Name) meets medical necessity based on the above diagnosis and significant impairment in dimensions (numbers with most severe risk ratings) of the ASAM Criteria as evidenced by _____. Due to (Name)'s (symptoms of SUD), (behaviors) resulting in (impairment). (Name) is most appropriate for (level of care) and will need (services that will address (Name)'s problems)."



Helpful Hints for CMBHS Deviations

- 1) Please provide clinical information such as symptoms and manifested behaviors for deviation request
- 2) Symptoms are observable/reportable-such as crying, rapid speech, auditory/visual hallucinations
- 3) Examples of possible manifested behaviors-loss of job, divorce, eviction, abuse
- 4) Clarification-Statements like-Symptoms include depression and anxiety-are not accurate. Depression and anxiety are classifications not symptoms.
- 5) A second Deviation request to a higher LOC will require information concerning hours of service if the previous service hours did not meet TRR guidelines.

For a request for a lower LOC:

(Name) calculated to LOC-____ and have requested a lower LOC. (Name) has been informed of the service array in the calculated LOC and the service array in the lower LOC and has chosen the lower LOC. By signing the Recovery Plan they understand the service array that they will receive.

For a deviation into a higher LOC:

(Name) has calculated to LOC-____. Due to current symptoms-____,____,____, and manifested behaviors-____,____,____ a higher level of care to LOC-____ is clinically indicated.

If you have any questions, feel free to contact:

Robert Johnson, Director of Outpatient, Utilization and Evaluation
Rjohnson@ntbha.org

Documents / Deliverables to Submit to NTBHA

***If any documents are needed please contact Alvin Mott at amott@ntbha.org

**** When submitting documents to NTBHA All Emails should have the following in the Subject Line:

[(Provider Name); FY & Month; and name of Report]

Example: NTBHA FY21 March CMBHS Security and Attestation Form

Documents To Submit to NTBHA:

- **Confidential Incident Report and Death Reviews (CMHP & SUD)**
 - This report is to be turned as needed when an incident happens to QM@ntbha.org
 - Death reports and reviews must be submitted within 24 hours of being informed of death
- **Monthly QM Incident Report (CMHP & SUD)**
 - This report needs to be turned in monthly by the 5th business day of the following month reporting.
 - Submit form to QM@ntbha.org
- **HHSC Substance Intervention and Treatment Programs (SITP) Call & Other Agency Attendance Report (SUD)**
 - This report is to be submitted to QM@ntbha.org by the 5th business day following the month reporting.
- **RSS Providers:**
 - RSS Performance Measure Report
 - Due by the 10th day of the following month reporting.
 - Submit to amott@ntbha.org
 - RSS Invoice Report
 - Due by the 5th day of the following month reporting.
 - Document should be sent monthly to the following: (Accounts Payable) ap@ntbha.org; (Provider Relations) provider.relations@ntbha.org
- **YES Wavier Inquiry List (YES Waiver)**
- **NTBHA Inquiry Data (CMHP)**
- **Form LL – Consumer Complaint Reporting (CMHP)**
- **Encounter Data (CMHP)**

Administrative Task Per SOW for SUD Providers:

- **Provider Daily Capacity Report**
 - **Providers are to enter daily capacity via CMBHS.**
 - Providers will report daily available capacity, Monday through Friday, by 10:00 a.m. Central Standard Time. Saturday and Sunday capacity management reports will be submitted Monday, by 10:00 a.m., Central Standard Time for the following services.
 - a. residential detoxification;
 - b. intensive residential
 - Providers will report the previous day's attendance in the daily capacity management report the next day, Monday through Friday, by 10:00 a.m. Central Time. i.e., Monday's daily attendance will be reported on Tuesday and Friday's attendance will be reported on the following Monday for the following services:
 - a. ambulatory detoxification; or
 - b. outpatient treatment.



NTBHA SUD Providers: HHSC and/or NTBHA Held Meetings

****If a password is given for a call; Providers need to email the Password to the appropriate NTBHA department and/or HHSC staff as requested.**

NTBHA Meetings and/or Calls:

- NTBHA Monthly Provider Network / Provider Advisory Council Meeting
 - Last Friday of every month. 10 am – 11:30 am
 - Meeting (normally in person; currently call-in or video conferencing format)
 - Contact Alvin Mott, Director, Provider Relations at amott@ntbha.org for any questions
- NTBHA OSAR Quarterly Call
 - 3rd Friday of the following Months at 1pm: November; February; May; August
 - Contact Person: Janet Cowan, NTBHA OSAR Director; jcowan@ntbha.org or osar@ntbha.org
- NTBHA Physician Leadership Advisory Group (PLAG)
 - 1st Wednesday of every Month at 8:30 am
 - Contact: Matt Roberts, Chief Operations Officer at mroberts@ntbha.org

HHSC SUD Meetings and/or Calls: (For all HHSC Calls NTBHA Providers follow HHSC guidance and if a password is provided, email the password to QM@ntbha.org at the conclusion of the call or within 12hrs). If no password is given, NTBHA providers still need to email QM@ntbha.org with a one liner stating that someone from your organization was on the call.

CMBHS

- CMBHS: cmbhstrainingteam@hhs.texas.gov
 - Monthly call alternating topic of SUD and MH; 2nd Tuesday at 10 am
 - Contact cmbhstraining team to receive link to register

Training Opportunities

Training Site	Link	Notes
HHSC – Texas Health Steps	Texas Health Steps (txhealthsteps.com)	Various topics and levels of MI trainings. Links to other state approved sites with free trainings. Medicaid Eligibility training.
Cardea Training Center	Cardea Training Center (matrixlms.com)	Various topics to include a specific focus on MI methods with adolescents
Addiction Technology Transfer Center (ATTC)	Training and Events Calendar Addiction Technology Transfer Center (ATTC) Network (attcnetwork.org)	Various topics specific to addiction and recovery
Centralized Training	Centralized Training: Log in to the site	Various topics: ANSA/CANS; Abuse, Neglect, etc.
HHSC	Texas DSHS HIV/STD Program - Training - Motivational Interviewing	Specific to MI, HIV, STD's
International Society of Substance Use Professionals	Motivational Interviewing Course Recordings International Society of Substance Use Professionals (issup.net)	Specific to addiction and recovery
HHSC – Behavioral Health Awareness	Behavioral Health Awareness (uthscsa.edu)	Each module in this series addresses a different mental or behavioral health topic and provides information about symptoms, treatment, recovery, and more
The Association for Addiction Professionals	Home (naadac.org)	Various Topics for Substance abuse and recovery
HHS	Texas DSHS HIV/STD Program	
UT Health San Antonio Project ECHO	https://wp.uthscsa.edu/echo/echo-programs/	ECHO® is a model for learning and guided practice that uses education to exponentially increase workforce capacity to improve access to best-practice care and reduce health disparities in communities, including rural, remote, and underserved settings.
HHSC YES Wavier Training	https://yeswaivertraining.uthscsa.edu/	The Youth Empowerment Services Waiver is a 1915(c) Medicaid program that helps children and youth with serious mental, emotional and behavioral difficulties.



Physician Leadership Advisory Group (PLAG)
Meeting Notes
October 1, 2025

Attendees: Drs. Bennett, Mehta, Young, Starling, Medlock, Grable. NTHBA Staff: Amy Cunningham, Matt Roberts, Samatha Cosby, Jessica Martinez, Caitlyn Traylor. Lakes Staff: Toni Hughes. IPM Staff: Melissa Hawkins, Jaspreet Singh.

1. Dr. Bennett called the meeting to order at 8:16.
2. Routine Updates
 - a. State Hospital Update:
 - Jessica Martinez reported that NTBHA and TSH have agreed to the content of an MOU covering the new diversion project, including assigning space. Signature of the document is expected soon.
 - b. Pharmacy Highlights (IPM representative)
 - Melissa Hawkins described recent medication trends including trends in long acting injectables. Of note is the lack of PAP information in the reporting. This is due to changes in the labeling of medications and consequentially the medication is not visible in the MedData system.
3. New Business
 - a. None
4. Old Business
 - a. Ms. Martinez provided information on discharge coordination and the email addresses that in-network clinics can use to obtain hospital discharge records from NTHBA.
 - b. A discussion ensued regarding Private Psychiatric Bed funding and catchment areas.
 - c. Mr. Roberts reported that NTBHA is still looking for an EKG provider.
5. The meeting adjourned at 8:44

Next Meeting: November 5, 2025



Health and Human Services Commission

Maternal Depression Strategic Plan for Fiscal Years 2026-2030

Link to Report: [HHSC Maternal Depression Strategic Plan FY 2026-2030](#)

The 2024 Texas Maternal Mortality and Review Committee and the Texas Department of State Health Services (DSHS) found that:

- 80% of pregnancy-related deaths were preventable.
- The six leading underlying causes of reviewed pregnancy-related deaths were infections, cardiovascular conditions, obstetric hemorrhage, non-cerebral thrombotic embolism, cerebrovascular accidents and mental health conditions.
- Mental health conditions accounted for 7% of the reviewed pregnancy-related conditions.

Strategic Plan

Strategy 1: Increase women's access to formal and informal peer support services, including access to certified peer specialists who have received additional training related to postpartum depression.

Objective: By 2030, provide specialized training opportunities in maternal mental health and substance use disorders; promote training opportunities to peer specialists; track participation in specialized training; and measure the impact on peer services delivered to pregnant and postpartum women.

Strategy 2: Increase awareness among state-administered program providers.

Objective: By 2030, develop, promote, and deliver trainings and awareness events to HHS program providers and measure the impact on provider identification of postpartum depression and other maternal mental health and substance use disorders.

Strategy 3: Leverage sources of funding to support existing communitybased postpartum depression screening, referral, treatment, and support services.

Objective: By 2030, collaborate with the Texas Child Mental Health Consortium, the Perinatal Psychiatry Access Network, Be Well Texas, and The University of Texas Center for Health Care Data, as well as other state agencies to maximize resources that result in increases to maternal mental health and substance use disorder services delivered to women.

Strategy 4: Identify, prevent, and reduce substance use among pregnant and postpartum women.

Objective: By 2030, increase HHSC provider utilization of Screening, Brief Intervention, and Referral to Treatment (SBIRT) for pregnant and postpartum women.

This document is intended for informational purposes only and is not intended to indicate a position for or against any legislation. If you have questions, please contact at jmetzinger@ntbha.org

Strategy 5: Raise public awareness of and reduce the stigma related to postpartum depression.

Objective: By 2030, develop and deliver public awareness initiatives related to postpartum depression and related maternal mental health and substance use disorders and measure public engagement.

Objective: By 2030, develop and deliver initiatives that improve public perceptions that act as barriers to treatment access and recovery and measure impact on treatment initiation for postpartum depression and related maternal mental health and substance use disorders.

Strategy 6: Establish a referral network of community-based mental health providers and support services addressing postpartum depression.

Objective: By 2030, expand the referral network of community-based providers addressing postpartum depression and related maternal mental health and substance use disorders.



2025-2026 Sunset Commission Review

Health and Human Services Commission

HHSC Self-Report—Behavioral Health

September 2025

On a regular, rotating basis the Texas Legislature, through the Texas Sunset Commission, reviews the need for, performance of, and possible improvements in all state agencies. The Sunset Commission is comprised of five members of the Texas House of Representatives, five members of the Texas Senate, and two individuals from the public. This biennium, sixteen agencies are under review, including the Texas Health and Human Services Commission, which oversees a wide variety of health-related programs, including behavioral health.

The process begins with a self-report document submitted by each agency. The Sunset Commission staff reviews this report and conducts its own research to explore ways the agency could become more effective and efficient. When the staff report and recommendations is presented, the agency prepares its response to the staff report. Public hearings on the report and recommendations are conducted, and both public and written testimony are accepted by the Sunset Commission. The Sunset Commission then meets to consider the staff recommendations, agency response and public comments before voting on final recommendations to submit to the Texas Legislature.

In the next regular session, a Sunset bill to enact the recommended changes will be considered by the Legislature through normal legislative processes. If passed, the bill is sent to the Governor for approval or veto.

Link to Report: [Texas HHSC Self-Report to Sunset Commission](#)

Portion related to Behavioral Health Services is from page 473 to 562.

Portion related to State Hospitals is from page 552 to 580.

This document is intended for informational purposes only and is not intended to indicate a position for or against any legislation. If you have questions, please contact at jmetzinger@ntbha.org

Mental Health Programs Children's Mental Health

Selected Statewide Data

Average monthly number of children receiving community mental health services	26,835
Percent of children receiving community mental health services whose functional level improved	50%
Behavioral Health Partnership Program with ISDs-Mental Health First Aid and Youth Mental Health First Aid trainings	7,717
Number of children served with Multi-Systemic Therapy (MST) Statewide, 16 LBHAs/LMHA22 MST teams	379
• Percentage of children living at home	84.9%
• Percentage of children in school or working	87.1%
• Percent of children with no new arrests	89.7%

Barriers and Challenges

“1. Most Texas counties are designated as provider shortage areas for mental health. Due to variance across local entities and symptoms, not all services are available in every county.

2. Texans in need of mental health services are increasingly presenting with multiple, complex diagnoses, including aggressive behavior disorders. These individuals—both adults and children—often require highly specialized, coordinated care that traditional mental health programs are not equipped to provide. The severity and complexity of their behavioral challenges make it difficult to find appropriate treatment settings that can safely and effectively address their needs, leaving many families and providers struggling to secure the right services.

3. HHSC receives requests from other agencies including DFPS, Texas Juvenile Justice Department (TJJD), and Texas Education Agency (TEA) for System Navigators and other intensive youth programs that are not available statewide.”

Adult, Crisis and Forensic Mental Health Services

Selected Statewide Data

Average Monthly number of adults receiving community mental health services	96,748
Yearly number of people receiving crisis outpatient services funded by general revenue	83,846
Total crisis hotline service calls	110,227
Number served	58,603
Percent of crisis hotline calls resulting in a face-to-face encounter	61.3%

Number of people receiving mobile crisis intervention services in the community	48,015
Average daily number of occupied meant health community hospital beds	794
Number served by Private Psychiatric Beds (PPB)	16,388
• Average Length of Stay (in days)	9.28

Barriers and Challenges

“1. Most Texas counties are designated as provider shortage areas for mental health. Due to variance across local entities and symptoms, not all services are available in every county.

2. Texans in need of mental health services are increasingly presenting with multiple, complex diagnoses, including aggressive behavior disorders. These individuals—both adults and children—often require highly specialized, coordinated care that traditional mental health programs are not equipped to provide. The severity and complexity of their behavioral challenges make it difficult to find appropriate treatment settings that can safely and effectively address their needs, leaving many families and providers struggling to secure the right services.

3. Providers report that navigating available resources for supported employment services is challenging due to variance across local communities and systems impacting some programs’ performance due to communication gaps across entities and general employment opportunities, which varies by community.

4. The lack of affordable housing and housing resources limit PATH providers’ ability to link homeless individuals to appropriate housing solutions. Similarly, SHSPD programs are designed to be provided in a home-like setting with community living and outdoor activity areas. Rented property may not allow LMHAs and LBHAs to make the necessary renovations to accommodate participants’ Americans with Disabilities Act (ADA) needs.

5. HHSC state-funded grants to establish jail diversion centers (JDCs) are legislatively required to include matching dollars which can be a challenge for potential applicants. Additionally, JDCs experience challenges collecting effective and efficient data across stakeholders to strengthen funding applications.

6. Several programs including jail diversion centers require a lengthy implementation timeline due to acquiring a facility, hiring staff, establishing policies and procedures. This ramp-up time affects the ability to spend funds within the biennium to serve clients, reach peak contractor performance and achieve required deliverables.”

Mental Health First Aid

Selected Statewide Data

Number of people trained in the MHFA curriculum	40,325
Number of service members, veterans, and their family members trained in an MHFA curriculum and the veterans’ module of MHFA.	8,613

Home and Community-Based Services-Adult Mental Health

Selected Statewide Data

Average monthly number of clients served by HCBS-AMH Program (FY 2024)	390

Barriers and Challenges

“Complex reporting and documentation requirements for compliance with federal regulations create challenges for provider recruitment and retention.”

Youth Empowerment Services (YES) Waiver

Selected Statewide Data

Average monthly number of clients served by YES Waiver (FY 2024)	673
Number receiving services	2,389

Barriers and Challenges

“Complex reporting and documentation requirements for compliance with federal regulations create challenges for provider recruitment and retention. Some resistance from families due to stigma or lack of understanding of mental health services and program requirements contributes to low engagement as well.”

Disaster Behavioral Health Coordination

LBHA/LMHAs are prepared to deliver disaster-related services in cases of state- or federally declared emergencies, natural disasters, incidents of mass violence.

Substance Use Programs

Selected Statewide Data

Number of people served by Community Health Workers	55,055
Number of people served by OSAR	31,399
Number of overdose reversal kits distributed to eligible people	9,020
Number of persons served with adult substance use treatment	36,543
Number of served in Specialized Female Substance Use Treatment	4,992
Co-Occurring Psychiatric and Substance Use Disorder Services	3,863

Barriers and Challenges

“Intervention programs generally face operational barriers related to limited access to safe housing, transportation, and local services available in specific regions. These challenges are particularly acute for people with criminal records,

Stigma related to substance use, particularly regarding the use of medication for opioid use disorder, remains a significant barrier, most notably within Criminal Justice settings.”

State Hospitals

- Replacement of Terrell State Hospital is expected by July 2027—250 beds.
- Replacement of North Texas State Hospital in Wichita Falls is expected in 2027—250 beds.
- Construction of the new state hospital in Dallas will have 200 adult beds, with at least 75 percent designated for forensic patients. Children’s Health gave HHSC funding for an additional 92 beds designated for pediatric patients.

Office of Forensic Services and Coordination

NTBHA receives Mental Health Block Grant funds for Jail-Based Competency Restoration services.

Barriers and Challenges:

“The Texas Code of Criminal Procedures and the Texas Health and Safety Code, as well as administrative rules under the Texas Administrative Code, are the primary Section VII – CPSO:HSCS – Page 579 statutes governing competency restoration programs. Statutes and rules can become outdated and conflict with the growing use of community-based competency restoration programs and current needs such as individualized treatment, and consideration of how to serve the growing forensic IDD population. Further, statutes and rules may not allow for standardization of service provisions and guidelines across community and inpatient settings.”



Fiscal Year
2025

Service Month
All

Provider
All

Measure
All

6 Month View
True

Performance Measures FY25 - All

Measure	Description	2025 FY Second Half						YTD
		202503	202504	202505	202506	202507	202508	2025
Adult Improvement	At least 20% of all adults authorized in a FLOC shall show improvement in at least one domain							49.5%
Adult Service Target	100% of 23,677	103.3%	105.7%	108.3%	111.2%	114.8%	116.5%	
	Count	24481	25033	25664	26334	27182	27587	
Child Improvement	At least 25.0% of all children authorized in a FLOC shall show improvement in at least one domain							49.3%
Child Service Target	100% of 8,173	94.3%	98.1%	98.8%	96.3%	92.9%	93.1%	
	Count	7714	8022	8075	7876	7594	7612	
Community Tenure	At least 96.8% of adults and children authorized in a FLOC shall avoid hospitalization in an HHSC Inpatient Bed	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	
Crisis 7 Day Follow-up	At least 22% of crisis episodes for adults and children in LOC-A 0 with a follow-up service contact 1-7 days after the date of the last crisis service in the crisis episode	38.0%	46.3%	46.5%	34.4%	41%	35.6%	
Effective Crisis Response	At least 75.1% of crisis episodes during the measurement period shall not be followed by admission to an HHSC Inpatient Bed within 30 days	95.2%	97.9%	95.8%	98.4%	98.2%	98.4%	
Hospital 7 Day Follow-up	At least 62.3% of individuals discharged from a state hospital, an HHSC Contracted Bed, a CMHH, or a PPB shall receive follow-up within 7 days of discharge	65.9%	63.0%	69.8%	62.1%	56.3%	51.1%	

RESOLUTION

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

RESOLUTION NO: 476-2025 Ratify HHSC Contract for Local Mental Health Authority Performance Agreement Grant Program (LMHA) FY 2026—FY 2027 (HHSC Contract No. HHS001598600026)

DATE: October 8, 2025

STATE OF TEXAS }

COUNTY OF DALLAS }

BE IT REMEMBERED at a regular meeting of the North Texas Behavioral Health Authority held on the 8th day of October 2025, the following Resolution was adopted:

WHEREAS, the Health and Human Service Commission has designated the North Texas Behavioral Health Authority (NTBHA) as the Local Behavioral Health Authority (LBHA) for a service area consisting of the following six counties: Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall, effective January 1, 2017; and

WHEREAS, the NTBHA Board of Directors was created to govern the affairs of NTBHA; and

WHEREAS, NTBHA seeks to create a well-managed, integrated, and high-quality delivery system of behavioral health services available to eligible consumers residing in our catchment area; and

WHEREAS, NTBHA is responsible for the management of the network of behavioral health providers; and

WHEREAS, NTBHA seeks to (1) Maintain a competent and committed workforce, (2) Facilitate access to behavioral health services, (3) Manage core operations efficiently and effectively, and (4) Identify and develop additional opportunities for service area development.

IT IS THEREFORE RESOLVED that the North Texas Behavioral Health Authority Board of Directors ratifies the signature of the CEO on the HHSC Contract for Local Mental Health Authority Performance Agreement Grant Program (LMHA) for FY 2026—FY 2027 (HHSC Contract No. HHS001598600026).

DONE IN OPEN MEETING, this the 8th day of October 2025.

Recommended by:

Carol E. Lucky
Chief Executive Officer
North Texas Behavioral Health Authority

Commissioner Dr. Elba Garcia
Chair, Board of Directors
North Texas Behavioral Health Authority



BOARD OF DIRECTORS MEETING

Summary

DATE: October 8, 2025

AGENDA ITEM #11: Resolution 476-2025 Ratify HHSC Contract for Local Mental Health Authority Performance Agreement Grant Program (LMHA) for FY2026–FY2027. (HHSC Contract No. HHS001598600026)

Recommendation/Motion: Ratify the signature of the CEO on the HHSC Contract for Local Mental Health Authority Performance Agreement Grant Program (LMHA) for FY2026 – FY2027 (HHSC Contract No. HHS001598600026)

Background:

TxHHSC has issued a “new” Local Mental Health Authority Performance Agreement, including all updated, current contract attachments, to replace previous LMHA Agreement documents. This new LMHA Contract shall not exceed a total value amount of \$160,908,324 for FY2026-FY2027. Matching funds in the amount of \$11,922,396 will be required.

The purpose of this Grant Agreement is to provide publicly-funded mental health services in the following Texas counties: Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall.

Financial Information:

This new Grant Contract reflects an increase of **\$22,015,196**, over the previous award amount.

The total Grant Value, covering FY26 through FY27 shall not exceed: **\$160,908,324.00**.
Contractual requirement to provide Matching Funds to this program: **\$11,922,396.00**.

Each Program allocation amount across the contract term is detailed below:

PROGRAM ID	HHSC AGENCY SHARE	NTBHA MATCH	ALLOCATION
MH/PCN	\$108,385,426	\$11,922,396	\$120,307,822
MH/COS	\$260,000	\$0.00	\$260,000
MH/OCR	\$959,428	\$0.00	\$959,428
MH/PPB	\$37,481,600	\$0.00	\$37,481,600
MH/SHR	\$1,458,718	\$0.00	\$1,458,718
MH/VET	\$99,270	\$0.00	\$99,270
MH/ESC	\$230,000	\$0.00	\$230,000
MH/PDMCC	\$111,486	\$0.00	\$111,486
LMHA CONTRACT TOTAL VALUE:			\$160,908,324.00



Implementation Schedule: Upon Ratification by the NTBHA board.

Attachments: 11. *LMHA_HHS001598600026_NTBHA FY26-FY27*

Aligns with Visions #1, 2, 3, and 4

NTBHA Strategic Visions
Vision #1 NTBHA will maintain a competent and committed workforce.
Vision #2 NTBHA will facilitate access to behavioral health services.
Vision #3 NTBHA will manage core operations efficiently and effectively.
Vision #4 NTBHA will identify and develop additional opportunities for service area development.

Presented By: Carol E. Lucky, Chief Executive Officer

**SIGNATURE DOCUMENT FOR
HEALTH AND HUMAN SERVICES COMMISSION GRANT AGREEMENT
CONTRACT NO. HHS001598600026**

**UNDER THE
LOCAL MENTAL HEALTH AUTHORITY PERFORMANCE AGREEMENT GRANT PROGRAM**

The parties to this agreement (“Grant Agreement” or “Contract”) are the Health and Human Services Commission (“HHSC” or “System Agency”), a pass-through entity, and North Texas Behavioral Health Authority (“Grantee” or “Contractor”), having its principal office at 8111 LBJ Fwy, Suite 900, Dallas, TX 75251 (each a “Party” and collectively the “Parties”).

I. PURPOSE

The purpose of this Grant Agreement is to provide publicly-funded mental health services in the following Texas counties: Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall.

II. LEGAL AUTHORITY

This Grant Agreement is entered into pursuant to the provisions of Chapter 791 (the “Interlocal Cooperation Act”) of the Texas Government Code and Chapters 533 and 534 of the Texas Health and Safety Code.

III. DURATION

This Grant Agreement is effective upon signature, covers the period of performance starting September 1, 2025, and expires on August 31, 2027, unless sooner terminated pursuant to the terms and conditions of the Grant Agreement. This Grant Agreement does not include renewals.

IV. STATEMENT OF WORK

The Scope of Grant Project to which Grantee is bound is incorporated into and made a part of this Grant Agreement for all purposes and included in attachments to **ATTACHMENT A, STATEMENTS OF WORK**.

V. BUDGET AND INDIRECT COST RATE

A. Budget

1. The total amount of this Grant Agreement will not exceed \$160,908,324.00. This includes HHSC’s share of \$148,985,928.00 and Grantee’s required match amount of \$11,922,396.00.
2. The total not-to-exceed amount includes the following:
 - a. Total Federal Funds: \$22,492,654.00
 - b. Total State Funds: \$126,493,274.00
3. Grantee agrees to provide those services stated in the **STATEMENTS OF WORK** listed in the table below, in accordance with all contractual requirements.

System Agency Grant Agreement, Contract No. HHS001598600026

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Statement of Work Number	Program ID	HHSC Share (\$)	Grantee Share (\$)	Total Statement of Work Value (\$)
A01	MH/PCN	\$108,385,426.00	\$11,922,396.00	\$120,307,822.00
A02	MH/CMHH	\$0.00	\$0.00	\$0.00
A03	MH/COS	\$260,000.00	\$0.00	\$260,000.00
A04	MH/MHD	\$0.00	\$0.00	\$0.00
A05	MH/OCR	\$959,428.00	\$0.00	\$959,428.00
A06	MH/CRISIS	\$0.00	\$0.00	\$0.00
A07	MH/PPB	\$37,481,600.00	\$0.00	\$37,481,600.00
A08	MH/RTCI	\$0.00	\$0.00	\$0.00
A09	MH/RTPCM	\$0.00	\$0.00	\$0.00
A10	MH/SHR	\$1,458,718.00	\$0.00	\$1,458,718.00
A11	MH/VET	\$99,270.00	\$0.00	\$99,270.00
A12	MH/IRS	\$0.00	\$0.00	\$0.00
A13	MH/CF	\$0.00	\$0.00	\$0.00
A14	MH/PASRR	\$0.00	\$0.00	\$0.00
A15	MH/RPA	\$0.00	\$0.00	\$0.00
A16	MH/RBI	\$0.00	\$0.00	\$0.00
A17	MH/PSR	\$0.00	\$0.00	\$0.00
A18	MH/CR	\$0.00	\$0.00	\$0.00
A19	MH/DC	\$0.00	\$0.00	\$0.00
A20	MH/HFSEP	\$0.00	\$0.00	\$0.00
A21	MH/JDSES	\$0.00	\$0.00	\$0.00
A22	MH/VCP	\$0.00	\$0.00	\$0.00
A23	MH/NJBCR	\$0.00	\$0.00	\$0.00
A24	MH/ESC	\$230,000.00	\$0.00	\$230,000.00
A25	MH/PDMCC	\$111,486.00	\$0.00	\$111,486.00
TOTAL		\$148,985,928.00	\$11,922,396.00	\$160,908,324.00

NOTE: An HHSC Share value of \$0.00 in the table above signifies either that: (1) no funding is associated with that particular Statement of Work; or (2) that Statement of Work is not currently applicable to this Grant Agreement.

B. Indirect Cost Rate

1. Grantee's acknowledged or approved indirect cost rate (ICR) is contained within **REPORT III-IV**, which is incorporated by reference and made part of this Grant Agreement for all purposes and posted at:
<https://www.hhs.texas.gov/providers/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
2. Grantee's ICR Letter, De Minimis, is included as **ATTACHMENT I** and incorporated in and made part of this Grant Agreement for all purposes.

3. If HHSC approves or acknowledges an updated indirect cost rate, the Grant Agreement will be amended accordingly.

VI. REPORTING REQUIREMENTS

Grantee shall submit reports according to **Information Item S (LMHA/LBHA Submission Calendar)**, which is incorporated by reference and made part of this Grant Agreement for all purposes and posted at:

<https://www.hhs.texas.gov/providers/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.

VII. CONTRACT REPRESENTATIVES

The following persons will act as the representative authorized to administer activities under this Grant Agreement on behalf of their respective Party.

HHSC

Health and Human Services Commission
4601 W. Guadalupe St., Mail Code 2058
Austin, Texas 78751
Judith Tyler
judith.tyler@hhs.texas.gov
Agency No.: 35295295295

Grantee

North Texas Behavioral Health Authority
8111 LBJ Fwy, Suite 900
Dallas, Texas 75251
Carol Lucky
clucky@ntbha.org
Agency No.: 17528112695

VIII. NOTICE REQUIREMENTS

- A. All notices given by Grantee shall be in writing, include the Grant Agreement contract number, comply with all terms and conditions of the Grant Agreement, and be delivered to the above-referenced HHSC Contract Representative.
- B. Grantee shall send legal notices to HHSC at the address below and provide a copy to the above-referenced HHSC Contract Representative:

Health and Human Services Commission
Attention: Office of Chief Counsel
4601 W. Guadalupe, Mail Code 1100
Austin, Texas 78751
- C. Notices given by HHSC to Grantee may be emailed, mailed or sent by common carrier. Email notices shall be deemed delivered when sent by HHSC. Notices sent by mail shall be deemed delivered when deposited by HHSC in the United States mail, postage paid, certified, return receipt requested. Notices sent by common carrier shall be deemed delivered when deposited by HHSC with a common carrier, overnight, signature required.
- D. Notices given by Grantee to HHSC shall be deemed delivered when received by HHSC.
- E. Either Party may change its Contract Representative or legal notice contact by providing written notice to the other Party.

System Agency Grant Agreement, Contract No. HHS001598600026

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IX. FEDERAL AWARD INFORMATION

Grantee's Unique Entity Identifier is: MSNLLGML43G3

Federal funding under this Grant Agreement is a subaward under the following federal award(s).

A. Federal Award Identification Number: B09SM090328

1. Assistance Listings Title, Number, and Dollar Amount:
Mental Health Block Grant – 93.958 – \$15,069,020.00
2. Federal Award Date: February 3, 2025
3. Federal Award Period: October 1, 2024, through September 30, 2026
4. Name of Federal Awarding Agency: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration
5. Federal Award Project Description: To provide community mental health services
6. Awarding Official Contact Information:
 - a. Wendy Pang
Telephone No.: (240) 276-1419
E-mail: wendy.pang@samhsa.hhs.gov
 - b. Bethany Myers
Telephone No.: (240) 276-1579
E-mail: bethaney.myers@samhsa.hhs.gov
7. Total Amount of Federal Funds Awarded to HHSC: \$35,630,311.00
8. Amount of Funds Awarded to Grantee: \$15,069,020.00
9. Identification of Whether the Award is for Research and Development: No

B. Federal Award Identification Number: 2501TXTANF

1. Assistance Listings Title, Number, and Dollar Amount:
TANF Transfer to Title XX Block Grant – 93.558.667 – \$6,449,352.00
2. Federal Award Date: March 3, 2025
3. Federal Award Period: October 1, 2024, through September 30, 2025
4. Name of Federal Awarding Agency: U.S. Department of Health and Human Services, Administration for Children and Families
5. Federal Award Project Description: To help low-income families with children achieve economic self-sufficiency
6. Awarding Official Contact Information:
 - a. Ms. Diana Bengson
Telephone No.: (214) 767-8075

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E-mail: diana.bengson@acf.hhs.gov
Julie Siegel
Telephone No.: (202) 320-6882
E-mail: julie.siegel@acf.hhs.gov

7. Total Amount of Federal Funds Awarded to HHSC: \$290,951,726.00
8. Amount of Funds Awarded to Grantee: \$6,449,352.00
9. Identification of Whether the Award is for Research and Development: No

C. Federal Award Identification Number: 2401TXSOSR

1. Assistance Listings Title, Number, and Dollar Amount:
Title XX, Social Services Block Grant – 93.667 – \$974,282.00
2. Federal Award Date: June 20, 2024
3. Federal Award Period: October 1, 2023, through September 30, 2025
4. Name of Federal Awarding Agency: U.S. Department of Health and Human Services, Administration for Children and Families
5. Federal Award Project Description: To provide essential social services that help achieve a myriad of goals to reduce dependency and promote self-sufficiency; protect children and adults from neglect, abuse, and exploitation; and help individuals who are unable to take care of themselves to stay in their homes or to find the best institutional arrangements
6. Awarding Official Contact Information
 - a. Angel Chen
Telephone No.: (646) 905-8120
E-mail: angel.chen@acf.hhs.gov
 - b. J. Janelle George
Telephone No.: (202) 401-4830
E-mail: jolleen.george@acf.hhs.gov
7. Total Amount of Federal Funds Awarded to HHSC: \$36,297,723.00
8. Amount of Funds Awarded to Grantee: \$974,282.00
9. Identification of Whether the Award is for Research and Development: No

X. CONTRACTUAL DOCUMENTS

The following documents are incorporated by reference and made a part of this Grant Agreement for all purposes.

Unless expressly stated otherwise in this Grant Agreement, in the event of conflict, ambiguity or inconsistency between or among any documents, all HHSC documents take precedence over Grantee's documents and the Data Use Agreement takes precedence over all other contractual documents.

ATTACHMENT A01	PERFORMANCE CONTRACT NOTEBOOK (MH/PCN), VERSION 1
ATTACHMENT A02	COMMUNITY MENTAL HEALTH HOSPITAL (MH/CMHH), PLACEHOLDER DOCUMENT
ATTACHMENT A03	CONSUMER OPERATED SERVICES (MH/COS), VERSION 1
ATTACHMENT A04	MENTAL HEALTH DEPUTY (MH/MHD), PLACEHOLDER DOCUMENT
ATTACHMENT A05	OUTPATIENT COMPETENCY RESTORATION (MH/OCR), VERSION 1
ATTACHMENT A06	COMMUNITY-BASED CRISIS PROGRAMS (MH/CRISIS), PLACEHOLDER DOCUMENT
ATTACHMENT A07	PRIVATE PSYCHIATRIC BEDS (MH/PPB), VERSION 1
ATTACHMENT A08	RESIDENTIAL TREATMENT CENTER INTEGRATION (MH/RTCI), VERSION 1
ATTACHMENT A09	RESIDENTIAL/TRANSITION PROGRAM CONTRACT MANAGEMENT (MH/RTPCM), PLACEHOLDER DOCUMENT
ATTACHMENT A10	SUPPORTIVE HOUSING RENTAL ASSISTANCE PROJECT (MH/SHR), VERSION 1
ATTACHMENT A11	VETERANS SERVICE PROGRAM (MH/VET), ENHANCED, VERSION 1
ATTACHMENT A12	INFORMATION RESOURCE SYSTEMS (MH/IRS), VERSION 1
ATTACHMENT A13	CRISIS FACILITIES (MH/CF), PLACEHOLDER DOCUMENT
ATTACHMENT A14	PRE-ADMISSION, SCREENING, AND RESIDENT REVIEW (MH/PASRR), VERSION 1
ATTACHMENT A15	REAL PROPERTY ACQUISITION (MH/RPA), PLACEHOLDER DOCUMENT
ATTACHMENT A16	RURAL BORDER INTERVENTION PROGRAM (MH/RBI), PLACEHOLDER DOCUMENT
ATTACHMENT A17	PEER SUPPORT RE-ENTRY PILOT (MH/PSR), PLACEHOLDER DOCUMENT
ATTACHMENT A18	COMPETENCY RESTORATION (MH/CR), PLACEHOLDER DOCUMENT
ATTACHMENT A19	DIVERSION CENTER, PLACEHOLDER DOCUMENT
ATTACHMENT A20	HIGH-FIDELITY SUPPORTED EMPLOYMENT PILOT PROGRAM (MH/HFSEP), PLACEHOLDER DOCUMENT
ATTACHMENT A21	JOB DEVELOPMENT - SUPPORTED EMPLOYMENT SERVICES (MH/JDSES), PLACEHOLDER DOCUMENT
ATTACHMENT A22	VETERAN COUNSELOR PROGRAM (MH/VCP), PLACEHOLDER DOCUMENT
ATTACHMENT A23	NON-HHSC FUNDED JAIL-BASED COMPETENCY RESTORATION PROGRAM (MH/NJBCR), VERSION 1
ATTACHMENT A24	EDUCATION SERVICE CENTER BASED NON-PHYSICIAN MENTAL HEALTH PROFESSIONAL (MH/ESC), VERSION 1
ATTACHMENT A25	POST-DISCHARGE MEDICATIONS FOR CIVIL COMMITMENTS (MH/PDMCC), VERSION 1

ATTACHMENT B	HEALTH AND HUMAN SERVICES COMMISSION (HHS)
ATTACHMENT C	CONTRACT AFFIRMATIONS (VERSION 2.6), JULY 2025
ATTACHMENT D	HHS UNIFORM TERMS AND CONDITIONS (GRANT, VERSION 3.5), SEPTEMBER 2024
ATTACHMENT E	LOCAL MENTAL HEALTH AUTHORITY (LMHA) SPECIAL
ATTACHMENT F	CONDITIONS (VERSION 1)
ATTACHMENT G	ASSURANCES (NON-CONSTRUCTION PROGRAMS)
ATTACHMENT H	CERTIFICATION REGARDING LOBBYING
ATTACHMENT I	FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY
	ACT (FFATA) CERTIFICATION FORM
	HHS DATA USE AGREEMENT VERSION 8.5, JANUARY 25, 2023,
	COMMUNITY CENTER VERSION (LMHA, LA, LIDDA)
	INDIRECT COST RATE LETTER, DE MINIMIS

XI. MODIFICATIONS TO HHS AFFIRMATIONS AND HHS UNIFORM TERMS AND CONDITIONS

A. ATTACHMENT B, HHS CONTRACT AFFIRMATIONS (VERSION 2.6), JULY 2025, is hereby modified by deleting Section 57 (Federal Occupational Safety and Health Law) in its entirety and replacing it with the following:

57. Federal Occupational Safety and Health Law

To the extent applicable by state and federal law, Contractor represents and warrants that all articles and services shall meet or exceed the safety standards established and promulgated under the Federal Occupational Safety and Health Act of 1970, as amended (29 U.S.C. Chapter 15).

B. ATTACHMENT C, HHS UNIFORM TERMS AND CONDITIONS (GRANT, VERSION 3.5), SEPTEMBER 2024, is hereby modified by revising **ARTICLE X, INDEMNITY**, to add the following sentence at the beginning of the Article:

“This Article X is only applicable to the extent permitted by Texas law and the Texas Constitution.” The remainder of Article X remains unchanged.

XII. SIGNATURE AUTHORITY

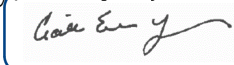
Each Party represents and warrants that the person executing this Grant Agreement on its behalf has full power and authority to enter into this Grant Agreement. Any services or work performed by Grantee before this Grant Agreement is effective or after it ceases to be effective are performed at the sole risk of Grantee.

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE
HEALTH AND HUMAN SERVICES COMMISSION GRANT AGREEMENT
CONTRACT NO. HHS001598600026

HEALTH AND HUMAN SERVICES COMMISSION

NORTH TEXAS BEHAVIORAL HEALTH
AUTHORITY

By: DocuSigned by:

C80071B769504E9...

Signature
Cecile Young

Printed Name
Executive Commissioner

Title
October 1, 2025

Date of Signature

By: DocuSigned by:

8CEA892CF99146F...

Signature
Carol Lucky

Printed Name
CEO

Title
September 30, 2025

Date of Signature

ATTACHMENTS FOLLOW

ATTACHMENT A01 PERFORMANCE CONTRACT NOTEBOOK (MH/PCN), VERSION 1

CONTRACT NO. HHS001598600026

GRANTEE: NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

This Statement of Work outlines Grantee's responsibilities for providing publicly funded mental health services within Grantee's local service area (LSA), which includes the following Texas Counties: Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall.

Upon request, HHSC Designees and/or Grantee Designees will be provided and identified through the Party's designated Contract Manager by written notification.

SECTION I. GRANTEE RESPONSIBILITIES

A. Authority and Administrative Services

1. Local Planning:

Grantee is the designated local mental health authority (LMHA) or local behavioral health authority (LBHA) for the LSA defined above. As the LMHA or LBHA, Grantee is required to:

- a) Comply with Title 26, Texas Administrative Code (TAC) Chapter 301, Subchapter F (Provider Network Development), and applicable HHSC directives, communicated by written notification from the designated Contract Manager, related to Local Network Development, as specified and set forth within this Statement of Work;
- b) Follow the Instructions for Local Planning found in **Information Item I, Local Planning**, posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>¹;
- c) Submit the local planning documents to HHSC according to the Submission Calendar in **Information Item S, LMHA/LBHA Submission Calendar**, posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;
- d) Maintain a current version of the Consolidated Local Services Plan (CLSP) and the Local Planning and Network Development (LPND) Plan on Grantee's website, with revision dates noted as appropriate for each plan revision;
- e) Post annually on Grantee's website a list of persons with whom Grantee had a contract or agreement related to the provision of mental health services. The list shall include the number of peer support and family partner contracts and agreements, but not the names of the providers without their written consent. The list shall include all contracts or agreements in effect during all or part of the previous state fiscal year;

¹ The information accessible at this URL, and all others cited in this Attachment, are hereby incorporated by reference.

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- f) Maintain a toll-free phone number for routine services and for crisis services posted on the Grantee's website and on any other advertising documents used;
- g) Answer the phone during regular business hours. Grantee must maintain a voicemail, answering service, or other system utilized for after-hour inquiries. Grantee must notify the HHSC Contract Manager if Grantee experiences technical issues or a service disruption that exceeds 48 hours and impacts Grantee's responsiveness to routine service requests, which may include disaster events;
- h) Not deny access to services at any level consistent with Texas' non-discrimination policy at Title 26 TAC §301.325(b);
- i) Appoint, charge, and support, through its local board, one or more Planning and Network Advisory Committees (PNAC) necessary to perform the committee's advisory functions, as follows:
 - (1) PNAC shall be composed of at least nine members, 50 percent of whom shall be clients or family members of clients, including family members of children served or another composition approved by HHSC; and include at least one person with lived experience with homelessness or housing instability;
 - (2) PNAC members shall be objective and avoid even the appearance of conflicts of interest in performing the responsibilities of the committee;
 - (3) Grantee shall establish outcomes and reporting requirements for each PNAC;
 - (4) Grantee shall ensure that all PNAC members receive initial and ongoing training and information necessary to achieve expected outcomes. Grantee shall ensure that PNAC receives training and information related to Title 26 TAC Chapter 301, Subchapter F (Provider Network Development), and that PNAC is actively involved in the development of the CLSP and the LPND plan;
 - (5) Grantee shall ensure that PNAC has access to all information regarding total funds available through this Statement of Work for services in each program area, as well as all required performance targets and outcomes;
 - (6) Grantee shall ensure that PNAC receives a written copy of the final annual budget and biennial plan for each program area as approved by Grantee's Board of Trustees, and a written explanation of any variance from PNAC's recommendations;
 - (7) Grantee shall ensure that PNAC has access to and reports to Grantee's Board of Trustees, at least quarterly, on issues related to: (a) the needs and priorities of the LSA; (b) implementation of plans and contracts; and (c) PNAC's actions that respond to special assignments given to PNAC by the local board;
 - (8) Grantee may develop alliances with other LMHAs or LBHAs to form regional PNACs; and
 - (9) Grantee may develop a combined Mental Health and Intellectual and Developmental Disability (IDD) PNAC. If Grantee develops such a PNAC, the 50 percent client and family member representation shall consist of equal numbers of mental health and IDD clients and family members. Expanded membership may

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be necessary to ensure equal representation.

2. Policy Development and Management:

Grantee shall develop, implement, and update policies and procedures to address the needs of the LSA in accordance with state and federal laws and the requirements of this Statement of Work. Policies shall include consideration of public input, best value, and client-care issues.

3. Coordination of Service System with Community and HHSC:

Grantee shall:

- a) Adhere to HHSC directives related to Client Benefits Plan as described in **Information Item H, Client Benefits Plan**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;
- b) Ensure coordination of services within the LSA. Such coordination shall ensure collaboration with other agencies, including local hospitals, nursing facilities, other health and human service agencies, criminal justices entities, including law enforcement agencies, nonprofit and for-profit housing providers, Community Coalition Partnerships, Prevention Resource Centers, Outreach Screening Assessment and Referral organizations, other child-serving agencies (*e.g.*, Texas Education Agency (TEA), Department of Family and Protective Services (DFPS), Texas Juvenile Justice Department (TJJD), family advocacy organizations, local businesses, and community organizations). Evidence of the coordination of services shall be maintained. Evidence may include memorandums of agreement, memorandums of understanding, sign-in sheets from community strategic planning activities, or sign-in sheets from community-based focus group meetings;
- c) In accordance with applicable rules under Title 26 TAC Chapters 301 and 306, ensure that services are coordinated:
 - (1) Among network providers; and
 - (2) Between network providers and other persons or entities necessary to establish and maintain continuity of services;
- d) Designate a physician to act as the Medical Director as a part of the administrative management team. The Medical Director must be a physician licensed to practice in the State of Texas, with a specialization in psychiatry. If Grantee is unable to employ a psychiatrist, Grantee must obtain psychiatric consultation relative to the responsibilities outlined below. Grantee shall submit the Medical Director's contact information as part of **Form S, Contact List**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. The Medical Director's responsibilities include:
 - (1) Oversight of the quality and appropriateness of clinical services delivered, including participation in the ongoing Continuous Quality Improvement Plan;

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- (2) Peer Review;
 - (3) Death Review;
 - (4) Oversight of the Utilization Management (UM) process as outlined in the UM Manual and Title 26 TAC § 301.335, ensuring that all services provided are medically necessary and appropriate;
 - (5) Provides clinical leadership in shaping programs through active involvement in health care and policy issues, and program design and development; and
 - (6) Administrative Reviews regarding medical necessity determinations;
- e) Dedicate at least one full-time staff member that is a Qualified Mental Health Professional-Community Services (QMHP-CS) or Licensed Practitioner of the Healing Arts (LPHA) to act as the Continuity of Care Liaison to support continuity-of-care activities. The Continuity of Care Liaison must not have assigned duties outside of activities supporting continuity of care and related functions. The Continuity of Care Liaison must support adults and children discharged from a hospital, including adults on forensic commitments, or discharged to the Home and Community Based Services-Adult Mental Health program. The Continuity of Care Liaison must coordinate continuity of care activities related to the application packet for Waco Center for Youth and provide continuity of care upon admission and discharge;
- f) Include Continuity of Care Liaison's contact information as part of **Form S, Contact List**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;
- g) Ensure that there is an alternate staff member to act as the Continuity of Care Liaison in the absence of the individual identified on **Form S, Contact List**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;
- h) Ensure that each client has an appointment scheduled with a physician or designee authorized by law to prescribe needed medications, consistent with the Continuing Care Plan, as defined in Title 26 TAC Chapter 306, Subchapter D (Mental Health Services – Admission, Discharge, and Continuity of Care);
- i) Provide discharge planning in accordance with Title 26 TAC Chapter 306, Subchapter D (Mental Health Services – Admission, Discharge, and Continuity of Care) and **Information Item J, Continuity of Care Liaison Service Standards**, as they exist at the time of Contract execution or as modified during the Contract term. In addition, if a child has an IQ below 75 or receives a diagnosis of Intellectual Developmental Disability, Grantee shall refer the individual to the Local Intellectual and Developmental Disability Authority. All activities associated with discharge planning for an individual in any HHSC-funded psychiatric bed shall be documented

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- by the Grantee using the continuity-of-care service code H0032;
- j) Ensure that the continuity of care appointment shall be on a date prior to the earlier of the following events:
 - (1) The exhaustion of the client's supply of medications; or
 - (2) The expiration of 14 calendar days from the client's discharge or furlough from a state hospital;
 - k) To the maximum extent possible, provide individuals a choice of qualified physicians or designees authorized by law to prescribe needed medications, perform programmatic consultations, confer signature authority, and render other medical consultative services.
 - (1) Contracting with or employing a qualified physician or designee authorized by law to prescribe needed medications;
 - (2) Establishing a coverage plan that will assure individuals' needs are met even when the employed or contracted physician is unavailable;
 - (3) Notifying HHSC within one business day if both employing and contracting with a qualified physician or designee authorized by law to prescribe needed medications is not possible for any period of time during the contract period. Planned efforts shall be documented and submitted to HHSC by Grantee who shall seek technical assistance from HHSC if this situation persists for five consecutive business days within the contract period. Ongoing efforts shall be documented, and the Grantee shall provide choice to individuals as outlined below in (5) and (6) until the situation has been remedied;
 - (4) Referring the individual to a qualified physician or designee authorized by law to prescribe needed medications, who is not employed or contracted by the Grantee but is within 75 miles of the individual's residence; and
 - (5) Identifying the nearest available non-local (more than 75 miles from the individual's residence) qualified physician or designee authorized by law to prescribe needed medications, if the Grantee lacks the capacity to meet any of the above requirements. If the individual indicates the distance to the provider is not a barrier to accessing services, then Grantee shall refer the individual to the available service provider. Grantee shall document the discussion with the individual and the individual's decision regarding traveling to the non-local provider. If the individual indicates that the distance to the non-local qualified physician or designee authorized by law to prescribe needed medications is a barrier to accessing services, Grantee shall document a strategy to establish access to a provider;
 - l) Provide clients a choice among all eligible network providers in accordance with Title 26 TAC, Chapter 301, Subchapter F (Provider Network Development);
 - m) Offer each level of care (LOC) as outlined in the Texas Resiliency and Recovery (TRR) UM Guidelines, incorporated by reference and posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health->

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[services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual](#), and provide core services available within each LOC.

- (1) Contracting with or employing staff who meet the qualifications (*i.e.* licensure, training, and competency) to provide the core service;
 - (2) Notifying HHSC immediately if neither employing nor contracting with a qualified provider is possible for fifteen consecutive days during the contract term. This notification shall include the Grantee's plan to resolve the unavailability of services. Ongoing efforts shall be documented, and the Grantee shall provide choice to individuals as outlined in (4) and (5) below until the situation has been remedied;
 - (3) Referring the individual to a qualified provider who is not employed or contracted by the Grantee but is within 75 miles of the individual's residence;
 - (4) Identifying the nearest available non-local (more than 75 miles from the individual's residence) qualified provider, if the Grantee lacks the capacity to meet any of the above requirements. If the individual indicates the distance to the provider is not a barrier to the individual accessing services, then Grantee shall refer the individual to the available service provider. Grantee shall document the discussion with the individual and the individual's decision regarding traveling to the non-local provider. If the individual identifies that the distance to the non-local qualified provider is a barrier to accessing services, Grantee shall document a strategy to establish access to the core service;
- n) Develop an adequate array of qualified service providers in the provider network for the provision of the Youth Empowerment Services (YES) Waiver program, in accordance with the YES Waiver Policy Manual (YES Manual), incorporated by reference and posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>. This shall be accomplished by:
- (1) Contracting and/or employing qualified providers of the YES Waiver service array;
 - (2) Offering and providing access to all services in the YES array, and delivering requested services on a HHSC-approved Individual Plan of Care (IPC) within ten (10) business days of IPC approval, or later, at the participant or LAR's request;
 - (3) Providing participant choice among qualified providers of individual services;
 - (4) Serving as a Comprehensive YES Waiver provider and Wraparound Provider Organization (WPO). Grantee may stop accepting client referrals as a Comprehensive YES Waiver provider if Grantee ensure that there are at least two other contracted provider organizations serving the entire local mental/behavioral health authority service area that are in good standing and are able to assure that:
 - (a) YES Waiver participants are offered provider choice;
 - (b) YES Waiver participants have access to adequate continuity of YES Waiver services despite changes in contract status or unavailability of providers contracted with HHSC; and

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- (c) Contracted providers are able to provide all services in the YES Waiver service array and offer sufficient service capacity to meet community need;
- (5) Providing the core services available within LOC-YES, as outlined in the TRR UM Guidelines, incorporated by reference and posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual>, for the entire geographical service area. Core services include Wraparound (as delivered by a WPO) and Comprehensive Waiver Provider (CWP) services. A WPO is currently defined as a qualified entity responsible for coordinating YES Waiver services for individuals enrolled in the YES Waiver and for developing a person-centered plan using the HHSC-approved model. As Grantee serves as both the CWP and the WPO, as well as provider of last resort, Grantee shall mitigate conflict of interest by maintaining a clear separation of provider and WPO functions by ensuring the following:
 - (a) The role of the distinct individual staff member of the WPO must be administratively separate from other comprehensive YES Waiver provider functions and any related utilization review units and functions;
 - (b) The distinct individual staff member of the WPO shall not be the provider of a YES Waiver service that is on the IPC of a YES Waiver participant if he/she is providing intensive case management services to the participant;
 - (c) CWP services are being provided free of conflict and in accordance with requirements outlined in the Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 441 (Medical Assistance Programs; Services: Requirements and Limits Applicable to Specific Services), and the YES Manual, incorporated by reference and posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>; and
 - (d) The programs are operating with conflict-of-interest protections in place that are approved by HHSC, as well as developing and maintaining policies that keep the YES CWP role administratively separate from the provision-of-case management services for participants in the YES Waiver;
- o) Operate a continuity-of-care and services program for individuals who are justice involved in compliance with Texas Health & Safety Code Chapter 614 and the guidelines outlined in the **Information Item T, Jail Match Report and Jail Diversion Standards**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. Accordingly, Grantee shall:
 - (1) Develop and implement policies and procedures to be submitted annually to HHSC for review and approval related to the Grantee requirements for reviewing the Jail Match Reports and providing continuity of care to people identified as a Texas Law Enforcement Telecommunications System (TLETS) match. This shall include:
 - (a) Designating on **Form S, Contact List**, a staff member to act as the TLETS point of contact who will oversee the monitoring of people identified as

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- TLETS matches;
 - (b) Contacting the jail territory LMHA when a person identified as a TLETS match is booked in a jail outside of the continuity of care LMHA's local service area; and
 - (c) Providing treatment and follow-up for the purposes of continuity of care for people identified as TLETS matches.
- (2) Offer and provide technical assistance and training to Community Supervision and Corrections Department (CSCD), County Juvenile Probation Departments (JPD), and Texas Juvenile Justice Department (TJJD) and other criminal justice entities (e.g., pre-trial, jail, courts) on mental health and related issues. Training must include instructions on how to access Grantee's services and outline the full array of services available;
 - (3) Assist criminal justice and judicial agencies with the identification and diversion of individuals, who have a history of state mental health care, through a local continuity-of-care and services program; and
 - (4) Review available records of each incarcerated individual who has been formally determined by a court to be Incompetent to Stand Trial, and assist criminal justice and judicial agencies with diversion through a local continuity-of-care and services program. Complete **Form Z, Forensic Clearinghouse Waitlist Template**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, following submission guidelines in the Submission Calendar located in **Information Item S, LMHA/LBHA Submission Calendar**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;
- p) Provide services to clients referred by TJJD pursuant to Title 37 TAC Chapter 380, §380.8779 (Discharge of Non-Sentenced Offenders with Mental Illness or Intellectual Disability);
 - q) Notify HHSC of its intent to operate a county-funded Jail-Based Competency Restoration (JBCR) program at least 90 days before serving people deemed incompetent to stand trial and court-ordered into JBCR services;
 - r) Notify HHSC of its intent to cease operating a county-funded JBCR program at least 90 days before the last day of operations;
 - s) Grantee must develop policies and procedures for coordination with criminal justice entities for people on an outpatient commitment under the Texas Code of Criminal Procedure Chapter 46C in which Grantee has been ordered to provide treatment, supervision, or both.
 - t) Identify and document clients who have been court-ordered to receive outpatient mental health treatment to be provided by the Grantee, including, but not limited to:

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Not Guilty by Reason of Insanity (NGRI) mental health outpatient commitments under the Texas Code of Criminal Procedure Chapter 46C; extended mental health outpatient commitments; and temporary mental health outpatient commitments. The following data is to be tracked locally and electronically via the Clinical Management for Behavioral Health Services (CMBHS) database. The data elements listed below—located in CMBHS under Provider Tools>Development Documentation and Supporting Materials>MH Outpatient Commitment—allow for batching:

- (1) CMBHS Commitment Number <CMBHS Generated>;
 - (2) Commitment Category <CMBHS Generated>: Always Outpatient;
 - (3) Local Commitment Number <Required>;
 - (4) Local Case Number <Required>;
 - (5) Commitment Effective Date <Required>;
 - (6) Commitment Expiration Date <Required>;
 - (7) Commitment County <Requested>;
 - (8) Court Type <Requested>:
 - (a) District Court;
 - (b) Probate Court; or
 - (c) Other;
 - (9) Court Detail (Text) <Requested>;
 - (10) Cause Number <Required>;
 - (11) Commitment Type <Requested>:
 - (a) Extended-MH (Not to exceed 12 months);
 - (b) Temporary-MH (Not to exceed 90 days); or
 - (c) Other;
 - (12) Commitment Type Details <Requested>;
 - (13) Commitment Offense List <Requested>;
 - (14) Comments (Text) <Requested>;
 - (15) Document Status <Required>; and
 - (16) Document Status Date <CMBHS Generated>.
- u) Maintain communication with the court and other relevant parties regarding changes to outpatient mental health treatment orders. Grantee shall communicate order disposition recommendations (i.e., renew, modify, revoke, or expire) to the court when clinically indicated or instructed by the court. Consistent with the Code of Criminal Procedure, Chapter 46C, Article 46C.261 (b), order disposition recommendations for the NGRI population should be filed with the court annually and no later than the 30th calendar day before order expiration;
- v) Participate in Community Resource Coordination Groups (CRCGs) for children, and

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adults in the Local Service Area (LSA) by providing one or more representatives to each CRCG with expertise in mental health, with authority to: (1) contribute to the CRCG's decisions and recommendations; (2) contribute resources toward resolving problems of individuals needing agency services identified by the CRCG; and (3) by providing information concerning how to access Grantee's services and outlining the full array of services available. Duties shall be performed in accordance with Memorandum of Understanding for Coordinated Services to Persons Needing Multiagency Services, incorporated by reference and posted at <https://crcg.hhs.texas.gov/training-and-technical-assistance/>;

- w) Cooperate with schools in individual transition planning for child, and adult clients receiving special education services, in accordance with 34 CFR Part 300 (Assistance to States for the Education of Children with Disabilities);
- x) Establish and maintain a continuum of care for children transitioning from the Early Childhood Intervention (ECI) program into children's mental health services described in this Statement of Work, including:
 - (1) Responding to referrals from ECI programs;
 - (2) Verifying eligibility for mental health services;
 - (3) Informing the family about the available mental health services, service charges, and funding options such as Medicaid and Children's Health Insurance Program (CHIP);
 - (4) Participating in transition planning no later than 90 calendar days prior to the child's third birthday;
 - (5) Assisting in the development of a written transition plan to ensure continuity of care;
 - (6) Supporting joint training and technical assistance plans to enhance the skills and knowledge base of providers; and
 - (7) Submitting local agency disputes that are not resolved in a reasonable time period (*i.e.*, not to exceed 45 calendar days unless the involved parties agree otherwise) to the ECI or HHSC Mental Health Program Services Unit for resolution at the state level;
- y) Designate a staff member to act as Grantee's Suicide Prevention Coordinator, and submit, as part of **Form S, Contact List**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, this staff member's contact information. Grantee's Suicide Prevention Coordinator shall work collaboratively with local staff, LMHA/LBHA suicide prevention staff statewide, and HHSC's Suicide Prevention Office to reduce suicide deaths and attempts by:
 - (1) Developing a collaborative relationship with any existing local suicide prevention coalition;

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- (2) Participating in Suicide Prevention Coordinator conference calls scheduled and facilitated by HHSC Suicide Prevention Officer;
 - (3) Developing local Community Suicide Postvention Protocols for how to provide postvention services in the catchment area when the need for suicide postvention arises as described by the Center for Disease Control Postvention Guideline: CDC's Preventing Suicide: A Technical Package of Policy, Programs and Practices <https://www.cdc.gov/violence-prevention/index.html>;
 - (4) Contacting the HHSC Suicide Prevention Coordinator to inform via email (Suicide.Prevention@hhs.texas.gov) of any suicide deaths contributing to a possible suicide cluster or contagion, as part of the local Community Suicide Postvention Protocols;
 - (5) Completing **Form Y, Organizational Readiness Assessment for Suicide Safe Care/ Zero Suicide**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, according to the instructions on the form and by the due date on the contained in the Submission Calendar located in **Information Item S, LMHA/LBHA Submission Calendar**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>; and
 - (6) Participating in local community suicide prevention efforts;
- z) Ensure access to routine care by:
- (1) Providing access to care to individuals seeking services regardless of ability to pay;
 - (2) Providing access to a screening and Uniform Assessment (UA) conducted by a QMHP-CS to determine eligibility for individuals presenting for routine care services, regardless of an individual having proof of personal information (*e.g.*, address, phone number, personal identification, Social Security card) and funding source information (*e.g.*, insurance card and pay stub);
 - (3) Demonstrating efforts to collaborate with other health care agencies and community resources to address the physical and behavioral health care needs of individuals, as well as ensuring that these needs are met; and
 - (4) Ensuring the availability of a telephone system and call center that allows individuals to contact the LMHA or LBHA through a toll-free number that must:
 - (a) Operate without using telephone answering equipment at least on business days during normal business hours, except on national holidays, unless due to uncontrollable interruption of service, or with prior HHSC approval;
 - (b) Have sufficient staff to operate efficiently;
 - (c) Collect, document, and store detailed information, on all telephone inquiries and calls;
 - (d) Provide electronic call answering methods that include an outgoing message

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- providing the crisis hotline telephone number, in languages relevant to the service area, for callers to leave a message outside of normal business hours;
- (e) Return routine calls within two business days for all messages left during and after hours; and
 - (f) Provide access to a screening conducted by a QMHP-CS in person or via telephone no later than one business day after an individual presents for services;
- aa) Ensure that two designated staff members are certified as a Super User for the Adult Needs and Strengths Assessment (ANSA) and equally for a Super User for the Children's Needs and Strengths Assessment (CANS). A single staff member certified as a Super User of both the ANSA and the CANS may count toward totals for both the ANSA and the CANS. The individual(s) shall keep the Super User status current and shall be identified on **Form S, Contact List**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. If there is a vacancy, Grantee shall submit a plan of correction to HHSC to ensure that the position is filled and able to perform prescribed activities within six months. ANSA or CANS Super Users must:
- (1) Be certified as a QMHP-CS, and meet the training requirements indicated in **Information Item A, Training and Competency**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;
 - (2) Perform a quality assurance training activity at least two times annually with a minimum of 40% of the practitioners who are certified to administer the ANSA or CANS as part of their primary functions. Grantee shall make the following data available to HHSC upon request:
 - (a) Average number of employees certified to administer the ANSA or CANS during the six-month reporting period;
 - (b) Total number of unduplicated employees who participated in the quality assurance training activity during the six-month reporting period; and
 - (c) Sign-in sheet for participation in the quality assurance training activity;
- bb) Upon notification by HHSC that the Home and Community Based Services - Adult Mental Health (HCBS-AMH) program is operational in Grantee's local service area, Grantee shall utilize CMBHS when made available to adhere to the referral and enrollment process for the HCBS-AMH program for individuals residing in the community who meet the initial eligibility criteria of HCBS-AMH. Comprehensive instructions to complete the referral process can be requested by email: HCBS-AMH-EnrollmentandReferral@hhs.texas.gov. Grantee shall:
- (1) Operate a phone line to receive and respond to inquiries about HCBS-AMH within one business day, and set up a voicemail, answer service, or other system of the LMHA's or LBHA's choosing to receive after-hours inquiries;

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- (2) Designate a Point of Contact (POC) to coordinate the HCBS-AMH referral process for individuals residing in the community;
 - (3) Review the Mental and Behavioral Health Outpatient Warehouse (MBOW) 1915i reports located in the Consumer Analysis (CA) Continuity of Care folder, on HHSC's IAMOnline webpage, for evidence or supporting documentation of meeting initial eligibility criteria;
 - (4) Coordinate with state hospital staff regarding individuals referred to the program who are currently in the state hospital;
 - (5) Coordinate with criminal justice staff or emergency department staff for individuals referred to the program;
 - (6) Complete the HCBS-AMH referral process by assisting the individual and/or LAR in completing all required HCBS-AMH forms, including completion of the HCBS-AMH Uniform Assessment and Clinical Eligibility Screen; assist in coordinating the date and location of the assessment, and attach supporting documentation, if applicable, for individuals on the MBOW 1915i reports, on HHSC's IAMOnline webpage, or who otherwise meet referral criteria who are currently in the community; and verify CARE ID of the referred individual; complete Medicaid Eligibility Verification and submit via CMBHS. (Contact LMHA or LBHA security administrator for access to CMBHS.) For additional information, email HCBS-AMH-EnrollmentandReferral@hhs.texas.gov;
 - (7) Assist eligible participants to complete documents needed to enroll in the HCBS-AMH program;
 - (8) Coordinate with the participant's HCBS-AMH recovery manager to address needs of the participant, and participate in the individual's HCBS-AMH recovery plan meetings;
 - (9) Conduct initial assessment, annual assessment, and reassessments for all HCBS-AMH participants residing in a community setting and update in CMBHS; and
 - (10) Assist participants enrolled in HCBS-AMH with provider transfers as needed;
- cc) Designate a staff member to act as Grantee's Housing Coordinator and submit, as part of **Form S, Contact List**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, this staff member's contact information. Grantee shall work collaboratively with local staff and the state housing program staff to improve access to safe, decent, affordable housing and an array of voluntary pre-tenancy and tenancy support services by:
- (1) Serving as a point of contact for local staff in need of training and technical assistance to serve persons who are homeless or at risk of homelessness and provide supportive housing (pre-tenancy and tenancy) services;
 - (2) Developing a collaborative relationship with any existing local public housing authorities;
 - (3) Participating in the development of local community homeless and/or housing

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strategic plans; and

(4) Participating in local community homeless and housing efforts;

dd) Ensure that Grantee stays informed and continues receiving updated information, Grantee must assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the organization;

ee) If Grantee is a Certified Community Behavioral Health Clinic (CCBHC), Grantee shall adhere to CCBHC certification criteria requirements for the duration of the certification period; and

ff) Act upon referrals within 15 calendar days of receipt from the Long-Term Services and Supports (LTSS) Screen. Grantee shall demonstrate successful action on a referral by utilizing the H0023 procedure code (grid code 100) for adults and the H0023HA procedure code (grid code 200) for children.

4. Resource Development and Management:

Grantee shall:

- a) Identify and create opportunities, including grant development, to make additional resources available to the LSA;
- b) Optimize earned revenues and maximize dollars available to provide services, which shall include implementing strategies to minimize overhead and administrative costs and achieve purchasing efficiencies. Strategies that an LMHA or LBHA shall consider in achieving this objective include joint efforts with other local authorities regarding planning, service delivery, purchasing and procurement, and other administrative/authority functions;
- c) Assemble and maintain a network of service providers and serve as a provider of services as set forth in Title 26 TAC Chapter 301, Subchapter F (Provider Network Development). In assembling the network, the LMHA or LBHA shall seek to offer clients a choice of qualified providers to the maximum extent possible;
- d) Submit required information via a post-procurement report to HHSC within 30 calendar days of completing a procurement described in the LMHA's or LBHA's approved LPND plan.;
- e) Award new subcontracts in accordance with applicable laws and Title 26 TAC Chapter 301, Subchapter A (Contracts Management for Local Authorities) and Subchapter F (Provider Network Development);
- f) Pay providers a fair and reasonable rate in relation to the local prevailing market;
- g) Ensure that providers are informed of and in compliance with the applicable terms and conditions of this Statement of Work by developing provider contracts which include the Statement of Work requirements;

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- h) Implement network management practices to promote the effectiveness and stability of the provider network, including a credentialing and re-credentialing process that requires providers to meet the same professional qualifications as internal providers;
- i) Implement a provider relations process to provide the support and resources necessary for maintaining an available and appropriate provider network that meets HHSC standards, including:
 - (1) Distributing information to providers on an ongoing basis to inform them of HHSC requirements;
 - (2) Informing providers of available training and other resources;
 - (3) Interpreting contract provisions and clarifying policies and procedures;
 - (4) Assisting providers in accessing the information or department they need;
 - (5) Resolving payment and other operational issues; and
 - (6) Resolving provider grievances and disputes; and
- j) Ensure that the providers are monitored and contracts are enforced in accordance with applicable laws and Title 26 TAC Chapter 301, Subchapter A (Contract Management for Local Authorities).

5. Resource Allocation and Management:

Grantee shall:

- a) Maintain an administrative and fiscal structure that separates local authority and provider functions, by allocating funding specifically and as specified within the various budget and quarterly financial reports Grantee submits to HHSC per this Statement of Work;
- b) Maintain a Utilization Management (UM) Committee that includes the following Grantee staff:
 - (1) The UM physician, who:
 - (a) Is a board eligible or board-certified psychiatrist;
 - (b) Is licensed to practice medicine in the State of Texas; and
 - (c) Provides oversight of the UM program's design and implementation;
 - (2) UM staff representative;
 - (3) Quality management staff representative; and
 - (4) Fiscal/financial services staff representative;
- c) Hire and ensure that its UM Manager:
 - (1) Is licensed to practice in the State of Texas as a:
 - (a) Physician;
 - (b) Registered nurse or a registered nurse-advance practice nurse;
 - (c) Physician assistant;

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- (d) Licensed clinical social worker;
 - (e) Licensed professional counselor;
 - (f) Licensed doctoral level psychologist; or
 - (g) Licensed marriage and family therapist;
 - (2) Has a minimum of five years of experience in direct care of individuals with a serious mental illness and/or children with serious emotional disturbances, which may include experience in an acute care or crisis setting;
 - (3) Has a demonstrated understanding of psychopharmacology and medical/psychiatric comorbidity through training or experience;
 - (4) Has one year of experience in program oversight of mental health care services; and
 - (5) Has demonstrated competence in performing UM and review activities;
- d) If Grantee is unable to employ a UM Manager that meets the criteria outlined in Section I(A)(5)(c), and delegates UM activities to other staff, Grantee must hire a UM Director and Utilization Reviewer or Utilization Care Manager with the requirements below:
- (1) A UM Director who is:
 - (a) Licensed to practice in the State of Texas as a:
 - i. Qualified UM physician as specified above in Section I(A)(5)(b)(1);
 - ii. Registered nurse or a registered nurse-advance practice nurse;
 - iii. Physician assistant;
 - iv. Licensed clinical social worker;
 - v. Licensed professional counselor;
 - vi. Licensed doctoral level psychologist; or
 - vii. Licensed marriage and family therapist;
 - (b) Has a minimum of three years of experience in the treatment of individuals with mental illness or chemical dependency; or
 - (2) Grantee may employ a UM Director who is not licensed. However, the unlicensed UM Director must only oversee the UM Program administratively, not clinically. Clinical oversight must be provided by staff member who is licensed in accordance with Section I(A)(5)(d)(1)(a) above;
 - (3) A Utilization Reviewer or Utilization Care Manager, who is QMHP-CS, shall have at least three years of experience in direct care for adults with serious mental illness or children with serious emotional disturbances, and be directly supervised by an individual who meets the qualifications of a UM Manager;
- e) Ensure that UM job functions are included in each UM staff member's job description, and that documentation of licenses, training, and supervision are maintained in the staff member's signed and approved personnel record;
- f) Ensure that the UM Committee meets at least quarterly to ensure effective management of clinical resources, fiscal resources, and the efficiency and ongoing

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improvement of the UM process. Grantee shall ensure and document that members of the UM Committee receive appropriate training to fulfill the responsibilities of the committee. Training is needed when a new member is added to the committee and as needed, at least annually, for the entire committee. Documentation of training contents may be included in committee minutes. The committee shall review:

- (1) Appropriateness of eligibility determinations;
 - (2) Use of exceptions and overrides to service authorization, ensuring rationale is clinically appropriate and documented in the administrative and clinical record;
 - (3) Over- and under-utilization of services;
 - (4) Appeals and denials;
 - (5) Fairness and equity in the organization and provision of services; and
 - (6) Cost-effectiveness of all services provided;
- g) Implement a UM Program using HHSC's approved Texas Resiliency and Recovery (TRR) UM Guidelines, incorporated by reference and posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual>, which shall include documented and approved processes and procedures for:
- (1) Authorization and reauthorization of level of care (LOC) for outpatient services;
 - (2) Authorization of inpatient admissions to state hospitals and to community psychiatric hospitals and reauthorization for continued stay when general revenue allocation or local match funding is being used for all or part of that hospitalization;
 - (3) Verification and documentation that services provided are medically necessary;
 - (4) The role for UM in ensuring continuity and coordination of services among multiple mental health community service providers;
 - (5) A timely authorization system designed to ensure that medically necessary services are delivered without delay and after requested services have been authorized (backdating of authorizations is not permissible). Crisis services do not require prior authorization; however, the authorization shall be completed within two business days after the provision of the crisis intervention service;
 - (6) Automatic authorization processes shall be based on a documented agreement with providers that only allows automatic authorization if the LOC recommended is the same one to be authorized, and only with providers who have documented competence in UA assessments;
 - (7) Notification of clients and providers of the authorization determinations;
 - (8) A timely and objective appeal process in accordance with Title 26 TAC §301.155, and for Medicaid recipients in accordance with Title 26 TAC § 301.335;

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- (9) Procedures to provide notice pursuant to **Information Item Q, Fair Hearings Procedures**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>); and
- (10) Maintaining documentation on appeals;
- h) Review and update the quality management plan each biennium, including the UM Program Plan, and ensure that the plan includes a description of:
 - (1) Requirements relating to the UM Committee credentials, meetings, and training;
 - (2) How the UM Program’s effectiveness in meeting goals shall be evaluated;
 - (3) How improvements shall be made on a regular basis;
 - (4) How the content of Sections I(A)(5)(c – e) in this Statement of Work are addressed and included as a part of the UM Program Plan; and
 - (5) The oversight and control mechanisms which will ensure that UM activities meet required standards when they are delegated to an administrative services organization or a HHSC-approved entity;
- i) Comply with **Information Item R, Texas Resiliency and Recovery (TRR) Waiting List Maintenance Manual**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, for all individuals (adult or child) who have requested mental health services from Grantee, which Grantee anticipates will not be available upon request, by doing as follows:
 - (1) Initial Intake and Placement on Waiting Lists – Grantee shall develop and ensure the implementation of procedures to triage and prioritize service needs of individuals determined eligible for a LOC, but for which Grantee has reached or exceeded its capacity to provide the LOC.
 - (2) These procedures shall include a process for the assessment of an individual’s urgency-of-needs using the CANS, or ANSA, and a requirement that they be placed immediately on a waiting list for the unavailable LOCs for which they are eligible.
 - (3) The waiting list shall include individuals who are underserved due to resource limitations as well as those who have been authorized for LOC-8 (*i.e.*, waiting for all services). Individuals with Medicaid entitlement or whose assessment indicates a need for LOC-0 (*i.e.*, crisis) services shall not be placed on a waiting list and must be provided services that are determined medically necessary. Additionally, Clients with Medicaid who are determined to be in need of Case Management and/or Medicaid Mental Health Rehabilitative Services shall be authorized for a LOC that meets their needs and shall not be underserved or placed on a waiting list.
 - (4) All medically necessary services shall be provided within timeframes specified by HHSC within this Statement of Work.

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- (5) If an individual is determined to have an urgent need for services (*e.g.*, use of crisis services), they shall be given priority to enter ongoing services.
- j) Specific Requirements for Medicaid Recipients
- (1) General: Grantee shall deliver services to an individual who is a Medicaid recipient and has an identified need for Targeted Case Management or Mental Health Rehabilitative Services shall not be put on the waiting list, and must be provided services that are determined medically necessary. Individuals who were assessed to need Targeted Case Management or Mental Health Rehabilitative Services but did not become Medicaid eligible until after they were placed on the waiting list may not remain on a waiting list for longer than 60 calendar days. The date of eligibility will be the Medicaid Certification date or the Medicaid Effective date, whichever is later. A person who declines all services from Grantee may be taken off the waiting list.
 - (2) Mental Health Rehabilitative and Mental Health Targeted Case Management Services (both Intensive and Routine): Medicaid recipients who are eligible for full Medicaid benefits shall not be placed on a waiting list for medically necessary Targeted Case Management or Mental Health Rehabilitative Services. Grantee shall provide services that are determined medically necessary. make these services available to the individual whenever such services are indicated by the Uniform Assessment (UA) and in accordance with the Texas Resiliency and Recovery (TRR) Utilization Management (UM) Guidelines. If the UA process recommends that an individual receive a LOC that includes one or both of these services, and a LPHA determines that the service or services are not medically necessary, then the LPHA shall document the reasons that the service is not indicated.
 - (3) Other Medicaid Mental Health Services: For Medicaid recipients who are eligible for full Medicaid benefits and have an identified need for medically necessary mental health services other than Mental Health Rehabilitative Services and Targeted Case Management (such as counseling or physician's services), Grantee may remove them from the waiting list and provide these services to the individual or refer the individual to other local Medicaid providers. Grantee shall provide assistance with the referral if requested by the client. Grantee shall document actions taken on behalf of the client.
 - (a) If Grantee lacks the capacity to deliver the services and no qualified local Medicaid provider is available, Grantee shall identify the nearest qualified Medicaid provider of the needed service or services. If the distance to the nearest available non-local (more than 75 miles from the individual's residence) provider is not, in the individual's opinion, a barrier to the individual accessing services, then Grantee shall refer the individual to the available service provider. Grantee shall document the discussion with the individual, and the individual's decision, regarding traveling to the non-local provider.
 - (b) Grantee may place an individual on a waiting list for the needed service only if Grantee lacks the capacity to provide the needed service and there are no

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other internal or external qualified or accessible providers available to deliver the needed service. In such cases, Grantee shall review the availability of the service monthly in order to ensure that the individual receives the needed service once it becomes available. Grantee shall document the steps taken in the client file.

- (4) Policies and Procedures for Waiting List Management: Grantee shall develop and maintain written policies and procedures, which ensure that individuals who are already on a waiting list and subsequently establish Medicaid eligibility are identified, removed from the waiting list, and provided services as indicated and in accordance with this Statement of Work.
- k) Grantee shall assess adults on the waiting list at least every 180 calendar days using the ANSA, or children on the waiting list every 90 days using the CANS.
- l) Monitoring and Maintenance Requirements:
 - (1) Frequency of Monitoring:
 - (a) Grantee shall ensure that all children on the waiting list are monitored at least once every 30 calendar days from the date of placement on the waiting list to determine the continued need for services. Grantee shall ensure that adults on the waiting list(s) who have a Level of Care Authorized (*i.e.*, LOC-A 8 or waiting for all services), and with a Level of Care Recommended (*i.e.*, LOC-R) of 3 or 4, are monitored at least once every 30 calendar days from the date of placement on the waiting list to determine the continued need for services. Grantee shall ensure that individuals on the waiting list who have an LOC-A 8 (*i.e.*, waiting for all services) with an LOC-R of 1 or 2 are monitored at least once every 90 calendar days from the date of placement on the waiting list to determine the continued need for services. This monitoring shall be conducted by a QMHP-CS and shall include a brief clinical screening to determine the current urgency of need for services.
 - (b) Grantee shall remove individuals placed on the waiting list when the individual begins to receive the recommended LOC, or no longer wants services. Except as described above, Grantee shall allow individuals who seek services to remain on the waiting list if the service need continues to be indicated and the individual desires to remain on the waiting list.
 - (c) Regarding all children on the waiting list and adults with LOC-R of 3 or 4, if the client is not able to be contacted during the 30 calendar day period, Grantee shall document all good faith efforts to contact that person or his/her LAR to determine the continued need for services. Regarding adults with LOC-R of 1 or 2, if the client is not able to be contacted during the 90 calendar day period, Grantee shall document all good faith efforts to contact that person or his/her LAR to determine the continued need for services. Good faith efforts are defined as two or more attempts to contact the client, collateral contact, or LAR regarding service needs. A “collateral contact” or “collateral” is a source of information that is knowledgeable about the consumer or the consumer’s life situation and serves to support or augment

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the available information relating to a consumer or the consumer's service needs. Possible collateral contacts include, but are not limited to, past or present landlords, employers, school officials, neighbors, teachers, day care providers, and friends. One effort to contact must be in the form of a letter. Other efforts may be phone calls or letters to a client's home, jobsite, or school. The QMHP-CS or designated staff may want to review the CARE system/ CMBHS for designated collateral contacts who may assist in locating clients. Contacts with collaterals are subject to HHSC privacy and confidentiality requirements. Based on the information gathered, the waiting list data should be updated. If the client has not been contacted after a good faith effort has been made, the client may be removed from the waiting list. However, the client shall not be removed from the waiting list until at least 30 calendar days after the preceding contact.

- (2) Individuals who have limited financial resources:
 - (a) Grantee shall demonstrate that individuals who are placed on the waiting list for medically necessary services receive a screening for benefits assistance.
 - (b) Grantee shall notify its UM staff of dates relevant to each application (filed by or on behalf of a consumer screened or served by Grantee) for medical or other public assistance. For a Medicaid application, such dates include, at a minimum, the date which benefits begin (known as the "effective date") and the date of notification of benefit (known as the "certification date").
- (3) Waiting List Manual: Grantee shall implement processes defined in the most current version of the Waiting List Maintenance Manual contained in the **Information Item R, TRR Waiting List Maintenance Manual**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- (4) An active duty military service member, or the spouse or children of an active duty service member, shall be maintained on the waiting list as outlined in **Information Item R, TRR Waiting List Maintenance Manual**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- m) Pursuant to Title 26 TAC Chapter 301, Subchapter G, pertaining to Access to Mental Health Community Services and Standards of Care, Grantee shall utilize and enter information into the Inpatient Care Waitlist (ICW) through CMBHS within one business day of the LMHA or LBHA determination that a client requires inpatient services, and there are no resources available in the local service area (*i.e.*, no beds available locally or at Grantee's designated state hospital). Information entered in CMBHS must include documentation of exhaustion of all good faith efforts to secure local resources. Grantee must designate a primary and secondary clinical staff person to act as the contact person to participate in ICW activities and provide current clinical information on clients when necessary to support continuity of care. Grantee's local psychiatric provider or medical director may confer with the primary

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and secondary clinical staff person to identify all possible community based mental health treatment options and to discuss the individual's clinical status and need to remain on the ICW. These individuals will be responsible for communicating, on an as-needed basis (at least daily), with HHSC and other parties relating to ICW and must respond to client information requests within one business day. Submit these staff person's contact information as part of **Form S, Contact List**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. Grantee may convene Community Resource Coordination Group (CRCG) meetings on an as-needed basis for children on the ICW to ensure that local resources have been identified and exhausted.

n) Specific Requirements for Telemedicine and Telehealth Services:

- (1) If providing a behavioral health service that has a procedure code that is billable in Medicaid, providers must follow the appropriate Telemedicine and Telehealth Services requirements in the Texas Medicaid Provider Procedures Manual, Behavioral Health and Case Management Handbook, incorporated by reference and posted at <https://www.tmhp.com/resources/provider-manuals/tmppm>, to provide the behavioral health service using synchronous audiovisual technology or synchronous audio-only technology.
- (2) If a behavioral health service does not have a procedure code that is billable in Medicaid, providers must follow contract requirements, HHSC rules, and guidance concerning delivery of services using synchronous audiovisual or audio-only technology.
- (3) Providers may conduct assessments in-person, by synchronous audiovisual technology, or by synchronous audio-only technology in order to determine adult mental health Priority Population eligibility (*i.e.*, reference Sections I(B)(2), and I(C)(2) of this Statement of Work). Initial assessments may only be conducted by synchronous audio-only technology when clinically appropriate and agreed to by the person receiving services or their legally authorized representative.
- (4) When service delivery is permitted using synchronous audiovisual or synchronous audio-only technology for a procedure code that is not billable in Medicaid, providers must comply with the following:
 - (a) Services may only be delivered by synchronous audiovisual or synchronous audio-only technology if clinically appropriate and safe, as determined by the provider and agreed to by the person receiving services or their legally authorized representative;
 - (b) Providers must defer to the needs of the person receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience;
 - (c) Documentation requirements for telemedicine and telehealth services are the same as for an in-person interaction, which means the provider must accurately reflect the services rendered, identify the means of service delivery, and bill using the appropriate modifier;

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- (d) Providers must document the treatment team's approval to deliver case management and rehabilitation services by synchronous audiovisual or synchronous audio-only technology in the plan of care of the person receiving services;
- (e) Providers must deliver services in-person or use synchronous audiovisual technology over synchronous audio-only technology whenever possible. Therefore, providers must document in the person's medical record the reason(s) why the provider delivered services by synchronous audio-only technology; and
- (f) Providers delivering services by synchronous audiovisual or synchronous audio-only technology must maintain the confidentiality of protected health information as required by applicable federal and state laws and regulations.

6. Oversight of Authority and Provider Functions:

Grantee shall:

- a) Objectively monitor and evaluate service delivery and provider performance, including providing oversight information to Grantee's Board;
- b) Ensure that each provider's non-compliance is corrected as soon as possible;
- c) Require providers to use a Level Three-certified sign language interpreter, if available, and if not, a Level Two or Level One-certified sign language interpreter, for persons with hearing impairments who request sign language interpreter services;
- d) Follow the National Culturally and Linguistically Appropriate Services (CLAS) Standards, which are posted at <https://thinkculturalhealth.hhs.gov/clas>;
- e) Assist in the completion of Mental Health Adult Client or Child and Family surveys as required by HHSC;
- f) Implement a Quality Management Program that includes:
 - (1) A structure, which ensures that the program is implemented, including the involvement of stakeholders;
 - (2) Allocation of resources supporting implementation;
 - (3) Oversight by staff members with appropriate experience in quality management;
 - (4) Activities and processes that address identified clinical and organizational problems including data integrity and the processes to evaluate and continuously improve data accuracy;
 - (5) An established set of remedies and timeline options for areas that need improvement or correction;
 - (6) Routine reporting of Quality Management Program activities to its governing body, providers, other appropriate organizational staff members, and community stakeholders;

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- (7) Consistent analysis of grievances, appeals, fair hearings, and expedited hearings, as well as data regarding incidents/accidents and mortality, as part of the Quality Management process;
- (8) Measuring, assessing, and improving Grantee's local authority functions;
- (9) Processes to systematically monitor, analyze, and improve performance of quality management activities, administrative services, client services, and outcomes for individuals;
- (10) Biennial update of the Quality Management Plan approved by Grantee's Board of Trustees;
- (11) Review of providers to determine whether they are consistent in delivery of evidence-based practices (EBPs), assessment accuracy, and person-directed recovery planning requirements;
- (12) Ongoing monitoring of the quality of access to services, service delivery, and continuity of care;
- (13) Ongoing monitoring of psychoactive medications in accordance with Title 26, TAC Chapter 320, Subchapter D (Prescribing of Psychoactive Medications);
- (14) Provision of technical assistance to providers related to quality oversight necessary to improve the quality and accountability of provider services;
- (15) Use of reports and data from HHSC to inform performance improvement activities, and assess unmet needs, service delivery problems, and effectiveness of authority functions for the LSA;
- (16) Oversight of all services, contracts, employees, volunteers and subcontractors, regardless in any variance in amount of funding;
- (17) Ensure compliance with TRR UM Guidelines for the delivery of community mental health services within the TRR model and monitor providers use of EBPs within their scope of licensure, with all relevant training requirements described in **Information Item A, Training and Competency**, are met with documented completion;
- (18) Ensure compliance with EBPs, incorporated by reference and posted at <https://www.hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/behavioral-health-services/texas-resilience-recovery>, and fidelity protocols, per **Information Item A, Training and Competency**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, and TRR UM Guidelines, incorporated by reference and posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual>, as well as monitor and maintain documentation of employee training per EBP, which includes the following guidelines:

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- (a) Fidelity monitoring (*i.e.*, measuring compliance with established standards or protocols) is required for the following Children’s Mental Health (CMH) EBPs:
 - i. Cognitive Behavior Therapy;
 - ii. Trauma-Focused Cognitive Behavior Therapy;
 - iii. Seeking Safety;
 - iv. Skill streaming and Aggression Replacement Techniques (ST-ART); and
 - v. Wraparound Implementation.
- (b) Fidelity monitoring, or measuring compliance with established standards or protocols, is recommended for the CMH EBPs and promising practices
 - i. Nurturing Parenting;
 - ii. Safety Planning Intervention
 - iii. Conduct Suicide Screenings, such as:
 - a. C-SSRS – Columbia Suicide Severity Rating Scale;
 - b. PHQ9 – Patient Health Questionnaire (9-question version);
 - c. Sheehan – Suicide Tracking Scale; and
 - d. SAFE-T
 - iv. Parent-Child Psychotherapy, including Parent Child Interaction Therapy (PCIT)
 - v. Barkley’s Defiant Child and Barkley’s Defiant Teen
 - vi. Preparing Adolescents for Young Adulthood (PAYA)
 - vii. Incredible Years
 - viii. Motivational Interviewing
 - ix. Family Therapy
 - x. Play Therapy
- (19) Mechanisms to measure, assess, and reduce incidents of client abuse, neglect, and exploitation and to improve the client-rights protection processes. Suspicion and incidents of abuse, neglect, or exploitation of children, or adults must be reported to the Department of Family & Protective Services as required by law. In addition, an employee, agent, or Grantee who suspects or has knowledge that an individual served is being abused, neglected or exploited shall e-mail a written report to performance.contracts@hhs.texas.gov within 48 hours after suspicion or learning of an incident allegedly perpetrated by an employee, agent, or Grantee. The report to HHSC must include the DFPS report number; must include the DFPS report number;
- (20) Risk Management processes such as competency determinations and the management and reporting of incidents and deaths; and
- (21) Coordination of activities and information with the UM Program including participation in UM oversight activities as defined and scheduled by HHSC, which includes, but is not limited to, submission of data and supporting

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documentation, submission of self-audit reports, and participation in HHSC onsite reviews.

- g) Ensure that all providers are implementing the Texas Resiliency and Recovery (TRR) model, as described on the TRR webpage and in accordance with the TRR UM Guidelines, which is posted at <https://www.hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/behavioral-health-services/texas-resilience-recovery>, in accordance with HHSC fidelity requirements. Providers who do not meet adequate implementation shall submit a Plan of Improvement (POI) for identified problems and meet the following standards:
 - (1) Within five business days after receipt of a request from HHSC, develop a POI that adequately addresses the correction of any critical health, safety, rights, abuse or neglect issues identified by HHSC, and that includes a description of local oversight activities to monitor and maintain the correction of the identified problem, and submit to HHSC for approval; and
 - (2) Within 14 business days after receipt of a request from HHSC, develop a POI that adequately addresses the correction of organizational, clinical, or compliance problems identified by HHSC during oversight activities, which includes a description of local oversight activities to monitor and maintain the improvement of the identified problem, and submit to HHSC for approval in accordance with **Information Item S, LMHA/LBHA Submission Calendar**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- h) If applicable, submit to HHSC evidence of initial or continued accreditation by a national accreditation organization (e.g., American Association of Suicidology, Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), The Council on Quality and Leadership (CQL)), in accordance with the Submission Calendar in **Information Item S, LMHA/LBHA Submission Calendar**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. The submission shall include the accreditation review report and any plan of improvement created by Grantee in response to the accreditation review report;
- i) Ensure that Grantee's buildings and associated properties are compliant with the Texas Accessibility Standards (TAS), Texas Health and Safety Code, Texas Department of Licensing and Regulation requirements, the National Fire Protection Association (NFPA) Life Safety Code or International Fire Code, and all other applicable laws;
- j) Ensure that Grantee's Americans with Disabilities Act (ADA) Self-Evaluation and Transition Plan (ADA Plan) is reviewed by Grantee at least annually and updated as necessary, and ensure that the following information is posted prominently at each service location:

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- (1) The name, address, telephone number, Telecommunications Device for the Deaf (TDD) telephone number, fax number, and e-mail address of the ADA and the Rehabilitation Act of 1973 Coordinator(s);
 - (2) The location at which the ADA Plan may be viewed; and
 - (3) The process for requesting and obtaining copies of the ADA Plan.
- k) Grantee shall enforce a Tobacco-Free Workplace. Certification shall be a policy that meets or exceeds all of the following minimum standards:
- (1) Prohibits the use of all forms of tobacco products, including but not limited to cigarettes, cigars, pipes, water pipes (hookah), bidis, kreteks, electronic cigarettes, smokeless tobacco, snuff, and chewing tobacco;
 - (2) Designates the property to which the policy applies (“designated area”). The designated area must at least comprise all buildings and structures where activities funded under this Contract are taking place, as well as Grantee owned, leased, or controlled sidewalks, parking lots, walkways, and attached parking structures immediately adjacent to the designated area;
 - (3) Applies to all employees and visitors in the designated area; and
 - (4) Provides for or refers employees to tobacco use cessation services. If Grantee cannot meet the minimum standards as set forth in this section, it must obtain a waiver from the HHSC.
- l) Grantee shall incorporate jail diversion strategies into the authority’s resilience and recovery practices to reduce involvement with the criminal justice system:
- (1) Jail diversion strategies shall address the needs of children with serious emotional disturbances and adults with the following disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5):
 - (a) schizophrenia,
 - (b) bipolar disorder,
 - (c) post-traumatic stress disorder,
 - (d) schizoaffective disorder, including bipolar and depressive types,
 - (e) anxiety disorder, and
 - (f) delusional disorder;
 - (2) Plans for jail diversion shall be incorporated into the Consolidated Local Service Plan.
- m) Consumer Complaints: In accordance with Government Code Section 531.011, and HHS Consumer Inquiry and Complaint Policy, Circular C-052, which is posted at <https://hhsconnection.hhs.texas.gov/sites/intranet/files/policies/ombudsman/c-052.pdf>, HHSC shall collect consumer complaints and inquiry information from Grantee.
- (1) Grantees shall:

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- (a) Establish a process for tracking, reporting, and analyzing consumer complaints and inquiries received locally to report to HHSC on a monthly schedule;
 - (b) Maintain records sufficiently to allow for verification, tracking, and analysis; and
 - (c) Report consumer complaint and inquiry information to HHSC via **Form LL, Consumer Complaint Form**, incorporated by reference and posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts> in accordance with **Information Item S, LMHA/LBHA Submission Calendar**, incorporated by reference and posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;
- (2) The data submitted by Grantee shall include, at a minimum:
- (a) The numbers of inquiries and complaints,
 - (b) The number of complaints resolved (from that month and previous months),
 - (c) The number of complaints resolved that were substantiated,
 - (d) The average time for resolution of complaints,
 - (e) The percent resolved within 10 business days, and
 - (f) Summaries of cases that illustrate relevant patterns or trends.
- (3) Additionally, Grantee must post its complaint process and Client's Rights Officer's contact information on Grantee's website and establish a process for consumers to submit complaints and advise consumers how to contact the Office of the Ombudsman (OO) should Grantee not resolve the complaint to the client's satisfaction.
7. Disaster Services:
- a) In the event of a local, state, or federal emergency, a mass violence incident, a public health emergency, or a disaster, either natural or human-caused as declared by the Governor, Grantee shall:
 - (1) Assist HHSC's Disaster Behavioral Health Coordination (DBHC) program in providing disaster behavioral health services to mitigate the psychological trauma experienced by crime victims, survivors, and emergency responders from such an emergency, incident, or disaster. Disaster services may need to be provided outside Grantee's Local Service Area (LSA);
 - (2) Assist survivors, emergency responders, and communities in returning to a normal (pre-disaster) level of functioning and shall assist in reducing the psychological effects of acute or prolonged distress;
 - (3) Provide disaster behavioral health services to the affected individuals in conjunction with the individual's current support system, in the event that individuals already receiving mental health services are affected;

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- (4) Provide cost-effective disaster behavioral health services in a manner that is most responsive to the needs of the emergency, incident, or disaster and which is as unobtrusive as possible to the primary services provided by Grantee under this Contract;
 - (5) Be prepared to provide disaster behavioral health services with little or no advance notice; and
 - (6) Provide disaster behavioral health services that include but are not limited to: Psychological First Aid (PFA), stress relief, Critical Incident Stress Management (CISM) modalities, crisis counseling, stress management, and the provision of referral services. Grantee shall use standardized data gathering, expense tracking, and reporting forms as provided by the HHSC.
- b) Grantee's responsibilities may include, without being limited to, the following:
- 1) Every six months beginning with the first quarter, Grantee shall provide the DBHC office, using **Form T, Disaster Contact List**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, the names and 24-hour contact information of:
 - (a) At least two individuals identified by Grantee who serve as the disaster behavioral health point of contact and are trained in providing disaster behavioral health services;
 - (b) Grantee's Risk Manager or Safety Officer; and
 - (c) Grantee's Chief Fiscal Officer or Agent.
 - 2) Information submitted by Grantee shall include whether the identified individuals in 7(a)(1) have been trained in PFA, National Incident Management System 100, 200, 300, 700, 800 and/or CISM modalities on the HHSC's **Form T, Disaster Contact List**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
 - 3) Grantee shall collaborate with HHSC to coordinate disaster/emergency, incident, and/or disaster response activities, including but not limited to community post-emergency, incident, and/or disaster behavioral health needs assessments, standard report of damage to facilities, impact on staff/consumers (evacuated or displaced from residence), and service provision.
 - 4) Grantee shall assign employees trained in PFA, National Incident Management System 100, 200, 700 and/or CISM modalities to assist HHSC during local, state, or federally-declared disasters to meet staffing needs for Disaster District Committees, shelters, morgues, schools, hospitals, Disaster Recovery Centers (DRCs), Medical Operations Centers (MOC), Points of Distribution (POD), community support centers, death notification centers, family assistance centers (FAC), Family Resiliency Centers (FRC), or other locations identified by DBHC.
 - 5) Grantee shall contract with HHSC to provide crisis counseling services following federal disaster declarations that include Individual Assistance. These services

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are funded through the Federal Emergency Management Agency - Crisis Counseling Assistance and Training Program (FEMA-CCP). CCP services include housing, hiring, and co-managing CCP Team(s). (See the following link for further federal guidance: <https://www.samhsa.gov/dtac/ccp-toolkit>.) Contractual responsibilities include adhering to all HHSC required programmatic and financial deadlines, all federal grant guidelines and regulations, and ensuring grant funds are used as efficiently as possible to reduce the risk of fraud, waste, and abuse.

- 6) Grantee shall participate in emergency management and disaster preparedness response and recovery programs, exercises, drills, and trainings relating to the provision of behavioral health services in emergencies, mass violence incidents, or disasters, which focus on prevention, preparedness, response, and recovery.
8. YES Waiver:
- a) HHSC is the Texas Medicaid Agency and operates the Section 1915(c) Medicaid Home and Community-Based Services Waiver Program called “YES Waiver.” The YES Waiver is administered under Social Security Act § 1915(c). The purpose of this Section is to outline the requirements of the Grantee in providing intake, Wraparound facilitation, and access to the core services for the YES Waiver (“the Waiver”). The YES Waiver serves to prevent or reduce institutionalization or other out-of-home placement of children and adolescents ages 3 through 18 with serious emotional disturbance (SED), enable more flexibility in providing intensive community-based services for children and adolescents with SED, and provide support for their families by improving access to services.
 - b) As part of the Medicaid application and clinical eligibility determination process, an individual’s financial eligibility to receive services under the Waiver based upon Medicaid eligibility requirements is assessed in accordance with Title 26 TAC § 307.5, YES Eligibility Criteria, and all other eligibility requirements in the YES Manual. Parental income is not included in the determination of financial eligibility, thereby reducing the current incentive for parents to relinquish custody in order to obtain access to Medicaid coverage for mental health treatment.
 - c) Grantee shall comply with all policies outlined in the current version of the YES Manual and the YES Waiver User Guide (YES User Guide), the CMS YES Waiver Application, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>, and Title 26 TAC Chapter 307, Subchapter A (Youth Empowerment Services). To the extent this Statement of Work imposes a higher standard, or additional requirements beyond those required by the YES Manual, the terms of this Statement of Work will control. This includes but is not limited to:
 - (1) Local YES Administrative Activities:
 - (a) Including requirements found on the LMHA or LBHA website, at a minimum, for LMHA or LBHAs, WPOs, and CWP:
 - i. Use HHSC-approved online content, which is posted at

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- <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>, and information about the YES Waiver program;
- ii. List the YES Waiver service array and CWP's available in the LMHA or LBHA service area;
 - iii. Provide information describing the Wraparound process; and
 - iv. Use any HHSC-approved multimedia content, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>, directed and intended for individuals and providers.
- (b) Managing and maintaining an Inquiry List of individuals who are seeking YES Waiver services. This inquiry list should include every caller who contacts the inquiry line to inquire about YES Waiver services even if they are immediately determined to not meet demographic eligibility criteria or are immediately referred to another Level of Care (LOC) or program. This includes but is not limited to:
- i. Establishing and maintaining an Inquiry phone line with voice messaging capabilities;
 - ii. Notifying HHSC if the program experiences any technical issues that impede functionality of the Inquiry Line;
 - iii. Utilizing HHSC-approved language on the voice message, which shall include all required information (see User Guide for Inquiry Line Script, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>) when answering and returning calls to individuals;
 - iv. Operating a phone line that is monitored by a live person within normal business hours;
 - v. Answering or returning calls made to the Inquiry phone line within one business day;
 - vi. Registering interested individuals on the Inquiry List in the order in which their call is received;
 - vii. Scheduling an in-person clinical eligibility assessment within seven business days of the date that each individual was determined to meet demographic eligibility. Exceptions to the timeline are considered only at the request of the individual and/or LAR, and must be documented in the individual's case records; and
 - viii. Submitting a complete and up-to-date Inquiry List to HHSC by the fifth business day of the following month, utilizing the Inquiry List template provided by the HHSC, which is available on the YES Waiver Providers Website: <https://hhs.texas.gov/doing-business-hhs/provider->

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[portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers.](https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/yes-waiver-data)

- (c) Grantee shall not exceed their maximum enrollment number (capacity) without prior approval from HHSC. Grantee's capacity number is maintained on the YES Waiver Data webpage, which is incorporated by reference and can be found at <https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/yes-waiver-data>. Grantee shall not exceed the maximum enrollment threshold at any time of the contract year, subject to the following:
 - i. Except as authorized by HHSC to enroll an individual determined to be at imminent risk of relinquishment in accordance with Title 26 TAC §307.13 and the YES Manual, posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers;>
 - ii. Except when an LMHA or LBHA accepts for transfer a client enrolled in the YES Waiver from another LMHA or LBHA; or
 - iii. Upon approval from HHSC to serve above the stated capacity.
- (d) Grantee shall not maintain a wait list for individuals who have called in and inquired about YES Waiver services, or for YES Waiver enrollment for children determined to meet eligibility criteria for YES Waiver. LMHA or LBHA shall not assess individuals from the YES Inquiry List unless the LMHA or LBHA is below the maximum enrollment or authorized by HHSC to enroll a client determined to be at imminent risk of relinquishment, in accordance with Title 26 TAC §307.13 and the YES Manual, posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>.
- (e) Assist with the Waiver enrollment activities of interested individuals by completing all activities necessary for Waiver enrollment. This includes, but is not limited to, assisting in the completion of enrollment activities in accordance with the YES Manual posted at: <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>.
- (f) Assisting individuals in obtaining and maintaining Medicaid eligibility;
- (g) Assisting in the completion of necessary enrollment processes, including enrollment forms, provider selections, and notifications and transfers to selected providers as applicable.
- (h) Maintaining open and professional communication and coordination with each Wraparound Provider Organization (WPO) and Comprehensive Waiver Provider (CWP);
- (i) Responding to or delivering information or documentation to ensure health and safety of clients and timely delivery of YES Waiver services;
- (j) Submitting Critical Incident Reports to HHSC within 72 hours of receiving the report, and in compliance with all other requirements contained in the YES Manual;
- (k) Adhering to all other requirements in the YES Manual related to conducting

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child and family team meetings and updating the crisis and safety plan following a critical incident;

- (l) Performing Quality Management (QM) activities. Grantee shall collect data, measure, assess, and work to improve dimensions of performance through focus on various aspects of care. Grantee shall include the following activities in the QM Plan outlined above in Section I(A)(5)(h):
 - i. Assisting in the timely provision of enrollment and delivery of services to Waiver participants;
 - ii. Adhering to established policies and procedures in the YES Manual and YES User Guide;
 - iii. Ensuring continuity of care, as applicable; and
 - iv. Participating in desk or onsite reviews conducted by YES QM department or Wraparound fidelity reviews conducted by HHSC or HHSC Designee at any time designated by HHSC.
- (m) Responding to HHSC requests for information and documentation within three (3) business days, unless provided a HHSC-approved extension.
- (2) Serve as a WPO when chosen by YES Waiver participants. This includes but is not limited to:
 - (a) Providing WPO services according to policies outlined as they exist during the Contract term in the YES Manual, which is posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>, YES User Guide, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>, in the Centers for Medicare and Medicaid Services (CMS) waiver application, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>, and in Title 26 TAC Chapter 307, Subchapter A;
 - (b) Participating in onsite, telephonic, and/or virtual support with HHSC or an HHSC Designee related to Wraparound fidelity;
 - (c) Participating in trainings, technical assistance calls, or webinars scheduled and conducted by HHSC or HHSC Designee;
 - (d) Providing Wraparound according to fidelity requirements outlined by HHSC or HHSC Designee;
 - (e) Facilitating the development of Waiver participant Individual Plans of Care (IPCs) in accordance with the YES Manual, which is posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>;
 - (f) Submitting Initial and Renewal IPCs within 10 business days of the latter of HHSC's authorizing the Clinical Eligibility Determination or being selected by the participant to serve as the WPO. Exceptions to the timeline are

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considered only at the request of the Waiver participant, LAR or medical consentor, and must be documented in the Waiver participant's case records.

- (g) Submitting revision IPCs to CMBHS for approval within five business days of completion and in accordance with the YES Manual, incorporated by reference and posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>;
- (h) Developing the person-centered plan for waiver services using Wraparound Planning Process, in accordance with applicable Waiver standards, policies, and procedures, including Title 26 TAC Chapter 307, Subchapter A (Youth Empowerment Services);
- (i) Providing transition planning and service coordination in accordance with requirements in the YES Manual, incorporated by reference and posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>, and submitting transition plans within CMBHS in accordance with requirements in the YES Manual and YES User Guide, incorporated by reference and posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>;
- (j) Ensuring that staff providing Wraparound are within the recommended Wraparound provider organizational caseload ratios, including caseloads for other levels of care, outlined in the YES Manual, incorporated by reference and posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>, and submitting a written request for HHSC Contract Manager approval to exceed caseload sizes, including caseloads for other levels of care, if the situation arises where that is necessary. The written request to exceed caseload sizes, including caseloads for other levels of care, should include a plan to remedy the issue and should be submitted to the HHSC Contract Manager for review and approval;
- (k) Monitoring service utilization for compliance with the HHCS-approved IPC for each Waiver participant;
- (l) Ensuring all YES providers meet all criminal history, state, and federal registry checks and training requirements, prior to delivery of services and thereafter as required in the YES Manual, incorporated by reference and posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>;
- (m) Providing engagement activities to facilitate Waiver participation in all Waiver services in the IPC;
- (n) Performing Quality Management (QM) activities: Grantee shall collect data, measure, assess and work to improve dimensions of performance through a

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focus on various aspects of care. Grantee shall include the following activities in the QM Plan outlined in Section I(A)(5)(h):

- i. Providing timely access to services;
 - ii. Developing plans of care and services based on underlying needs and outcome statements;
 - iii. Ensuring services are provided according to the Waiver participant's HHSC-approved IPC;
 - iv. Ensuring documented attempts are made to engage natural and formal supports to participate in child and family team meetings;
 - v. Assuring development and revision of Waiver participant's Wraparound Plan and IPC;
 - vi. Ensuring health and safety risk factors are identified and updated;
 - vii. Collecting and analyzing critical incident data;
 - viii. Ensuring individual service providers are credentialed and trained;
 - ix. Adhering to established policies and procedures; and
 - x. Providing continuity of care.
- (o) Maintaining open and professional communication and coordination with each Waiver Provider;
- (p) Maintaining staff that are dedicated to providing Wraparound facilitation; and
- (q) Submitting a written request for approval to operate a blended caseload if any Wraparound facilitators are providing all levels of care and any other services other than Wraparound. The written request to operate a blended caseload should be submitted to the HHSC Contract Manager for review and approval.
- (3) Grantee's cooperation with HHSC shall include the following, at minimum:
- (a) Cooperating with and assisting HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse, including the Office of Inspector General at HHSC;
 - (b) Allowing HHSC access to information or records related to Waiver participants, in accordance with applicable law, rules, or regulations, at no cost to the requesting agency;
 - (c) Allowing representatives of the HHSC, or the HHSC Designee who is responsible for Wraparound coaching and training and fidelity assessments, and the Texas Department of Family and Protective Services, Office of the Attorney General Medicaid Fraud, and United States Department of Health and Human Services full and free access, when applicable, to Grantee's staff or subcontractors and all locations where the Grantee or subcontractors perform activities related to the Waiver;
 - (d) Participating in Wraparound fidelity reviews, which includes providing requested client or organizational data and information to HHSC or HHSC Designee; and

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- (e) Participating in scheduled meetings, webinars, or trainings related to the YES Waiver or Wraparound.

B. Adult Services

1. Community Services:

- a) Grantee shall provide for the community-based services outlined in Texas Health and Safety Code Chapter § 534.053, which are incorporated into services defined in **Information Item G, Service Definitions**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- b) Grantee shall establish a reasonable standard charge for each service containing an asterisk (*) in **Information Item G, Service Definitions**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, as required by Title 26 TAC, Part 1, Chapter 301, Subchapter C (Charges for Community Services).

2. Populations Served:

- a) Adult Mental Health (MH) Priority Population: Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, anxiety disorder, attention deficit/hyperactivity disorder, mood disorders, delusional disorder, bulimia nervosa, anorexia nervosa, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.
- b) Initial Eligibility:
 - (1) An individual age 18 or older who has a diagnosis of severe and persistent mental illness with the application of significant functional impairment and the highest need for intervention, which is determined by the Uniform Assessment; or
 - (2) An individual age 18 or older who was served in children's MH services and meets the children's MH Priority Population definition prior to turning 18, who is considered eligible for one year.
- c) Individuals with only the following diagnoses are excluded from this provision:
 - (1) Substance Related Disorders as defined in the following DSM-5 diagnostic codes: F10.10-F19.99, Z72.0;
 - (2) Mental disorders due to known physiological conditions as defined in the following DSM-5 diagnostic codes: F01-F09;
 - (3) Intellectual and Developmental Disability (IDD) as defined in the following DSM-5 diagnostic codes: F70, F71, F72, F73, F79; and
 - (4) Autism spectrum disorder as defined in the following DSM-5 diagnostic code F84.0.

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d) Service Determination:

- (1) In determining services to be provided to the adult MH priority population, the choice of and admission to medically necessary services is determined jointly by the individual, or their LAR if applicable, seeking service and Grantee.
- (2) Criteria used to make these determinations are the level of care-recommended (LOC-R) of the individual as derived from the needs of the individual, the Uniform Assessment (UA), Texas Resiliency and Recovery (TRR) Utilization Management (UM) Guidelines, and the availability of resources. Clients authorized for care by Grantee through a clinical override are eligible for the duration of the authorization.

e) Continued Eligibility for Services:

- (3) Reassessment by the provider and reauthorization of services by Grantee determines the continued need for services. This activity is completed according to the UA protocols and TRR UM Guidelines.
- (4) Assignment of diagnosis in Client Assignment and Registration System (CARE) is required any time the diagnosis changes and at least annually from the last diagnosis entered into CARE.

f) Documentation Required:

In order to assign a primary diagnosis to an individual, documentation of the required diagnostic criteria, and the specific justification of significant functional impairment, shall be included in the client record. This information shall be included as a part of the required assessment information.

g) Uniform Assessment (UA) Requirements:

- (1) The HHSC-approved UA for Adults includes the following instruments:
 - (a) ANSA
 - (b) Diagnosis-specific clinical rating scales;
 - (c) Community data; and
 - (d) Authorized LOC.
- (2) The above instruments are required to be completed once an individual has been screened and determined in need of assessment by Grantee. The initial assessment is the clinical process of obtaining and evaluating historical, social, functional, psychiatric, developmental, or other information from the individual seeking services, to determine specific treatment and support needs.
- (3) Staff administering the instruments must have documented training in the use of the instruments and must be a QMHP-CS, with the exception of the Diagnosis-Specific Clinical Rating Scales which may be administered by a QMHP-CS or Licensed Vocational Nurse (LVN). Staff administering the instruments must have documentation of certification in the ANSA. Certification must be updated annually through a HHSC-approved entity.

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- (4) The UA shall be administered according to the timeframes delineated in **Information Item C, Service Targets, Outcomes, and Performance Measures**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- (5) If an individual has a documented need (that is, scoring a 2 or 3) on the Employment, Residential Stability or Substance Use items of the ANSA, Grantee shall document encounters following documentation rules outlined in Title 26 TAC Chapter 306, Subchapter F (Mental Health Rehabilitative Services), and Title 26 TAC Chapter 306, Subchapter A (Standards for Services to Individuals with Co-occurring Psychiatric and Substance Use Disorders) using the modifiers:
- (a) H2014U3, H2017U3, and H2023 for Employment;
 - (b) H2014U2, H2017U2, H0046U2, and H0046U1U2 for Residential Stability; and
 - (c) base procedure codes H2011, H2014, H2017, H0034, and T1017 with the service identifier, "COPSD," for Co-occurring Psychiatric and Substance Use Disorders.
- h) Adult Data Submission Requirements:
- (1) Grantee shall submit all required information in compliance with the schedule established by HHSC through either CARE/WebCare or CMBHS as set forth in the following table:

Required Submission	Approved Data Submission Methods			
	CMBHSOnline (Use of the CMBHS web interface)	CMBHS Batch	CARE/WebCare Online	CARE/WebCare Batch
TRR Adult UA using the Adult Needs and Strengths Assessment (ANSA)	Yes	Yes	No	No
Assignments (Service, Activity, and Destination)	No	No	Yes	Yes
Case Maintenance (Case delete, ID merge, and ID split)	No	No	Yes	No
Client Profile (New and Updated)	Yes	No	Yes	Yes
Diagnosis	Yes	No	Yes	Yes
Follow-up Contact	No	No	Yes	Yes
CARE County of Residence	No	No	Yes	No

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Required Submission	Approved Data Submission Methods			
	CMBHSONline (Use of the CMBHS web interface)	CMBHS Batch	CARE/WebCare Online	CARE/WebCare Batch
Separations	No	No	Yes	No
Consent	Yes	No	N/A	N/A

(2) Grantee can only batch to CMBHS once it has submitted the **Form U, CMBHS Assessment Attestation**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, regarding data exchange.

(3) Grantee shall no longer enter, and HHSC will no longer accept, UA information through WebCare or the CARE System. UA data must be entered into CMBHS online or through a HHSC-approved data exchange process.

3. Service Requirements:

Grantee shall:

- a) Comply with UA requirements outlined in Section I(B)(2)(g) above. (UA is not required for individuals whose services are not funded with funds paid to Grantee under this Statement of Work);
- b) Implement a Patient and Family Education Program (PFEP) in which clients and their LAR, if applicable, and any family or other support individuals with the client or LAR's consent, are provided with education and educational materials related to diagnosis and medication. Guidelines to meet this requirement are available from the National Institute of Mental Health (NIMH), and are incorporated by reference and can be found at <http://www.nimh.nih.gov/health/index.shtml>. SAMHSA's Illness Management and Recovery Evidence-Based Practices KIT, posted at <https://library.samhsa.gov/product/illness-management-and-recovery-evidence-based-practices-ebp-kit/sma09-4462>, or alternative guidelines approved by HHSC and posted at <https://www.hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/behavioral-health-services/texas-resilience-recovery> (on a schedule determined by HHSC) can be used to satisfy this requirement as well. If clients and/or their families and caregivers have not been educated about their diagnosis, the reason for the lack of education shall be documented in the clinical progress notes;
- c) Implement Texas Resiliency and Recovery (TRR) model and apply to all clients whose services are funded with Statement of Work funds:
 - (1) Develop a service delivery system in accordance with the most current versions of HHSC's TRR UM Guidelines,

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- (2) Ensure that each adult who is identified as being potentially in need of services is screened to determine if services may be clinically necessary;
- (3) Ensure that clients seeking services are assessed to determine if they meet the requirements of adult MH priority population, and, if so, ensure that a full assessment is conducted and documented using the most current versions of the HHSC UA instruments. Individuals who are admitted into services whose services are not funded in whole or in part with contract funds are exempt from inclusion in TRR regardless of adult MH priority population status;
- (4) Make available to each client recommended and authorized for a level of care (LOC), as indicated by the Adult Needs and Strengths Assessment (ANSA) all services and supports within the authorized LOC (an authorized LOC is herein referred to as “LOC-A”):
 - (a) If a non-Medicaid-eligible individual cannot be served in the recommended LOC, or if the individual refuses the recommended LOC, the individual may be served at the next most appropriate LOC. If no services are available at the next most appropriate LOC, then the non-Medicaid-eligible individual shall be placed and monitored on a waiting list until services are available;
 - (b) Medicaid-eligible individuals may not have services denied, reduced, suspended, delayed, or terminated due to lack of available resources; and
 - (c) If a Medicaid-eligible individual refuses the recommended LOC, the individual may be served at the next most appropriate LOC;
- (5) Ensure that providers use EBPs within their scope of licensure, meet all relevant training requirements with documented completion for all services and supports delivered within the TRR model in accordance with TRR UM Guidelines and described in **Information Item A, Training and Competency**;
- (6) Ensure that supervisors of services and supports delivered within the TRR model are trained in EBPs as described in the TRR UM Guidelines, as either trainers for specific EBP delivery or has provided the EBP prior to the supervision of the EBP services. Supervisors must complete this requirement within 180 calendar days of assuming a supervisory position. If supervisors are unable to complete this requirement within calendar 180 days of assuming the supervisory position, the LMHA or LBHA must submit a plan to HHSC outlining how the supervisor will fulfill this requirement;
- (7) Ensure that Cognitive-Behavioral Therapy (CBT) is provided by a Licensed Practitioner of the Healing Arts (LPHA), practicing within the scope of a license, or, when appropriate and not in conflict with billing requirements, by an individual with a master’s degree in a human services field (*e.g.*, psychology, social work, family therapy or counseling), who is pursuing licensure under the direct supervision of an LPHA. The LPHA providing CBT shall meet HHSC competency requirements as outlined in **Information Item A, Training and Competency**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;

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- (8) Provide a certified Family Partner in accordance with the standards defined in Title 1 TAC § 354.2603;
 - (9) Assertive Community Treatment (ACT) Services provided by Grantee shall meet the minimum TRR UM Guidelines for LOC-4, and shall follow the most current Dartmouth Assertive Community Treatment Scale (DACTS) Fidelity Instrument;
 - (10) Use the UA and other relevant clinical information to document the assessment of individuals seeking services and to reassess current clients in services when update assessments are due or significant changes in functioning occur, in order to determine the recommended LOC for a client;
 - (11) An LMHA or LBHA shall capture referrals due to a positive postpartum depression screening in the “Referral Source” drop-down in the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescents Needs and Strengths Assessment (CANS). This data shall be submitted to HHSC. Diagnosis of Postpartum Depression by the LMHA or LBHA will be recorded in the uniform assessment diagnostic screen;
 - (12) Utilize information from the Adult Needs and Strengths Assessment (ANSA) and other relevant clinical information to:
 - (a) Recommend a LOC;
 - (b) Determine whether the client should be transferred to another provider; and
 - (c) Determine if a client should be discharged from services;
 - (13) Use the flexible funds that shall be made available by Grantee, in accordance with the TRR UM Guidelines;
 - (14) Serve individuals, with monies allocated through the General Appropriations Act, Article II, Community Mental Health Services (*i.e.*, Senate Bill 1, General Appropriations Bill, 89th Texas Legislature, 2025, Article II - HHSC Appropriation D.2.1), for engagement, transition, and intensive ongoing services in accordance with TRR UM Guidelines. CARE Report III shall be completed in accordance with, **Information Item D, Instructions for Report III**, and submission timelines as outlined in **Information Item S, LMHA/LBHA Submission Calendar**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. Performance measures are outlined in Section II below; and
 - (15) Maintain access to CMBHS even if Grantee utilizes an approved batch process.
- d) Submit encounter data for all services according to the procedures, instructions, and schedule established by HHSC, including all required data fields and values in the current version of the HHSC Community Mental Health Service Array. The current version of HHSC Community Mental Health Service Array (*i.e.*, Report Name: INFO Mental Health Service Array Combined) can be found in the Mental and Behavioral Health Outpatient Warehouse (MBOW), in the General Warehouse Information, Specifications subfolder, on HHSC’s IAMOnline webpage;

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- e) Comply with the following Medicaid-related items:
 - (1) Contract to be a provider of Medicaid MH Rehabilitative Services and Medicaid MH Case Management;
 - (2) Contract with HHSC to participate in Medicaid Administrative Claiming;
 - (3) Recognize that funding earned through billings to Texas Medicaid and Healthcare Partnership (TMHP) for Medicaid MH Case Management and Medicaid MH Rehabilitative Services represents the federal share and the State match; and
 - (4) Submit billing for the provision of Medicaid MH Case Management and Medicaid MH Rehabilitative Services to TMHP in accordance with the Texas Medicaid Provider Procedures Manual, which is posted at <https://www.tmhp.com/resources/provider-manuals/tmppm>;
- f) Utilize non-contract funds and other funding sources (*i.e.*, any person or entity that is legally responsible for paying for all or part of the services provided, including commercial health or liability insurance carriers, Medicaid, or other Federal, State, or local, or private, funding sources) whenever possible to maximize Grantee's financial resources. Grantee therefore must:
 - (1) Enter into network provider agreements with, and bill, managed care organizations (MCOs) for Medicaid- and CHIP-covered services, provided Grantee can reach mutually agreeable terms and conditions with Medicaid and CHIP MCOs;
 - (2) Become a Medicaid provider and bill the HHSC claims administrator for Medicaid-covered services provided to traditional Medicaid clients;
 - (3) Provide assistance to individuals to enroll in such programs when the screening process indicates possible eligibility for such programs;
 - (4) Comply with the Charges for Community Services Rule as set forth in Title 26 TAC Chapter 301, Subchapter C (Charges for Community Services), to maximize reimbursement from individuals with an ability to pay for services provided;
 - (5) Bill all other funding sources for services provided under this Contract before submitting any request for reimbursement to HHSC;
 - (6) Provide all billing functions at no cost to the client;
 - (7) Use Temporary Assistance for Needy Families (TANF), and Social Services Block Grant (SSBG or Title XX) funds allocated under 42 USC § 1397 (also known as Title XX of the Social Security Act) to provide the following services as defined in **Information Item G, Service Definitions**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>:
 - (a) Case management services;
 - (b) Education and training services;
 - (c) Housing services;

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- (d) Employment services;
 - (e) Counseling services;
 - (f) Health related and home health services; and
 - (g) Other services meeting the requirements for TANF or Title XX funds, as approved by HHS.
- (8) Report this information on **Form L, Expenditures for Title XX**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- g) Provide services to all clients without regard to the client's history of arrest, charge, fine, indictment, incarceration, sentence, conviction, probation, deferred adjudication, or community supervision for a criminal offense;
 - h) Develop and implement written procedures to identify clients with co-occurring psychiatric and substance use disorders (COPSD), identify available resources, provide referrals and continuity of care for ongoing services as necessary to address the client's unmet substance-use treatment needs in accordance with Title 26 TAC Chapter 306, Subchapter A (Standards for Services to Individuals with COPSD). Nothing herein shall prohibit a physician from considering a client's substance use in prescribing medications;
 - i) Conduct assessments to determine adult mental health priority population eligibility. Assessments not conducted in person must comply with the requirements in Section I(B)(2)(g) above;
 - j) Submit financial data regarding co-pays, deductibles, and premiums related to Medicare Part D or other information related to expenditures for medications as requested by HHSC in the form and format prescribed by HHSC within its request; and
 - k) Implement crisis services in compliance with the standards outlined in **Information Item V, Crisis Service Standards**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.

C. Children Services

1. Community Services:

- a) Grantee shall provide for the community-based services outlined in Texas Health and Safety Code Texas Health and Safety Code Chapter § 534.053, as incorporated into services defined in **Information Item G, Service Definitions**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.

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- b) Grantee shall establish a reasonable standard charge for each service containing an asterisk (*) in **Information Item G, Service Definitions**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, as required under Title 26 TAC, Part 1, Chapter 301, Subchapter C (Charges for Community Services).

2. Populations Served:

- a) Child Mental Health (MH) Priority Population – The children’s MH Priority Population are children ages three through 17 years of age with serious emotional disturbance (excluding a single diagnosis of substance use, intellectual or developmental disability, or autism spectrum disorder), who have a serious functional impairment, or who:

- (1) Are at risk of disruption of a preferred living or children care environment due to psychiatric symptoms; or
- (2) Are enrolled in special education because of a serious emotional disturbance.

- b) CMH Ineligible Codes:

- (1) Ineligible single diagnoses of Substance Related Disorders are defined in the following DSM-5 diagnostic codes (same as Adult Mental Health (AMH)):
- F10.10, F10.121, F10.129, F10.14, F10.159, F10.180, F10.181, F10.20, F10.221, F10.229, F10.231, F10.232, F10.239, F10.24, F10.259, F10.26, F10.27, F10.280, F10.281, F10.182 F10.288, F10.921, F10.929, F10.94, F10.959, F10.96, F10.97, F10.980, F10.981, F10.982, F10.988, F10.99, F11.10, F11.121, F11.122, F11.129, F11.14, F11.181, F11.188, F11.20, F11.221, F11.222, F11.229, F11.23, F11.24, F11.182, F11.281, F11.282, F11.288, F11.921, F11.922, F11.929, F11.94, F11.981, F11.982, F11.988, F11.99, F12.10, F12.121, F12.122, F12.129, F12.159, F12.180, F12.188, F12.20, F12.221, F12.222, F12.229, F12.259, F12.280, F12.288, F12.921, F12.922, F12.929, F12.959, F12.980, F12.988, F12.99, F13.10, F13.121, F13.129, F13.14, F13.159, F13.180, F13.181, F13.182, F13.20, F13.221, F13.229, F13.231, F13.232, F13.239, F13.24, F13.259, F13.27, F13.280, F13.281, F13.282, F13.288, F13.921, F13.929, F13.94, F13.959, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99, F14.10, F14.121, F14.122, F14.129, F14.14, F14.159, F14.180, F14.181, F14.182, F14.188, F14.20, F14.221, F14.222, F14.229, F14.23, F14.24, F14.259, F14.280, F14.281, F14.282, F14.288, F14.921, F14.922, F14.929, F14.94, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99, F15.229, F15.10, F15.121, F15.122, F15.129, F15.14, F15.159, F15.180, F15.181, F15.188, F15.20, F15.221, F15.222, F15.23, F15.24, F15.259, F15.280, F15.281, F15.288, F15.921, F15.922, F15.929, F15.93, F15.94, F15.959, F15.980, F15.981, F15.988, F15.99, F16.10, F16.121, F16.129, F16.14, F16.159, F16.180, F16.20, F16.221, F16.229, F16.24, F16.259, F16.280, F16.921, F16.929, F16.94, F16.959, F16.980, F16.983, F16.99, F17.200, F17.203, F17.208, F17.209, F18.10, F18.121, F18.129, F18.14, F18.159, F18.17, F18.180, F18.188, F18.20, F18.221, F18.229, F18.24, F18.259, F18.27, F18.280, F18.288, F18.921, F18.929, F18.94, F18.959,

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F18.97, F18.980, F18.988, F18.99, F19.10, F19.121, F19.129, F19.14, F19.159, F19.17, F19.180, F19.181, F19.182, F19.188, F19.20, F19.221, F19.229, F19.231, F19.239, F19.24, F19.259, F19.27, F19.280, F19.281, F19.282, F19.288, F19.921, F19.94, F19.959, F19.97, F19.980, F19.981, F19.982, F19.988, F19.99, Z72.0;

(2) Ineligible diagnoses for IDD (same as AMH): F70, F71, F72, F73, F79; and

(3) Ineligible diagnosis for Autism spectrum disorder: F84.0.

c) Age Limitations:

(1) Children under the age of three who have been diagnosed with a physical or mental health condition are to be served through the Early Childhood Intervention (ECI) program; and

(2) Children 17 years old or younger must be screened for CMH services. Children receiving CMH services who are approaching their 16th birthday and continue to need mental health services shall be screened for Transition-Age Youth (LOC-TAY) Services or be transferred to Adult Mental Health (AMH) Services on their 18th birthday. Children may be referred to another community provider, depending upon the individual's needs. Individuals reaching 18 years of age who continue to need mental health services may be transferred to AMH services without meeting the adult MH Priority Population criteria and served for up to one additional year. Individuals who are 18 years of age or older and have previously received CMH services must be screened for LOC-TAY or AMH services using HHSC-approved UA.

(3) For purposes of this Contract, definitions of "child," and "transition age youth" are as follows:

(a) "Child" means an individual who is at least three years of age, but younger than 17 years of age; and

(b) "Transition Age Youth" means an individual who is at least 16 years of age, but younger than 26 years of age.

d) Service Determination:

(1) In determining services and supports to be provided to the child and family, the choice of and admission to medically necessary services and supports are determined in full partnership with the child and/or family/LAR and the Grantee.

(2) Criteria used to make these determinations are from the recommended LOC (LOC-R) of the individual, as derived from the UA, the needs of the individual, TRR UM Guidelines, and the availability of resources.

(3) Children authorized for care by Grantee through a clinical override are eligible for the duration of the authorization. A clinical override for ineligible children may not exceed a maximum of two (2) consecutive authorizations.

(4) If denial of eligibility for services, or the child or family declines services, Grantee must document efforts to explore additional referral sources and ensure

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that the family has received referral information in their first language prior to closing out services.

- (5) Should any indication of IDD, autism, or a related condition from school eligibility or evaluations, other assessments, or concerns from caregivers be present, Grantee must assist the caregiver/LAR to confirm or rule out the diagnosis. If a diagnosis of IDD, autism or related condition is confirmed, Grantee must coordinate with LIDDA and school resources to provide coordinated services and supports for the child and family.
- e) Continued Eligibility for Services:
- (1) Reassessment by the provider and reauthorization of services by Grantee determine whether a continued need for services is warranted. This activity is completed according to the UA protocols and TRR UM Guidelines every 90days or more frequently, as needed; and
 - (2) Assignment of diagnosis in CARE is required at any time the primary diagnosis changes and at least annually from the last diagnosis entered into CARE.
- f) The LPHA's determination of diagnosis shall include an interview with the individual and/or guardian/LAR. In order to assign a diagnosis to an individual, documentation by Grantee of the required diagnostic criteria shall be included in Grantee's client record and transmitted to HHSC as part of the required assessment information.
- g) Uniform Assessment (UA) Requirements:
- (1) HHSC-approved UA, which is posted at <https://www.hhs.texas.gov/regulations/forms/3000-3999/form-3042-mh-child-adolescent-needs-strengths-cans-age-3-5>, and <https://www.hhs.texas.gov/regulations/forms/3000-3999/form-3043-mh-child-adolescent-needs-strengths-cans-age-6-17>, for children includes the following instruments:
 - (a) Child and Adolescent Needs and Strengths Assessment (CANS);
 - (b) Community Data;
 - (c) Deviation Reason Required; and
 - (d) Authorized LOC.
 - (2) The above instruments are required to be completed once an individual has been screened and determined in need of assessment from Grantee. The initial assessment is the clinical process of obtaining and evaluating historical, familial, educational, social, functional, psychiatric, and developmental systems involved, or other information from the individual seeking services, in order to determine specific treatment and support needs.
 - (3) Staff administering the instruments shall be a Qualified Mental Health Professional - Community Services (QMHP-CS) and have documented training in the use of the instruments. Staff administering the instruments must have documentation of current certification in the CANS. Certification must be updated annually through a HHSC-approved entity. Grantee can find information related to CANS training and certification requirements posted at:

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<https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/local-mental-health-authorities/child-adolescent-needs-strengths-assessment>.

- (4) The UA shall be administered according to the timeframes delineated in **Information Item C, Service Targets, Outcomes, and Performance Measures**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts> (Child and Adolescent Uniform Assessment).

h) Child Data Submission Requirements:

- (1) Grantee shall submit all required information in compliance with the schedule established by HHSC through either CARE/WebCare or CMBHS, as set forth in the following table:

Required Submission	Approved Data Submission Methods			
	CMBHSONline (Use of the CMBHS web interface)	CMBHS Batch	CARE/WebCare Online	CARE/WebCare Batch
TRR Child UA using the Child and Adolescent Needs Assessment (CANS)	Yes	Yes	No	No
Assignments (Service, Activity, and Destination)	No	No	Yes	Yes
Case Maintenance (Case delete, ID merge, and ID split)	No	No	Yes	No
Client Profile (New and Updated)	Yes	No	Yes	Yes
Diagnosis	Yes	No	Yes	Yes
Follow-up Contact	No	No	Yes	Yes
CARE County of Residence	No	No	Yes	No
Separations	No	No	Yes	No
Consent	Yes	No	N/A	N/A

- (2) Grantee may only batch to CMBHS if Grantee has submitted **Form U, CMBHS Assessment Attestation**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral->

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[health-provider-resources/community-mental-health-contracts](#), regarding data exchange.

- (3) Grantee shall no longer enter, and HHSC will no longer accept, UA information through WebCare or the CARE System.
- (4) UA data must be entered into CMBHS online or through a HHSC-approved data exchange process.

3. Service Requirements:

- a) Grantee shall comply with UA requirements outlined in Section I(C)(2)(g) above. (UA is not required for individuals whose services are not funded with funds paid to Grantee under this Statement of Work).
- b) Children's MH case managers can access and use Texas' Health and Human Services 211, <https://www.211texas.org/cms/>, to facilitate access to a continuum of services both locally and throughout the state.
- c) Grantee shall implement a Patient and Family Education Program (PFEP) in which clients and family are provided with education and educational materials related to diagnosis and medication. Guidelines to meet this requirement are available from the NIMH, and are which is posted at <http://www.nimh.nih.gov/health/index.shtml>. Other alternative guidelines approved by HHSC and posted on the HHSC website at <https://www.hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/behavioral-health-services/texas-resilience-recovery> (on a schedule determined by HHSC) can also be used to satisfy this requirement. If clients and/or their families and caregivers have not been educated about their diagnosis, the reason for the lack of education shall be documented in the clinical progress notes.
- d) Grantee shall apply Texas Resiliency and Recovery (TRR) to all client services funded with contract funds in accordance with the following standards:
 - (1) Provide services in accordance with the most current versions of HHSC's TRR Utilization Management (UM) Guidelines, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual>, the Uniform Assessment (UA), including the CANS, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/local-mental-health-authorities/child-adolescent-needs-strengths-assessment>, and **Information Item V, Crisis Services**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
 - (2) Each child for whom services are requested shall be screened in order to determine if they are part of the children's MH Priority Population and if services are warranted.
 - (3) Children seeking services are assessed in order to determine if they meet the requirements of children's MH Priority Population, and, if so, a full assessment

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shall be conducted and documented using the most current versions of the HHSC UA instruments, including the CANS, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/local-mental-health-authorities/child-adolescent-needs-strengths-assessment>. Individuals whose services are not funded with Contract funds are exempt from inclusion in TRR, regardless of children's MH Priority Population status.

- (4) Make available to each client who is recommended and authorized for a LOC, as indicated by the UA, which includes the CANS, all services and supports within the LOC-A:
 - (a) Any eligible child may not be deviated downward more than one LOC without written documentation supporting clinical need for the deviation. If client and LAR refuse the entire LOC, the child may not be deviated downward more than one LOC without written documentation that the child and LAR have received a detailed explanation of the increased risks that the child may experience by not receiving the appropriate LOC and the impact that providing a lower LOC may have on the treatment outcomes and negative impact on the prognosis of the child. (For example, LOC-4 may not be deviated downward to LOC-1.)
 - (b) Medicaid-eligible children may not have services denied, reduced, suspended, delayed, or terminated due to lack of available resources. If a Medicaid-eligible child, or his/her LAR, refuses the recommended LOC, the child may be served at the next most appropriate LOC.
- (5) Medicaid-eligible children shall be provided with any medically necessary Medicaid-funded MH services within the recommended LOC without undue delay;
- (6) Grantee shall meet all training requirements, as well as require all TRR service subcontractors to meet all training requirements of the EBPs, which is posted at <https://www.hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/behavioral-health-services/texas-resilience-recovery>, prior to the provision of these services and supports as outlined in **Information Item A, Training and Competency**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. Completion of the training requirements shall be documented and maintained by Grantee and Grantee's subcontractors.
- (7) Wraparound Treatment Planning: This is a required component of Intensive Case Management (ICM) and shall be implemented as outlined in Title 26 TAC Chapter 306, Subchapter E. Training requirements are outlined in **Information Item A, Training and Competency**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.

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- (a) Case Managers must provide a Wraparound Planning Process when providing Intensive Case Management in the TRR levels of care where ICM is a core service.
 - (b) Case Managers must provide a Wraparound Planning Process according to the HHSC-approved model, which is posted at <https://www.nwic.org/>, with further information posted at: <https://theinstitute.umaryland.edu/our-work/texas-center/wraparound/>.
 - (c) Grantee shall maintain sufficient staff to provide Wraparound services for eligible children authorized through LOC-4.
- (8) Supervisors of services and supports within the TRR must demonstrate training and competency in evidence-based or promising practices relevant to their roles, as outlined in **Information Item A, Training and Competency**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. Training should be completed within 180 calendar days of assuming supervisory responsibilities. Providers unable to meet this timeline must submit a compliance plan to HHSC.
- (9) Use the UA, which includes CANS, to:
- (a) Document the assessment of individuals seeking services;
 - (b) Reassess current children in services when update assessments are due, which is every 90 days, or when service needs have changed, in order to determine the recommended LOC for a child as indicated in **Information Item C, Services Targets, Outcomes, and Performance Measures**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;
 - (c) Help family partners guide the treatment/recovery plan, and support, and engage families utilizing skills training, education, resources, and advocacy; and
 - (d) Review the recovery plan to determine if the plan adequately assists the individual in achieving recovery through the identified goals, objectives, and needs in collaboration with the child and/or LAR:
 - i. at intervals outlined in the TRR UM Guidelines, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual>;
 - ii. as clinically indicated; or
 - iii. as guided/requested by the individual, LAR, or primary caregiver.
- (10) Grantee shall develop a safety plan in the individual's chart when suicide risk is present.
- (11) Grantee shall set aside Flexible Funds totaling \$1,500 per child for 10% of those children eligible to receive LOC-4 or authorized in Level of Care Residential Treatment Center (LOC-RTC). Use of Flexible Funds should occur in accordance

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with the TRR UM Guidelines. Flexible funds to support family visitation are approved for children authorized in LOC-RTC.

- (12) Grantee shall hire or contract with a Certified Family Partner to provide peer mentoring and support to parents/primary caregivers of children. Certified Family Partners hired or contracted must meet the qualifications outlined in Title 26 TAC §306.305, or the qualifications, as modified under Title 1 TAC Chapter 354, Subchapter N (Peer Specialist Services), during the term of this Contract.
- (14) Grantee shall ensure that the Family Partner:
 - (a) Receives the appropriate training and supervision (by a Qualified Mental Health Professional - Community Services (QMHP-CS) or higher); and
 - (b) Attends the monthly HHSC-scheduled Certified Family Partner (CFP) technical assistance call. Grantee can find the CFP technical assistance call schedule at:
<https://txhhs.sharepoint.com/sites/hhsc/hsosm/iddbhs/bhs/mhppp/mhs/cmhs/cfp/SitePages/Certified-Family-Partners.aspx>.
- (15) Grantee shall identify a person licensed as a QMHP-CS or higher to supervise the Certified Family Partner(s):
 - (a) The CFP Supervisor must successfully complete the Certified Family Partner supervisor's training within one year of assuming this role; and
 - (b) The CFP Supervisor must attend the regularly scheduled HHSC CFP Technical Assistance Call. The CFP Supervisor may delegate attendance to the CFP during the CFP Supervisor's absence.
- (16) Grantee shall serve individuals with funding allocated through the General Appropriations Act, Article II, Community Mental Health Services (*i.e.*, Senate Bill 1, General Appropriations Bill, 89th Texas Legislature, 2025, Article II - HHSC Appropriation D.2.1) for engagement, transition, and intensive ongoing services in accordance with TRR UM Guidelines, which is posted at
<https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual>.
- (17) CARE Report III shall be completed in accordance with **Information Item D, Instructions for Report III**, and submission timelines as outlined in **Information Item S, LMHA/LBHA Submission Calendar**, which are posted at
<https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- (18) Performance measures are outlined below in Section II.
- (19) Grantee shall make family support groups, which shall meet at least on a monthly basis, available to the caregivers of children with serious emotional disturbances.
- (20) Grantee shall maintain access to CMBHS even if Grantee utilizes an approved batch process.

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- e) Submit encounter data for all services according to the procedures, instructions, and schedule established by HHSC, including all required data fields and values in the current version of the HHSC Community Mental Health Service Array. The current version of HHSC Community Mental Health Service Array (*i.e.*, Report Name: INFO Mental Health Service Array Combined) can be found in the Mental and Behavioral Health Outpatient Warehouse (MBOW) in the Consumer Analysis (CA) General Warehouse Information, Specifications subfolder, on HHSC's IAMOnline webpage.
- f) Grantee shall comply with the following Medicaid-related requirements:
 - (1) Contract to be a provider for Medicaid MH Rehabilitative Services and Medicaid MH Case Management;
 - (2) Contract with HHSC to participate in Medicaid Administrative Claiming;
 - (3) Recognize that funding earned through billings to Texas Medicaid & Healthcare Partnership (TMHP) for Medicaid MH Case Management and Medicaid MH Rehabilitative Services represents the federal share and the State match;
 - (4) Submit billing for the provision of Medicaid MH Case Management and Medicaid MH Rehabilitative Services to TMHP in accordance with the Texas Medicaid Provider Procedures Manual, which is posted at <https://www.tmhp.com/resources/provider-manuals/tmppm>; and
 - (5) Adhere to MH Rehabilitative Service delivery requirements outlined in Title 26 TAC Chapter 306, Subchapter F.
- g) Grantee shall utilize non-contract funds and other funding sources (*i.e.*, any person or entity who has the legal responsibility for paying all or part of the services provided, including commercial health or liability insurance carriers, Medicaid, or other Federal, State, or local, or private, funding sources) whenever possible to maximize Grantee's financial resources. Grantee shall comply with the following requirements:
 - (1) Provided the Grantee can reach mutually agreeable terms and conditions with Medicaid and CHIP managed care organizations (MCOs), Grantee shall enter into network provider agreements with and bill MCOs for Medicaid- and CHIP-covered services;
 - (2) Become a Medicaid provider and bill the HHSC claims administrator for Medicaid-covered services provided to traditional Medicaid clients;
 - (3) Provide assistance to individuals to enroll in such programs when the screening process indicates possible eligibility for such programs;
 - (4) Comply with the Charges for Community Services Rule as set forth in Title 26 TAC Chapter 301, Subchapter C *et seq.* (Charges for Community Services), to maximize reimbursement from individuals with an ability to pay for services provided.
 - (5) Maintain appropriate documentation from the third-party payors reflecting attempts to obtain reimbursement;

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- (6) Bill all other funding sources for services provided under this Contract before submitting any request for reimbursement to HHSC; and
- (7) Provide all billing functions at no cost to the client.
- h) Grantee shall use Temporary Assistance for Needy (TANF), and Social Services Block Grant (SSBG or Title XX) funds allocated under 42 USC § 1397 *et seq.* (also known as Title XX of the Social Security Act) for following services as defined in **Information Item G, Service Definitions**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts> :
 - (1) Case management services;
 - (2) Education and Training Services;
 - (3) Counseling services;
 - (4) Health-related and home health services;
 - (5) Special services for clients involved; and
 - (6) Other services meeting the requirement of TANF or Title XX funds as approved by HHSC.
- i) Report this information on **Form L, Expenditures for Title XX Funds**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- j) Grantee shall provide services to all clients without regard to the client's history of arrest, charge, fine, indictment, incarceration, sentence, conviction, probation, deferred adjudication, or community supervision for a criminal offense.
- k) Grantee shall develop and implement written procedures to identify clients and to ensure continuity of screening, assessment, and treatment services provided to individuals with Co-Occurring Psychiatric and Substance Use Disorders (COPSD), in accordance with Title 26 TAC Chapter 306, Subchapter A.
 - (1) Grantee shall ensure that both mental health and substance use needs are being concurrently addressed.
 - (2) Grantee shall for continuity-of-care purposes:
 - (a) Identify available resources (internal and external); and
 - (b) Provide referrals and referral follow-up for ongoing services as clinically indicated to address the client's substance use needs while receiving mental health services, and document in his/her electronic health record.
 - (3) Nothing herein shall prohibit a physician from considering a client's substance use in prescribing medications.
- l) Coordinate Residential Treatment Center (RTC) services as required in **ATTACHMENT A08, RESIDENTIAL TREATMENT CENTER INTEGRATION (MH/RTCI)**, and:

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- (1) Designate a Point of Contact (POC) to coordinate the referral process for children referred to a HHSC-funded RTC, and participate HHSC RTC Technical Assistance Calls as scheduled and conducted by HHSC;
 - (2) Conduct initial and on-going diagnostic assessments with the individual to determine children's MH Priority Population eligibility. (Use of ongoing synchronous audiovisual or synchronous audio-only technology for diagnostic assessments, utilizing data collected from the child, the child's LAR, and/or child's RTC therapist, are only approved for children referred to a HHSC-funded RTC outside of Grantee's LSA);
 - (3) When the child's insurance is unable to cover the cost of a psychological evaluation, Grantee may use funding provided under this Statement of Work to cover the cost of the evaluation for the purpose of admittance into the RTC Project.
 - (4) Enroll the child into Level of Care Residential Treatment Center (LOC-RTC) within 14 calendar days of admission to a HHSC-funded RTC;
 - (5) Provide core services (i.e., routine case management and family partner supports) which are available within the LOC-RTC, as outlined in the TRR UM Guidelines, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual>; and
 - (6) Collaborate with the child, or his/her LAR, and the RTC, to ensure continuity of care and transitional outpatient services post-discharge from a HHSC-funded RTC.
 - (7) Should any indication of IDD, autism, or a related condition from school eligibility or evaluations, other assessments, or concerns from caregivers are present, Grantee must assist the caregiver/LAR to confirm or rule out the diagnosis. If a diagnosis of IDD, autism or related condition is confirmed, Grantee will coordinate with LIDDA and school resources to provide coordinated services and supports for the child and family.
- m) Grantee shall implement crisis services in compliance with the standards outlined in **Information Item V, Crisis Service Standards**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- n) Grantee shall require the Children's Mental Health Director to attend the regularly scheduled HHSC Children's Mental Health Directors Technical Assistance Call, or any other Children's Mental Health Director-specific calls as scheduled and conducted by HHSC, upon which Grantee will be notified by written communication.

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SECTION II. SERVICE TARGETS, OUTCOMES, AND PERFORMANCE MEASURES

- A.** Grantee shall meet the service targets, performance measures, and outcomes outlined below. Detailed information pertaining to calculations and data sources can be found in **Information Item C, Service Targets, Outcomes, and Performance Measures**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- B.** Remedies and Sanctions associated with these service targets, performance measures, and outcomes will be imposed in accordance with the terms included in this Statement of Work or Article V of **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.

C. At-Risk Performance Measures

Ten percent of general revenue funds allocated from the General Appropriations Act, Article II, Community Mental Health Services (*i.e.*, Senate Bill 1, General Appropriations Bill, 89th Texas Legislature, 2025, Article II - HHSC Appropriation D.2.1) appropriations are held at risk and subject to recoupment if Contractor does not meet At-Risk Performance Measure targets.

With the exception of the Adult Improvement and Child Improvement measures, At-Risk Measures shall be assessed 37 calendar days following the close of Quarter 2 (measuring Quarters 1 and 2) and Quarter 4 (measuring Quarters 3 and 4). The Adult Improvement and Child Improvement measures shall be assessed 37 calendar days following the close of Quarter 4 (measuring Quarters 1 through 4). Quarters start September 1st of each year and end August 31st of each year.

The Adult Improvement and Child Improvement measures are weighted at 2.0 percent of total general revenue funding; the remaining measures are weighted equally at 1.2 percent of general revenue funding. If the Grantee does not meet the annual targets for the Adult Improvement and/or Child Improvement measures, then HHSC shall recoup a percentage of Grantee's general revenue funding for the current fiscal year (Quarters 1 through 4). For each of the remaining outcome targets Grantee does not meet, HHSC shall recoup a percentage of Grantee's general revenue funding for the current two quarters. Funding shall be recouped from the Adult, Child, and Crisis strategies in proportion to the percentage of funding in each strategy. Grantees meeting all At-Risk Measure targets may be eligible for redistribution of recouped general revenue funds.

1. Adult Improvement: At least 32.5% of adults recommended and authorized into a Full Level of Care (FLOC) shall show improvement in at least one of the following ANSA domains/modules: Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Strengths, Adjustment to Trauma, or Substance Use.
 - a) If the percentage improved is at least 30.9% but less than 32.5%, the amount

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- recouped is 0.4%.
- b) If the percentage improvement is at least 29.3% but less than 30.9%, the amount recouped is 0.8%.
 - c) If the percentage improved is at least 27.6% but less than 29.3%, the amount recouped is 1.2%.
 - d) If the percentage improved is at least 26.0% but less than 27.6%, the amount recouped is 1.6%.
 - e) If the percentage improved is less than 26.0%, the amount recouped is 2.0%.
2. Child Improvement: At least 42.8% of children recommended and authorized in a FLOC shall show reliable improvement in at least one of the following CANS domains/modules: Child Risk Behaviors, Child Behavioral and Emotional Needs, Life Domain Functioning, Child Strengths, Adjustment to Trauma, or Substance Use.
- a) If the percentage improved is at least 40.7% but less than 42.8%, the amount recouped is 0.4%.
 - b) If the percentage improved is at least 38.5% but less than 40.7%, the amount recouped is 0.8%.
 - c) If the percentage improved is at least 36.4% but less than 38.5%, the amount recouped is 1.2%.
 - d) If the percentage improved is at least 34.2% but less than 36.4%, the amount recouped is 1.6%.
 - e) If the percentage improved is less than 34.2%, the amount recouped is 2.0%.
3. School Performance: At least 65.2% of children authorized in a FLOC shall have acceptable or improved school performance.
- a) If the percentage improved is at least 61.9% but less than 65.2%, the amount recouped is 0.24%.
 - b) If the percentage improved is at least 58.7% but less than 61.9%, the amount recouped is 0.48%.
 - c) If the percentage improved is at least 55.4% but less than 58.7%, the amount recouped is 0.72%.
 - d) If the percentage improved is at least 52.2% but less than 55.4%, the amount recouped is 0.96%.
 - e) If the percentage improved is less than 52.2%, the amount recouped is 1.2%.
4. Community Tenure: At least 98.2% of individuals (adults and children) authorized in a FLOC shall avoid hospitalization in a HHSC Inpatient Bed throughout the measurement period.
- a) If the percentage avoiding hospitalization is at least 93.3% but less than 98.2%, the amount recouped is 0.24%.

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- b) If the percentage avoiding hospitalization is at least 88.4% but less than 93.3%, the amount recouped is 0.48%.
 - c) If the percentage avoiding hospitalization is at least 83.5% but less than 88.4%, the amount recouped is 0.72%.
 - d) If the percentage avoiding hospitalization is at least 78.6% but less than 83.5%, the amount recouped is 0.96%.
 - e) If the percentage avoiding hospitalization is less than 78.6%, the amount recouped is 1.2%.
5. Effective Crisis Response: At least 78.6% of crisis episodes during the measurement period shall not be followed by admission to an HHSC Inpatient Bed within 30 days of the first day of the crisis episode.
- a) If the percentage avoiding hospitalization is at least 74.7% but less than 78.6%, the amount recouped is 0.24%.
 - b) If the percentage avoiding hospitalization is at least 70.7% but less than 74.7%, the amount recouped is 0.48%.
 - c) If the percentage avoiding hospitalization is at least 66.8% but less than 70.7%, the amount recouped is 0.72%.
 - d) If the percentage avoiding hospitalization is at least 62.9% but less than 66.8%, the amount recouped is 0.96%.
 - e) If the percentage avoiding hospitalization is less than 62.9%, the amount recouped is 1.2%.
6. Hospital 7-Day Follow-up: At least 57.4% of individuals discharged from a state hospital, an HHSC Contracted Bed, a CMHH, or a PPB shall receive a service contact within 0-7 calendar days of discharge.
- a) If the percentage avoiding hospitalization is at least 54.5% but less than 57.4%, the amount recouped is 0.24%.
 - b) If the percentage avoiding hospitalization is at least 51.7% but less than 54.5%, the amount recouped is 0.48%.
 - c) If the percentage avoiding hospitalization is at least 48.8% but less than 51.7%, the amount recouped is 0.72%.
 - d) If the percentage avoiding hospitalization is at least 45.9% but less than 48.8%, the amount recouped is 0.96%.
 - e) If the percentage avoiding hospitalization is less than 45.9%, the amount recouped is 1.2%.
7. Crisis 7-Day Follow-up: At least 21.4% of adults and children in LOC-A 0 shall receive a follow-up service contact within 1-7 calendar days after the date of the last crisis service in the crisis episode.
- a) If the percentage receiving follow-up is at least 20.3% but less than 21.4%, the

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amount recouped is 0.24%.

- b) If the percentage receiving follow-up is at least 19.3% but less than 20.3%, the amount recouped is 0.48%.
- c) If the percentage receiving follow-up is at least 18.2% but less than 19.3%, the amount recouped is 0.72%.
- d) If the percentage receiving follow-up is at least 17.1% but less than 18.2%, the amount recouped is 0.96%.
- e) If the percentage receiving follow-up is less than 17.1%, the amount recouped is 1.2%.

D. Adult Services

With the exception of the High-Need Adult Functioning measure, adult service performance measures shall be assessed 37 calendar days following the close of Quarter 2 (measuring Quarters 1 and 2) and Quarter 4 (Measuring Quarters 3 and 4). The High-Need Adult Functioning measure shall be assessed 37 calendar days following the close of Quarter 4 (measuring Quarters 1 through 4). Quarters start September 1st of each year and end August 31st of each year. Remedies and sanctions associated with failure to achieve the following measures are specified in Article V of **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, as applicable.

1. Adult Service Target:

Target is 23,677. This target equals the average monthly number of adults authorized in a FLOC. The statewide performance level for this target is 100%.

2. Adult Monthly Service Provision:

An average of at least 49.6% of adults authorized in a FLOC shall receive at least one encounter each month. FLOCs included in this measure are LOC-1S, LOC-2, LOC-3, LOC-4, and LOC-TAY. LOC-1M is excluded from this measure. Additionally, individuals who are both recommended and authorized for LOC-1S are excluded from this measure. Encounters may be for any service and for any length of time.

3. Depression Response at Six Months:

At least 15.1% of adults authorized in a FLOC with a diagnosis of major depression and an initial Quick Inventory of Depressive Symptomatology (QIDS) score greater than or equal to 11 shall have a follow-up QIDS score at six months that is reduced by 50% or greater from the initial QIDS score and is less than or equal to 7.

4. Educational or Volunteering Strengths:

At least 28.4% of adults authorized in a FLOC shall have acceptable or improved employment-preparatory skills as evidenced by either the Educational or Volunteering Strengths items on the ANSA.

5. Employment Functioning:

At least 51.7% of adults authorized in a FLOC shall have acceptable or improved

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functioning on the ANSA Employment item.

6. High-Need Adult Functioning:

At least 17.6% of adults authorized in a FLOC and recommended for LOC-3 or LOC-4 shall have acceptable or improved functioning in the Life Domain Functioning or the Strengths domains of the ANSA. HHSC will not employ remedies or sanctions for failure to achieve this measure during fiscal year 2026.

7. Residential Stability:

At least 82.4% of adults authorized in a FLOC shall have acceptable or improved functioning on the ANSA Residential Stability item.

8. Adults Served with TANF or Title XX:

Expected Fiscal Year targets are listed in **Information Item C, Service Targets, Outcomes, and Performance Measures**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.

E. Child Services

Children's service performance measures shall be assessed 37 calendar days following the close of Quarter 2 (measuring Quarters 1 and 2) and Quarter 4 (Measuring Quarters 3 and 4). Quarters start September 1st of each year and end August 31st of each year. Remedies and sanctions associated with failure to achieve the following measures are specified in Article V of **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, as applicable.

1. Child Service Target:

Target is 8,173. This target equals the average monthly number of children authorized in a FLOC or LOC-Y (YES Waiver). The statewide performance level for this target is 100%.

2. Child Monthly Service Provision:

An average of at least 64.5% of children authorized in a FLOC or LOC-Y (YES Waiver) shall receive at least one encounter each month. Encounters may be for any service and for any length of time.

3. Family and Living Situation:

At least 72.6% of children authorized in a FLOC shall have acceptable or improved functioning on the CANS Family and Living Situation items.

4. Family Partner Response:

At least 56.2% of children authorized in a FLOC who receive any Family Partner Support Service, as defined in Information Item C, shall have acceptable or improved functioning in one or more of the following CANS Caregiver Strengths & Needs domain items: Family Stress, Involvement, or Knowledge. HHSC will not employ

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remedies or sanctions for failure to achieve this measure during fiscal year 2026.

5. Children Served with TANF or Title XX Funds:

Expected Fiscal Year targets are listed in **Information Item C, Service Targets, Outcomes, and Performance Measures**, which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.

F. Crisis Services

Crisis service performance measures shall be assessed 37 calendar days following the close of Quarter 2 (measuring Quarters 1 and 2) and Quarter 4 (Measuring Quarters 3 and 4). Quarters start September 1st of each year and end August 31st of each year. Remedies and sanctions associated with failure to achieve the following measures are specified in Article V of **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, as applicable.

1. Access to Crisis Response Services:

At least 69.9% of crisis hotline calls shall result in an encounter on the same day or within one day of a hotline call.

2. Hospital 30-Day Readmission:

No more than 11.3% of those discharged from a state hospital, an HHSC Contracted Bed, a CMHH, or a PPB and reassigned to the LMHA/LBHA shall be readmitted to an HHSC Inpatient Bed within 30 days of discharge.

G. YES Waiver

1. Inquiry List Submission:

At least 80% of preferred Inquiry List Templates shall be submitted according to the schedule outlined in the YES Manual, which is incorporated by reference and posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>).

2. Inquiry List – Clinical Eligibility Assessment:

At least 90% of individuals who meet demographic eligibility criteria shall receive a clinical eligibility assessment for YES Waiver within seven business days of meeting demographic eligibility criteria.

3. Inquiry List – Return Calls:

100% of individuals who inquire about YES Waiver services shall receive a return call according to the schedule outlined in the YES Manual, which is incorporated by reference and posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>).

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PERFORMANCE CONTRACT NOTEBOOK (MH/PCN), VERSION 1**

4. Critical Incident Reporting:

At least 90% of critical incidents shall be submitted according to the schedule outlined in the YES Manual, which is incorporated by reference and posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>).

5. Wraparound Provider Organization Caseload Ratios:

At least 90% of YES Waiver wraparound facilitator staff shall meet the Wraparound facilitator-to-client ratio of one facilitator to ten clients.

6. Transition Plan Development and Submission:

At least 90% of individuals aging out, transitioning to a different LOC, or graduating shall have a Transition plan that was developed and submitted within required timeframes outlined in the YES Manual, which is incorporated by reference and posted at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers>).

7. Wraparound Staff Training and Credentialing:

At least 90% of Wraparound staff and subcontractor files shall be compliant with employment checks and training requirements.

SECTION III. PAYMENT METHOD

Quarterly Allocation

SECTION IV. OUTCOME IF GRANTEE CANNOT COMPLETE REQUIRED PERFORMANCE

Unless otherwise specified in this Statement of Work, if Grantee cannot complete or otherwise comply with a requirement included in this Statement of Work, HHSC, at its sole discretion, may impose remedies or sanctions outlined under **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 5.09 (Remedies, Sanctions, and Liquidated Damages).

ATTACHMENT A03

CONSUMER OPERATED SERVICE PROGRAM (MH/COS), VERSION 1

CONTRACT NO. HHS001598600026
GRANTEE: NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

SECTION I. PURPOSE

The purpose of this Statement of Work is to enhance and expand peer supported outreach and programming to individuals who currently receive, have received, or are at significant risk of requiring mental health support services. Peer-led organizations such as Consumer Operated Service Programs (COSP) or Recovery Community Organizations (RCOs) are evidence-based programs directed, administratively controlled, and managed by individuals with lived mental health experiences. Peer-led organizations offer recovery-based and person-centered support services through certified peer specialists in non-clinical settings.

SECTION II. GRANTEE RESPONSIBILITIES

Grantee shall serve as the contract manager for the COSP or RCO, and shall:

1. Renew or enter into a subcontract with a peer-run organization (Subcontractor) for the development, maintenance, or expansion of a COSP or RCO. This subcontract will specify the services to be provided by the COSP that will supplement services provided by Grantee.
2. Develop, maintain, and implement written procedures for monitoring Subcontractor, and collaborate with Subcontractor to revise procedures, as necessary throughout the Contract's term.
3. Monitor, support, and report Subcontractor's provision of peer-led programs and services that support and enhance the capacity and impact of peer services.
4. Maintain a contract administration system to monitor how Subcontractor performs in accordance with the terms, conditions, and specifications of its subcontract. The system shall include but is not limited to the following:
 - a. Quarterly meetings with Subcontractor;
 - b. Review and monitoring of expenditures;
 - c. Review and monitoring of Service provision as advertised on organizations website, promotional materials and as reported on
 - d. Ensure Governing or advisory board(s) activity to verify members are trained and informed of their responsibilities and obligations under Subcontractor's subcontract, and that meetings are occurring quarterly, at a minimum;
 - e. Ensure Subcontractors compliance with all applicable rules adopted by the System Agency related to [Peer Specialist Services](#); and
 - f. Ensure Subcontractors participation in required training, technical assistance, and research efforts.
5. Ensure that services are peer-led and are in alignment with the Substance Abuse and Mental Health Services Administration's (SAMHSA):
 - a. Guidance on Allowable Recovery Support Services (RSS), which can be found at <https://library.samhsa.gov/sites/default/files/pep12-recdef.pdf> and/or
 - b. Consumer Evidence-Based Practices Kit, which can be found at: <https://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633>
6. Ensure the COSP or RCO provides a broad range of peer support services to people experiencing mental health challenges, such as one-on-one and group peer support,

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CONSUMER OPERATED SERVICE PROGRAM (MH/COS), VERSION 1

computer training, supported employment, skills training, and linkages to transitional housing.

7. Ensure all COSP or RCO staff or contracted providers that deliver services and support are certified as peer specialists and/or peer specialist supervisors in accordance with Title 1, Texas Administrative Code, Part 15, Chapter 354, Subchapter N ([Peer Specialist Services](#)) regardless of the organization's ability to bill Medicaid. If not currently certified as a peer specialist or peer specialist supervisor, staff or contracted providers must be certified within six months of the Contract's effective date. Peer specialist and peer specialist supervisor certification can be confirmed either by the submission of the certification to Grantee, or by confirming certification at with Texas Certification Board, found at <https://www.tcbap.org/>. Other mental health or substance use licenses and/or certifications may not be substituted for peer specialist and peer supervisor certification. Training and certification information can be found at PeerForce, found at <https://peerforce.org/>, or by contacting the Peer Support and Recovery mailbox at BHS_PeerServices@hhs.texas.gov.
8. Ensure that services are delivered at the times and locations posted on the organization's website.
9. Grantee shall ensure sub-contractors maintain a physical location that is easily accessible to the public, including individuals with disabilities. Sub-contractors shall display visible signage at all building sites and entrances indicating the organization's name, contact information, hours of operation, and services provided. This information must be current and listed on all social media platforms, websites, and any public-facing materials associated with the organization. The program is designed for in-person service delivery, with virtual and telephonic services intended to supplement and support in-person services, not replace them.
10. Grantee shall ensure sub-contractors emergency support is available after hours and during weekends via telephone and virtual support by certified peer specialists. Sub- contractor will post telephone and virtual support information at all building entrances.
11. Grantee shall ensure sub-contractors provide flexible hours of services based on the needs of individuals seeking services.
12. Ensure that services are delivered at the times and locations posted on the organizations website;
13. Require the Subcontractor to participate in any training and technical assistance provided by or monitored by HHSC, or its contractors, with relevance to the consumer operated service program providers, such as peer training and certification through the state-approved training and certification body.
14. Require Subcontractors to participate in all research efforts to include staff, Board and program participant surveys, interviews and/or site visits complete and submit in a timely manner all surveys, requests for interviews provided by or monitored by HHSC, or its contractors, with relevance to the peer-led program providers.
15. Require Subcontractor to submit monthly expense reports to Grantee to document Subcontractor's allowable costs for the month. The monthly expense reports shall include copies of receipts for Subcontractor's expenses. If requested by HHSC, submit detailed accounting of Subcontractor costs that have been reimbursed by Grantee.
16. Ensure that Subcontractor does not provide direct cash assistance to program participants or family members for:
 - a. Health services;

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- b. Housing/rental assistance;
- c. Utility services assistance;
- d. Tuition, fees, or educational related costs for secondary school, college, technical school or other educational institutions;
- e. Computer equipment, software, Wi-Fi; and
- f. Transportation (funding is limited to bus pass, Uber, Lyft or Taxicab vouchers).

SECTION III. PERFORMANCE MEASURES

The terms of this Statement of Work, including the following performance measures, will be used to assess Grantee's effectiveness in providing the services described in this Statement of Work.

- A. Grantee shall submit to HHSC a copy of the executed contract between Grantee and Subcontractor by the due date in the Submission Calendar located in Information Item S; which is posted at <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- B. Grantee shall submit **Form N, Consumer Operated Services Program Report**, monthly to HHSC according to the **Information Item S, LMHA/LBHA Submission Calendar**, both of which are incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- C. Within 10 days of execution of the contract between Grantee and Subcontractor, Grantee shall submit to HHSC a copy of Grantee's written monitoring procedures. Whenever Grantee deems it necessary to revise the procedures, Grantee shall submit a copy of the revised procedures to HHSC.
- D. Grantee shall submit all reports electronically to the Performance Contract Mailbox at performance.contracts@hhs.texas.gov with a copy to the assigned HHSC Contract Manager.
- E. Grantee shall submit a detailed accounting of Subcontractor costs that have been reimbursed by Grantee no later than 20 business days after Grantee receives a written request from HHSC.

SECTION IV. PAYMENT METHOD

Quarterly Allocation

SECTION V. BUDGET

During the term of this Contract, Grantee shall pay Subcontractor in advance approximately one-twelfth of the Subcontractor's total annual budget per month for costs associated with the operation of a COSP or RCO within Grantee's local service area. Grantee may pay Subcontractor more than the one-twelfth monthly payment amount if Subcontractor incurs one-time costs during a month, such as for insurance. However, Subcontractor payments shall not exceed 25 percent of the total annual budget of this Statement of Work in a quarter. Grantee shall return any unspent funds to HHSC as required by **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 2.06 (Return of Funds).

**ATTACHMENT A03
CONSUMER OPERATED SERVICE PROGRAM (MH/COS), VERSION 1**

**SECTION VI. OUTCOME IF GRANTEE CANNOT COMPLETE REQUIRED
PERFORMANCE**

Unless otherwise specified in this Statement of Work, if Grantee cannot complete or otherwise comply with a requirement included in this Statement of Work, HHSC, at its sole discretion, may impose remedies or sanctions outlined under **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 5.09 (Remedies, Sanctions, and Liquidated Damages).

ATTACHMENT A05

OUTPATIENT COMPETENCY RESTORATION (MH/OCR), VERSION 1

CONTRACT NO. HHS001598600026
GRANTEE: NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

SECTION I. PURPOSE

Outpatient Competency Restoration (OCR) programs provide community-based competency restoration services, which include mental health and substance-use treatment services, as well as competency education, for individuals found Incompetent to Stand Trial (IST). In general, OCR programs are designed to:

1. Reduce the number of individuals determined to be IST with mental illness or co-occurring psychiatric and substance-use disorders on the HHSC clearinghouse waiting list for inpatient competency restoration services.
2. Increase prompt access to clinically appropriate OCR services for individuals determined to be IST who do not require the restrictiveness of a hospital setting.
3. Reduce the number of bed-days in state hospitals or contracted inpatient mental health facilities used by forensic patients from the Grantee's local service area.

SECTION II. GRANTEE RESPONSIBILITIES

Grantee shall deliver an OCR program ("Program") in accordance with the following requirements:

1. Comply with applicable statutes and rules, including those referenced in this Statement of Work (SOW): Title 26 of the Texas Administrative Code (TAC) Chapter 301, Subchapter G, the Texas Code of Criminal Procedure (CCP) Chapter 46B and Title 4 of the Texas Health and Safety Code (HSC) Chapter 247.
2. Serve 75 clients each fiscal year, all admitted within the fiscal year, with mental illness or co-occurring psychiatric and substance-use disorders (COPSD) by providing OCR services as measured and documented through the Encounter Data and WebCARE reports defined in Section III (below) of this SOW.
3. For individuals who have completed the program, achieve a combined total rate of 40% of either restored to competency to stand trial, as determined by the court, or charges dropped.
4. Maintain an average length of stay of no longer than 180 days for all individuals admitted during the fiscal year.
5. Recruit, train, and maintain qualified staff. All staff must be solely dedicated to the Program and may not serve in any other capacity, unless approved by Health and Human Services Commission (HHSC). This includes the Program Coordinator and any additional staff providing program services.
6. Recruit, train, and maintain a Program Coordinator, who must be a Licensed Practitioner of the Healing Arts (LPHA), as defined in 26 Texas Administrative Code (TAC), Part 1, Chapter 301, Subchapter G, unless an exception is approved by HHSC, who shall work as a liaison with the local criminal justice system in the Grantee's area.
7. If available, coordinate peer support services with qualified peer support staff.

ATTACHMENT A05 OUTPATIENT COMPETENCY RESTORATION (MH/OCR), VERSION 1

8. OCR case manager shall coordinate specialty care as applicable with Program participants . Specialty care refers to health services that focus on a specific area of medicine or group of patients with specific types of symptoms and conditions. Specialty care providers include doctors as well as other specialists such as nurses and physical therapists.
9. To determine an individual's appropriateness for OCR treatment, provide prompt screening for Program eligibility by:
 - a) conducting an eligibility and intake assessment;
 - b) conducting a psychosocial assessment;
 - c) administering the HHSC Substance Use Screening Tool;
 - d) administering a risk assessment such as the Historical, Clinical, Risk Management, and Violence Risk Assessment Scheme (HCR-20); and
 - e) administer, if appropriate, the Outreach, Screening, Assessment, and Referral measure.
10. If a substance-use issue is identified, provide referral and access to substance-use treatment within 21 days to include inpatient or outpatient treatment.
11. Upon notification of an individual's commitment to OCR, complete a uniform assessment in compliance with **Information Item R, Texas Resilience and Recovery (TRR) Utilization Management Guidelines**, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual>, and a treatment plan. The treatment plan shall address:
 - a) physical health concerns and issues;
 - b) medication and medication management;
 - c) level of family and community support;
 - d) COPSD concerns or issues;
 - e) supported housing, including rental and utility subsidy;
 - f) transportation; and
 - g) assistance with benefits applications (if applicable).
12. Update the individualized treatment plan within five (5) business days of an individual's enrollment in the Program to include all assessments.
13. Grantee's program staff shall work with courts and law enforcement personnel to secure release to Grantee during the standard operating hours of Grantee that fall within daylight hours to avoid nighttime releases of incarcerated individuals. Program staff shall coordinate the timely release of the individual to the Local Mental Health Authority (LMHA), or Local Behavioral Health Authority (LBHA), or the individual's place of residence while in the program, and shall meet with the individual upon jail or court release regardless of time of release. Program staff shall provide documented services to the individual on the day of release from jail.
14. Maintain written policies and procedures that describe the eligibility for the program, intake assessment, and treatment planning processes. The policies and procedures shall also address admission of individuals referred by other LMHAs or LBHAs. Such policies shall include individuals who are in close proximity to the program and who are without a program in their services-area and are potentially appropriate for admission. Any admission requires the

ATTACHMENT A05 OUTPATIENT COMPETENCY RESTORATION (MH/OCR), VERSION 1

consent of the courts with jurisdiction over the individual as well as cooperation with the admitting LMHA or LBHA.

15. Upon receipt of the order for competency restoration services and/or notification from the court, provide the first service within 24 hours of such notification. Grantee shall provide individuals in the Program access to TRR Level of Care 3 or 4 psychosocial services and supports where clinically appropriate. Grantee shall also provide individuals in the program access to a physician, preferably a psychiatrist, no later than seven (7) business days after release from jail or court.
16. Grantee shall meet or exceed the minimum expected hours associated with authorized levels of care as outlined in the TRR Utilization Management Guidelines, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual> to promote successful outcomes. The majority of the rehabilitative hours shall be provided in the individual's home or in the Grantee's office location.
17. Provide, or engage other educators to provide, competency didactic education for all individuals following HHSC-approved competency restoration curricula, based on the needs of the individual.
18. Provide supported housing, including rental subsidies, for individuals in the Program who lack adequate housing. Supported housing does not include support for individuals to live in assisted living facilities that are not licensed under Texas Health and Safety Code (HSC) Chapter 247.
19. Screen eligible individuals for permanent supportive housing and basic rental assistance programming (*e.g.*, Project Access, rental assistance) offered by the LMHA or LBHA if funding for such programs is available.
20. Provide in-person services at least twice weekly for individuals served in the program to ensure participation, promote adherence to treatment, and assess that the individual's living environment is safe and that his or her basic needs, such as food, clothing, and hygiene, are being met. Synchronous audio-visual services may be used if clinically appropriate and when it is the only feasible option to ensure service requirements are met.
21. Maintain and follow written procedures to monitor an individual's restoration to competency and readiness for return to court. Comply with reporting procedures specified in CCP Article 46B.079. Coordinate with the court to timely determine an individual's competency. Grantee's written procedures shall also address requests for a court order extending the initial restoration period from the court and competency re-evaluation in the event an extension is granted.
22. Contact the state hospital and contracted inpatient competency restoration provider, if applicable, and the LMHA, or LBHA, Utilization Manager(s) a minimum of once a week to identify IST individuals currently in the hospital on an inpatient competency restoration commitment and who may be appropriate for transition to the OCR Program. Petition local courts to revise commitment status for those identified individuals; and work jointly with all parties to develop a discharge and continuity plan.
23. Document attempts monthly to meet with representatives from the District Attorney's Office, key judges involved with competency restoration commitments, and other criminal justice

ATTACHMENT A05 OUTPATIENT COMPETENCY RESTORATION (MH/OCR), VERSION 1

agencies, including but not limited to local, county, and state law enforcement agencies located in local service area, for the following purposes:

- a) identification of individuals pending initial orders of competency restoration commitment who could be served through the program;
 - b) identification of individuals currently receiving competency restoration treatment in an inpatient setting whose order of commitment can be modified for a continuation of treatment in an outpatient setting; and
 - c) to provide general education related to crisis services and mental health programs available as diversions to incarceration and hospitalization.
24. During the duration of commitment, an OCR provider must evaluate the individual's progress and report to the court as outlined in 26 TAC, Part 1, Chapter 307, Subchapter D, Rule §307.163.
25. Provide continuity of care for individuals completing the program as required by 26 TAC, Part 1, Chapter 307, Subchapter D, Rule §307.165. All discharge planning activities shall be documented in the individual's record.
26. Provide continuity of care for persons who do not complete the Program or who are determined to have not restored to competency. Grantee shall document the reason for non-completion of the Program (*e.g.*, failed to restore, absconded, re-offended or otherwise terminated before completing Program) using the Outpatient Competency Restoration Admission (*i.e.*, screen 358) and Discharge (*i.e.*, screen 359) screens in WebCARE, which is located at the following link:
https://hhsportal.hhs.state.tx.us/helpGuide/Content/16_CARE/CAREWebCARE%20Reference%20Manual.htm.
27. Prior to an individual being released from the program, work closely with courts to encourage timely resolution of legal issues.
28. Grantee shall provide HHSC with the contact information of all dedicated Program staff on **Form S, Contact List**. Changes in program coordinating staff must be reported to HHSC within 72 hours of any change.

SECTION III. PERFORMANCE MEASURES

HHSC shall use the terms of this Statement of Work, including without limitation, the following performance measures, to assess Grantee's effectiveness in providing the services described in this Statement of Work. Grantee shall perform the following activities and provide documentation to HHSC in the manner and timeframes specified below.

1. In accordance with the timetable and frequency specified in CCP Articles 46B.077 and 46B.079, and as determined by the court who has jurisdiction over individuals in the program, Grantee shall provide the required notices and reports to the court.
2. Grantee shall submit encounter data for all services according to the procedures, instructions, and schedule established by HHSC, including all required data fields and values in the current version of the HHSC Community Mental Health Service Array. The current version of HHSC Community Mental Health Service Array (*i.e.*, Report Name: INFO Mental Health Service

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OUTPATIENT COMPETENCY RESTORATION (MH/OCR), VERSION 1

Array Combined) can be found in the Mental and Behavioral Health Outpatient Warehouse (MBOW), in the General Warehouse Information, Specifications subfolder, incorporated by reference and posted on HHSC's IAMOnline page: <https://iamonline.hhs.state.tx.us>

3. For facility-based programs, Grantee shall follow all guidelines as put forth in **Information Item V, Crisis Standards**, incorporated by reference and posted at: <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
4. Grantee shall submit a budget on **Form P, Various Programs**, in accordance with **Information Item S, LMHA/LBHA Submission Calendar**, both of which are incorporated by reference and posted at: <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, to be approved by HHSC.
5. Grantee shall enter and submit required data in WebCARE for OCR services using the admission (*i.e.*, screen 358) and Discharge (*i.e.*, screen 359) screens within 72 hours of all individuals' Program admission or discharge.
6. Grantee shall submit the **Form I, OCR Quarterly Budget Expenditure Report**, in accordance with **the Information Item S, LMHA/LBHA Submission Calendar**, both of which are incorporated by reference and posted at: <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
7. Grantee shall report expenditure data on the Client Assignment and Registration (CARE) **Report III-IV 2024**, incorporated by reference and posted at: <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, within Strategy B.2.3 using line 760 – Crisis Services, Outpatient Competency Restoration.
8. Grantee shall submit reports in accordance with the **Information Item S, LMHA/LBHA Submission Calendar**, incorporated by reference and posted at: <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
9. Grantee shall submit to HHSC a copy of all written policies and procedures required by this Statement of Work, in accordance with the **Information Item S, LMHA/LBHA Submission Calendar**, incorporated by reference and posted at: <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, to be approved by HHSC.
10. Upon request by HHSC, Grantee shall submit documentation of:
 - a) attempts to meet with representatives from the District Attorney's Office, key judges involved with competency restoration commitments, and other criminal justice agencies, including but not limited to local, county, and state law enforcement; and
 - b) written updates on OCR-committed individuals' progression in the program.
11. Grantee shall submit deliverables required by HHSC to Performance.Contracts@hhs.texas.gov with a copy to the assigned HHSC Contract Manager.

ATTACHMENT A05
OUTPATIENT COMPETENCY RESTORATION (MH/OCR), VERSION 1

12. Grantee's Local Service Area includes the following Texas Counties: Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall.

SECTION IV. PAYMENT METHOD

Quarterly Allocation.

SECTION V. FUNDING

1. HHSC may adjust funds or reduce funding on a one-time or permanent basis based on utilization and statewide needs.
2. Grantee may transfer money between direct cost categories of this Statement of Work, without prior approval, but after notifying HHSC Contract Manager of the transfer in writing, and subject to the following restrictions:
 - a) No budget category transfer or cumulative transfers may exceed 10% of the total value of this Statement of Work; and
 - b) A formal Contract Amendment is required if the budget category transfer(s) or cumulative transfers exceed 10% of the value of this Statement of Work.
3. If Grantee's total allowable expenditures for the term of this Contract are less than the total amount disbursed by HHSC in Grantee's four quarterly allocations, Grantee shall be subject to recoupment of the difference between the total amount of state fiscal year allocation disbursed by HHSC and Grantee's state fiscal year total expenditures.
4. If by the end of the second quarter of each state fiscal year (February 28th, or February 29th on leap years) Grantee has not expended at least 70% of Quarter 1 and Quarter 2 combined allocations, HHSC may recoup the difference between the 70% benchmark and the Grantee's expenditures for Quarter 1 and Quarter 2.

SECTION VI. OUTCOME IF GRANTEE CANNOT COMPLETE REQUIRED PERFORMANCE

Unless otherwise specified in this Statement of Work, if Grantee cannot complete or otherwise comply with a requirement included in this Statement of Work, HHSC, at its sole discretion, may impose remedies or sanctions outlined under **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 5.09 (Remedies, Sanctions, and Liquidated Damages).

**ATTACHMENT A07
PRIVATE PSYCHIATRIC BEDS (MH/PPB), VERSION 1**

**CONTRACT NO. HHS001598600026
GRANTEE: NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY**

SECTION I. PURPOSE

The purpose of this Statement of Work is to support the provision of inpatient mental health hospital services staffed with medical and nursing professionals who provide 24-hour professional monitoring, supervision and assistance in an environment designed to provide safety and security during an acute behavioral health crisis. Staff provides intensive interventions designed to relieve acute symptomatology and restore the patient's ability to function in a less restrictive setting.

SECTION II. GRANTEE RESPONSIBILITIES

A. GENERAL

1. Grantee shall expend funds allocated under this Statement of Work on the provision of inpatient mental health services located at a licensed psychiatric hospital (the "Hospital").
2. Grantee shall require the Hospital to provide Grantee with evidence that it maintains, throughout the term of this Statement of Work, a license as a private psychiatric hospital in accordance with Chapter 577 of the Texas Health and Safety Code and with Title 26 Texas Administrative (TAC) Chapter 510 (Private Psychiatric Hospitals and Crisis Stabilization Units), or a General or Special Hospital in accordance with Chapter 241 of the Texas Health and Safety Code and with Title 26 TAC Chapter 505 (Hospital Licensing).
3. Grantee shall require the Hospital to provide Grantee with evidence that it maintains, throughout the term of this Contract, its accreditation with The Joint Commission (TJC), or other accrediting body granted deeming authority by the Centers for Medicare and Medicaid Services (CMS), as a hospital.
4. Grantee shall designate a point of contact who shall be responsible for all communication, correspondence, and reporting to the Health and Human Services Commission (HHSC) and who must accompany HHSC personnel on all site visits scheduled with the Hospital during the term of this Statement of Work.
5. Grantee shall respond to capacity management contacts initiated by HHSC within one hour.
6. Grantee shall require the Hospital to notify Grantee no later than 90 calendar days prior to discontinuing the provision of inpatient mental health services at the Hospital.
7. If Grantee determines that the safety and well-being of patients served by the Hospital is in jeopardy, Grantee shall make arrangements, including all appropriate or required consents or notifications, to transfer the patients to another hospital that meets the requirements outlined in Section II(A)(2- 3) of this Statement of Work and shall notify HHSC immediately.
8. Funds allocated and paid under this Statement of Work, once any available third-party insurance, indigent care programs, or other local medical care programs are exhausted, must cover the costs for all medical care and treatment including the cost of psychiatric and

**ATTACHMENT A07
PRIVATE PSYCHIATRIC BEDS (MH/PPB), VERSION 1**

medical services and all non-prescription and prescription medications (including discharge medications) incurred by or on behalf of patients, who qualify under Sections II(B) and II(C) below, admitted to the Hospital. This includes all on-site medical care and treatment, as well as all outside medical care and treatment, emergency room and hospitalization costs, as well as any and all charges by specialists, consultants, and laboratories, incurred by or on behalf of patients admitted. No additional HHSC funds will be made available under this Statement of Work.

9. Grantee shall not use funds allocated under this Statement of Work to pay the cost of services provided to patients admitted to the Hospital who do not meet the requirements specified in Sections II(B) and II(C). of this Statement of Work.
10. During the term of this Statement of Work, HHSC will evaluate demand and utilization based upon occupancy within the county(ies) served. If HHSC determines that demand and utilization within the county(ies) served does not align with the total amount allocated to Grantee under this Statement of Work, HHSC will provide Grantee a 90 days' notice on its decision to reduce or increase funding to address statewide need.

B. CIVIL CAPACITY AND PATIENTS SERVED

1. Grantee shall use funding to purchase psychiatric inpatient services, as needed. Grantee is funded to purchase at least 19,776 bed days (equivalent to 54.2 beds per day). Grantee shall negotiate the lowest possible rate with the subcontracting hospital, to the extent possible. Grantee's total per bed rate, including the Hospital payment and Grantee's indirect costs, shall not exceed \$800.00 per day.
2. The primary local service area for patients served under this Section includes the following Texas counties: Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall.
3. As requested by HHSC, Grantee shall work with HHSC on the capacity management program for State Hospitals. As part of the capacity management program, HHSC may request access to beds purchased under this Statement of Work to assist with State Hospital diversion activities. If capacity is available within the Hospital, then HHSC may attempt to divert admissions from State Hospitals to the Hospital. Individuals diverted may be from outside of Grantee's primary local service area. Grantee shall evaluate these individuals for admission and serve them with funds allocated as part of this Statement of Work.
4. Grantee shall require the Hospital to serve patients who present either voluntarily or through the civil commitment process.
5. Grantee shall serve as the gatekeeper or single point of entry for patients served at the Hospital under this Statement of Work and shall establish a process for approving patient admissions to, and continued stay at, the Hospital. This process must incorporate provisions that allow the Hospital to conduct medical screening evaluations, make medical condition determinations, and admit individuals who either present voluntarily or through the civil commitment process.

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C. CAPACITY FOR CHILDREN AT RISK OF RELINQUISHMENT OR IN DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES CONSERVATORSHIP

1. In addition to the services described under Sections II(A) and II(B) above, Grantee shall use funding to purchase inpatient mental health services, as needed, for children who require up to 90 days of treatment focusing on integrating psychiatric symptom stabilization with cognitive behavioral therapy and skills programming in a psychiatric hospital. The extended-term care focuses on emotional dysregulation and awareness, reducing impulsivity and teaching effective communication strategies. Grantee is funded to purchase at least 3,650 bed days (equivalent to 10.0 beds per day). Grantee shall negotiate the lowest possible rate with the subcontracting hospital, to the extent possible. Grantee's total per bed rate, including the Hospital payment and Grantee's indirect costs, shall not exceed \$800.00 per day.
2. Grantee shall subcontract with one Hospital that provides comprehensive treatment strategies that go beyond acute stabilization, including, but not limited to:
 - a. Individual therapy, including but not limited to the following therapy modalities:
 - 1) Cognitive behavioral therapy;
 - 2) Dialectical behavior therapy; and
 - 3) Play therapy.
 - b. Family therapy as clinically appropriate with legally authorized representative (LAR) or other collateral individuals as needed;
 - c. Group therapy as appropriate;
 - d. Recreational therapy;
 - e. Experiential therapies as clinically indicated;
 - f. Rehabilitative services, skills training;
 - g. Case management as needed;
 - h. Age and developmentally appropriate education support;
 - i. Pharmacological management and medication reconciliation;
 - j. Substance use screening, assessment, intervention and referral as clinically indicated; and
 - k. Comprehensive discharge and community re-entry planning, and continuity of care services as required in 26 Texas Administrative Code, Chapter 306, Subchapter D, to include scheduled appointments and obtaining necessary releases with Grantee and LAR.
3. Grantee shall use funds allocated under this section solely for children at risk of parental relinquishment or who are in DFPS conservatorship and who are experiencing multiple psychiatric hospitalizations and need an extended period of inpatient care. Any stay beyond 90 days must be approved by HHSC, including all appropriate or required consents or notifications. Extended stay requests shall be sent to:
CMH_interagency_request@hhs.texas.gov
4. Grantee shall require the Hospital to serve patients who present either voluntarily or through the civil commitment process.
5. Grantee must bill insurance for any allowable activities, if any.
6. If a patient served is under DFPS conservatorship, Grantee must ensure Hospital cooperates with all requests for information by DFPS staff, and authorized parties, and provides any information needed for court proceedings or updates.

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7. In the event a child admitted to inpatient mental health services under this section requires care in a general hospital setting for longer than 72 hours, Grantee is expected to keep patients on their census until an effective transfer occurs.
8. The primary local service area for patients served under this Statement of Work include the following Texas counties: Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall. However, Grantee may also authorize inpatient mental health services for eligible children referred by DFPS, HHSC, or another Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA) statewide.
9. Grantee shall serve as the gatekeeper or single point of entry for patients served at the Hospital under this Statement of Work and shall establish a process for approving patient admissions to, and continued stay at, the Hospital. This process must incorporate provisions that allow the Hospital to conduct medical screening evaluations, make medical condition determinations, and admit individuals who either present voluntarily or through the civil commitment process.

D. COMPLIANCE WITH APPLICABLE LAW:

1. Grantee shall require the Hospital to comply with all applicable state and federal laws and regulations, including those related to:
 - a. The provision of inpatient mental health services, including, but not limited to:
 - 1) Emergency Medical Treatment and Labor Act, 42 U.S.C.A. § 1395dd;
 - 2) Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations at 45 CFR Part 164, and substance use record regulations at 42 CFR Part 2;
 - 3) Texas Health and Safety Code Chapters 241, 571, 572, 573, 574, 575, 576, 577, 611, and 614; and
 - 4) Title 26 of the Texas Administrative Code:
 - a) Chapter 306 (Behavioral Health Delivery System);
 - b) Chapter 320 (Rights of Individuals);
 - c) Chapter 505 (Hospital Licensing);
 - d) Chapter 510 (Private Psychiatric Hospitals and Crisis Stabilization Units); and
 - e) Chapter 568 (Standards of Care and Treatment in Psychiatric Hospitals).
 - b. Medications and medication-related services provided to patients served under this Statement of Work as specified in 26 TAC Chapter 306, Subchapter G (Use and Maintenance of the Health and Human Services Commission Psychiatric Drug Formulary)
2. In addition to the reporting requirements outlined in 26 TAC Chapter 510 (Private Psychiatric Hospitals and Crisis Stabilization Units), Grantee shall report the investigation disposition of all reports of death, abuse, neglect, exploitation, or illegal, unethical or unprofessional conduct using **Exhibit B, Investigation Outcome**, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.

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3. If Grantee suspects any abuse, neglect, or exploitation of a client served, Grantee shall report to the Department of Family and Protective Services Statewide Intake phone number at 800-252-5400, or Texas Abuse Hotline website at <https://www.txabusehotline.org>.

E. OVERSIGHT REQUIREMENTS:

1. Grantee shall develop written oversight policies and procedures, by which Grantee and the Hospital will manage the admission, service delivery, continuity of care and discharge requirements outlined in Section II(G) of this Statement of Work, coordinate with LMHAs, LBHAs, and Local Intellectual and Developmental Disability Authorities (LIDDAs) affected by this Statement of Work, and report to HHSC's Contract Manager in accordance with the terms and conditions in Section II(F) below; and
2. Grantee shall develop and enter into written agreements with other LMHAs, LBHAs, LIDDAs, or other entities involved in patient care affected by this Statement of Work, if applicable, that specify the processes by which patients are to be admitted, served, and discharged, and how services are reported in accordance with the terms and conditions of this Statement of Work.

F. DATA COLLECTION AND REPORTING

1. Grantee shall develop and use local reporting units that will provide an assigned Hospital location that will distinguish between clients served under Sections II(B) and II(C) This information shall also be entered into Client Assignment and Registration (CARE) when reporting on beds utilized at the Hospital.
2. Grantee shall budget and report expenditure data on the CARE **Report III-IV**, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, within the Community Hospital strategy C.2.1.1 using line 764 - Project Private Beds.
3. Grantee shall ensure that patient registration, diagnostics, admission and discharge data is reported by using the CARE screens and action codes listed below:
 - a. Screen: Campus-Based Assignments (Add/Change/Delete), Action Code: 305;
 - b. Screen: Campus-Based Discharge/Community Placement (Add/Change/Delete), Action Code: 310;
 - c. Screen: Joint Community Support Plan (Add/Change/Delete), Action Code: 312;
 - d. Screen: Register Client, Action Code: 325;
 - e. Screen: Diagnostics (Add/Change/Delete), Action Code: 330;
 - f. Screen: Voluntary Admission and Commitment (Add/Change/Delete), Action Code 332;
 - g. Screen: Campus-Based Residential Ward/Dorm (Add/Change/Delete), Action Code 615; and
 - h. Screen: MH Bed Allocation Exception (Add/Change/Delete), Action Code 345.
4. For details related to the use of these screens and action codes, Grantee can refer to the CARE Reference Manual which can be found under the CARE (WebCARE) section on the portal at: https://hhsportal.hhs.state.tx.us/helpGuide/Content/16_CARE/CAREWebCARE%20Refere

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[nce%20Manual.htm](#)

G. ADMISSION, CONTINUITY OF CARE, AND DISCHARGE REQUIREMENTS

1. Grantee shall ensure that the Hospital provides a full array of services that comply with the following principles for treatment:
 - a. Follow the steps as outlined in **Exhibit E, Psychiatric Emergency Flow Chart**, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts-for> clients served under Section II(B).
 - b. Apply preadmission comprehensive assessment criteria consistent with those outlined below:
 - 1) Individuals under consideration for referral to the Hospital must meet the criteria in the Texas Health and Safety Code Chapters 571-576, and those outlined in Title 26, TAC, Chapter 306, §§ 306.171, and 306.175-306.178, as applicable to voluntary admission or the civil commitment process;
 - 2) Acute and Chronic Medical Condition Criteria: The presence of any of the following represent acute or chronic medical conditions that the Hospital does not have the capability to treat and so, in accordance with the Emergency Medical Treatment & Labor Act (EMTALA) and state law, the Hospital will provide evaluation and treatment within its capability to stabilize the person and will arrange for the person to be transferred to a hospital that has the capability to treat the condition:
 - a) Medical Emergency Indicators, including:
 - i. Overdose;
 - ii. Chest pain;
 - iii. Fluctuating consciousness;
 - iv. Stab wound, bleeding, or serious injury;
 - v. Seizure activity;
 - vi. Complications from Diabetes;
 - vii. Injured in assault or flight;
 - viii. Victim of a sexual assault; or
 - ix. Resident of a nursing home or assisted living facility.
 - b) Acute Medical Conditions, including:
 - i. Acute overdose resulting in any vital sign instability in the prior 24 hours;
 - ii. Acute drug intoxication (blood alcohol level over 0.1);
 - iii. Unconscious or fluctuating consciousness;
 - iv. Delirium, including substance induced syndromes;
 - v. Uncontrolled seizure activity;
 - vi. Recent trauma that has not received medical evaluation, including fractures, lacerations, burns, head trauma, and bleeding;
 - vii. Recent assault or fight that has not received medical evaluation;
 - viii. Recent sexual assault that has not received medical evaluation;
 - ix. Blood pressure greater than 160/110;
 - x. Pulse less than 50, or any symptomatic bradycardia, in the prior 24 hours;
 - xi. Pulse greater than 120 in the prior 24 hours;
 - xii. Temperature above 101° F;
 - xiii. White blood count (WBC) greater than 15,000;
 - xiv. Hemoglobin (HGB) less than 10;

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- xv. Hematocrit (HCT) less than 30;
- xvi. Any abnormal electrolytes;
- xvii. Creatinine4 phosphokinase (CPK) greater than 1500 or, CPK greater than 1000 with elevated temperature and muscular rigidity;
- xviii. Serum glucose below 70 or over 400 during the prior 48 hours;
- xix. Acute O2 saturation below 90%;
- xx. Chest pain;
- xxi. Shortness of breath;
- xxii. Unstable arrhythmia;
- xxiii. Pulmonary edema;
- xxiv. Acute congestive heart failure;
- xxv. Acute respiratory distress syndrome;
- xxvi. Acute asthma;
- xxvii. Acute cardiovascular accident;
- xxviii. Acute CNS trauma;
- xxix. Gastrointestinal (GI) bleeding during the prior 48 hours;
- xxx. Requires indwelling tubing (for example, a nasogastric tube);
- xxxi. Post-op instability, demonstrated as any instability in vital signs or laboratory values in the prior 48 hours; or
- xxxii. Open wounds and/or wounds requiring sterile equipment to manage.
- c) Chronic Medical Conditions, including individuals who:
 - i. Require specialized cancer care, including radiation or chemotherapy;
 - ii. Required medical care from a nursing home prior to admission;
 - iii. Require care for decubiti – Stage 3-4;
 - iv. Require blood or blood product transfusions;
 - v. Require continuous oxygen, oximetry, or support equipment (CPCPs, BiPAPs, O2 concentrators);
 - vi. Are being treated for active tuberculosis (TB);
 - vii. Require isolation for the purpose of infection control;
 - viii. Require on-going intravenous (IV) therapy;
 - ix. Have a subclavian line, arterial line, or require hyperalimentation or total parenteral nutrition (TPN);
 - x. Require suctioning;
 - xi. Require peritoneal or hemodialysis treatments;
 - xii. Require complex care or sterile equipment for managing the care of wounds;
 - xiii. Require tracheotomy care and have a chronic condition that causes non-ambulation to an extent to preclude the engagement in treatment programming;
 - xiv. Are considered a high-risk pregnancy;
 - xv. Have a multiparous pregnancy; or
 - xvi. Are pregnant and at 38-weeks' gestation or later.
- c. Provide effective, responsive, individualized, and least restrictive treatment;
- d. Provide treatment and care through the development and implementation of a comprehensive treatment plan and corresponding intervention(s) including but not limited to:

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- 1) A reasonable and appropriate discharge plan that is jointly developed by the Grantee and the Hospital as outlined in 26 Texas Administrative Code, Chapter 306, Subchapter D; and
 - 2) Communication that will facilitate the exchange of information needed to accomplish Utilization Management activities.
 - e. Promotion of recovery, independence, and self-sufficiency;
 - f. Comprehensive client/patient rights consistent with regulatory and TJC requirements;
 - g. Interdisciplinary, goal-directed, and evidence-based treatment;
 - h. Behavior management program;
 - i. Culturally competent treatment; and
 - j. Telemedicine provided in accordance with applicable rules and regulations.
2. Grantee shall ensure that the Hospital demonstrates efforts to reduce restraint and seclusion by adopting and implementing the following restraint/seclusion reduction tools in accordance with Title 26 Texas Administrative Code, Chapter 320, Subchapter C:
- a. Using assessment tools to identify risk factors for violence and seclusion and restraint history;
 - b. Using a trauma assessment;
 - c. Using tools to identify persons with risk factors for death and injury;
 - d. Using de-escalating or safety surveys; and
 - e. Making environmental changes to include comfort and sensory rooms and other meaningful clinical interventions that assist people in emotional self-management.
3. Grantee shall ensure that the Hospital complies with the following standards regarding Admission, Discharge, and Continuity of Care (Title 26 Texas Administrative Code, Chapter 306, Behavioral Health Delivery System):
- a. The Hospital must not allow admissions without Grantee approval;
 - b. When the Hospital admits a patient, a physician must issue and sign a written order admitting the patient;
 - c. The Hospital must conduct an intake process as soon as possible, but not later than 24 hours after the patient is admitted;
 - d. When the Hospital admits a patient, the Hospital must promptly notify Grantee of the admission and the admission status;
 - e. Upon admission of a patient to the Hospital, the Hospital and Grantee must begin discharge planning for the patient;
 - f. Discharge planning must involve the Hospital treatment team, Grantee liaison staff or other Grantee designated staff, the designated Local Intellectual and Developmental Disability Authority (LIDDA) liaison staff, if appropriate, the patient, the patient's legally authorized representative (LAR), if any, and any other individual authorized by the patient;
 - g. Discharge planning for individuals served under Section II(B) of this Statement of Work must address all requirements outlined in Title 26 of the Texas Administrative Code 306, Subchapter D, Mental Health Services—Admission, Discharge, and Continuity of Care.
 - h. Discharge planning for individuals served under Section II(C) of this Statement of Work must address all requirements outlined in Title 26 of the Texas Administrative Code 306, Subchapter D, Mental Health Services—Admission, Discharge, and Continuity of Care, and must specifically address:

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- 1) Provisions to ensure a smooth transition to a level of care that includes wraparound services; and
- 2) A transportation plan that includes procedures accounting for instances when a parent or legally authorized guardian refuses or is otherwise unable to pick up a child from the Hospital upon discharge.

SECTION III. PERFORMANCE MEASURES

The terms and conditions of this Statement of Work and the following performance measures will be used to assess Grantee's effectiveness in providing the services described in this Statement of Work:

- A. Grantee shall submit to HHSC the name of the designated point(s) of contact who will be responsible for communication, correspondence, and reporting to HHSC during and after business hours no later than 15 days after this Contract is executed.
- B. Grantee shall complete and submit **CARE Report III-IV** in accordance with **Information Item D, Instructions for Report III**, and submission timelines as outlined in **Information Item S, LMHA/LBHA Submission Calendar**, all of which are incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- C. Grantee shall report on the daily utilization of beds using an HHSC-approved format each business day by 10:00AM.
- D. Grantee shall report subcontractor information using **Form DD, Inpatient Subcontractor Information**, in accordance with the submission timelines outlined in **Information Item S, LMHA/LBHA Submission Calendar**, which is incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- E. Grantee shall complete and submit **Form JJ, DFPS Discharges Report**, on children served under Section II(C) of this Statement of Work in accordance with the submission timelines outlined in **Information Item S, LMHA/LBHA Submission Calendar**, which is incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.
- F. Grantee shall send all reports, documentation, and other information required of Grantee by this Statement of Work to Performance.Contracts@hhs.texas.gov, as well as to the assigned HHSC Contract Manager.

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SECTION IV. PAYMENT METHOD

Quarterly Allocations

SECTION V. OUTCOME IF GRANTEE CANNOT COMPLETE REQUIRED PERFORMANCE

Unless otherwise specified in this Statement of Work, if Grantee cannot complete or otherwise comply with a requirement included in this Statement of Work, HHSC, at its sole discretion, may impose remedies or sanctions outlined under **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 5.09 (Remedies, Sanctions, and Liquidated Damages).

ATTACHMENT A08
RESIDENTIAL TREATMENT CENTER INTEGRATION (MH/RTCI), VERSION 1

CONTRACT NO. HHS001598600026
GRANTEE: NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

SECTION I. PURPOSE

The Residential Treatment Center (RTC) Project is a partnership between the Health and Human Services Commission (HHSC) and the Department of Family and Protective Services (DFPS) that provides a child with serious mental health needs access to intensive treatment in a residential setting. The RTC Project supports families who have a child at risk of entering DFPS conservatorship due to their mental health care needs, and who have exhausted all community mental health resources. Specifically, the program covers the cost of room and board in Residential Treatment Centers, aiming to prevent the surrender of parental conservatorship to the DFPS as the sole means of accessing mental health services for a child experiencing a serious emotional disturbance.

SECTION II. GRANTEE RESPONSIBILITIES

A. Grantee shall provide assessment, track treatment progress, participate in discharge planning, and provide outpatient services to children who are referred by HHSC, or its designee, for placement in a residential treatment center (RTC) funded by HHSC. Children referred for assessment are those whose legally authorized representative (LAR) cannot access medically indicated RTC placement due to exhausting their available resources and are at risk of parental custody relinquishment to DFPS solely to obtain mental health services for their child.

B. Provision of Services:

Grantee shall:

1. Designate an RTC liaison as the point of contact responsible for these objectives.
2. Assess children referred for RTC services. A referral for assessment may be received from HHSC, DFPS, or from a child's LAR.
 - a. Schedule an intake assessment as soon as possible, but no later than two business days after receiving referral.
 - 1) Administer a complete a uniform assessment in compliance with **Information Item R, Texas Resilience and Recovery (TRR) Utilization Management Guidelines**, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual>, by a Licensed Practitioner of the Healing Arts (LPHA) or Qualified Mental Health Professional – Community Services (QMHP-CS), as defined in Title 26 Texas Administrative Code §301.303.
 - 2) Administer the Child and Adolescent Needs and Strengths (CANS) assessment for children currently receiving services from Grantee who are referred for RTC services.
 - b. Notify the HHSC RTC Coordinator (RTCC) of the assessment results and provide a copy of the CANS by close of business of the following business day.

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RESIDENTIAL TREATMENT CENTER INTEGRATION (MH/RTCI), VERSION 1

- c. Provide crisis services to any child whose assessment and presentation indicate the need for such services at the time of the assessment.
- 3. Offer clinically appropriate services to all children who are referred for RTC services.
 - a. When CANS scores do not indicate residential treatment as an appropriate Level of Care (LOC), Grantee shall:
 - 1) Offer services and enter the child into the appropriate LOC indicated by CANS scores for the Medicaid eligible child and family; or
 - 2) Offer services at the appropriate LOC indicated by CANS scores or the next most intensive LOC in which service capacity exists to the child and family who is not Medicaid-eligible; or
 - 3) Offer services at the appropriate LOC when the LAR's preference is for LMHA/LBHA outpatient services.
 - b. When CANS scores indicate residential treatment as an appropriate LOC, Grantee shall:
 - 1) Provide the family information and support in referring to and accessing Youth Empowerment Services (YES) Waiver and offer the child and family wraparound services in:
 - i. LOC-4 Intensive Family Services; or
 - ii. YES Waiver when the child is eligible; or
 - 2) Offer the child and family the most intensive LOC in which there is capacity to serve when the child is not Medicaid eligible.
 - c. Offer Family Partner services from the Grantee to provide engagement activity services and skills training and development to the LAR, at least once a month, based upon the family's preference. Family partner services are defined in the Texas Medicaid Provider Procedures Manual - Behavioral Health and Case Management Services Handbook and in HHSC Broadcast Message No. 25.009
 - d. When appropriate, request a local Community Resource Coordination Group (CRCG) staffing at the earliest possible date for the child who is referred for RTC services. If a CRCG meeting is held, attend the staffing in person or virtually.
- 4. Provide assistance to the child's family in completing the RTC placement packet when CANS scores indicate residential treatment as an appropriate LOC.
 - a. Standard Application for Residential Treatment Services. Grantee shall provide assistance to the child's family in completing the RTC Standard Application for Residential Treatment Services.
 - b. Psychological Evaluation. Grantee shall assist the family to obtain a psychological evaluation that includes both clinical and functional needs, including intelligent quotient score, if an evaluation has not been completed in the past 12 months.
 - 1) If a psychological evaluation has been completed in the past 12 months, obtain a copy to be included in the RTC placement packet.
 - c. Parental Authorization of Understanding. Grantee shall ensure a Parental Authorization of Understanding form is signed by the child's LAR.
 - d. Communicate at least twice a month with the child's LAR regarding progress toward completion of the child's placement packet. Grantee should follow up with the LAR on topics including, but not limited to:
 - 1) Outstanding documents needed to complete the RTC Project referral;
 - 2) Current status of the RTC Project referral; and

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- 3) Additional services and support that may benefit the family.
5. Collaborate with the HHSC RTCC to assist the family in identifying an approved RTC that is the best match for the child and family. When determining the best match, factors that should be considered include the availability of services, needs of the child and family, and proximity of the RTC.
6. Collaborate with the RTC to provide ongoing treatment and support for the child and family.
 - a. Upon admission to an RTC, complete the CANS assessment to enroll the child in LOC-RTC within 14 calendar days. If the child is placed in an RTC outside of the LMHA service area, ongoing diagnostic assessments may be provided by telephone (audio-only) and synchronous audio/visual technologies, utilizing data collected from the child, child's LAR, and child's RTC therapist.
 - b. Coordinate with the RTC to develop a recovery plan that focuses on a six-month timeframe for treatment. A longer length of stay may be approved based upon the child's clinical need and in collaboration with the RTC treatment team and the family.
 - c. Communicate at least twice monthly with the child's case manager at the RTC regarding progress toward discharge and reunification of the child with their LAR.
 - d. Complete the HHSC-approved **Form 2817, Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA) Monthly Report**, incorporated by reference and posted at: <https://www.hhs.texas.gov/laws-regulations/forms/2000-2999/form-2817-local-mental-health-authority-lmha-or-local-behavioral-health-authority-lbha-monthly> and submit to HHSC no later than the 5th business day of each month for the month prior.
 - e. Participate in monthly Recovery Team meetings at the RTC for the placed child to adequately follow recovery progress and prepare for discharge and re-engagement in Grantee's services.
 - f. Participate in a transition planning meeting with the Recovery Team when the child's recovery team determines that the child clinically is ready for discharge.
 - 1) The child may remain in treatment in the RTC during custody or funding transitions if other arrangements are made and agreed upon by the LAR and any party or payor other than HHSC.
 - 2) In the event that the child is determined to be clinically eligible for return to the community, but the LAR refuses to accept the child into the home, DFPS will assume responsibility for case coordination. Grantee will participate in any subsequent meetings with DFPS and HHSC to ensure coordination of care if the child returns to the home community.
7. Participate in the discharge and transition planning process to ensure coordination of care when the child returns to the home community.
 - a. Provide the family information about how to access YES Waiver services at least 30 calendar days prior to the child's scheduled discharge date. Provide the family with information about all other children's mental health services offered at the LMHA/LBHA.
 - b. Coordinate with the family to schedule a discharge follow-up appointment to administer a Uniform Assessment (UA) that includes the CANS assessment. This appointment must occur within seven days of discharge from the RTC.
 - 1) Schedule an appointment to ensure the child meets with a physician or designee

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RESIDENTIAL TREATMENT CENTER INTEGRATION (MH/RTCI), VERSION 1

authorized by law to prescribe needed medications within seven days of discharge from the RTC.

- 2) Upon return to the community, offer services for the child in YES Waiver or LOC-4 Intensive Family Services to facilitate the maintenance of recovery goals and to minimize return to an RTC.
- c. Provide HHSC and the RTC with a list of the planned array of services the child will receive from Grantee prior to the child's discharge. This information should be included by the RTC on the child's discharge summary.

C. Meeting Criteria for Residential Treatment Using the CANS

The following scores on the Uniform Assessment may indicate a need for placement in a residential treatment facility:

1. Considerations for Alternative Treatment

- a. If the child is rated as a "2" or "3" within the CANS Medical, Life Functioning Domain, of **Information Item R, Texas Resilience and Recovery (TRR) Utilization Management Guidelines** incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/utilization-management-guidelines-manual>, the child should be evaluated to determine if medical stability exists and the child does not require 24-hour medical/nursing care.
- b. If the child is rated as a "3" within the CANS Substance Use, Life Functioning Domain, the child should be referred to substance abuse treatment services to rule out the need for residential treatment in a substance abuse treatment facility.
- c. Prior to considering residential treatment, a child scoring a "3" on the following three CANS assessment items should be evaluated to rule out immediate hospitalization:
 - 1) Suicide Risk;
 - 2) Self-Mutilation; and
 - 3) Danger to Others.

2. Considerations for Residential Treatment

- a. Two of the following three CANS assessment items must be scored at a 2 or 3:
 - 1) Living Situation= 2 or 3: The child has profound problems with functioning in current living situation. Child is at immediate risk of being removed from living situation due to his/her behaviors.
 - 2) Involvement with Care= 2 or 3: Caregiver wishes for child to be removed from their care. (The reason for wanting the child removed may be to access residential treatment services through DFPS.)
 - 3) Family Stress= 2 or 3: Caregiver is unable to manage the stress associated with child/children's needs. This stress prevents caregiver from parenting.
- b. In addition to meeting the criteria above, one of the following criteria must be met:
 - 1) Criterion 1: Two or more scores of "3" OR three or more scores of "2" on the following CANS assessment items:
 - a) Psychosis
 - b) Impulse/Hyperactivity
 - c) Depression
 - d) Anxiety
 - e) Oppositional

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RESIDENTIAL TREATMENT CENTER INTEGRATION (MH/RTCI), VERSION 1

- f) Conduct
- g) Anger Control
- h) Relationship Permanence
- 2) Criterion 2: At least one “3” among the following CANS assessment item risk behaviors:
 - a) Suicide Risk: NOTE: This score indicates crisis.
 - b) Self-Mutilation: NOTE: This score indicates crisis.
 - c) Other Self Harm: NOTE: This score indicates crisis.
 - d) Danger to Others: NOTE: This score indicates crisis.
 - e) Sexual Aggression
 - f) Fire Setting
 - g) Delinquency
- 3) Criterion 3: Three or more ratings of “2 or 3” among the following CANS assessment item risk behaviors.
 - a) Suicide Risk
 - b) Self-Mutilation
 - c) Other Self Harm
 - d) Danger to Others
 - e) Runaway
 - f) Sexual Aggression
 - g) Fire Setting
 - h) Delinquency
 - i) Judgment
 - j) Social Behavior
 - k) Bullying

SECTION III. PERFORMANCE MEASURES

HHSC will use the terms of this Statement of Work and the following performance measures to assess Grantee’s effectiveness in providing the services described in Statement of Work:

Grantee shall:

- A. Designate an RTC Liaison as the single point of contact and notify the HHSC RTCC in writing, at RTCProject@hhs.texas.gov, of the person’s name and contact information no later than five business days after execution of this contract. If the single point of contact changes, Grantee shall notify the HHSC RTCC in writing, at RTCProject@hhs.texas.gov, no later than five business days after making the change.
- B. Administer the Uniform Assessment, including the CANS, to the referred child no later than 48 hours after being contacted by the HHSC RTCC. This is to be administered by a Licensed Practitioner of the Healing Arts or Qualified Mental Health Practitioner. Score the CANS using the criteria outlined in Section II(C). Notify the HHSC RTCC by email, at RTCProject@hhs.texas.gov, of the qualifications of the administrator, assessment date, and results by close of business the following business day. Submit a copy of the CANS by email to the HHSC RTCC by close of business on the business day following the assessment.

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RESIDENTIAL TREATMENT CENTER INTEGRATION (MH/RTCI), VERSION 1

- C. Notify the HHSC RTCC by email, at RTCProject@hhs.texas.gov, by close of business the following business day if the uniform assessment indicates a child is in crisis. Include the qualifications of the administrator, assessment date, and crisis services being provided.
- D. Offer services as described in Sections II(B)(3) within ten business days to the child and family when CANS scores do not indicate residential treatment as an appropriate LOC, and to the child who meets RTC criteria, but parent/guardian preference is for LMHA/LBHA outpatient services. Notify the HHSC RTCC by email, at RTCProject@hhs.texas.gov, no later than five business days after the family provides a response, including the date services were offered, the family's response and the date the response was made, the start date of services if the family agrees to receive services, and the LOC to be provided.
- E. Attend CRCG meetings in person or by phone, and notify the HHSC RTCC by email, at RTCProject@hhs.texas.gov, of the CRCG's recommendation by close of business the following business day.
- F. Assist the family to complete the RTC Standard Application for Residential Treatment Services within ten business days of being approved for an HHSC RTC Project funded RTC placement. Obtain a psychological assessment for the child, if one is not present from within the past 12 months. If a psychological assessment from the past 12 months is available, obtain a copy to be included in the RTC application packet. Notify the HHSC RTCC by email, at RTCProject@hhs.texas.gov, when the family's RTC application packet is complete and email, at RTCProject@hhs.texas.gov, the documents to the HHSC RTCC.
- G. Within 14 calendar days of the child's admission to the RTC, enroll the child in LOC-RTC. If the child is placed in an RTC outside of the LMHA service area, ongoing diagnostic assessments may be provided by telephone (audio-only) and synchronous audio/visual technologies, utilizing data collected from the child, child's LAR, and child's RTC therapist.
- H. Attend, in person or virtually, recovery planning and review meetings with the RTC every month. Notify by email, at RTCProject@hhs.texas.gov, the HHSC RTCC no later than the close of business the following business day regarding the outcome of the meetings.
- I. Communicate at least twice monthly with the child's Case Manager at the RTC regarding progress toward discharge and reunification. Complete and send the progress report via email, at RTCProject@hhs.texas.gov, to the HHSC RTCC on a monthly basis.
- J. Assign the Family Partner within 30 calendar days of the child's admission to the RTC, to provide engagement activity services and skills training and development to the parents/guardians at least twice a month and more if necessary, to prepare the family for reunification. Provide updates about progress with the parents/guardians by email, at RTCProject@hhs.texas.gov, or through telephone (audio-only) and synchronous audio/visual technologies to the HHSC RTCC when requested. If the family declines this service, Grantee shall document rationale in the child's electronic health record.
- K. Attend, in person or virtually, meetings organized by the HHSC RTCC to discuss the child's progress or potential discharge.

ATTACHMENT A08 RESIDENTIAL TREATMENT CENTER INTEGRATION (MH/RTCI), VERSION 1

- L. Schedule a discharge follow-up appointment, including administration of a UA with the CANS assessment, to occur within seven days of the child's discharge from the RTC.
- M. Schedule an appointment for the child and family to meet with a physician or designee authorized by law to prescribe needed medications within seven days of discharge from the RTC. Notify the HHSC RTCC by email, at RTCProject@hhs.texas.gov, of the date on which the meeting took place no later than close of business of the day following the appointment.
- N. Schedule an appointment for the child and family to meet with their local CRCG, if one exists for their county, and participate in a staffing to identify any additional community resources within 30 days of the child's scheduled discharge date.
- O. Provide by email, at RTCProject@hhs.texas.gov, to the HHSC RTCC a list of the planned array of services the child will receive from Grantee in YES Waiver or LOC-4 Intensive Family Services no later than one week prior to the child's scheduled discharge date.
- P. When requested, provide to the HHSC RTCC by email, at RTCProject@hhs.texas.gov, or phone progress reports of the transitional outpatient services the child is receiving from the Grantee.

SECTION IV. PAYMENT METHOD

HHSC Payments to Grantee: The expected average length of stay in RTC services through these placement funds is six months. When a child is successfully discharged earlier than six months, the child may be in need of more intensive transition services from Grantee. When Grantee meets the terms of this Statement of Work up to the child's discharge date and the child is successfully discharged in less than six months, HHSC will pay Grantee 10% of the monthly amount saved based on a six-month average length of stay to assist Grantee to provide transitional outpatient services to the child. If Grantee continues to meet Performance Measures while providing outpatient services to the child, HHSC will pay Grantee up to an additional 40% of the monthly amount saved, up to the first six months, contingent upon amount and availability of such funding at the end of the State fiscal year.

SECTION V. OUTCOME IF GRANTEE CANNOT COMPLETE REQUIRED PERFORMANCE

Unless otherwise specified in this Statement of Work, if Grantee cannot complete or otherwise comply with a requirement included in this Statement of Work, HHSC, at its sole discretion, may impose remedies or sanctions outlined under **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 5.09 (Remedies, Sanctions, and Liquidated Damages).

ATTACHMENT A10
SUPPORTIVE HOUSING RENTAL ASSISTANCE PROJECT (MH/SHR), VERSION 1

CONTRACT NO. HHS001598600026
GRANTEE: NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

SECTION I. PURPOSE

The Supportive Housing Rental Assistance (SHR) Project assists those 18 or older who are homeless or at-risk of becoming homeless to find affordable housing with the goal of obtaining skills required to maintain housing and live independently.

SECTION II. GRANTEE RESPONSIBILITIES

A. Components of Program

Grantee's operation of the Supportive Housing Rental Assistance Project shall include:

1. Up to 12 months of rental assistance, utility assistance, necessary deposits, and moving expenses as specified in this Statement of Work;
2. Ongoing clinical services for project participants through Texas Resilience and Recovery;
3. Supportive housing services using the Substance Abuse and Mental Health Service Administration's (SAMHSA) Permanent Supportive Housing Evidence-Based Practices (EBP) Toolkit, which is incorporated by reference and can be found at: <https://library.samhsa.gov/>

B. Program Design

Grantee shall:

1. Establish, expand, or enhance supportive housing services to persons who are homeless or at-risk of becoming homeless, and authorized for Adult Levels of Care (LOC) 1-5, Early Onset, or Transition Age Youth with a priority being given to those individuals transitioning from HHSC-funded psychiatric beds;
2. Provide rental assistance (up to 12 months), utility assistance, necessary deposits, and moving expenses to persons who are homeless or at-risk of becoming homeless, and authorized for Adult LOC 1-5, Early Onset, or Transition Age Youth where at least 10% of individuals receiving assistance are referrals from HHSC-funded psychiatric beds;
3. Provide assistance locating and maintaining safe and affordable housing according to SAMHSA's Permanent Supportive Housing Toolkit, incorporated by reference and posted at: <https://library.samhsa.gov/>;
4. Provide services utilizing the following HHSC-approved EBPs, incorporated by reference and posted at: <https://www.hhs.texas.gov/providers/behavioral-health-services-providers-programs/behavioral-health-provider-resources>:
 - a. Assertive Community Treatment: SAMHSA Assertive Community Treatment;
 - b. Counseling: Cognitive Behavioral Therapy;
 - c. Psychosocial Rehabilitation: SAMHSA Illness Management and Recovery;
 - d. Supported Employment: Dartmouth Psychiatric Research Center – Individual; Placement and Support or SAMHSA Supported Employment; and
 - e. Supported Housing: SAMHSA Permanent Supported Housing;
5. Never use unlicensed boarding home facilities, as defined in Texas Health and Safety Code, Chapter 260 *et seq.*, or other facilities that are operating without appropriate licensure or certification;

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SUPPORTIVE HOUSING RENTAL ASSISTANCE PROJECT (MH/SHR), VERSION 1

6. Develop a transition plan that evaluates in specific terms *how* each individual will secure and maintain permanent housing once this funding ends. Transition plan must include, at a minimum, the following information:
 - a. A plan to transition to affordable housing and/or permanent supportive housing programs:
 - (1) Grantee shall provide rental assistance, not to exceed 12 months at a rate that does not exceed the Fair Market Rent established by The United States Department of Housing and Urban Development (HUD), as provided under 24 CFR part 888;
 - (a) With prior approval from HHSC, Grantee may exceed this cap for individuals with unique circumstances. Requests shall be submitted on the Extension Request Form incorporated by reference and posted at <https://www.hhs.texas.gov/providers/behavioral-health-services-providers-programs/behavioral-health-provider-resources/community-mental-health-contracts> to performance.contracts@hhs.texas.gov, the Housing Subject Matter Expert, and HHSC Contract Manager.
 - b. Availability of existing local housing resources, such as Tenant-Based Rental Assistance (TBRA) like Housing Choice Vouchers or Section 811 Project-based Rental Assistance (PBRA), and whether the individual is eligible for such housing;
 - c. Assessment of unique housing barriers including, but not limited to: criminal record, poor credit, housing history issues (non-payment of rent, lease violations), and back utility bills and plan(s) to mitigate issues;
 - d. The estimated length of time it would take for the individual to access permanent housing resources; and
 - e. Should the individual not be eligible for subsidized housing resources, develop a plan to maintain housing with individual's personal, or other, financial resources.
7. Connect clients with any available housing resources, employment services, and/or provide assistance obtaining benefits, as needed, to support a successful individual transition plan;
8. Provide ongoing coordination with other services and providers as needed to support Project Participants' success of being able to sustain rental payments without SHR project assistance. This includes coordination with substance use disorder treatment providers and programs serving those with criminal justice involvement;
9. Actively participate in community efforts related to housing such as joining the Local Homeless Coalition if one is present;
10. Actively pursue increased housing resources for project participants through partnerships with local Public Housing Authorities (PHAs), non-profit and for-profit affordable housing developers, owners and/or their property managers, and others;
11. Meet the following established service targets and expenditure benchmarks:
 - a. Service Targets
 - (1) Grantee shall serve the following number of clients during each state fiscal year, beginning September 1st and ending August 31st: 84
 - (2) Rental assistance: not to exceed a total of 12 months
 - (3) Deposits: not to exceed one-time rental deposit and potentially multiple utility deposits. This includes water, gas, electricity. It does not include other deposits, such as cable or internet
 - (4) Utility Assistance: not to exceed 12 months

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SUPPORTIVE HOUSING RENTAL ASSISTANCE PROJECT (MH/SHR), VERSION 1

- (5) Move-in Expenses: one-time as needed, which may include, but not limited to truck rental, moving company, and payment of temporary storage fees for up to 3 months
- b. Expenditure Benchmark: Expend a minimum of 25% of the Fiscal Year (FY) allocation each quarter. Grantee will have dollars permanently removed from the project budget and re-allocated to new project sites or existing sites if benchmarks are not achieved.
12. Ensure all deposit dollars expended and returned are reinvested in the SHR project.

C. Applicable Statutes and Rules

1. Grantee shall comply with the rules and statutes set forth in this subsection and require the same of all its vendors and subrecipient contractors.
2. Grantee, vendor or subrecipient operating as a mental health treatment provider shall comply with applicable standards for mental health providers contained in the following Texas Administrative Code (TAC) chapters and/or subchapters:
 - a. 26 TAC 301, Subchapter G (Mental Health Community Service Standards);
 - b. 26 TAC 306, Subchapter F (Mental Health Rehabilitative Services);
 - c. 26 TAC 320, Subchapter A (Rights of Persons Receiving Mental Health Services); and
 - d. 26 TAC 320, Subchapter C (Interventions in Mental Health Services).
3. Grantee, vendor or subrecipient operating as a substance use treatment provider shall comply with applicable standards for substance abuse treatment providers contained in the following TAC chapters and/or subchapters.
 - a. 26 TAC 564, Subchapter A (General Provisions).
 - b. 26 TAC 564, Subchapter B (Standard of Care Applicable to All Providers).
4. Grantee, vendor or subrecipient operating as a housing provider in the supportive housing portion of the program, shall maintain compliance with the following federal and state housing laws.

Federal Laws:

- a. The Fair Housing Act,
https://www.hud.gov/program_offices/fair_housing_equal_opp/fair_housing_rights_and_obligations
- b. Fair Housing Act Nondiscrimination Requirements Related to Disability,
https://www.hud.gov/program_offices/fair_housing_equal_opp/fair_housing_rights_and_obligations
- c. Section 504 of the Rehabilitation Act of 1973,
<https://www.dol.gov/agencies/oasam/centers-offices/civil-rights-center/statutes/section-504-rehabilitation-act-of-1973>.
- d. Title VI of the Civil Rights Act of 1964,
<https://www.hhs.gov/civil-rights/for-individuals/special-topics/needy-families/civil-rights-requirements/index.html>.
- e. Americans with Disabilities Act (ADA), <https://www.ada.gov/>.
- f. Age Discrimination Act of 1975,
- g. <https://www.dol.gov/general/topic/discrimination/agedisc#:~:targetText=The%20Age%20Discrimination%20Act%20of,that%20meet%20the%20Act's%20requirements..>

State Laws:

- h. Texas Property Code, Chapter 92, Residential Tenancies,
<https://statutes.capitol.texas.gov/Docs/PR/htm/PR.92.htm>.

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SUPPORTIVE HOUSING RENTAL ASSISTANCE PROJECT (MH/SHR), VERSION 1

5. Any entities with whom the Grantee has entered into a written vendor and/or subrecipient contract shall have documentation of compliance from the applicable regulatory agencies that establish and maintain client safety, the rights and benefits of individuals who participate in their program, or who are offered service.

D. Program Reporting

Grantee shall:

1. Complete and submit **Form H, Supportive Housing Rental Assistance Project Report**, to HHSC in accordance with the timeframes specified in Information Item S, both of which are incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;
2. Follow the submission schedule and reporting requirements for financial information in **Report III-IV**, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>; and
3. Report service delivery using procedure codes data in the current version of Mental Health Service Array (Info Mental Health Service Array Combined) which can be found in the Mental and Behavioral Health Outpatient Warehouse (MBOW), in the CA General Warehouse Information, Specifications subfolder, incorporated by reference and posted on HHSC's IAMOnline page: <https://iamonline.hhs.state.tx.us>.

E. Quality Assurance

Grantee shall:

1. Develop and implement written policies and procedures outlining how Grantee will comply with the terms and conditions of this Statement of Work including monitoring of expenditures, ensuring quality care and client satisfaction; and
2. Incorporate oversight of this Statement of Work into its overall Quality Management Plan to measure compliance, and client and local stakeholder satisfaction; and
3. Submit its Quality Management Plan to HHSC upon request.

SECTION III. PERFORMANCE MEASURES

The terms of this Statement of Work, including the following performance measures, will be used to assess Grantee's effectiveness in providing the services described in this Statement of Work. Grantee shall submit the following for quarterly reports:

1. Grantee shall electronically submit to HHSC **Form H, Supportive Housing Rental Assistance Project Report**, in accordance with **Information Item S, LMHA/LBHS Submission Calendar**, both of which are incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. **Form H, Supportive Housing Rental Assistance Project Report**, shall include project data on:

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SUPPORTIVE HOUSING RENTAL ASSISTANCE PROJECT (MH/SHR), VERSION 1

- a. Description of participation in community efforts related to housing such as local Continuums of Care and local homeless coalitions (Quarter 1, or September 1st through November 30th, only);
 - b. Number of new housing resources identified and/or procured for project participants (Quarter 1, or September 1st through November 30th, only);
 - c. Description of overall coordination efforts and client-specific coordination with other services and providers, including substance use providers and programs serving those in the criminal justice system (Quarter 1, or September 1st through November 30th, only);
 - d. Number of adults authorized for LOC 1-5, Early Onset, or Transition Age Youth receiving services through the Supportive Housing Rental Assistance Project in totality and by assistance type;
 - e. Description of overall coordination efforts and client-specific coordination with other services and providers, including substance use providers and programs serving those in the criminal justice system;
 - f. Number of individuals residing in each type of SHR project-funded housing options;
 - g. Number of individuals who are no longer receiving SHR project assistance since last report;
2. Grantee shall submit **Form P, Various Programs**, in accordance with **Information Item S, LMHA/LBHS Submission Calendar**, both of which are incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.

SECTION IV. PAYMENT METHOD

Quarterly Allocation

SECTION V. BUDGET

After notifying HHSC's Contract Manager of the transfer, Grantee may, without HHSC prior approval, transfer money between budget categories of within this Statement of Work subject to the following terms:

1. Grantee may transfer money between direct cost categories of this Statement of Work, without prior approval, but after notifying HHSC Contract Manager of the transfer in writing, and subject to the following restrictions:
 - a. No budget category transfer or cumulative transfers may exceed 10% of the total value of this Statement of Work; and
 - b. A formal Contract Amendment is required if the budget category transfer(s) or cumulative transfers exceed 10% of the value of this Statement of Work.

SECTION VI. FUNDING

If Grantee's total allowable expenditures for the term of this Statement of Work are less than the total amount disbursed by HHSC in Grantee's four quarterly allocations, Grantee shall be subject

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SUPPORTIVE HOUSING RENTAL ASSISTANCE PROJECT (MH/SHR), VERSION 1

to recoupment of the difference between the total amount disbursed by HHSC and Grantee's total expenditures.

SECTION VII. OUTCOME IF GRANTEE CANNOT COMPLETE REQUIRED PERFORMANCE

Unless specified in this Statement of Work, if Grantee cannot complete or otherwise comply with a requirement included in this Statement of Work, HHSC, at its sole discretion, may impose remedies or sanctions outlined under **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 5.09 (Remedies, Sanctions, and Liquidated Damages).

ATTACHMENT A11

VETERANS SERVICE PROGRAM (MH/VET), ENHANCED VERSION 1

CONTRACT NO. HHS001598600026
GRANTEE: NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

SECTION I. PURPOSE

HHSC and the Texas Veterans Commission partner to administer the Mental Health Program for Veterans, which provides peer-to-peer counseling to service members, veterans and their families through local mental health authorities and local behavioral health authorities across the state.

SECTION II. GRANTEE RESPONSIBILITIES

Specific deliverables for the Mental Health Program for Veterans (MHPV) are implemented through this Statement of Work (SOW) which enhances access to, awareness of, connection to services and resources for trauma-affected military service members, veterans and their families (collectively, "SMVF").

- A. Texas Health and Human Services Commission (HHSC) administers this SOW in coordination with the Texas Veterans Commission (TVC). Through this SOW, local mental health authorities/local behavioral health authorities (LMHAs/LBHAs) employ or contract for a Peer Service Coordinator (PSC) to implement local networks of the Military Veteran Peer Network (MVPN) which:
 1. Provide direct peer-to-peer services to trauma-affected military SMVF;
 2. Train MVPN peer volunteers, the SMVF community, and communities at-large on the issues and impacts of military-related traumas using TVC-developed curriculum approved by HHSC;
 3. Assist SMVF to identify and access appropriate, culturally competent mental health services, including access to licensed mental health professionals (LMHPs) and supportive services within their service coverage area;
 4. Make referrals to community-based resources, programs, and activities which provide health-focused supportive services; and
 5. Provide peer-to-peer services to justice-involved veterans (JIV) who may be impacted by military-related traumas.

- B. Grantee shall achieve the objectives of the MHPV, specifically stated in Section II(C)(1-6) in this Statement of Work, by hiring or contracting for services from at least one MVPN PSC and one Part-Time PSC. LMHA/LBHA-employed or -contracted PSCs and Part-Time PSCs are trained and certified by TVC's Veteran Mental Health Department (VMHD) using curriculum approved by HHSC to achieve the deliverables of this SOW. The PSC shall serve 40 hours per week and the Part-Time PSC shall serve a minimum of 15 hours a week, exclusively to achieve the objectives of the program as below in Section II(C)(1-6), Program Design and Objectives. The PSC's base of operations should be a site selected by agreement between Grantee and the PSC. As a best practice, the site should:
 1. Be a Peer Networking Center, which is a facility that the PSC determines SMVF would likely be comfortable visiting; and

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VETERANS SERVICE PROGRAM (MH/VET), ENHANCED VERSION 1

2. Be near or co-located with one or more of the following: County Veteran Service Officers (CVSOs), TVC representatives, or Texas Workforce Commission (TWC) Veterans Resource & Referral Specialists.

C. Program Design and Objectives

1. The Grantee shall ensure the program enhances and expands access to, awareness of, and connection to services and resources for trauma-affected military SMVF, including peer-to-peer counseling services.
2. The Grantee shall train MVPN peer volunteers, the SMVF community, and communities at-large on the issues and impacts of military-related traumas using TVC-developed curriculum approved by HHSC. To train listed personnel and entities, Grantee shall, within its local service area:
 - a) Coordinate or conduct trainings using TVC-developed curriculum approved by HHSC, incorporated by reference and posted at: <https://veteransmentalhealth.texas.gov/> to educate SMVF and the community on military-related traumas and associated mental health impacts;
 - b) Coordinate or conduct trainings on veteran suicide prevention topics and tools; and
 - c) Coordinate with the local Mental Health First Aid Coordinator for delivery of Mental Health First Aid-Veterans (MHFA-V) module to educate SMVF and the community on mental health conditions and their symptoms with veteran-specific information.
3. The Grantee shall assist SMVF to identify and access appropriate mental health services, including access to LMHPs and supportive mental health services within their local service coverage area. To enhance access to appropriate services, Grantee shall coordinate with, collaborate with, and make appropriate and necessary referrals to the following organization:
 - a) Veterans Health Administration (VA) LMHPs;
 - b) Veteran Counselors at select LMHA/LBHA pilot sites;
 - c) Community-based LMHPs trained to serve trauma affected military SMVF;
 - d) VA-funded Vet Centers;
 - e) Substance-use-disorder treatment centers; and
 - f) Suicide and crisis-intervention centers and organizations.
4. The Grantee shall make referrals to local community-based resources, programs, and activities which provide mental health-focused supportive services. Grantee shall coordinate with, collaborate with, and make referrals to local organizations with activities which may include:
 - a) VA hospital systems, clinics, and Vet Centers;
 - b) CVSO, TVC, and TWC representatives;
 - c) Programs focused on veteran-suicide awareness and prevention;
 - d) Programs for substance-use screening, assessment, and treatment;
 - e) Programs that support veteran housing and employment;
 - f) Programs that support veterans who are women;
 - g) Community-based veteran peer networking centers; and,
 - h) Programs that support veterans in rural areas (if applicable to the Grantee's service area).

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5. The Grantee shall provide peer-to-peer services to JIV who may be impacted by military-related traumas. Grantee shall coordinate for and deliver direct peer services to JIV and participate in JIV initiatives and programs which may include:
 - a) Local municipal law enforcement agency initiatives for JIV;
 - b) County jail diversion programs for veterans;
 - c) County or regional veteran treatment courts;
 - d) State jail and/or prison re-entry programs for veterans; and
 - e) Incarceration-based in-reach programs for JIV implemented by HHSC, TVC, Texas County Jails, the Texas Department of Criminal Justice (TDCJ), and the Federal Bureau of Prisons.

6. Grantee shall, at a minimum:
 - a) Ensure the PSC, Part-Time PSC and trained peers deliver direct peer services for the purposes of this SOW including:
 - 1) One-on-one peer counseling;
 - 2) SMVF peer group participation and facilitation;
 - 3) Referral to mental health services provided by military-trauma informed LMHPs;
 - 4) Referral to community-based organizations for mental health supportive services; and
 - 5) Maintain a record of direct peer service delivery by the PSC and trained peers.
 - b) Coordinate, promote awareness of, and conduct no fewer than three MVPN Basic Trainings per quarter (Quarter 1 begins September 1st and ends November 30th, Quarter 2 begins on December 1st and ends on February 28th of 29th during leap years, Quarter 3 begins on March 1st and ends on May 31st, and Quarter 4 begins on June 1st and ends on August 31st) of each State Fiscal Year (SFY) for SMVF peers, community members and LMHPs to be trained by TVC-certified MVPN Basic Trainers by:
 - 1) Scheduling and posting trainings on the TVC-provided Platform for Peers and Providers, incorporated by reference and posted at: <https://veteransmentalhealth.texas.gov/>
 - 2) Registering participants on the TVC-provided Platform for Peers and Providers;
 - 3) Maintaining local training attendance rosters; and
 - 4) Submitting training completion rosters to VMHD staff.
 - c) Ensure the PSC, Part-Time PSC, and trained peers refer trauma affected military SMVF seeking mental health services to appropriate, culturally competent providers including:
 - 1) VA LMHPs;
 - 2) Staff, contracted Veteran Counselors or LMHPs trained to serve trauma affected military SMVF; and
 - 3) Community-based LMHPs trained in military-related trauma.
 - d) Maintain, and provide to upon HHSC's or TVC's request a list of trained volunteer SMVF peers, community members and LMHPs;
 - e) Ensure PSC and Part-Time PSC coordinates locally for the delivery of MHFA-V, as trained by TVC's VMHD;

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VETERANS SERVICE PROGRAM (MH/VET), ENHANCED VERSION 1

- f) Ensure the PSC maintains records of contacts, or contact attempts, with each trained volunteer SMVF peer. Contact must be attempted at least once per month;
 - g) Cooperate with HHSC and VMHD requests for information related to local delivery of mental health services, mental health supportive services, and activities of the program;
 - h) Verify that the activities listed in Sections II(C)(2-5) and (6)(a-d) are documented and submitted as required by Section III of this Statement of Work, Performance Measures; and
 - i) Maintain a local MVPN site on TVC's Platform for Peers and Providers and include an MVPN banner on the Grantee's website, hyperlinked to the local MVPN site on TVC's Platform for Peers and Providers.
7. Grantee shall participate in technical assistance and training as required by HHSC:
- a) Ensuring PSCs, Part-Time PSCs and (when requested by HHSC) local program supervisors participate in statewide and regional trainings and meetings led by HHSC and/or VMHD staff for the following purposes:
 - 1) Certification, continuing education, and recertification training for PSCs;
 - 2) Sharing of information regarding the activities of the MHPV; and
 - 3) Sharing of information regarding evidence-based practices to enhance MVPN peers' ability to meet the deliverables of this SOW.
 - b) Maintaining TVC-managed certification of no less than two Grantee staff personnel or volunteer peers as trainers of MVPN Basic Training (the TVC-developed curriculum approved by HHSC for delivery to volunteer SMVF peers, LHPs, and community members);
 - c) Participating in HHSC-provided and approved surveys, program assessments, interviews, focus groups, and workgroups, in order to evaluate Grantee's ability to accomplish the deliverables of this SOW; and
 - d) Participating in HHSC-provided and approved initiatives to drive efficiencies in program performance.

D. Peer Service Coordinator:

Grantee shall hire or contract for a PSC. This PSC is a 1.0 Full Time Equivalent (FTE), dedicating, at minimum, 40 hours per week exclusively to achieve the objectives of the program found in Section II(C)(1-6) of this Statement of Work. Grantee shall monitor and verify their PSC focuses on training Peers in MVPN Basic Training, providing direct peer services, and, where appropriate, organizing and directing trained Peers to provide direct Peer services to trauma-affected military SMVF. Grantee shall verify their PSC's skills and experience include the following:

- 1. Experience as a SMVF;
- 2. Completion of TVC-delivered PSC certification training within six months of hire;
- 3. Demonstrated leadership skills;
- 4. Demonstrated ability to use limited resources to achieve objectives;
- 5. Knowledge about community resources and services;
- 6. Experience in a volunteer-focused program;
- 7. Demonstrated public speaking/presentation ability; and

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8. Training in suicide-risk behavior identification and suicide prevention (*e.g.*, Columbia Suicide Severity Rating Scale, Applied Suicide Intervention Skills Training, Ask About Suicide to Save a Life) within six months of hire.
- E. Part-Time Peer Service Coordinator:
- Grantee shall hire or contract for a Part-Time PSC, a 0.5 Full Time Equivalent (FTE), dedicating, at minimum, 15 hours per week exclusively to achieve the objectives of the program found in Section II(C)(1-6) in this Statement of Work. Grantee shall monitor and verify their part-time PSC focuses on training Peers in MVPN Basic Training, providing direct Peer services, and, where appropriate, organizing and directing trained Peers to provide direct peer services to trauma-affected military SMVF. Grantee shall verify their part-time PSC's skills and experience include the following:
1. Experience as a SMVF;
 2. Completion of TVC-delivered PSC certification training within six months of hire;
 3. Demonstrated leadership skills;
 4. Demonstrated ability to use limited resources to achieve objectives;
 5. Knowledge about community resources and services;
 6. Experience in a volunteer-focused program;
 7. Demonstrated public speaking/presentation ability; and
 8. Training in suicide-risk behavior identification and suicide prevention (*e.g.*, Columbia Suicide Severity Rating Scale, Applied Suicide Intervention Skills Training, Ask About Suicide to Save a Life) within six months of hire.
- F. Single Point of Contact:
- Grantee shall designate a single point of contact, other than the PSC and part-time PSC, to receive and transmit information required for effective implementation and monitoring of the Program (Veteran Service Program Coordinator). Grantee shall inform HHSC of a change in their single point of contact no later than ten calendar days after the single point of contact changes.
- G. Project Implementation Plan:
- Grantee shall use the HHSC-authorized template provided by TVC to submit to HHSC's Contract Manager its written Program Implementation Plan, which includes, at a minimum, the following elements for each SFY:
1. Activities for organizing veteran peer-to-peer counseling and services under the terms of this Statement of Work;
 2. Tactics for enhancing collaboration by the local MVPN Program with Veteran Counselors, LMHPs trained in military-related trauma, CVSOs, TVC, and TWC;
 3. Tactics that Grantee will use to generate and disseminate information about the local MVPN Program and its related activities for use by news services, print, broadcast, and social media;
 4. MVPN descriptions, including the MVPN benefits statement ("Trust, Camaraderie, Hope"), and materials to be distributed by Grantee at events;
 5. A Uniform Resource Locators (URLs) list of Grantee's website where the MVPN-hyperlinked banner is located;

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6. A timeline for task(s) to be accomplished and persons or entities responsible for each task; and
7. Anticipated outcomes and objectives.

H. Project and Fiscal Reporting

Grantee shall:

1. Follow the Information Item S, Submission Calendar, and reporting requirements for financial information in Client Assignment and Registration System (CARE) Report III, both of which are incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;
2. On or before the due date, develop and submit an annual budget for the MVPN Program. Grantee shall electronically submit the annual budget using the Budget Schedule Form P, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, directly to HHSC's Contract Manager at performance.contracts@hhsc.state.tx.us in MS Excel XLS or XLSX format. Adobe PDF files or scans of handwritten forms will not be accepted. Grantee will copy submission of the annual budget to mhpn@hhsc.state.tx.us;
3. On or before each due date, develop and submit SFY quarterly expenditure reports for the MVPN Program. Grantee shall electronically submit quarterly expenditure reports using Form V-Veteran Expenditures, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, to HHSC's Contract Manager at performance.contracts@hhsc.state.tx.us in MS Excel XLS or XLSX format. PDF files or scans of handwritten forms will not be accepted. Grantee will copy submission of quarterly expenditure reports to mhpn@hhsc.state.tx.us;
4. On or before the due date, develop and submit an annual Project Implementation Plan identified at Section II(G) in this Statement of Work for the MVPN Program. Grantee shall electronically submit the Project Implementation Plan to HHSC's Contract Manager at: performance.contracts@hhsc.state.tx.us in Microsoft Office Word format. Adobe PDF files are acceptable. Scans of handwritten forms will not be accepted. Grantee will copy submission of the implementation plan to mhpn@hhsc.state.tx.us and mhpn.reports@tvc.texas.gov; and
5. On or before each due date, Grantee shall electronically submit verification of the SFY quarterly performance numbers reported through MVPN Digital Reporting Tools. Grantee shall electronically submit the verification via email, attaching the information being verified attached to HHSC's Contract Manager to: performance.contracts@hhsc.state.tx.us, mhpn@hhsc.state.tx.us, and mhpn.reports@tvc.texas.gov.

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SECTION III. PERFORMANCE MEASURES

HHSC will use the following performance measures, along with any additional terms of this Statement of Work, to assess Grantee's effectiveness in providing the services required within this Statement of Work:

- A. Grantee shall designate a single point of contact, other than the PSC and Part-Time PSC (Veteran Service Program Coordinator) and notify HHSC, in writing, of the person's name and contact information no later than 10 business days after execution of this Contract. If the single point of contact changes, Grantee shall provide written notification to HHSC no later than 10 business days after making the change.
- B. Grantee shall inform HHSC about the hiring of or contracting with any PSCs and part-time PSCs (*see* Section II(D) and Section II(E)) within 10 business days after Grantee's PSC and/or part-time PSC has been hired or contracted. Grantee shall inform HHSC's Contract Manager about any staffing changes regarding the PSCs and part-time PSCs no later than 10 business days after the changes are made.
- C. Grantee shall, on or before the due date in accordance with Information Item S, Submission Calendar, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, develop and submit an SFY budget for the MVPN Program. Grantee shall electronically submit the SFY budget using the Budget Schedule Form P, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, in MS Excel XLS or XLSX format. Adobe PDF files or scans of handwritten forms will not be accepted.
- D. Grantee shall, on or before the due date, in accordance with the submission calendar, develop and submit an annual Project Implementation Plan identified (*see* Section II(G), above) for the MVPN Program. Grantee shall electronically submit the Project Implementation Plan, as noted in Section II(G), in this Statement of Work, in Microsoft Office Word format. Adobe PDF files are acceptable. Scans of handwritten forms will not be accepted.
- E. Grantee shall, on or before each due date, develop and submit quarterly expenditure reports for the MVPN Program. Grantee shall electronically submit SYF quarterly expenditure reports using Form V-Veteran Expenditures, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, in MS Excel XLS or XLSX format. Adobe PDF files or scans of handwritten forms will not be accepted.

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- F. Grantee shall, on or before each due date, electronically submit verification of the SFY quarterly performance numbers reported through the MVPN Digital Reporting Tools. The verification shall be submitted electronically, attaching all information being verified, as noted in Section II(H)(5).
- G. Grantee shall submit in a format and timeframe prescribed by HHSC's Contract Manager and TVC's VMHD:
 - 1. Upon request, the names of individuals contacted, or those whom the Grantee attempted to contact, and the dates the contacts or attempts were made as required in Section II(C)(6)(f), above;
 - 2. The names of trained SMVF peers and the identity of trainers (*see* Sections I.C(6)(a) and II(C)(6)(d)); and
 - 3. The results of surveys, critiques, and other data gathering information found in Section II(C)(7)(c).
- H. Grantee shall submit all performance measures electronically to the Performance Contract Mailbox at performance.contracts@hhsc.state.tx.us and mhvpv@hhsc.state.tx.us, with a copy to the assigned HHSC Contract Manager.

SECTION IV. PAYMENT METHOD

Quarterly Allocation, dependent upon timely receipt of completed deliverables and adherence to contractual requirements as set forth in this Statement of Work.

SECTION V. BUDGET

- A. After notifying HHSC's Contract Manager of the transfer, Grantee may, without HHSC prior approval, transfer money between budget categories of within this Statement of Work subject to the following terms:
 - 1. No program budget category transfer or cumulative transfers may exceed 25% of the total value of this Statement of Work or \$100,000, whichever is less;
 - 2. Grantee shall request prior written approval from HHSC if the budget transfer(s) exceed(s) \$100,000, alone or cumulatively;
 - 3. A formal contract amendment is required if the budget category transfer(s) or cumulative transfers exceed(s) 25% of the value of this Statement of Work; or
 - 4. Grantee shall receive HHSC prior approval for budget transfers amongst more than one program.
- B. The amount expended by Grantee for administration of the provision of services under this Statement of Work shall not exceed 5% of the total.
- C. Budget and expenditure reporting shall be entered into CARE Report III on line 758 – "Other General Revenue, HHSC," incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.

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SECTION VI. FUNDING

If Grantee's total allowable expenditures for the term of this Statement of Work are less than the total amount disbursed by HHSC in Grantee's allocations, Grantee shall be subject to recoupment of the difference between the total amount disbursed by HHSC and Grantee's total allowable expenditures.

SECTION VII. OUTCOME IF GRANTEE CANNOT COMPLETE REQUIRED PERFORMANCE

Unless otherwise specified in this Statement of Work, if Grantee cannot complete or otherwise comply with a requirement included in this Statement of Work, HHSC, at its sole discretion, may impose remedies or sanctions outlined under **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 5.09 (Remedies, Sanctions, and Liquidated Damages).

ATTACHMENT A12
INFORMATION RESOURCE SYSTEMS (MH/IRS), VERSION 1

CONTRACT NO. HHS001598600026
GRANTEE: NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

SECTION I. PURPOSE

The provisions below outline both the Health and Human Services Commission (HHSC) and Grantee's responsibilities regarding the development, maintenance, and use of HHSC information systems and Software.

SECTION II. RESPONSIBILITIES OF THE PARTIES

HHSC has developed information resources for the delivery of behavioral health services to include: the Clinical Management for Behavioral Health Services (CMBHS) system, the CMBHS website, and a portal for submitting batch submissions to the Secure File Transfer Protocol Server (SFTP Server) to support the delivery of outpatient behavioral health services, other tools to support program operations and information exchange, and currently uses a third-party Electronic Health Record system for managing inpatient services in the state hospitals. Collectively, these resources, along with applicable source code, business rules, manuals, help guides, and other similar resources, are referred to as "Software."

- A. HHSC may make changes to its technology systems to improve its ability to manage clients' health care, enhance coordination of care between state mental hospitals and outpatient services, enhance coordination of care with other providers, improve the management and delivery of behavioral health services, increase system functionality, facilitate reporting of required data to HHSC, and provide other services related to behavioral health.
- B. Grantee shall collaborate with HHSC in developing and/or testing information systems and projects that support the delivery of behavioral health care provided through HHSC and Grantee. HHSC may establish an Advisory Council and/or workgroup(s) (Workgroup) to assist in coordinating system development and testing.
- C. HHSC may select a representative sample of Local Mental Health Authorities (LMHAs), in conjunction with the Texas Council of Community Centers, for participation in the Advisory Council or Workgroup(s) to ensure representation from a diverse array of urban and rural organizations and those using different information systems to support local operations.
- D. As an Advisory Council or Workgroup member, Grantee may participate in discussions with HHSC regarding data standards and system specifications and may make recommendations on alternative message content structure, message content, and file formats.
- E. HHSC will solicit input on test schedules and procedures from the Workgroup associated with a particular project or information system and/or the Advisory Council.
- F. Advisory Council and Workgroup meeting schedule(s) may be established and maintained by HHSC.

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INFORMATION RESOURCE SYSTEMS (MH/IRS), VERSION 1

- G. Grantee may participate in appropriate meetings, conference calls, and webinars.
- H. HHSC has the sole, final decision regarding system requirements and adoption of data standards.
- I. HHSC will identify and maintain service-specific points of contact (POC) for all Grantee questions and maintain this information on the appropriate HHSC website.
- J. Grantee shall make any necessary changes to its local information system(s) to ensure and maintain interoperability with HHSC-specified information systems including, but not necessarily limited to CMBHS and Mental and Behavioral Health Outpatient Warehouse (MBOW), to exchange and/or provide required data and perform other functions that are not supported by Grantee's information systems. Changes shall be implemented by Grantee on a reasonable, mutually agreeable, activity/project-specific, schedule. The final schedule shall be maintained, in tangible form, by HHSC and shall be available on a website designated by HHSC.
- K. Grantee shall test interoperability between its information systems and information systems provided by HHSC, including the capabilities to exchange and correct data as required by HHSC, statute, or regulation, using systems, environment(s) and following schedule(s) and methodologies identified or provided by HHSC. Relevant results will be shared with Workgroup and Grantee.
 - 1. Grantee shall notify the appropriate HHSC POC within 24 hours via email of all problems using the HHSC-designated test environments.
 - 2. Grantee shall provide written feedback weekly to HHSC via email during active testing by the Grantee. Active testing is defined as the active use of the testing environment(s) specified by HHSC, such as the actual submission of a test file/test data by a Grantee or using a HHSC-identified website for error correction.
 - a) Grantee shall notify HHSC in writing when it begins and ends testing.
 - b) No feedback is required if no Grantee activity occurred during the week (*e.g.*, Grantee who submits a file/data should report on the results of the test, identifying if the test was successful or what problems, if any, were encountered. If no file was submitted, no feedback report is necessary.)
 - 3. Grantee shall complete testing (*e.g.*, submit a file and have it processed with no errors) before it may submit data into a production system. HHSC may require attestation by the Grantee's Executive Director certifying readiness.
- L. HHSC will:
 - 1. Provide Grantee access to CMBHS, the CMBHS Website, SFTP Server, select CMBHS components, MBOW, other systems, additional tools, and select resources to facilitate information exchange between Grantee and HHSC.
 - 2. Provide website(s) or links to websites that Grantee may use to access materials relevant to implementing mental health assessments, data exchange, and other services in local health information systems and data submission/exchange/reporting file formats and instructions. This material may include select system specifications, interface specifications, file format specifications, select business rules, testing methodology and

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INFORMATION RESOURCE SYSTEMS (MH/IRS), VERSION 1

criteria, sample code, and other material HHSC believes may provide Grantee assistance with modifying its local information system(s) to implement and maintain interoperability with applicable HHSC systems and support the delivery of behavioral healthcare.

3. Provide Grantee access, including at least one user ID and password, to CMBHS, the SFTP Server, and other resources necessary for testing interoperability and other required functionality. Grantee is responsible for managing access, consistent with applicable requirements, including signing and following all Data Use Agreement terms and conditions (Attachment D of the Contract).
4. Provide Grantee technical assistance in developing, implementing, and addressing problems with system interoperability and data exchange, as resources permit.
5. Work to develop and adopt Health Level 7(HL7)-based data standards to support clinical data exchange for continuity of care in addition to standards used for administrative reporting.
6. Conduct scheduled conference calls with Grantees and other entities to discuss issues related to HHSC information systems and interoperability.

M. Terms of Use

1. CMBHS, including the CMBHS Website and the SFTP Server, is the sole property of HHSC.
2. The HHSC Health Services Gateway (HSG) is operated by or on behalf of HHSC.
3. The inpatient Electronic Healthcare Record (EHR) system utilized in the state hospitals is operated by or on behalf of HHSC and may contain proprietary information. Only specific information identified by HHSC regarding the EHR may be disclosed or redisclosed, as specified in writing by HHSC.
4. Grantee shall treat information resources provided by HHSC as confidential and shall not, without the express written permission of HHSC or as specified in this Statement of Work, take any action that will compromise the confidentiality of HHSC information systems and data it contains, including, but not limited to, the following:
 - a) Grantee shall not provide detailed demonstrations, copy, sell, loan, lease, assign, license, transfer or market CMBHS, any portion of CMBHS, or other technology or service provided by HHSC without the prior written consent of HHSC.
 - b) Except for developing and implementing technology to fulfill contracted services between Grantee and HHSC (*i.e.*, delivery of mental health services), Grantee shall not modify, prepare derivative works, reuse, disassemble, decompile, reverse engineer or otherwise translate CMBHS or any other resource, information system, or tool provided to Grantee by HHSC without the prior written consent of HHSC.
 - c) HHSC expressly grants to Grantee permission, subject to the constraints in (a) and (b) above, to consult and collaborate with contractor(s) of the Grantees and other LMHAs with contracts with HHSC with identical constraints on technology development to utilize HHSC-provided resources identified in this Statement of Work to make or test any required modification(s) to computer software and information systems maintained or utilized by the Grantee and data exchange functionality to support the delivery of HHSC-contracted services and coordination of care between Grantee and HHSC facilities or as directed by HHSC. Grantee shall provide a list of all entities with whom it has consulted or collaborated with to HHSC at HHSC's request.

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INFORMATION RESOURCE SYSTEMS (MH/IRS), VERSION 1

- d) Grantee shall ensure that any entity or individual to which it discloses information about HHSC information systems will adhere to all provisions of this Statement of Work regarding system confidentiality as if the entity/individual were a Grantee.
5. Grantee hereby assigns to HHSC all right, title and interest to any recommendations regarding modifications or additions to Software provided by HHSC and all property rights therein, including without limitation all patent, copyright, trade secret, mask work, trademark, moral right, or other intellectual property rights.
6. Grantee shall not utilize test environments provided by HHSC for ongoing business activities involving current clients, including conducting assessments or managing care delivery. Every effort shall be made to use data for testing that consists of hypothetical patient information and does not contain real patient information. Any use of real patient data shall be subject to Health Insurance Portability and Accountability Act (HIPAA) and/or other applicable law.
7. No actual patient data or protected identifiable information shall be used in any testing file submitted by entities other than those that are Covered Entities or Business Associates as defined by HIPAA.
8. In accordance with the HIPAA Privacy Rule's Minimum Necessary standard, Grantee may, if it is a HIPAA Covered Entity or Business Associate of a Covered Entity (as such terms are defined in the HIPAA regulations) and the function being tested requires it, enter actual patient data that includes all requisite fields included in the CMBHS file submission layout. The entry or use of actual patient data for certain CMBHS testing may be required to ensure that the data exchange between Grantee and HHSC is performing properly, ensuring that when additional functionality is released into production, the data exchanged is in a format consistent with the data specifications established by HHSC and the Software produces accurate information regarding patient care, consistent with the information contained in other state information systems. This exchange of patient data between covered entities and business associates of covered entities is authorized by the HIPAA Privacy Rule to support health care operations, and authorized under Texas Health and Safety Code Section 533.009(a).
9. Grantee shall immediately notify HHSC of any access, use or disclosure of confidential information that may be in violation of HIPAA, other applicable statute or regulation, this Statement of Work or the Data Use Agreement and shall assist HHSC in performing any investigation and notice that may be required pursuant to applicable law.
10. HHSC may, at its own discretion and without prior communication to the Grantee, eliminate, alter, or add information to any or all record(s) in a HHSC-provided development or test environment. HHSC will not implement alteration of the record submission layout without prior consultation with Grantee.
11. Grantee is responsible, subject to the terms of this Statement of Work, for all costs incurred by Grantee, including but not limited to any costs associated with data standards-setting activities, local information system modifications or changes required for testing and staff, contracting costs associated with staff time involved in participating in testing, and all costs associated with conference calls and meetings.
12. Notwithstanding other agreements between HHSC and Grantee, Grantee assumes all liability arising from the use of testing environments specified by HHSC. HHSC will not be liable in any manner for any damages arising out of Grantee's use of, or inability to use,

**ATTACHMENT A12
INFORMATION RESOURCE SYSTEMS (MH/IRS), VERSION 1**

information systems identified by HHSC or any incidental or consequential damages, including, without limitation, loss of data.

N. Materials Provided under Prior Memorandum of Understanding (MOU)

If Grantee is actively engaged in testing, Grantee may continue to retain test scripts and Software and continue to access Software provided by HHSC subject to the terms of this Statement of Work.

O. Termination

At the termination of the testing period or at the termination of this Statement of Work, whichever is earlier, Grantee shall immediately return to HHSC or destroy all copies of test scripts and Software in its possession and cease accessing the Software version provided by HHSC for use in testing and certify to HHSC that it has done so.

SECTION III. OUTCOME IF GRANTEE CANNOT COMPLETE REQUIRED PERFORMANCE

Unless specified in this Statement of Work, if Grantee cannot complete or otherwise comply with a requirement included in this Statement of Work, HHSC, at its sole discretion, may impose remedies or sanctions outlined under **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 5.09 (Remedies, Sanctions, and Liquidated Damages).

ATTACHMENT A14
PREADMISSION SCREENING, AND RESIDENT REVIEW (MH/PASRR), VERSION 1

CONTRACT NO. HHS001598600026
GRANTEE: NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

SECTION I. PURPOSE

The Preadmission, Screening and Resident Review (PASRR) program supports prescreening all people, regardless of payer source or age, seeking admission to or who are residents of a Medicaid-certified nursing facility (NF), and has the following goals:

1. To identify people with mental illness (MI), intellectual or developmental disability (IDD) and related conditions, including adults and children.
2. To ensure appropriate placement, whether in the community or the NF.
3. To ensure people receive the required PASRR specialized services for MI, and/or IDD.

SECTION II. GRANTEE RESPONSIBILITIES

A. Grantee shall contract with the Health and Human Services Commission (HHSC) to complete PASRR Evaluations (PEs) for individuals seeking admission to a Medicaid-certified NF or a resident of a NF that is suspected of having a mental illness.

B. Grantee shall:

1. Comply with applicable standards for local mental health authorities (LMHAs) and local behavioral health authorities (LBHAs) contained in this Statement of Work and Title 26, Texas Administrative Code (TAC), Part 1, Chapter 303 (Preadmission, Screening and Resident Review (PASRR)).
2. Respond to and conduct all requests for PEs and Resident Reviews (RRs) within Grantee's Local Service Area (LSA) within seventy-two (72) hours after (Title 26, TAC §303.302) notification in the manner prescribed in Title 26, TAC, Part 1, Chapter 303, Subchapters B and C.
3. Document and submit all PEs, RR in the Long-Term Care (LTC) Online Portal within seven (7) calendar days after notification and related activities in a manner that complies with Title 26, TAC, Chapter 303, Subchapters B and C, as well as compliance with this Statement of Work.
4. Maintain access to the Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC) Online Portal, which is incorporated by reference and posted at the link below. Grantee shall check the TMHP LTC Online Portal daily for alerts.

<https://www.tmhp.com/>

5. Maintain a reliable fax line, or other communication mechanism acceptable to HHSC that will document the date and time of receipt of a Preadmission PASRR Level 1 (PL1) Screening Form, which is incorporated by reference and posted at: <https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider->

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PREADMISSION SCREENING, AND RESIDENT REVIEW (MH/PASRR), VERSION 1

[resources/preadmission-screening-resident-review-pasrr/pasrr-forms-instructions.](#)

Identify the telephone number for the identified fax line or the other communication mechanism to be used for PASRR purposes on Form S, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.

6. Provide, track and ensure that all Preadmission PL1 Screening Forms are entered in the TMHP LTC Online Portal for PASRR immediately upon receipt and not to exceed the timeframe as outlined in the Title 26, TAC Chapter 303, §303.302. Grantee shall adhere to HHSC required timelines.
7. Dedicate at least one (1) full time staff member as the primary mental health PASRR Program Specialist. The PASRR Program Specialist must not have assigned duties outside of activities supporting PASRR. The PASRR Program Specialist must be a credentialed Qualified Mental Health Professional - Community Services (QMHP-CS) or otherwise meet the staffing requirements outlined in Title 26, TAC, Chapter 303, §303.303. Grantee shall ensure there is an alternative staff member to act as the PASRR Program Specialist in the absence of the primary PASRR Program Specialist. Grantee shall identify the primary and alternative PASRR Program Specialist on Form S when submitting such documentation to HHSC.
8. Develop policies and procedures in accordance with Title 26, TAC, Chapter 303, Subchapters B, C, and I, that outline the PASRR process and include methods for tracking the status of requests for PEs and RRs and the provision of behavioral health services including assessment and admission information to ensure timely entry of the following:
 - a. All evaluations and encounters carried out and entered into the TMHP LTC Online Portal;
 - b. The HHSC registration into Client Assignment and Registration (CARE) system, materials posted at: <https://www.hhs.texas.gov/providers/behavioral-health-services-providers-programs/behavioral-health-provider-resources/client-assignment-registration-system>;
 - c. The HHSC Uniform Assessment (UA) entered in the Clinical Management for Behavioral Health Services (CMBHS) posted on HHSC's IAMOnline page: <https://iamonline.hhs.state.tx.us>; and
 - d. The HHSC Encounter Data submission for all services according to the procedures, instructions, and schedule established by HHSC, including all required data fields and values in the current version of the HHSC Community Mental Health Service Array. The current version of HHSC Community Mental Health Service Array (*i.e.*, Report Name: INFO Mental Health Service Array Combined) can be found in the Mental and Behavioral Health Outpatient Warehouse (MBOW), in the General Warehouse Information, Specifications subfolder, incorporated by reference and posted on HHSC's IAMOnline page: <https://iamonline.hhs.state.tx.us>.
9. Ensure timely entry of all required PASRR forms and related information into the TMHP LTC Online Portal.

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PREADMISSION SCREENING, AND RESIDENT REVIEW (MH/PASRR), VERSION 1

10. When conducting a PE or RR, provide information, as required in Title 26, TAC, Chapter 303, §303.302, to an individual seeking admission to the NF or resident and the individual's or individual's legally authorized representative (LAR) about community services, supports, and programs for which the individual may be eligible.
11. If the PE or RR is PASRR positive for mental illness (MI), provide the individual, and/or their LAR, in writing, using HHSC forms, a summary of the results of the PE or RR. If the PE or RR is PASRR negative, Grantee shall inform the individual or their LAR of the negative determination in writing using HHSC forms.
12. In accordance with Title 26, TAC, Chapter 303, §303.302 and §303.904:
 - a. Participate in the Initial and Annual Interdisciplinary Team (IDT) meetings for all people who have a PASRR positive PE determination, including those who refused services at the initial IDT meeting.
 - b. Explain the requirement for a UA for individuals who agree in the IDT meeting to receive services.
 - c. After the IDT meeting, confirm in the TMHP LTC Online Portal Grantee's participation in the IDT meeting and the agreed upon or refused MI specialized services.
13. Conduct a UA and develop a Person-Centered Recovery Plan (PCRP) for any individual who has a PASRR positive PE and accepts MI specialized services and convene a meeting to discuss the results of the UA and PCRP within 20 calendar days of the IDT meeting, as specified in Title 26, TAC, Chapter 303, Subchapter I.
14. If Medicaid or other funding is available for MI specialized services, ensure those individuals with a positive PE are admitted into the appropriate Level of Care (LOC) and provided the MI specialized services agreed upon in the IDT meeting without undue delay and within the timeframe as specified in the Title 26, TAC, Chapter 303, Subchapter C.
15. Consistent with Title 26, TAC, Chapter 303, §303.905, provide a copy of the individual's UA and PCRP to the NF to be included in the NF's comprehensive care plan. This includes all updates and revisions to the PCRP while the individual is receiving MI specialized services.
16. If the individual is discharged from MI specialized services, document the individual's discharge from MI specialized services and provide such documentation to the NF to be included in the NF's comprehensive care plan. HHSC may require additional PASRR-related information as requested. If a individual refuses MI specialized services in the initial IDT meeting, Grantee shall ask the individual or their LAR to indicate their refusal in writing using Form 1041, which is posted at:

<https://www.hhs.texas.gov/regulations/forms/1000-1999/form-1041-refusal-pasrr-mental-illness-specialized-services>.

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17. Convene quarterly meetings consistent with Title 26, TAC, Chapter 303, §303.903, for all individuals with a positive PE for MI who accepted MI specialized services and include members of the MI specialized services team.

SECTION III. PERFORMANCE MEASURES

- A. HHSC may impose remedies or sanctions against Grantee as stated in **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Article VI, and as stated within Section III(E) of this Statement of Work, for failure to comply with the provisions of this Statement of Work. Factors to be considered in determining assessment of the sanctions shall include:
 1. Any major event that interfered with the ability of Grantee to complete the task in a timely manner including weather conditions that made travel hazardous and thereby interfered with the ability of Grantee to complete the PE.
 2. Equipment malfunctions of the TMHP LTC Online Portal that made the timely entry of data impossible for Grantee.
 3. Local equipment malfunctions beyond the control of Grantee that made the timely entry of data into the TMHP LTC Online Portal impossible for Grantee.
- B. Grantee shall submit a copy of the policies and procedures outlined in Section II(B)(8) of this Statement of Work no later than October 1st of each state fiscal year (beginning September 1st through August 31st) to performance.contracts@hhs.texas.gov with a courtesy copy to the assigned HHSC Contract Manager.
- C. Grantee shall notify HHSC, through submission of **Form S, Contact List**, within one (1) business day of any change to the primary PASRR Program Specialist or the telephone number for the identified PASRR fax line. **Form S, Contact List**, is incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. This form shall be submitted to performance.contracts@hhs.texas.gov with a copy to the assigned HHSC contract manager.
- D. Grantee shall meet the following performance measures which are reviewed by HHSC semi-annually:
 1. Percent of all PEs or resident reviews completed and entered into the TMHP LTC Online Portal within seven calendar days after receiving a copy of the PL1 from the referring entity or notification from the TMHP LTC Online Portal: Grantee shall enter at least 95% of all PEs or resident reviews completed within seven (7) calendar days after receiving a copy of the PL1 each quarter.
 2. Percent of compliance with providing follow-up visits every 30 days for 90 days after the initial IDT meeting, and make the 90th day follow-up visit the first MI quarterly meeting

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for individuals who have refused MI specialized services in the initial IDT Meeting. Grantee shall complete at least 95% of the required follow-up visits.

3. Percent of compliance with confirming attendance and the specialized services agreed upon in the IDT meeting on the LTC Online Portal within five (5) business days after receiving notification from the LTC Online Portal that the NF entered the information from the IDT meeting. Grantee shall confirm attendance at the IDT meeting and all specialized services agreed to in the IDT meeting within the LTC Online Portal for at least 95% of notifications received each quarter.

- E. Sanctions associated with the Performance Measures in Section III(D) may be imposed based on the following chart:

LMHA/LBHA Total Adjusted Annual Allocation	Amount
Up to \$1.5 million	\$1,000.00
Not to exceed	\$6,000.00
Up to \$3 million	\$2,000.00
Not to exceed	\$12,000.00
Greater than \$3 million	\$3,000.00
Not to exceed	\$18,000.00

The allocation noted above equals Grantee's total annual allocation minus Grantee's one-time funding adjustments, as applicable. Each sanction will be applied separately to each of the five applicable sanctions listed in Section III(D) above.

If services are not provided as prescribed, HHSC may require enhanced oversight, which may include monthly reporting on PASRR activities.

SECTION IV. PAYMENT METHOD

HHSC will not make payments to Grantee for services described in this Statement of Work. Grantee bills and receives payment by submitting applicable Medicaid claims to TMHP.

SECTION V. OUTCOME IF GRANTEE CANNOT COMPLETE REQUIRED PERFORMANCE

Unless otherwise specified in this Statement of Work, if Grantee cannot complete or otherwise comply with a requirement included in this Statement of Work, HHSC, at its sole discretion, may impose remedies or sanctions outlined under **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 5.09 (Remedies, Sanctions, and Liquidated Damages).

ATTACHMENT A23
NON-HHSC FUNDED JAIL-BASED COMPETENCY RESTORATION PROGRAM
(MH/NJBCR), VERSION 1

CONTRACT NO. HHS001598600026
GRANTEE: NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

SECTION I. PURPOSE

The purpose of the Non-HHSC Funded Jail-Based Competency Restoration Program Statement of Work is to outline operational and reporting requirements supporting HHSC's statewide oversight efforts for Jail-Based Competency Restoration Programs.

SECTION II. GRANTEE RESPONSIBILITIES

- A. A local mental health authority (LMHA) or local behavioral health authority (LBHA) contracting with a county to provide non-HHSC funded county-based jail-based competency restoration (JBCR) services shall:
- 1) Comply with Texas Administrative Code (TAC), Title 26, Part 1, Chapter 307, Subchapter C, relating to Jail-Based Competency Restoration Program;
 - 2) Comply with Code of Texas Criminal Procedure (CCP), Chapter 46B, including Article 46B.091 (Jail-Based Competency Restoration Program Implemented by County);
 - 3) Notify HHSC's Contract Manager of the intention to become a provider of JBCR services or of the intention to use a subcontractor to provide JBCR services, prior to entering an agreement with a county to provide JBCR services;
 - 4) In accordance with Texas CCP, Chapter 46B, Article 46B.091 (Jail-Based Competency Restoration Program Implemented by County):
 - a. allow HHSC to inspect the JBCR program prior to serving individuals and as further deemed appropriate by HHSC; and
 - b. ensure no JBCR services are provided until HHSC confirms the LMHA or LBHA is a provider of JBCR services, or an LMHA or LBHA who subcontracts for JBCR services and is in good standing with HHSC as defined in 26 TAC section 307.105(9).
- B. Grantee shall perform the following activities and provide documentation in the manner and timeframes specified below:
- 1) Grantee shall complete registration for each individual admitted to the JBCR program into the Client Assignment and Registration system no later than 24 hours following admission;
 - 2) Grantee shall complete a "client profile" for each individual admitted to the JBCR program into the Clinical Management for Behavioral Health Services system no later than 24 hours following admission;
 - 3) Grantee shall collect and report data to HHSC in accordance with the **Information Item S, LMHA/LBHA Submission Calendar**, incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>, as required per 26 TAC, Part 1, Chapter 307, Subchapter C, Rule §307.129.

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NON-HHSC FUNDED JAIL-BASED COMPETENCY RESTORATION PROGRAM
(MH/NJBCR), VERSION 1**

- 4) All reports, documentation, and other information specified as required within this Statement of Work shall be submitted electronically to: performance.contracts@hhs.texas.gov, as well as to the assigned HHSC Contract Manager.

SECTION III. OUTCOME IF GRANTEE CANNOT COMPLETE REQUIRED PERFORMANCE

Unless otherwise specified in this Statement of Work, if Grantee cannot complete or otherwise comply with a requirement included in this Statement of Work, HHSC, at its sole discretion, may impose remedies or sanctions outlined under **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 5.09 (Remedies, Sanctions, and Liquidated Damages).

ATTACHMENT A24
EDUCATION SERVICE CENTER BASED BEHAVIORAL HEALTH PARTNERSHIP
PROGRAM (MH/ESC), VERSION 1

CONTRACT NO. HHS001598600026
GRANTEE: NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

SECTION I. PURPOSE

The Non-Physician Mental Health Professional (NPMHP) program is now referred to as the Behavioral Health Partnership Program (BHPP). Pursuant to Education Code §8.152(a), a Grantee shall employ an individual to serve as a non-physician mental health professional (NPMHP), who shall be a mental health and substance use resource for school districts located in the region served by a regional education service center (ESC). The definition of an NPMHP is included within Texas Health and Safety Code § 571.003, and the duties of an NPMHP are outlined in Texas Education Code § 8.155. Senate Bill (S.B.) 26 (88th Regular Session, 2023) amended Texas Education Code §8.152 to allow Local Mental Health Authorities (LMHAs) or Local Behavioral Health Authorities (LBHAs) unable to employ an NPMHP, to seek a waiver from HHSC to instead employ a licensed master social worker (LMSW) or a licensed professional counselor associate (LPC-A) to fulfill the duties of an NPMHP. The program's name was changed to the Behavioral Health Partnership Program (BHPP) due to the expansion of the types of professionals that may potentially fulfill the NPMHP role, and the position was renamed Behavioral Health Partnership Program Liaison (BHPP Liaison).

SECTION II. GRANTEE RESPONSIBILITIES

A. The Grantee must:

1. Enter into an agreement with the regional ESC to provide the services outlined in this Statement of Work. Such agreement must include the annual cost-recovery fee as outlined in Texas Education Code § 8.153 (Interagency Collaboration; Memorandum of Understanding);
2. Employ a BHPP liaison to serve as a mental health and substance use resource for school districts located in the region served by an ESC and in which the LMHA or LBHA delivers services; Pay a reasonable negotiated cost-recovery fee for the space and administrative cost to the ESC for the BHPP liaison to carry out the professional duties outlined in Texas Education Code §8.155; Not pay a cost-recovery fee exceeding \$15,000 per year unless the LMHA or LBHA and the ESC agree to a higher amount;
3. Supervise the BHPP liaison;
4. Consult with any other LMHA or LBHA in the region and the regional ESC for input on supervising the BHPP liaison;
5. Submit **Form R, Behavioral Health Partnership Quarterly Report**, to HHSC's Contract Manager and the BHPP mailbox at BHPP@hhs.texas.gov according to the schedule defined in **Information Item S, LMHA/LBHA Submission Calendar**, both of which are incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;

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6. Compile quarterly reports to submit annually, within **Form W, Behavioral Health Partnership Annual Report**, to HHSC's Contract Manager and the BHPP mailbox at BHPP@hhs.texas.gov according to the schedule defined in **Information Item S, LMHA/LBHA Submission Calendar**, both of which are incorporated by reference and posted at: <https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>;
7. If unable to fill the BHPP Liaison with an NPMHP, submit a written waiver request, as required under Texas Education Code 8.152(c), to the BHPP mailbox and ensure an LMSW or an LPC associate is eligible for an HHSC waiver request as outlined in this subchapter and the LMSW or LPC associate has the ability to fulfill the duties outlined in this subchapter if a waiver is requested;
8. Retain documentation in accordance with the LMHA's and LBHA's policies and procedures on efforts made to hire an NPMHP before submitting a waiver request;
9. Submit a new waiver request, as needed, if the HHSC BHPP liaison vacates the position.
 - a. If a BHPP liaison vacates the position within one year of approval of the waiver under subsection (a)(12) of this section, a new waiver request is not required.
 - b. If a BHPP liaison vacates the position more than a year after approval of the waiver under subsection (a)(12) of this section, the LMHA or LBHA must attempt to hire a professional pursuant to Texas Education Code §8.152 before requesting a waiver under subsection (a)(12) of this section;
10. Determine which Local Mental Health Authority or Local Behavioral Health Authority employs a Behavioral Health Partnership Program Liaison; and
11. If two or more LMHAs or LBHAs provide services in a region served by a regional ESC, the LMHA or LBHA that primarily operates in the county in which the center is located shall:
 - a. In making a hiring decision about a BHPP liaison, consult with the other LMHAs or LBHAs providing services in the region;
 - b. Consult with the ESC before making the final hiring decision; and
 - c. Employ the BHPP liaison.

SECTION III. BEHAVIORAL HEALTH PARTNERSHIP PROGRAM LIAISON RESPONSIBILITIES

- A. BHPP liaison is responsible for carrying out the following functions and duties required of an NPMHP in accordance with Texas Education Code §8.155:
 1. Helping school district personnel gain awareness and a better understanding of mental health and co-occurring mental health and substance use disorders;
 2. Assisting school district personnel to implement initiatives related to mental health or substance use under state law or agency rules, interagency memorandums of understanding, and related programs; and
 3. Ensuring school district personnel are aware of:

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PROGRAM (MH/ESC), VERSION 1

- a. The list of recommended best practice-based programs and research-based practices developed under Texas Education Code §38.351;
 - b. Other public and private mental health and substance use prevention, treatment, and recovery programs available in the school district, including evidence-based programs delivered by an LMHA or LBHA and other public and private mental health resources, such as the Texas School Mental Health Resources database as required by Texas Education Code §38.253; and
 - c. Other available public and private mental health and substance use prevention, treatment, and recovery program resources administered by the LMHA or LBHA or HHSC to support school districts, students, and families.
4. Monthly, the BHPP Liaison must:
- a. Facilitate the provision of mental health first aid training;
 - b. Facilitate the provision of training on the effects of grief and trauma and providing support to children with intellectual or developmental disabilities who suffer from grief or trauma; and
 - c. Facilitate the provision of training on prevention and intervention programs that have been shown to be effective in helping students cope with pressures to use alcohol, cigarettes, or illegal drugs or misuse prescription drugs.
- B. A BHPP liaison employed under this subchapter must not treat or provide counseling to a student or provide advice to school district personnel regarding a specific student.

SECTION IV. TEXAS HEALTH AND HUMAN SERVICES COMMISSION WAIVER
PROCESS RESPONSIBILITIES

- A. HHSC agrees to provide Grantees the ability to request a waiver through an HHSC-approved process for the purpose of allowing a Licensed Master Social Worker (LMSW) or a Licensed Professional Counselor Associate (LPC-A) the ability to fulfill the responsibilities outlined in Section II of this contract.
- B. The HHSC Executive Commissioner or Designee will deliver written notification to the LMHA or LBHA within ten business days after receipt of the submission regarding:
 - 1. whether the waiver request is approved; or
 - 2. the opportunity to remedy and resubmit the waiver request if the waiver request is denied.

SECTION V. CONTRACT DELIVERABLES, PERFORMANCE MEASURES, AND
PERFORMANCE MEASURES REPORTING

- A. Grantee shall participate in technical assistance calls scheduled by HHSC.
- B. The terms of this Statement of Work, including the following performance measures, will be used to assess Grantee's effectiveness in providing the services described in this Statement of Work, without waiving the enforceability of any of the terms of the Contract into which this Statement of Work is incorporated. For each reporting period, Grantee shall report the following:

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PROGRAM (MH/ESC), VERSION 1

1. How Grantee shared recommended evidence-based best practices, including:
 - a. A list of school districts;
 - b. A list of methods used to share evidence-based best practices; and
 - c. A list of specific practices shared.
2. How Grantee assisted school and ESC personnel to implement initiatives related to mental health, including:
 - a. A list of school districts;
 - b. Number of people this activity reached; and
 - c. A list of methods used to implement initiatives related to mental health.
3. How Grantee assisted school or ESC personnel to implement initiatives related to substance use, including:
 - a. A list of school districts;
 - b. Number of people this activity reached; and
 - c. A list of methods used to implement initiatives related to mental health.
4. How Grantee increased awareness of local mental health and substance use resources in your area, including:
 - a. A list of school districts;
 - b. Number of people this activity reached; and
 - c. A list of methods used to implement initiatives related to mental health.
5. Number of Mental Health First Aid Trainings conducted including:
 - a. If the training conducted was for adults, teens, or youths;
 - b. The date the training was presented;
 - c. The number of participants reached;
 - d. The name of the Mental Health Aid presenter;
 - e. The county the training was conducted in; and
 - f. The location the training was conducted at.
6. Trauma and Grief Trainings:
 - a. The training topic or title; Date training was presented;
 - b. Number of participants this training reached;
 - c. Name of the Mental Health First Aid Presenter;
 - d. Identification of the audience: adults, youth, or both;
 - e. County the training was conducted in; and
 - f. Location the training was conducted at.
7. Trauma and Grief-Focused Training for Children with Intellectual and Developmental Disabilities:
 - a. Training topic or title; Date training was presented;
 - b. Number of participants this training reached;
 - c. Name of the Mental Health First Aid Presenter;
 - d. Identification of the audience: adults, youth, or both;
 - e. County the training was conducted in; and

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- f. Location the training was conducted.
- C. Substance Use Prevention and Intervention Trainings:
 - 1. Training topic or title; Date training was presented;
 - 2. Number of participants this training reached;
 - 3. Name of the Mental Health First Aid Presenter;
 - 4. Identification of the audience: adults, youth, or both;
 - 5. County the training was conducted in; and
 - 6. Location the training was conducted.

SECTION VI. PAYMENT METHOD

Quarterly Allocation. The quarterly allocation must be used to cover the salary, benefits, and associated operational expenses of the BHPP Liaison.

SECTION VII. OUTCOME IF GRANTEE CANNOT COMPLETE REQUIRED PERFORMANCE

Unless otherwise specified in this Statement of Work, if Grantee cannot complete or otherwise comply with a requirement included in this Statement of Work, HHSC, at its sole discretion, may impose remedies or sanctions outlined under **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 5.09 (Remedies, Sanctions, and Liquidated Damages).

ATTACHMENT A25
POST-DISCHARGE MEDICATIONS FOR CIVIL COMMITMENTS (MH/PDMCC),
VERSION 1

CONTRACT No. HHS001598600026
GRANTEE: NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

SECTION I. PURPOSE

The Post-Discharge Medications for Civil Commitments project is designed to support Grantee's requirement to provide or pay for psychoactive medication and any other medication prescribed to a qualified individual, as defined below, to counteract adverse side effects of psychoactive medication.

SECTION II. GRANTEE RESPONSIBILITIES

- A. Grantee shall develop and deploy policies and procedures to provide or pay for medication(s) for individuals receiving court-ordered mental health treatment and discharging from HHSC-funded private psychiatric beds (MH/PPB) and community mental health hospital (MH/CMHH) beds in compliance with Texas Health and Safety Code (THSC) Section 574.081, Subchapter F. (Continuing Care Plan Before Furlough or Discharge).
 - 1. Section 574.081 only applies to individuals receiving court-ordered mental health treatment who are scheduled to be furloughed or discharged from a subcontracted MH/PPB or MH/CMHH facility. It excludes individuals on Emergency Detention, THSC, Chapter 573, *et seq.*, and excludes individuals on Orders of Protective Custody, THSC, Chapter 574, Subchapter B, *et seq.*
 - 2. Section 574.081 requires the provision of psychoactive medication, and any other medication to counteract adverse side effects of psychoactive medication, to patients as outlined in their continuing care plan.
- B. Grantee shall utilize the funds allocated under this Statement of Work to provide for seven days of medication(s) to individuals prior to furlough or discharge from a subcontracted MH/PPB or MH/CMHH facility.

SECTION III. FUNDING

- A. Funds allocated provide or pay for psychoactive medications, as specified in Texas Health and Safety Code Section 574.081 are subject to change each fiscal year.
- B. Once Grantee exhausts funds allocated under this Statement of Work, Grantee is no longer required to provide or pay for medication(s) under this Statement of Work.
- C. Grantee shall report the expenditure of funding allocated under this Statement of Work using **Form AA, SB 362 Tracking**, and on a schedule outlined in **Information Item S, LMHA/LBHA Submission Calendar**, both of which are incorporated by reference and posted at:
<https://www.hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>.

**ATTACHMENT A25
POST-DISCHARGE MEDICATIONS FOR CIVIL COMMITMENTS (MH/PDMCC),
VERSION 1**

SECTION IV. PAYMENT METHOD

Quarterly allocations.

SECTION V. OUTCOME IF GRANTEE CANNOT COMPLETE REQUIRED PERFORMANCE

Unless otherwise specified in this Statement of Work, if Grantee cannot complete or otherwise comply with a requirement included in this Statement of Work, HHSC, at its sole discretion, may impose remedies or sanctions outlined under **ATTACHMENT D, LOCAL MENTAL HEALTH AUTHORITY SPECIAL CONDITIONS**, Section 5.09 (Remedies, Sanctions, and Liquidated Damages).

ATTACHMENT D

LOCAL MENTAL HEALTH AUTHORITY (LMHA) SPECIAL CONDITIONS, VERSION 1

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ATTACHMENT D

LOCAL MENTAL HEALTH AUTHORITY (LMHA) SPECIAL CONDITIONS, VERSION 1

ARTICLE I FORMS

1.01 Manuals, Reports, Exhibits and Forms

Manuals, reports, exhibits and forms referenced in this Grant Agreement are located at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. Grantee shall use the reports and forms required by this Grant Agreement as they now exist and as they may be revised during the Grant term. HHSC will notify Grantee of revisions to the reports and forms. All manuals, reports, exhibits and forms are incorporated by reference into this Grant Agreement.

1.02 Information Items

Information items referenced in this Grant Agreement are located at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. These items provide instructions regarding service delivery, reporting requirements and report preparation for this Grant Agreement. Nothing in such instructions shall be interpreted as changing or superseding the terms of this Grant Agreement. All information items are incorporated by reference into this Grant Agreement.

1.03 Submission Calendar

Information Item S (Submission Calendar) is located at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>. The Submission Calendar is a listing of due dates applicable to the submission and reporting requirements of this Grant Agreement. Grantee shall submit all reports and information required under this Grant Agreement in accordance with the Submission Calendar.

1.04 Texas Grant Management Standards

Texas Government Code Chapter 783 and the Texas Grant Management Standards (TxGMS) referenced in this Grant Agreement are located on the Internet at <https://statutes.capitol.texas.gov/> and <https://comptroller.texas.gov/purchasing/grant-management/>, respectively.

ARTICLE II FUNDING

2.01 Budget

Grantee shall maintain a system of budget control that complies with TxGMS. Grantee shall earn and expend funds according to a budget, in the format of Report III-IV.

2.02 Program Income

Program Income shall be reported on the appropriate form and shall offset expenditures within general revenue. Any program income funds shall only be used for the program/area where the funds are earned. Program Income may be used as part of the required local match.

2.03 Use of Funds.

- a. This Grant Agreement shall not be construed as creating any debt on behalf of the State of Texas or HHSC in violation of Article III, Section 49, of the Texas Constitution. In compliance with Article VIII, Section 6 of the Texas Constitution, it is understood that all obligations of HHSC hereunder are subject to the availability of state funds.
- b. Grantee shall spend funds provided under a Statement of Work, including local match funds, solely for reasonable and allowable expenses directly related to the functions provided pursuant to that Statement of Work.

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LOCAL MENTAL HEALTH AUTHORITY (LMHA) SPECIAL CONDITIONS, VERSION 1

- c. Grantee shall expend funds appropriated for adult and child mental health services as specified in the Statement of Work.
- d. Grantee shall expend at least ten percent (10%) of mental health block grant funds for children's services identified in the Statement of Work.
- e. Grantee shall expend funds as directed under the Statement of Work for services to individuals identified in the "Populations Served" section of the Statement of Work, as applicable, or to any person determined to be eligible based on screening and assessment.
- f. Grantee shall limit use of funds allocated for Community Mental Health Crisis Services to the development, expansion, and delivery of crisis services.
- g. Grantee shall maintain funding levels in the use of general funds allocated to Adult Services and Children's Services for support and delivery of crisis services and shall not use funds allocated for Community Mental Health Crisis Services to supplant funds historically expended for the delivery of crisis services.

2.04 Use for Match Prohibited

Grantee shall not use the same local match funds required under this Grant Agreement to satisfy any local match requirement of another System Agency.

2.05 Non-Supplanting

Grantee shall make a good faith effort to maintain the level of funding for activities covered under this Contract. Grantee shall not use any new state funding received, or that may be received, under this Grant Agreement to supplant previously allocated state or local funds. Federal block grant funds may be used to increase state or local funds currently available for a particular activity. HHSC may require Grantee to submit evidence that a reduction in local funding, if any, resulted for reasons other than receipt or expected receipt of block grant funding under this Grant Agreement.

2.06 Return of Funds

Grantee shall return to HHSC all funds allocated that have not been encumbered for purposes authorized by this Grant Agreement. Grantee shall return to HHSC all unauthorized funds no later than thirty (30) days after submission of each fiscal year's independent audit.

2.07 Directed Payment Program for Behavioral Health Services (DPP-BHS)

Grantee may expend general revenue to obtain federal financial participation under the DPP-BHS for activities in accordance with this Grant Agreement and applicable state regulations. Grantee shall report such expenditures on the form provided by HHSC.

ARTICLE III ALLOWABLE COSTS AND AUDIT REQUIREMENTS

3.01 Allowable Costs

Only those costs allowable under TxGMS and 2 CFR 200 are allowable under this Grant Agreement.

3.02 Purchases with Grant Agreement Funds

Grantee may use Grant Agreement funds for:

- a. Cumulative expenditures up to **ONE HUNDRED THOUSAND DOLLARS (\$100,000)** during the Grant Agreement term for the acquisition of automatic data processing resources (which includes computer hardware and software), whether by outright purchase, rental-purchase agreement, or other method of purchase;
- b. Rental or lease expenditures on buildings and related facilities up to the market value of the lease space;

ATTACHMENT D

LOCAL MENTAL HEALTH AUTHORITY (LMHA) SPECIAL CONDITIONS, VERSION 1

- c. Cumulative reconversion costs incurred in the restoration or rehabilitation of Grantee's rental or lease property in an amount equal to the greater of twenty-five percent (25%) of the annual lease or rental expense or **FIFTY THOUSAND DOLLARS (\$50,000.00)**;
- d. Expenditures for insurance, up to the following coverage limits:
 - 1) workers compensation, up to the statutory limit;
 - 2) public official's errors and omissions, up to **ONE MILLION DOLLARS (\$1,000,000.00)** per claim and **ONE MILLION DOLLARS (\$1,000,000.00)** annual aggregate;
 - 3) professional liability, up to **ONE MILLION DOLLARS (\$1,000,000.00)** per occurrence/**THREE MILLION DOLLARS (\$3,000,000.00)** annual aggregate;
 - 4) general liability, up to **ONE MILLION DOLLARS (\$1,000,000.00)** per occurrence;
 - 5) automobile liability, up to **ONE MILLION DOLLARS (\$1,000,000.00)** per occurrence;
 - 6) automobile physical damage, up to the actual cash value of the vehicles;
 - 7) property, up to the replacement cost value of properties;
 - 8) flood coverage; and
 - 9) windstorm coverage;
- e. Cumulative expenditures up to **ONE HUNDRED FIFTY THOUSAND DOLLARS (\$150,000.00)** of Grantee's operating budget for management studies by third parties to improve the effectiveness and efficiency of Grantee; and
- f. Costs of contracted professional services.

ALL OTHER EXPENDITURES REQUIRE PRIOR APPROVAL BY AN AUTHORIZED HHSC REPRESENTATIVE.

3.03 Indirect Costs

Grantee shall expend no more than Grantee's HHSC-acknowledged or approved indirect cost rate (ICR) on indirect costs under this Grant Agreement. Grantee's HHSC-acknowledged or approved ICR is incorporated into this Grant Agreement as **Attachment I**.

3.04 Disallowance of Costs

HHSC will reject all requests for approval of expenditures that are inconsistent with or not authorized under the Statement of Work.

3.05 Independent Audit

Grantee shall conduct, or cause to be conducted, an annual comprehensive financial and compliance audit for the previous state fiscal year. This audit shall be prepared in accordance with the provisions outlined below and shall be submitted in accordance with the Submission Calendar.

- a. Texas Health & Safety Code § 534.068;
- b. Title 26, Texas Administrative Code, Part 1, Chapter 300, Subchapter A; and
- c. HHSC's *Guidelines for Annual Financial and Compliance Audits of Community MHMR Centers* (21st Revision - February 2005) (the "Audit Guidelines"). HHSC's Audit Guidelines, Part 1 Annual Financial Audit, Section III. Engagement of External Auditors, Letter C. Selection of Auditor is deleted in its entirety and replaced with the following language:

C. Selection of Auditor

The Board of Trustees is required to obtain a single audit each year and must competitively reprocure single audit services once every six (6) years.

HHSC may require Grantee to complete a single audit or program-specific audit. The single audit online determination form is located at <https://heart.hhs.state.tx.us/heartwebextr/hhscSau>.

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If the single audit online determination form is not completed within thirty (30) days after notification by HHSC to do so, the Grantee may be subject to sanctions and remedies for non-compliance with the Grant Agreement.

3.06 Interest Earned

Interest earned in excess of \$250 on state funds allocated to Adult Services, Children's Services, or Community Mental Health Crisis Services may be used only for the services described, and during the term of this Grant Agreement. Interest earned on funds received from the federal government must be handled in accordance with federal law.

ARTICLE IV REPORTS AND OTHER SUBMISSION REQUIREMENTS

4.01 Financial Reports

- a. Grantee shall submit a quarterly financial report on the form provided by HHSC and in accordance with the Submission Calendar. Copies of Grantee's quarterly financial statements for the general fund account groups, including the balance sheet, income statement and general fund balance for Grantee in total, as prepared for presentation to Grantee's governing body, and a certification of the accuracy of such statements, shall also be submitted on the form provided.
- b. In addition to the required quarterly financial reports, HHSC may require Grantee to submit monthly financial statements in accordance with the Submission Calendar. HHSC will notify Grantee, through technical guidance correspondence, of its requirement to submit, or no longer submit, monthly financial statements. If HHSC requires submission of monthly financial statements, then copies of Grantee's statements shall include a balance sheet, statement of revenues and expenditures, and projected cash flow. A certification of the accuracy of such statements is not required for the monthly financial statement submission.

4.02 Program and Progress Reports

Grantee shall submit required program and progress reports in the format specified by HHSC.

4.03 Significant Incidents

Grantee shall report any incidents that result in substantial disruption (*i.e.*, significant interference with or impact on standard operations) of program operation involving or potentially affecting persons served to the HHSC Contract Manager within seventy-two (72) hours if the incident.

4.04 Other Submissions

Grantee shall submit accurate and timely information to HHSC in accordance with the Submission Calendar or, if not included in the Submission Calendar, the timelines below, as follows:

- a. comprehensive monthly encounter data for all Services, including all required data fields and values in the current version of the HHSC Community Mental Health Service Array. The HHSC Community Mental Health Service Array is incorporated by reference in this Grant Agreement and is found within the General Warehouse Information, Specifications subfolder using [IAMOnline](#);
- b. supporting reports, data, work papers and information, as requested by HHSC;
- c. within ten business days after request:
 - 1) data and information required for reporting to the Center for Mental Health Services' Inventory of Mental Health Organizations;
 - 2) data and information regarding Grantee's efforts to use the most cost-effective medication purchasing arrangements possible; and
 - 3) affidavits of the members of Grantee's governing body and of the executive director on the forms provided by HHSC.

ATTACHMENT D

LOCAL MENTAL HEALTH AUTHORITY (LMHA) SPECIAL CONDITIONS, VERSION 1

- d. within five business days following a request by HHSC, copies of the minutes of Grantee's board meetings;
- e. within one business day after completion of a Client Abuse and Neglect Report required under Title 25, Texas Administrative Code, Part 1, Chapter 414, Subchapter L, § 414.558, the information contained in or a copy of the completed form;
- f. Cost Accounting Methodology (CAM) report information according to the procedures, instructions and schedule established by HHSC;
- g. if applicable, Historically Underutilized Businesses (HUB) Subcontracting Plan Prime Contractor Progress Assessment Report located at <https://comptroller.texas.gov/purchasing/docs/hub-forms/ProgressAssessmentReportForm.xls> to HHSC HUB Coordinator to HHSCHUB@hhs.texas.gov;
- h. expenditures for Title XX and TANF transfer to Title XX intended use, on the form provided by HHSC; and
- i. as necessary and as requested by HHSC, all other submissions.

4.05 Child Abuse Reporting Requirement

Grantee shall comply with child abuse reporting guidelines and requirements in Texas Family Code Chapter 261 relating to investigations of reports of child abuse and neglect. Grantee shall develop, implement, and enforce a written child abuse reporting policy, and shall train all staff on reporting requirements.

ARTICLE V MISCELLANEOUS PROVISIONS

5.01 Duty of Compliance

- a. Grantee and its board of trustees shall bear full responsibility for the integrity of the fiscal and programmatic management of the organization. Such responsibility shall include:
 - 1) accountability for all funds and materials received from HHSC;
 - 2) compliance with the standards of administration for boards of trustees described in Title 26, Texas Administrative Code § 300.15, and other applicable HHSC rules, policies, procedures, and applicable federal and state laws and regulations; and
 - 3) correction of fiscal and program deficiencies identified through self-evaluation and HHSC's monitoring processes.
- b. Grantee's board of trustees shall ensure a separation of powers, duties, and functions between board members and Grantee staff. Grantee staff members, including the executive director, shall not serve on Grantee's board. Ignorance of any provisions or other requirements contained or referenced in this Grant Agreement shall not constitute a defense or basis for waiving or appealing such provisions or requirements.

5.02 Management and Control Systems

Grantee shall maintain an appropriate contract administration system to ensure that all Grant Agreement terms, conditions, and specifications are met. Grantee shall develop, implement, and maintain financial management and control systems that meet or exceed the requirements of TxGMS, and that adhere to the following requirements:

- a. budgets must adequately reflect all functions and resources necessary to carry out authorized activities and the adequate determination of costs;
- b. accounting records must be accurate, correct, and must completely identify the source and application of Grant Agreement funds, and support the information contained in required financial reports;

ATTACHMENT D

LOCAL MENTAL HEALTH AUTHORITY (LMHA) SPECIAL CONDITIONS, VERSION 1

- c. systems must provide for: cost source documentation; effective internal and budgetary controls; determination of reasonableness, allowability, and allocability of costs; and timely and appropriate audits and resolution of any findings; and
- d. systems must provide for billing and collection policies that comply with Title 26, Texas Administrative Code, Part 1, Chapter 301, Subchapter C, Charges for Community Services.

5.03 Fund Accounting

Grantee shall maintain accounting systems that comply with TxGMS. Grantee shall separately report actual expenditures and actual revenues attributable to Community Mental Health for Adults and Children. Grantee shall report expenditures by object of expense and method of finance in accordance with the strategies indicated in Report III-IV. On a quarterly basis, Grantee shall reconcile accounting transactions from its general ledger to Report III-IV by object of expense and method of finance.

5.04 Cost Accounting Methodology (CAM)

Grantee shall use the Cost Accounting Methodology Manual (CAM Manual) to provide a consistent methodology for determining the cost of services, and analysis of provider productivity. Using the CAM data, Grantee shall develop and implement management processes for the allocation and development of resources and the oversight of services, as required in the Statement of Work.

5.05 Productivity Benchmarks

Grantee shall maintain productivity benchmarks for each server type, as defined in the CAM Manual, Schedule C.

5.06 General Appropriations Act Requirements

Grantee shall comply with the limitations and reporting requirements specified in Article IX, § 4.04 ("Limitation on Grants to Units of Local Governments") of the General Appropriations Act.

5.07 Real Property Acquisition and Construction

Grantee shall comply with the provisions of Texas Health and Safety Code §§ 534.020-.022 ("Acquisition and Construction of Property and Facilities by Community Center"), Texas Health and Safety Code §534.021 ("Approval and Notification Requirements"), Title 26, Texas Administrative Code, Part 1, Chapter 300, Subchapter A, Rules §310.15, C (1-3), and Title 40, Texas Administrative Code, Part 1, Chapter 1, Subchapter G, Rules §1.310, C (1-3).

Grantee shall use Form KK - Real Property Acquisition and Construction Review Form found at this website: <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/behavioral-health-provider-resources/community-mental-health-contracts>

In no event shall acquisition or construction occur without prior written approval, timely notification or a form notification period waiver signed by the HHSC Executive Commissioner or designee.

5.08 References

- a. Captions contained in this Grant Agreement are for reference purposes only and do not affect the meaning of this Grant Agreement.
- b. Unless otherwise noted, all references in this Grant Agreement to "days" shall mean calendar days.
- c. All references to quarterly allocations in this Grant Agreement shall mean state fiscal quarter as follows:
 - 1) Quarter 1: September 1 through November 30;
 - 2) Quarter 2: December 1 through February 28;

ATTACHMENT D

LOCAL MENTAL HEALTH AUTHORITY (LMHA) SPECIAL CONDITIONS, VERSION 1

- 3) Quarter 3: March 1 through May 31; and
- 4) Quarter 4: June 1 through August 31.

5.09 Remedies and Sanctions and Liquidated Damages

Remedies, Sanctions, and Liquidated Damages. HHSC may, at its sole discretion, impose remedies, sanctions, and liquidated damages identified below for each occurrence of noncompliance with a requirement of this Grant Agreement on a case-by-case basis.

- a. Remedies may include any one or more of the following:
 - 1) limit general revenue allocations to monthly distributions instead of quarterly allocations;
 - 2) require removal of any officer or employee of Grantee who has been convicted of misusing state or federal funds, fraud, or illegal acts that compromise Grantee's continued performance of obligations under this Grant Agreement;
 - 3) require Grantee to retain a consultant or to obtain technical, training, or managerial assistance in the areas of concern at Grantee's sole cost;
 - 4) suspend all or part of this Grant Agreement. Suspension is, depending on the context, either (a) the temporary withdrawal of Grantee's authority to obligate Grant Agreement funds pending corrective action or pending a decision to terminate or amend the Grant Agreement, or (b) an action taken to immediately exclude a person from participating in Grant Agreement transactions for a period, pending completion of an investigation and such legal or debarment proceedings as may ensue. Grantee costs resulting from obligations incurred during a suspension are not allowable unless expressly authorized by the notice of suspension;
 - 5) deny additional or future contracts or renewals;
 - 6) designate Grantee as High Risk (*e.g.*, there is a significant risk of harm to individuals served or Grantee's operations or HHSC-funded services, or potential misuse of funding or resources, or concerns of fraud, waste, or abuse);
 - 7) establish additional prior approvals for expenditure of Grant Agreement funds;
 - 8) require submission of additional, more detailed, financial and/or programmatic reports; and/or
 - 9) impose other remedies provided by law.
- b. Sanctions include:
 - 1) Recoupments for failing to meet a service target or performance measure as outlined in the Statement of Work.
 - 2) Temporarily withhold allocated funds, pending resolution of issues of noncompliance with Grant Agreement requirements or indebtedness to the United States or to the State of Texas.
 - 3) Permanently withhold allocated funds or require Grantee to return allocated funds for:
 - a. unallowable, undocumented, inaccurate, or improper expenditures;
 - b. failure to comply with Grant Agreement requirements; or
 - c. indebtedness to the United States or to the State of Texas.
 - 4) Recoup improper payments when it is verified that Grantee has been overpaid because of improper billing or accounting practices or failure to comply with Grant Agreement terms.
 - 5) Reduce allocated funds for failure to achieve local match.
 - 6) Reduce allocated funds for failure to expend funds at a rate that will make full use of the allocation.
 - 7) Reducing the term of this Grant Agreement.
- c. Liquidated Damages. Grantee agrees that noncompliance with the requirements specified in this section is a breach of the Grant Agreement and may subject Grantee to liquidated damages. Further, the Parties agree actual damages, in such instances, may be difficult to calculate. Accordingly, the Parties agree the liquidated damage amounts herein are fair and equitable. Grantee must use funds allocated for allowable administrative costs to cover liquidated damages imposed by HHSC. For failing to comply with any of the Grant Agreement requirements

ATTACHMENT D

LOCAL MENTAL HEALTH AUTHORITY (LMHA) SPECIAL CONDITIONS, VERSION 1

identified below in this section, without prior HHSC written approval, HHSC may impose liquidated damages of \$3,000 for the first occurrence of noncompliance during a fiscal year; \$3,000 for the second occurrence of noncompliance with the same requirement during the same fiscal year, and \$6,000 for the third and subsequent occurrence(s) of noncompliance with the same requirement during the same fiscal year:

- 1) ensuring the provision of a required service indicated in the relevant Statement of Work;
- 2) submitting reports, forms, or other required information by the due date outlined in Information Item S (Submission Calendar), or in its required format as follows:
 - a. a rate of 95% of all submissions, other than Report III-IV, by state fiscal year half (*i.e.*, First Half: September through February, and Second Half: March through August); and
 - b. each instance of Report III-IV.
- 3) retaining records as required;
- 4) providing unrestricted access to and allowing inspection of information as required;
- 5) responding to deficiencies as required;
- 6) failing to implement a Corrective Action Plan (CAP) in response to a quality assurance review in the manner and within the timeframe stated in the CAP. This includes, but is not limited to, providing training, developing policies and procedures, and/or correcting specific records. HHSC will consider noncompliance during previous quality assurance reviews when imposing liquidated damages under this provision;
- 7) complying with each rule as required; or
- 8) complying with any other requirement, outside of submission of reports, forms, or other required information, or meeting a service target or performance measure within this Grant Agreement.

Notice of Remedies, Sanctions, and Liquidated Damages. HHSC will formally notify Grantee in writing when a remedy or sanction is imposed, stating the nature of the remedy, sanction, or liquidated damage, the reasons for imposing it, and the method of appealing the remedy, sanction, or liquidated damage imposed. Grantee may file, within ten (10) days of receipt of the notice, a written appeal, which must demonstrate that the findings on which the remedy, sanction, or liquidated damage is based are either invalid or do not warrant the remedy, sanction, or liquidated damage. A properly filed appeal of the imposition of a remedy, sanction, or liquidated damage for failure to submit information in accordance with the Submission Calendar shall include written proof that Grantee submitted the information by the due date. If HHSC, in its sole discretion, determines that a remedy or sanction is warranted and rejects Grantee's appeal, HHSC's decision will become final, and the remedy, sanction, or liquidated damage shall be imposed.

Emergency Action. In an emergency, HHSC may immediately impose a sanction by delivering written notice, by any verifiable method, when the Grantee's act or omission is likely to endanger or does endanger the life, health, welfare, or safety of a client.

HHSC may withhold any payments and reserves all available legal and equitable remedies to satisfy any remedy, sanction, or liquidated damages imposed or fulfill Grantee's repayment obligations..

RESOLUTION

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

RESOLUTION NO: 477-2025 Approve Inpatient Psychiatric Hospital Contract Renewals for FY 2026 and FY 2027

DATE: October 8, 2025

STATE OF TEXAS }

COUNTY OF DALLAS }

BE IT REMEMBERED at a regular meeting of the North Texas Behavioral Health Authority held on the 8th day of October 2025, the following Resolution was adopted:

WHEREAS, the Health and Human Service Commission has designated the North Texas Behavioral Health Authority (NTBHA) as the Local Behavioral Health Authority (LBHA) for a service area consisting of the following six counties: Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall, effective January 1, 2017; and

WHEREAS, the NTBHA Board of Directors was created to govern the affairs of NTBHA; and

WHEREAS, NTBHA seeks to create a well-managed, integrated, and high-quality delivery system of behavioral health services available to eligible consumers residing in our catchment area; and

WHEREAS, NTBHA is responsible for the management of the network of behavioral health providers; and

WHEREAS, NTBHA seeks to (1) Maintain a competent and committed workforce, (2) Facilitate access to behavioral health services, (3) Manage core operations efficiently and effectively, and (4) Identify and develop additional opportunities for service area development.

IT IS THEREFORE RESOLVED that the North Texas Behavioral Health Authority Board of Directors approves the CEO, in consultation with NTBHA legal Counsel, to negotiate and execute Inpatient Psychiatric Hospital Contract Renewals for FY 2026 and FY 2027.

DONE IN OPEN MEETING, this the 8th day of October 2025.

Recommended by:

Carol E. Lucky
Chief Executive Officer
North Texas Behavioral Health Authority

Commissioner Dr. Elba Garcia
Chair, Board of Directors
North Texas Behavioral Health Authority

RESOLUTION

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

RESOLUTION NO: 478-2025 Approve Substance Use Disorder Provider Contract Renewals for FY 2026 and FY 2027

DATE: October 8, 2025

STATE OF TEXAS }

COUNTY OF DALLAS }

BE IT REMEMBERED at a regular meeting of the North Texas Behavioral Health Authority held on the 8th day of October 2025, the following Resolution was adopted:

WHEREAS, the Health and Human Service Commission has designated the North Texas Behavioral Health Authority (NTBHA) as the Local Behavioral Health Authority (LBHA) for a service area consisting of the following six counties: Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall, effective January 1, 2017; and

WHEREAS, the NTBHA Board of Directors was created to govern the affairs of NTBHA; and

WHEREAS, NTBHA seeks to create a well-managed, integrated, and high-quality delivery system of behavioral health services available to eligible consumers residing in our catchment area; and

WHEREAS, NTBHA is responsible for the management of the network of behavioral health providers; and

WHEREAS, NTBHA seeks to (1) Maintain a competent and committed workforce, (2) Facilitate access to behavioral health services, (3) Manage core operations efficiently and effectively, and (4) Identify and develop additional opportunities for service area development.

IT IS THEREFORE RESOLVED that the North Texas Behavioral Health Authority Board of Directors approves the CEO, in consultation with NTBHA legal counsel, to negotiate and execute the Substance Use Disorder Provider Contract Renewals for FY 2026 and FY 2027.

DONE IN OPEN MEETING, this the 8th day of October 2025.

Recommended by:

Carol E. Lucky
Chief Executive Officer
North Texas Behavioral Health Authority

Commissioner Dr. Elba Garcia
Chair, Board of Directors
North Texas Behavioral Health Authority

BOARD OF DIRECTORS MEETING

Summary

DATE: October 8, 2025

AGENDA ITEM #13: Resolution 478-2025 Approve Substance Use Provider Network Contracts for FY26-FY27

Recommendation/Motion:

Authorize the CEO, in consultation with NTBHA legal counsel as appropriate, to enter into, negotiate, adjust, or extend and execute the FY26-FY27 SUD Provider Network Services Contracts, in accordance with TxHHS State-allocated funding levels.

Background:

FY2026 NTBHA SUD Providers and associated SUD Service Contracts shall be issued, and allocated, based on service utilization patterns and local community needs. Funds may be reallocated accordingly, in order to meet the NTBHA consumer needs.

Evaluation:

All NTBHA Network Provider – Service Agreements are entered into, following the Eligibility & Evaluations of respective Providers, per the applicable service procurement/solicitation.

Financial Information:

All Substance Use Disorder/Substance Abuse Service Providers listed in the table below, are eligible to proceed with updated NTBHA Contract Services for the FY26-FY27 Term, with capacity and funding allocations to be negotiated and finalized by NTBHA CEO prior to the execution of a Network Provider – Services Agreement and associated Scope of Work/Contract Attachments. All amounts are issued and allocated according to current TxHHS State funding levels and approved NTBHA Program budgets, subject to Funds Availability.

Provider	Contract Service
Cenikor	CCMS, TSG (TRA), MAT/MOUD
Finch Clinic	MAT/MOUD
Guiding Minds	OBOT
Homeward Bound	CCMS, TSG (TRA+TRF), MAT/MOUD
Inspired Hope Group	MAT/MOUD
IPS	TSG (TRA+TRF), MAT/MOUD, OBOT
Lakes Regional	TSG (TRA+TRY)
Med Pro	MAT/MOUD, OBOT
Metrocare Services	TSG (TRA+TRY), MAT/MOUD
Nexus Recovery Center	CCMS, TSG (TRA+TRF), MAT/MOUD
Step Med LLC	MAT/MOUD
West Texas Counseling & Rehab (WTCR)	MAT/MOUD
Your Discovery Place (YDP)	TSG (TRA+TRY)
Youth 180, Inc.	TSG (TRA+TRY)

****Please note, the above list only includes Providers in need of renewal/update or new service Agreements****



Implementation Schedule:

Upon approval by NTBHA Board of Directors.

Attachments:

- NTBHA SUD Service Provider Agreement – v.2025.09.01 (*Template*)
- TxHHSC LMHA Data Use Agreement & Subcontractor Attachment
- NTBHA Business Associate Agreement – Contract Attachment (*Template*)

Aligns with Visions #1, 2, 3, and 4

NTBHA Strategic Visions
Vision #1 NTBHA will maintain a competent and committed workforce.
Vision #2 NTBHA will facilitate access to behavioral health services.
Vision #3 NTBHA will manage core operations efficiently and effectively.
Vision #4 NTBHA will identify and develop additional opportunities for service area development.

Presented By:

Carol E. Lucky, MAHS // Chief Executive Office

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (“BAA” or “Agreement”), is entered into by and between Parties:

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY or NTBHA (“Covered Entity”), and;

PROVIDER NAME: _____ (“Business Associate”).

WHEREAS, Covered Entity and Business Associate are parties to one or more agreements and/or may in the future become parties to additional agreements (collectively, the “Underlying Agreements”), pursuant to which Business Associate provides certain services to Covered Entity and, in connection with such services, creates, receives, uses or discloses for or on behalf of Covered Entity certain individually identifiable Protected Health Information relating to patients of Covered Entity (“PHI”) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 as amended by the Health Information Technology for Economic and Clinical Health Act Title XIII of Division A of the American Recovery and Reinvestment Act, 2009 (HITECH Act) and regulations promulgated there under, as such law and regulations may be amended from time to time (collectively, “HIPAA”); and

WHEREAS, Covered Entity and Business Associate wish to comply in all respects with the requirements of HIPAA, including requirements applicable to the relationship between a covered entity and its business associates;

NOW, THEREFORE, the parties agree that each of the Underlying Agreements shall hereby be amended as follows:

1. **Catch-all definition:** The following terms used in this Agreement shall have the same meaning as those terms in the Health Information Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d (“HIPAA”), the Health Information Technology Act of 2009, as codified at 42 U.S.C.A. prec. § 17901 (“HITECH”), and any current and future regulations promulgated under HIPAA or HITECH: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Definitions.

- (a) “Breach”- shall have same meaning given to such term as defined in 45 CFR § 164.402.
- (b) “Business Associate” shall have the same meaning given to such term as defined in 45 CFR § 160.103.
- (c) “Covered Entity” shall have the same meaning given to such term as defined in 45 CFR § 160.103.
- (d) “Designated Record Set” shall have the same meaning given to such term as defined in 45 CFR § 164.501.
- (e) “Disclosure” shall have the same meaning given to such terms as defined in 45 CFR § 160.103.
- (f) “Electronic Protected Health Information” or “e-PHI” shall have the same meaning given to such term as defined in 45 CFR § 160.103 limited to the information transmitted or maintained by the Business Associate in electronic form format or media.
- (g) “Individual” shall have the same meaning given to such term as defined in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
- (h) “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E respectively.
- (i) “Protected Health Information” or “PHI” shall have the same meaning given to such term as defined in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- (j) “Required by Law” shall have the same meaning given such term as defined in 45 CFR § 164.103 and The Health Information Technology for Economic and Clinical Health Act (HITECH) Division A: Title XIII, Subtitle D.
- (k) “Security” or “Security Measures” encompass all of the administrative, physical, and technical safeguards in an information system specified in subpart C of 45, CFR § 164.
- (l) “Security Rule” shall mean the Standards for Security of Electronic Protected Health Information as specified in subparts A and C in 45 C.F.R. Parts 160 and 164, respectively.

- (m) "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

2. Obligations and Activities of Business Associate.

- (a) Business Associate may not use or disclose protected health information other than as permitted or required by the Underlying Agreement or as required by law:
- (b) Business Associate agrees to use appropriate safeguards, including without limitation, administrative, physical and technical safeguards, to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement and to reasonably and appropriately employ the same standards as required by law to, protect the confidentiality, integrity and availability of any electronic Protected Health Information (e- PHI) that it may receive, maintain or transmit on behalf of the Covered Entity in compliance with Subpart C of 45 CFR Part 164.
- (c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- (d) Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement or any security incident of which it becomes aware, involving Protected Health Information of the Covered Entity as required at 45 CFR 164.410.
- (e) Business Associate must in accordance with 45 CFR §164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors, agents or affiliates of the Business Associate that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree, in writing, to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information. Subject to the United States and State of Texas export control and foreign outsourcing laws, rules and regulations, the Business Associate will require any of its subcontractors and agents either based in the United States or a foreign country, to provide a reasonable assurance, evidenced in writing, that the subcontractor or agent will comply with the same privacy and security obligations as the Business Associate with respect to such PHI either set forth in this Agreement or in applicable law, rules and regulations.
- (f) Business Associate agrees to provide access, at the written request of Covered Entity, and in the time and manner designated by Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity in order to meet the requirements under 45 CFR §164.524.
- (g) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR §164.526 at the written request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.
- (h) Business Associate agrees to make available internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity, or at the request of the Covered Entity to the Secretary, the Texas Office of the Attorney General, or any officer or employee to whom the Secretary or the Texas Attorney General has delegated such authority for the purpose of determining Covered Entity's compliance with the HIPAA Regulations and/or the Texas Medical Records Privacy Act, in a time and manner designated by the Covered Entity or the Secretary or the Texas Attorney General, for purposes of the Secretary or the Texas Attorney General determining Covered Entity's or Business Associate's compliance with the Privacy and Security Rules.
- (i) Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR §164.528.
- (j) Business Associate agrees to provide to Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with Section (2)(I) of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR §164.528.
- (k) Business Associate hereby acknowledges and agrees that Covered Entity has notified Business

Associate that Business Associate is required to comply with the confidentiality, disclosure and re-disclosure requirements of Texas law to the extent such requirements may be applicable.

- (l) If Business Associate, in performance of the contracted services, extends, renews or continues credit to patients or regularly allows patients to defer payment for services including setting up payment plans in connection with one or more covered accounts, as defined at 16 C.F.R. § 681.2(b)(3), the Business Associate shall comply with the Federal Trade Commission's "Red Flag" Rules, if applicable, or develop and implement a written identity theft prevention program designed to identify, detect, mitigate and respond to suspicious activities that could indicate that identity theft has occurred in the Business Associate practice or business.
- (m) Business Associate understands and agrees that it will not access or use any Protected Health Information of any patient except for those patients whose accounts have been assigned to Business Associate, and it will further limit access to that Protected Health Information that is necessary to the activities undertaken by Business Associate on behalf of Covered Entity.
- (n) Business Associate will, pursuant to the HITECH Act and its implementing regulations, comply with all additional applicable requirements of the Privacy Rule, including those contained in 45 CFR §§ 164.502(e) and 164.504(e)(1)(ii), at such time as the requirements are applicable to Business Associate. Business Associate will not directly or indirectly receive remuneration in exchange for any Protected Health Information, subject to the exceptions contained in the HITECH Act, without a valid authorization from the applicable individual. Business Associate will not engage in any communication which might be deemed to be "Marketing" under the HITECH Act. In addition, Business Associate will, pursuant to the HITECH Act and its implementing regulations, comply with all applicable requirements of the Security Rule, contained in 45 CFR §§ 164.308, 164.310, 164.312, and 164.316, at such time as the requirements are applicable to Business Associate.

3. Permitted Uses and Disclosures by Business Associate.

In case Business Associate obtains or creates Protected Health Information, Business Associate may use or disclose Protected Health Information, or any information derived from that Protected Health Information, only as explicitly permitted in the underlying agreement, and only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR § 164.504(e). It means that:

- (a) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- (b) Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- (c) Business Associate understands and agrees that its access to Protected Health Information stored in databases and information systems at the Covered Entity is subject to review and audit by the Covered Entity or agents of the State of Texas at any time, that remote audits of such access may occur at any time, that on-site audits of such access will be conducted during regular business hours, and that any review or audit may occur with or without prior notice by the Covered Entity.

4. Responsibilities of the Parties with Respect to Protected Health Information

- (a) Responsibilities of Covered Entity. With regard to the use and/or disclosure of Protected Health Information by the Business Associate, Covered Entity hereby agrees:
 - (1) to inform the Business Associate of any limitations in the form of notice of privacy practices that Covered Entity provides to individuals pursuant to 45CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
 - (2) to inform the Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose Protected Health Information, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

- (3) to notify the Business Associate, in writing and in a timely manner, of any restriction on the use or disclosure of Protected Health Information that Covered Entity has agreed to or is required to abide by under 45 CFR §164.522, to the extent that such restriction may impact in any manner the use and/or disclosure of Protected Health Information by the Business Associate under this Agreement. Except if the Business Associate will use or disclose Protected Health Information for (and the Underlying Agreement includes provisions for) data aggregation or management and administration and legal responsibilities of the Business Associate, Covered Entity will not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy and Security Rule if done by the Covered Entity.

5. Application of Security and Privacy Provisions to Business Associate.

- (a) Security Measures: 45 CFR §164.308, 164.310, 164.312 and 164.316, dealing with the administrative, physical and technical safeguards as well as policies, procedures and documentation requirements that apply to Covered Entity shall in the same manner apply to Business Associate as Required by Law. Any additional security requirements contained in Division a Title XIII Health Information Technology of the American Recovery and Reinvestment Act that apply to Covered Entity shall also apply to Business Associate as of February 17, 2010. Business Associates that require access to Covered Entity electronic patient systems and electronic infrastructure systems (either on site or remote) will supply the necessary information of employees to uniquely identify such employees, as employees with a need to access systems and will supply to Covered Entity Information Security Officer a valid state or federal issued photo ID for such employees to receive a unique user name and password to access the system(s).
- (b) Application of Civil and Criminal Penalties- If Business Associate violates any security provision as Required by Law specified in subparagraph (a) above, sections 1176 and 1177 of the Social Security Act 42 U.S.C. §1320d-5, 1320d-6 shall apply to Business Associate with respect to such violation in the same manner that such sections apply to Covered Entity if it violates such security provision.

6. Information Breach Notification Requirements.

- (a) Business Associate expressly recognizes that Covered Entity has certain reporting and disclosure obligations to the Secretary of the Department of Health and Human Services and the Individual in case of a security breach of unsecured Protected Health Information (as defined in 45 CFR §164.402).
- (b) Where Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured Protected Health Information, Business Associate without unreasonable delay and in no case later than thirty (30) days following the discovery of a breach of such information, shall notify Covered Entity of such breach. Such notice shall include the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired or disclosed during the breach.
- (c) Covered Entity and Business Associate recognizes that the Unsecured Protected Health Information may contain the social security numbers, financial account information or driver's license number or non-driver identification card number. Business Associate shall be liable for the costs associated with such breach if caused by the Business Associate's negligent or willful acts or omissions, or the negligent or willful acts or omissions of Business Associate's agents, officers, employees or subcontractors.

7. State Privacy Laws.

Business Associate shall comply with laws of the State of Texas that are More Stringent than HIPAA Regulations because the laws provide greater privacy protections for PHI or provide greater rights to individuals with respect to PHI, including without limitation the Texas Medical Records Privacy Act, chapter 181 of the Texas Health and Safety Code and the Identity Theft Enforcement and Protection Act, chapter 521 of the Texas Business and Commerce Code.

8. Term and Termination.

- (a) Term. The Term of this Agreement shall be effective as of the Effective Date (as defined below) and

shall terminate at termination of underlying agreement or on the date Covered Entity terminates this agreement for cause as authorized on paragraph (b) of this section, whichever is sooner.

- (b) Termination for Cause. The parties acknowledge that in the event the Covered Entity learns of a pattern or activity or practice of the Business Associate that constitutes violation of a material term of this Agreement, then the parties promptly shall take reasonable steps to cure the violation. If such steps are, in the judgment of the Covered Entity, unsuccessful, ineffective or not feasible, then the Covered Entity may terminate, in its sole discretion, any or all of the Underlying Agreements upon written notice to the Business Associate, if feasible, and if not feasible, shall report the violation to the Secretary of the Department of Health and Human Services.
- (c) Effect of Termination.
 - (1) Except as provided in paragraph (2) of this section, upon termination of this Agreement or the Underlying Agreement(s) for any reason, Business Associate shall return or destroy all Protected Health Information pursuant to 45 CFR § 164.504(e)(2)(I) received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
 - (2) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification, in writing, of the conditions that make return or destruction infeasible. Said notification shall include: (i) a statement that the Business Associate has determined that it is not feasible to return or destroy the Protected Health Information in its possession, and (ii) the specific reasons for such determination. The Covered Entity may disagree with the Business Associate's determination. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information. If it is infeasible for the Business Associate to obtain, from a subcontractor or agent, any Protected Health Information in the possession of the subcontractor or agent, the Business Associate must provide a written explanation to the Covered Entity and require the subcontractors and agents to agree to extend any and all protections, limitations, and restrictions contained in this Agreement to the subcontractors and/or agents' use and/or disclosure of any Protected Health Information retained after the termination of this Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of Protected Health Information infeasible.
- (d) Automatic Termination. This Agreement will automatically terminate without any further action of the Parties upon termination or expiration of the Underlying Agreement.
- (e) Effective Date. This Agreement shall be in effect as of the date last signed below.

9. Insurance and Indemnification.

Indemnification. The Business Associate agrees to indemnify, defend and hold harmless Covered Entity and Covered Entity's employees, directors, officers, subcontractors, agents or other members of its workforce from any costs, damages, expenses, judgments, losses, and attorney's fees arising from any breach of this Agreement by Business Associate, or arising from any negligent or wrongful acts or omissions of Business Associate, including failure to perform its obligations under the Privacy Rule. The Business Associate's indemnification obligation shall survive the expiration or termination of this Agreement for any reason.

10. Miscellaneous.

- (a) Regulatory References. A reference in this Agreement to a section in the Privacy and Security Rules means the section as in effect or as amended, and for which compliance is required.
- (b) Agreement. The Parties agree to take such action as is necessary to amend the Underlying Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law §104-

191; provided, however, that no Agreement shall be deemed valid unless signed by both parties.

- (c) Amendments / Waiver. This agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. A waiver with respect to one event shall not be construed as continuing, or as a bar to a waiver of any right or remedy as to subsequent events. The Parties agree to take such actions as is necessary to amend this agreement from time to time as is necessary for compliance with the requirements of the HIPAA rules and any other applicable law.
- (d) Survival. The respective rights and obligations of Business Associate under Section 6(c) of this Agreement shall survive the termination of this Agreement and/or the Underlying Agreements, as shall the rights of access and inspection of Covered Entity.
- (e) No Third Party Beneficiaries. Nothing expressed or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.
- (f) Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Privacy and Security Rules.
- (g) Equitable Relief. Business Associate understands and acknowledges that any disclosure or misappropriation of any PHI in violation of this Attachment will cause Covered Entity irreparable harm, the amount of which may be difficult to ascertain, and therefore agrees that Covered Entity shall have the right to apply to a court of competent jurisdiction for specific performance and/or an order restraining and enjoining any such further disclosure or breach and for such other relief as Covered Entity shall deem appropriate. Such right of Covered Entity is to be in addition to the remedies otherwise available to Covered Entity at law or in equity. Business Associate expressly waives the defense that a remedy in damages will be adequate and further waives any requirement in an action for specific performance or injunction for the posting of a bond by Covered Entity.

11. Governing Law; Conflict.

This Agreement shall be construed and enforced in accordance with the laws of the State of Texas. This Agreement is performable in Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties, Texas and venue shall lie in Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties, Texas. In the event of a conflict between the terms of this Agreement and the terms of any of the Underlying Agreements, the terms of this Agreement shall control.

COVERED ENTITY
NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

BUSINESS ASSOCIATE
PROVIDER NAME:

Signature
Carol E. Lucky, MAHS - C.E.O.

Printed Name and Title

Date Signed

Signature

Printed Name and Title

Date Signed

SERVICE PROVIDER AGREEMENT
BETWEEN
NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY
AND
[PROVIDER]

THIS AGREEMENT is made and entered into by and between NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY (“NTBHA” or “Authority”), the Local Behavioral Health Authority under the provisions of Chapter §533.0356 of the Texas Health & Safety Code Ann. (Vernon 1992), as amended, and [PROVIDER] (“Provider” or “Contractor”), for the purpose of providing behavioral health services currently not available to the Local Authority through its present staff of employees.

RECITALS

WHEREAS, North Texas Behavioral Health Authority is the Texas Health and Human Services Commission (“HHSC”) designated behavioral health local authority established to plan, coordinate, develop policy, develop and allocate resources, supervise, and ensure the provision of behavioral health services for the residents of Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties, Texas; and

WHEREAS, Local Authority desires to assemble and maintain a network of participating providers to provide certain mental health and substance abuse services funded by the Local Authority (the “Network”); and

WHEREAS, Provider is a facility or individuals who is or are duly licensed or certified in the State of Texas to provide the behavioral health services as described in this Agreement; and

WHEREAS, this Agreement sets forth the terms and conditions evidencing the agreement of the parties hereto.

NOW THEREFORE, in consideration of the mutual covenants, rights and obligations set forth herein, the benefits to be derived therefrom, and other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties agree as follows:

I. DEFINITIONS

For purposes of the Agreement and its referenced Attachments, Exhibits, Addendums, Amendments, and/or other related documents, the following words and phrases are defined as follows:

1. **Assessment.** The clinical process of looking at a person’s mental health or substance abuse and medical history, his or her functioning, relationships, and development to determine their need for treatment.
2. **Authorization/Authorization Number.** All Covered Services may include a unique identifying number which is given by Authority to the Provider for Covered Services to a Consumer.
3. **Clinically Appropriate.** Covered Services are authorized by a Plan of Care, which are determined to be Medically Necessary and include all of the following: An adequate and essential therapeutic response provided for evaluation or treatment consistent with the assessed needs, proper diagnosis and treatment appropriate for the individual’s specific illness, disease or conditions; Reasonably expected to improve the illness, condition or level of functioning; Safe and effective according to nationally accepted practices and standards of evidence generally recognized by licensed professionals or publications; The appropriate and cost-effective level of service that can safely be provided for the specific intensity of need in accordance with the professional and technical standards adopted by the Utilization Management and Quality Management Departments of Authority.
4. **Confidential Information.** Any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) prepared, created, received, maintained, used, disclosed or have access to by the Local Authority or Provider which concerns the Consumer, Covered Individual, or Non-Covered Individual that consists of or includes any or all of the following:
 - a. Consumer Information;
 - b. Protected Health Information or Unsecured Protected Health Information;

- c. Sensitive Personal Information defined by Texas Business and Commerce Code Ch.521;
 - d. Federal Tax Information;
 - e. Personally Identifiable Information;
 - f. Social Security Administration Data; and
 - g. All privileged work product; and also includes:
 - h. All information designated as confidential under the constitution and laws of the State of Texas and of the United States, Texas Health & Safety Code, Texas Public Information Act, and Texas Government Code, Chapter 552.
5. **Consumer.** Individuals residing in Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties who have been determined by Authority to meet the definition of Priority Population.
 6. **Covered Individual.** Individuals residing in Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties, who meet the HHSC definition of Priority Population and are authorized by the Authority to receive services.
 7. **Covered Services.** Mental health and substance use disorder services within the scope of the benefit plan.
 8. **Episode of Care.** The care provided by a reasonably prudent health care facility or provider for a specific psychiatric problem or condition during a set time period, but specifically excluding emergency medical treatment that is unrelated to the psychiatric problem or condition and any Potential Preventable Readmission.
 9. **Local Case Number.** (“LCN”) A unique number assigned to each NTBHA consumer receiving services.
 10. **Medically Necessary.** Medically Necessary means that Covered Services: (a) are reasonable and necessary for the treatment of a behavioral health disorder or to improve or prevent deterioration of functioning resulting from such a disorder; (b) are in accordance with accepted standards of practice in behavioral health care; (c) are furnished in the most appropriate and least restrictive setting in which Covered Services can be safely provided; (d) are the most appropriate level or supply of service which can be safely provided; and (e) could not have been omitted without adversely affecting the Consumer’s mental and/or physical health or the quality of care rendered.
 11. **Non-Covered Individual.** Any individual residing in Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties for whom the Provider has not obtained an authorization for services.
 12. **Non-Covered Services.** Any services not specified in the Plan of Care and for which Provider has not obtained an authorization.
 13. **Payor of Last Resort.** The payor or program responsible for adjudication once all other funding sources have been exhausted.
 14. **Plan of Care.** A written plan that a Consumer develops in collaboration with a Provider in accordance with the State standards applicable to a specific Consumer. The Plan of Care, based on a Consumer’s choices and assessments, addresses the problems, goals, and direction of service delivery.
 15. **Potentially Preventable Readmission.** A Clinically Related Readmission of a Covered Individual that occurs up to and including fifteen (15) calendar days after the Covered Individual’s date of discharge from his or her most recent hospital admission. A clinical review involving NTBHA and Provider will be conducted to allow NTBHA to determine if the underlying reason for the readmission was plausibly related to the care and treatment rendering during or immediately following a prior hospitalization as a prerequisite to recoupment or non-payment for a Covered Service.
 16. **Prior Authorization/Pre-Authorization.** A determination made by NTBHA to prospectively approve or deny payment for a service or course of treatment of a specific duration and scope to a member prior to the provider’s initiating provision of the requested service.
 17. **Priority Population.** Provider shall not restrict or expand the definition of Priority Population or any other Consumer defined in this Agreement. The definition of the Priority Population for Provider is as follows:
 - a. **Adults:** who have severe and persistent mental illness 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.
 - b. **Child and Adolescent:** Children ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, mental retardation, autism or pervasive development disorder) who exhibit serious emotional, behavioral or mental disorders and who: (1) Have a serious functional impairment; or (2) Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or (3) Are enrolled in a school system’s special education program because of serious emotional disturbance.
 - c. **Substance Abuse:** HHSC has established a priority order for treatment in accordance with SAPT Block Grant regulations and state designation. SUD Providers shall give preference for treatment in

the following order: (1) Pregnant, injecting drug users; (2) Pregnant substance abusers, and; (3) Injecting drug users.

18. **Protected Health Information (“PHI”).** Individually Identifiable Health Information that is or has been electronically transmitted or maintained by either party and includes such information in any other form.
19. **Provider.** An entity that delivers direct behavioral health services to an enrollee.
20. **Provider Directory.** A published list of service providers currently contracted with NTBHA.
21. **Provider Manual.** Resources to NTBHA service provisions, processes, procedures, and policy guidelines with explanations, for working with NTBHA.
22. **System Agency/Performing Agency.** In pertaining to this Agreement, its Attachments, Exhibits, Addendums, and Amendments, System Agency shall refer to NTBHA and Performing Agency shall refer to Provider.

II. RELATIONSHIP BETWEEN THE PARTIES

1. **Independent Contractor.** The relationship between the Local Authority and Provider will be that of an independent contractor. The parties agree that none of the provisions of this Agreement are intended to create, nor will be deemed or construed to create, any relationship between the Local Authority and Provider other than that of independent parties contracting with each other to carry out this Agreement. It is expressly agreed that Provider and Provider’s personnel, if any, may not for any purposes be deemed to be an officer, employee, agent, partner, joint ventures, ostensible or apparent agent, servant or borrowed servant of the Local Authority. Provider agrees that it will not hold itself out as an agent of the Local Authority to Consumers served under this Agreement or to any other persons. Provider understands and agrees that:
 - a. Local Authority will not:
 - 1) withhold on Provider’s behalf any sums for income tax, unemployment insurance, social security, or any other withholding under any law or requirement of any governmental body relating to Provider; or
 - 2) make available to Provider any benefits afforded to employees of Local Authority.
 - b. All the payments, withholdings, and benefits, if any, are Provider’s sole responsibility under this Agreement; and
 - c. In the event the Internal Revenue Service should question or challenge Provider’s independent contractor status, the parties mutually agree that all parties to this Agreement will have the right to participate in any discussion or negotiation occurring with the Internal Revenue Service.
2. **Professional Judgment.** In the performance of all services under this Agreement, Provider is at all times acting as an independent contractor engaged in the delivery of professional services. Provider and its personnel, if any, will employ their own means and methods and exercise their own professional judgment in performing the services under this Agreement. The sole concern of the Local Authority under this Agreement is that, irrespective of the means selected, the services will be performed in a competent, efficient, and satisfactory manner in compliance with the policies and procedures of the Local Authority and HHSC.
3. **Liability for Treatment or Service.** Nothing in this Agreement shall be deemed to change or alter any relationship which exists or may come to exist between the Provider and the person served. Provider shall have and be subject to the same duties, liabilities and responsibilities toward the Local Authority’s Consumers served as exist generally between Provider and its other patients. Further, the Utilization Review and Quality Management Procedures of the Local Authority shall not diminish the Provider’s obligation to render patients served consistently with the applicable standards of care.

III. OBLIGATIONS OF THE PROVIDER

1. **Provision of Covered Services.** Provider agrees to provide Covered Services to the eligible Consumers of Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties, Texas, to Local Authority’s designated individuals in accordance with the terms of this Agreement, admission criteria, and the Provider Manual. Provider will render services to all Covered Individuals in the same manner, subject to the same standards, and within the same time availability as offered to Provider’s other patients or clients. Provider will not discriminate on the basis of payment source in matters involving the provision of Covered Services to said individuals. Provider will not refuse to accept or continue to serve any individual unless the individual does not meet Priority Population, or Provider and Local Authority admission criteria.

- a. The professional services to be provided by Provider will be provided in accordance with the Plans of Care/Treatment Plans of Consumers.
 - b. Provider agrees that no person who is eligible for services under this Agreement will be denied services solely on the basis of the person's arrest, charge, fine, probation, indictment, incarceration, deferred adjudication, community supervision, sentencing or conviction of a criminal offense.
 - c. Provider agrees that it may not restrict or expand the definitions of Priority Population or any other Consumer served as defined in this Agreement.
 - d. Provider agrees that it will not deny services to a Consumer served under this Agreement because of the Consumer's inability to pay.
2. **Authorization of Covered Services.** All authorizations for the provision of Covered Services will be approved by Local Authority only.
3. **Non-Exclusivity.** Nothing contained in this Agreement shall be construed to confer upon the Provider the exclusive right to render services to Consumers in any geographic area, and Local Authority explicitly reserves the right to contract with any other Provider in the geographic area of the Local Authority, Dallas, Ellis, Navarro, Hunt, Kaufman and Rockwall Counties, Texas.
4. **Referrals.** Consistent with sound medical practice and in accordance with accepted community standards, or as otherwise required by law, Provider agrees to coordinate Covered Services, and planning with Local Authority staff to assure continuity of Covered Services during and following Covered Services delivery. Provider's failure to obtain preauthorization, as defined in the Provider Manual per service from Local Authority, may result in Provider liability for charges incurred. In no event shall Provider seek compensation from the Consumer (or representative of the Consumer), Local Authority, or any payor for Provider's failure to obtain preauthorization of any services.
5. **Continuity of Care.** Provider agrees to participate in treatment planning with Local Authority staff through Care Management Manager and/or Utilization Manager to assure continuity of services for each Covered Individual.
6. **Quality Management and Utilization Management Programs.** Provider agrees to participate in, cooperate with, and comply with Local Authority Quality Management ("QM") and Utilization Management ("UM") activities and standards. Provider will be required to have a written QM Plan; identified quality related goals with supportive objectives; and implementation of processes to show progress towards goal attainment. Provider shall allow Local Authority to have access at any time to the treatment records of its Consumers as permitted by state and federal confidentiality laws. Provider understands that sanctions for noncompliance with Local Authority requirements may include termination of this Agreement. Provider understands that Local Authority will actively evaluate and oversee QM measures to ensure they meet and/or exceed Local Authority expectations and standards. Provider agrees to implement continuous QM to gain improvement in service delivery processes. Provider shall:
 - a. Develop a QM Plan and conduct QM activities including organizational self-assessments and measures of satisfaction as specified by the Local Authority.
 - b. Establish and conduct corporate compliance reviews, assessments, and implement remedies for identified areas of improvement.
 - c. Comply with the Local Authority's monitoring procedures, including submission of reports and data and other information requested.
 - d. Conduct monthly reviews to ensure that documentation of services are in compliance with the HHSC Data Verification definitions.
 - e. Adhere to quality of care indicators including but not limited to the following:
 - 1) Appropriateness of admission/discharge to the program
 - 2) Unusual incident trends
 - 3) Unauthorized absences and outcomes
 - f. Local Authority shall monitor each community services contractor's compliance with the contract and evaluate the contractor's provisions of services, including but not limited to:
 - 1) Competency of the contractor to provide care;
 - 2) Consumers' access to services;
 - 3) Safety of the environment in which services are provided;
 - 4) Continuity of care;
 - 5) Compliance with the performance expectations;
 - 6) Satisfaction of consumers and family members with services provided; and
 - 7) Utilization of resources.

7. **Response to Contract Monitoring.** The Local Authority is responsible for routine monitoring of this Agreement to ensure the Provider complies with the terms of this Agreement, with the responsibilities and requirements of HHSC through contractual obligations with NTBHA, and to ensure that performance measures and monitoring outcomes are appropriately met and managed. In response to routine monitoring of this agreement, provider shall fully cooperate with NTBHA requests.
8. **Covered Individual Appeals and Complaints.** Provider agrees to abide by, and cooperate with, Local Authority's complaint, grievance, and appeal processes maintained fairly and expeditiously to resolve a Covered Individual's and/or Provider's concerns pertaining to any service provided by Provider and/or to allow a Covered Individual or Provider to appeal determinations that a service was not authorized. Notice of adverse determinations that a service is not Medically Necessary will be communicated to consumers by the Provider and in accordance with applicable federal, state, or local laws, rules, or regulations to which the NTBHA program is subject. Provider agrees to cooperate with and participate in Local Authority's procedures and those of other payors to resolve any complaints by Covered Individuals regarding Provider's services. Provider agrees to inform in writing Covered Individuals served by the Provider of the right to file a complaint regarding Provider in accordance with Local Authority's complaint process. Provider agrees to take such corrective action as required by Local Authority to resolve any complaint related to its provision of services pursuant to this Agreement.
 - a. Covered Individual(s) can initiate complaints via the Local Authority's Client Rights Officer or his/her case manager. A notice to NTBHA consumers must be posted on Provider premises concerning the process for resolving complaints, including the Texas Department of Insurance's toll-free number.
 - b. Provider shall furnish such current administrative policies and procedures, data and/or documentation as Local Authority or its designee may reasonably request. In the event deficits are found, Local Authority reserves the right to re-audit Provider's site to ensure remedial efforts for improvement have been implemented. Following on-site audits, Local Authority will deliver to the Provider a list of comments with regard to the manner in which services are being provided. Failure to provide a plan of improvement, and correction (or justification for lack of action) within a reasonable time as specified by the Local Authority may result in sanctions including the termination of this Agreement.
9. **Transfer to Another Provider.** Providers aware of Covered Individuals wishing to transfer/change Providers after services have already begun must notify the Covered Individuals with appropriate referrals and coordination to complete transfer to desired Provider.
10. **Marketing.** Provider hereby authorizes Local Authority to identify Provider in Local Authority's Provider Directory. This identification may only include Provider's name, address, telephone number, and Provider profile with a description of Provider's services and facilities. Notwithstanding the Provider Directory, Provider additionally authorizes Local Authority to maintain and make available to Consumers and potential Consumers, current information on Provider as would be available for each Provider of community services participating in the network. Provider is aware that material may include results from Consumer satisfaction surveys. In all other respects, Local Authority and Provider reserve the right to control the use of their respective names, symbols, trademarks and service marks existing or established during the term of this Agreement. Provider shall obtain prior approval in writing to use Local Authority's name in any promotional materials. Any use of the Local Authority's name in advertising or any other promotional material by the Provider must be approved by the Local Authority in writing prior to distribution of materials.
11. **Qualifications.** Necessary documentation regarding Provider's professional and educational qualifications and any additional required qualification documentation are set forth in Information Item A, as published by HHSC.
12. **Authority Approval of Provider Personnel.** Provider agrees not to subcontract any services until approval of such subcontractors are approved by Local Authority in writing. Any subcontractors or employees of Provider are the direct responsibility of Provider. Provider further agrees to secure from any assignee or subcontractor their written agreement to comply with all of the terms and conditions, including without limitation the representations and warranties made herein, of this Agreement. Provider further understands and agrees that the subcontracting or assignment of any of the terms or conditions of this Agreement does not release or excuse the Provider from its obligations to perform under this Agreement.
13. **Representations and Warranties.**
 - a. Provider represents and warrants at all times during this Agreement, that Provider, its officers, employees, and agents will comply with:

- 1) The terms of this Agreement, all applicable policies of the Local Authority, policies as specified in the Provider Manual; and
 - 2) All applicable local, state, and federal laws, rules, regulations, handbooks, standards and guidelines now in effect and that become effective during the term of this Agreement including but not limited to all applicable standards set forth by HHSC and found in Title 26 of the Texas Administrative Code, Chapter 301, Subchapter G and Title 40 of the Texas Administrative Code, Chapter 5, a current copy of which may be requested from the Local Authority or may be obtained at the following website address: www.sos.state.tx.us/tac/index.
- b.** Provider, its officers, employees, and agents, will maintain, as applicable to service delivery, any certifications, registrations, or licenses, set forth in the Provider Manual and applicable law, and are required to remain in good standing in its/his/her profession during the term of the Agreement. Additionally, Provider must inform the Local Authority immediately of any changes -- including any court or governmental agency proceeding, investigation, termination, reduction, revocation or suspension -- to any certifications, registrations, or licenses held by the Provider, its officers, employees, or agents. Provider shall submit a written report to Local Authority within three (3) calendar days of any allegation that a professional licensed or certified by the State of Texas and employed by the Provider has committed an action that constitutes grounds for the denial, suspension, or revocation of the certification or licensure. If Provider's employee receives a denial, suspension, or revocation, and Provider fails to remove such employee from providing Covered Services to Covered Individuals, then this Agreement may be immediately terminated without prior notice.
- c.** Provider will ensure the performance of services within the standards and scope of its profession and in a manner designed to assist in the Local Authority's efficient operation of the Local Authority. Provider agrees to interact with Local Authority staff, other Providers with the Local Authority, and consultants in a cooperative manner. The adequacy of the performance of this obligation will be determined at the Local Authority's sole discretion.
- d.** The Provider represents and warrants that the execution and performance of this Agreement by Provider will not conflict with or create a default under any agreement, contract, instrument, order or judgment to which Provider is a party.
- e.** The Provider represents and warrants that AIDS/HIV workplace guidelines, similar to those adopted by HHSC, and AIDS/HIV confidentiality guidelines, consistent with state and federal law, will be adopted and implemented by the Provider.
- f.** The Provider represents and warrants that at the time of executing this Agreement, neither Provider, its officers nor directors are currently held in abeyance or barred from the award of a federal, state or county contract. Provider agrees to disclose this information in the event such abeyance occurs at any time during the term of this Agreement, pursuant to the regulations implementing Executive Order 12549 and Executive Order 12689, Debarment and Suspension, 2 C.F.R. Part 376. This provision shall be included in its entirety in a Provider's subcontracts if payment in whole or in part is from federal funds. Such disclosure shall include when Provider:
- 1) is held in abeyance from or barred from the award of a federal, state or county contract or if this occurs anytime during the term of this Agreement;
 - 2) has been convicted of a criminal offense related to any county, state or federally funded program;
 - 3) is placed on "vendor hold" status for any county, state, or federally funded Local Authority or program; or
 - 4) is placed on the Federal Government's terrorism watch list, as described in Executive Order 13224.
- g.** Provider represents and warrants that it/he/she is not currently an employee of the Local Authority.
- h.** Contractor understands that the Enterprise Agency does not tolerate any type of fraud. The Enterprise Agency's policy is to promote consistent, legal, and ethical organizational behavior by assigning responsibilities and providing guidelines to enforce controls. Violations of law, agency policies, or standards of ethical conduct will be investigated, and appropriate actions will be taken. All employees or contractors who suspect fraud, waste or abuse (including employee misconduct that would constitute fraud, waste, or abuse) are required to immediately report the questionable activity to both the Health and Human Services Commission's Office of the Inspector General at 1-

800-436-6184 and the State Auditor's Office. Contractor agrees to comply with all applicable laws, rules, regulations, and Enterprise Agency policies regarding fraud including, but not limited to, HHS Circular C-027.

14. **Receipts and Records.** Provider agrees to provide the Local Authority upon request with original receipts for the purchases of all goods and services involving the use of Local Authority funds as well as all other financial and supporting documents and statistical records. Provider shall retain these and any other records pertinent to the services for which a claim or cost report was submitted to the Local Authority, including Plans of Service, for a period of six (6) years from the latest date of the expiration or termination of this Agreement.
15. **Immigration Reform and Control Act.** Provider agrees to maintain appropriate identification and employment eligibility documents to meet requirements of the Immigration Reform and Control Act of 1986.
16. **Reports of Abuse and Neglect.** Provider must report any allegations of abuse, neglect, or exploitation to the Texas Department of Family and Protective Services (DFPS) at 800-252-5400 and to Local Authority's QM Department at qm@ntbha.org or 877-653-6363 in compliance with federal and state law, and Local Authority policies and procedures. Reporting to the Local Authority's QM Department shall include (1) a written incident report completed by the individual who reported the allegation to DFPS, (2) DFPS report number, and (3) be submitted within 24 hours of knowledge of allegation.
17. **Required Information for Criminal Conviction Checks.**
 - a. Provider shall provide to the Local Authority proof that criminal history record checks have been conducted on Provider/subcontractor's officers, employees, and agents whose duties place them in direct contact with Consumers, pursuant to Texas Health and Safety Code, Section §533.007 and Chapter 250, the Texas Government Code, Section §411.115.
 - b. If an officer, employee, or agent of the Provider/subcontractor has a criminal history relevant to his or her employment, then the Provider/subcontractor will take appropriate action with respect to the officer, employee, or agent, including terminating or removing the officer, employee, or agent from direct contact with Consumers with a mental disability served by the Provider/subcontractor; and
 - c. If Provider/subcontractor's officer, employee, or agent has such a conviction, and Provider/subcontractor fails to remove such officer, employee, or agent, then this Agreement may be terminated without prior notice.
 - d. Provider/subcontractor shall provide the Local Authority with a letter of assurance upon request or by no later than January 15 of each calendar year that an annual criminal background check (such as the Texas DPS criminal check) has been conducted on all Provider/subcontractor's officers, employees, and agents who have direct contact with Consumers, and that Provider/subcontractor is in compliance with the terms of this Agreement. Failure to provide the requested information may result in suspension and/or termination of this Agreement.
18. **Pre-Employment Drug Screening.** Service Providers must maintain a drug-free work environment and complete a pre-employment drug screening in accordance with Title 25 of the Texas Administrative Code, Part 1, Chapter §448.601 (e), on all applicants hired after August 31st, 2004.
19. **Provider's Governing Body.** Upon request, Provider agrees to provide Local Authority with a list of the members of Provider's governing body, if applicable.
20. **Retention of Records.** Provider agrees to retain all records pertinent to the Agreement, including appropriate treatment plans, for a period of seven (7) years. Provider shall retain for seven (7) years following the latest date of the expiration or termination of this Agreement, or the termination of Covered Services, or for a longer period if required by statute or regulation, PHI and all records, reports, and source documentation related to services and treatment sufficient to support an audit concerning expenses and services.
21. **Optimizing Revenue.** Provider agrees to optimize earned revenues and maintain best cost value through coordination of insurance benefits and third-party revenues.
22. **Responsibility for Consumer Funds.** If Provider assumes responsibility for the funds of a Consumer, Provider will abide by written policies approved by the Local Authority and will protect and account for such funds in accordance with generally accepted accounting principles.
23. **Medical Care.** If Consumer receiving services from Provider requires immediate and/or emergency medical attention during the delivery of the services, Provider agrees to provide or procure appropriate hospital, surgical, medical, and dental care for the Consumer as specified in Provider's emergency policy and procedures.
24. **Solicitation prohibitions involving Potential Consumers.** Provider agrees and is aware that Provider is prohibited from the following, and any violation will result in immediate termination of this Agreement:

- a. Offering any gift with a value in excess of \$10 to potential Consumers; and,
 - b. Soliciting potential Consumers in person, through direct mail, by telephone or other means of communication.
25. **Managed Care Organizations.** Provider shall make a reasonable effort to join a managed care network as a provider. Failure to make such effort is grounds for immediate termination of this Agreement.
26. **Credentialing.** Provider agrees and represents that its licensed staff and other appropriate staff (such as QMHP-CS) will be credentialed before services are delivered to Consumers by such Provider and staff. Local Authority will review all of the Provider's officers, staff, employees, and agents at the professional level (i.e. licensed staff). Provider will maintain completed credentialing application forms and submit updated rosters to the Local Authority for each licensed professional providing services to Covered Individuals on a semi-annual basis. These files and rosters are subject to audit by Local Authority. Provider must make modifications to its own credentialing process to meet or exceed standards set forth by Local Authority's credentialing policies and procedures.
27. **Assignment.** Provider assigns to Local Authority any and all claims for overcharges associated with this Agreement arising under the antitrust laws of the United States 15 U.S.C. Section 1, et seq. (1973), as amended, and the antitrust laws of the State of Texas, Tex. Bus. & Com. Code Ann. Sec. 15.01 et seq. (1967), as amended.
28. **Telemedicine Medical Services.** If Provider provides telemedicine medical services, Provider represents that the services are implemented in accordance with written procedures and using protocol approved by the Provider's medical director that includes the following requirements:
- a. Clinical oversight by Provider's designated physician responsible for medical leadership;
 - b. Contraindication considerations for telemedicine use;
 - c. Priority in scheduling the system for clinical care of Consumers;
 - d. Quality oversight and monitoring of satisfaction of the Consumers served; and
 - e. Management of information and documentation for services that allows timely access to accurate information between the two sites.
29. **Training.** Provider agrees to participate in Provider Training as required and approved by the Local Authority. Proof of all required training shall be maintained by the Provider and made available on request by the Local Authority within thirty (30) calendar days of Agreement start date (all training needs to occur before the Provider serves Consumers). Required training may be obtained from the Local Authority, NTBHA QM, and/or NTBHA designee; however, Provider shall not bill Local Authority for said training hours. Failure to obtain and/or keep current required training will be deemed non-compliance and may be grounds for termination of this Agreement.

IV. REIMBURSEMENT OF SERVICES

1. **Bills for Payment.** Provider will submit Certified Covered Services Encounter Claims by the tenth day of each calendar month following the month the services were rendered in accordance with the Statement of Work.
2. **Acceptance of Payment.** Provider will accept payment received from Local Authority in accordance with the Reimbursement Schedule set forth in the Statement of Work as payment in full for Covered Services provided pursuant to this Agreement. Provider shall not submit a claim or bill or collect compensation from a Consumer. Further, Provider shall not submit a claim or bill or collect compensation from Local Authority for any Non-Covered Service, Service(s) eligible or covered by any third-party payor, State/Federal Grant funding, or Benefit/Assistance programs outside of NTBHA funding.
3. **Coordination of Covered Individual's Benefits.** Provider agrees to cooperate with Local Authority in coordination of Covered Individuals' benefits, to provide Local Authority any relevant information that Provider may reasonably have relating to any other coverage held by a Covered Individual, and to abide by the coordination of benefits, subrogation and duplicate coverage policies as set forth in the Provider Manual. Provider acknowledges that Local Authority is considered the payor of last resort and that all other funding sources must be exhausted prior to billing Local Authority for authorized Covered Services. It is the obligation of the Provider to submit written evidence documenting its efforts to collect fees from any and all payment sources prior to submitting claims to Local Authority. Provider agrees that Local Authority reserves the right to refuse payment to Provider.
4. **Non-Covered Services.** Provider agrees that compensation for providing Non-Covered Services will be solely between the individual and the Provider, and that the individual must be informed in writing before

such services are provided, and that Local Authority is not responsible for payment for such services. Prior to providing any non-covered services to any individual, Provider shall, in writing, advise the individual (a) of the nature of the service; (b) that the service is a Non-Covered Service for which a payor will not pay; and (c) that the individual will be responsible for paying for the service. Provider shall request individual to sign such writing and return to Provider.

5. **Overpayment.** In the event a Provider receives an overpayment for services performed, Provider and Local Authority mutually agree that such identified overpayment will be deducted in total from the following month's payment, unless the Local Authority's Legal Department states that the overpayment should be withheld immediately.
6. **Referrals and Utilization.** The Local Authority does not guarantee utilization of the Covered Services to be provided under this Agreement. Provider acknowledges that there is no warranty or guarantee that Provider will be utilized by an individual or any number of Covered Individuals. Provider further acknowledges that the parties do not intend to create an exclusive arrangement by this Agreement.
7. **Franchise Tax.** If Provider is a corporation and is or becomes delinquent in the payment of its Texas franchise tax, then payments to the Provider due under this Agreement may be withheld until such delinquency is remedied.

V. RESPONSIBILITIES OF LOCAL AUTHORITY

1. **Provider Manual.** Local Authority shall maintain a Provider Manual, available to view or download on its website. Local Authority may amend the Provider Manual from time to time, at its sole discretion, with the most up-to-date version published online, at <https://ntbha.org/providers/manuals-forms/>. In the event of any inconsistency between the terms of this Agreement and the Provider Manual, the terms of the Provider Manual shall govern and control.
2. **Payment.** Local Authority will pay Provider for charges verified and billed for which Local Authority has authorized in accordance with the Statement of Work. In consideration of the obligations undertaken by Provider, Local Authority projects to pay Provider for charges submitted by Provider for the provision of Covered Services, during the term of this Agreement. This projection in no way guarantees a maximum amount or utilization of Provider by a Consumer or any number of Consumers. *This Agreement is at all times contingent upon the approval of HHSC and the availability and receipt of state or federal funds, and if funds for this Agreement become unavailable during any budget period, this Agreement may be immediately terminated or reduced at the discretion of the Local Authority. Provider understands and agrees if this Agreement is modified or terminated due to an insufficient amount of state or federal funds allocated to Local Authority, the Local Authority shall not be responsible for any amounts allegedly owed to Provider.*
3. **Provider Reporting.** Unless otherwise instructed, all required and requested submissions or reporting shall be sent to the email provided below, when electronic versions are permitted, or to the address provided below for paper copies and originals.

North Texas Behavioral Health Authority
Heath Frederick, Contracts Director
(469) 523-0529 – hfrederick@ntbha.org
Contracting Dept (Cc: contracts@ntbha.org)
8111 LBJ Frwy., Suite 900
Dallas, TX 75251

4. **Freedom of Choice.** Local Authority shall allow Consumers to choose freely any participating Provider within the network without influence by any Local Authority staff or representative.

VI. RECORDS, CONFIDENTIALITY, AND ACCESS

1. **Disclosure Under the Texas Public Information Act.** The Local Authority operating under the Texas Public Information Act is required upon written request to release information regarding Provider which may include Provider Profile or other documents. Information deemed proprietary by Provider must be clearly indicated as such and may still be subject to disclosure depending on a ruling from the Attorney General's Office. Provider shall be solely responsible for contesting or defending the release of any information it

deems to be proprietary and hereby releases the Local Authority from any duty, responsibility, or liability with regard to the release of any information delivered to the Local Authority by Provider.

2. **Records.** Provider will create and maintain records in accordance with the Provider Manual and this Agreement.
3. **Confidentiality of Records of Covered Individuals Served by This Agreement.** Provider agrees to comply with all applicable Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations including the HHSC Data Use Agreement incorporated by reference to this Agreement. In accordance with HIPAA and the Privacy Rule (45 CFR Parts 160 and 164):
 - a. Provider agrees and acknowledges that in receiving, storing, processing, or otherwise dealing with Consumer's information, if any, accessed or generated during services as a Provider for the Local Authority, that Provider and its officers, employees, agents and subcontractors are bound by the provisions of laws, statutes, and regulations protecting the confidentiality of this information.
 - b. Provider agrees and acknowledges that in receiving, storing, processing or otherwise dealing with information, if any, pertaining to or about a Consumer with respect to alcohol or drug abuse, Provider and its officers, employees and agents are bound by the provisions of 42 C.F.R. Part 2.
 - c. Provider agrees to follow, undertake, or institute appropriate procedures of safeguarding Consumer's information, if any, with particular reference to Consumer identifying information or protected health information. The term "Consumer identifying information" and/or "protected health information" includes, but is not limited to, a Consumer's medical record, graphs, or charts; statements made by the Consumer, either orally or in writing, while receiving services; photographs, videotapes, etc., and any acknowledgment that a Consumer is or has received services at the facility, center, or other designated provider.
 - d. Provider agrees to resist in judicial proceedings any efforts to obtain access to protected health information pertaining to Consumers except as expressly stated in applicable laws, rules and regulations. Provider agrees to inform the Local Authority of any attempts to gain access to protected health information pertaining to Consumers.
 - e. Provider agrees to report to Local Authority any use or disclosure of protected health information not provided for by this Agreement.
 - f. Provider agrees to make available to the appropriate federal or state agency its internal practices, books, records, and policies and procedures or those of Local Authority used by Provider related to the use and disclosure of protected health information for the purpose of determining Provider's compliance with the Privacy Rule.
 - g. Provider agrees to maintain documentation of, and information related to its uses and disclosures of protected health information to permit Local Authority to provide an accounting of disclosures as prescribed by 45 CFR §164.528.
 - h. Provider acknowledges that Local Authority is not permitted to enter into any agreement with Provider to, create, receive, maintain, use, disclose, have access to or transmit Confidential Information, on behalf of Local Authority without requiring that Provider to first execute the Subcontractor Agreement Form, which ensures that the Provider (Subcontractor) will comply with the identical terms, conditions, safeguards and restrictions as contained in the Data Use Agreement ("DUA") for PHI executed between the Local Authority and HHSC. A copy of the executed DUA is available upon request.
4. **Access to Facilities, Books and Records by Local Authority or HHSC.** Pursuant to Texas Health and Safety Code §534.061, Provider agrees to allow the Local Authority or other authorized governmental agencies unrestricted access during usual business hours to all facilities, service providers, individuals served, records, data, and other information as necessary to enable HHSC and the Local Authority or other authorized agencies to audit, monitor, and review all financial or programmatic activities and services associated with this Agreement. Provider authorizes Local Authority and HHSC or their designated agents to make copies of, at no charge, Provider's medical, financial and administrative books, documents, and records related to providing services to Covered Individuals and the cost thereof, subject to applicable laws and regulations.
5. **Right of Audit and Recovery.** Provider hereby authorizes Local Authority to conduct retrospective audits of Provider's claims and other records related to any service rendered to a Covered Individual for a period of up to two (2) years following payment to Provider. In the event such an audit reveals that Provider was paid by Local Authority for services not rendered or properly documented, Local Authority may recover any compensation paid to Provider for such services, and Provider agrees to pay Local Authority within thirty

(30) calendar days such amount as determined by the Local Authority to have been paid for services not rendered or not properly documented.

VII. INSURANCE

1. **General Policy Requirements:** Provider agrees to maintain the following insurance policies, with the specified coverages and limits, to protect and insure the Local Authority and Provider against any claim for damages arising in connection with Provider's responsibilities or the responsibilities of Provider's personnel under this Agreement and all extensions and amendments thereto.

a. Policies, Coverages, and Endorsements.

(A): Commercial General Liability

General Aggregate	\$1,000,000
Products/Completed Operations Aggregate	\$500,000
Each Occurrence	\$500,000
Fire Legal Liability	\$50,000

Note: Limits shown above shall apply to Abuse and Molestation claims without sub-limits or exclusions.

(B): Professional Liability

General Aggregate	\$1,000,000
Each Occurrence	\$500,000

(C): Business Automobile if transporting Consumers

Combined Single Limit Bodily Injury & Property	\$500,000

(D): Workers' Compensation & Employers' Liability

Medical & Indemnity	Statutory Requirements
Bodily Injury by Accident	\$500,000 Each Accident
Bodily Injury by Disease	\$500,000 Each Employee
Bodily Injury by Disease	\$500,000 Policy Limit

(E): Medical Malpractice Insurance for Physicians if applicable

General Aggregate	\$3,000,000
Each Occurrence	\$100,000

(F): Providers that are self-insured through their own self-insurance program must comply with all the insurance regulations applicable to the Provider and shall furnish appropriate evidence to the Local Authority of the existence of such coverage for the services being provided to the Local Authority.

- b. Insured Parties. All policies excluding professional liability and worker's compensation shall contain a provision naming the Local Authority (and its officers, agents and employees) as an Additional Insured Party and a Certificate Holder on the original policy and all renewals or replacements during the term of this Agreement.
- c. Subrogation. All policies must contain a Waiver of Subrogation endorsement to the effect that the issuer waives any claim or right in the nature of subrogation to recover against the Local Authority, its officers, agents or employees.
- d. Proof of Insurance. The policies, coverages and endorsements required by this provision shall be shown on a Certificate of Insurance on which the Local Authority must be listed as an Additional Insured Party (excluding professional liability and worker's compensation) and the Certificate Holder, and which should be furnished to the Local Authority prior to the commencement of this Agreement. All such insurance shall be secured and maintained with an insurance company, or companies, licensed to do business in the State of Texas. The Local Authority may withhold payments under the terms of this Agreement until the Provider furnishes the Local Authority copies of all Certificates of Insurance from the insurance carrier, or carriers, showing that such insurance is in full force and effect.
- e. Cancellation. New Certificates of Insurance shall be furnished to the Local Authority at the renewal date of all policies named on these Certificates. Provider shall give the Local Authority thirty (30) calendar days prior written notice of any proposed cancellation of any of the above described insurance policies.

- f. Providers that are self-insured through their own self-insurance program must comply with all regulations applicable to the Provider and shall furnish appropriate evidence to the Local Authority of the existence of such coverage for the services being provided to the Local Authority.
- g. If Provider is a Texas state agency or governmental entity, including an institution of higher education of the State of Texas, subject to Chapters 101 and 104 of the Texas Civil Practice and Remedies Code, it shall not be required to maintain the insurance coverage set forth in Part VII. herein. In lieu of such coverages, Provider agrees to maintain a self-insurance plan for Professional Liability Insurance, and a self-insured Worker's Compensation Insurance Plan pursuant to Texas Labor Code Chapter 502, 503 or 504 as applicable. Providers authorized pursuant to the Texas Education Code must comply with all regulations applicable to the Provider and shall furnish appropriate evidence to the Local Authority of the existence of such coverage for the services being provided to the Local Authority.

VIII. INDEMNIFICATION

Provider shall defend, indemnify, and hold harmless the Local Authority and/or its officers, employees, agents, and representatives from any and all claims, actions, suits, demands, proceedings, judgment, costs, damages, and liabilities, including attorneys' fees and court costs arising out of, connected with, or resulting from:

- Provider's performance of the Agreement, including any negligent acts or omissions of Provider, or any officer, agent, employee, subcontractor, or supplier of Provider, or any third party under the control or supervision of Provider, in the execution or performance of this Agreement; or
- Any breach or violation of a statute, ordinance, governmental regulation, standard, rule, or breach of contract by Provider, any officer, agent, employee, subcontractor, or supplier of Provider, or any third party under the control or supervision of Provider, in the execution or performance of this Agreement; or
- Employment or alleged employment, including claims of discrimination against Provider, its officers, agents, employees, subcontractors, or suppliers; or
- Work under this Agreement that infringes or misappropriates any right of any third person or entity based on copyright, patent, trade secret, or other intellectual property rights.

Provider shall provide written notice to Local Authority of any claim, whether actual or threatened, promptly upon receipt of notice thereof. Provider will coordinate its defense with the Local Authority and its counsel, if requested by Local Authority. This paragraph is not intended to and will not be construed to require Provider to indemnify or hold harmless the Local Authority for any claims or liabilities resulting solely from the gross negligence of the Local Authority or its employees. The provisions of this section will survive termination of this Agreement.

IX. TERM AND TERMINATION

1. **Term.** This Agreement is effective from **September 1st, 2025** and remain in effect until one of the following occurs.
 - a) In the event Local Authority and Provider are negotiating, preparing, and/or reviewing the services of Provider for renewal, this Agreement shall expire sixty (60) calendar days following the end of the current fiscal year in the event a mutual agreement is not made.
 - b) **Immediate Termination.** Local Authority may terminate this Agreement immediately if (a) Local Authority does not receive the funding to pay for designated services under this Agreement from the Texas Legislature, HHSC, or DADS (***Fund Availability**); (b) Local Authority has cause to believe that termination of the Agreement is in the best interests of the health and safety of the Consumers with mental disability served under this Agreement; (c) Provider has become ineligible to receive Local Authority funds; (d) Provider or its employees has its Texas license or certification suspended or revoked; (e) in the case of Providers providing direct services to Consumers, failure to disclose a criminal arrest, deferred adjudication, and/or conviction; (f) the Provider submits falsified documents and/or fraudulent billings, or if the Provider makes false statements; (g) Provider violates Section III of this Agreement; (h) Provider commits any violations of any HIPPA requirements; (i) Provider violates the Local Authority's Privacy Policy, Procedures, and/or Practices; or (j) Provider violates any provision contained in this Agreement.

***Fund Availability.** This Agreement is at all times contingent upon the availability and receipt of state or federal funds that Local Authority has allocated to this Agreement, and if funds for this Agreement become unavailable during any budget period, this Agreement may be immediately terminated or reduced at the sole discretion of the Local Authority.

- c) **Termination Without Cause.** Local Authority reserves the right to terminate this Agreement, without cause, upon thirty (30) calendar days written notice to the Provider.
2. **Effect Upon Notice of Termination.** Upon notice of termination, Provider will cooperate fully with Local Authority in the transfer of Covered Individuals to other providers. Provider recognizes that during any notice period preceding the effective date of termination, Local Authority, may at its sole discretion, deny authorization to Covered Individuals to receive Covered Services from Provider.
3. **Effect upon Termination.** Upon termination, the rights of Local Authority and Provider under this Agreement will terminate, except that termination will not release the parties of their respective obligations with respect to:
 - a. Payments accrued for authorized Covered Services by Provider prior to termination of this Agreement;
 - b. Provider's agreement not to seek compensation from Covered Individuals for Covered Services prior to termination of this Agreement;
 - c. The continuation of Provider's service(s) for Covered Individuals receiving Covered Services from Provider until continuation of the Covered Individuals' service can be transferred by Local Authority. Local Authority will reimburse Provider for such service pursuant to the terms of this Agreement; and
 - d. Requirements of this Agreement regarding confidentiality and record retention will survive this Agreement.
4. **Changes to Provider Service/Operation.** The opening and/or closure of a line of business, line of service, facility or location, and/or any operational changes that impact service delivery or the performance of this Agreement, including the termination of said Agreement, must be reported to Local Authority via written notice ninety (90) calendar days prior to the proposed change. Provider shall also notify NTBHA of any new partnerships and/or collaborations that affect NTBHA or the NTBHA Provider Network.
5. **Dispute Resolution.** All disputes or controversies arising under or related to this Agreement shall first be attempted to be resolved through good faith efforts between the parties.
6. **Reviews.** Contingent upon Funds Availability, and at the full discretion of NTBHA, this Agreement and any program attachments, as amended, may be reviewed by NTBHA QM (see Section III: Obligations of Provider, Item 6: Quality Management) on a routine basis, at least once every two year term.

X. NON-COMPLIANCE BY THE PROVIDER

1. **Penalties/Sanctions.** The failure of the Provider to perform any responsibility set forth in this Agreement, its exhibits or attachments, or any law, regulation, rule or requirement incorporated by reference may result in any one or more of the following penalties to be imposed or taken by the Local Authority, subject to notice as provided herein:
 - a. Provider training and technical assistance;
 - b. Submission of a Plan of Correction to the Local Authority;
 - c. Return funds to the Local Authority:
 - 1) For serving Non-Covered Individuals with Local Authority funds subject to this Agreement or
 - 2) For using Local Authority funds for unauthorized purposes.
 - d. Withholding by the Local Authority, in whole or in part, any payments due and owing to the Provider until the Provider has cured any breach of this Agreement to the satisfaction of the Local Authority;
 - e. Requiring service delivery at no additional cost to the Local Authority;
 - f. Suspending participation in the Provider Network;
 - g. Unilateral Contract Amendment;
 - h. Contract termination; and
 - i. Legal action to protect or remove Consumers when the life, health, welfare, or safety of one or more Consumers is endangered, or could be endangered or if the Local Authority has a reasonable belief that the Provider has engaged in the misuse of state or federal funds, fraud, or illegal acts.

If Local Authority is able to demonstrate a direct link between a sanction or penalty imposed upon Local Authority by HHSC or any other state agency due to Provider's performance, Provider will refund/reimburse/remit, upon request, to Local Authority those portions of the sanction/penalty assessed to Local Authority. Examples of such instances would be documentation chart audits, CARE accuracy, failure to report accurate and timely information/data, and etc.

2. **Imposition of Sanctions.** Local Authority may, at its own discretion, impose remedies and sanctions for noncompliance with requirements of this Agreement. Local Authority retains sole discretion to determine which situations constitute noncompliance and will determine appropriate remedies and sanctions on a case-by-case basis. High level deficiencies in compliance, as determined by Local Authority, may result in a suspension of contract until remedied.
3. **Appeals.** Any Provider receiving a "Notice of Penalties" may appeal the imposition by filing a "Notice of Appeal" with the Local Authority's Chief Executive Officer, in accordance with the timeline provided in the Notice of Penalties. Written Notice of Appeals must address the finding(s) in question and provide clear justification for repeal. In the event a written Notice of Appeals meets all stated requirements, a decision will be made no later than fifteen (15) calendar days of the date of receipt of the Notice of Appeal.

XI. MISCELLANEOUS

1. **Nondiscrimination.** Each party to this Agreement agrees that no person, on the basis of race, color, national origin, religion, sex, age, handicap, or political affiliation, will be excluded from participation, be denied the benefits of, or be subject to discrimination in the provision of any services hereunder. The parties hereto agree to comply with the Civil Rights Act of 1991 and Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.); Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107); Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688); Food and Nutrition Act of 2008 (7 U.S.C. §2011 et seq.); and all amendments to each and all requirements imposed by the regulations issued pursuant to these acts.
2. **Corporate Compliance.** Local Authority has an ongoing commitment that its affairs are conducted in accordance with applicable law and sound ethical business practice. Provider agrees to adopt and implement a Business Code of Conduct and Corporate Compliance Plan, if applicable, similar to those adopted by Local Authority and consistent with state and federal law. Provider shall develop and implement a process for its employees, volunteers and subcontractors to report possible compliance issues including a process for such reports to be fully and independently reviewed.
3. **Professional Conduct.** During the term of this Agreement, Provider shall not engage in a business, calling, treatment, conduct or enterprise which is or may be, in Local Authority's sole discretion, contrary to the interest, benefit, or reputation of Local Authority. Provider will conduct its/his/her relationships with Local Authority and its employees and consumers referred by Local Authority in a professional and positive manner and not make untruthful or otherwise disparaging statements regarding its/his/her relationship with Local Authority, its employees or persons served.
4. **Lobbying and Political Activity.** Provider shall not use funds received under this Agreement to pay any person for influence or attempting to influence an officer or employee or any agency, federal or state, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any contract or grant or the extension, continuation, renewal, amendment, or modification of any contract or grant.
5. **Amendment.** Unless otherwise specifically provided herein, this Agreement may be amended or changed only by mutual written consent of an authorized representative of the Local Authority and Provider.
6. **Entire Agreement.** This Agreement constitutes the sole and only agreement of the parties hereto and supersedes any prior understandings, written or oral agreement between the parties respecting the subject matter herein.
7. **Additional Requirements/Renegotiation.** If Provider is required to comply with an additional requirement pursuant to compliance with standards, regulations, resolutions, settlements, or plans, and compliance results in a material change in Provider's rights or obligations under this Agreement or places a significant financial burden on the Provider, the Provider may, upon giving sixty (60) calendar days written notice to Local Authority of such intention, be entitled to discuss amendments to the Agreement.

8. **Governing Law and Venue.** This Agreement shall be construed and enforced in accordance with the laws of the State of Texas, and venue shall lie in a state or federal district court of Dallas County, Texas.
9. **Notices.** Any required notice shall be in writing and shall be sent, postage prepaid, by certified mail, return receipt requested, to Local Authority or Provider at the address below. The notice shall be effective on the date of delivery indicated on the return receipt. Carbon copies may be provided to the email address(es) below:

If to the Local Authority:

Carol E. Lucky
Chief Executive Officer
8111 LBJ Frwy., Suite 900
Dallas, TX 75251
clucky@ntbha.org
contracts@ntbha.org

If to Provider:

Attn:
Chief Executive Officer
Admin. Address
City, State, Zip Code
Email address

10. **Severability.** The invalidity or unenforceability of any term or provision hereof shall not affect the validity or enforceability of any other term(s) or provision(s).
11. **Exhibits and Provider Manual.** All Exhibits and the Provider Manual referred to in this Agreement and attached hereto are incorporated into this Agreement by reference.
12. **Authority to Bind Local Authority.** This Agreement is not binding upon the Local Authority unless and until it has been executed by the Chief Executive Officer or Executive Director.
13. **Provider's Authority.** The person or persons executing and signing this Agreement on behalf of the Provider represent that they have been fully authorized by the Provider to execute the Agreement and to legally bind the Provider to all the terms and provisions of the Agreement.
14. **No Third-Party Beneficiary.** Unless otherwise specifically stated in this Agreement, nothing in this Agreement is intended to, or shall be deemed or construed to, create any rights or remedies in any third party, including a Consumer. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to create any rights of any Consumer or duties or any responsibilities of Provider or Local Authority with respect to such Consumer.
15. **Electronic or Facsimile Signatures and Duplicate Originals.** Pursuant to the requirements of the Uniform Electronic Transactions Act in Chapter 322 of the Texas Business and Commerce Code and the Federal Electronic Signatures in Global and National Commerce Act (beginning at 15 U.S.C. Section 7001), the parties have agreed that the transactions under this Agreement may be conducted by electronic means. Pursuant to these statutes, this Agreement may not be denied legal effect or enforceability solely because it is in electronic form or because it contains an electronic signature. This Agreement may be executed in duplicate counterparts and with electronic or facsimile signatures with the same effect as if the signatures were on the same document. Each multiple original of this document shall be deemed an original, but all multiple copies together shall constitute one and the same instrument.
16. **Attachments.** The following exhibits, schedules, and annexes attached to this Agreement are incorporated herein and shall be considered a part of this Agreement in full.

- NTBHA Provider Key Personnel Contact List & Clinic Locations
- Attachment A: _____ Statement of Work
- Attachment A.01: _____ Data Use Agreement-Subcontractor Attachment (A.01)
- Attachment B: _____ Business Associate Agreement (NTBHA-BAA)
- Attachment C: _____ CCBHC Provider Assurances for DCO/Formal Partner/Joint Employer
- Exhibit No. 1: _____ TxHHS Uniform Terms and Conditions (UTC)
- Exhibit No. 2: _____ HHSC Additional/Supplemental Conditions, as applicable

IN WITNESS WHEREOF, the Parties hereto have duly executed this Agreement by their respective authorized representatives as evidenced by their signatures, with an execution date indicated by the last signatory below.

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

[PROVIDER]

Signature

Carol E. Lucky, MAHS, CEO.

Printed Name and Title

Date Signed

Signature

Printed Name and Title

Date Signed

ATTACHMENT H
DATA USE AGREEMENT
BETWEEN THE
TEXAS HEALTH AND HUMAN SERVICES SYSTEM
AND
CONTRACTOR

This Data Use Agreement (“DUA”), effective as of the date of the Base Contract into which it is incorporated (“Effective Date”), by and between the Texas Health and Human Services System, which includes the Texas Health and Human Services Commission and the Department of State Health Services (“HHS”) and Contractor (the “Base Contract”).

ARTICLE 1. PURPOSE; APPLICABILITY; ORDER OF PRECEDENCE

The purpose of this DUA is to facilitate creation, receipt, maintenance, use, disclosure or access to Confidential Information with CONTRACTOR, and describe CONTRACTOR’s rights and obligations with respect to the Confidential Information and the limited purposes for which the CONTRACTOR may create, receive, maintain, use, disclose or have access to Confidential Information. 45 CFR 164.504(e)(1)-(3) This DUA also describes HHS’s remedies in the event of CONTRACTOR’s noncompliance with its obligations under this DUA. This DUA applies to both Business Associates and contractors who are not Business Associates who create, receive, maintain, use, disclose or have access to Confidential Information on behalf of HHS, its programs or clients as described in the Base Contract.

As of the Effective Date of this DUA, if any provision of the Base Contract, including any General Provisions or Uniform Terms and Conditions, conflicts with this DUA, this DUA controls.

ARTICLE 2. DEFINITIONS

For the purposes of this DUA, **capitalized, underlined terms have the meanings set forth in the following:** Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (42 U.S.C. §1320d, *et seq.*) and regulations thereunder in 45 CFR Parts 160 and 164, including all amendments, regulations and guidance issued thereafter; The Social Security Act, including Section 1137 (42 U.S.C. §§ 1320b-7), Title XVI of the Act; The Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a and regulations and guidance thereunder; Internal Revenue Code, Title 26 of the United States Code and regulations and publications adopted under that code, including IRS Publication 1075; OMB Memorandum 07-18; Texas Business and Commerce Code Ch. 521; Texas Government Code, Ch. 552, and Texas Government Code §2054.1125. In addition, the following terms in this DUA are defined as follows:

“**Authorized Purpose**” means the specific purpose or purposes described in the Scope of Work of the Base Contract for CONTRACTOR to fulfill its obligations under the Base Contract, or any other purpose expressly authorized by HHS in writing in advance.

“**Authorized User**” means a Person:

- (1) Who is authorized to create, receive, maintain, have access to, process, view, handle, examine, interpret, or analyze Confidential Information pursuant to this DUA;
- (2) For whom CONTRACTOR warrants and represents has a demonstrable need to create, receive, maintain, use, disclose or have access to the Confidential Information; and
- (3) Who has agreed in writing to be bound by the disclosure and use limitations pertaining to the Confidential Information as required by this DUA.

“**Confidential Information**” means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to CONTRACTOR or

that CONTRACTOR may create, receive, maintain, use, disclose or have access to on behalf of HHS that consists of or includes any or all of the following:

- (1) Client Information;
- (2) Protected Health Information in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information;
- (3) Sensitive Personal Information defined by Texas Business and Commerce Code Ch. 521;
- (4) Federal Tax Information;
- (5) Personally Identifiable Information;
- (6) Social Security Administration Data, including, without limitation, Medicaid information;
- (7) All privileged work product;
- (8) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

“Legally Authorized Representative” of the Individual, as defined by Texas law, including as provided in 45 CFR 435.923 (Medicaid); 45 CFR 164.502(g)(1) (HIPAA); Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164; Estates Code Ch. 752 and Texas Prob. Code § 3.

ARTICLE 3. CONTRACTOR'S DUTIES REGARDING CONFIDENTIAL INFORMATION

Section 3.01 *Obligations of CONTRACTOR*

CONTRACTOR agrees that:

(A) CONTRACTOR will exercise reasonable care and no less than the same degree of care CONTRACTOR uses to protect its own confidential, proprietary and trade secret information to prevent any portion of the Confidential Information from being used in a manner that is not expressly an Authorized Purpose under this DUA or as Required by Law. ***45 CFR 164.502(b)(1); 45 CFR 164.514(d)***

(B) CONTRACTOR will not disclose or allow access to any portion of the Confidential Information to any Person or other entity, other than Authorized User's Workforce or Subcontractors of CONTRACTOR who have completed training in confidentiality, privacy, security and the importance of promptly reporting any Event or Breach to CONTRACTOR's management, to carry out the Authorized Purpose or as Required by Law.

HHS, at its election, may assist CONTRACTOR in training and education on specific or unique HHS processes, systems and/or requirements. CONTRACTOR will produce evidence of completed training to HHS upon request. ***45 C.F.R. 164.308(a)(5)(i); Texas Health & Safety Code §181.101***

All of CONTRACTOR's Authorized Users, Workforce and Subcontractors with access to a state computer system or database will complete a cybersecurity training program certified under Texas Government Code Section 2054.519 by the Texas Department of Information Resources.

(C) CONTRACTOR will establish, implement and maintain appropriate sanctions against any member of its Workforce or Subcontractor who fails to comply with this DUA, the Base Contract or applicable law. CONTRACTOR will maintain evidence of sanctions and produce it to HHS upon request. ***45 C.F.R. 164.308(a)(1)(ii)(C); 164.530(e); 164.410(b); 164.530(b)(1)***

(D) CONTRACTOR will not disclose or provide access to any Confidential Information on the basis that such act is Required by Law without notifying either HHS or CONTRACTOR's own legal counsel to determine whether CONTRACTOR should object to the disclosure or access and seek appropriate relief. CONTRACTOR will maintain an accounting of all such requests for disclosure and responses and provide such accounting to HHS within 48 hours of HHS' request. **45 CFR 164.504(e)(2)(ii)(A)**

(E) CONTRACTOR will not attempt to re-identify or further identify Confidential Information or De-identified Information, or attempt to contact any Individuals whose records are contained in the Confidential Information, except for an Authorized Purpose, without express written authorization from HHS or as expressly permitted by the Base Contract. **45 CFR 164.502(d)(2)(i) and (ii)** CONTRACTOR will not engage in prohibited marketing or sale of Confidential Information. **45 CFR 164.501, 164.508(a)(3) and (4); Texas Health & Safety Code Ch. 181.002**

(F) CONTRACTOR will not permit, or enter into any agreement with a Subcontractor to, create, receive, maintain, use, disclose, have access to or transmit Confidential Information, on behalf of CONTRACTOR without requiring that Subcontractor first execute the Form Subcontractor Agreement, Attachment 1, which ensures that the Subcontractor will comply with the identical terms, conditions, safeguards and restrictions as contained in this DUA for PHI and any other relevant Confidential Information and which permits more strict limitations; and **45 CFR 164.502(e)(1)(1)(ii); 164.504(e)(1)(i) and (2)**

(G) CONTRACTOR is directly responsible for compliance with, and enforcement of, all conditions for creation, maintenance, use, disclosure, transmission and Destruction of Confidential Information and the acts or omissions of Subcontractors as may be reasonably necessary to prevent unauthorized use. **45 CFR 164.504(e)(5); 42 CFR 431.300, et seq.**

(H) If CONTRACTOR maintains PHI in a Designated Record Set, CONTRACTOR will make PHI available to HHS in a Designated Record Set upon request. CONTRACTOR will provide PHI to an Individual, or Legally Authorized Representative of the Individual who is requesting PHI in compliance with the requirements of the HIPAA Privacy Regulations. CONTRACTOR will release PHI in accordance with the HIPAA Privacy Regulations upon receipt of a valid written authorization. CONTRACTOR will make other Confidential Information in CONTRACTOR's possession available pursuant to the requirements of HIPAA or other applicable law upon a determination of a Breach of Unsecured PHI as defined in HIPAA. CONTRACTOR will maintain an accounting of all such disclosures and provide it to HHS within 48 hours of HHS' request. **45 CFR 164.524 and 164.504(e)(2)(ii)(E)**

(I) CONTRACTOR will make PHI as required by HIPAA available to HHS for amendment and incorporate any amendments to this information that HHS directs or agrees to pursuant to the HIPAA. **45 CFR 164.504(e)(2)(ii)(E) and (F)**

(J) CONTRACTOR will document and make available to HHS the PHI required to provide access, an accounting of disclosures or amendment in compliance with the requirements of the HIPAA Privacy Regulations. **45 CFR 164.504(e)(2)(ii)(G) and 164.528**

(K) If CONTRACTOR receives a request for access, amendment or accounting of PHI from an individual with a right of access to information subject to this DUA, it will respond to such request in compliance with the HIPAA Privacy Regulations. CONTRACTOR will maintain an accounting of all responses to requests for access to or amendment of PHI and provide it to HHS within 48 hours of HHS' request. **45 CFR 164.504(e)(2)**

(L) CONTRACTOR will provide, and will cause its Subcontractors and agents to provide, to HHS periodic written certifications of compliance with controls and provisions relating to information

privacy, security and breach notification, including without limitation information related to data transfers and the handling and disposal of Confidential Information. **45 CFR 164.308; 164.530(c); 1 TAC 202**

(M) Except as otherwise limited by this DUA, the Base Contract, or law applicable to the Confidential Information, CONTRACTOR may use or disclose PHI for the proper management and administration of CONTRACTOR or to carry out CONTRACTOR's legal responsibilities if: **45 CFR 164.504(e)(ii)(1)(A)**

(1) Disclosure is Required by Law, provided that CONTRACTOR complies with Section 3.01(D);

(2) CONTRACTOR obtains reasonable assurances from the Person to whom the information is disclosed that the Person will:

(a) Maintain the confidentiality of the Confidential Information in accordance with this DUA;

(b) Use or further disclose the information only as Required by Law or for the Authorized Purpose for which it was disclosed to the Person; and

(c) Notify CONTRACTOR in accordance with Section 4.01 of any Event or Breach of Confidential Information of which the Person discovers or should have discovered with the exercise of reasonable diligence. **45 CFR 164.504(e)(4)(ii)(B)**

(N) Except as otherwise limited by this DUA, CONTRACTOR will, if requested by HHS, use PHI to provide data aggregation services to HHS, as that term is defined in the HIPAA, 45 C.F.R. §164.501 and permitted by HIPAA. **45 CFR 164.504(e)(2)(i)(B)**

(O) CONTRACTOR will, on the termination or expiration of this DUA or the Base Contract, at its expense, send to HHS or Destroy, at HHS's election, and to the extent reasonably feasible and permissible by law, all Confidential Information received from HHS or created or maintained by CONTRACTOR or any of CONTRACTOR's agents or Subcontractors on HHS's behalf if that data contains Confidential Information. CONTRACTOR will certify in writing to HHS that all the Confidential Information that has been created, received, maintained, used by or disclosed to CONTRACTOR, has been Destroyed or sent to HHS, and that CONTRACTOR and its agents and Subcontractors have retained no copies thereof. Notwithstanding the foregoing, CONTRACTOR acknowledges and agrees that it may not Destroy any Confidential Information if federal or state law, or HHS record retention policy or a litigation hold notice prohibits such Destruction. If such delivery or Destruction is not reasonably feasible, or is impermissible by law, CONTRACTOR will immediately notify HHS of the reasons such delivery or Destruction is not feasible, and agree to extend indefinitely the protections of this DUA to the Confidential Information and limit its further uses and disclosures to the purposes that make the return delivery or Destruction of the Confidential Information not feasible for as long as CONTRACTOR maintains such Confidential Information. **45 CFR 164.504(e)(2)(ii)(J)**

(P) CONTRACTOR will create, maintain, use, disclose, transmit or Destroy Confidential Information in a secure fashion that protects against any reasonably anticipated threats or hazards to the security or integrity of such information or unauthorized uses. **45 CFR 164.306; 164.530(c)**

(Q) If CONTRACTOR accesses, transmits, stores, and/or maintains Confidential Information, CONTRACTOR will complete and return to HHS at infosecurity@hhsc.state.tx.us the HHS information security and privacy initial inquiry (SPI) at Attachment 2. The SPI identifies basic privacy and security controls with which CONTRACTOR must comply to protect HHS Confidential Information. CONTRACTOR will comply with periodic security controls compliance assessment and monitoring by HHS as required by state and federal law, based on the type of Confidential Information CONTRACTOR creates, receives, maintains, uses, discloses or has access to and the Authorized Purpose and level of risk.

CONTRACTOR's security controls will be based on the National Institute of Standards and Technology (NIST) Special Publication 800-53. CONTRACTOR will update its security controls assessment whenever there are significant changes in security controls for HHS Confidential Information and will provide the updated document to HHS. HHS also reserves the right to request updates as needed to satisfy state and federal monitoring requirements. **45 CFR 164.306**

(R) CONTRACTOR will establish, implement and maintain any and all appropriate procedural, administrative, physical and technical safeguards to preserve and maintain the confidentiality, integrity, and availability of the Confidential Information, and with respect to PHI, as described in the HIPAA Privacy and Security Regulations, or other applicable laws or regulations relating to Confidential Information, to prevent any unauthorized use or disclosure of Confidential Information as long as CONTRACTOR has such Confidential Information in its actual or constructive possession. **45 CFR 164.308 (administrative safeguards); 164.310 (physical safeguards); 164.312 (technical safeguards); 164.530(c)(privacy safeguards)**

(S) CONTRACTOR will designate and identify, subject to HHS approval, a Person or Persons, as Privacy Official **45 CFR 164.530(a)(1)** and Information Security Official, each of whom is authorized to act on behalf of CONTRACTOR and is responsible for the development and implementation of the privacy and security requirements in this DUA. CONTRACTOR will provide name and current address, phone number and e-mail address for such designated officials to HHS upon execution of this DUA and prior to any change. **45 CFR 164.308(a)(2)**

(T) CONTRACTOR represents and warrants that its Authorized Users each have a demonstrated need to know and have access to Confidential Information solely to the minimum extent necessary to accomplish the Authorized Purpose pursuant to this DUA and the Base Contract, and further, that each has agreed in writing to be bound by the disclosure and use limitations pertaining to the Confidential Information contained in this DUA. **45 CFR 164.502; 164.514(d)**

(U) CONTRACTOR and its Subcontractors will maintain an updated, complete, accurate and numbered list of Authorized Users, their signatures, titles and the date they agreed to be bound by the terms of this DUA, at all times and supply it to HHS, as directed, upon request.

(V) CONTRACTOR will implement, update as necessary, and document reasonable and appropriate policies and procedures for privacy, security and Breach of Confidential Information and an incident response plan for an Event or Breach, to comply with the privacy, security and breach notice requirements of this DUA prior to conducting work under the DUA. **45 CFR 164.308; 164.316; 164.514(d); 164.530(i)(1)**

(W) CONTRACTOR will produce copies of its information security and privacy policies and procedures and records relating to the use or disclosure of Confidential Information received from, created by, or received, used or disclosed by CONTRACTOR on behalf of HHS for HHS's review and approval within 30 days of execution of this DUA and upon request by HHS the following business day or other agreed upon time frame. **45 CFR 164.308; 164.514(d)**

(X) CONTRACTOR will make available to HHS any information HHS requires to fulfill HHS's obligations to provide access to, or copies of, PHI in accordance with HIPAA and other applicable laws and regulations relating to Confidential Information. CONTRACTOR will provide such information in a time and manner reasonably agreed upon or as designated by the Secretary, or other federal or state law. **45 CFR 164.504(e)(2)(i)(I)**

(Y) CONTRACTOR will only conduct secure transmissions of Confidential Information whether in paper, oral or electronic form. A secure transmission of electronic Confidential Information in

motion includes secure File Transfer Protocol (SFTP) or Encryption at an appropriate level or otherwise protected as required by rule, regulation or law. HHS Confidential Information at rest requires Encryption unless there is adequate administrative, technical, and physical security, or as otherwise protected as required by rule, regulation or law. All electronic data transfer and communications of Confidential Information will be through secure systems. Proof of system, media or device security and/or Encryption must be produced to HHS no later than 48 hours after HHS's written request in response to a compliance investigation, audit or the Discovery of an Event or Breach. Otherwise, requested production of such proof will be made as agreed upon by the parties. De-identification of HHS Confidential Information is a means of security. With respect to de-identification of PHI, "secure" means de-identified according to HIPAA Privacy standards and regulatory guidance. **45 CFR 164.312; 164.530(d)**

(Z) CONTRACTOR will comply with the following laws and standards *if applicable to the type of Confidential Information and Contractor's Authorized Purpose*:

- Title 1, Part 10, Chapter 202, Subchapter B, Texas Administrative Code;
- The Privacy Act of 1974;
- OMB Memorandum 07-16;
- The Federal Information Security Management Act of 2002 (FISMA);
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) as defined in the DUA;
- Internal Revenue Publication 1075 – Tax Information Security Guidelines for Federal, State and Local Agencies;
- National Institute of Standards and Technology (NIST) Special Publication 800-66 Revision 1 – An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule;
- NIST Special Publications 800-53 and 800-53A – Recommended Security Controls for Federal Information Systems and Organizations, as currently revised;
- NIST Special Publication 800-47 – Security Guide for Interconnecting Information Technology Systems;
- NIST Special Publication 800-88, Guidelines for Media Sanitization;
- NIST Special Publication 800-111, Guide to Storage of Encryption Technologies for End User Devices containing PHI;
- Texas Business and Commerce Code Chapter 521; and
- Any other State or Federal law, regulation, or administrative rule relating to the specific HHS program area that CONTRACTOR supports on behalf of HHS.

ARTICLE 4. BREACH NOTICE, REPORTING AND CORRECTION REQUIREMENTS

Section 4.01. Breach or Event Notification to HHS. 45 CFR 164.400-414

(A) CONTRACTOR will cooperate fully with HHS in investigating, mitigating to the extent practicable and issuing notifications directed by HHS, for any Event or Breach of Confidential Information to the extent and in the manner determined by HHS.

(B) CONTRACTOR'S obligation begins at the Discovery of an Event or Breach and continues as long as related activity continues, until all effects of the Event are mitigated to HHS's satisfaction (the "incident response period"). **45 CFR 164.404**

(C) Breach Notice:

1. Initial Notice.

a. For federal information, including without limitation, Federal Tax Information, Social Security Administration Data, and Medicaid Client Information, within the first, consecutive clock hour of Discovery, and for all other types of Confidential Information not more than 24 hours after Discovery, ***or in a timeframe otherwise approved by HHS in writing***, initially report to HHS's Privacy and Security Officers via email at: privacy@HHSC.state.tx.us and to the HHS division responsible for this DUA; and ***IRS Publication 1075; Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a; OMB Memorandum 07-16 as cited in HHSC-CMS Contracts for information exchange.***

b. Report all information reasonably available to CONTRACTOR about the Event or Breach of the privacy or security of Confidential Information. **45 CFR 164.410**

c. Name, and provide contact information to HHS for, CONTRACTOR's single point of contact who will communicate with HHS both on and off business hours during the incident response period.

2. 48-Hour Formal Notice. No later than 48 consecutive clock hours after Discovery, or a time within which Discovery reasonably should have been made by CONTRACTOR of an Event or Breach of Confidential Information, **provide** formal notification to the State, including all reasonably available information about the Event or Breach, and CONTRACTOR's investigation, including without limitation and to the extent available: ***For (a) - (m) below: 45 CFR 164.400-414***

a. The date the Event or Breach occurred;

b. The date of CONTRACTOR's and, if applicable, Subcontractor's Discovery;

c. A brief description of the Event or Breach; including how it occurred and who is responsible (or hypotheses, if not yet determined);

d. A brief description of CONTRACTOR's investigation and the status of the investigation;

e. A description of the types and amount of Confidential Information involved;

f. Identification of and number of all Individuals reasonably believed to be affected, including first and last name of the individual and if applicable the, Legally authorized representative, last known address, age, telephone number, and email address if it is a preferred contact method, to the extent known or can be reasonably determined by CONTRACTOR at that time;

g. CONTRACTOR's initial risk assessment of the Event or Breach demonstrating whether individual or other notices are required by applicable law or this DUA for HHS approval, including an analysis of whether there is a low probability of compromise of the Confidential Information or whether any legal exceptions to notification apply;

h. CONTRACTOR's recommendation for HHS's approval as to the steps Individuals and/or CONTRACTOR on behalf of Individuals, should take to protect the Individuals from potential harm, including without limitation CONTRACTOR's provision of notifications, credit protection,

claims monitoring, and any specific protections for a Legally Authorized Representative to take on behalf of an Individual with special capacity or circumstances;

i. The steps CONTRACTOR has taken to mitigate the harm or potential harm caused (including without limitation the provision of sufficient resources to mitigate);

j. The steps CONTRACTOR has taken, or will take, to prevent or reduce the likelihood of recurrence of a similar Event or Breach;

k. Identify, describe or estimate of the Persons, Workforce, Subcontractor, or Individuals and any law enforcement that may be involved in the Event or Breach;

l. A reasonable schedule for CONTRACTOR to provide regular updates to the foregoing in the future for response to the Event or Breach, but no less than every three (3) business days or as otherwise directed by HHS, including information about risk estimations, reporting, notification, if any, mitigation, corrective action, root cause analysis and when such activities are expected to be completed; and

m. Any reasonably available, pertinent information, documents or reports related to an Event or Breach that HHS requests following Discovery.

Section 4.02 ***Investigation, Response and Mitigation. For A-F below: 45 CFR 164.308, 310 and 312; 164.530***

(A) CONTRACTOR will immediately conduct a full and complete investigation, respond to the Event or Breach, commit necessary and appropriate staff and resources to expeditiously respond, and report as required to and by HHS for incident response purposes and for purposes of HHS's compliance with report and notification requirements, to the satisfaction of HHS.

(B) CONTRACTOR will complete or participate in a risk assessment as directed by HHS following an Event or Breach, and provide the final assessment, corrective actions and mitigations to HHS for review and approval.

(C) CONTRACTOR will fully cooperate with HHS to respond to inquiries and/or proceedings by state and federal authorities, Persons and/or Individuals about the Event or Breach.

(D) CONTRACTOR will fully cooperate with HHS's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such Event or Breach, or to recover or protect any Confidential Information, including complying with reasonable corrective action or measures, as specified by HHS in a Corrective Action Plan if directed by HHS under the Base Contract.

Section 4.03 ***Breach Notification to Individuals and Reporting to Authorities. Tex. Bus. & Comm. Code §521.053; 45 CFR 164.404 (Individuals), 164.406 (Media); 164.408 (Authorities)***

(A) HHS may direct CONTRACTOR to provide Breach notification to Individuals, regulators or third-parties, as specified by HHS following a Breach.

(B) CONTRACTOR must obtain HHS's prior written approval of the time, manner and content of any notification to Individuals, regulators or third-parties, or any notice required by other state or federal authorities, including without limitation, notifications required by Texas Business and Commerce Code, Chapter 521.053(b) and HIPAA. Notice letters will be in CONTRACTOR's name and on CONTRACTOR's letterhead, unless otherwise directed by HHS, and will contain contact information, including the name and title of CONTRACTOR's representative, an email address and a toll-free telephone number, for the Individual to obtain additional information.

(C) CONTRACTOR will provide HHS with copies of distributed and approved communications.

(D) CONTRACTOR will have the burden of demonstrating to the satisfaction of HHS that any notification required by HHS was timely made. If there are delays outside of CONTRACTOR's control, CONTRACTOR will provide written documentation of the reasons for the delay.

(E) If HHS delegates notice requirements to CONTRACTOR, HHS shall, in the time and manner reasonably requested by CONTRACTOR, cooperate and assist with CONTRACTOR's information requests in order to make such notifications and reports.

ARTICLE 5. SCOPE OF WORK

Scope of Work means the services and deliverables to be performed or provided by CONTRACTOR, or on behalf of CONTRACTOR by its Subcontractors or agents for HHS that are described in detail in the Base Contract. The Scope of Work, including any future amendments thereto, is incorporated by reference in this DUA as if set out word-for-word herein.

ARTICLE 6. GENERAL PROVISIONS

Section 6.01 *Oversight of Confidential Information*

CONTRACTOR acknowledges and agrees that HHS is entitled to oversee and monitor CONTRACTOR's access to and creation, receipt, maintenance, use, disclosure of the Confidential Information to confirm that CONTRACTOR is in compliance with this DUA.

Section 6.02 *HHS Commitment and Obligations*

HHS will not request CONTRACTOR to create, maintain, transmit, use or disclose PHI in any manner that would not be permissible under applicable law if done by HHS.

Section 6.03 *HHS Right to Inspection*

At any time upon reasonable notice to CONTRACTOR, or if HHS determines that CONTRACTOR has violated this DUA, HHS, directly or through its agent, will have the right to inspect the facilities, systems, books and records of CONTRACTOR to monitor compliance with this DUA. For purposes of this subsection, HHS's agent(s) include, without limitation, the HHS Office of the Inspector General or the Office of the Attorney General of Texas, outside consultants or legal counsel or other designee.

Section 6.04 *Term; Termination of DUA; Survival*

This DUA will be effective on the date on which CONTRACTOR executes the DUA, and will terminate upon termination of the Base Contract and as set forth herein. If the Base Contract is extended or amended, this DUA is updated automatically concurrent with such extension or amendment.

(A) HHS may immediately terminate this DUA and Base Contract upon a material violation of this DUA.

(B) Termination or Expiration of this DUA will not relieve CONTRACTOR of its obligation to return or Destroy the Confidential Information as set forth in this DUA and to continue to safeguard the Confidential Information until such time as determined by HHS.

(D) If HHS determines that CONTRACTOR has violated a material term of this DUA; HHS may in its sole discretion:

1. Exercise any of its rights including but not limited to reports, access and inspection under this DUA and/or the Base Contract; or
2. Require CONTRACTOR to submit to a corrective action plan, including a plan for monitoring and plan for reporting, as HHS may determine necessary to maintain compliance with this DUA; or
3. Provide CONTRACTOR with a reasonable period to cure the violation as determined by HHS; or
4. Terminate the DUA and Base Contract immediately, and seek relief in a court of competent jurisdiction in Travis County, Texas.

Before exercising any of these options, HHS will provide written notice to CONTRACTOR describing the violation and the action it intends to take.

(E) If neither termination nor cure is feasible, HHS shall report the violation to the Secretary.

(F) The duties of CONTRACTOR or its Subcontractor under this DUA survive the expiration or termination of this DUA until all the Confidential Information is Destroyed or returned to HHS, as required by this DUA.

Section 6.05 *Governing Law, Venue and Litigation*

(A) The validity, construction and performance of this DUA and the legal relations among the Parties to this DUA will be governed by and construed in accordance with the laws of the State of Texas.

(B) The Parties agree that the courts of Travis County, Texas, will be the exclusive venue for any litigation, special proceeding or other proceeding as between the parties that may be brought, or arise out of, or in connection with, or by reason of this DUA.

Section 6.06 *Injunctive Relief*

(A) CONTRACTOR acknowledges and agrees that HHS may suffer irreparable injury if CONTRACTOR or its Subcontractor fails to comply with any of the terms of this DUA with respect to the Confidential Information or a provision of HIPAA or other laws or regulations applicable to Confidential Information.

(B) CONTRACTOR further agrees that monetary damages may be inadequate to compensate HHS for CONTRACTOR's or its Subcontractor's failure to comply. Accordingly, CONTRACTOR agrees that HHS will, in addition to any other remedies available to it at law or in equity, be entitled to seek injunctive relief without posting a bond and without the necessity of demonstrating actual damages, to enforce the terms of this DUA.

Section 6.07 *Limitation of Liability*

To the extent permitted by the Texas Constitution, laws and rules, and without waiving any immunities or defenses available to CONTRACTOR as a governmental entity, CONTRACTOR will defend and hold harmless HHS and its Workforce against all actual and direct losses suffered by HHS and its Workforce arising from or in connection with any breach of this DUA or from any acts or omissions related to this DUA by CONTRACTOR or its employees, directors, officers, Subcontractors, or agents or other members

of its Workforce, including, but not limited to, the costs of required notices and mitigation of a breach and any fines or penalties imposed on HHS by any regulatory authority.

Section 6.08 *Insurance*

(A) As a governmental entity, CONTRACTOR either maintains commercial insurance or self-insures with policy limits in an amount sufficient to cover CONTRACTOR's liability arising under this DUA and under which policy HHS is added as an additional insured. HHSC reserves the right to consider alternative means for CONTRACTOR to satisfy CONTRACTOR's financial responsibility under this DUA. Nothing herein shall relieve CONTRACTOR of its financial obligations set forth in this DUA if CONTRACTOR fails to maintain insurance.

(B) CONTRACTOR will provide HHS with written proof that required insurance coverage is in effect, at the request of HHS.

Section 6.09 *Fees and Costs*

Except as otherwise specified in this DUA or the Base Contract, including but not limited to requirements to insure and/or indemnify HHS, if any legal action or other proceeding is brought for the enforcement of this DUA, or because of an alleged dispute, contract violation, Event, Breach, default, misrepresentation, or injunctive action, in connection with any of the provisions of this DUA, each party will bear their own legal expenses and the other cost incurred in that action or proceeding.

Section 6.10 *Entirety of the Contract*

This Data Use Agreement is incorporated by reference into the Base Contract and, together with the Base Contract, constitutes the entire agreement between the parties. No change, waiver, or discharge of obligations arising under those documents will be valid unless in writing and executed by the party against whom such change, waiver, or discharge is sought to be enforced.

Section 6.11 *Automatic Amendment and Interpretation*

Upon the effective date of any amendment or issuance of additional regulations to HIPAA, or any other law applicable to Confidential Information, this DUA will automatically be amended so that the obligations imposed on HHS and/or CONTRACTOR remain in compliance with such requirements. Any ambiguity in this DUA will be resolved in favor of a meaning that permits HHS and CONTRACTOR to comply with HIPAA or any other law applicable to Confidential Information.

ATTACHMENT 1. SUBCONTRACTOR AGREEMENT FORM**HHS CONTRACT NUMBER** _____

The DUA between HHS and CONTRACTOR establishes the permitted and required uses and disclosures of Confidential Information by CONTRACTOR.

CONTRACTOR has subcontracted with _____ (SUBCONTRACTOR) for performance of duties on behalf of CONTRACTOR which are subject to the DUA. SUBCONTRACTOR acknowledges, understands and agrees to be bound by the identical terms and conditions applicable to CONTRACTOR under the DUA, incorporated by reference in this Agreement, with respect to HHS Confidential Information. CONTRACTOR and SUBCONTRACTOR agree that HHS is a third-party beneficiary to applicable provisions of the subcontract.

HHS has the right but not the obligation to review or approve the terms and conditions of the subcontract by virtue of this Subcontractor Agreement Form.

CONTRACTOR and SUBCONTRACTOR assure HHS that any Breach or Event as defined by the DUA that SUBCONTRACTOR Discovers will be reported to HHS by CONTRACTOR in the time, manner and content required by the DUA.

If CONTRACTOR knows or should have known in the exercise of reasonable diligence of a pattern of activity or practice by SUBCONTRACTOR that constitutes a material breach or violation of the DUA or the SUBCONTRACTOR's obligations CONTRACTOR will:

1. Take reasonable steps to cure the violation or end the violation, as applicable;
2. If the steps are unsuccessful, terminate the contract or arrangement with SUBCONTRACTOR, if feasible;
3. Notify HHS immediately upon discovery of the pattern of activity or practice of SUBCONTRACTOR that constitutes a material breach or violation of the DUA and keep HHS reasonably and regularly informed about steps CONTRACTOR is taking to cure or end the violation or terminate SUBCONTRACTOR's contract or arrangement.

This Subcontractor Agreement Form is executed by the parties in their capacities indicated below.

CONTRACTOR**SUBCONTRACTOR****BY:** _____**BY:** _____**NAME:** _____**NAME:** _____**TITLE:** _____**TITLE:** _____**DATE** _____, **202** .**DATE:** _____

RESOLUTION

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

RESOLUTION NO: 479-2025 Approve Mental Health Provider Contract Renewals for FY 2026 and FY 2027

DATE: October 8, 2025

STATE OF TEXAS }

COUNTY OF DALLAS }

BE IT REMEMBERED at a regular meeting of the North Texas Behavioral Health Authority held on the 8th day of October 2025, the following Resolution was adopted:

WHEREAS, the Health and Human Service Commission has designated the North Texas Behavioral Health Authority (NTBHA) as the Local Behavioral Health Authority (LBHA) for a service area consisting of the following six counties: Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall, effective January 1, 2017; and

WHEREAS, the NTBHA Board of Directors was created to govern the affairs of NTBHA; and

WHEREAS, NTBHA seeks to create a well-managed, integrated, and high-quality delivery system of behavioral health services available to eligible consumers residing in our catchment area; and

WHEREAS, NTBHA is responsible for the management of the network of behavioral health providers; and

WHEREAS, NTBHA seeks to (1) Maintain a competent and committed workforce, (2) Facilitate access to behavioral health services, (3) Manage core operations efficiently and effectively, and (4) Identify and develop additional opportunities for service area development.

IT IS THEREFORE RESOLVED that the North Texas Behavioral Health Authority Board of Directors approves the CEO, in consultation with NTBHA legal counsel, to negotiate and execute the Mental Health Provider Contract Renewals for FY 2026 and FY 2027.

DONE IN OPEN MEETING, this the 8th day of October 2025.

Recommended by:

Carol E. Lucky
Chief Executive Officer
North Texas Behavioral Health Authority

Commissioner Dr. Elba Garcia
Chair, Board of Directors
North Texas Behavioral Health Authority

BOARD OF DIRECTORS MEETING

Summary

DATE: October 8, 2025

AGENDA ITEM #14: Resolution 479-2025 Approve Mental Health Provider Network Contracts for FY26-FY27

Recommendation/Motion:

Authorize the CEO, in consultation with NTBHA legal counsel as appropriate, to enter into, negotiate, adjust, or extend and execute the FY26-FY27 Mental Health Provider Network Services Contracts, in accordance with TxHHS State-allocated funding levels.

Background:

FY2026 NTBHA Mental Health Providers and associated MH Service Contracts shall be issued, and allocated, based on service utilization patterns and local community needs. Funds may be reallocated accordingly, in order to meet the NTBHA consumer needs.

Evaluation:

All NTBHA Network Provider – Service Agreements are entered into, following the Eligibility & Evaluations of respective Providers, per the applicable service procurement/solicitation.

Financial Information:

All Mental Health, MH Expansion, or LMHA-PCN funded Service Providers listed in the table below, are eligible to proceed with updated NTBHA Contract Services for the FY26-FY27 Term, with capacity and funding allocations to be negotiated and finalized by NTBHA CEO prior to the execution of a Network Provider – Services Agreement and associated Scope of Work/Contract Attachments. All amounts are issued and allocated according to current TxHHS State funding levels and approved LMHA-PCN budgets, subject to Funds Availability.

Provider	Contract Service
Aadhar, Inc.	CMHP, Eval/Assess
Adelson Behavioral Mental Health Clinic	CMHP (Comprehensive Mental Health Provider)
APAA (Association of Persons Affected by Addiction)	MH/Peer or Consumer Operated Service Provider
ARM Ministries	MH/Peer
Austin Street Center	Shelter Based MH Services
Bienstar Counseling Services	CMHP
Bridging the Gap	MH-Expansion
Centro de Mi Salud	CMHP
Child and Family Guidance Center	CMHP
CPL (Clinical Path Laboratories)	Labs
Dallas Behavioral Healthcare Hospital	PPB
e-Psychiatry, LLC	CMHP
Glen Oaks Hospital (UHS)	PPB

Harris Center	Crisis Hotline
Hickory Trail Hospital (UHS)	PPB
Homeward Bound	CMHP w/MHX, Diversion Center, Crisis Respite, Crisis Residential
Innovations CMHC	CMHP
IPS Psych Programs, LLC	CMHP
Jewish Family Service of Greater Dallas	MH-Expansion
Lakes Regional MHMR Center	CMHP, MH-Expansion
Life Enhancement Services (LES)	MH-Expansion
Metrocare Services	CMHP, MH/Vet (FY26 Only)
Nexus Recovery Center	MH-Expansion
Perimeter Behavioral Hospital of Dallas	PPB
Southern Area Behavioral Health	CMHP, Crisis Walk-In Urgent Care, Dallas LivingRoom Clinic
The Bridge	MH-Expansion
The Wood Group	Facility-Based Crisis Respite (Corsicana)
THR-Presbyterian Dallas	PPB
Unity Behavioral Health	MH-Expansion
Valiant Behavioral Healthcare Services	CMHP
Youth 180, Inc.	MH-Expansion, Co-Occurring

Please note, the above list only includes Providers in need of renewal/update or new service Agreements

Implementation Schedule:

Upon approval by NTBHA Board of Directors.

Attachments:

- NTBHA MH Service Provider Agreement – v.2025.09.01 (*Template*)
- TxHHSC LMHA Data Use Agreement & Subcontractor Attachment
- NTBHA Business Associate Agreement – Contract Attachment (*Template*)

Aligns with Visions #1, 2, 3, and 4

NTBHA Strategic Visions
Vision #1 NTBHA will maintain a competent and committed workforce.
Vision #2 NTBHA will facilitate access to behavioral health services.
Vision #3 NTBHA will manage core operations efficiently and effectively.
Vision #4 NTBHA will identify and develop additional opportunities for service area development.

Presented By:

Carol E. Lucky, MAHS // Chief Executive Office

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (“BAA” or “Agreement”), is entered into by and between Parties:

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY or NTBHA (“Covered Entity”), and;

PROVIDER NAME: _____ (“Business Associate”).

WHEREAS, Covered Entity and Business Associate are parties to one or more agreements and/or may in the future become parties to additional agreements (collectively, the “Underlying Agreements”), pursuant to which Business Associate provides certain services to Covered Entity and, in connection with such services, creates, receives, uses or discloses for or on behalf of Covered Entity certain individually identifiable Protected Health Information relating to patients of Covered Entity (“PHI”) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 as amended by the Health Information Technology for Economic and Clinical Health Act Title XIII of Division A of the American Recovery and Reinvestment Act, 2009 (HITECH Act) and regulations promulgated there under, as such law and regulations may be amended from time to time (collectively, “HIPAA”); and

WHEREAS, Covered Entity and Business Associate wish to comply in all respects with the requirements of HIPAA, including requirements applicable to the relationship between a covered entity and its business associates;

NOW, THEREFORE, the parties agree that each of the Underlying Agreements shall hereby be amended as follows:

1. **Catch-all definition:** The following terms used in this Agreement shall have the same meaning as those terms in the Health Information Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d (“HIPAA”), the Health Information Technology Act of 2009, as codified at 42 U.S.C.A. prec. § 17901 (“HITECH”), and any current and future regulations promulgated under HIPAA or HITECH: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Definitions.

- (a) “Breach”- shall have same meaning given to such term as defined in 45 CFR § 164.402.
- (b) “Business Associate” shall have the same meaning given to such term as defined in 45 CFR § 160.103.
- (c) “Covered Entity” shall have the same meaning given to such term as defined in 45 CFR § 160.103.
- (d) “Designated Record Set” shall have the same meaning given to such term as defined in 45 CFR § 164.501.
- (e) “Disclosure” shall have the same meaning given to such terms as defined in 45 CFR § 160.103.
- (f) “Electronic Protected Health Information” or “e-PHI” shall have the same meaning given to such term as defined in 45 CFR § 160.103 limited to the information transmitted or maintained by the Business Associate in electronic form format or media.
- (g) “Individual” shall have the same meaning given to such term as defined in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
- (h) “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E respectively.
- (i) “Protected Health Information” or “PHI” shall have the same meaning given to such term as defined in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- (j) “Required by Law” shall have the same meaning given such term as defined in 45 CFR § 164.103 and The Health Information Technology for Economic and Clinical Health Act (HITECH) Division A: Title XIII, Subtitle D.
- (k) “Security” or “Security Measures” encompass all of the administrative, physical, and technical safeguards in an information system specified in subpart C of 45, CFR § 164.
- (l) “Security Rule” shall mean the Standards for Security of Electronic Protected Health Information as specified in subparts A and C in 45 C.F.R. Parts 160 and 164, respectively.

- (m) “Secretary” shall mean the Secretary of the Department of Health and Human Services or his/her designee.

2. Obligations and Activities of Business Associate.

- (a) Business Associate may not use or disclose protected health information other than as permitted or required by the Underlying Agreement or as required by law:
- (b) Business Associate agrees to use appropriate safeguards, including without limitation, administrative, physical and technical safeguards, to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement and to reasonably and appropriately employ the same standards as required by law to, protect the confidentiality, integrity and availability of any electronic Protected Health Information (e- PHI) that it may receive, maintain or transmit on behalf of the Covered Entity in compliance with Subpart C of 45 CFR Part 164.
- (c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- (d) Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement or any security incident of which it becomes aware, involving Protected Health Information of the Covered Entity as required at 45 CFR 164.410.
- (e) Business Associate must in accordance with 45 CFR §164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors, agents or affiliates of the Business Associate that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree, in writing, to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information. Subject to the United States and State of Texas export control and foreign outsourcing laws, rules and regulations, the Business Associate will require any of its subcontractors and agents either based in the United States or a foreign country, to provide a reasonable assurance, evidenced in writing, that the subcontractor or agent will comply with the same privacy and security obligations as the Business Associate with respect to such PHI either set forth in this Agreement or in applicable law, rules and regulations.
- (f) Business Associate agrees to provide access, at the written request of Covered Entity, and in the time and manner designated by Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity in order to meet the requirements under 45 CFR §164.524.
- (g) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR §164.526 at the written request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.
- (h) Business Associate agrees to make available internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity, or at the request of the Covered Entity to the Secretary, the Texas Office of the Attorney General, or any officer or employee to whom the Secretary or the Texas Attorney General has delegated such authority for the purpose of determining Covered Entity’s compliance with the HIPAA Regulations and/or the Texas Medical Records Privacy Act, in a time and manner designated by the Covered Entity or the Secretary or the Texas Attorney General, for purposes of the Secretary or the Texas Attorney General determining Covered Entity’s or Business Associate’s compliance with the Privacy and Security Rules.
- (i) Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR §164.528.
- (j) Business Associate agrees to provide to Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with Section (2)(I) of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR §164.528.
- (k) Business Associate hereby acknowledges and agrees that Covered Entity has notified Business

Associate that Business Associate is required to comply with the confidentiality, disclosure and re-disclosure requirements of Texas law to the extent such requirements may be applicable.

- (l) If Business Associate, in performance of the contracted services, extends, renews or continues credit to patients or regularly allows patients to defer payment for services including setting up payment plans in connection with one or more covered accounts, as defined at 16 C.F.R. § 681.2(b)(3), the Business Associate shall comply with the Federal Trade Commission's "Red Flag" Rules, if applicable, or develop and implement a written identity theft prevention program designed to identify, detect, mitigate and respond to suspicious activities that could indicate that identity theft has occurred in the Business Associate practice or business.
- (m) Business Associate understands and agrees that it will not access or use any Protected Health Information of any patient except for those patients whose accounts have been assigned to Business Associate, and it will further limit access to that Protected Health Information that is necessary to the activities undertaken by Business Associate on behalf of Covered Entity.
- (n) Business Associate will, pursuant to the HITECH Act and its implementing regulations, comply with all additional applicable requirements of the Privacy Rule, including those contained in 45 CFR §§ 164.502(e) and 164.504(e)(1)(ii), at such time as the requirements are applicable to Business Associate. Business Associate will not directly or indirectly receive remuneration in exchange for any Protected Health Information, subject to the exceptions contained in the HITECH Act, without a valid authorization from the applicable individual. Business Associate will not engage in any communication which might be deemed to be "Marketing" under the HITECH Act. In addition, Business Associate will, pursuant to the HITECH Act and its implementing regulations, comply with all applicable requirements of the Security Rule, contained in 45 CFR §§ 164.308, 164.310, 164.312, and 164.316, at such time as the requirements are applicable to Business Associate.

3. Permitted Uses and Disclosures by Business Associate.

In case Business Associate obtains or creates Protected Health Information, Business Associate may use or disclose Protected Health Information, or any information derived from that Protected Health Information, only as explicitly permitted in the underlying agreement, and only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR § 164.504(e). It means that:

- (a) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- (b) Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- (c) Business Associate understands and agrees that its access to Protected Health Information stored in databases and information systems at the Covered Entity is subject to review and audit by the Covered Entity or agents of the State of Texas at any time, that remote audits of such access may occur at any time, that on-site audits of such access will be conducted during regular business hours, and that any review or audit may occur with or without prior notice by the Covered Entity.

4. Responsibilities of the Parties with Respect to Protected Health Information

- (a) Responsibilities of Covered Entity. With regard to the use and/or disclosure of Protected Health Information by the Business Associate, Covered Entity hereby agrees:
 - (1) to inform the Business Associate of any limitations in the form of notice of privacy practices that Covered Entity provides to individuals pursuant to 45CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
 - (2) to inform the Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose Protected Health Information, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

- (3) to notify the Business Associate, in writing and in a timely manner, of any restriction on the use or disclosure of Protected Health Information that Covered Entity has agreed to or is required to abide by under 45 CFR §164.522, to the extent that such restriction may impact in any manner the use and/or disclosure of Protected Health Information by the Business Associate under this Agreement. Except if the Business Associate will use or disclose Protected Health Information for (and the Underlying Agreement includes provisions for) data aggregation or management and administration and legal responsibilities of the Business Associate, Covered Entity will not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy and Security Rule if done by the Covered Entity.

5. Application of Security and Privacy Provisions to Business Associate.

- (a) Security Measures: 45 CFR §164.308, 164.310, 164.312 and 164.316, dealing with the administrative, physical and technical safeguards as well as policies, procedures and documentation requirements that apply to Covered Entity shall in the same manner apply to Business Associate as Required by Law. Any additional security requirements contained in Division a Title XIII Health Information Technology of the American Recovery and Reinvestment Act that apply to Covered Entity shall also apply to Business Associate as of February 17, 2010. Business Associates that require access to Covered Entity electronic patient systems and electronic infrastructure systems (either on site or remote) will supply the necessary information of employees to uniquely identify such employees, as employees with a need to access systems and will supply to Covered Entity Information Security Officer a valid state or federal issued photo ID for such employees to receive a unique user name and password to access the system(s).
- (b) Application of Civil and Criminal Penalties- If Business Associate violates any security provision as Required by Law specified in subparagraph (a) above, sections 1176 and 1177 of the Social Security Act 42 U.S.C. §1320d-5, 1320d-6 shall apply to Business Associate with respect to such violation in the same manner that such sections apply to Covered Entity if it violates such security provision.

6. Information Breach Notification Requirements.

- (a) Business Associate expressly recognizes that Covered Entity has certain reporting and disclosure obligations to the Secretary of the Department of Health and Human Services and the Individual in case of a security breach of unsecured Protected Health Information (as defined in 45 CFR §164.402).
- (b) Where Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured Protected Health Information, Business Associate without unreasonable delay and in no case later than thirty (30) days following the discovery of a breach of such information, shall notify Covered Entity of such breach. Such notice shall include the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired or disclosed during the breach.
- (c) Covered Entity and Business Associate recognizes that the Unsecured Protected Health Information may contain the social security numbers, financial account information or driver's license number or non-driver identification card number. Business Associate shall be liable for the costs associated with such breach if caused by the Business Associate's negligent or willful acts or omissions, or the negligent or willful acts or omissions of Business Associate's agents, officers, employees or subcontractors.

7. State Privacy Laws.

Business Associate shall comply with laws of the State of Texas that are More Stringent than HIPAA Regulations because the laws provide greater privacy protections for PHI or provide greater rights to individuals with respect to PHI, including without limitation the Texas Medical Records Privacy Act, chapter 181 of the Texas Health and Safety Code and the Identity Theft Enforcement and Protection Act, chapter 521 of the Texas Business and Commerce Code.

8. Term and Termination.

- (a) Term. The Term of this Agreement shall be effective as of the Effective Date (as defined below) and

shall terminate at termination of underlying agreement or on the date Covered Entity terminates this agreement for cause as authorized on paragraph (b) of this section, whichever is sooner.

- (b) Termination for Cause. The parties acknowledge that in the event the Covered Entity learns of a pattern or activity or practice of the Business Associate that constitutes violation of a material term of this Agreement, then the parties promptly shall take reasonable steps to cure the violation. If such steps are, in the judgment of the Covered Entity, unsuccessful, ineffective or not feasible, then the Covered Entity may terminate, in its sole discretion, any or all of the Underlying Agreements upon written notice to the Business Associate, if feasible, and if not feasible, shall report the violation to the Secretary of the Department of Health and Human Services.
- (c) Effect of Termination.
 - (1) Except as provided in paragraph (2) of this section, upon termination of this Agreement or the Underlying Agreement(s) for any reason, Business Associate shall return or destroy all Protected Health Information pursuant to 45 CFR § 164.504(e)(2)(I) received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
 - (2) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification, in writing, of the conditions that make return or destruction infeasible. Said notification shall include: (i) a statement that the Business Associate has determined that it is not feasible to return or destroy the Protected Health Information in its possession, and (ii) the specific reasons for such determination. The Covered Entity may disagree with the Business Associate's determination. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information. If it is infeasible for the Business Associate to obtain, from a subcontractor or agent, any Protected Health Information in the possession of the subcontractor or agent, the Business Associate must provide a written explanation to the Covered Entity and require the subcontractors and agents to agree to extend any and all protections, limitations, and restrictions contained in this Agreement to the subcontractors and/or agents' use and/or disclosure of any Protected Health Information retained after the termination of this Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of Protected Health Information infeasible.
- (d) Automatic Termination. This Agreement will automatically terminate without any further action of the Parties upon termination or expiration of the Underlying Agreement.
- (e) Effective Date. This Agreement shall be in effect as of the date last signed below.

9. Insurance and Indemnification.

Indemnification. The Business Associate agrees to indemnify, defend and hold harmless Covered Entity and Covered Entity's employees, directors, officers, subcontractors, agents or other members of its workforce from any costs, damages, expenses, judgments, losses, and attorney's fees arising from any breach of this Agreement by Business Associate, or arising from any negligent or wrongful acts or omissions of Business Associate, including failure to perform its obligations under the Privacy Rule. The Business Associate's indemnification obligation shall survive the expiration or termination of this Agreement for any reason.

10. Miscellaneous.

- (a) Regulatory References. A reference in this Agreement to a section in the Privacy and Security Rules means the section as in effect or as amended, and for which compliance is required.
- (b) Agreement. The Parties agree to take such action as is necessary to amend the Underlying Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law §104-

191; provided, however, that no Agreement shall be deemed valid unless signed by both parties.

- (c) Amendments / Waiver. This agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. A waiver with respect to one event shall not be construed as continuing, or as a bar to a waiver of any right or remedy as to subsequent events. The Parties agree to take such actions as is necessary to amend this agreement from time to time as is necessary for compliance with the requirements of the HIPAA rules and any other applicable law.
- (d) Survival. The respective rights and obligations of Business Associate under Section 6(c) of this Agreement shall survive the termination of this Agreement and/or the Underlying Agreements, as shall the rights of access and inspection of Covered Entity.
- (e) No Third Party Beneficiaries. Nothing expressed or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.
- (f) Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Privacy and Security Rules.
- (g) Equitable Relief. Business Associate understands and acknowledges that any disclosure or misappropriation of any PHI in violation of this Attachment will cause Covered Entity irreparable harm, the amount of which may be difficult to ascertain, and therefore agrees that Covered Entity shall have the right to apply to a court of competent jurisdiction for specific performance and/or an order restraining and enjoining any such further disclosure or breach and for such other relief as Covered Entity shall deem appropriate. Such right of Covered Entity is to be in addition to the remedies otherwise available to Covered Entity at law or in equity. Business Associate expressly waives the defense that a remedy in damages will be adequate and further waives any requirement in an action for specific performance or injunction for the posting of a bond by Covered Entity.

11. Governing Law; Conflict.

This Agreement shall be construed and enforced in accordance with the laws of the State of Texas. This Agreement is performable in Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties, Texas and venue shall lie in Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties, Texas. In the event of a conflict between the terms of this Agreement and the terms of any of the Underlying Agreements, the terms of this Agreement shall control.

COVERED ENTITY
NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

BUSINESS ASSOCIATE
PROVIDER NAME:

Signature
Carol E. Lucky, MAHS - C.E.O.

Printed Name and Title

Date Signed

Signature

Printed Name and Title

Date Signed

SERVICE PROVIDER AGREEMENT
BETWEEN
NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY
AND
[PROVIDER]

THIS AGREEMENT is made and entered into by and between NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY (“NTBHA” or “Authority”), the Local Behavioral Health Authority under the provisions of Chapter §533.0356 of the Texas Health & Safety Code Ann. (Vernon 1992), as amended, and [PROVIDER] (“Provider” or “Contractor”), for the purpose of providing behavioral health services currently not available to the Local Authority through its present staff of employees.

RECITALS

WHEREAS, North Texas Behavioral Health Authority is the Texas Health and Human Services Commission (“HHSC”) designated behavioral health local authority established to plan, coordinate, develop policy, develop and allocate resources, supervise, and ensure the provision of behavioral health services for the residents of Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties, Texas; and

WHEREAS, Local Authority desires to assemble and maintain a network of participating providers to provide certain mental health and substance abuse services funded by the Local Authority (the “Network”); and

WHEREAS, Provider is a facility or individuals who is or are duly licensed or certified in the State of Texas to provide the behavioral health services as described in this Agreement; and

WHEREAS, this Agreement sets forth the terms and conditions evidencing the agreement of the parties hereto.

NOW THEREFORE, in consideration of the mutual covenants, rights and obligations set forth herein, the benefits to be derived therefrom, and other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties agree as follows:

I. DEFINITIONS

For purposes of the Agreement and its referenced Attachments, Exhibits, Addendums, Amendments, and/or other related documents, the following words and phrases are defined as follows:

1. **Assessment.** The clinical process of looking at a person’s mental health or substance abuse and medical history, his or her functioning, relationships, and development to determine their need for treatment.
2. **Authorization/Authorization Number.** All Covered Services may include a unique identifying number which is given by Authority to the Provider for Covered Services to a Consumer.
3. **Clinically Appropriate.** Covered Services are authorized by a Plan of Care, which are determined to be Medically Necessary and include all of the following: An adequate and essential therapeutic response provided for evaluation or treatment consistent with the assessed needs, proper diagnosis and treatment appropriate for the individual’s specific illness, disease or conditions; Reasonably expected to improve the illness, condition or level of functioning; Safe and effective according to nationally accepted practices and standards of evidence generally recognized by licensed professionals or publications; The appropriate and cost-effective level of service that can safely be provided for the specific intensity of need in accordance with the professional and technical standards adopted by the Utilization Management and Quality Management Departments of Authority.
4. **Confidential Information.** Any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) prepared, created, received, maintained, used, disclosed or have access to by the Local Authority or Provider which concerns the Consumer, Covered Individual, or Non-Covered Individual that consists of or includes any or all of the following:
 - a. Consumer Information;
 - b. Protected Health Information or Unsecured Protected Health Information;

- c. Sensitive Personal Information defined by Texas Business and Commerce Code Ch.521;
 - d. Federal Tax Information;
 - e. Personally Identifiable Information;
 - f. Social Security Administration Data; and
 - g. All privileged work product; and also includes:
 - h. All information designated as confidential under the constitution and laws of the State of Texas and of the United States, Texas Health & Safety Code, Texas Public Information Act, and Texas Government Code, Chapter 552.
5. **Consumer.** Individuals residing in Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties who have been determined by Authority to meet the definition of Priority Population.
 6. **Covered Individual.** Individuals residing in Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties, who meet the HHSC definition of Priority Population and are authorized by the Authority to receive services.
 7. **Covered Services.** Mental health and substance use disorder services within the scope of the benefit plan.
 8. **Episode of Care.** The care provided by a reasonably prudent health care facility or provider for a specific psychiatric problem or condition during a set time period, but specifically excluding emergency medical treatment that is unrelated to the psychiatric problem or condition and any Potential Preventable Readmission.
 9. **Local Case Number.** (“LCN”) A unique number assigned to each NTBHA consumer receiving services.
 10. **Medically Necessary.** Medically Necessary means that Covered Services: (a) are reasonable and necessary for the treatment of a behavioral health disorder or to improve or prevent deterioration of functioning resulting from such a disorder; (b) are in accordance with accepted standards of practice in behavioral health care; (c) are furnished in the most appropriate and least restrictive setting in which Covered Services can be safely provided; (d) are the most appropriate level or supply of service which can be safely provided; and (e) could not have been omitted without adversely affecting the Consumer’s mental and/or physical health or the quality of care rendered.
 11. **Non-Covered Individual.** Any individual residing in Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties for whom the Provider has not obtained an authorization for services.
 12. **Non-Covered Services.** Any services not specified in the Plan of Care and for which Provider has not obtained an authorization.
 13. **Payor of Last Resort.** The payor or program responsible for adjudication once all other funding sources have been exhausted.
 14. **Plan of Care.** A written plan that a Consumer develops in collaboration with a Provider in accordance with the State standards applicable to a specific Consumer. The Plan of Care, based on a Consumer’s choices and assessments, addresses the problems, goals, and direction of service delivery.
 15. **Potentially Preventable Readmission.** A Clinically Related Readmission of a Covered Individual that occurs up to and including fifteen (15) calendar days after the Covered Individual’s date of discharge from his or her most recent hospital admission. A clinical review involving NTBHA and Provider will be conducted to allow NTBHA to determine if the underlying reason for the readmission was plausibly related to the care and treatment rendering during or immediately following a prior hospitalization as a prerequisite to recoupment or non-payment for a Covered Service.
 16. **Prior Authorization/Pre-Authorization.** A determination made by NTBHA to prospectively approve or deny payment for a service or course of treatment of a specific duration and scope to a member prior to the provider’s initiating provision of the requested service.
 17. **Priority Population.** Provider shall not restrict or expand the definition of Priority Population or any other Consumer defined in this Agreement. The definition of the Priority Population for Provider is as follows:
 - a. **Adults:** who have severe and persistent mental illness 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.
 - b. **Child and Adolescent:** Children ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, mental retardation, autism or pervasive development disorder) who exhibit serious emotional, behavioral or mental disorders and who: (1) Have a serious functional impairment; or (2) Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or (3) Are enrolled in a school system’s special education program because of serious emotional disturbance.
 - c. **Substance Abuse:** HHSC has established a priority order for treatment in accordance with SAPT Block Grant regulations and state designation. SUD Providers shall give preference for treatment in

the following order: (1) Pregnant, injecting drug users; (2) Pregnant substance abusers, and; (3) Injecting drug users.

18. **Protected Health Information (“PHI”).** Individually Identifiable Health Information that is or has been electronically transmitted or maintained by either party and includes such information in any other form.
19. **Provider.** An entity that delivers direct behavioral health services to an enrollee.
20. **Provider Directory.** A published list of service providers currently contracted with NTBHA.
21. **Provider Manual.** Resources to NTBHA service provisions, processes, procedures, and policy guidelines with explanations, for working with NTBHA.
22. **System Agency/Performing Agency.** In pertaining to this Agreement, its Attachments, Exhibits, Addendums, and Amendments, System Agency shall refer to NTBHA and Performing Agency shall refer to Provider.

II. RELATIONSHIP BETWEEN THE PARTIES

1. **Independent Contractor.** The relationship between the Local Authority and Provider will be that of an independent contractor. The parties agree that none of the provisions of this Agreement are intended to create, nor will be deemed or construed to create, any relationship between the Local Authority and Provider other than that of independent parties contracting with each other to carry out this Agreement. It is expressly agreed that Provider and Provider’s personnel, if any, may not for any purposes be deemed to be an officer, employee, agent, partner, joint ventures, ostensible or apparent agent, servant or borrowed servant of the Local Authority. Provider agrees that it will not hold itself out as an agent of the Local Authority to Consumers served under this Agreement or to any other persons. Provider understands and agrees that:
 - a. Local Authority will not:
 - 1) withhold on Provider’s behalf any sums for income tax, unemployment insurance, social security, or any other withholding under any law or requirement of any governmental body relating to Provider; or
 - 2) make available to Provider any benefits afforded to employees of Local Authority.
 - b. All the payments, withholdings, and benefits, if any, are Provider’s sole responsibility under this Agreement; and
 - c. In the event the Internal Revenue Service should question or challenge Provider’s independent contractor status, the parties mutually agree that all parties to this Agreement will have the right to participate in any discussion or negotiation occurring with the Internal Revenue Service.
2. **Professional Judgment.** In the performance of all services under this Agreement, Provider is at all times acting as an independent contractor engaged in the delivery of professional services. Provider and its personnel, if any, will employ their own means and methods and exercise their own professional judgment in performing the services under this Agreement. The sole concern of the Local Authority under this Agreement is that, irrespective of the means selected, the services will be performed in a competent, efficient, and satisfactory manner in compliance with the policies and procedures of the Local Authority and HHSC.
3. **Liability for Treatment or Service.** Nothing in this Agreement shall be deemed to change or alter any relationship which exists or may come to exist between the Provider and the person served. Provider shall have and be subject to the same duties, liabilities and responsibilities toward the Local Authority’s Consumers served as exist generally between Provider and its other patients. Further, the Utilization Review and Quality Management Procedures of the Local Authority shall not diminish the Provider’s obligation to render patients served consistently with the applicable standards of care.

III. OBLIGATIONS OF THE PROVIDER

1. **Provision of Covered Services.** Provider agrees to provide Covered Services to the eligible Consumers of Dallas, Ellis, Navarro, Hunt, Kaufman, and Rockwall Counties, Texas, to Local Authority’s designated individuals in accordance with the terms of this Agreement, admission criteria, and the Provider Manual. Provider will render services to all Covered Individuals in the same manner, subject to the same standards, and within the same time availability as offered to Provider’s other patients or clients. Provider will not discriminate on the basis of payment source in matters involving the provision of Covered Services to said individuals. Provider will not refuse to accept or continue to serve any individual unless the individual does not meet Priority Population, or Provider and Local Authority admission criteria.

- a. The professional services to be provided by Provider will be provided in accordance with the Plans of Care/Treatment Plans of Consumers.
 - b. Provider agrees that no person who is eligible for services under this Agreement will be denied services solely on the basis of the person's arrest, charge, fine, probation, indictment, incarceration, deferred adjudication, community supervision, sentencing or conviction of a criminal offense.
 - c. Provider agrees that it may not restrict or expand the definitions of Priority Population or any other Consumer served as defined in this Agreement.
 - d. Provider agrees that it will not deny services to a Consumer served under this Agreement because of the Consumer's inability to pay.
2. **Authorization of Covered Services.** All authorizations for the provision of Covered Services will be approved by Local Authority only.
3. **Non-Exclusivity.** Nothing contained in this Agreement shall be construed to confer upon the Provider the exclusive right to render services to Consumers in any geographic area, and Local Authority explicitly reserves the right to contract with any other Provider in the geographic area of the Local Authority, Dallas, Ellis, Navarro, Hunt, Kaufman and Rockwall Counties, Texas.
4. **Referrals.** Consistent with sound medical practice and in accordance with accepted community standards, or as otherwise required by law, Provider agrees to coordinate Covered Services, and planning with Local Authority staff to assure continuity of Covered Services during and following Covered Services delivery. Provider's failure to obtain preauthorization, as defined in the Provider Manual per service from Local Authority, may result in Provider liability for charges incurred. In no event shall Provider seek compensation from the Consumer (or representative of the Consumer), Local Authority, or any payor for Provider's failure to obtain preauthorization of any services.
5. **Continuity of Care.** Provider agrees to participate in treatment planning with Local Authority staff through Care Management Manager and/or Utilization Manager to assure continuity of services for each Covered Individual.
6. **Quality Management and Utilization Management Programs.** Provider agrees to participate in, cooperate with, and comply with Local Authority Quality Management ("QM") and Utilization Management ("UM") activities and standards. Provider will be required to have a written QM Plan; identified quality related goals with supportive objectives; and implementation of processes to show progress towards goal attainment. Provider shall allow Local Authority to have access at any time to the treatment records of its Consumers as permitted by state and federal confidentiality laws. Provider understands that sanctions for noncompliance with Local Authority requirements may include termination of this Agreement. Provider understands that Local Authority will actively evaluate and oversee QM measures to ensure they meet and/or exceed Local Authority expectations and standards. Provider agrees to implement continuous QM to gain improvement in service delivery processes. Provider shall:
 - a. Develop a QM Plan and conduct QM activities including organizational self-assessments and measures of satisfaction as specified by the Local Authority.
 - b. Establish and conduct corporate compliance reviews, assessments, and implement remedies for identified areas of improvement.
 - c. Comply with the Local Authority's monitoring procedures, including submission of reports and data and other information requested.
 - d. Conduct monthly reviews to ensure that documentation of services are in compliance with the HHSC Data Verification definitions.
 - e. Adhere to quality of care indicators including but not limited to the following:
 - 1) Appropriateness of admission/discharge to the program
 - 2) Unusual incident trends
 - 3) Unauthorized absences and outcomes
 - f. Local Authority shall monitor each community services contractor's compliance with the contract and evaluate the contractor's provisions of services, including but not limited to:
 - 1) Competency of the contractor to provide care;
 - 2) Consumers' access to services;
 - 3) Safety of the environment in which services are provided;
 - 4) Continuity of care;
 - 5) Compliance with the performance expectations;
 - 6) Satisfaction of consumers and family members with services provided; and
 - 7) Utilization of resources.

7. **Response to Contract Monitoring.** The Local Authority is responsible for routine monitoring of this Agreement to ensure the Provider complies with the terms of this Agreement, with the responsibilities and requirements of HHSC through contractual obligations with NTBHA, and to ensure that performance measures and monitoring outcomes are appropriately met and managed. In response to routine monitoring of this agreement, provider shall fully cooperate with NTBHA requests.
8. **Covered Individual Appeals and Complaints.** Provider agrees to abide by, and cooperate with, Local Authority's complaint, grievance, and appeal processes maintained fairly and expeditiously to resolve a Covered Individual's and/or Provider's concerns pertaining to any service provided by Provider and/or to allow a Covered Individual or Provider to appeal determinations that a service was not authorized. Notice of adverse determinations that a service is not Medically Necessary will be communicated to consumers by the Provider and in accordance with applicable federal, state, or local laws, rules, or regulations to which the NTBHA program is subject. Provider agrees to cooperate with and participate in Local Authority's procedures and those of other payors to resolve any complaints by Covered Individuals regarding Provider's services. Provider agrees to inform in writing Covered Individuals served by the Provider of the right to file a complaint regarding Provider in accordance with Local Authority's complaint process. Provider agrees to take such corrective action as required by Local Authority to resolve any complaint related to its provision of services pursuant to this Agreement.
 - a. Covered Individual(s) can initiate complaints via the Local Authority's Client Rights Officer or his/her case manager. A notice to NTBHA consumers must be posted on Provider premises concerning the process for resolving complaints, including the Texas Department of Insurance's toll-free number.
 - b. Provider shall furnish such current administrative policies and procedures, data and/or documentation as Local Authority or its designee may reasonably request. In the event deficits are found, Local Authority reserves the right to re-audit Provider's site to ensure remedial efforts for improvement have been implemented. Following on-site audits, Local Authority will deliver to the Provider a list of comments with regard to the manner in which services are being provided. Failure to provide a plan of improvement, and correction (or justification for lack of action) within a reasonable time as specified by the Local Authority may result in sanctions including the termination of this Agreement.
9. **Transfer to Another Provider.** Providers aware of Covered Individuals wishing to transfer/change Providers after services have already begun must notify the Covered Individuals with appropriate referrals and coordination to complete transfer to desired Provider.
10. **Marketing.** Provider hereby authorizes Local Authority to identify Provider in Local Authority's Provider Directory. This identification may only include Provider's name, address, telephone number, and Provider profile with a description of Provider's services and facilities. Notwithstanding the Provider Directory, Provider additionally authorizes Local Authority to maintain and make available to Consumers and potential Consumers, current information on Provider as would be available for each Provider of community services participating in the network. Provider is aware that material may include results from Consumer satisfaction surveys. In all other respects, Local Authority and Provider reserve the right to control the use of their respective names, symbols, trademarks and service marks existing or established during the term of this Agreement. Provider shall obtain prior approval in writing to use Local Authority's name in any promotional materials. Any use of the Local Authority's name in advertising or any other promotional material by the Provider must be approved by the Local Authority in writing prior to distribution of materials.
11. **Qualifications.** Necessary documentation regarding Provider's professional and educational qualifications and any additional required qualification documentation are set forth in Information Item A, as published by HHSC.
12. **Authority Approval of Provider Personnel.** Provider agrees not to subcontract any services until approval of such subcontractors are approved by Local Authority in writing. Any subcontractors or employees of Provider are the direct responsibility of Provider. Provider further agrees to secure from any assignee or subcontractor their written agreement to comply with all of the terms and conditions, including without limitation the representations and warranties made herein, of this Agreement. Provider further understands and agrees that the subcontracting or assignment of any of the terms or conditions of this Agreement does not release or excuse the Provider from its obligations to perform under this Agreement.
13. **Representations and Warranties.**
 - a. Provider represents and warrants at all times during this Agreement, that Provider, its officers, employees, and agents will comply with:

- 1) The terms of this Agreement, all applicable policies of the Local Authority, policies as specified in the Provider Manual; and
 - 2) All applicable local, state, and federal laws, rules, regulations, handbooks, standards and guidelines now in effect and that become effective during the term of this Agreement including but not limited to all applicable standards set forth by HHSC and found in Title 26 of the Texas Administrative Code, Chapter 301, Subchapter G and Title 40 of the Texas Administrative Code, Chapter 5, a current copy of which may be requested from the Local Authority or may be obtained at the following website address: www.sos.state.tx.us/tac/index.
- b.** Provider, its officers, employees, and agents, will maintain, as applicable to service delivery, any certifications, registrations, or licenses, set forth in the Provider Manual and applicable law, and are required to remain in good standing in its/his/her profession during the term of the Agreement. Additionally, Provider must inform the Local Authority immediately of any changes -- including any court or governmental agency proceeding, investigation, termination, reduction, revocation or suspension -- to any certifications, registrations, or licenses held by the Provider, its officers, employees, or agents. Provider shall submit a written report to Local Authority within three (3) calendar days of any allegation that a professional licensed or certified by the State of Texas and employed by the Provider has committed an action that constitutes grounds for the denial, suspension, or revocation of the certification or licensure. If Provider's employee receives a denial, suspension, or revocation, and Provider fails to remove such employee from providing Covered Services to Covered Individuals, then this Agreement may be immediately terminated without prior notice.
- c.** Provider will ensure the performance of services within the standards and scope of its profession and in a manner designed to assist in the Local Authority's efficient operation of the Local Authority. Provider agrees to interact with Local Authority staff, other Providers with the Local Authority, and consultants in a cooperative manner. The adequacy of the performance of this obligation will be determined at the Local Authority's sole discretion.
- d.** The Provider represents and warrants that the execution and performance of this Agreement by Provider will not conflict with or create a default under any agreement, contract, instrument, order or judgment to which Provider is a party.
- e.** The Provider represents and warrants that AIDS/HIV workplace guidelines, similar to those adopted by HHSC, and AIDS/HIV confidentiality guidelines, consistent with state and federal law, will be adopted and implemented by the Provider.
- f.** The Provider represents and warrants that at the time of executing this Agreement, neither Provider, its officers nor directors are currently held in abeyance or barred from the award of a federal, state or county contract. Provider agrees to disclose this information in the event such abeyance occurs at any time during the term of this Agreement, pursuant to the regulations implementing Executive Order 12549 and Executive Order 12689, Debarment and Suspension, 2 C.F.R. Part 376. This provision shall be included in its entirety in a Provider's subcontracts if payment in whole or in part is from federal funds. Such disclosure shall include when Provider:
- 1) is held in abeyance from or barred from the award of a federal, state or county contract or if this occurs anytime during the term of this Agreement;
 - 2) has been convicted of a criminal offense related to any county, state or federally funded program;
 - 3) is placed on "vendor hold" status for any county, state, or federally funded Local Authority or program; or
 - 4) is placed on the Federal Government's terrorism watch list, as described in Executive Order 13224.
- g.** Provider represents and warrants that it/he/she is not currently an employee of the Local Authority.
- h.** Contractor understands that the Enterprise Agency does not tolerate any type of fraud. The Enterprise Agency's policy is to promote consistent, legal, and ethical organizational behavior by assigning responsibilities and providing guidelines to enforce controls. Violations of law, agency policies, or standards of ethical conduct will be investigated, and appropriate actions will be taken. All employees or contractors who suspect fraud, waste or abuse (including employee misconduct that would constitute fraud, waste, or abuse) are required to immediately report the questionable activity to both the Health and Human Services Commission's Office of the Inspector General at 1-

800-436-6184 and the State Auditor's Office. Contractor agrees to comply with all applicable laws, rules, regulations, and Enterprise Agency policies regarding fraud including, but not limited to, HHS Circular C-027.

14. **Receipts and Records.** Provider agrees to provide the Local Authority upon request with original receipts for the purchases of all goods and services involving the use of Local Authority funds as well as all other financial and supporting documents and statistical records. Provider shall retain these and any other records pertinent to the services for which a claim or cost report was submitted to the Local Authority, including Plans of Service, for a period of six (6) years from the latest date of the expiration or termination of this Agreement.
15. **Immigration Reform and Control Act.** Provider agrees to maintain appropriate identification and employment eligibility documents to meet requirements of the Immigration Reform and Control Act of 1986.
16. **Reports of Abuse and Neglect.** Provider must report any allegations of abuse, neglect, or exploitation to the Texas Department of Family and Protective Services (DFPS) at 800-252-5400 and to Local Authority's QM Department at qm@ntbha.org or 877-653-6363 in compliance with federal and state law, and Local Authority policies and procedures. Reporting to the Local Authority's QM Department shall include (1) a written incident report completed by the individual who reported the allegation to DFPS, (2) DFPS report number, and (3) be submitted within 24 hours of knowledge of allegation.
17. **Required Information for Criminal Conviction Checks.**
 - a. Provider shall provide to the Local Authority proof that criminal history record checks have been conducted on Provider/subcontractor's officers, employees, and agents whose duties place them in direct contact with Consumers, pursuant to Texas Health and Safety Code, Section §533.007 and Chapter 250, the Texas Government Code, Section §411.115.
 - b. If an officer, employee, or agent of the Provider/subcontractor has a criminal history relevant to his or her employment, then the Provider/subcontractor will take appropriate action with respect to the officer, employee, or agent, including terminating or removing the officer, employee, or agent from direct contact with Consumers with a mental disability served by the Provider/subcontractor; and
 - c. If Provider/subcontractor's officer, employee, or agent has such a conviction, and Provider/subcontractor fails to remove such officer, employee, or agent, then this Agreement may be terminated without prior notice.
 - d. Provider/subcontractor shall provide the Local Authority with a letter of assurance upon request or by no later than January 15 of each calendar year that an annual criminal background check (such as the Texas DPS criminal check) has been conducted on all Provider/subcontractor's officers, employees, and agents who have direct contact with Consumers, and that Provider/subcontractor is in compliance with the terms of this Agreement. Failure to provide the requested information may result in suspension and/or termination of this Agreement.
18. **Pre-Employment Drug Screening.** Service Providers must maintain a drug-free work environment and complete a pre-employment drug screening in accordance with Title 25 of the Texas Administrative Code, Part 1, Chapter §448.601 (e), on all applicants hired after August 31st, 2004.
19. **Provider's Governing Body.** Upon request, Provider agrees to provide Local Authority with a list of the members of Provider's governing body, if applicable.
20. **Retention of Records.** Provider agrees to retain all records pertinent to the Agreement, including appropriate treatment plans, for a period of seven (7) years. Provider shall retain for seven (7) years following the latest date of the expiration or termination of this Agreement, or the termination of Covered Services, or for a longer period if required by statute or regulation, PHI and all records, reports, and source documentation related to services and treatment sufficient to support an audit concerning expenses and services.
21. **Optimizing Revenue.** Provider agrees to optimize earned revenues and maintain best cost value through coordination of insurance benefits and third-party revenues.
22. **Responsibility for Consumer Funds.** If Provider assumes responsibility for the funds of a Consumer, Provider will abide by written policies approved by the Local Authority and will protect and account for such funds in accordance with generally accepted accounting principles.
23. **Medical Care.** If Consumer receiving services from Provider requires immediate and/or emergency medical attention during the delivery of the services, Provider agrees to provide or procure appropriate hospital, surgical, medical, and dental care for the Consumer as specified in Provider's emergency policy and procedures.
24. **Solicitation prohibitions involving Potential Consumers.** Provider agrees and is aware that Provider is prohibited from the following, and any violation will result in immediate termination of this Agreement:

- a. Offering any gift with a value in excess of \$10 to potential Consumers; and,
 - b. Soliciting potential Consumers in person, through direct mail, by telephone or other means of communication.
25. **Managed Care Organizations.** Provider shall make a reasonable effort to join a managed care network as a provider. Failure to make such effort is grounds for immediate termination of this Agreement.
26. **Credentialing.** Provider agrees and represents that its licensed staff and other appropriate staff (such as QMHP-CS) will be credentialed before services are delivered to Consumers by such Provider and staff. Local Authority will review all of the Provider's officers, staff, employees, and agents at the professional level (i.e. licensed staff). Provider will maintain completed credentialing application forms and submit updated rosters to the Local Authority for each licensed professional providing services to Covered Individuals on a semi-annual basis. These files and rosters are subject to audit by Local Authority. Provider must make modifications to its own credentialing process to meet or exceed standards set forth by Local Authority's credentialing policies and procedures.
27. **Assignment.** Provider assigns to Local Authority any and all claims for overcharges associated with this Agreement arising under the antitrust laws of the United States 15 U.S.C. Section 1, et seq. (1973), as amended, and the antitrust laws of the State of Texas, Tex. Bus. & Com. Code Ann. Sec. 15.01 et seq. (1967), as amended.
28. **Telemedicine Medical Services.** If Provider provides telemedicine medical services, Provider represents that the services are implemented in accordance with written procedures and using protocol approved by the Provider's medical director that includes the following requirements:
- a. Clinical oversight by Provider's designated physician responsible for medical leadership;
 - b. Contraindication considerations for telemedicine use;
 - c. Priority in scheduling the system for clinical care of Consumers;
 - d. Quality oversight and monitoring of satisfaction of the Consumers served; and
 - e. Management of information and documentation for services that allows timely access to accurate information between the two sites.
29. **Training.** Provider agrees to participate in Provider Training as required and approved by the Local Authority. Proof of all required training shall be maintained by the Provider and made available on request by the Local Authority within thirty (30) calendar days of Agreement start date (all training needs to occur before the Provider serves Consumers). Required training may be obtained from the Local Authority, NTBHA QM, and/or NTBHA designee; however, Provider shall not bill Local Authority for said training hours. Failure to obtain and/or keep current required training will be deemed non-compliance and may be grounds for termination of this Agreement.

IV. REIMBURSEMENT OF SERVICES

1. **Bills for Payment.** Provider will submit Certified Covered Services Encounter Claims by the tenth day of each calendar month following the month the services were rendered in accordance with the Statement of Work.
2. **Acceptance of Payment.** Provider will accept payment received from Local Authority in accordance with the Reimbursement Schedule set forth in the Statement of Work as payment in full for Covered Services provided pursuant to this Agreement. Provider shall not submit a claim or bill or collect compensation from a Consumer. Further, Provider shall not submit a claim or bill or collect compensation from Local Authority for any Non-Covered Service, Service(s) eligible or covered by any third-party payor, State/Federal Grant funding, or Benefit/Assistance programs outside of NTBHA funding.
3. **Coordination of Covered Individual's Benefits.** Provider agrees to cooperate with Local Authority in coordination of Covered Individuals' benefits, to provide Local Authority any relevant information that Provider may reasonably have relating to any other coverage held by a Covered Individual, and to abide by the coordination of benefits, subrogation and duplicate coverage policies as set forth in the Provider Manual. Provider acknowledges that Local Authority is considered the payor of last resort and that all other funding sources must be exhausted prior to billing Local Authority for authorized Covered Services. It is the obligation of the Provider to submit written evidence documenting its efforts to collect fees from any and all payment sources prior to submitting claims to Local Authority. Provider agrees that Local Authority reserves the right to refuse payment to Provider.
4. **Non-Covered Services.** Provider agrees that compensation for providing Non-Covered Services will be solely between the individual and the Provider, and that the individual must be informed in writing before

such services are provided, and that Local Authority is not responsible for payment for such services. Prior to providing any non-covered services to any individual, Provider shall, in writing, advise the individual (a) of the nature of the service; (b) that the service is a Non-Covered Service for which a payor will not pay; and (c) that the individual will be responsible for paying for the service. Provider shall request individual to sign such writing and return to Provider.

5. **Overpayment.** In the event a Provider receives an overpayment for services performed, Provider and Local Authority mutually agree that such identified overpayment will be deducted in total from the following month's payment, unless the Local Authority's Legal Department states that the overpayment should be withheld immediately.
6. **Referrals and Utilization.** The Local Authority does not guarantee utilization of the Covered Services to be provided under this Agreement. Provider acknowledges that there is no warranty or guarantee that Provider will be utilized by an individual or any number of Covered Individuals. Provider further acknowledges that the parties do not intend to create an exclusive arrangement by this Agreement.
7. **Franchise Tax.** If Provider is a corporation and is or becomes delinquent in the payment of its Texas franchise tax, then payments to the Provider due under this Agreement may be withheld until such delinquency is remedied.

V. RESPONSIBILITIES OF LOCAL AUTHORITY

1. **Provider Manual.** Local Authority shall maintain a Provider Manual, available to view or download on its website. Local Authority may amend the Provider Manual from time to time, at its sole discretion, with the most up-to-date version published online, at <https://ntbha.org/providers/manuals-forms/>. In the event of any inconsistency between the terms of this Agreement and the Provider Manual, the terms of the Provider Manual shall govern and control.
2. **Payment.** Local Authority will pay Provider for charges verified and billed for which Local Authority has authorized in accordance with the Statement of Work. In consideration of the obligations undertaken by Provider, Local Authority projects to pay Provider for charges submitted by Provider for the provision of Covered Services, during the term of this Agreement. This projection in no way guarantees a maximum amount or utilization of Provider by a Consumer or any number of Consumers. *This Agreement is at all times contingent upon the approval of HHSC and the availability and receipt of state or federal funds, and if funds for this Agreement become unavailable during any budget period, this Agreement may be immediately terminated or reduced at the discretion of the Local Authority. Provider understands and agrees if this Agreement is modified or terminated due to an insufficient amount of state or federal funds allocated to Local Authority, the Local Authority shall not be responsible for any amounts allegedly owed to Provider.*
3. **Provider Reporting.** Unless otherwise instructed, all required and requested submissions or reporting shall be sent to the email provided below, when electronic versions are permitted, or to the address provided below for paper copies and originals.

North Texas Behavioral Health Authority
Heath Frederick, Contracts Director
(469) 523-0529 – hfrederick@ntbha.org
Contracting Dept (Cc: contracts@ntbha.org)
8111 LBJ Frwy., Suite 900
Dallas, TX 75251

4. **Freedom of Choice.** Local Authority shall allow Consumers to choose freely any participating Provider within the network without influence by any Local Authority staff or representative.

VI. RECORDS, CONFIDENTIALITY, AND ACCESS

1. **Disclosure Under the Texas Public Information Act.** The Local Authority operating under the Texas Public Information Act is required upon written request to release information regarding Provider which may include Provider Profile or other documents. Information deemed proprietary by Provider must be clearly indicated as such and may still be subject to disclosure depending on a ruling from the Attorney General's Office. Provider shall be solely responsible for contesting or defending the release of any information it

deems to be proprietary and hereby releases the Local Authority from any duty, responsibility, or liability with regard to the release of any information delivered to the Local Authority by Provider.

2. **Records.** Provider will create and maintain records in accordance with the Provider Manual and this Agreement.
3. **Confidentiality of Records of Covered Individuals Served by This Agreement.** Provider agrees to comply with all applicable Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations including the HHSC Data Use Agreement incorporated by reference to this Agreement. In accordance with HIPAA and the Privacy Rule (45 CFR Parts 160 and 164):
 - a. Provider agrees and acknowledges that in receiving, storing, processing, or otherwise dealing with Consumer's information, if any, accessed or generated during services as a Provider for the Local Authority, that Provider and its officers, employees, agents and subcontractors are bound by the provisions of laws, statutes, and regulations protecting the confidentiality of this information.
 - b. Provider agrees and acknowledges that in receiving, storing, processing or otherwise dealing with information, if any, pertaining to or about a Consumer with respect to alcohol or drug abuse, Provider and its officers, employees and agents are bound by the provisions of 42 C.F.R. Part 2.
 - c. Provider agrees to follow, undertake, or institute appropriate procedures of safeguarding Consumer's information, if any, with particular reference to Consumer identifying information or protected health information. The term "Consumer identifying information" and/or "protected health information" includes, but is not limited to, a Consumer's medical record, graphs, or charts; statements made by the Consumer, either orally or in writing, while receiving services; photographs, videotapes, etc., and any acknowledgment that a Consumer is or has received services at the facility, center, or other designated provider.
 - d. Provider agrees to resist in judicial proceedings any efforts to obtain access to protected health information pertaining to Consumers except as expressly stated in applicable laws, rules and regulations. Provider agrees to inform the Local Authority of any attempts to gain access to protected health information pertaining to Consumers.
 - e. Provider agrees to report to Local Authority any use or disclosure of protected health information not provided for by this Agreement.
 - f. Provider agrees to make available to the appropriate federal or state agency its internal practices, books, records, and policies and procedures or those of Local Authority used by Provider related to the use and disclosure of protected health information for the purpose of determining Provider's compliance with the Privacy Rule.
 - g. Provider agrees to maintain documentation of, and information related to its uses and disclosures of protected health information to permit Local Authority to provide an accounting of disclosures as prescribed by 45 CFR §164.528.
 - h. Provider acknowledges that Local Authority is not permitted to enter into any agreement with Provider to, create, receive, maintain, use, disclose, have access to or transmit Confidential Information, on behalf of Local Authority without requiring that Provider to first execute the Subcontractor Agreement Form, which ensures that the Provider (Subcontractor) will comply with the identical terms, conditions, safeguards and restrictions as contained in the Data Use Agreement ("DUA") for PHI executed between the Local Authority and HHSC. A copy of the executed DUA is available upon request.
4. **Access to Facilities, Books and Records by Local Authority or HHSC.** Pursuant to Texas Health and Safety Code §534.061, Provider agrees to allow the Local Authority or other authorized governmental agencies unrestricted access during usual business hours to all facilities, service providers, individuals served, records, data, and other information as necessary to enable HHSC and the Local Authority or other authorized agencies to audit, monitor, and review all financial or programmatic activities and services associated with this Agreement. Provider authorizes Local Authority and HHSC or their designated agents to make copies of, at no charge, Provider's medical, financial and administrative books, documents, and records related to providing services to Covered Individuals and the cost thereof, subject to applicable laws and regulations.
5. **Right of Audit and Recovery.** Provider hereby authorizes Local Authority to conduct retrospective audits of Provider's claims and other records related to any service rendered to a Covered Individual for a period of up to two (2) years following payment to Provider. In the event such an audit reveals that Provider was paid by Local Authority for services not rendered or properly documented, Local Authority may recover any compensation paid to Provider for such services, and Provider agrees to pay Local Authority within thirty

(30) calendar days such amount as determined by the Local Authority to have been paid for services not rendered or not properly documented.

VII. INSURANCE

1. **General Policy Requirements:** Provider agrees to maintain the following insurance policies, with the specified coverages and limits, to protect and insure the Local Authority and Provider against any claim for damages arising in connection with Provider's responsibilities or the responsibilities of Provider's personnel under this Agreement and all extensions and amendments thereto.

a. Policies, Coverages, and Endorsements.

(A): Commercial General Liability

General Aggregate	\$1,000,000
Products/Completed Operations Aggregate	\$500,000
Each Occurrence	\$500,000
Fire Legal Liability	\$50,000

Note: Limits shown above shall apply to Abuse and Molestation claims without sub-limits or exclusions.

(B): Professional Liability

General Aggregate	\$1,000,000
Each Occurrence	\$500,000

(C): Business Automobile if transporting Consumers

Combined Single Limit Bodily Injury & Property	\$500,000

(D): Workers' Compensation & Employers' Liability

Medical & Indemnity	Statutory Requirements
Bodily Injury by Accident	\$500,000 Each Accident
Bodily Injury by Disease	\$500,000 Each Employee
Bodily Injury by Disease	\$500,000 Policy Limit

(E): Medical Malpractice Insurance for Physicians if applicable

General Aggregate	\$3,000,000
Each Occurrence	\$100,000

(F): Providers that are self-insured through their own self-insurance program must comply with all the insurance regulations applicable to the Provider and shall furnish appropriate evidence to the Local Authority of the existence of such coverage for the services being provided to the Local Authority.

- b. Insured Parties. All policies excluding professional liability and worker's compensation shall contain a provision naming the Local Authority (and its officers, agents and employees) as an Additional Insured Party and a Certificate Holder on the original policy and all renewals or replacements during the term of this Agreement.
- c. Subrogation. All policies must contain a Waiver of Subrogation endorsement to the effect that the issuer waives any claim or right in the nature of subrogation to recover against the Local Authority, its officers, agents or employees.
- d. Proof of Insurance. The policies, coverages and endorsements required by this provision shall be shown on a Certificate of Insurance on which the Local Authority must be listed as an Additional Insured Party (excluding professional liability and worker's compensation) and the Certificate Holder, and which should be furnished to the Local Authority prior to the commencement of this Agreement. All such insurance shall be secured and maintained with an insurance company, or companies, licensed to do business in the State of Texas. The Local Authority may withhold payments under the terms of this Agreement until the Provider furnishes the Local Authority copies of all Certificates of Insurance from the insurance carrier, or carriers, showing that such insurance is in full force and effect.
- e. Cancellation. New Certificates of Insurance shall be furnished to the Local Authority at the renewal date of all policies named on these Certificates. Provider shall give the Local Authority thirty (30) calendar days prior written notice of any proposed cancellation of any of the above described insurance policies.

- f. Providers that are self-insured through their own self-insurance program must comply with all regulations applicable to the Provider and shall furnish appropriate evidence to the Local Authority of the existence of such coverage for the services being provided to the Local Authority.
- g. If Provider is a Texas state agency or governmental entity, including an institution of higher education of the State of Texas, subject to Chapters 101 and 104 of the Texas Civil Practice and Remedies Code, it shall not be required to maintain the insurance coverage set forth in Part VII. herein. In lieu of such coverages, Provider agrees to maintain a self-insurance plan for Professional Liability Insurance, and a self-insured Worker's Compensation Insurance Plan pursuant to Texas Labor Code Chapter 502, 503 or 504 as applicable. Providers authorized pursuant to the Texas Education Code must comply with all regulations applicable to the Provider and shall furnish appropriate evidence to the Local Authority of the existence of such coverage for the services being provided to the Local Authority.

VIII. INDEMNIFICATION

Provider shall defend, indemnify, and hold harmless the Local Authority and/or its officers, employees, agents, and representatives from any and all claims, actions, suits, demands, proceedings, judgment, costs, damages, and liabilities, including attorneys' fees and court costs arising out of, connected with, or resulting from:

- Provider's performance of the Agreement, including any negligent acts or omissions of Provider, or any officer, agent, employee, subcontractor, or supplier of Provider, or any third party under the control or supervision of Provider, in the execution or performance of this Agreement; or
- Any breach or violation of a statute, ordinance, governmental regulation, standard, rule, or breach of contract by Provider, any officer, agent, employee, subcontractor, or supplier of Provider, or any third party under the control or supervision of Provider, in the execution or performance of this Agreement; or
- Employment or alleged employment, including claims of discrimination against Provider, its officers, agents, employees, subcontractors, or suppliers; or
- Work under this Agreement that infringes or misappropriates any right of any third person or entity based on copyright, patent, trade secret, or other intellectual property rights.

Provider shall provide written notice to Local Authority of any claim, whether actual or threatened, promptly upon receipt of notice thereof. Provider will coordinate its defense with the Local Authority and its counsel, if requested by Local Authority. This paragraph is not intended to and will not be construed to require Provider to indemnify or hold harmless the Local Authority for any claims or liabilities resulting solely from the gross negligence of the Local Authority or its employees. The provisions of this section will survive termination of this Agreement.

IX. TERM AND TERMINATION

1. **Term.** This Agreement is effective from **September 1st, 2025** and remain in effect until one of the following occurs.
 - a) In the event Local Authority and Provider are negotiating, preparing, and/or reviewing the services of Provider for renewal, this Agreement shall expire sixty (60) calendar days following the end of the current fiscal year in the event a mutual agreement is not made.
 - b) **Immediate Termination.** Local Authority may terminate this Agreement immediately if (a) Local Authority does not receive the funding to pay for designated services under this Agreement from the Texas Legislature, HHSC, or DADS (***Fund Availability**); (b) Local Authority has cause to believe that termination of the Agreement is in the best interests of the health and safety of the Consumers with mental disability served under this Agreement; (c) Provider has become ineligible to receive Local Authority funds; (d) Provider or its employees has its Texas license or certification suspended or revoked; (e) in the case of Providers providing direct services to Consumers, failure to disclose a criminal arrest, deferred adjudication, and/or conviction; (f) the Provider submits falsified documents and/or fraudulent billings, or if the Provider makes false statements; (g) Provider violates Section III of this Agreement; (h) Provider commits any violations of any HIPPA requirements; (i) Provider violates the Local Authority's Privacy Policy, Procedures, and/or Practices; or (j) Provider violates any provision contained in this Agreement.

***Fund Availability.** This Agreement is at all times contingent upon the availability and receipt of state or federal funds that Local Authority has allocated to this Agreement, and if funds for this Agreement become unavailable during any budget period, this Agreement may be immediately terminated or reduced at the sole discretion of the Local Authority.

- c) **Termination Without Cause.** Local Authority reserves the right to terminate this Agreement, without cause, upon thirty (30) calendar days written notice to the Provider.
2. **Effect Upon Notice of Termination.** Upon notice of termination, Provider will cooperate fully with Local Authority in the transfer of Covered Individuals to other providers. Provider recognizes that during any notice period preceding the effective date of termination, Local Authority, may at its sole discretion, deny authorization to Covered Individuals to receive Covered Services from Provider.
3. **Effect upon Termination.** Upon termination, the rights of Local Authority and Provider under this Agreement will terminate, except that termination will not release the parties of their respective obligations with respect to:
 - a. Payments accrued for authorized Covered Services by Provider prior to termination of this Agreement;
 - b. Provider's agreement not to seek compensation from Covered Individuals for Covered Services prior to termination of this Agreement;
 - c. The continuation of Provider's service(s) for Covered Individuals receiving Covered Services from Provider until continuation of the Covered Individuals' service can be transferred by Local Authority. Local Authority will reimburse Provider for such service pursuant to the terms of this Agreement; and
 - d. Requirements of this Agreement regarding confidentiality and record retention will survive this Agreement.
4. **Changes to Provider Service/Operation.** The opening and/or closure of a line of business, line of service, facility or location, and/or any operational changes that impact service delivery or the performance of this Agreement, including the termination of said Agreement, must be reported to Local Authority via written notice ninety (90) calendar days prior to the proposed change. Provider shall also notify NTBHA of any new partnerships and/or collaborations that affect NTBHA or the NTBHA Provider Network.
5. **Dispute Resolution.** All disputes or controversies arising under or related to this Agreement shall first be attempted to be resolved through good faith efforts between the parties.
6. **Reviews.** Contingent upon Funds Availability, and at the full discretion of NTBHA, this Agreement and any program attachments, as amended, may be reviewed by NTBHA QM (see Section III: Obligations of Provider, Item 6: Quality Management) on a routine basis, at least once every two year term.

X. NON-COMPLIANCE BY THE PROVIDER

1. **Penalties/Sanctions.** The failure of the Provider to perform any responsibility set forth in this Agreement, its exhibits or attachments, or any law, regulation, rule or requirement incorporated by reference may result in any one or more of the following penalties to be imposed or taken by the Local Authority, subject to notice as provided herein:
 - a. Provider training and technical assistance;
 - b. Submission of a Plan of Correction to the Local Authority;
 - c. Return funds to the Local Authority:
 - 1) For serving Non-Covered Individuals with Local Authority funds subject to this Agreement or
 - 2) For using Local Authority funds for unauthorized purposes.
 - d. Withholding by the Local Authority, in whole or in part, any payments due and owing to the Provider until the Provider has cured any breach of this Agreement to the satisfaction of the Local Authority;
 - e. Requiring service delivery at no additional cost to the Local Authority;
 - f. Suspending participation in the Provider Network;
 - g. Unilateral Contract Amendment;
 - h. Contract termination; and
 - i. Legal action to protect or remove Consumers when the life, health, welfare, or safety of one or more Consumers is endangered, or could be endangered or if the Local Authority has a reasonable belief that the Provider has engaged in the misuse of state or federal funds, fraud, or illegal acts.

If Local Authority is able to demonstrate a direct link between a sanction or penalty imposed upon Local Authority by HHSC or any other state agency due to Provider's performance, Provider will refund/reimburse/remit, upon request, to Local Authority those portions of the sanction/penalty assessed to Local Authority. Examples of such instances would be documentation chart audits, CARE accuracy, failure to report accurate and timely information/data, and etc.

2. **Imposition of Sanctions.** Local Authority may, at its own discretion, impose remedies and sanctions for noncompliance with requirements of this Agreement. Local Authority retains sole discretion to determine which situations constitute noncompliance and will determine appropriate remedies and sanctions on a case-by-case basis. High level deficiencies in compliance, as determined by Local Authority, may result in a suspension of contract until remedied.
3. **Appeals.** Any Provider receiving a "Notice of Penalties" may appeal the imposition by filing a "Notice of Appeal" with the Local Authority's Chief Executive Officer, in accordance with the timeline provided in the Notice of Penalties. Written Notice of Appeals must address the finding(s) in question and provide clear justification for repeal. In the event a written Notice of Appeals meets all stated requirements, a decision will be made no later than fifteen (15) calendar days of the date of receipt of the Notice of Appeal.

XI. MISCELLANEOUS

1. **Nondiscrimination.** Each party to this Agreement agrees that no person, on the basis of race, color, national origin, religion, sex, age, handicap, or political affiliation, will be excluded from participation, be denied the benefits of, or be subject to discrimination in the provision of any services hereunder. The parties hereto agree to comply with the Civil Rights Act of 1991 and Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794); Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.); Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107); Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688); Food and Nutrition Act of 2008 (7 U.S.C. §2011 et seq.); and all amendments to each and all requirements imposed by the regulations issued pursuant to these acts.
2. **Corporate Compliance.** Local Authority has an ongoing commitment that its affairs are conducted in accordance with applicable law and sound ethical business practice. Provider agrees to adopt and implement a Business Code of Conduct and Corporate Compliance Plan, if applicable, similar to those adopted by Local Authority and consistent with state and federal law. Provider shall develop and implement a process for its employees, volunteers and subcontractors to report possible compliance issues including a process for such reports to be fully and independently reviewed.
3. **Professional Conduct.** During the term of this Agreement, Provider shall not engage in a business, calling, treatment, conduct or enterprise which is or may be, in Local Authority's sole discretion, contrary to the interest, benefit, or reputation of Local Authority. Provider will conduct its/his/her relationships with Local Authority and its employees and consumers referred by Local Authority in a professional and positive manner and not make untruthful or otherwise disparaging statements regarding its/his/her relationship with Local Authority, its employees or persons served.
4. **Lobbying and Political Activity.** Provider shall not use funds received under this Agreement to pay any person for influence or attempting to influence an officer or employee or any agency, federal or state, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any contract or grant or the extension, continuation, renewal, amendment, or modification of any contract or grant.
5. **Amendment.** Unless otherwise specifically provided herein, this Agreement may be amended or changed only by mutual written consent of an authorized representative of the Local Authority and Provider.
6. **Entire Agreement.** This Agreement constitutes the sole and only agreement of the parties hereto and supersedes any prior understandings, written or oral agreement between the parties respecting the subject matter herein.
7. **Additional Requirements/Renegotiation.** If Provider is required to comply with an additional requirement pursuant to compliance with standards, regulations, resolutions, settlements, or plans, and compliance results in a material change in Provider's rights or obligations under this Agreement or places a significant financial burden on the Provider, the Provider may, upon giving sixty (60) calendar days written notice to Local Authority of such intention, be entitled to discuss amendments to the Agreement.

8. **Governing Law and Venue.** This Agreement shall be construed and enforced in accordance with the laws of the State of Texas, and venue shall lie in a state or federal district court of Dallas County, Texas.
9. **Notices.** Any required notice shall be in writing and shall be sent, postage prepaid, by certified mail, return receipt requested, to Local Authority or Provider at the address below. The notice shall be effective on the date of delivery indicated on the return receipt. Carbon copies may be provided to the email address(es) below:

If to the Local Authority:

Carol E. Lucky
Chief Executive Officer
8111 LBJ Frwy., Suite 900
Dallas, TX 75251
clucky@ntbha.org
contracts@ntbha.org

If to Provider:

Attn:
Chief Executive Officer
Admin. Address
City, State, Zip Code
Email address

10. **Severability.** The invalidity or unenforceability of any term or provision hereof shall not affect the validity or enforceability of any other term(s) or provision(s).
11. **Exhibits and Provider Manual.** All Exhibits and the Provider Manual referred to in this Agreement and attached hereto are incorporated into this Agreement by reference.
12. **Authority to Bind Local Authority.** This Agreement is not binding upon the Local Authority unless and until it has been executed by the Chief Executive Officer or Executive Director.
13. **Provider's Authority.** The person or persons executing and signing this Agreement on behalf of the Provider represent that they have been fully authorized by the Provider to execute the Agreement and to legally bind the Provider to all the terms and provisions of the Agreement.
14. **No Third-Party Beneficiary.** Unless otherwise specifically stated in this Agreement, nothing in this Agreement is intended to, or shall be deemed or construed to, create any rights or remedies in any third party, including a Consumer. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to create any rights of any Consumer or duties or any responsibilities of Provider or Local Authority with respect to such Consumer.
15. **Electronic or Facsimile Signatures and Duplicate Originals.** Pursuant to the requirements of the Uniform Electronic Transactions Act in Chapter 322 of the Texas Business and Commerce Code and the Federal Electronic Signatures in Global and National Commerce Act (beginning at 15 U.S.C. Section 7001), the parties have agreed that the transactions under this Agreement may be conducted by electronic means. Pursuant to these statutes, this Agreement may not be denied legal effect or enforceability solely because it is in electronic form or because it contains an electronic signature. This Agreement may be executed in duplicate counterparts and with electronic or facsimile signatures with the same effect as if the signatures were on the same document. Each multiple original of this document shall be deemed an original, but all multiple copies together shall constitute one and the same instrument.
16. **Attachments.** The following exhibits, schedules, and annexes attached to this Agreement are incorporated herein and shall be considered a part of this Agreement in full.

- NTBHA Provider Key Personnel Contact List & Clinic Locations
- Attachment A: _____ Statement of Work
- Attachment A.01: _____ Data Use Agreement-Subcontractor Attachment (A.01)
- Attachment B: _____ Business Associate Agreement (NTBHA-BAA)
- Attachment C: _____ CCBHC Provider Assurances for DCO/Formal Partner/Joint Employer
- Exhibit No. 1: _____ TxHHS Uniform Terms and Conditions (UTC)
- Exhibit No. 2: _____ HHSC Additional/Supplemental Conditions, as applicable

IN WITNESS WHEREOF, the Parties hereto have duly executed this Agreement by their respective authorized representatives as evidenced by their signatures, with an execution date indicated by the last signatory below.

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

[PROVIDER]

Signature

Carol E. Lucky, MAHS, CEO.

Printed Name and Title

Date Signed

Signature

Printed Name and Title

Date Signed

ATTACHMENT H
DATA USE AGREEMENT
BETWEEN THE
TEXAS HEALTH AND HUMAN SERVICES SYSTEM
AND
CONTRACTOR

This Data Use Agreement (“DUA”), effective as of the date of the Base Contract into which it is incorporated (“Effective Date”), by and between the Texas Health and Human Services System, which includes the Texas Health and Human Services Commission and the Department of State Health Services (“HHS”) and Contractor (the “Base Contract”).

ARTICLE 1. PURPOSE; APPLICABILITY; ORDER OF PRECEDENCE

The purpose of this DUA is to facilitate creation, receipt, maintenance, use, disclosure or access to Confidential Information with CONTRACTOR, and describe CONTRACTOR’s rights and obligations with respect to the Confidential Information and the limited purposes for which the CONTRACTOR may create, receive, maintain, use, disclose or have access to Confidential Information. 45 CFR 164.504(e)(1)-(3) This DUA also describes HHS’s remedies in the event of CONTRACTOR’s noncompliance with its obligations under this DUA. This DUA applies to both Business Associates and contractors who are not Business Associates who create, receive, maintain, use, disclose or have access to Confidential Information on behalf of HHS, its programs or clients as described in the Base Contract.

As of the Effective Date of this DUA, if any provision of the Base Contract, including any General Provisions or Uniform Terms and Conditions, conflicts with this DUA, this DUA controls.

ARTICLE 2. DEFINITIONS

For the purposes of this DUA, **capitalized, underlined terms have the meanings set forth in the following:** Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (42 U.S.C. §1320d, *et seq.*) and regulations thereunder in 45 CFR Parts 160 and 164, including all amendments, regulations and guidance issued thereafter; The Social Security Act, including Section 1137 (42 U.S.C. §§ 1320b-7), Title XVI of the Act; The Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a and regulations and guidance thereunder; Internal Revenue Code, Title 26 of the United States Code and regulations and publications adopted under that code, including IRS Publication 1075; OMB Memorandum 07-18; Texas Business and Commerce Code Ch. 521; Texas Government Code, Ch. 552, and Texas Government Code §2054.1125. In addition, the following terms in this DUA are defined as follows:

“**Authorized Purpose**” means the specific purpose or purposes described in the Scope of Work of the Base Contract for CONTRACTOR to fulfill its obligations under the Base Contract, or any other purpose expressly authorized by HHS in writing in advance.

“**Authorized User**” means a Person:

- (1) Who is authorized to create, receive, maintain, have access to, process, view, handle, examine, interpret, or analyze Confidential Information pursuant to this DUA;
- (2) For whom CONTRACTOR warrants and represents has a demonstrable need to create, receive, maintain, use, disclose or have access to the Confidential Information; and
- (3) Who has agreed in writing to be bound by the disclosure and use limitations pertaining to the Confidential Information as required by this DUA.

“**Confidential Information**” means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to CONTRACTOR or

that CONTRACTOR may create, receive, maintain, use, disclose or have access to on behalf of HHS that consists of or includes any or all of the following:

- (1) Client Information;
- (2) Protected Health Information in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information;
- (3) Sensitive Personal Information defined by Texas Business and Commerce Code Ch. 521;
- (4) Federal Tax Information;
- (5) Personally Identifiable Information;
- (6) Social Security Administration Data, including, without limitation, Medicaid information;
- (7) All privileged work product;
- (8) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

“Legally Authorized Representative” of the Individual, as defined by Texas law, including as provided in 45 CFR 435.923 (Medicaid); 45 CFR 164.502(g)(1) (HIPAA); Tex. Occ. Code § 151.002(6); Tex. H. & S. Code § 166.164; Estates Code Ch. 752 and Texas Prob. Code § 3.

ARTICLE 3. CONTRACTOR'S DUTIES REGARDING CONFIDENTIAL INFORMATION

Section 3.01 *Obligations of CONTRACTOR*

CONTRACTOR agrees that:

(A) CONTRACTOR will exercise reasonable care and no less than the same degree of care CONTRACTOR uses to protect its own confidential, proprietary and trade secret information to prevent any portion of the Confidential Information from being used in a manner that is not expressly an Authorized Purpose under this DUA or as Required by Law. ***45 CFR 164.502(b)(1); 45 CFR 164.514(d)***

(B) CONTRACTOR will not disclose or allow access to any portion of the Confidential Information to any Person or other entity, other than Authorized User's Workforce or Subcontractors of CONTRACTOR who have completed training in confidentiality, privacy, security and the importance of promptly reporting any Event or Breach to CONTRACTOR's management, to carry out the Authorized Purpose or as Required by Law.

HHS, at its election, may assist CONTRACTOR in training and education on specific or unique HHS processes, systems and/or requirements. CONTRACTOR will produce evidence of completed training to HHS upon request. ***45 C.F.R. 164.308(a)(5)(i); Texas Health & Safety Code §181.101***

All of CONTRACTOR's Authorized Users, Workforce and Subcontractors with access to a state computer system or database will complete a cybersecurity training program certified under Texas Government Code Section 2054.519 by the Texas Department of Information Resources.

(C) CONTRACTOR will establish, implement and maintain appropriate sanctions against any member of its Workforce or Subcontractor who fails to comply with this DUA, the Base Contract or applicable law. CONTRACTOR will maintain evidence of sanctions and produce it to HHS upon request. ***45 C.F.R. 164.308(a)(1)(ii)(C); 164.530(e); 164.410(b); 164.530(b)(1)***

(D) CONTRACTOR will not disclose or provide access to any Confidential Information on the basis that such act is Required by Law without notifying either HHS or CONTRACTOR's own legal counsel to determine whether CONTRACTOR should object to the disclosure or access and seek appropriate relief. CONTRACTOR will maintain an accounting of all such requests for disclosure and responses and provide such accounting to HHS within 48 hours of HHS' request. **45 CFR 164.504(e)(2)(ii)(A)**

(E) CONTRACTOR will not attempt to re-identify or further identify Confidential Information or De-identified Information, or attempt to contact any Individuals whose records are contained in the Confidential Information, except for an Authorized Purpose, without express written authorization from HHS or as expressly permitted by the Base Contract. **45 CFR 164.502(d)(2)(i) and (ii)** CONTRACTOR will not engage in prohibited marketing or sale of Confidential Information. **45 CFR 164.501, 164.508(a)(3) and (4); Texas Health & Safety Code Ch. 181.002**

(F) CONTRACTOR will not permit, or enter into any agreement with a Subcontractor to, create, receive, maintain, use, disclose, have access to or transmit Confidential Information, on behalf of CONTRACTOR without requiring that Subcontractor first execute the Form Subcontractor Agreement, Attachment 1, which ensures that the Subcontractor will comply with the identical terms, conditions, safeguards and restrictions as contained in this DUA for PHI and any other relevant Confidential Information and which permits more strict limitations; and **45 CFR 164.502(e)(1)(1)(ii); 164.504(e)(1)(i) and (2)**

(G) CONTRACTOR is directly responsible for compliance with, and enforcement of, all conditions for creation, maintenance, use, disclosure, transmission and Destruction of Confidential Information and the acts or omissions of Subcontractors as may be reasonably necessary to prevent unauthorized use. **45 CFR 164.504(e)(5); 42 CFR 431.300, et seq.**

(H) If CONTRACTOR maintains PHI in a Designated Record Set, CONTRACTOR will make PHI available to HHS in a Designated Record Set upon request. CONTRACTOR will provide PHI to an Individual, or Legally Authorized Representative of the Individual who is requesting PHI in compliance with the requirements of the HIPAA Privacy Regulations. CONTRACTOR will release PHI in accordance with the HIPAA Privacy Regulations upon receipt of a valid written authorization. CONTRACTOR will make other Confidential Information in CONTRACTOR's possession available pursuant to the requirements of HIPAA or other applicable law upon a determination of a Breach of Unsecured PHI as defined in HIPAA. CONTRACTOR will maintain an accounting of all such disclosures and provide it to HHS within 48 hours of HHS' request. **45 CFR 164.524 and 164.504(e)(2)(ii)(E)**

(I) CONTRACTOR will make PHI as required by HIPAA available to HHS for amendment and incorporate any amendments to this information that HHS directs or agrees to pursuant to the HIPAA. **45 CFR 164.504(e)(2)(ii)(E) and (F)**

(J) CONTRACTOR will document and make available to HHS the PHI required to provide access, an accounting of disclosures or amendment in compliance with the requirements of the HIPAA Privacy Regulations. **45 CFR 164.504(e)(2)(ii)(G) and 164.528**

(K) If CONTRACTOR receives a request for access, amendment or accounting of PHI from an individual with a right of access to information subject to this DUA, it will respond to such request in compliance with the HIPAA Privacy Regulations. CONTRACTOR will maintain an accounting of all responses to requests for access to or amendment of PHI and provide it to HHS within 48 hours of HHS' request. **45 CFR 164.504(e)(2)**

(L) CONTRACTOR will provide, and will cause its Subcontractors and agents to provide, to HHS periodic written certifications of compliance with controls and provisions relating to information

privacy, security and breach notification, including without limitation information related to data transfers and the handling and disposal of Confidential Information. **45 CFR 164.308; 164.530(c); 1 TAC 202**

(M) Except as otherwise limited by this DUA, the Base Contract, or law applicable to the Confidential Information, CONTRACTOR may use or disclose PHI for the proper management and administration of CONTRACTOR or to carry out CONTRACTOR's legal responsibilities if: **45 CFR 164.504(e)(ii)(1)(A)**

(1) Disclosure is Required by Law, provided that CONTRACTOR complies with Section 3.01(D);

(2) CONTRACTOR obtains reasonable assurances from the Person to whom the information is disclosed that the Person will:

(a) Maintain the confidentiality of the Confidential Information in accordance with this DUA;

(b) Use or further disclose the information only as Required by Law or for the Authorized Purpose for which it was disclosed to the Person; and

(c) Notify CONTRACTOR in accordance with Section 4.01 of any Event or Breach of Confidential Information of which the Person discovers or should have discovered with the exercise of reasonable diligence. **45 CFR 164.504(e)(4)(ii)(B)**

(N) Except as otherwise limited by this DUA, CONTRACTOR will, if requested by HHS, use PHI to provide data aggregation services to HHS, as that term is defined in the HIPAA, 45 C.F.R. §164.501 and permitted by HIPAA. **45 CFR 164.504(e)(2)(i)(B)**

(O) CONTRACTOR will, on the termination or expiration of this DUA or the Base Contract, at its expense, send to HHS or Destroy, at HHS's election, and to the extent reasonably feasible and permissible by law, all Confidential Information received from HHS or created or maintained by CONTRACTOR or any of CONTRACTOR's agents or Subcontractors on HHS's behalf if that data contains Confidential Information. CONTRACTOR will certify in writing to HHS that all the Confidential Information that has been created, received, maintained, used by or disclosed to CONTRACTOR, has been Destroyed or sent to HHS, and that CONTRACTOR and its agents and Subcontractors have retained no copies thereof. Notwithstanding the foregoing, CONTRACTOR acknowledges and agrees that it may not Destroy any Confidential Information if federal or state law, or HHS record retention policy or a litigation hold notice prohibits such Destruction. If such delivery or Destruction is not reasonably feasible, or is impermissible by law, CONTRACTOR will immediately notify HHS of the reasons such delivery or Destruction is not feasible, and agree to extend indefinitely the protections of this DUA to the Confidential Information and limit its further uses and disclosures to the purposes that make the return delivery or Destruction of the Confidential Information not feasible for as long as CONTRACTOR maintains such Confidential Information. **45 CFR 164.504(e)(2)(ii)(J)**

(P) CONTRACTOR will create, maintain, use, disclose, transmit or Destroy Confidential Information in a secure fashion that protects against any reasonably anticipated threats or hazards to the security or integrity of such information or unauthorized uses. **45 CFR 164.306; 164.530(c)**

(Q) If CONTRACTOR accesses, transmits, stores, and/or maintains Confidential Information, CONTRACTOR will complete and return to HHS at infosecurity@hhsc.state.tx.us the HHS information security and privacy initial inquiry (SPI) at Attachment 2. The SPI identifies basic privacy and security controls with which CONTRACTOR must comply to protect HHS Confidential Information. CONTRACTOR will comply with periodic security controls compliance assessment and monitoring by HHS as required by state and federal law, based on the type of Confidential Information CONTRACTOR creates, receives, maintains, uses, discloses or has access to and the Authorized Purpose and level of risk.

CONTRACTOR's security controls will be based on the National Institute of Standards and Technology (NIST) Special Publication 800-53. CONTRACTOR will update its security controls assessment whenever there are significant changes in security controls for HHS Confidential Information and will provide the updated document to HHS. HHS also reserves the right to request updates as needed to satisfy state and federal monitoring requirements. **45 CFR 164.306**

(R) CONTRACTOR will establish, implement and maintain any and all appropriate procedural, administrative, physical and technical safeguards to preserve and maintain the confidentiality, integrity, and availability of the Confidential Information, and with respect to PHI, as described in the HIPAA Privacy and Security Regulations, or other applicable laws or regulations relating to Confidential Information, to prevent any unauthorized use or disclosure of Confidential Information as long as CONTRACTOR has such Confidential Information in its actual or constructive possession. **45 CFR 164.308 (administrative safeguards); 164.310 (physical safeguards); 164.312 (technical safeguards); 164.530(c)(privacy safeguards)**

(S) CONTRACTOR will designate and identify, subject to HHS approval, a Person or Persons, as Privacy Official **45 CFR 164.530(a)(1)** and Information Security Official, each of whom is authorized to act on behalf of CONTRACTOR and is responsible for the development and implementation of the privacy and security requirements in this DUA. CONTRACTOR will provide name and current address, phone number and e-mail address for such designated officials to HHS upon execution of this DUA and prior to any change. **45 CFR 164.308(a)(2)**

(T) CONTRACTOR represents and warrants that its Authorized Users each have a demonstrated need to know and have access to Confidential Information solely to the minimum extent necessary to accomplish the Authorized Purpose pursuant to this DUA and the Base Contract, and further, that each has agreed in writing to be bound by the disclosure and use limitations pertaining to the Confidential Information contained in this DUA. **45 CFR 164.502; 164.514(d)**

(U) CONTRACTOR and its Subcontractors will maintain an updated, complete, accurate and numbered list of Authorized Users, their signatures, titles and the date they agreed to be bound by the terms of this DUA, at all times and supply it to HHS, as directed, upon request.

(V) CONTRACTOR will implement, update as necessary, and document reasonable and appropriate policies and procedures for privacy, security and Breach of Confidential Information and an incident response plan for an Event or Breach, to comply with the privacy, security and breach notice requirements of this DUA prior to conducting work under the DUA. **45 CFR 164.308; 164.316; 164.514(d); 164.530(i)(1)**

(W) CONTRACTOR will produce copies of its information security and privacy policies and procedures and records relating to the use or disclosure of Confidential Information received from, created by, or received, used or disclosed by CONTRACTOR on behalf of HHS for HHS's review and approval within 30 days of execution of this DUA and upon request by HHS the following business day or other agreed upon time frame. **45 CFR 164.308; 164.514(d)**

(X) CONTRACTOR will make available to HHS any information HHS requires to fulfill HHS's obligations to provide access to, or copies of, PHI in accordance with HIPAA and other applicable laws and regulations relating to Confidential Information. CONTRACTOR will provide such information in a time and manner reasonably agreed upon or as designated by the Secretary, or other federal or state law. **45 CFR 164.504(e)(2)(i)(I)**

(Y) CONTRACTOR will only conduct secure transmissions of Confidential Information whether in paper, oral or electronic form. A secure transmission of electronic Confidential Information in

motion includes secure File Transfer Protocol (SFTP) or Encryption at an appropriate level or otherwise protected as required by rule, regulation or law. HHS Confidential Information at rest requires Encryption unless there is adequate administrative, technical, and physical security, or as otherwise protected as required by rule, regulation or law. All electronic data transfer and communications of Confidential Information will be through secure systems. Proof of system, media or device security and/or Encryption must be produced to HHS no later than 48 hours after HHS's written request in response to a compliance investigation, audit or the Discovery of an Event or Breach. Otherwise, requested production of such proof will be made as agreed upon by the parties. De-identification of HHS Confidential Information is a means of security. With respect to de-identification of PHI, "secure" means de-identified according to HIPAA Privacy standards and regulatory guidance. **45 CFR 164.312; 164.530(d)**

(Z) CONTRACTOR will comply with the following laws and standards *if applicable to the type of Confidential Information and Contractor's Authorized Purpose*:

- Title 1, Part 10, Chapter 202, Subchapter B, Texas Administrative Code;
- The Privacy Act of 1974;
- OMB Memorandum 07-16;
- The Federal Information Security Management Act of 2002 (FISMA);
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) as defined in the DUA;
- Internal Revenue Publication 1075 – Tax Information Security Guidelines for Federal, State and Local Agencies;
- National Institute of Standards and Technology (NIST) Special Publication 800-66 Revision 1 – An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule;
- NIST Special Publications 800-53 and 800-53A – Recommended Security Controls for Federal Information Systems and Organizations, as currently revised;
- NIST Special Publication 800-47 – Security Guide for Interconnecting Information Technology Systems;
- NIST Special Publication 800-88, Guidelines for Media Sanitization;
- NIST Special Publication 800-111, Guide to Storage of Encryption Technologies for End User Devices containing PHI;
- Texas Business and Commerce Code Chapter 521; and
- Any other State or Federal law, regulation, or administrative rule relating to the specific HHS program area that CONTRACTOR supports on behalf of HHS.

ARTICLE 4. BREACH NOTICE, REPORTING AND CORRECTION REQUIREMENTS

Section 4.01. Breach or Event Notification to HHS. 45 CFR 164.400-414

(A) CONTRACTOR will cooperate fully with HHS in investigating, mitigating to the extent practicable and issuing notifications directed by HHS, for any Event or Breach of Confidential Information to the extent and in the manner determined by HHS.

(B) CONTRACTOR'S obligation begins at the Discovery of an Event or Breach and continues as long as related activity continues, until all effects of the Event are mitigated to HHS's satisfaction (the "incident response period"). **45 CFR 164.404**

(C) Breach Notice:

1. Initial Notice.

a. For federal information, including without limitation, Federal Tax Information, Social Security Administration Data, and Medicaid Client Information, within the first, consecutive clock hour of Discovery, and for all other types of Confidential Information not more than 24 hours after Discovery, ***or in a timeframe otherwise approved by HHS in writing***, initially report to HHS's Privacy and Security Officers via email at: privacy@HHSC.state.tx.us and to the HHS division responsible for this DUA; and ***IRS Publication 1075; Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a; OMB Memorandum 07-16 as cited in HHSC-CMS Contracts for information exchange.***

b. Report all information reasonably available to CONTRACTOR about the Event or Breach of the privacy or security of Confidential Information. **45 CFR 164.410**

c. Name, and provide contact information to HHS for, CONTRACTOR's single point of contact who will communicate with HHS both on and off business hours during the incident response period.

2. 48-Hour Formal Notice. No later than 48 consecutive clock hours after Discovery, or a time within which Discovery reasonably should have been made by CONTRACTOR of an Event or Breach of Confidential Information, **provide** formal notification to the State, including all reasonably available information about the Event or Breach, and CONTRACTOR's investigation, including without limitation and to the extent available: ***For (a) - (m) below: 45 CFR 164.400-414***

a. The date the Event or Breach occurred;

b. The date of CONTRACTOR's and, if applicable, Subcontractor's Discovery;

c. A brief description of the Event or Breach; including how it occurred and who is responsible (or hypotheses, if not yet determined);

d. A brief description of CONTRACTOR's investigation and the status of the investigation;

e. A description of the types and amount of Confidential Information involved;

f. Identification of and number of all Individuals reasonably believed to be affected, including first and last name of the individual and if applicable the, Legally authorized representative, last known address, age, telephone number, and email address if it is a preferred contact method, to the extent known or can be reasonably determined by CONTRACTOR at that time;

g. CONTRACTOR's initial risk assessment of the Event or Breach demonstrating whether individual or other notices are required by applicable law or this DUA for HHS approval, including an analysis of whether there is a low probability of compromise of the Confidential Information or whether any legal exceptions to notification apply;

h. CONTRACTOR's recommendation for HHS's approval as to the steps Individuals and/or CONTRACTOR on behalf of Individuals, should take to protect the Individuals from potential harm, including without limitation CONTRACTOR's provision of notifications, credit protection,

claims monitoring, and any specific protections for a Legally Authorized Representative to take on behalf of an Individual with special capacity or circumstances;

i. The steps CONTRACTOR has taken to mitigate the harm or potential harm caused (including without limitation the provision of sufficient resources to mitigate);

j. The steps CONTRACTOR has taken, or will take, to prevent or reduce the likelihood of recurrence of a similar Event or Breach;

k. Identify, describe or estimate of the Persons, Workforce, Subcontractor, or Individuals and any law enforcement that may be involved in the Event or Breach;

l. A reasonable schedule for CONTRACTOR to provide regular updates to the foregoing in the future for response to the Event or Breach, but no less than every three (3) business days or as otherwise directed by HHS, including information about risk estimations, reporting, notification, if any, mitigation, corrective action, root cause analysis and when such activities are expected to be completed; and

m. Any reasonably available, pertinent information, documents or reports related to an Event or Breach that HHS requests following Discovery.

Section 4.02 ***Investigation, Response and Mitigation. For A-F below: 45 CFR 164.308, 310 and 312; 164.530***

(A) CONTRACTOR will immediately conduct a full and complete investigation, respond to the Event or Breach, commit necessary and appropriate staff and resources to expeditiously respond, and report as required to and by HHS for incident response purposes and for purposes of HHS's compliance with report and notification requirements, to the satisfaction of HHS.

(B) CONTRACTOR will complete or participate in a risk assessment as directed by HHS following an Event or Breach, and provide the final assessment, corrective actions and mitigations to HHS for review and approval.

(C) CONTRACTOR will fully cooperate with HHS to respond to inquiries and/or proceedings by state and federal authorities, Persons and/or Individuals about the Event or Breach.

(D) CONTRACTOR will fully cooperate with HHS's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such Event or Breach, or to recover or protect any Confidential Information, including complying with reasonable corrective action or measures, as specified by HHS in a Corrective Action Plan if directed by HHS under the Base Contract.

Section 4.03 ***Breach Notification to Individuals and Reporting to Authorities. Tex. Bus. & Comm. Code §521.053; 45 CFR 164.404 (Individuals), 164.406 (Media); 164.408 (Authorities)***

(A) HHS may direct CONTRACTOR to provide Breach notification to Individuals, regulators or third-parties, as specified by HHS following a Breach.

(B) CONTRACTOR must obtain HHS's prior written approval of the time, manner and content of any notification to Individuals, regulators or third-parties, or any notice required by other state or federal authorities, including without limitation, notifications required by Texas Business and Commerce Code, Chapter 521.053(b) and HIPAA. Notice letters will be in CONTRACTOR's name and on CONTRACTOR's letterhead, unless otherwise directed by HHS, and will contain contact information, including the name and title of CONTRACTOR's representative, an email address and a toll-free telephone number, for the Individual to obtain additional information.

(C) CONTRACTOR will provide HHS with copies of distributed and approved communications.

(D) CONTRACTOR will have the burden of demonstrating to the satisfaction of HHS that any notification required by HHS was timely made. If there are delays outside of CONTRACTOR's control, CONTRACTOR will provide written documentation of the reasons for the delay.

(E) If HHS delegates notice requirements to CONTRACTOR, HHS shall, in the time and manner reasonably requested by CONTRACTOR, cooperate and assist with CONTRACTOR's information requests in order to make such notifications and reports.

ARTICLE 5. SCOPE OF WORK

Scope of Work means the services and deliverables to be performed or provided by CONTRACTOR, or on behalf of CONTRACTOR by its Subcontractors or agents for HHS that are described in detail in the Base Contract. The Scope of Work, including any future amendments thereto, is incorporated by reference in this DUA as if set out word-for-word herein.

ARTICLE 6. GENERAL PROVISIONS

Section 6.01 *Oversight of Confidential Information*

CONTRACTOR acknowledges and agrees that HHS is entitled to oversee and monitor CONTRACTOR's access to and creation, receipt, maintenance, use, disclosure of the Confidential Information to confirm that CONTRACTOR is in compliance with this DUA.

Section 6.02 *HHS Commitment and Obligations*

HHS will not request CONTRACTOR to create, maintain, transmit, use or disclose PHI in any manner that would not be permissible under applicable law if done by HHS.

Section 6.03 *HHS Right to Inspection*

At any time upon reasonable notice to CONTRACTOR, or if HHS determines that CONTRACTOR has violated this DUA, HHS, directly or through its agent, will have the right to inspect the facilities, systems, books and records of CONTRACTOR to monitor compliance with this DUA. For purposes of this subsection, HHS's agent(s) include, without limitation, the HHS Office of the Inspector General or the Office of the Attorney General of Texas, outside consultants or legal counsel or other designee.

Section 6.04 *Term; Termination of DUA; Survival*

This DUA will be effective on the date on which CONTRACTOR executes the DUA, and will terminate upon termination of the Base Contract and as set forth herein. If the Base Contract is extended or amended, this DUA is updated automatically concurrent with such extension or amendment.

(A) HHS may immediately terminate this DUA and Base Contract upon a material violation of this DUA.

(B) Termination or Expiration of this DUA will not relieve CONTRACTOR of its obligation to return or Destroy the Confidential Information as set forth in this DUA and to continue to safeguard the Confidential Information until such time as determined by HHS.

(D) If HHS determines that CONTRACTOR has violated a material term of this DUA; HHS may in its sole discretion:

1. Exercise any of its rights including but not limited to reports, access and inspection under this DUA and/or the Base Contract; or
2. Require CONTRACTOR to submit to a corrective action plan, including a plan for monitoring and plan for reporting, as HHS may determine necessary to maintain compliance with this DUA; or
3. Provide CONTRACTOR with a reasonable period to cure the violation as determined by HHS; or
4. Terminate the DUA and Base Contract immediately, and seek relief in a court of competent jurisdiction in Travis County, Texas.

Before exercising any of these options, HHS will provide written notice to CONTRACTOR describing the violation and the action it intends to take.

(E) If neither termination nor cure is feasible, HHS shall report the violation to the Secretary.

(F) The duties of CONTRACTOR or its Subcontractor under this DUA survive the expiration or termination of this DUA until all the Confidential Information is Destroyed or returned to HHS, as required by this DUA.

Section 6.05 *Governing Law, Venue and Litigation*

(A) The validity, construction and performance of this DUA and the legal relations among the Parties to this DUA will be governed by and construed in accordance with the laws of the State of Texas.

(B) The Parties agree that the courts of Travis County, Texas, will be the exclusive venue for any litigation, special proceeding or other proceeding as between the parties that may be brought, or arise out of, or in connection with, or by reason of this DUA.

Section 6.06 *Injunctive Relief*

(A) CONTRACTOR acknowledges and agrees that HHS may suffer irreparable injury if CONTRACTOR or its Subcontractor fails to comply with any of the terms of this DUA with respect to the Confidential Information or a provision of HIPAA or other laws or regulations applicable to Confidential Information.

(B) CONTRACTOR further agrees that monetary damages may be inadequate to compensate HHS for CONTRACTOR's or its Subcontractor's failure to comply. Accordingly, CONTRACTOR agrees that HHS will, in addition to any other remedies available to it at law or in equity, be entitled to seek injunctive relief without posting a bond and without the necessity of demonstrating actual damages, to enforce the terms of this DUA.

Section 6.07 *Limitation of Liability*

To the extent permitted by the Texas Constitution, laws and rules, and without waiving any immunities or defenses available to CONTRACTOR as a governmental entity, CONTRACTOR will defend and hold harmless HHS and its Workforce against all actual and direct losses suffered by HHS and its Workforce arising from or in connection with any breach of this DUA or from any acts or omissions related to this DUA by CONTRACTOR or its employees, directors, officers, Subcontractors, or agents or other members

of its Workforce, including, but not limited to, the costs of required notices and mitigation of a breach and any fines or penalties imposed on HHS by any regulatory authority.

Section 6.08 *Insurance*

(A) As a governmental entity, CONTRACTOR either maintains commercial insurance or self-insures with policy limits in an amount sufficient to cover CONTRACTOR's liability arising under this DUA and under which policy HHS is added as an additional insured. HHSC reserves the right to consider alternative means for CONTRACTOR to satisfy CONTRACTOR's financial responsibility under this DUA. Nothing herein shall relieve CONTRACTOR of its financial obligations set forth in this DUA if CONTRACTOR fails to maintain insurance.

(B) CONTRACTOR will provide HHS with written proof that required insurance coverage is in effect, at the request of HHS.

Section 6.09 *Fees and Costs*

Except as otherwise specified in this DUA or the Base Contract, including but not limited to requirements to insure and/or indemnify HHS, if any legal action or other proceeding is brought for the enforcement of this DUA, or because of an alleged dispute, contract violation, Event, Breach, default, misrepresentation, or injunctive action, in connection with any of the provisions of this DUA, each party will bear their own legal expenses and the other cost incurred in that action or proceeding.

Section 6.10 *Entirety of the Contract*

This Data Use Agreement is incorporated by reference into the Base Contract and, together with the Base Contract, constitutes the entire agreement between the parties. No change, waiver, or discharge of obligations arising under those documents will be valid unless in writing and executed by the party against whom such change, waiver, or discharge is sought to be enforced.

Section 6.11 *Automatic Amendment and Interpretation*

Upon the effective date of any amendment or issuance of additional regulations to HIPAA, or any other law applicable to Confidential Information, this DUA will automatically be amended so that the obligations imposed on HHS and/or CONTRACTOR remain in compliance with such requirements. Any ambiguity in this DUA will be resolved in favor of a meaning that permits HHS and CONTRACTOR to comply with HIPAA or any other law applicable to Confidential Information.

ATTACHMENT 1. SUBCONTRACTOR AGREEMENT FORM**HHS CONTRACT NUMBER** _____

The DUA between HHS and CONTRACTOR establishes the permitted and required uses and disclosures of Confidential Information by CONTRACTOR.

CONTRACTOR has subcontracted with _____ (SUBCONTRACTOR) for performance of duties on behalf of CONTRACTOR which are subject to the DUA. SUBCONTRACTOR acknowledges, understands and agrees to be bound by the identical terms and conditions applicable to CONTRACTOR under the DUA, incorporated by reference in this Agreement, with respect to HHS Confidential Information. CONTRACTOR and SUBCONTRACTOR agree that HHS is a third-party beneficiary to applicable provisions of the subcontract.

HHS has the right but not the obligation to review or approve the terms and conditions of the subcontract by virtue of this Subcontractor Agreement Form.

CONTRACTOR and SUBCONTRACTOR assure HHS that any Breach or Event as defined by the DUA that SUBCONTRACTOR Discovers will be reported to HHS by CONTRACTOR in the time, manner and content required by the DUA.

If CONTRACTOR knows or should have known in the exercise of reasonable diligence of a pattern of activity or practice by SUBCONTRACTOR that constitutes a material breach or violation of the DUA or the SUBCONTRACTOR's obligations CONTRACTOR will:

1. Take reasonable steps to cure the violation or end the violation, as applicable;
2. If the steps are unsuccessful, terminate the contract or arrangement with SUBCONTRACTOR, if feasible;
3. Notify HHS immediately upon discovery of the pattern of activity or practice of SUBCONTRACTOR that constitutes a material breach or violation of the DUA and keep HHS reasonably and regularly informed about steps CONTRACTOR is taking to cure or end the violation or terminate SUBCONTRACTOR's contract or arrangement.

This Subcontractor Agreement Form is executed by the parties in their capacities indicated below.

CONTRACTOR**SUBCONTRACTOR****BY:** _____**BY:** _____**NAME:** _____**NAME:** _____**TITLE:** _____**TITLE:** _____**DATE** _____, **202** .**DATE:** _____

RESOLUTION

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

RESOLUTION NO: 480-2025 Approve Harris County Crisis Hotline Interlocal Agreement (Renewal) for FY 2026 and FY 2027

DATE: October 8, 2025

STATE OF TEXAS }

COUNTY OF DALLAS }

BE IT REMEMBERED at a regular meeting of the North Texas Behavioral Health Authority held on the 8th day of October 2025, the following Resolution was adopted:

WHEREAS, the Health and Human Service Commission has designated the North Texas Behavioral Health Authority (NTBHA) as the Local Behavioral Health Authority (LBHA) for a service area consisting of the following six counties: Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall, effective January 1, 2017; and

WHEREAS, the NTBHA Board of Directors was created to govern the affairs of NTBHA; and

WHEREAS, NTBHA seeks to create a well-managed, integrated, and high-quality delivery system of behavioral health services available to eligible consumers residing in our catchment area; and

WHEREAS, NTBHA is responsible for the management of the network of behavioral health providers; and

WHEREAS, NTBHA seeks to (1) Maintain a competent and committed workforce, (2) Facilitate access to behavioral health services, (3) Manage core operations efficiently and effectively, and (4) Identify and develop additional opportunities for service area development.

IT IS THEREFORE RESOLVED that the North Texas Behavioral Health Authority Board of Directors approves the CEO, in consultation with NTBHA legal counsel, to negotiate and execute the Harris County Crisis Hotline Interlocal Agreement (Renewal) for FY 2026 and FY 2027.

DONE IN OPEN MEETING, this the 8th day of October 2025.

Recommended by:

Carol E. Lucky
Chief Executive Officer
North Texas Behavioral Health Authority

Commissioner Dr. Elba Garcia
Chair, Board of Directors
North Texas Behavioral Health Authority

RESOLUTION

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

RESOLUTION NO: 481-2025 Approve Clinical Pathology Laboratories (CPL) Contract Renewal for FY 2026 and FY 2027

DATE: October 8, 2025

STATE OF TEXAS }

COUNTY OF DALLAS }

BE IT REMEMBERED at a regular meeting of the North Texas Behavioral Health Authority held on the 8th day of October 2025, the following Resolution was adopted:

WHEREAS, the Health and Human Service Commission has designated the North Texas Behavioral Health Authority (NTBHA) as the Local Behavioral Health Authority (LBHA) for a service area consisting of the following six counties: Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall, effective January 1, 2017; and

WHEREAS, the NTBHA Board of Directors was created to govern the affairs of NTBHA; and

WHEREAS, NTBHA seeks to create a well-managed, integrated, and high-quality delivery system of behavioral health services available to eligible consumers residing in our catchment area; and

WHEREAS, NTBHA is responsible for the management of the network of behavioral health providers; and

WHEREAS, NTBHA seeks to (1) Maintain a competent and committed workforce, (2) Facilitate access to behavioral health services, (3) Manage core operations efficiently and effectively, and (4) Identify and develop additional opportunities for service area development.

IT IS THEREFORE RESOLVED that the North Texas Behavioral Health Authority Board of Directors approves the CEO, in consultation with NTBHA legal counsel, to negotiate and execute the Clinical Pathology Laboratories (CPL) Contract Renewal for FY 2026 and FY 2027.

DONE IN OPEN MEETING, this the 8th day of October 2025.

Recommended by:

Carol E. Lucky
Chief Executive Officer
North Texas Behavioral Health Authority

Commissioner Dr. Elba Garcia
Chair, Board of Directors
North Texas Behavioral Health Authority

RESOLUTION

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

RESOLUTION NO: 482-2025 Ratify Be Well Texas Contract for Medications for Opioid Use Disorder (MOUD) Treatment Services Agreement for FY 2026 (BWT Contract No. 178474/42943/MOUD-SUPTRS-17)

DATE: October 8, 2025

STATE OF TEXAS }

COUNTY OF DALLAS }

BE IT REMEMBERED at a regular meeting of the North Texas Behavioral Health Authority held on the 8th day of October 2025, the following Resolution was adopted:

WHEREAS, the Health and Human Service Commission has designated the North Texas Behavioral Health Authority (NTBHA) as the Local Behavioral Health Authority (LBHA) for a service area consisting of the following six counties: Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall, effective January 1, 2017; and

WHEREAS, the NTBHA Board of Directors was created to govern the affairs of NTBHA; and

WHEREAS, NTBHA seeks to create a well-managed, integrated, and high-quality delivery system of behavioral health services available to eligible consumers residing in our catchment area; and

WHEREAS, NTBHA is responsible for the management of the network of behavioral health providers; and

WHEREAS, NTBHA seeks to (1) Maintain a competent and committed workforce, (2) Facilitate access to behavioral health services, (3) Manage core operations efficiently and effectively, and (4) Identify and develop additional opportunities for service area development.

IT IS THEREFORE RESOLVED that the North Texas Behavioral Health Authority Board of Directors ratifies the signature of the CEO on the Be Well Texas Contract for Medications for Opioid Use Disorder (MOUD) Treatment Services Agreement for FY2026. (BWT Contract No. 178474/42943/MOUD-SUPTRS-17).

DONE IN OPEN MEETING, this the 8th day of October 2025.

Recommended by:

Carol E. Lucky
Chief Executive Officer
North Texas Behavioral Health Authority

Commissioner Dr. Elba Garcia
Chair, Board of Directors
North Texas Behavioral Health Authority



BOARD OF DIRECTORS MEETING

Summary

DATE: October 8, 2025

AGENDA ITEM #17: Resolution 482-2025 Ratify Be Well Texas Contract for Medications for Opioid Use Disorder (MOUD) Treatment Services Agreement for FY2026. (BWT Contract No. 178474 / 42943 / MOUD-SUPTRS-17)

Recommendation/Motion: Ratify the signature of the CEO on the Be Well Texas Contract for Medications for Opioid Use Disorder (MOUD) Treatment Services Agreement for FY2026 (BWT Contract No. 178474 / 42943 / MOUD-SUPTRS-17)

Background:

This is a new contract from Be Well Texas that replaces the previous contract with HHSC for Medication Assisted Treatment (MAT) with a total not-to-exceed amount of \$5,419,473.36 for FY2026. No matching funds are required.

The purpose of this Grant Agreement is to ensure the provision of recovery-oriented Medications for Opioid Use Disorder Treatment (MOUD), as part of Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) services, to meet the individualized needs of persons seeking treatment, by providing access to all reimbursable U.S. Food and Drug Administration (FDA) approved medications. Individuals receiving MOUD (“Client”) must receive medical, counseling, peer-based recovery support, educational, and other assessment and treatment services, in addition to prescribed medication.

Financial Information:

The total budgeted amount of this Grant Agreement for the life of the contract is \$5,419,473.36.

The Grantee is not required to provide any matching funds over the life of the contract. Funds will be disbursed on an invoice/reimbursement for services basis.

<u>FISCAL YEAR</u>	<u>BWT SHARE</u>	<u>MATCH</u>	<u>TOTAL CV</u>
FY26	\$5,419,473.36	\$0.00	\$5,419,473.36

Implementation Schedule: Upon Ratification by the NTBHA board.

Attachments: 17. BeWellTx_MOUD-SUPTRS-PSAgreement

Aligns with Visions #1, 2, 3, and 4



NTBHA Strategic Visions	
Vision #1	NTBHA will maintain a competent and committed workforce.
Vision #2	NTBHA will facilitate access to behavioral health services.
Vision #3	NTBHA will manage core operations efficiently and effectively.
Vision #4	NTBHA will identify and develop additional opportunities for service area development.

Presented By: Carol Lucky, Chief Executive Officer



AGREEMENT NUMBER: 178474 / 42943 / MOUD-SUPTRS-17

**PURCHASED SERVICES AGREEMENT
Medications for Opioid Use Disorder (MOUD) Treatment**

This Purchased Services Agreement (hereinafter “Agreement”) is entered to specify the terms and conditions under which The University of Texas Health Science Center at San Antonio (hereinafter “UTHSA”) shall purchase services from North Texas Behavioral Health Authority (hereinafter “Provider”) in support of UTHSA’s project entitled “Medications for Opioid Use Disorder (MOUD) Treatment” (hereinafter “Initiative”). Funds from this appropriation were awarded to the Texas Health and Human Services Commission (HHSC). Funding for this project is made available from the Texas Health and Human Services Commission (hereinafter “system agency”) under HHS001646400001.

- 1. Term of Performance.** This Agreement term is from September 1, 2025 through August 31, 2026, with eligible expenditures allowed from September 1, 2025 through August 31, 2026.
- 2. Statement of Work.** Provider will be providing all the necessary qualified personnel, equipment, materials and facilities to accomplish the services as set forth attached hereto and incorporated herein with the Statement of Work (Attachment A).
- 3. Termination.** This Agreement may be terminated in whole or in part in any of the following cases: a) by either party upon thirty (30) days prior written notice; b) by either party if the other party materially fails to comply with the terms and conditions of this Agreement; or c) by either party without prior notice when such action is necessary to protect the safety of patients.
- 4. Consideration and Payment.** Provider shall submit billable medication service notes and/or billable progress notes through the Clinical Management for Behavioral Health Services (CMBHS) System after services are rendered. Monthly claims shall be generated by the 5th calendar day in CMBHS. Provider will be reimbursed for services provided utilizing the established unit rates. Final deadline to submit billable medication service notes and/or billable progress notes through CMBHS will be no later than September 5, 2026. Additional information regarding Consideration and Payment is outlined in Attachment B, Program Services and Unit Rates.

5. **Reports.** Provider shall submit reports as specified in the Statement of Work (Attachment A), attached hereto and incorporated herein. In addition, Provider may be asked to furnish other reports, at such time and in such form, as reasonably requested by UTHSA during the term of this Agreement.
6. **Right to Access.** Provider shall allow UT Health, Texas Health and Human Services, State Auditor's Office (SAO), Office of Inspector General (OIG), and the Comptroller General of the United States, and any of their representatives, the right of access to inspect the work and the premises on which any work is performed and the right to audit the Provider in accordance with §200.300 of the OMB Uniform Guidance.
7. **Publications, Copyrights, and Confidentiality.** No party shall, without the prior written consent of the other party, use in advertising, publicity, or otherwise, the name, trademark, logo, symbol, or other image of the other party, its employees or agents, including without limitation, any of such relating to UTHSA and Provider. Provider (including its employees, agents, and representatives) shall not issue or disseminate any press release or statement, nor initiate any communication of information regarding this initiative (written or oral) to the communications media without the prior written consent of UTHSA.

Disclosure of information the parties wish to remain confidential and proprietary information (hereinafter collectively, "Confidential Information") directly pertaining to the project is in confidence and thus the Parties agree to:

- a. (1) Not disclose the Confidential Information, as defined above, to any other person and (2) use at least the same degree of care to maintain the Confidential Information as the Receiving Party uses in maintaining its own confidential information, but always at least a reasonable degree of care;
- b. Use the Confidential Information only for the Purpose;
- c. Restrict disclosure of the Confidential Information solely to those employees of the Receiving Party having a need to know such Confidential Information in order to accomplish the Purpose;
- d. Advise each such employee, before he or she receives access to the Confidential Information, of the obligations of the Parties under this Agreement, and require each such employee to maintain those obligations. The Confidential Information may be communicated to the University's scientific and/or institutional review committee(s) under a similar, appropriate understanding of the confidential and/or proprietary nature of the Confidential Information supplied and to further the Purpose.
- e. Within fifteen (15) days following written request of the Disclosing Party return to the Disclosing Party all documentation, copies, notes, diagrams, computer memory media and other materials containing any portion of the Confidential Information which was provided by the Disclosing Party, or confirm to Disclosing Party, in writing, the destruction of such materials. The Parties shall have the right to retain one (1) copy in a secure location for the sole purpose of determining any continuing obligations of confidentiality under this Agreement. This Agreement imposes no obligation on the Receiving Party with respect to any portion of the Confidential Information received from the Disclosing Party which (a) was known to Receiving Party prior to disclosure by Disclosing Party, (b) is lawfully obtained by Receiving Party from a third party under no obligation of confidentiality, (c) is or becomes generally known or publicly available other than by unauthorized disclosure, (d) is independently developed by Receiving Party, (e) is disclosed by Disclosing Party to a third party without a duty of confidentiality on the third party, or (f) is not disclosed in writing or

reduced to writing and marked with an appropriate confidentiality legend within thirty (30) days after disclosure. In addition, a Party may disclose to third parties Confidential Information of the other Party to the minimal extent such disclosure is required to comply with law or regulation, provided that to the extent possible the Party required to make such disclosure shall notify disclosing Party and assert or allow disclosing Party to assert any exclusions or exemptions that may be available to it and/or seek a protective order with respect thereto. The Confidential Information provided by the Disclosing Party shall remain the sole property of Disclosing Party.

- 8. Patents and Intellectual Property.** Ideas, know-how, data (including initiative results), and other intellectual property generated under this Agreement shall be the sole and exclusive property of UTHSA and inventorship shall be determined in accordance with U.S. Patent laws. Provider shall also grant to UTHSA an irrevocable, royalty-free, worldwide, non-exclusive license to each invention for which it is unable to assign rights to UTHSA.
- 9. HIPAA.** Provider shall be responsible for full compliance with all applicable HIPAA regulations. Provider shall collect, use, and disclose Protected Health Information, as defined in the HIPAA regulations. The Business Associate Agreement (BAA) agreement terms and conditions attached hereto as Attachment D are incorporated herein and must be signed and executed for non-covered entities. Covered entities are not required to execute Attachment D, but must mark they are a HIPAA covered entity in Attachment D. In the event of conflict between this agreement and Attachment D, Attachment D supersedes for all issues regarding Protected Health Information as defined in the BAA.
- 10. Liability and Insurance.** Each party shall be responsible for its own negligent acts or omissions and the negligent acts or omissions of its employees, agents, officers, or directors, to the extent allowed by law. Provider represents and certifies that it and its employees are covered by sufficient malpractice and general liability insurance, or program of self-insurance to fully perform their responsibilities hereunder.
- 11. Debarment.** Provider certifies that it has not been debarred under the provisions of the Generic Drug Enforcement Act of 1992, or other applicable government regulations and Provider represents that, to the best of its knowledge after reasonable inquiry, its employees are not and have never been so debarred and that it will not use in any capacity, in connection with the services to be performed under this Agreement, any individual who has been so debarred.
- 12. Federal Funding.** This Agreement is made with federal funds awarded to Provider, the following provisions are made a part of this Agreement, as applicable:
 - a. Equal Employment Opportunity. Provider agrees to comply with E.O. 11246, "Equal Employment Opportunity," as amended by E.E. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."
 - b. Copeland "Anti-kickback" Act (18 U.S.C. 874 and U.S.C. 276c). Provider will comply with Copeland "Anti-Kickback" Act (18 U.S.C. 874), as supplemented by Department of Labor regulations (29 CFR Par 3, "Contractors and Sub-contractors on Public Buildings or Public Works Financed in Whole or in Part by Loans or Grants from the United States"). The Act provides that each contractor or sub-recipient will be prohibited from inducing, by any means, any person employed in the construction,

completion or repair of public work, to give up any part of the compensation to which he is otherwise entitled. Provider is bound to report all suspected or reported violations to the federal awarding agency.

- c. Davis-Bacon Act, as amended (40 U.S.C. 276a to a-7). Provider will comply with the Davis-Bacon Act (40 U.S.C. 276a- to a-7) as supplemented by Department of Labor regulations (29 CFR part 5, “Labor Standards Provisions Applicable to Contracts Governing Federally Financed and Assisted Construction”). Under this Act, contractors will be required to pay wages to laborers and mechanics at a rate not less than the minimum wages specified in a wage determination made by the Secretary of Labor. In addition, contractors will be required to pay wages not less than once a week. Should the Davis-Bacon Act apply to this Agreement, this Contract is conditioned upon the acceptance by Provider of the wage determination. Provider is bound to report all suspected or reported violations to the federal awarding agency.
- d. Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended. Provider agrees to comply with all applicable standards, orders, or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 et seq.). University is bound to report violations to the federal awarding agency and the Regional Office of the Environmental Protection Agency.
- e. Byrd Anti-Lobbying Amendment (31 U.S.C. 1352). Provider is required to file the required Anti-Lobbying Certification certifying that it will not and has not used federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of a member of Congress in connection with obtaining any federal contract, grant, or any other award covered by 31 U.S.C. 1352.
- f. EEOC and Veterans. Provider shall abide by the requirements of 41 CFR §§ 60- 1.4(a), 60-300.5(a) and 60-741.5(a). These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities and prohibit discrimination against all individuals based on their race, color, religion, sex, or national origin. Moreover, these regulations require that covered prime contractors and Provider’s take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, national origin, protected veteran status or disability.

13. Independent Contractor. Provider’s relationship to UTHSA under this Agreement shall be that of an independent contractor and not an agent, joint venture, or partner of UTHSA and, as such, no employees, staff, or agents of Provider shall be entitled to any benefits applicable to employees of UTHSA.

14. Boycotting Israel. Pursuant to Chapter 2271, *Texas Government Code*, Provider certifies it (1) does not currently boycott Israel; and (2) will not boycott Israel during the Term of this Agreement. Provider acknowledges this Agreement may be terminated and payment withheld if this certification is inaccurate.

15. Ethics Matters, No Financial Interest. Provider and its employees, agents, representatives and subcontractors have read and understand UTHSA Conflicts of Interest Policy, UTHSA’s Standards of Conduct Guide at <https://www.utsystem.edu/documents/docs/policies-rules/ut-system-administration-standards-conduct-guide>, and applicable state ethics laws and rules available at <https://www.utsystem.edu/offices/systemwide-compliance/ethics>. Neither Provider nor its employees, agents, representatives or subcontractors will assist or cause

UTHSA employees to violate UTHSA's Conflicts of Interest Policy, provisions described by UTHSA's Standards of Conduct Guide, or applicable state ethics laws or rules. Provider represents and warrants that no member of the Board has a direct or indirect financial interest in the transaction that is the subject of this Agreement.

- 16. Subcontracting and Assignment.** This Agreement may not be subcontracted, assigned or transferred by either party without the prior written consent of the other.
- 17. Entire Agreement.** This Agreement constitutes the entire agreement between the parties. Any alterations, modification, or amendment to this Agreement must be in writing and signed by authorized officials of both parties. No changes in the Statement of Work will be made unless agreed upon by UTHSA and Provider.
- 18. Notices.** Any notices to be given under these terms and conditions unless otherwise stated shall be submitted as follows:

To UTHSA:

For Technical Matters:

Cynthia Blaylock
The University of Texas Health
Science Center at San Antonio
5109 Medical Drive
San Antonio, TX 78229
210-450-7119
blaylockc@uthscsa.edu

For Business Matters:

Chris G. Green, CPA
AVP Sponsored Programs
The University of Texas Health
Science Center at San Antonio
7703 Floyd Curl Drive, MSC 7828
San Antonio, TX 78229
210-567-2340
grants@uthscsa.edu

To Provider:

For Technical Matters:

Name: _____
Title: _____
North Texas Behavioral Health
Authority
8111 LBJ Fwy., Ste. 900
Dallas, TX 75251
Phone: _____
Email: _____

For Business Matters:

Name: Carol Lucky
Title: Chief Executive Officer
North Texas Behavioral Health
Authority
8111 LBJ Fwy., Ste. 900
Dallas, TX 75251
Phone: 214-366-9407
Email: clucky@ntbha.org

The parties hereby accept and agree to this Agreement.

By: _____
Chris G. Green, CPA
Assistant Vice President, Sponsored
Programs
Date: _____

By: _____
Name: Carol Lucky
Title: Chief Executive Officer
Date: _____

Attachments:

- A. Statement of Work (SOW)**
- A1. Performance and Outcome Measures**
- B. Program Services and Unit Rates**
- C. Data Use Agreement (DUA)**
- D. Business Associate Agreement (BAA)**
- E. Qualified Services Organization Agreement (QSOA)**
- F. Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder**

ATTACHMENT A MOUD- SUPTRS SCOPE OF GRANT PROJECT

I. PURPOSE

To ensure the provision of recovery-oriented Medications for Opioid Use Disorder Treatment (MOUD), as part of Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) services, to meet the individualized needs of persons seeking treatment, by providing access to all reimbursable U.S. Food and Drug Administration (FDA) approved medications. Individuals receiving MOUD (“Client”) must receive medical, counseling, peer-based recovery support, educational, and other assessment and treatment services, in addition to prescribed medication.

II. GOALS

1. Implement service delivery models that enable the full spectrum of treatment that facilitates long-term recovery from opioid use disorders.
2. Increase access to all FDA approved treatment medications for opioid use disorder MOUD in Opioid Treatment Program (OTPs) by expanding capacity at new and existing clinics, including treatment for co-morbid conditions.

III. TARGET POPULATION

Texas residents who meet financial criteria for Health and Human Services Commission (HHSC)-funded substance use disorder (SUD) services and have met the Diagnostic and Statistical Manual of Mental Disorders criteria for opioid use disorder (OUD).

IV. SERVICE AREA

Provider will provide services to the **SECTION III, TARGET POPULATION**, in the HHS health region and counties documented, as follows:

Region: Statewide

To review counties within an HHS health region, refer to the below link for a list of counties within a region: <https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/hhs-regional-map.pdf>

V. SERVICE REQUIREMENTS

A. Administrative Requirements

Provider shall:

1. Ensure the administration and dispensing of medication for the treatment of Opioid Use Disorder (OUD).
2. Ensure organizations providing opioid treatment medications comply with certification and licensure-related statutes, guidelines, and regulations related to MOUD adopted by HHSC, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), Drug

Enforcement Agency (DEA), and additional third-party accreditation requirements. Specifically, Provider shall:

- a. Comply with Title 26 of the Texas Administrative Code (TAC) Part 1, Chapter 563, specifically 26 TAC 563.148, Minimum Standards for Narcotic Treatment Programs;
 - b. Comply with the 42 Code of Federal Regulations (CFR) Chapter 1, Subpart A, Part 8, Medications for the Treatment of Opioid Use Disorder, [eCFR :42 CFR Part 8 -- Medication Assisted Treatment for Opioid Use Disorders](#);
 - c. Comply with HHSC Guidelines for the Use of Extended-Release Injectable Naltrexone (included as ATTACHMENT A-2 to the Contract).
 - d. Utilize and adhere to the most current Texas Health and Human Psychiatric Drug Formulary, including Reserve Drug Criteria and Audit Criteria, which can be found at: <https://www.hhs.texas.gov/providers/health-care-facilities-regulation/psychiatric-drug-formulary>.
3. Ensure establishment, submission and implementation of policies and procedures for client selection criteria and appropriateness for each FDA-approved medication for the treatment of opioid use disorder.
 4. Ensure documentation of all specified required activities and services in the Clinical Management for Behavioral Health Services (CMBHS) system.
 5. Ensure the provision of communicable disease testing, immunizations, chronic disease prevention, and address comorbid psychiatric disorders within the context of MOUD to provide clients with an opportunity to improve the health and overall quality of life, while also promoting recovery. The individual's consent shall be obtained and documented in CMBHS prior to performing any of the aforementioned services.
 6. Ensure documentation of Financial Eligibility appropriately in CMBHS before charging any individuals for screening and assessment and ensure payments are not required from individuals determined by the Financial Eligibility function of CMBHS to be eligible for state-funded services for screening and assessments.
 7. Ensure the following related to counselor caseload size:
 - a. Limits are set on counselor caseload size to support effective, individualized treatment;
 - b. Documentation and justification in a policy and procedure the caseload size based on the service design, characteristics and needs of the funded population served, and any other relevant factors;
 - c. Compliance with 26 TAC 563.142(5):
 - i. Approved to treat (ATT)--The maximum number of patients the NTP is allowed to treat at any point in time under the approved permit. This number is based on a maximum of 50 patients for each counselor employed by the program; and
 - d. Ensure CMBHS "Assign Clinician" function is utilized to track caseload size.
 8. Ensure the performance and submission of Governmental Performance and Results Act (GPRA) assessments in compliance with 107 Stat. 285 – Public Law No. 103-62

- (08/03/1993) for all participants who are engaged in treatment services in the following manner:
- a. The primary counselor shall conduct the GPRA assessment immediately after the client is stabilized or within four weeks after admission, whichever is sooner.
 - b. The GPRA assessments must be completed at intake, six-month follow-up, and discharge. Additionally, the six-month follow-up must be conducted between months five through seven, depending on the client's availability. Provider must use CMBHS to conduct, document and enter assessments as close to real time as possible. Provider will aim to upload their data into CMBHS within one (1) day – but it must be entered into CMBHS no later than seven (7) business days – after the GPRA assessment is conducted.
 - c. Maintenance of a minimum 80% follow-up rate for the six-month assessment, regardless of discharge status (including closed cases, administrative discharges, and participants who have left the program); and
 - d. When directed the Provider shall ensure a new initial GPRA assessment is performed for all clients in services at the beginning of each fiscal year.
9. Ensure the adoption and availability of organizational policies and procedures within six months from contract execution on the following:
- a. A marketing plan to engage local referral sources and provide information to these sources regarding the availability of MOUD and the eligibility criteria for admissions; All marketing materials shall publish the federal and state priority population admissions (as defined further below in Section II(C)(1)-(2)); and
 - b. The retention of clients in services, including protocols for addressing clients absent from treatment, policies defining treatment noncompliance, and policies and procedures regarding discharging from MOUD services.
10. Ensure active attendance and sharing representative knowledge and proof of attendance to Be Well Texas upon request regarding Provider's system and services at the following meetings:
- a. Outreach, Screening, Assessment, and Referrals (OSAR) contractor's quarterly regional collaborative meetings within Provider's region;
OSAR Regional locations can be found at this website: [Outreach, Screening, Assessment and Referral | Texas Health and Human Services](#).
 - b. Recovery Oriented Systems of Care (ROSC) meetings in Provider's region;
ROSC Regional locations can be found at this website: [Recovery-Oriented Systems of Care | Texas Health and Human Services](#).
11. **Ensure all project materials include the following attribution statement:** "This project is supported by Texas Targeted Opioid Response, a public health initiative operated by the Texas Health and Human Services Commission through federal funding from the Substance Abuse and Mental Health Services Administration grant award number –" The grant awards number will be provided by Be Well Texas.

12. Ensure requirements of Texas residency eligibility, Financial Eligibility, and clinical eligibility are met, as determined by CMBHS client profile, CMBHS SUD assessment, and financial eligibility documentation in CMBHS; as referenced above in Section V(A)(6).
13. Provider shall develop local agreements within six months of initial contract execution date to address referral processes, coordination of services, education, and sharing of information as allowed per the CMBHS consent form with and provide to Be Well Texas upon request.
 - a. Department of Family and Protective Services (DFPS) local offices;
 - b. Office Based Treatment (OBT) providers receiving federal and/or State funds;
 - c. Local Prevention Resource Center that can be found at this website: [Prevention Resource Centers | Texas Health and Human Services](#)
 - d. HHSC-funded co-occurring psychiatric and substance use disorders (COPSD) providers; and
 - e. Federally Qualified Health Centers (FQHCs).
14. Provider Shall have and submit upon Be Well Texas request, an executed Memorandum of Understanding (MOU) with the local Outreach, Screening, Assessment, and Referral (OSAR) provider in Provider's region within six months of initial contract execution date, which shall address, at a minimum, the following:
 - a. How capacity and treatment availability information to each OSAR provider will be reported in the region;
 - b. Referral processes when immediate capacity is not available;
 - c. Whether Provider or OSAR provider will provide initial required interim services;
 - d. Emergency referrals and transportation assistance for clients in crisis;
 - e. Subcontractor-specific policy on how and when clients are removed from the waiting list; and
 - f. Describe quarterly updating of specific contact information for key agency staff that handle day to day client placement activities.
15. Provider shall have and submit upon request, an executed MOU with Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA) providers known as a Health Authority (HA) in Provider's region within six months of initial contract execution date, which shall address, at a minimum, the following:
 - a. Objectives, roles, and responsibilities of each Party;
 - b. Scope of services provided by each Party to meet the needs of the clients served;
 - c. Confidentiality requirements;
 - d. Description of how quality of and efficacy of services provided will be assessed;
 - e. the federal and State priority populations and requirements;
 - f. requirements for referral and referral follow up;
 - g. non-duplication of services;
 - h. Emergency referrals and transportation assistance for clients in crisis;
 - i. Coordination of enrollment and engagement of clients in HA services;

- j. Coordination with concurrent and subsequent services; and
 - k. Documentation of referral, referral follow-up, and other case management services provided;
 - l. Implementation and expiration dates; and
 - m. Contain signatures by both Parties.
16. Provider shall have and submit upon request to Be Well Texas, an executed MOU with Recovery Support Services (RSS) provider(s) in Provider's region within six months of initial contract execution date, which shall address, at a minimum, the following: RSS Organizations can be found at this website: [Recovery Support Services|Texas Health and Human Services](#).
- a. Appropriate referrals to and from Provider and RSS for indicated services;
 - b. Coordination of the enrollment and engagement of clients;
 - c. Coordination of non-duplication of services;
 - d. Collaboration between treatment staff and Recovery Support Services for improved client outcomes; and
 - e. Documentation of referral, referral follow-up and other case management services provided;
 - f. Implementation and expiration dates; and
 - g. Contain signatures by both Parties.
17. **Ensure all presentation and training materials include the following disclaimer statement:** "The views expressed do not necessarily reflect the official policies of the Department of Health and Human Services or Texas Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. or Texas Government."
18. **Ensure submission of public-facing project materials to Be Well Texas for approval at least two weeks prior to publication.** Public-facing materials include but are not limited to press releases, publications, reports, fact sheets, and advertisements. Be Well Texas will provide guidance on the approval process and timeline.
19. Ensure adherence to the TTOR Brand Guidelines, **ATTACHMENT A-2, TTOR BRAND GUIDELINES, v.3.0**, for all communications. Provider may apply for an exception to be approved by Be Well Texas, but at a minimum Provider shall utilize the approved voice, tone, brand architecture, and TTOR logo described in the TTOR Brand Guidelines. The TTOR Brand Guidelines provide a guide for the TTOR team and all TTOR-funded projects to ensure brand consistency.

B. Overdose Prevention and Reversal Education

Provider shall:

- 1. Provide overdose prevention, reversal education, and materials to:
 - a. Individuals on the Provider's wait list;
 - b. All clients prior to discharge, including those that received overdose prevention, reversal education, and materials prior to admission or on admission.

2. Document all overdose prevention, reversal education, and materials that have been disseminated in CMBHS.
Information regarding bulk ordering of Naloxone can be found at this website: <https://naloxonetexas.com>.
3. Required overdose prevention activities is conducted with clients with an OUD and with clients that use drugs intravenously to include:
 - a. Education on overdose prevention and risk reduction strategies;
 - b. Education about and referral to community based and State-funded services for clients with intravenous drug use history;
 - c. Referral to local community resources that work to reduce harm associated with high-risk behaviors associated with drug use; and
 - d. For detailed guidance, refer to SAMHSA's Opioid Overdose Prevention Toolkit found at this website: [Overdose Prevention and Response Toolkit | SAMHSA](#).

C. Service Delivery

Provider shall:

1. Admit individuals based on the following federal priority populations established for entering state-funded substance use disorder services, in accordance with 45 CFR §96.131:
 - a. Pregnant injecting individuals must be admitted immediately;
 - b. Pregnant individuals must be admitted immediately; and
 - c. Injecting drug users must be admitted within fourteen (14) calendar days.
2. Admit individuals based on the state priority populations, state priority populations have been established for entering state-funded substance use disorder services:
 - a. Individuals identified as being at high risk for overdose must be admitted within 72 hours;
 - b. Individuals referred by the Department of Family and Protective Services (DFPS) must be admitted within 72 hours;
 - c. Individuals experiencing housing instability or homelessness will be admitted to requested services within 72 hours; and
 - d. All other populations.
3. Establish screening procedures to identify individuals of federal and state priority populations.
4. Ensure successful referral and admittance within the above-referenced time frames to another HHSC-funded contractor. If unable to secure successful referral and admittance, contact Be Well Texas at BeWellTX@uthscsa.edu.
5. Accept clients from every region in the State and from the OSAR, when capacity is available to accommodate federal and State priority population.
 - a. If two individuals are of equal priority status, preference may be given to the individual living in the OSAR's service area region.

- b. Provider will include a statement in all brochures and will post a notice in all applicable provider lobbies, of the federal and state priority population admission requirements.
 - c. When space is not available, Provider will immediately contact the Be Well Texas Wait List and Capacity Management Coordinator regarding the DFPS priority population individual placed on the waitlist at [Substance Use Disorder@hhs.texas.gov](mailto:Substance_Use_Disorder@hhs.texas.gov) & BeWellTX@uthscsa.edu
6. Document the previous day's capacity in CMBHS, Daily Capacity Management Report, on Monday through Friday by 11:00am Central Time.
7. Maintain a wait list in CMBHS to track all eligible individuals who have been screened but cannot be admitted to MOUD immediately.
8. Implement written procedures that address maintaining weekly contact with individuals waiting for admission, as well as what referrals are made, when a client cannot be admitted for services immediately.
9. Implement written procedures that address monthly contact with clients currently receiving MOUD services and waiting for a state-funded slot.
10. When Provider cannot admit a client, Provider shall:
 - a. Ensure that an emergency medical care provider is notified immediately if applicable;
 - b. Coordinate with an alternate provider for immediate admission;
 - c. Notify Be Well Texas Waitlist and Capacity Management Coordinator at Substance Use Disorder ([Substance Use Disorder@hhs.texas.gov](mailto:Substance_Use_Disorder@hhs.texas.gov) & BeWellTx@uthscsa.edu) so that assistance can be provided that ensures immediate admission to other appropriate services and proper coordination when appropriate.
11. At Be Well Texas discretion, coordinate services with Be Well Texas identified stakeholders to improve access to the continuum of services offered by the Be Well Texas. Coordination may include, but is not limited to, scheduled meetings, collaboration on related initiatives, and service referrals.

D. Medication

Provider shall ensure that physicians:

1. Prescribe and monitor adequate dosage levels for each client; and
2. Not impose and/or limit dosage capitations for any prescribed medication for the treatment of opioid use disorder.

E. Screening and Assessment

Provider shall:

1. Comply with all rules in the TAC, Title 26, Part I Chapter 563 Minimum Standards for Narcotic Treatment Programs, and specifically, 26 TAC 563.148, State Operational Requirements.

2. Utilize the *Diagnostic and Statistical Manual of Mental Disorders – V* (DSM-V) criteria for a substance use disorder to determine client diagnosis.
3. When conducting a CMBHS Substance Use Disorder screening, Provider shall conduct the screening in a confidential, face-to-face interview unless there is documented justification for an interview by phone.
4. Conduct face-to face and document a CMBHS Substance Use Disorder Initial Assessment, and GPRA as directed by Be Well Texas, with the client. The CMBHS assessment will identify the impact of substances on physical, mental health and other identified physical health issues including tuberculosis, Hepatitis B and C, sexually transmitted disease (STD) and Human Immunodeficiency Virus (HIV).
5. Provider shall conduct and document a CMBHS Substance Use Disorder Update Assessment with the client six months after admission and then annually thereafter.

F. Testing

Provider shall:

1. Provide, arrange and document interim services including screening for tuberculosis, hepatitis B and C, sexually transmitted diseases (STDs), and Human Immunodeficiency Virus (HIV) while only subcontracting laboratory services and hepatitis C virus testing components.
2. If the client is living with HIV, refer the client to appropriate community resources to complete the necessary referrals and health-related paperwork. If the client needs residential services refer to HHSC HIV-statewide provider if available.
3. Provide health screenings, testing, and prevention education.
 - a. Provider shall provide testing for clients who self-identify as already testing positive for HIV or hepatitis B or C unless it is confirmed that the client is currently receiving medical care for these conditions.
 - b. If the client indicates that they had a positive test for tuberculosis (TB) in the past, Provider shall screen for TB to determine whether symptoms exist and provide a referral to the local health department for further assistance and/or treatment if needed.
 - c. If any other screenings or tests indicate a need for medical services, Provider shall ensure that the client is able to access those services.
 - d. Provider shall contact the local health department to report all positive results for hepatitis B on pregnant women, and all positive results on HIV, gonorrhea, chlamydia, syphilis, and other relevant results.
 - e. Provider shall comply with 26 TAC Part I, Chapter 563, Minimum Standards for Narcotic Treatment Programs, and specifically, 26 TAC 563.148 for scheduling of drug testing.
4. Document and upload in CMBHS with client signature the informed consent for routine opt-out testing:
 - a. Tuberculosis;
 - b. Hepatitis B;

- c. Hepatitis C;
 - d. Gonorrhea;
 - e. Chlamydia;
 - f. Human Immunodeficiency Virus (HIV) Initial;
 - g. Human Immunodeficiency Virus (HIV) Confirmatory (Note: Confirmatory may only be billed after the results from the initial results are obtained.); and
 - h. Diabetes (using A1c testing).
5. Provide testing and screening results to the client by the physician or his/her designee. All positive results must be provided to the client in person.
 6. Document screening and testing results in the client's CMBHS record and medical needs resulting from testing are incorporated into the client's treatment plan.
 7. Physician may choose to consult with the client on comorbid conditions and provide services upon admission or as indicated for the following:
 - a. First-line wound care therapy which could include wound cleansing, use of systemic or topical antibiotics, use of pressure loading devices, perform compression, and apply dressing.
 - b. Co-occurring psychiatric disorders (Note: The initial interview for diagnosis of psychiatric condition may not be billed as the initial evaluation for admission to MOUD); and
 - c. Hepatitis C Virus (HCV) treatment coordination.

G. Treatment Planning, Implementation, and Review

Provider shall:

1. Comply with all rules in 26 TAC Part I Chapter 563 Minimum Standards for Narcotic Treatment Programs, and specifically, 26 TAC 563.148, State Operational Requirements, and 42 Code of Federal Regulations (CFR) Chapter 1, Subchapter A, Part 8 – Medications for the Treatment of Opioid Use Disorder .
2. Collaborate actively with clients and family, when appropriate, to develop and implement an individualized, written treatment plan that identifies services and support needed to address problems and needs identified in the assessment. The treatment plan shall document the expected length of stay.
3. Document referral and referral follow up in CMBHS to the appropriate community resources based on the individual needs of the client.

H. Recovery Oriented Medication Assisted Treatment

Provider shall Provide:

1. Access to peer-based recovery support for all individuals served;
2. Upon Be Well Texas request, provide space for Medication Assisted Recovery Patient advocacy groups to train and support clients receiving services and staff providing service, and
3. Utilize and reference the following: <https://atforum.com/documents/Recovery.pdf>

I. Discharge

Provider shall:

1. Comply with all applicable rules in 26 TAC Part I, Chapter 563, Minimum Standards for Narcotic Treatment Programs, and specifically 26 TAC 563.148 and 42 CFR Part 8.
2. Develop and implement an individualized discharge plan with the client to assist in sustaining medication assisted recovery.
3. Identify a specific physician or authorized healthcare professional, as appropriate, to whom the client is being discharged and will ensure that an appointment has been made with that provider to occur within 72 hours to maximize the client's chances for success. The name, address, and telephone number of the provider caring for the client after discharge will be recorded in the client's record and given to the client in writing.
4. Document the client-specific information that supports the reason for discharge listed on the discharge report. Appropriate referrals shall be made and documented in CMBHS.
 - a. A client's treatment is considered successfully completed if both of the following criteria are met:
 - i. client has completed the clinically recommended number of treatment units (either initially projected or modified with clinical justification) as indicated in CMBHS; and
 - ii. All problems on the treatment plan have been addressed.
 - b. Use the treatment plan component of CMBHS to create a final and completed treatment plan version. Problems designated as "treat" or "case manage" status shall have all objectives resolved prior to discharge.
 - c. Problems that have been "referred" shall have associated documented referrals in CMBHS:
 - i. Problems with "deferred" status shall be re-assessed. Upon successful discharge, all deferred problems shall be resolved, either through referral, withdrawal, treatment, or case management with clinical justification reflected in CMBHS, through the Progress Note and Treatment Plan Review Components; and
 - ii. "Withdrawn" problems shall have clinical justification reflected in CMBHS, through the Progress Note and Treatment Plan Review Components.
 - d. If the discharge plan includes the use of extended-release injectable naltrexone, the medical director or qualified designee will either administer the medication prior to discharge or Provider will ensure that the client has immediate access to such medication services upon discharge.
5. In addition to 26 TAC Part I, Chapter 563, Minimum Standards for Narcotic Treatment Programs and 26 TAC 563.148, follow 26 TAC Part 1, Chapter 564 standards listed below:

- a. Subchapter B, Standard of Care Applicable to All Providers
 - i. Rule §564.4: General Standard
 - ii. Rule §564.5: Scope of Practice
 - iii. Rule §564.6: Competence and Due Care
 - iv. Rule §564.7: Appropriate Services
 - v. Rule §564.8: Accuracy
 - vi. Rule §564.9: Documentation
 - vii. Rule §564.10: Discrimination
 - viii. Rule §564.11: Access to Services
 - ix. Rule §564.12: Location
 - x. Rule §564.13: Confidentiality
 - xi. Rule §564.14: Environment
 - xii. Rule §564.15: Communications
 - xiii. Rule §564.16: Exploitation
 - xiv. Rule §564.17: Duty to Report
 - xv. Rule §564.18: Impaired Providers
 - xvi. Rule §564.19: Ethics
 - xvii. Rule §564.20: Specific Acts Prohibited
 - xviii. Rule §564.21: Standards of Conduct
- b. Subchapter E, Facility Requirements
 - i. Rule §564.504: Quality Management
 - ii. Rule §564.506: Required Postings
 - iii. Rule §564.508: Client Records
- c. Subchapter G, Client Rights
 - i. Rule §564.704: Program Rules
 - ii. Rule §564.707: Responding to Emergencies

J. Staff Requirements

Provider shall ensure:

1. All personnel shall receive the training and supervision necessary to ensure compliance with Be Well Texas rules, provision of appropriate and individualized treatment, and protection of client health, safety, and welfare.
2. Ensure that all direct care staff receive a copy of this Contract.
3. Ensure that all direct care staff review all policies and procedures related to the Program or organization on an annual basis.
4. Provider shall ensure that appropriate staff participate in Be Well Texas webinars, conference calls, and trainings at the specified dates, times, and locations as required by Be Well Texas.
5. Within ninety (90) calendar days of hire and prior to service delivery, direct care staff shall have specific documented training in the following:
 - a. Motivational Interviewing Techniques or Motivational Enhancement Therapy;

- b. Trauma, Abuse and Neglect, Exploitation, Violence, Post-Traumatic Stress Disorder, and Related conditions as Be Well Texas sees fit;
 - c. Cultural Sensitivity and Competency, specifically including but not limited to gender and Sexual identity and orientation;
 - d. Overdose Prevention Training;
 - e. Harm Reduction trainings; and
 - f. Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2 training.
- 6. Ensure all direct care staff complete annual education on HIPAA and 42 CFR Part 2 training.
- 7. Ensure all direct care staff complete a minimum of 10 hours of training each State Fiscal Year in any of the following areas:
 - a. Motivational Interviewing Techniques;
 - b. Culturally competencies;
 - c. Reproductive health education;
 - d. Risk and harm reduction strategies;
 - e. Trauma Informed Care;
 - f. Seeking Safety or
 - g. Suicide prevention and intervention
- 8. Within six months of hire, direct care staff shall have documented training in the following:
 - a. Medication Assisted Recovery, and/or
 - b. Certified Medication Assisted Treatment Advocacy Training
 - c. If training is not immediately available, please visit website: <https://opioidresponesenetwork.org/> and document the attempts made to schedule and/or attend training to comply with the following requirements:
 - i. Individuals responsible for planning, directing, or supervising treatment services shall be Qualified Credentialed Counselors (QCCs).
 - ii. Substance Use Disorder counseling shall be provided by a QCC, or Chemical Dependency Counselor Intern. Substance use disorder education and life skills training shall be provided by counselors or individuals who have appropriate specialized education and expertise. All counselor interns shall work under the direct Supervision of a QCC.
 - iii. Provider shall train staff and develop a policy to ensure that information gathered from clients is conducted in a respectful, non-threatening, and culturally competent manner. Provider will make available to the Be Well Texas upon request.

K. Third-Party Payors

Provider shall:

- 1. Not seek reimbursement from Be Well Texas if the individual is covered by a third-party payor.

2. Demonstrate the capacity to bill insurance, Medicaid, and/or Medicare for individuals with health insurance coverage and
 - a. Contract with Medicaid and the identified Managed Care Organizations in service delivery region;
 - b. Contract with Medicare in the service delivery region.
3. Refer individuals to a treatment program that is approved by the individual's third-party payor if Provider is not eligible for reimbursement.
 - a. If the approved treatment program refuses treatment services to the client and documents that refusal, Provider may provide treatment services and bill Be Well Texas;
 - b. The refusal, including third-party payor and approved treatment program, shall be documented in the client file;
 - i. If the client meets the diagnostic criteria for substance use disorder; and
 - ii. If client's third-party payor will cover or approves partial or full payment for treatment services, Provider may bill Be Well Texas for the non-reimbursed costs, including the deductible, provided:
 - 1) The client's parent/guardian refuses to file a claim with the third-party payor, or refuses to pay either the deductible or the non-reimbursed portion of the cost of treatment, and Provider has obtained a signed statement from the parent/guardian of refusal to pay, and Provider has received written approval from the Be Well Texas substance use disorder treatment Program services clinical coordinator to bill for the deductible or non-reimbursed portion of the cost;
 - 2) The client or parent/guardian cannot afford to pay the deductible or the non-reimbursed portion of the cost of treatment; or
 - 3) The client or parent/guardian has an adjusted income at or below 200% of the Federal poverty guidelines.
 - c. If a client has exhausted all insurance coverage and requires continued treatment, Provider may provide the continued treatment services and bill Be Well Texas if the client meets criteria specified in **Section V (C) (1-3), Service Delivery**.

L. Annual Survey

Provider shall:

1. Complete the MOUD Programs Opioid Treatment Services (OTS) annual survey.
2. Use the HHSC approved client satisfaction OTS annual survey template for collecting information from clients who have received MOUD Program services.
3. Develop and coordinate a process for collecting client survey data.
4. Submit results of client survey.

M. Conference Calls

Provider Shall:

- a. Ensure essential staff (e.g. program directors, program administrators, clinicians, contract manager, and/or medical directors) participate in monthly Provider conference calls as scheduled by BWTX to address programmatic, documentation, or testing issues.
- b. Additionally, BWTX may facilitate weekly and/or monthly conference calls with the Provider to review the Monthly Activity Report deliverables and to discuss all issues and/or concerns with implementing the scope of work.
- c. Provider may be requested to participate in quarterly interviews with the BWTX

evaluation and quality assurance department to discuss program implementation and process improvement.

N. BWTX Training and Technical Assistance

- i. Provider shall participate in a minimum of one (1) BWTX TxRx (Medications for Substance Use Disorder) Extension for Community Healthcare Outcomes (ECHO) per month-Online.
- ii. **TxRx ECHO sessions** are held on the second and fourth Thursday of each month, from 12:00-1:00 PM Central Time. Provider shall attend the TxRx ECHO as members of the learning network.
- iii. Participating staff members should include clinical care team members.
- iv. Provider will lead at least one (1) case presentation during the term of this Agreement. BWTX will ensure appropriate technical assistance in presenting this case presentation.
- v. Provider will not be held responsible for attending any ECHO sessions cancelled by BWTX throughout the grant period or those that occur prior to the Provider's contract execution date.

O. Program and Quality Improvement Evaluations

- a. Provider shall complete evaluations for all training and technical assistance programs completed, including the TxRx ECHO, Texas Substance Use Symposium, and technical assistance. Provider will complete evaluations on or before the date indicated on individual evaluation forms and surveys.
- b. BWTX Event Attendance
 - i. Provider shall attend BWTX custom technical assistance or training events when determined by BWTX to be directly relevant for the provider and staff providing MOUD or related services. If it is not possible for the provider to attend, a video/audio recording will be made available.

P. Quality Management Requirements

Provider shall:

1. Provider shall comply with all applicable rules published in the Texas Administrative Code (TAC). Provider shall also comply with all applicable Texas Health and Safety Codes, including laws related to drug paraphernalia under Health & Safety Code Chapter 481.
2. BWTX will provide Quality Management (QM) and oversight as outlined in Texas Administrative Code Chapter 564 Quality Management, for all subcontractors performing activities required within Attachment A.
3. Providers shall be reviewed on their compliance with contract and regulatory requirements and delivery of client care at least once per Fiscal Year during the term of the contract.
4. Provider shall participate in onsite and/or desk reviews and continuous quality improvement (CQI) activities as defined and scheduled by BWTX which includes but not limited to data verification, performing reviews; and submitting supporting documentation and client records for review. Reviews may be conducted either announced or unannounced, as determined by BWTX.
5. Providers found to be underperforming or noncompliant as a result of the quality monitoring performed shall submit a Performance Improvement Plan (PIP) or Corrective Action Plan (CAP) with supporting documentation for every audit finding, as requested by BWTX. These PIPs are to be monitored for completion and effectiveness at a future date to be determined by BWTX.
6. Provider shall participate in and actively pursue CQI activities that support performance and outcomes improvement.
7. Provider shall respond to consultation recommendations by BWTX, which may include, but are not limited to the following:
 - a. Staffing training;
 - b. Self-monitoring activities guided by BWTX, including use of quality management tools by BWTX to identify compliance to contract and regulatory requirements and measure quality of the delivery of client care. A walkthrough of these audit tools is part of the Entrance Conference scheduled by BWTX at the beginning of the audit process for the Fiscal Year.
 - c. Monitoring of performance reports in HHSC's electronic clinical management system.

8. Provider shall maintain financial and programmatic performance records pertaining to but not limited to Spend Down: Expenses vs. Fiscal Year budget; Capacity vs. Allocated Census that is made available for inspection by BWTX, upon request.
9. Failure to comply with the terms and conditions of the agreement may result in termination of the agreement with or without prior notice. Please reference section 3 Termination Clause.
10. Provider shall maintain receipts for purchases for 7 years and will be subject to audit by BWTX. Failure to provide proof can result in refunding the monies to BWTX and a PIP.
11. Right to Access- The Provider shall allow UT Health, Texas Health and Human Services, State Auditor's Office (SAO), Office of Inspector General (OIG), and the Comptroller General of the United States, and any of their representatives, the right to access to inspect the work and the premises on which any work is performed and the right to audit the Provider in accordance with §200.300 of the OMB Uniform Guidance.
12. BWTX will develop a quarterly review schedule, and ensure all providers are reviewed at least once per fiscal year. BWTX shall document the Quality Management (QM) activities performed in the period being reported and include them in a section of the Quarterly Report. At a minimum, the QM activities section of the Quarterly Report should include the following: Date of review;
 - a. Name of contractor;
 - b. Unique subcontractor's Identifier for the review;
 - c. Type of review;
 - d. Name of staff conducted review;
 - e. List of findings;
 - f. Number of monitoring reviews conducted;
 - g. Types of monitoring reviews conducted;
 - h. Summary evaluation of findings and plan of oversight to facilitate compliance, if applicable;
 - i. Number and nature of complaints received with resolutions for the complaints; and
 - j. List of significant findings that must, at a minimum, include the following:
 - a. Immediate risk to health or safety;
 - b. Participant abuse, neglect, or exploitation;
 - c. Fraud, waste, or abuse reports; and
 - d. Report criminal activity of any subcontractor's staff.
13. BWTX will develop and utilize a quality management monitoring tool that must be completed to document all quality reviews. All completed tools with corrective actions documentation must be stored and made available to BWTX upon request.
14. BWTX will monitor all subcontracts to ensure compliance. The required Quality Management report will include activities to support the QM activities for this project.

Q. SUBMISSION SCHEDULE and REPORTING REQUIREMENTS

Provider shall:

- A. Submit all deliverables to Clinical Management Behavioral Health Services (CMBHS) and/or any alternative method required by Be Well Texas for documenting MOUD- related activities, services, and testing. Provider is required to maintain access to required systems or platforms for the term of this Grant Agreement
- B. Submit additional required deliverables for this contract upon request.
- C. Ensure the use of CMBHS components and/or functionality, in accordance with Be Well Texas instructions. Provider will use the updated components and/or functionality as directed. Provider's duty to submit documents survives the termination or expiration of this Contract.
- D. Ensure that the required number of clients are served per year based on the amount funded.
- E. Ensure the performance and submission of Governmental Performance and Results Act (GPRA) assessments in compliance with 107 Stat. 285 – Public Law No. 103-62 (08/03/1993) for all participants who are engaged in treatment services in the following manner:
 - 1. Assessments must be conducted face to face, unless a waiver is granted by the Be Well Texas
 - 2. Conduct the GPRA assessment immediately after the client is stabilized on medication or within four weeks after admission, whichever is sooner;
 - 3. The GPRA assessments must be completed at intake, six-month follow-up, and discharge. Additionally, the six-month follow-up must be conducted between months five through seven, depending on the client's availability. Subcontractor will use CMBHS to conduct, document and enter assessments as close to real time as possible. Provider will aim to upload their data into CMBHS within 1 day, but it must be entered into CMBHS no later than 7 days after the GPRA assessment is conducted;
 - 4. Maintenance of a minimum of 80% follow-up rate for the six-month assessment, regardless of discharge status (including closed cases, administrative discharges, and participants who have left the program); and,
 - 5. When directed by Be Well Texas, ensure a new initial GPRA assessments is performed for all clients in services at the beginning of each fiscal year.
- F. Note that if the due date is on a weekend or holiday, the due date is the following business day.
- G. Submitted documents will survive the termination or expiration of this Contract.
- H. Respond to requests and provide information and/or data meeting federal and state legislative requirements as requested and within the timelines specified.

- I. Monitor performance of the requirements in this Attachment and comply with the Contract's terms and conditions.
- J. Submit all documents listed in the table displayed in this section using the naming conventions provided by the stated due date.

Deliverable Type	Due Date	SUBMISSION
CMBHS Attestation Form, List of Authorized Users, if applicable, HHSC Cybersecurity and HIPPA Training Certificates.	15 th day after contract start date and April 15 th , and as requested	BeWellTXHelpDesk@uthscsa.edu
Monthly Capacity Report	10 th day of the following month	Monthly in CMBHS
Wait List	Daily, update as needed	CMBHS daily, as needed
GPRA Assessments	Ongoing	CMBHS
Closeout Documents	9/5/2026	Claims and GPRA Assessment final deadline entered in CMBHS
Claims	5 th calendar day for services rendered from previous month.	CMBHS
Quality Audit	TBD	BeWellTXQuality@uthscsa.edu
Monthly Conference Calls	Third Thursday of each month, from 10:00-11:00 AM Central Time	Attendance Required
TxRx ECHO Session	Second and fourth Thursday of each month, from 12:00-1:00 PM Central Time	Attendance Required (1 session per month)
MOUs		
Executed MOU with OSAR (Outreach, Screening, Assessment, Referral)	Upon request.	Provider will maintain documentation and provide to BWTX Quality upon request.
Executed MOU with LMHA/LBHA (Local Mental/Behavioral Health Authority)	Upon request.	Provider will maintain documentation and provide to BWTX Quality upon request.
Executed MOU with RSS (Recovery Support Services)	Upon request.	Provider will maintain documentation and provide to BWTX Quality upon request.
Executed MOU with COPSD (Co-Occurring Psychiatric Substance Abuse Disorder)	Upon request.	Provider will maintain documentation and provide to BWTX Quality upon request.
Executed MOU with FQHC (Federally Qualified Health Center)	Upon request.	Provider will maintain documentation and provide to BWTX Quality upon request.
Executed MOU with OBT (Office Based Opioid Treatment)	Upon request.	Provider will maintain documentation and provide to BWTX Quality upon request.
Executed MOU with Local Prevention Resource Center	Upon request.	Provider will maintain documentation and provide to BWTX Quality upon request.
Policies & Procedures		
Waitlist Policy & Procedure	Upon request.	BWTX Quality upon request.

Quality Monitoring Policy & Procedure	Upon request.	To be provided to BWTX Quality upon request.
Policy and Procedure on Criteria for Prescribed Medications	Upon request.	To be provided to BWTX Quality upon request.
Caseload Policy and Procedure	Upon request.	To be provided to BWTX Quality upon request.
Policy and Procedure on Client Retention for Services	Upon request.	To be provided to BWTX Quality upon request.
Policy and Procedure on a Marketing Plan to engage local referral sources and provide information to these sources	Upon request.	To be provided to BWTX Quality upon request.

ATTACHMENT A-1
PERFORMANCE AND OUTCOME MEASURES

A. PERFORMANCE MEASURES:

1. Provider is responsible for the measures for the programs Provider received funding, in accordance with the Section V, Budget, of the Contract Signature Document.
2. Provider's performance will be measured in part on the achievement of the key performance measures stated below.
3. Provider will ensure that Clients achieve sustained remission from the symptoms of their substance use disorder as indicated in **Table 1** below.
4. Provider shall ensure compliance to the following performance measures:

Table 1:

Medications for Opioid Use Disorder Treatment (MOUD) Program Services	Target
1. Number of unduplicated Clients served per state fiscal year	3,266
2. Percent of active Clients who complete OTS Survey at time of administration	70%
3. Percent of Clients receiving overdose prevention education	95%
4. Percent of Clients receiving naloxone	80%
5. Percent of Clients reporting engagement with Recovery Support Services in the state fiscal reporting year	50%

B. PERFORMANCE MEASURES METHODOLOGY

The MOUD Program services performance measures methodology are as follows:

1. Numbers Served
The target numbers served is calculated using **ATTACHMENT B, PROGRAM SERVICES UNIT RATES**, and the contracted funding amount.
2. Percent of active Clients who complete Opioid Treatment Services (OTS) Survey at time of administration.
 - a. The numerator is the number of OTS Surveys submitted.
 - b. The denominator is the total number of people that meet the following criteria:
 - i. Were actively enrolled in services for 60 days or more prior to taking the survey.
 - ii. Must have State Funding and a valid claim during the survey administration period.

3. Percent of clients receiving overdose prevention education:
 - a. The numerator is the number of clients that received overdose prevention education in one Fiscal Year on the annual OTS survey.
 - b. The denominator is the total number of new clients served at the time of the OTS survey conducted on an annual Fiscal Year basis.
4. Percent of clients receiving naloxone:
 - a. The numerator is the number of clients that received naloxone in one Fiscal Year on the annual OTS survey.
 - b. The denominator is the total number of new clients served at the time of the OTS survey conducted on an annual Fiscal Year basis.
5. Percent of clients reporting engagement with Recovery Support Services (RSS) in the state fiscal reporting year:
 - a. The numerator is the number of clients served who meet one or more of the following criteria:
 - i. Had an open recovery services case at any state-funded provider in the Clinical Management Behavioral Health System (CMBHS) (includes Recovery Services – Adult, Recovery Services – Adult – Texas Targeted Opioid Response (TTOR), and Recovery Services – Youth)
 - ii. Reported attendance at self-help groups or community support groups on their most recent Substance Use Disorder (SUD) assessment.
 - iii. Received a referral for Recovery Support Services in the Fiscal Year
 - b. The denominator is the total number of clients served in the Fiscal Year.

C. OUTCOME MEASURES

1. Provider must ensure compliance to the following outcome measures:

Medications for Opioid Use Disorder Treatment (MOUD) Program Services	Target
1. Percent of Clients whose length of stay is at least one (1) year	65%
2. Percent of Clients whose length of stay is at least six (6) months	80%
3. Percent of Clients with absence of drug use/misuse (including alcohol) in the state fiscal reporting year	60%
4. Percent of Clients with no arrest reported on most recent SUD assessment	90%
5. Percent of Clients reporting stable housing on most recent SUD assessment.	80%

6. Percent of Clients reporting as employed or enrolled in school on most recent SUD assessment.	50%

D. OUTCOME MEASURES METHODOLOGY

The MOUD Program services outcome measures methodology are as follows:

1. Percent of clients whose length of stay is at least one year:
 - a. The numerator is the number of clients served whose length of stay between their admission service begin date and service end date (or the last day of the Fiscal Year if still in services) is at least 365 days.
 - b. The denominator is the total number of clients served in the Fiscal Year, excluding active new clients who have not yet been in services for a year.
2. Percent of clients whose length of stay is at least six months:
 - a. The numerator is the number of clients served whose length of stay between their admission service begin date and service end date (or the last day of the Fiscal Year if still in services) is at least six months.
 - b. The denominator is the total number of clients served in the Fiscal Year, excluding active new clients who have not yet been in services for six months.
3. Percent of clients with absence of drug use/misuse (including alcohol) this year:
 - a. The numerator is the number of clients who report they have not used any substances for the past 30 days on their most recent SUD assessment, excluding assessments completed at intake.
 - b. The denominator is the total number of clients served in the Fiscal Year who had a valid SUD assessment and have been in services for at least six months.
4. Percent of clients with no arrest reported on most recent SUD assessment:
 - a. The numerator is the number of clients who report they have not been arrested in the past 30 days on their most recent SUD assessment, excluding assessments completed at intake.
 - b. The denominator is the total number of clients served in the Fiscal Year who had a valid SUD assessment and have been in services for at least six months.
5. Percent of clients reporting stable housing on most recent SUD assessment:
 - a. The numerator is the number of clients who report their living situation was “Independent” or “Dependent” on their most recent SUD assessment, excluding assessments completed at intake.
 - b. The denominator is the total number of clients served in the Fiscal Year who had a valid SUD assessment and have been in services for at least six months.

6. Percent of clients reporting as employed or enrolled in school on most recent SUD assessment:
 - a. The numerator is the number of clients who report they were currently in school or were enrolled full time or part time on their most recent SUD assessment, excluding assessments completed at intake.
 - b. The denominator is the total number of clients served in the Fiscal Year who had a valid SUD assessment and have been in services for at least six months, excluding Clients who reported they were “Not in the Labor Force.”

**ATTACHMENT B
PROGRAM SERVICES AND UNIT RATES**

- I.** Provider will submit all service claims through CMBHS monthly. Services claims submitted through CMBHS by Provider will be utilized by Be Well Texas to generate reimbursement to Provider. By execution of this agreement, Provider certifies and attests that all service claims submitted through CMBHS are true, complete and accurate. Provider is aware that any false, fictitious, or fraudulent submission may subject Provider to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise in accordance with U.S. Code Title 18, Section 1001 and Title 31, Sections 3729-3730 and 3801-3812. In addition, all submitted services entered into CMBHS by Provider will be made in accordance with the conditions of this agreement and will be subject to audit by Be Well Texas, Texas Health and Human Services or a third party.
- II.** Provider shall maintain receipts for purchases for 7 years and will be subject to audit by BWTX. Failure to provide proof can result in refunding the monies to BWTX and a PIP.

III. Funded Capacity

Funded capacity is defined as the stated number of clients who will be concurrently served as determined by this Contract.

Funded Capacity*	Budget*
600	\$5,419,473.36
<i>*Subject to change</i>	

IV. Service Unit Rates

The Treatment Rate Sheet link below is subject to change and contingent on available funding.

<https://www.hhs.texas.gov/providers/behavioral-health-services-providers/substance-use-service-providers>

V. Invoice and Payment

Provider shall generate billable medication service notes and/or billable progress notes to BWTX through the Clinical Management for Behavioral Health Services (CMBHS) System after services are rendered. Monthly claims shall be generated by the 5th calendar day in CMBHS. Provider will be reimbursed for services provided under this Contract utilizing the established unit rates. The final deadline to generate billable medication service notes and/or billable progress notes to BWTX through CMBHS for the grant term will be no later than 9/15/2026.

VI. Recapture of Funds

At its sole discretion, BWTX may withhold all or part of any payment to the Provider to offset overpayments, unallowable or ineligible costs made to the Provider, or require Provider to promptly refund or credit within (30) calendar days of written notice any funds erroneously paid by BWTX which are not expressly authorized under the Contract.

VII. Claims and Payment Requirements

- a. Provider will demonstrate their capacity to bill insurance and Medicaid for those clients with insurance coverage. Funds under the Contract can only be used as payment of last resort, which means that other applicable reimbursement resources such as Medicaid or other third-party payors will be billed first.
- b. If the client has Medicaid or other third-party payors and does cover Medication Assisted Treatment, the client will not qualify for funding under this grant.
- c. If the client has Medicaid or other third-party payors' insurance, but does not cover Medication Assisted Treatment, the client may still qualify for funding under this grant but will need to provide documentation Medication Assisted Treatment is not covered under their Medicaid or other third-party payor insurance.
- d. Provider shall operate within the funded capacity and awarded budget amount indicated in this Contract for the duration of the contract term.
- e. Submitted claims in excess of the Provider's stated funded capacity will be approved for payment based on availability of funds, and contingent upon approval of a subsequent amendment.
- f. BWTX, at its sole discretion, will adjust the funded capacity of this Contract based on Provider's performance and/or other criteria determined by BWTX, and contingent on availability of funds.
- g. Provider shall not exceed the awarded budget as indicated in this Contract for the duration of the contract term unless approved by the BWTX team.
- h. Except as indicated by the CMBHS financial eligibility assessment, Provider will accept reimbursement or payment from BWTX as payment in full for services or goods provided to clients or participants, and Provider will not seek additional reimbursement or payment for services or goods, to include benefits received from federal, state, or local sources, from clients or participants.
- i. Document all specified required activities and services in the Clinical Management for Behavioral Health Services (CMBHS) system.
- j. Document Financial Eligibility appropriately in CMBHS before charging any individuals for screening and assessment. Provider will not require payments from individuals determined by the Financial Eligibility function of CMBHS to be eligible for state-funded services for screening and assessments.
- k. Ensure requirements of Texas residency eligibility, Financial Eligibility, and clinical eligibility are met, as determined by CMBHS client profile, CMBHS SUD assessment, and financial eligibility documentation in CMBHS.
- l. If the client is eligible for state-funded services determined by the Financial Eligibility documented by the Provider in CMBHS;
- m. Provider shall upload proof of income and proof of residency in CMBHS under Financial Eligibility.
- n. Provider shall run the MEV every 30 days and prior to the 5th calendar day of each month. It is the provider's responsibility to ensure that claims entered into CMBHS are not eligible for Medicaid, Medicare, or any third party insurance.
- o. Please note, the client is not eligible for BWTX-funded services until all required documentation is submitted as referenced above.

- p. Failure to comply with the financial eligibility documentation, and MEV requirements will result in an audit finding. A PIP will follow to provide additional training and assistance.

VIII. Third-Party Payors

- a. Provider shall not seek reimbursement from BWTX if the individual is covered by a third-party payor.
- b. Demonstrate the capacity to bill insurance, Medicaid, and/or Medicare for individuals with health insurance coverage.
- c. Contract with Medicaid and the identified Managed Care Organizations in service delivery Region.
- d. Contract with Medicare in the service delivery region.
- e. Refer individuals to a treatment Program that is approved by the individual's third-party payor if Provider is not eligible for reimbursement.
- f. If the approved treatment Program refuses treatment services to the Client and documents that refusal, Provider may provide treatment services and bill BWTX; The refusal, including third-party payor and approved treatment Program, shall be documented in the Client file;
- g. The Client meets the diagnostic criteria for substance use disorder; and
- h. If Client's third-party payor would cover or approves partial or full payment for treatment services, Provider may bill BWTX for the non-reimbursed costs, including the deductible, provided:
- i. The Client's parent/guardian refuses to file a claim with the third party payor, or refuses to pay either the deductible or the non-reimbursed portion of the cost of treatment, and Provider has obtained a signed statement from the parent/guardian of refusal to pay, and Provider has received written approval from the BWTX substance use disorder treatment Program services clinical coordinator to bill for the deductible or non-reimbursed portion of the cost;
- j. The Client or parent/guardian cannot afford to pay the deductible or the non-reimbursed portion of the cost of treatment; or
- k. The Client or parent/guardian has an adjusted income at or below 200% of the Federal poverty guidelines.
- l. If a Client has exhausted all insurance coverage and requires continued treatment, Provider may provide the continued treatment services and bill BWTX if the Client meets the priority population mentioned under Service Delivery in the statement of work.

**ATTACHMENT C
DATA USE AGREEMENT**

The University of Texas Health Science Center at San Antonio (“UTHSA”) has contracted with North Texas Behavioral Health Authority (“Provider”) for performance of services on behalf of UT Health San Antonio which are subject to the Data Use Agreement (“DUA”). Provider acknowledges, understands and agrees to be bound by the identical terms and conditions applicable to UT Health San Antonio under the DUA, incorporated by reference in this Agreement, with respect to Texas Department of Health and Human Services (“HHSC”) Confidential Information. UTHSA and Provider agree that HHSC is a third-party beneficiary to applicable provisions of the subcontract.

HHSC has the right but not the obligation to review or approve the terms and conditions of the services agreement by virtue of this Data Use Agreement.

UT Health San Antonio and Provider assure HHSC that any Breach or Event as defined by the DUA that Provider discovers will be reported to HHSC by UTHSA in the time, manner and content required by its DUA with HHSC.

If UTHSA knows or should have known in the exercise of reasonable diligence of a pattern of activity or practice by Provider that constitutes a material breach or violation of the DUA or the Provider’s obligations UTHSA will:

1. Take reasonable steps to cure the violation or end the violation, as applicable;
2. If the steps are unsuccessful, terminate the service agreement with Provider, if feasible;
3. Notify HHSC immediately upon reasonably discovery of the pattern of activity or practice of Provider that constitutes a material breach or violation of the DUA and keep HHSC reasonably and regularly informed about steps UTHSA is taking to cure or end the violation or terminate Provider agreement or arrangement.

**The University of Texas Health
Science Center at San Antonio**

By: _____

Name: _____

Title: _____

Date: _____

North Texas Behavioral Health Authority

By: _____

Name: **Carol Lucky**

Title: **Chief Executive Officer**

Date: _____

ATTACHMENT D
BUSINESS ASSOCIATE AGREEMENT

Provider certifies that it is a HIPAA Covered Entity: Yes ☐ No ☐

(If yes, skip section below entitled, Business Associate Agreement)

Business Associate Agreement

This Business Associate Agreement (the “Agreement”) by and between Business Associate and Covered Entity (collectively the “Parties”) to comply with privacy standards adopted by the U.S. Department of Health and Human Services as they may be amended from time to time, 45 C.F.R. parts 160 and 164 (“the Privacy Rule”) and security standards adopted by the U.S. Department of Health and Human Services as they may be amended from time to time, 45 C.F.R. parts 160, 162 and 164, subpart C (“the Security Rule”), and the Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and regulations promulgated there under and any applicable state confidentiality laws.

RECITALS

WHEREAS, Business Associate provides services to or on behalf of Covered Entity;

WHEREAS, in connection with these services, Covered Entity discloses to Business Associate certain protected health information that is subject to protection under the HIPAA Rules; and

WHEREAS, the HIPAA Rules require that Covered Entity receive adequate assurances that Business Associate will comply with certain obligations with respect to the PHI received in the course of providing services to or on behalf of Covered Entity.

NOW THEREFORE, in consideration of the mutual promises and covenants herein, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree as follows:

- A. **Definitions.** Terms used herein, but not otherwise defined, shall have meaning ascribed by the Privacy Rule and the Security Rule.
1. **Breach.** “Breach” shall have the same meaning as the term “breach” in 45 C.F.R. §164.502.
 2. **Business Associate.** “Business Associate” shall mean **North Texas Behavioral Health Authority**.
 3. **Covered Entity.** “Covered Entity” shall mean **The University of Texas Health Science Center at San Antonio**.
 4. **Designated Record Set.** “Designated Record Set” shall mean a group of records maintained by or for a Covered Entity that is: (i) the medical records and billing records about Individuals maintained by or for a covered health care provider; (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) used, in whole or in part, by or for the covered entity to make decisions about Individuals. For purposes of this definition, the term “record” means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

5. HIPAA Rules. The Privacy Rule and the Security Rule and amendments codified and promulgated by the HITECH Act are referred to collectively herein as “HIPAA Rules.”
 6. Individual. “Individual” shall mean the person who is the subject of the protected health information.
 7. Protected Health Information (“PHI”). “Protected Health Information” or PHI shall have the same meaning as the term “protected health information” in 45 C.F.R. §160.103, limited to the information created, received, maintained or transmitted by Business Associate from or on behalf of covered entity pursuant to this Agreement.
 8. Required by Law. “Required by Law” shall mean a mandate contained in law that compels a use or disclosure of PHI.
 9. Secretary. “Secretary” shall mean the Secretary of the Department of Health and Human Services or his or her Designee.
 10. Sensitive Personal Information. “Sensitive Personal Information” shall mean an individual’s first name or first initial and last name in combination with any one or more of the following items, if the name and the items are not encrypted: a) social security number; driver’s license number or government-issued identification number; or account number or credit or debit card number in combination with any required security code, access code, or password that would permit access to an individual’s financial account; or b) information that identifies an individual and relates to: the physical or mental health or condition of the individual; the provision of health care to the individual; or payment for the provision of health care to the individual.
 11. Provider. “Provider” shall have the same meaning as the term “Contractor” in 45 C.F.R. §160.103.
 12. Unsecured PHI. “Unsecured PHI” shall mean PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
- B. Purposes for which PHI May Be Disclosed to Business Associate. In connection with the services provided by Business Associate to or on behalf of Covered Entity described in this Agreement, Covered Entity may disclose PHI to Business Associate for the purposes of providing services to alleviate the adverse physiological effects withdrawal from the use of opioids as required to meet the needs of the patient.
- C. Obligations of Covered Entity. If deemed applicable by Covered Entity, Covered Entity shall:
1. provide Business Associate a copy of its Notice of Privacy Practices (“Notice”) produced by Covered Entity in accordance with 45 C.F.R. 164.520 as well as any changes to such Notice;
 2. provide Business Associate with any changes in, or revocation of, authorizations by Individuals relating to the use and/or disclosure of PHI, if such changes affect Business Associate’s permitted or required uses and/or disclosures;
 3. notify Business Associate of any restriction to the use and/or disclosure of PHI to which Covered Entity has agreed in accordance with 45 C.F.R. 164.522, to the extent that such restriction may affect Business Associate’s use or disclosure of PHI;
 4. not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy rule if done by the Covered entity;

5. notify Business Associate of any amendment to PHI to which Covered Entity has agreed that affects a Designated Record Set maintained by Business Associate;
6. if Business Associate maintains a Designated Record Set, provide Business Associate with a copy of its policies and procedures related to an Individual's right to: access PHI; request an amendment to PHI; request confidential communications of PHI; or request an accounting of disclosures of PHI; and, notify individuals of breach of their Unsecured PHI in accordance with the requirements set forth in 45 C.F.R. §164.404.

D. Obligations of Business Associate. Business Associate agrees to comply with applicable federal and state confidentiality and security laws, specifically the provisions of the HIPAA Rules applicable to business associates, including:

1. Use and Disclosure of PHI. Except as otherwise permitted by this Agreement or applicable law, Business Associate shall not use or disclose PHI except as necessary to provide Services described above to or on behalf of Covered Entity, and shall not use or disclose PHI that would violate the HIPAA Rules if used or disclosed by Covered Entity. Also, knowing that there are certain restrictions on disclosure of PHI. Provided, however, Business Associate may use and disclose PHI as necessary for the proper management and administration of Business Associate, or to carry out its legal responsibilities. Business Associate shall in such cases:
 - (a) provide information and training to members of its workforce using or disclosing PHI regarding the confidentiality requirements of the HIPAA Rules and this Agreement;
 - (b) obtain reasonable assurances from the person or entity to whom the PHI is disclosed that: (a) the PHI will be held confidential and further used and disclosed only as Required by Law or for the purpose for which it was disclosed to the person or entity; and (b) the person or entity will notify Business Associate of any instances of which it is aware in which confidentiality of the PHI has been breached; and
 - (c) agree to notify the designated Privacy Officer of Covered Entity of any instances of which it is aware in which the PHI is used or disclosed for a purpose that is not otherwise provided for in this Agreement or for a purpose not expressly permitted by the HIPAA Rules.
2. Data Aggregation. In the event that Business Associate works for more than one Covered Entity, Business Associate is permitted to use and disclose PHI for data aggregation purposes, however, only in order to analyze data for permitted health care operations, and only to the extent that such use is permitted under the HIPAA Rules.
3. De-identified Information. Business Associate may use and disclose de-identified health information if written approval from the Covered Entity is obtained, and the PHI is de-identified in compliance with the HIPAA Rules. Moreover, Business Associate shall review and comply with the requirements defined under Section E. of this Agreement.
4. Safeguards.
 - (a) Business Associate shall maintain appropriate safeguards to ensure that PHI is not used or disclosed other than as provided by this Agreement or as Required by Law. Business Associate shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any paper or electronic PHI it creates, receives, maintains, or transmits on behalf of Covered Entity.

- (b) Business Associate shall assure that all PHI be secured when accessed by Business Associate's employees, agents or Provider. Any access to PHI by Business Associate's employees, agents or Provider's shall be limited to legitimate business needs while working with PHI. Any personnel changes by Business Associate, eliminating the legitimate business needs for employees, agents or contractors access to PHI – either by revision of duties or termination – shall be immediately reported to Covered Entity. Such reporting shall be made no later than the third business day after the personnel change becomes effective.
- 5. Minimum Necessary. Business Associate shall ensure that all uses and disclosures of PHI are subject to the principle of “minimum necessary use and disclosure,” i.e., that only PHI that is the minimum necessary to accomplish the intended purpose of the use, disclosure, or request is used or disclosed; and, the use of limited data sets when possible.
- 6. Disclosure to Agents and Provider's. If Business Associate discloses PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, to agents, including a Contractor, Business Associate shall require the agent or Contractor to agree to the same restrictions and conditions as apply to Business Associate under this Agreement. Business Associate shall ensure that any agent, including a Contractor, agrees to implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of the paper or electronic PHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity. Business Associate shall be liable to Covered Entity for any acts, failures or omissions of the agent or Contractor in providing the services as if they were Business Associate's own acts, failures or omissions, to the extent permitted by law. Business Associate further expressly warrants that its agents or Provider's will be specifically advised of, and will comply in all respects with, the terms of this Agreement.
- 7. Individual Rights Regarding Designated Record Sets. If Business Associate maintains a Designated Record Set on behalf of Covered Entity Business Associate agrees as follows:
 - (a) Individual Right to Copy or Inspection. Business Associate agrees that if it maintains a Designated Record Set for Covered Entity that is not maintained by Covered Entity, it will permit an Individual to inspect or copy PHI about the Individual in that set as directed by Covered Entity to meet the requirements of 45 C.F.R. § 164.524. If the PHI is in electronic form, the Individual shall have a right to obtain a copy of such information in electronic form and, if the Individual chooses, to direct that an electronic copy be transmitted directly to an entity or person designated by the individual in accordance with HITECH section 13405 (c). Under the Privacy Rule, Covered Entity is required to take action on such requests as soon as possible, but not later than 30 days following receipt of the request. Business Associate agrees to make reasonable efforts to assist Covered Entity in meeting this deadline. The information shall be provided in the form or form requested if it is readily producible in such form or form; or in summary, if the Individual has agreed in advance to accept the information in summary form. A reasonable, cost-based fee for copying health information may be charged. If Covered Entity maintains the requested records, Covered Entity, rather than Business Associate shall permit access according to its policies and procedures implementing the Privacy Rule.
 - (b) Individual Right to Amendment. Business Associate agrees, if it maintains PHI in a Designated Record Set, to make amendments to PHI at the request and direction of Covered Entity pursuant to 45 C.F.R. §164.526. If Business Associate maintains a record in a Designated Record Set that is not also maintained by Covered Entity, Business Associate agrees that it will accommodate an Individual's request to amend PHI only in conjunction

with a determination by Covered Entity that the amendment is appropriate according to 45 C.F.R. §164.526.

- (c) Accounting of Disclosures. Business Associate agrees to maintain documentation of the information required to provide an accounting of disclosures of PHI, whether PHI is paper or electronic for, in accordance with 45 C.F.R. §164.528 and HITECH Sub Title D Title VI Section 13405 (c), and to make this information available to Covered Entity upon Covered Entity's request, in order to allow Covered Entity to respond to an Individual's request for accounting of disclosures. Under the Privacy Rule, Covered Entity is required to take action on such requests as soon as possible but not later than 60 days following receipt of the request. Business Associate agrees to use its best efforts to assist Covered Entity in meeting this deadline but not later than 45 days following receipt of the request. Such accounting must be provided without cost to the individual or Covered Entity if it is the first accounting requested by an individual within any 12 month period; however, a reasonable, cost-based fee may be charged for subsequent accountings if Business Associate informs the individual in advance of the fee and is afforded an opportunity to withdraw or modify the request. Such accounting is limited to disclosures that were made in the six (6) years prior to the request (not including disclosures prior to the compliance date of the Privacy Rule) and shall be provided for as long as Business Associate maintains the PHI.
8. Internal Practices, Policies and Procedures. Except as otherwise specified herein, Business Associate shall make available its internal practices, policies and procedures relating to the use and disclosure of PHI, received from or on behalf of Covered Entity to the Secretary or his or her agents for the purpose of determining Covered Entity's compliance with the HIPAA Rules, or any other health oversight agency, or to Covered Entity. Records requested that are not protected by an applicable legal privilege will be made available in the time and manner specified by Covered Entity or the Secretary.
9. Notice of Privacy Practices. Business Associate shall abide by the limitations of Covered Entity's Notice of which it has knowledge. Any use or disclosure permitted by this Agreement may be amended by changes to Covered Entity's Notice; provided, however, that the amended Notice shall not affect permitted uses and disclosures on which Business Associate relied prior to receiving notice of such amended Notice.
10. Withdrawal of Authorization. If the use or disclosure of PHI in this Agreement is based upon an Individual's specific authorization for the use or disclosure of his or her PHI, and the Individual revokes such authorization, the effective date of such authorization has expired, or such authorization is found to be defective in any manner that renders it invalid, Business Associate shall, if it has notice of such revocation, expiration, or invalidity, cease the use and disclosure of the Individual's PHI except to the extent it has relied on such use or disclosure, or if an exception under the Privacy Rule expressly applies.
11. Knowledge of HIPAA Rules. Business Associate agrees to review and understand the HIPAA Rules as it applies to Business Associate, and to comply with the applicable requirements of the HIPAA Rule, as well as any applicable amendments.
12. Information Breach Notification for PHI. Business Associate expressly recognizes that Covered Entity has certain reporting and disclosure obligations to the Secretary and the Individual in case of a security breach of unsecured PHI. Where Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses or discloses unsecured paper or electronic PHI, Business Associate immediately following the "discovery" (within the meaning of 45 C.F.R.

§164.410(a)) of a breach of such information, shall notify Covered Entity of such breach. Initial notification of the breach does not need to be in compliance with 45 C.F.R. §164.404(c); however, Business Associate must provide Covered Entity with all information necessary for Covered Entity to comply with 45 C.F.R. §164.404(c) without reasonable delay, and in no case later than 30 days following the discovery of the breach. Business Associate shall be liable for the costs associated with such breach if caused by the Business Associate's negligent or willful acts or omissions, or the negligent or willful acts or omissions of Business Associate's agents, officers, employees or Provider's.

13. Breach Notification to Individuals. Business Associate's duty to notify Covered Entity of any breach does not permit Business Associate to notify those individuals whose PHI has been breached by Business Associate without the express written permission of Covered Entity to do so. Any and all notification to those individuals whose PHI has been breached shall be made under the direction, review and control of Covered Entity. The Business Associate will notify the Privacy Officer via telephone with follow-up in writing to include; name of individuals whose PHI was breached, information breached, date of breach, form of breach, etc. The cost of the notification will be paid by the Business Associate.
14. Information Breach Notification for Other Sensitive Personal Information. In addition to the reporting under Section D.12, Business Associate shall notify Covered Entity of any breach of computerized Sensitive Personal Information (as determined pursuant to Title 11, subtitle B, chapter 521, Subchapter A, Section 521.053. Texas Business & Commerce Code) to assure Covered Entity's compliance with the notification requirements of Title 11, Subtitle B, Chapter 521, Subchapter A, Section 521.053, Texas Business & Commerce Code. Accordingly, Business Associate shall be liable for all costs associated with any breach caused by Business Associate's negligent or willful acts or omissions, or those negligent or willful acts or omissions of Business Associate's agents, officers, employees or Provider's.

E. Permitted Uses and Disclosures by Business Associates. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Business Associates Agreement or in a Master Services Agreement, provided that such use or disclosure would not violate the HIPAA Rules if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity. Also, Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with the HIPAA Rules.

1. Use. Business Associate will not, and will ensure that its directors, officers, employees, contractors and other agents do not, use PHI other than as permitted or required by Business Associate to perform the Services or as required by law, but in no event in any manner that would constitute a violation of the Privacy Standards or Security standards if used by Covered Entity.
2. Disclosure. Business Associate will not, and will ensure that its directors, officers, employees, contractors, and other agents do not, disclose PHI other than as permitted pursuant to this arrangement or as required by law, but in no event disclose PHI in any manner that would constitute a violation of the Privacy Standards or Security Standards if disclosed by Covered Entity.
3. Business Associate acknowledges and agrees that Covered Entity owns all right, title, and interest in and to all PHI, and that such right, title, and interest will be vested in Covered Entity. Neither Business Associate nor any of its employees, agents, consultants or assigns will have any rights in any of the PHI, except as expressly set forth above. Business Associate represents, warrants, and covenants that it will not compile and/or distribute analyses to third parties using any PHI without Covered Entity's express written consent.

F. Application of Security and Privacy Provisions to Business Associate.

1. Security Measures. Sections 164.308, 164.310, 164.312 and 164.316 of Title 45 of the Code of Federal Regulations dealing with the administrative, physical and technical safeguards as well as policies, procedures and documentation requirements that apply to Covered Entity shall in the same manner apply to Business Associate. Any additional security requirements contained in Sub Title D of Title IV of the HITECH Act that apply to Covered Entity shall also apply to Business Associate. Pursuant to the foregoing requirements in this section, the Business Associate will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the paper or electronic PHI that it creates, has access to, or transmits. Business Associate will also ensure that any agent, including a Provider, to whom it provides such information, agrees to implement reasonable and appropriate safeguards to protect such information. Business Associate will ensure that PHI contained in portable devices or removable media is encrypted.
2. Annual Guidance. For the first year beginning after the date of the enactment of the HITECH Act and annually thereafter, the secretary shall annually issue guidance on the most effective and appropriate technical safeguards for use in carrying out the sections referred to in subsection (a) and the security standards in subpart C of part 164 of title 45, Code of Federal Regulations. Business Associate shall, at their own cost and effort, monitor the issuance of such guidance and comply accordingly.
3. Privacy Provisions. The enhanced HIPAA privacy requirements including but not necessarily limited to accounting for certain PHI disclosures for treatment, restrictions on the sale of PHI, restrictions on marketing and fundraising communications, payment and health care operations contained Subtitle D of the HITECH Act that apply to the Covered entity shall equally apply to the Business Associate.
4. Application of Civil and Criminal Penalties. If Business Associate violates any security or privacy provision specified in subparagraphs (1) and (2) above, sections 1176 and 1177 of the Social Security Act (42 U.S.C. 1320d-5, 1320d-6) shall apply to Business Associate with respect to such violation in the same manner that such sections apply to Covered Entity if it violates such provisions.

G. Term and Termination.

1. Term. This Agreement shall be effective as of the Effective Date and shall be terminated when all PHI provided to Business Associate by Covered Entity, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity.
2. Termination for Cause. Upon Covered entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
 - a. Provide an opportunity for Business associate to cure the breach or end the violation and terminate this Agreement, whether it is in the form of a standalone agreement or an addendum to a Master Services Agreement, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or
 - b. Immediately terminate this Agreement whether it is in the form of a standalone agreement or an addendum to a Master Services Agreement if Business associate has breached a material term of this Agreement and cure is not possible.
3. Effect of Termination. Upon termination of this Agreement for any reason, Business Associate agrees to return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, maintained by Business Associate in any form. If Business Associate determines that the return or destruction of PHI is not feasible, Business Associate shall inform Covered Entity in writing of the reason thereof, and shall agree to extend the protections of this Agreement to such PHI and limit

further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI not feasible for so long as Business Associate retains the PHI.

H. Miscellaneous.

1. Indemnification. To the extent permitted by law, Business Associate agrees to indemnify and hold harmless Covered Entity from and against all claims, demands, liabilities, judgments or causes of action of any nature for any relief, elements of recovery or damages recognized by law (including, without limitation, attorney's fees, defense costs, and equitable relief), for any damage or loss incurred by Covered Entity arising out of, resulting from, or attributable to any acts or omissions or other conduct of Business Associate or its agents in connection with the performance of Business Associate's or its agents' duties under this Agreement. This indemnity shall apply even if Covered Entity is alleged to be solely or jointly negligent or otherwise solely or jointly at fault; provided, however, that a trier of fact finds Covered Entity not to be solely or jointly negligent or otherwise solely or jointly at fault. This indemnity shall not be construed to limit Covered Entity's rights, if any, to common law indemnity.

Covered Entity shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of Business Associate. Covered Entity shall provide Business Associate with timely notice of the existence of such proceedings and such information, documents and other cooperation as reasonably necessary to assist Business Associate in establishing a defense to such action.

These indemnities shall survive termination of this Agreement, and Covered Entity reserves the right, at its option and expense, to participate in the defense of any suit or proceeding through counsel of its own choosing.

2. Mitigation. If Business Associate violates this Agreement or either of the HIPAA Rules, Business Associate agrees to mitigate any damage caused by such breach.
3. Rights of Proprietary Information. Covered Entity retains any and all rights to the proprietary information, confidential information, and PHI it releases to Business Associate.
4. Survival. The respective rights and obligations of Business Associate under Section E.3 of this Agreement shall survive the termination of this Agreement.
5. Notices. Any notices pertaining to this Agreement shall be given in writing and shall be deemed duly given when personally delivered to a Party or a Party's authorized representative as listed below or sent by means of a reputable overnight carrier, or sent by means of certified mail, return receipt requested, postage prepaid. A notice sent by certified mail shall be deemed given on the date of receipt or refusal of receipt. All notices shall be addressed to the appropriate Party as follows: If to Covered Entity:

The University of Texas Health
Science Center at San Antonio
Office of Sponsored Programs
Attention: AVP, Sponsored
Programs 7703 Floyd Curl
Drive, MSC 7828 San Antonio,
Texas 78229-3900 Phone
Number: 210-567-2340
Email: grants@uthscsa.edu

If to Business Associate:

North Texas Behavioral Health Authority

8111 LBJ Freeway, Ste. 900

Dallas, TX 75251

Attn: Carol Lucky

Phone Number: 214-366-9407

Email: clucky@ntbha.org

6. Amendments. This Agreement may not be changed or modified in any manner except by an instrument in writing signed by a duly authorized officer of each of the Parties hereto. The Parties, however, agree to amend this Agreement from time to time as necessary, in order to allow Covered Entity's to comply with the requirements of the HIPAA Rules.
7. Choice of Law. This Agreement and the rights and the obligations of the Parties hereunder shall be governed by and construed under the laws of the State of Texas, without regard to applicable conflict of laws principles.
8. Assignment of Rights and Delegation of Duties. This Agreement is binding upon and inures to the benefit of the Parties hereto and their respective successors and permitted assigns. However, neither Party may assign any of its rights or delegate any of its obligations under this Agreement without the prior written consent of the other Party, which consent shall not be unreasonably withheld or delayed. Notwithstanding any provisions to the contrary, however, Covered Entity retains the right to assign or delegate any of its rights or obligations hereunder to any of its wholly owned subsidiaries, affiliates or successor companies. Assignments made in violation of this provision are null and void.
9. Nature of Agreement. Nothing in this Agreement shall be construed to create (i) a partnership, joint venture or other joint business relationship between the Parties or any of their affiliates, (ii) any fiduciary duty owed by one Party to another Party or any of its affiliates, or (iii) a relationship of employer and employee between the Parties.
10. No Waiver. Failure or delay on the part of either Party to exercise any right, power, privilege or remedy hereunder shall not constitute a waiver thereof. No provision of this Agreement may be waived by either Party except by a writing signed by an authorized representative of the Party making the waiver.
11. Equitable Relief. Any disclosure of misappropriation of PHI by Business Associate in violation of this Agreement will cause Covered Entity irreparable harm, the amount of which may be difficult to ascertain. Business Associate therefore agrees that Covered Entity shall have the right to apply to a court of competent jurisdiction for specific performance and/or an order restraining and enjoining Business Associate from any such further disclosure or breach, and for such other relief as Covered Entity shall deem appropriate. Such rights are in addition to any other remedies available to Covered Entity at law or in equity. Business Associate expressly waives the defense that a remedy in damages will be adequate, and further waives any requirement in an action for specific performance or injunction for the posting of a bond by Covered Entity.

12. Severability. The provisions of this Agreement shall be severable, and if any provision of this Agreement shall be held or declared to be illegal, invalid or unenforceable, the remainder of this Agreement shall continue in full force and effect as though such illegal, invalid or unenforceable provision had not been contained herein.
13. No Third Party Beneficiaries. Nothing in this Agreement shall be considered or construed as conferring any right or benefit on a person not party to this Agreement nor imposing any obligations on either Party hereto to persons not a party to this Agreement.
14. Headings. The descriptive headings of the articles, sections, subsections, exhibits and schedules of this Agreement are inserted for convenience only, do not constitute a part of this Agreement and shall not affect in any way the meaning or interpretation of this Agreement.
15. Entire Agreement. This Agreement, together with all Exhibits, Riders and amendments, if applicable, which are fully completed and signed by authorized persons on behalf of both Parties from time to time while this Agreement is in effect, constitutes the entire Agreement between the Parties hereto with respect to the subject thereof and supersedes all previous written or oral understandings, agreements, negotiations, commitments, and any other writing and communication by or between the Parties with respect to the subject thereof. In the event of any inconsistencies between any provisions of this Agreement in any provisions of the Exhibits, Riders, or amendments, the provisions of this Agreement shall control.
16. Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Rules and any applicable state confidentiality laws. The provisions of this Agreement shall prevail over the provisions of any other agreement that exists between the Parties that may conflict with, or appear inconsistent with, any provision of this Agreement or the HIPAA Rules.
17. Regulatory References. A citation in this Agreement to the Code of Federal Regulations shall mean the cited section as that section may be amended from time to time.

Agreed to:

COVERED ENTITY

By: _____
(Authorized Signature)

Name: Chris G. Green, CPA
(Type or Print)

Title: AVP, Sponsored Programs

Date: _____

BUSINESS ASSOCIATE

By: _____
(Authorized Signature)

Name: Carol Lucky
(Type or Print)

Title: Chief Executive Officer

Date: _____

ATTACHMENT E
QUALIFIED SERVICE ORGANIZATION AGREEMENT (QSOA)

The University of Texas Health Science Center at San Antonio (“UTHSA”) on behalf of the Be Well Texas Clinic and North Texas Behavioral Health Authority (“Provider”) agree that this Agreement constitutes a Qualified Service Organization Agreement (“QSOA”) as required by 42 C.F.R. Part 2.

Accordingly, Provider agrees to provide the services outlined in the Services Agreement (“Agreement”) between such Parties. Information obtained by Provider relating to individuals who may have been diagnosed as needing, or who have received substance use disorder treatment services shall be maintained and used only for the purposes intended under this QSOA and in conformity with all applicable provisions of 42 USC 290dd-2 and the underlying federal regulations, 42 C.F.R. Part 2.

Furthermore, Provider:

- (1) Acknowledges that in receiving, storing, processing and otherwise dealing with any information from the UTHSA Part 2 Program about the patients in the Part 2 Program, it is fully bound by the provisions of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; and
- (2) Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for the Federal Confidentiality Regulations, 42 C.F.R. Part 2.

IN WITNESS WHEREOF, an authorized officer of each Party has duly executed and delivered this QSOA effective as of the date set forth below:

**The University of Texas Health
Science Center at San Antonio**

North Texas Behavioral Health Authority

By: _____

By: _____

Name: _____

Name: Carol Lucky

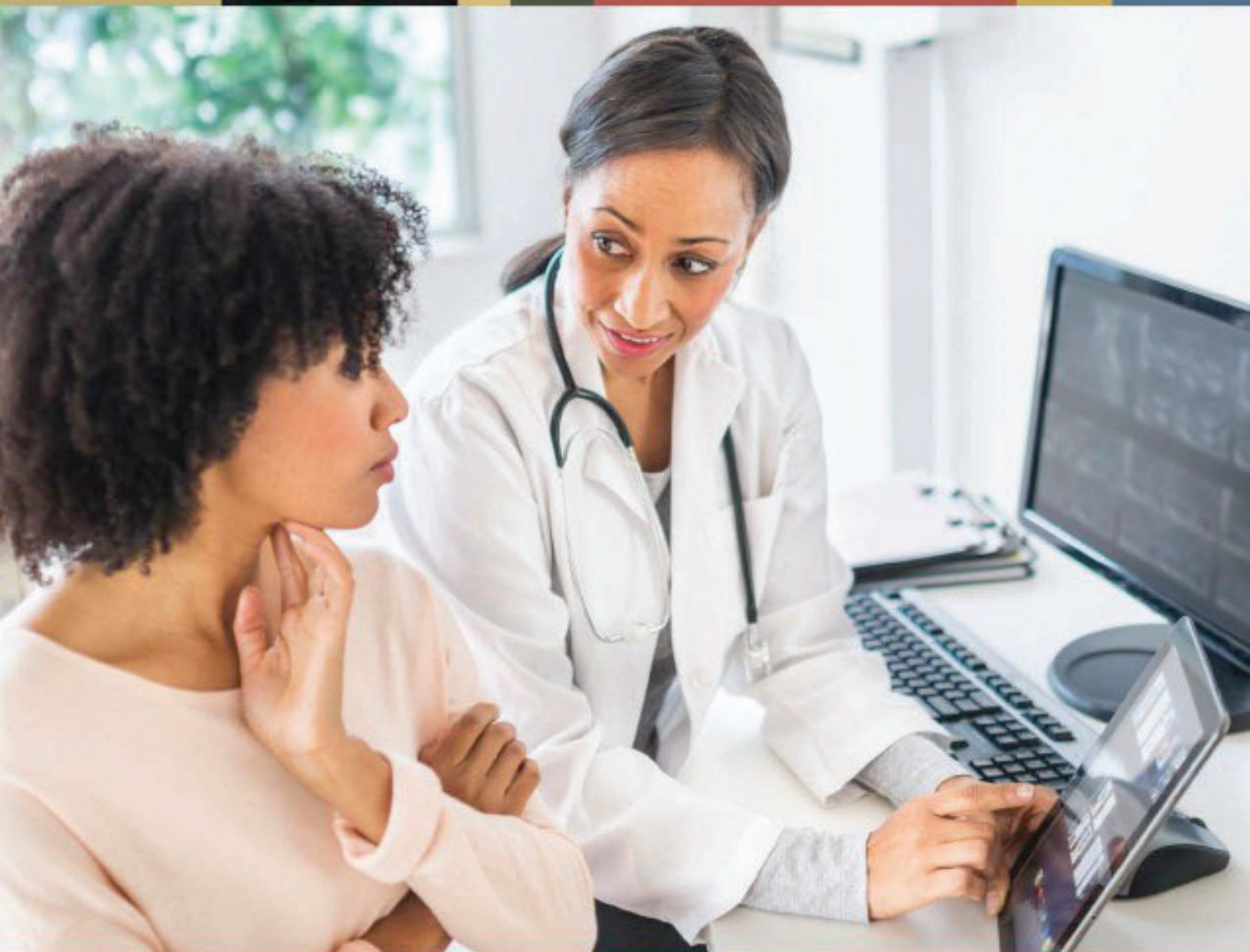
Title: _____

Title: Chief Executive Officer

Date: _____

Date: _____

Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide



Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide

Revised February 2, 2015

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Division of Pharmacologic Therapies

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Rockville, MD 20857

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INTRODUCTION

The profile of opioid misuse and opioid use disorder in the United States is changing, in that nonmedical use of prescription opioids has become as significant a problem as the use of heroin.¹ Federal data for 2013 indicate that approximately 4.5 million people in the United States reported nonmedical use of prescription pain relievers in the past month and 289,000 reported use of heroin in the past month.² Despite the dimensions of the problem, nearly 80 percent of people with an opioid use disorder do not receive treatment because of limited treatment capacity, financial obstacles, social bias, and other barriers to care.³

A diagnosis of opioid use disorder continues to carry significant social bias, which affects both the individuals who receive the diagnosis and the health care professionals to whom such individuals may turn for care.

Researchers, federal health agencies, and pharmaceutical manufacturers have focused on developing medications that can be used to expand access to treatment of an opioid use disorder in medical office settings, rather than limiting use to specialized opioid treatment programs (OTPs).⁴ This effort has yielded two important products that the Food and Drug Administration (FDA) has approved for use in treating an opioid use disorder and/or preventing relapse: buprenorphine (alone and in combination with naloxone) and naltrexone (in an oral formulation and an extended-release injectable formulation). These medications differ in mechanism of action, route and frequency of administration, and certain regulatory restrictions on their use as shown in Table 1 on page 4.

After reviewing multiple studies, many experts in addiction have concluded that patients who have an opioid use disorder should be offered medication-assisted treatments on a routine basis.⁵ However, considerable resistance to the use of such treatments persists. A diagnosis of opioid use disorder continues to carry significant social bias, which affects both the individuals who receive the diagnosis and the health care professionals to whom such individuals may turn for care.^{*6}

With practical resources, the unmet need for treatment and the largely untapped resource of primary care medicine can be brought together to yield healthier patients who are treated in safer environments and an expanded repertoire of effective professional practices for primary care providers. In fact, many studies show that the treatment of an opioid use disorder can be successfully integrated into general office practice by physicians and health providers who are not addiction specialists.^{7–15}

To review the options available for the treatment of opioid use disorder, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute on Drug Abuse (NIDA) jointly convened the Consensus Panel on New Pharmacotherapies for Opioid Use Disorders and Related Comorbidities (see Appendix A). Composed of experts in research, clinical care, medical education, and public policy, the panel reviewed current evidence on the effectiveness of available medications for the treatment of an opioid use disorder and developed a guidance for clinical practice.⁵ The panel's guidance is presented in this document.

* The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013)⁶ uses the term *opioid use disorder* to include abuse of or dependence on opioids. The specific indication for which extended-release injectable naltrexone was approved by FDA is prevention of relapse to opioid dependence, following opioid detoxification, which is subsumed by the DSM-5 term *opioid use disorder*.

ASSESSING THE NEED FOR TREATMENT

Patient Assessment

A patient who is identified with a potential opioid use disorder should undergo a thorough assessment to confirm the diagnosis.¹⁶ The objectives of the assessment are to determine the patient's need for treatment, to develop a treatment plan, and to establish a baseline measure for evaluating the patient's progress. Accordingly, the patient assessment should:

- Confirm the opioid use disorder diagnosis
- Establish current opioid use—when, what, and how much opioid the patient used most recently
- Document the patient's substance use history, including alcohol and other drugs of abuse
- Identify patients who require medically supervised detoxification from alcohol, benzodiazepines, or other sedatives, in addition to opioids
- Determine where and when such detoxification should be accomplished
- Identify comorbid medical and psychiatric conditions and disorders and prioritize and coordinate their management
- Screen for infectious diseases for which people who misuse opioids are at elevated risk, such as hepatitis B, hepatitis C and HIV/AIDS
- Assess the patient's access to social supports, family, friends, employment, housing, finances, and assistance with legal problems
- Evaluate the patient's degree of motivation for behavior change and readiness to participate in treatment

The physical examination should focus on problems the patient is experiencing and include screening for common consequences or co-occurring problems associated with the patient's current and past substance use.

Substance Use History. A complete substance use history is essential to development of a safe and appropriate treatment plan.¹⁷ In-depth interviews, combined with the use of standardized assessment instruments, are effective methods of gathering this information. Ideally, the substance use history should include

the nature of the patient's substance use disorders, underlying or co-occurring diseases or conditions, the effect of opioid use on the patient's physical and psychological functioning, and the outcomes of past treatment episodes.

It is essential to find out whether the patient is currently taking (or recently took) methadone or other long-acting opioids.^{18,19} Urine toxicology screens must also be completed. It also is advisable to access the patient's prescription drug use history through the state's prescription drug monitoring program (PDMP)²⁰ where available, both to confirm compliance in taking prescribed medications and to detect unreported use of other prescription medications.¹⁷ Information about PDMPs and how to access them is available from state boards of medicine and pharmacy.

Information about PDMPs and how to access them is available from state boards of medicine and pharmacy.

In addition to securing the patient's PDMP record, obtaining information from family members and significant others can provide useful perspectives on the patient's behavior and level of function, so consent to speak with family members and other providers must be obtained. Contact with or records from clinicians who have treated the patient in the past and information from the prescription benefit provider should also be sought out.¹⁰

Physical Examination. The physical examination of a patient who is being evaluated for a substance use disorder should focus on physical findings related to addiction and its complications. For example, examination of skin injection sites can provide useful information about the duration of injection drug use. Recent injection marks are small and red and sometimes are inflamed or surrounded by slight bruising. Older injection sites typically are not inflamed but sometimes show pigmentation changes (either lighter or darker), and the skin may have an atrophied or sunken appearance. A combination of recent and old injection sites suggests that the

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patient may be currently using opioids and may have a complex opioid use disorder.²¹

The physical examination should address body systems related to reported symptoms. In asymptomatic people, height, weight, and blood pressure should be recorded, and a cardiac examination (listening for murmurs or cardiac rhythm abnormalities) should be performed.²²

Laboratory Tests. A urine drug screen or other toxicology screen should be part of the patient assessment to confirm recent opioid use and to screen for use of other drugs. A urine test for alcohol (ethyl glucuronide) also needs to be included. Ideally, a drug screen should test for all opioids commonly prescribed and/or misused in the local community, as well as illicit drugs that are available locally.²³

Other useful tests include those of liver enzymes and serum bilirubin, as well as tests for hepatitis B and C and HIV, particularly in patients who have engaged in injection drug use. For those patients who inject drugs, serum creatinine levels should be tested for the presence of silent renal disease.²²

Developing a Treatment Plan

Treatment of an opioid use disorder should be guided by an individualized plan that is developed in consultation with the patient.²⁴ Elements of such a plan include the following:

- The role of medications in the patient’s treatment and the rationale for their selection
- Referral and follow-up plans for specialty addiction treatment, psychosocial treatment, and/or family therapy, if clinically indicated
- Motivation for participating in mutual-help groups
- A discussion of the involvement of family or significant others in treatment
- A plan for treating co-occurring medical or psychiatric disorders
- Schedules for follow-up office visits and laboratory testing to monitor the patient’s progress and health status
- Criteria for discontinuing use of the medication

The plan should be written to measure progress during the monitoring process.^{22,25} The plan and the steps taken to implement it should be documented in the patient’s medical record.¹⁷

Use of Medications. Whenever a medication is to be used, the treatment plan should give attention to steps that will promote medication adherence.²⁶ Depending on the needs of the patient, these steps might include specific strategies for remembering to take medications, use of blister-card packs or pill boxes, a schedule for monitoring medication adherence that reflects the patient’s history of adherence to other medication regimens, and steps to involve the patient’s family members in monitoring adherence.

Naltrexone functions as an opioid antagonist, whereas methadone is an opioid agonist and buprenorphine is an opioid partial agonist. Patients should abstain from using any opioids, including opioid-containing medicines, for a minimum of 7 to 10 days before starting extended-release injectable naltrexone to avoid precipitation of opioid withdrawal. Patients transitioning from buprenorphine or methadone may be vulnerable to precipitation of withdrawal symptoms for as long as 2 weeks.^{26,27}

All medications for the treatment of the opioid use disorder should be prescribed as part of a comprehensive treatment approach that includes counseling and other psychosocial therapies delivered by a psychiatrist, psychologist, or professional counselor, as well as social support through participation in Narcotics Anonymous (NA) and other mutual-help programs.^{1,5} Health care providers who choose to offer medication-assisted treatment in their office practices need to understand the nature of the underlying disorder, the specific actions of each available medication (and the associated contraindications or cautions), and the importance of careful patient selection and monitoring.⁸

Table 1 summarizes key information about three medications currently approved to treat opioid use disorders (extended-release injectable naltrexone, methadone, and buprenorphine). Only one column in the table is devoted to naltrexone because the prescribing considerations for extended-release injectable naltrexone and oral naltrexone are similar.²⁶

**TABLE 1: KEY FEATURES OF MEDICATIONS APPROVED FOR TREATING
OPIOID USE DISORDER***

Prescribing Considerations	Extended-Release Injectable Naltrexone	Methadone	Buprenorphine
Frequency of Administration	Monthly [†]	Daily	Daily (also alternative dosing regimens)
Route of Administration	Intramuscular (IM) injection into the gluteal muscle by a physician or other health care professional. [†]	Orally as liquid concentrate, tablet or oral solution of diskette or powder.	Oral tablet or film is dissolved under the tongue.
Who May Prescribe or Dispense	Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.	SAMHSA-certified OTPs dispense methadone for daily administration either on site or, for stable patients, at home.	Physicians must have board certification in addiction medicine or addiction psychiatry and/or complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waived physician.
Pharmacologic Category	Opioid antagonist	Opioid agonist	Opioid partial agonist Buprenorphine's partial agonist effect relieves withdrawal symptoms resulting from cessation of opioids. This same property will induce a syndrome of acute withdrawal in the presence of long-acting opioids or sufficient amounts of receptor-bound full agonists. Naloxone, an opioid antagonist, is sometimes added to buprenorphine to make the product less likely to be abused by injection.

* Table 1 highlights some properties of each medication. It does not provide complete information and is not intended as a substitute for the package inserts or other drug reference sources used by clinicians (see <http://www.dailymed.nlm.nih.gov> for current package inserts). For patient information about these and other drugs, visit the National Library of Medicine's MedlinePlus (<http://www.medlineplus.gov>). Whether a medication should be prescribed and in what amount are matters to be discussed between an individual and his or her health care provider. The prescribing information provided here is not a substitute for the clinician's judgment, and the National Institutes of Health and SAMHSA accept no liability or responsibility for use of the information in the care of individual patients.

[†] Naltrexone hydrochloride tablets (50 mg each) are also available for daily dosing.

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Prescribing Considerations	Extended-Release Injectable Naltrexone	Methadone	Buprenorphine
Clinical Uses/Ideal Candidates	Prevention of relapse to opioid use disorder following opioid detoxification; studies suggest benefits for patients who are experiencing increased stress or other relapse risks (e.g., visiting places of previous drug use, loss of spouse, loss of job). Appropriate for patients who have been detoxified from opioids and who are being treated for a co-occurring alcohol use disorder. Extended-release naltrexone should be part of a comprehensive management program that includes psychosocial support. Other good candidates include persons with a short or less severe addiction history or who must demonstrate to professional licensing boards or criminal justice officials that their risk of opioid use is low.	Detoxification and maintenance treatment of opioid addiction. Patients who are motivated to adhere to the treatment plan and who have no contraindications to methadone therapy. Methadone should be part of a comprehensive management program that includes psychosocial support.	Treatment of opioid dependence. Patients who are motivated to adhere to the treatment plan and who have no contraindications to buprenorphine therapy. Buprenorphine should be part of a comprehensive management program that includes psychosocial support.
Contraindications	Contraindicated in patients receiving long-term opioid therapy. Contraindicated in patients who are engaged in current opioid use (as indicated by self-report or a positive urine drug screen) or who are on buprenorphine or methadone maintenance therapy, as well as in those currently undergoing opioid withdrawal. Contraindicated in patients with a history of sensitivity to polylactide-co-glycolide, carboxymethylcellulose, or any components of the diluent. Should not be given to patients whose body mass precludes IM injection with the 2-inch needle provided; inadvertent subcutaneous injection may cause a severe injection site reaction. Should not be given to anyone allergic to naltrexone.	Contraindicated in patients who are hypersensitive to methadone hydrochloride or any other ingredient in methadone hydrochloride tablets, diskettes, powder or liquid concentrate. Contraindicated in patients with respiratory depression (in the absence of resuscitative equipment or in unmonitored settings) and in patients with acute bronchial asthma or hypercarbia. Contraindicated in any patient who has or is suspected of having a paralytic ileus.	Contraindicated in patients who are hypersensitive to buprenorphine or naloxone.

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Prescribing Considerations	Extended-Release Injectable Naltrexone	Methadone	Buprenorphine
Warnings	Use with caution in patients with active liver disease, moderate to severe renal impairment, and women of childbearing age. Discontinue in the event of symptoms or signs of acute hepatitis. As with any IM injection, extended-release injectable naltrexone should be used with caution in patients with thrombocytopenia or any coagulation disorder (e.g., hemophilia, severe hepatic failure); such patients should be closely monitored for 24 hours after naltrexone is administered. Patients may become sensitive to lower doses of opioids after treatment with extended-release injectable naltrexone. This could result in potentially life-threatening opioid intoxication and overdose if previously tolerated larger doses are administered. Clinicians should warn patients that overdose may result from trying to overcome the opioid blockade effects of naltrexone.	Methadone should be used with caution in elderly and debilitated patients; patients with head injury or increased intracranial pressure; patients who are known to be sensitive to central nervous system depressants, such as those with cardiovascular, pulmonary, renal, or hepatic disease; and patients with comorbid conditions or concomitant medications that may predispose to dysrhythmia or reduced ventilatory drive. Methadone should be administered with caution to patients already at risk for development of prolonged QT interval or serious arrhythmia. The label includes a warning about somnolence that may preclude driving or operating equipment.	Caution is required in prescribing buprenorphine to patients with polysubstance use and those who have severe hepatic impairment, compromised respiratory function, or head injury. Significant respiratory depression and death have occurred in association with buprenorphine, particularly administered intravenously or in combination with benzodiazepines or other central nervous system depressants (including alcohol). Buprenorphine may precipitate withdrawal if initiated before patient is in opioid withdrawal, particularly in patients being transferred from methadone. The label includes a warning about somnolence that may preclude driving or operating equipment.
Use in Pregnant and Postpartum Women	Pregnancy: FDA pregnancy category C[†] Nursing: Transfer of naltrexone and 6β-naltrexol into human milk has been reported with oral naltrexone. Because animal studies have shown that naltrexone has a potential for tumorigenicity and other serious adverse reactions in nursing infants, an individualized treatment decision should be made whether a nursing mother will need to discontinue breast feeding or discontinue naltrexone.	Pregnancy: FDA pregnancy category C[†] Methadone has been used during pregnancy to promote healthy pregnancy outcomes for more than 40 years. Neonatal abstinence syndrome may occur in newborn infants of mothers who received medication-assisted treatment with methadone during pregnancy. No lasting harm to the fetus has been recognized as a result of this therapy but individualized treatment decisions balancing the risk and benefits of therapy should be made with each pregnant patient. Nursing: Mothers maintained on methadone can breastfeed if they are not HIV positive, are not abusing substances, and do not have a disease or infection in which breastfeeding is otherwise contraindicated.	Pregnancy: FDA pregnancy category C[†] Neonatal abstinence syndrome may occur in newborn infants of mothers who received medication-assisted treatment with buprenorphine during pregnancy. No lasting harm to the fetus has been recognized as a result of this therapy but individualized treatment decisions balancing the risk and benefits of therapy should be made with each pregnant patient. Nursing: Buprenorphine and its metabolite norbuprenorphine are present in low levels in human milk and infant urine. Available data are limited but have not shown adverse reactions in breastfed infants.
Potential for Abuse and Diversion	No	Yes	Yes

SOURCES:^{1,26– 44}

[†] Animal studies have shown an adverse effect on the fetus and there are no adequate, well-controlled studies in humans, but potential benefits may warrant use of the drug in some pregnant women despite potential risks.

Extended-Release Injectable Naltrexone

The extended-release injectable formulation of naltrexone (Vivitrol®) was approved by the FDA in 2010 for the prevention of relapse to opioid dependence following opioid detoxification.¹ It is supplied as a 380 mg IM injection to be administered in the gluteal muscle every 28 to 30 days, alternating buttocks for each subsequent injection.

Packaging. The drug is packaged in a kit containing a vial of naltrexone microspheres as a dry powder, which must be suspended in a liquid diluent immediately before use. Kits must be refrigerated during storage but should be brought to room temperature approximately 45 minutes before an injection is given. The microspheres suspended in solution must be mixed vigorously to prevent clumping, which can clog the needle during injection.²⁷

Each kit also contains a syringe and five needles—one for mixing the microspheres with the diluent and four needles (two 1.5-inch needles and two 2-inch needles) for injecting the suspension into the upper outer quadrant of the gluteal muscle.²⁷

Formulation. Extended-release injectable naltrexone was developed by embedding the drug molecule in microspheres composed of a biodegradable copolymer, resulting in release of the active ingredient over a predetermined period. Upon injection, the microspheres begin to absorb water almost immediately, leading to a swelling of the microspheres. This process begins an initial release of the drug.

As water absorption continues, the polymer begins to undergo hydrolysis. Later, physical erosion of the polymer occurs. The drug diffuses into the surrounding media as the polymer continues to undergo hydrolysis and erosion, resulting in a sustained release of the drug from the microspheres. The polymer matrix eventually breaks down into lactic acid and glycolic acid, which are completely metabolized by the body and eliminated as carbon dioxide and water.

Pharmacodynamics and

Pharmacokinetics. Naltrexone is a competitive antagonist at the opioid receptors in the brain. It is

metabolized in the liver to the opioid antagonist 6- β -naltrexol. The absorption of extended-release naltrexone is mediated by its gradual and prolonged release for 2 to 4 weeks after injection through hydrolysis of the copolymer microspheres.^{27,45} Two peak blood levels occur after injection of the extended-release formulation: a transient initial peak occurs approximately 2 hours later and a second peak occurs about 2 to 3 days later. About 14 days after injection, the blood level slowly begins to decline in a linear fashion.

Efficacy. The phase 3 clinical trials of extended-release injectable naltrexone showed a consistent pattern of clinical efficacy for maintaining abstinence, achieving medication adherence, maintaining retention, protecting against reestablishment of opioid physical dependence, and may reduce craving for opioids for some individuals, while showing good safety and tolerability.^{27,29}

Indications, Contraindications, and

Cautions. The FDA-approved indication for extended-release injectable naltrexone is the prevention of relapse to an opioid use disorder following opioid detoxification.²⁷ Other information on indications, contraindications, and cautions appears in Table 1. It is advisable to download a copy of the full prescribing information from the FDA (available at <http://www.fda.gov/safety/medwatch/safetyinformation/ucm208449.htm>).

Safety. Based on its use in the treatment of alcohol dependence (an indication approved by the FDA in 2006), extended-release injectable naltrexone appears to be reasonably well tolerated. Its side effect profile is similar to that of oral naltrexone, with the addition of possible injection site reactions (ISRs).^{1,46}

Side effects reported in clinical trials include nasopharyngitis, influenza, upper respiratory tract infection, sinusitis, insomnia, headache, dizziness, upper abdomen pain, diarrhea, fatigue, and back pain.^{46–50} Muscle cramps, dizziness, sedation, decreased appetite, and an allergic form of pneumonia also have occurred in patients treated with extended-release injectable naltrexone, as have common cold symptoms, and toothaches.^{1,27,28}

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More serious adverse reactions, with advice on their management, include the following:

- **ISRs:** Extended-release injectable naltrexone injections may cause pain or tenderness at the injection site, which usually resolves in 2 to 5 days. However, more serious reactions such as swelling, erythema, bruising, and pruritus may occur, generally as the result of an inadvertent subcutaneous injection. Providers should be trained in proper techniques for IM injections to prevent problems.⁴⁵ The FDA issued an alert on this subject following phase 3 clinical trials because of reports of severe ISRs requiring surgical intervention.⁴⁶
- **Vulnerability to opioid overdose:** Following a person's treatment with extended-release injectable naltrexone, his or her opioid tolerance is reduced from pretreatment baseline, and patients are vulnerable to potentially fatal overdose at the end of a dosing interval, after missing a dose, or after discontinuing treatment. Attempts to overcome the blockade may also lead to fatal overdose.
- **Hypersensitivity reactions, including anaphylaxis:** Trial results included reactions such as urticaria and angioedema. Patients should be warned of these risks and advised to seek immediate medical attention should any symptoms of hypersensitivity reactions arise.²⁷
- **Hepatotoxicity:** Cases of hepatitis and clinically significant liver dysfunction were observed in association with extended-release injectable naltrexone treatment. Patients should be warned of the risk of such injury.^{27,45}
- **Depression and suicidality:** Depression-related adverse events and events of a suicidal nature were observed in clinical trials of extended-release injectable naltrexone. Patients should be monitored for development of depression, suicidal thinking, or mood or anxiety disorders and treated appropriately, and families and caregivers should be alerted to the need to monitor patients for the emergence of depression or suicidality.^{27,45}
- **Precipitated opioid withdrawal:** When withdrawal is precipitated abruptly by the administration of an opioid antagonist to a patient dependent on opioids, the resulting

withdrawal syndrome can be severe enough to require hospitalization. An opioid-free interval is recommended for patients previously dependent on opioids. This interval should be guided by the type of opioid that the patient had been taking previously—that is, short- or long-acting opioids. Health care providers should always be prepared to manage withdrawal symptomatically. Patients should receive supportive treatments (i.e., hydration and antispasmodic and antidiarrheal medications) until opioid withdrawal symptoms resolve. Benzodiazepines or $\partial 2$ -agonists such as clonidine should mitigate some withdrawal symptoms (watch for side effects of clonidine, including dizziness, hypotension, fatigue, and headache).

Drug Interactions. Patients taking naltrexone may not experience pain relief from opioid-containing medications because naltrexone antagonizes the opioid effects.²⁷

Clinical Recommendations. Although no definitive research supports which patients benefit most from extended-release injectable naltrexone, patients in the following categories may be good candidates for such treatment.¹

- **Patients who have not had treatment success with methadone or buprenorphine:** Depending on the reasons for treatment failure, individuals with an opioid use disorder who have not been successfully treated with methadone or buprenorphine may benefit from medically supervised withdrawal followed by a trial of extended-release injectable naltrexone.⁵¹
- **Patients who have a high degree of motivation for abstinence:** Individuals who are highly motivated to achieve and maintain abstinence from opioids may be good candidates for treatment with extended-release injectable naltrexone.⁵⁰ This category includes people who are required to demonstrate abstinence on urine drug screens, such as individuals in programs for impaired health care professionals, parolees, probationers, and airline pilots.⁵²
- **Patients who have been successful on opioid agonists who wish to discontinue agonist therapy or patients who are not interested in**

agonist therapy to treat their opioid use disorder: Some patients may be successful on agonist treatment and want continued pharmacologic help to prevent relapse but prefer another type of treatment.⁵¹ Other patients may not be interested in agonist therapy.¹ The latter group typically includes individuals who (1) feel they are discriminated against (or are embarrassed or ashamed) because they are on agonist therapy⁵³ or (2) would like to reduce the time devoted to daily or multiple OTP visits per week, as is frequently required for methadone treatment.¹

Patients may be suitable candidates for treatment with extended-release injectable naltrexone even if past episodes of medication-assisted treatment were not successful.⁵⁴ However, experts agree that the following patients are unlikely to do well on extended-release injectable naltrexone:¹

- Patients who do not tolerate extended opioid-free periods. For example, a patient who is not tolerating withdrawal is better managed with a partial agonist (buprenorphine) or an agonist (methadone) than with an antagonist medication.
- Patients who are unable to complete withdrawal.
- Patients who experience protracted abstinence symptoms following withdrawal.
- Patients whose psychiatric symptoms worsen during withdrawal.
- Patients whose chronic pain requires treatment with opioid analgesics. Treatment with extended-release injectable naltrexone is not a viable option if pain requires chronic opioid therapy.
- Patients who have advanced liver disease, impending liver failure, or acute hepatitis. Use of extended-release injectable naltrexone probably is safe in patients with chronic hepatitis B or C provided that the patient is not at the end stage and starting to go into liver failure. Patients with routine elevated liver enzymes usually tolerate naltrexone

Integrating Pharmacologic and Nonpharmacologic Therapies

Some patients respond to psychosocial interventions or medication therapy alone, but most patients need both. The different

approaches (medication-assisted treatment, professional counseling, and mutual-help groups) are complementary. They support the same goals while addressing different aspects of opioid use disorder: neurobiological, psychological, and social.

Offering the full range of effective treatments maximizes patient choice and outcomes, because no single approach is universally successful. Many studies show that the combination of pharmacologic and nonpharmacologic interventions may be more effective than either approach used alone.⁵⁵

Sources of information on psychosocial therapies suitable for patients being treated in medical office settings are shown in Appendix B.

Encouraging Participation in Mutual-Help Programs.

The support of a mutual-help group can be critical to long-term recovery. The oldest, best-known, and most accessible mutual-help program for people with an opioid use disorder is offered by NA. Patients may resist attending NA meetings and may fear that disclosure of medication use will make them unwelcome.²⁶ Although some NA members may have negative attitudes toward medication, the organization itself supports appropriate medication use. Providers should encourage patients to try meetings of different groups until they find one that is a good fit. Lists of local meetings to give to patients can be obtained from the Narcotics Anonymous World Services Web site (<http://www.na.org>).

Other mutual-help groups, although not as universally available as NA, have a strong presence in many communities. Contact information for several groups that may be helpful to patients and their families is provided in Appendix B.

The support of a mutual-help group can be critical. The oldest, best known, and most accessible mutual-help program for people with an opioid use disorder is offered by Narcotics Anonymous.

Special Considerations in Treatment Planning

Some patients present with specific conditions or at life stages that require special consideration in formulating a treatment plan.

Patients With Psychiatric Comorbidities.

Studies of treatment populations have shown that co-occurring psychiatric disorders are present in 20 percent to 60 percent of people entering treatment, depending on the treatment group of the study and its methodology.⁵⁶ Even higher rates have been reported among older adults, people with low socioeconomic status, and those who reside in urban areas,^{57,58} as well as those who are homeless⁵⁹ or incarcerated.⁶⁰

When psychiatric and substance use disorders co-occur, the two disorders typically become intertwined, thus complicating the treatment plan and process. Therefore, whenever a patient enters treatment for either a substance use disorder or a psychiatric disorder, he or she should be assessed for the co-occurrence of the other.²⁴ To establish how a patient's substance use and a psychiatric disorder are linked, the order of onset of their psychiatric disorder and substance use, family history, and effect of previous treatments of the co-occurring psychiatric disorder should be determined.⁵⁴

Patients With Co-Occurring Medical Disorders. Individuals with substance use disorders almost always are at higher risk for disease and other medical disorders than are those without addiction disorders. Furthermore, people with substance use disorders typically miss opportunities to receive preventive health care.^{22,61}

Like individuals with other chronic medical conditions, those who misuse opioids exist on a continuum ranging from less to more medically complicated.^{52,62,63} Moreover, the management of unrelated medical illnesses is complicated by addiction, its effect on adherence to the treatment regimen, and the direct consequences of the misused substances. This complication warrants a targeted approach to the conditions for which a patient is at risk.²²

Hepatic disorders: Hepatic monitoring is important because HCV seroprevalence is high among people with opioid use disorder. The U.S.

Departments of Veterans Affairs and Defense guidelines for the use of naltrexone recommend measuring baseline transaminase levels, followed by periodic monitoring at 6- or 12-month intervals.⁶⁴

HIV/AIDS: Methadone interacts with several antiretroviral treatments for HIV, buprenorphine causes fewer concerns, and extended-release injectable naltrexone causes almost none.⁶⁵ However, treatment is worth considering because of the prevalence of HIV infection among people who inject drugs.

Pain: Because of their opioid agonist activity, methadone and buprenorphine offer advantages in treating patients who have chronic pain. Naltrexone is not a good choice for people whose pain needs to be treated with opioid analgesics, but it can be used in patients whose pain is treated with non-opioid analgesics.

Obesity: In obese patients, a longer needle is needed to reach the muscle with injections. The risk of rare aseptic abscesses and other severe ISRs may increase when the injection goes subcutaneously into fatty tissue instead of the muscle.

Renal disorders: Renal problems do not require dose adjustments with naltrexone or buprenorphine.

Hospitalization: If a patient who is taking extended-release injectable naltrexone is hospitalized for medical reasons, special attention must be directed to the provision of adequate pain control.²²

Alcohol dependence: Extended-release injectable naltrexone has dual activity for the prevention of relapse to both high-risk drinking and opioid use.

Marijuana use: Patients who use marijuana or other substances containing tetrahydrocannabinol may need other types of pharmacotherapy until research studies clearly show whether extended-release injectable naltrexone increases the cardiovascular risks of cannabinoids.⁶⁶

Adolescents. The lack of treatment resources geared specifically to young people, coupled with the epidemic of prescription opioid and heroin abuse in this population, has left many young people with few effective treatment options.⁶⁷

Ample evidence demonstrates the failure of detoxification-only treatments and the high rates of dropout from psychosocial-only treatments on the part of adolescents and young adults. Yet, despite an increasing body of evidence that medications such as buprenorphine, methadone, and naltrexone are effective and easily combined with psychosocial treatments, only buprenorphine is approved by the FDA for the treatment of patients younger than 18, and the safety and effectiveness of buprenorphine hydrochloride sublingual tablets in patients younger than 16 have not been established. Therefore, the best course of action is to refer young patients to an addiction specialist or program with experience in treating adolescents.⁵

Pregnant and Postpartum Women. Opioid use disorder is associated with increased maternal and neonatal complications.⁵⁴ Currently, no medications have been approved by the FDA for treatment of opioid use disorder during pregnancy. Treatment with methadone or buprenorphine has been used, but the risks are not known.^{68–70} Although there is some interest in the potential for extended-release injectable naltrexone in this population, no research to evaluate its safety or efficacy has been conducted to date.⁷¹

FDA-approved prescribing information for extended-release injectable naltrexone states that “there are no adequate and well-controlled studies of either naltrexone or extended-release injectable naltrexone (Vivitrol®) in pregnant women. This product should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.”²⁷ Accordingly, patients dependent on opioids who are pregnant or nursing should be referred to an addiction specialist or program with experience in treating this population.

Older Adults. Members of the baby boom generation had more experience with nonmedical drug use than members of prior generations, and this continues to be true as members of this population reach retirement age and experience consequences of aging such as chronic pain. Furthermore, substance use disorders in older adults often are misdiagnosed, as are the consequences of such disorders.⁵⁴ For example,

dementia, malnutrition, self-neglect, functional decline, sleep problems, and anxiety or depression all may be attributed to “normal” aging when the true cause is substance misuse or a substance use disorder.²²

Studies show that older adults can and do benefit from treatment and in some cases have better outcomes than do younger adults.⁷² However, there are few studies of extended-release injectable naltrexone in this population.

In the absence of a specific evidence base for naltrexone in older adults, pharmacologic treatments should follow the evidence base for the general adult population. Health care providers may need to consider using oral naltrexone if the fixed dose extended-release injectable naltrexone is not appropriate in elderly patients with age-related pharmacokinetic and pharmacodynamic changes, as well as any mental or physical comorbidities.⁵⁴

Studies show that older adults can and do benefit from treatment and, in some cases, have better outcomes than do younger adults.

Other Populations. Certain highly motivated licensed individuals, such as health care professionals, attorneys, and pilots, may be ideal candidates to accept and persist with treatment with extended-release injectable naltrexone.^{52,73} Many professional groups have specialized programs that promote treatment, monitor recovery, and provide advocacy to maintain licensure. It has been suggested that professional advocacy might be the “voucher” or “contingency” that makes compliance with extended-release injectable naltrexone worthwhile for licensed professionals with opioid use disorder.⁷⁴ For example, some clinical evidence suggests that this may be the case with anesthesiologists.⁷⁵

In contrast, some individuals who are relatively less motivated or at an early stage in the addiction process may need specific counseling approaches to addressing their motivational issues before treatment with extended-release injectable naltrexone is initiated.⁷⁶

INITIATING MEDICATION-ASSISTED TREATMENT

Educating the Patient and Obtaining Informed Consent

The clinician should discuss with the patient the risks and benefits of medication-assisted treatment as compared with the risks associated with no treatment or treatment without medication.^{4,77–80} In addition, certain topics should be reviewed with every patient who is a candidate for medication-assisted treatment.⁸¹ Face-to-face conversations, supplemented by written fact sheets, are helpful in answering the following questions:

- Which medication is to be used? How is it administered? How does it work? What are its advantages and disadvantages?
- What is the duration of treatment, its cost, and associated routines?
- What are the known side effects?
- What are the contraindications?
- What are the issues related to pregnancy, lactation, and contraception?
- What are the dangers of concurrent use of nonprescribed drugs?
- What are the potential interactions between extended-release injectable naltrexone and other therapeutic medications?
- What is the potential impact of treatment with extended-release injectable naltrexone on driving, other activities of daily living, and employment?

Because methadone normalizes endocrine functions, it is not unusual for women in the early phases of medication-assisted treatment to become pregnant unintentionally, especially if they do not receive counseling for this possibility.⁸²

Patients should be educated about the effects of using opioids and other drugs while taking the prescribed medication and the potential for overdose if opioid use is resumed after tolerance is lost.^{83,84} Some health care providers supply a laminated card that identifies the individual as a patient of their practice. This is helpful to other health care providers who may see the patient in an emergency department.²⁴

Informed Consent. The patient's informed consent to treatment should be documented in a

written form that is discussed with and signed by the patient. Such a form can be helpful in reinforcing the information provided and establishing a set of ground rules. Typical provisions of an informed consent document include:¹⁷

- The medication and other therapies to be employed, with a rationale for their use
- Schedules for follow-up office visits and laboratory testing to monitor the patient's progress and health status
- Goals for attendance at meetings of mutual-help groups
- Involvement of family or significant others in treatment
- Symptoms that should be reported to the prescribing physician
- A plan for treating any co-occurring medical or psychiatric conditions, as well as other substance use disorders, including smoking
- Criteria for discontinuing the use of medication or other therapies and referral to specialty addiction treatment, if indicated

The patient should be advised to carry a medical alert card identifying the use of extended-release naltrexone, describing any potential adverse effects, and providing contact information for the treating clinician or institution in an emergency.¹⁷

The patient should be advised to carry a medical alert card identifying the use of extended-release naltrexone, describing any potential adverse effects, and providing contact information in an emergency.

The fact that a patient has received and understands this information should be documented in a written informed consent agreement, which should be signed before treatment is initiated and filed in the patient's medical record.¹⁷

Withdrawing the Patient From Opioids

Naltrexone displaces heroin or prescribed opioids from receptors to which they have bound, so it can precipitate significant withdrawal symptoms. Therefore, it is important that detoxification from

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opioids be completed at least 7 to 10 days before extended-release injectable naltrexone is initiated or resumed. A urine drug screen to confirm abstinence should be conducted before naltrexone is started.²⁷ Patients who are transitioning from buprenorphine or methadone to naltrexone may be vulnerable to precipitation of withdrawal symptoms for as long as 2 weeks. Clinicians should be prepared to manage withdrawal symptomatically with non-opioid medications.²⁷

The withdrawal syndrome that occurs spontaneously is marked by a predictable constellation of signs and symptoms that follow a rapid decrease in, or abrupt discontinuation of, intake of an opioid that has been used consistently for a period of time.

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Some patients experience prolonged withdrawal signs or symptoms, known as *protracted abstinence syndrome*. Symptoms of the syndrome include sleep disturbances, anxiety, irritability, and mood instability.¹ Suggested nonpharmacologic approaches include educating patients about expected symptoms, offering support and understanding, monitoring the patient for sleep disturbances or co-occurring disorders, encouraging physical and mental activities, and promoting the use of mutual-help groups. For some patients with protracted withdrawal, additional psychosocial interventions (such as cognitive behavioral therapy) or pharmacotherapy may be necessary to avoid relapse.⁸⁶

Precipitated withdrawal is much more severe than spontaneous withdrawal, and patients undergoing precipitated withdrawal can become very ill. Patients must understand that withdrawal precipitated by administration of an opioid antagonist may be severe enough to require hospitalization if they have not been opioid free for an adequate period and is different from the experience of spontaneous withdrawal that occurs

with discontinuation of opioid in an individual with an opioid use disorder.

Bell and colleagues⁸⁷ suggested that following one of the following two approaches to induction into naltrexone treatment can help avoid precipitated withdrawal:

1. The conventional approach is to undertake detoxification and, when patients have been free of opioids for 7 to 10 days or free of methadone for 10 days, begin treatment with naltrexone. Patient histories can be unreliable, so it is advisable to perform a naloxone challenge test before giving the first dose of naltrexone to avoid inadvertently precipitating a significant or prolonged withdrawal reaction. Patients may experience precipitated withdrawal despite tolerating a naloxone challenge test.
2. Antagonist-accelerated induction (rapid detoxification^{*88}) involves administration of naltrexone or naloxone, while providing symptomatic relief to make the ensuing precipitated withdrawal tolerable. See footnote for cautions on this procedure issued by the Centers for Disease Control and Prevention (CDC)⁸⁸

Health care providers should always be prepared to manage precipitated withdrawal, even if the steps identified above are taken.

Reported cases of precipitated withdrawal have frequently involved patients transitioning from buprenorphine.

Successful management of withdrawal can facilitate entry into addiction treatment by reducing uncomfortable withdrawal symptoms that negatively reinforce drug taking. This is best managed by a specialized practitioner or treatment program.⁵

Many individuals undergo withdrawal more than once, and some do so many times. When people who were recently dependent return for repeat detoxification they do so generally with a more

* Anesthesia-assisted rapid opioid detoxification (AAROD) for the purpose of induction onto naltrexone carries additional risks, including death. The CDC advises against the use of AAROD because of these risks and the fact that less risky yet effective protocols are available for detoxification and maintenance pharmacotherapy.⁸⁸

realistic expectation of what is needed to remain free from alcohol and drugs.⁸⁹

People in the early stages of treatment often relapse to substance use and get caught up in a revolving door of repeated detoxification. Therefore, it is important to educate patients that short-term treatment of withdrawal does not eliminate the need for long-term treatment of addiction.^{5,77,90}

Induction Onto Extended-Release Injectable Naltrexone Treatment

The clinician should consider how best to induct a patient into treatment with extended-release injectable naltrexone. Product labeling and standard practice call for 7 to 10 days of abstinence from short-acting opioids before starting naltrexone.⁹¹ A urine drug screen should be conducted to verify abstinence before beginning induction.⁵¹

Dosing and Administration. For patients who are appropriate candidates, the recommended dose of extended-release injectable naltrexone is 380 mg, delivered intramuscularly approximately every 30 days, alternating buttocks for each subsequent injection. The following cautions should be observed:^{1,83,92}

- Injectable naltrexone should be administered only by a medical professional (a physician, nurse, or physician assistant) who knows how to administer IM gluteal injections.
- Injectable naltrexone is packaged in a kit containing a vial of naltrexone microspheres as a dry powder that must be suspended in a liquid diluent immediately before use. Kits must be refrigerated during storage but should be brought to room temperature approximately 45 minutes before an injection is given. The powder and diluent must be mixed vigorously to prevent clumping, which can clog the needle during injection.
- A syringe and five needles are provided—one for mixing the microspheres with the diluent and four (two 1.5-inch needles and two 2-inch needles) for injecting the suspension into the upper outer quadrant of the gluteal muscle. Body habitus should be assessed before each injection for each patient to ensure that needle length is adequate for IM

administration. Injectable naltrexone must be administered only with one of the administration needles supplied in the carton. A spare administration needle of each size is provided in case of clogging.

- Proper IM injection technique is essential. Serious ISRs, some requiring extensive surgical debridement, have been observed with extended-release injectable naltrexone. It has been reported that likelihood of these severe reactions may increase if the product is inadvertently administered subcutaneously rather than intramuscularly.
- The medication should be administered every 4 weeks. If a dose is delayed or missed, the next injection should be administered as soon as possible. However, it is not recommended that medication be readministered at less than 4-week intervals.
- It is not recommended that the medication be administered at a dose higher than 380 mg.

Following IM injection, the plasma concentration time profile is characterized by a transient initial peak at about 2 hours after injection, followed by a second peak approximately 2 to 3 days later. At approximately 14 days after administration, concentrations begin to slowly decline, with measurable levels detectable for more than 30 days after administration. However, the therapeutic benefit of a single dose has not been established for periods longer than 4 weeks.²⁷

Supportive Care Following Induction.

Careful follow-up is a critical element in optimizing the benefits of naltrexone treatment. The practitioner performing induction onto naltrexone treatment should schedule two office visits in the first week of induction to assess the patient. Weekly clinical reviews should be conducted in the first month of treatment. Other elements of supportive care include the following:⁸⁷

- Medical monitoring such as a regular review by the prescribing physician, with monitoring of compliance, review of drug use, and sometimes urine drug screens to confirm self-report
- Counseling in regularly scheduled sessions with a professional counselor
- Mutual-help groups and family involvement

Transfer to Extended-Release Injectable Naltrexone. If a patient is being transferred to extended-release injectable naltrexone from methadone or buprenorphine, the taper should be completed 7 to 10 days before naltrexone induction begins.²⁷

Special Considerations in Pain

Management. Extended-release naltrexone blocks the effects of opioid analgesics. For acute pain (e.g., that associated with dental work, surgery, traumatic injury), regional analgesia, conscious sedation, use of non-opioid analgesics, or general anesthesia may be needed for pain management.^{24,83}

If regional anesthesia is not used, then a larger amount of opioid analgesic may be needed to override the opioid blockade, but this should be done in a hospital setting because it may result in respiratory depression that is deeper and more

prolonged than usual. For this reason, a rapid-acting opioid analgesic that minimizes the duration of respiratory depression is preferred. The amount administered should be titrated to the needs of the patient. In such cases, the patient should be monitored closely by trained medical personnel.^{5,24}

Careful follow-up is a critical element in optimizing the benefits of naltrexone treatment. The practitioner performing induction onto naltrexone treatment should schedule two office visits in the first week of induction to assess the patient. Weekly clinical reviews should be conducted in the first month of treatment.

MONITORING PATIENT PROGRESS AND ADJUSTING THE TREATMENT PLAN

As with patients with other chronic relapsing disorders, patients diagnosed with opioid use disorder require long-term monitoring and support, as well as periodic adjustment of the treatment regimen.

Monitoring Patient Progress

Use of medication-assisted treatment requires careful monitoring throughout treatment, with special attention to problems that may arise at the time of induction.

Monitoring patient progress is an ongoing process that assesses the patient on four dimensions:⁵ (1) adherence to the treatment plan, (2) ability to maintain abstinence, (3) levels of craving, and (4) overall health status and social functioning. Toxicology screening is an important part of monitoring patient compliance and progress. At each visit, the health care provider should:

- Assess the patient for continued use of any illicit or nonprescribed drug
- Assess the patient's adherence to the treatment regimen

- Assess changes in the patient's social functioning and relationships
- Review whether the patient is involved in counseling
- Monitor for side effects of the extended-release injectable naltrexone and other prescription medications

With this information, the clinician can decide whether to continue pharmacotherapy, modify the treatment plan as indicated, and address any co-occurring medical, psychiatric, and substance use issues.

Sources of Information. Patient self-reports can be useful indicators of treatment progress. In eliciting such information, it is important to avoid conveying a judgmental attitude toward the patient's behavior. The clinician should ask about the quantity and frequency of alcohol and drug use, especially during stressful periods (e.g., holidays, celebrations, major life changes). The patient also should be asked about current craving and how he or she felt over the preceding week (by assigning a rating between 1 and 10, with 1 indicating no craving and 10 the most

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intense craving the patient has ever experienced). In addition, the patient may be asked whether any episodes have caused particular problems. Identifying patterns of craving over time allows both the clinician and the patient to see that the patient's patterns of craving may fluctuate throughout the day and over longer periods, indicating the need to continue, adjust, supplement, or discontinue use of a particular medication.

Other sources and types of information that are useful in patient monitoring include the following:^{5,17}

- Laboratory tests, such as the ALT, AST, GGT, CDT, and random urine drug screens, including ethyl glucuronide, to detect recent alcohol use
- The patient's history of keeping (or not keeping) appointments for office visits, following-up on referrals, or attending mutual-help groups
- Data from the state PDMP (if available) on the patient's use of prescribed opioids or other prescribed medications
- Information about other nonprescribed drugs being used
- Reports from family members (obtained with a signed release from the patient)
- Periodic status reports from consultants on the patient's use of psychosocial therapies or other supports

Opioid use disorder is a chronic illness that, despite treatment, may wax and wane in intensity over time.

Documenting Patient Progress. In the event of a legal, regulatory, or civil (malpractice-related) challenge, detailed medical records documenting what was done and why are the foundations of the practitioner's defense. Every clinician needs to be aware of and understand the federal requirements for recordkeeping, as well as the laws and regulatory requirements of the state in which he or she practices.¹⁷ State laws and medical board rules may differ substantially from federal requirements and from one state to another. The board of medical licensure or board of pharmacy in each state can provide information about relevant requirements. At a minimum,

patient records should contain the following information:^{93,94}

- **Patient history and physical examination:** The patient's record must include a history of all controlled drugs used to treat the patient, a history of illicit substances used, and patient allergies. Past treatment attempts also should be documented. Medical records obtained from clinicians who have treated the patient in the past should be included. (Caution should be exercised in accepting records supplied by patients, because these occasionally are fraudulent.) The medical record also should include information about the patient's personal and family history of alcohol, tobacco, and other substance use as well as a personal history of major depression or other psychiatric disorder.
- **Treatment plan:** The treatment plan and goals should be documented in the record so that there is evidence of clear-cut, individualized objectives to guide the choice of therapy. Patient improvements after a brief trial should be documented in the record, as should all regimens that were tried but failed.
- **Consultants' reports:** Whenever the best clinical course is not clear or the patient's response is not as expected, consultation with an appropriate specialist should be obtained. Generally, the results of the consultation should be discussed with the consultant and a written consultation report should be added to the patient's medical record.
- **Prescription orders:** The patient record must include all prescription orders, whether written or telephoned. Written instructions for the use of all medications should be given to the patient and documented in the record. The prescription order should list medication name, formulation, route of administration, and amount.
- **Informed consent:** A written informed consent or treatment agreement signed by both patient and practitioner can be helpful in establishing a set of ground rules and appropriate expectations.
- **Monitoring visits:** Medication monitoring visits are billable and can be performed by a nurse. They should be carefully documented in the medical record, in the same manner as a visit with the physician.

- **Treatment progress/outcomes:** The patient's record should clearly reflect the decision-making process that led to a medical, psychiatric, or behavioral outcome.

A patient's goals may change over time, requiring the clinician to adapt to new objectives.

Good records demonstrate that a service was provided to the patient, and that the service was medically necessary. Even if the outcome is less than optimal, thorough records protect the clinician as well as the patient.⁹⁴

Adjusting the Treatment Plan

Opioid use disorder is a chronic illness that, despite treatment, may wax and wane in intensity over time.⁵ If a patient begins to experience problems with adherence, the clinician should revisit the treatment plan to determine whether different strategies or treatment modalities (pharmacologic and nonpharmacologic) might be useful. For example, switching the patient from oral naltrexone to extended-release injectable naltrexone may enhance compliance with medication use.

A patient's goals also may change over time, requiring the clinician to adapt to new objectives. Also, as with patients who receive treatment for other chronic diseases, patients receiving treatment for an opioid use disorder may relapse.

Responding to Changes in Treatment Progress.

Individuals receiving medication-assisted treatment often demonstrate dramatic improvement in addiction-related behaviors and psychosocial functioning. Such positive changes should be acknowledged and reinforced by the prescribing physician whenever possible.^{10,95}

However, lack of adherence to pharmacologic regimens occurs in a substantial proportion of patients, with some studies reporting that as many as 7 out of 10 patients fail to follow the treatment plan.⁵ If a patient experiences problems with adherence, the clinician should revisit the treatment plan to determine whether different strategies or treatment modalities (pharmacologic or nonpharmacologic) might be useful. Other strategies to improve adherence and reduce the risk of relapse during treatment include providing

incentives to take the monthly injections (i.e., contingency management); involving significant others in monitoring the patient to ensure adherence to the medication plan, in a manner consistent with patient privacy requirements; offering relapse prevention counseling; and using motivational interviewing techniques.^{44,47,96}

Behaviors that violate the treatment agreement or that indicate limited progress in treatment may not constitute grounds for automatic termination of medication-assisted treatment. Such behaviors should trigger a reassessment of the patient's needs and goals and a corresponding revision of the treatment plan. Aberrant or dysfunctional behaviors may indicate the need for more vigorous engagement in peer support, counseling, or psychotherapies or possibly referral to a more structured treatment setting.⁵⁵

Alternative pharmacologic therapies such as methadone or buprenorphine maintenance therapy also should be considered for these patients.^{27,84} Such changes should be documented in the patient's medical record.¹⁰

Relapse rarely is caused by a single factor and often is the result of an interaction of physiologic and environmental factors. It is best conceptualized as a dynamic process in which the patient's readiness to change interacts with other external and internal factors.

Preventing and Responding to Relapse.

As with patients who receive treatment for other chronic disorders, patients receiving treatment for an opioid use disorder may experience relapses. Relapse rarely is caused by a single factor and often is the result of an interaction of physiologic and environmental factors.⁹⁷ It is best conceptualized as a dynamic process in which the patient's readiness to change interacts with other external and internal factors.⁹⁸

If relapse occurs, the clinician should consider several options:

- Examine social, medical, or behavioral factors that contribute to the patient's substance use
- Increase monitoring
- Change the medication

- Increase or change the intensity of psychosocial services
- Refer the patient for specialty care

Relapse risk is highest in the first 6 to 12 months after achieving abstinence and then diminishes gradually over the years. It may be necessary to escalate other treatment or to resume therapy with extended-release injectable naltrexone services if relapse appears imminent. Patients should be cautioned that they will be more sensitive to lower doses of opioids after treatment with extended-release injectable naltrexone is discontinued.²⁴

Reinduction Onto Naltrexone Treatment.

Many patients who have relapsed express a desire to resume naltrexone treatment. If a patient experiences multiple relapses, the clinician should consider whether to continue treatment with naltrexone or whether to offer a different treatment modality.

Patients may benefit from referral to a specialist for additional evaluation and treatment. For example, the treatment of addiction for a patient with a comorbid psychiatric disorder may be best managed through consultation with or referral to a specialist in psychiatry or addiction psychiatry.⁹⁹

DECIDING WHETHER AND WHEN TO END MEDICATION-ASSISTED TREATMENT

Long-term treatment, which is common to many chronic medical conditions, should not be seen as a failure. In fact, it is a cost-effective way of prolonging life and improving the patient's quality of life by supporting the natural and ongoing process of change and recovery.²⁴ Nevertheless, the physician and patient may wish to weigh the potential benefits and risks of continuing medication-assisted treatment and discuss whether such therapy remains appropriate.

Factors to consider in determining a patient's suitability for long-term, medication-free status include the presence of stable housing and income, availability of adequate psychosocial supports, and the absence of legal problems. For patients who have not achieved these indices of stabilization, a period of maintenance to address these barriers usually is advised.⁵⁵

Ideally, the patient and practitioner will reach a decision about whether and when medication-assisted treatment should be discontinued, usually for one of the following reasons:²⁴

- The patient reports substantially diminished craving.
- The patient has maintained stable abstinence over a sustained period.
- The patient feels ready to discontinue the medication.

- The patient is engaged in ongoing recovery, including community supports (such as attendance at mutual-help group meetings).

Less than ideally, some patients simply stop taking their medication without consulting the prescriber. Alternatively, a patient may ask to discontinue medication use because of side effects or other reasons. Still other patients must discontinue medication use because of a significant negative laboratory finding or problem with their physical health status.^{5,24}

The clinician should help the patient withdraw from the medication at an appropriate pace and encourage the patient to continue with psychosocial therapies and participation in mutual-help groups. In the case of extended-release injectable naltrexone, withdrawal is termination of the monthly injection. Patients who resist treatment should be reassessed for co-occurring disorders.

If the patient wishes to continue treatment, his or her engagement in counseling and other psychosocial services should be intensified.¹⁰⁰ However, if the patient does not want to continue treatment, the physician may consider referring him or her to an addiction specialist or treatment program.¹⁷

Relapse can be fatal. Patients who relapse to opioid use after being treated with extended-release injectable naltrexone or other medications

are at risk for accidental overdose and overdose-related death.¹⁰¹ If a patient reverts to pretreatment opioid use, as the blockade wanes, he or she may experience overdose and life-threatening consequences, including respiratory arrest and circulatory collapse.²⁷ Therefore, it is recommended that clinicians and patients jointly develop a relapse prevention plan.⁸⁴ SAMHSA's Opioid Overdose Toolkit¹⁰² includes strategies for developing such a plan that includes ways to address emergency reversal of actual or suspected opioid overdose (see Appendix B for more information).

Relapse to drug use often is preceded by emotional and cognitive relapse. Negative mood states may be warning signs of impending relapse, as are behaviors such as isolating or overcommitting oneself or failing to maintain healthful sleeping and eating habits. People in recovery may need to plan how to respond to disappointments and celebrations without relapsing to drug use.

Cognitive patterns that may predict relapse include thinking that others are having more fun, glamorizing past drug use, and seeing opportunities to relapse without getting caught when others are otherwise occupied or away. The relapse prevention plan should include strategies for managing these thoughts when they arise, such as contacting a supportive person, imposing a specific waiting period before acting, distracting oneself with physical or enjoyable activities, making a list of the pros and cons of drug use, and deciding not to use drugs "just for today."

Although relapse may be seen as a normal part of a chronic medical disorder, relapse to using opioids after a period of abstinence is strongly associated with overdose. Patients should understand that medication treatment can be resumed if they find themselves unable to cope with negative moods or thoughts.

Every effort should be made to avoid secretiveness and shame about relapse. Providers may wish to consider providing newly medication-free patients with naloxone and supporting their family and friends in learning how to use it. This effort conveys the message that relapse may occur but that the patient has the opportunity to reenter treatment alive and well.

Voluntary Termination of Medication-Assisted Treatment

When the patient and physician agree to discontinue medication-assisted treatment, medically supervised withdrawal should be followed by long-term, drug-free treatment to minimize the risk of relapse.

Both the physician and the patient should accept that the patient may need or want to resume medication-assisted treatment, either with extended-release naltrexone or with another medication.¹⁰⁰ Patients also should be assured that relapse need not occur for them to be reinstated on medication-assisted treatment.¹⁰

If the best clinical course is not clear, consultation with a specialist may be helpful. The results of the consultation should be discussed with the patient and added to the patient's record.²⁵

Referring a Patient for More Intensive Care

If office-based interventions are not effective for a given patient or if the clinician does not have the resources to offer needed care, the patient should be referred for more intensive or specialized services. Many specialty treatment programs provide services that address withdrawal and craving; management of long-term abstinence through pharmacotherapy; case monitoring; individual, group, and family/couples counseling and therapy; other psychosocial services such as vocational counseling; and referral to mutual-help groups.⁵

Specialized treatment programs anywhere in the United States can be identified through use of the Substance Abuse Behavioral Health Treatment Services Locator on the SAMHSA Web site at <http://www.findtreatment.samhsa.gov>.

A physician who is planning to treat a patient for opioid use disorder should become familiar with local treatment resources. Developing relationships with such specialized practitioners and programs facilitates the process of consultation and referral. In addition, understanding a program's treatment duration, modality, philosophy, and continuing-care options helps the physician identify appropriate placements for patients who no longer are

candidates for treatment in the general medical office.

A patient may become a candidate for referral to a more structured treatment environment (such as an OTP) for the following reasons:

- **Noncompliance with the treatment plan:** For example, a patient may continue to misuse opioids or fail to appear for scheduled monthly doses of extended-release injectable naltrexone. In such a situation, it may be advisable to transfer the patient to another medication or to refer him or her to a specialized practitioner or treatment setting for more intensive care.
- **Noncompliance with agreed-on activities:** A patient who refuses to participate in counseling or mutual-help groups may need more structure than can be provided in a general medical office and may be better served by an addiction specialist or in an OTP.
- **Threats or verbal abuse:** The patient who verbally abuses office staff, exhibits out-of-control behavior, or otherwise threatens the safety and well-being of office personnel or other patients is a special concern. Such a patient requires more structure than can be provided in a general medical office and should be referred to an addiction specialist or OTP.
- **Nonpayment for services:** If payment is owed for a backlog of bills and the patient has made no effort to arrange a payment plan or to access resources for payment, treatment termination may be necessary but should be done with care to ensure the patient does not leave without treatment options (i.e., patient abandonment).

Conditions that result in termination of treatment in a general medical office setting should be outlined in the treatment agreement or informed consent.⁹⁹

Special Considerations

Situations that may require additional arrangements or a delay in referring or discharging a patient include the following:⁹⁹

- If the patient is in an acute phase of treatment, termination must be delayed until the acute phase has passed. If the practitioner is the only source of treatment for the patient's opioid use disorder in a reasonable driving distance, the practitioner may need to continue care until other arrangements can be made.
- If the practitioner is the only source of a particular type of specialized medical care, he or she may need to continue care until the patient can be safely transferred to another practitioner who can provide such care.
- If the patient is a member of a prepaid health plan, the patient cannot be discharged until the practitioner has communicated with the third-party payer to ask that the patient be transferred to another practitioner.

It may become necessary to reinstate pharmacotherapy with extended-release injectable naltrexone or another medication or to provide other treatment services if relapse appears imminent or occurs.²⁵

Documenting the Decision and Notifying the Patient

When terminating the physician–patient relationship (and no special considerations are present), the reasons for such termination should be formally documented in the patient record.

The patient also should be given a written notice that he or she must find another health care provider within a stipulated period. The notice should be mailed to the patient by certified mail, return receipt requested. Copies of the letter should be filed in the patient's medical record, along with the original certified mail receipt and the original certified mail return receipt (even if the patient refuses to sign for the certified letter).^{10,25}

SUMMARY

Medication-assisted treatment has shown much promise in reducing nonmedical use of opioids and restoring patients to a healthier life. Considerable research evidence and consensus among experts support the use of pharmacologic treatments for an opioid use disorder in primary care settings. In fact, primary care physicians and members of their health care provider teams are ideally situated to employ these medications to help their patients—particularly those who have been unwilling or unable to access treatment in specialized settings—achieve and sustain a robust recovery from drug use and a safer, healthier life.

A number of FDA-approved medications have been shown to be important elements of such treatment. Although some patients do not benefit from medication-assisted treatment, most do. For each patient deemed an appropriate candidate for

such treatment, multiple pharmacologic agents offer a variety of options so that treatment can be tailored to each patient's needs and circumstances.

Medication-assisted treatment has shown much promise in reducing nonmedical use of opioids and restoring patients to a healthier life.

In addition, new patient care models and improvements in the quality and quantity of treatment options are being encouraged through implementation of the Affordable Care Act. These new developments reveal the considerable potential for expanding the use of medication-assisted treatment as clinicians recognize their safety, efficacy, and cost-effectiveness.

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APPENDIX B: SOURCES OF INFORMATION

SAMHSA Publications and Web sites

National Registry of Evidence-based Programs and Practices

<http://www.nrepp.samhsa.gov/Index.aspx>

Treatment Improvement Protocol 45.

Detoxification and Substance Abuse Treatment.

HHS Publication No. (SMA) 08-4131

<http://www.kap.samhsa.gov/products/manuals/tips/pdf/TIP45.pdf>

SAMHSA Treatment Locator

<http://www.samhsa.gov/treatment/index.aspx>

SAMHSA Advisory: *The Role of Biomarkers in the Treatment of Alcohol Use Disorders*, 2012 Revision

http://www.kap.samhsa.gov/products/manuals/advisory/pdfs/Advisory_Biomarkers_Revision.pdf

Coding for Screening and Brief Intervention Reimbursement

<http://www.samhsa.gov/sbirt/coding-reimbursement>

General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occurring Mental and Substance Use Disorders

http://www.samhsa.gov/co-occurring/docs/Pharm_Principles_508.pdf

Opioid Overdose Toolkit

<http://www.store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742>

NIDA Publications and Web Sites

Comorbidity: Addiction and Other Mental Illness (Research Report Series; Publication Number 10-5771). Rockville, MD: National Institutes of Health, 2010.

Principles of Drug Addiction Treatment: A Research-Based Guide, Third Edition. Rockville, MD: National Institutes of Health, 2012.

Mentoring Network

Physician Clinical Support System for Medication-Assisted Treatment

<http://www.pcssmat.org>

Information About Mutual Support Groups

Narcotics Anonymous (NA)

<http://www.na.org>

Dual Recovery Anonymous (for patients with co-occurring psychiatric disorders)

<http://www.draonline.org>

Self-Management and Recovery Training

<http://www.smartrecovery.org>

Web-Based Courses

American Society of Addiction Medicine (ASAM) *SBIRT Core Training Program*

<http://www.sbirtraining.com/>

ASAM e-Live Learning Center

<http://www.softconference.com/asam/default.asp>

ASAM *From Assessment to Service Planning and Level of Care Course*

<http://www.changecompanies.net/asamcriteria/elearning.php>

Other Web Sites, Articles, and Texts

Alliance of States with Prescription Monitoring Programs

<http://www.pmpalliance.org/>

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Fact Sheet: Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services.*

<http://www.prescribetoprevent.files.wordpress.com/2012/01/sbirt-guidance-document.pdf>

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U.S. Departments of Veterans Affairs and Defense.
*VA/DoD Clinical Practice Guideline for
Management of Substance Use Disorders in the
Primary Care Setting.*

http://www.healthquality.va.gov/sud/sud_fulltext.pdf

The ASAM Criteria, Third Edition (PPC-3), 2013

[http://www.asam.org/publications/patient-
placement-criteria](http://www.asam.org/publications/patient-placement-criteria)

British Association for Psychopharmacology.
*Evidence-based guidelines for the pharmacological
management of substance abuse, harmful use,
addiction and comorbidity: Recommendations from
BAP.* London: June 2012.

[http://www.bap.org.uk/pdfs/BAPaddictionEBG_201
2.pdf](http://www.bap.org.uk/pdfs/BAPaddictionEBG_2012.pdf)

Principles of Addiction Medicine, Fifth Edition, 2014

[http://www.asam.org/publications/principles-of-
addiction-medicine](http://www.asam.org/publications/principles-of-addiction-medicine)

Principles of Addiction Medicine: The Essentials

[http://www.asam.org/publications/principles-the-
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Disorders*, Fifth Edition (DSM-5), 2013

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APPENDIX C: ACKNOWLEDGMENTS

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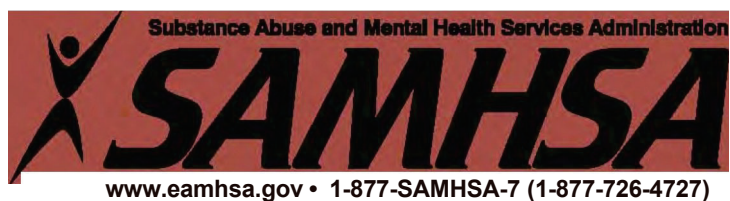
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RESOLUTION

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY

RESOLUTION NO: 483-2025 Ratify Be Well Texas Contract for Office-Based Treatment (OBT) Services Agreement for FY 2026 (BWT Contract No. 178475/42943/OBT-23)

DATE: October 8, 2025

STATE OF TEXAS }

COUNTY OF DALLAS }

BE IT REMEMBERED at a regular meeting of the North Texas Behavioral Health Authority held on the 8th day of October 2025, the following Resolution was adopted:

WHEREAS, the Health and Human Service Commission has designated the North Texas Behavioral Health Authority (NTBHA) as the Local Behavioral Health Authority (LBHA) for a service area consisting of the following six counties: Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall, effective January 1, 2017; and

WHEREAS, the NTBHA Board of Directors was created to govern the affairs of NTBHA; and

WHEREAS, NTBHA seeks to create a well-managed, integrated, and high-quality delivery system of behavioral health services available to eligible consumers residing in our catchment area; and

WHEREAS, NTBHA is responsible for the management of the network of behavioral health providers; and

WHEREAS, NTBHA seeks to (1) Maintain a competent and committed workforce, (2) Facilitate access to behavioral health services, (3) Manage core operations efficiently and effectively, and (4) Identify and develop additional opportunities for service area development.

IT IS THEREFORE RESOLVED that the North Texas Behavioral Health Authority Board of Directors ratifies the signature of the CEO on the Be Well Texas Contract for Office-Based Treatment (OBT) Services Agreement for FY2026. (BWT Contract No. 178475/42943/OBT-23).

DONE IN OPEN MEETING, this the 8th day of October 2025.

Recommended by:

Carol E. Lucky
Chief Executive Officer
North Texas Behavioral Health Authority

Commissioner Dr. Elba Garcia
Chair, Board of Directors
North Texas Behavioral Health Authority



BOARD OF DIRECTORS MEETING

Summary

DATE: October 8, 2025

AGENDA ITEM #18: Resolution 483-2025 Ratify Be Well Texas Contract for Office-Based Treatment (OBT) Services Agreement for FY2026. (BWT Contract No. 178475 / 42943 / OBT-23)

Recommendation/Motion: Ratify the signature of the CEO on the Be Well Texas Contract for Office-Based Treatment (OBT) Services Agreement for FY2026 (BWT Contract No. 178475 / 42943 / OBT-23)

Background:

This is a new contract from Be Well Texas with a total not-to-exceed amount of \$721,603.14 for FY2026. No matching funds are required.

The purpose of this Grant Agreement is to ensure the provision of office-based treatment (OBT) services to alleviate the adverse physiological effects of withdrawal from the use of opioids as required to meet the individualized needs of the client with opioid use disorders (OUD) through the provision of buprenorphine and extended-release injectable naltrexone in combination with counseling and behavioral therapies.

Financial Information:

The total budgeted amount of this Grant Agreement for the life of the contract is \$721,603.14.

The Grantee is not required to provide any matching funds over the life of the contract. Funds will be disbursed on an invoice/reimbursement for services basis.

<u>FISCAL YEAR</u>	<u>BWT SHARE</u>	<u>MATCH</u>	<u>TOTAL CV</u>
FY26	\$721,603.14	\$0.00	\$721,603.14

Implementation Schedule: Upon Ratification by the NTBHA board.

Attachments: 18. BeWellTx_OBOT_NTBHA_PSAgreement

Aligns with Visions #1, 2, 3, and 4

NTBHA Strategic Visions



Vision #1 NTBHA will maintain a competent and committed workforce.
Vision #2 NTBHA will facilitate access to behavioral health services.
Vision #3 NTBHA will manage core operations efficiently and effectively.
Vision #4 NTBHA will identify and develop additional opportunities for service area development.

Presented By: Carol Lucky, Chief Executive Officer



AGREEMENT NUMBER: 178475 / 42943 / OBT-23

**PURCHASED SERVICES AGREEMENT
Office-Based Treatment (OBT) Services**

This Purchased Services Agreement (hereinafter “Agreement”) is entered to specify the terms and conditions under which The University of Texas Health Science Center at San Antonio (hereinafter “UTHSA”) shall purchase services from North Texas Behavioral Health Authority (hereinafter “Provider”) in support of UTHSA’s project entitled “Office-Based Treatment (OBT) Services” (hereinafter “Initiative”). Funds from this appropriation were awarded to the Texas Health and Human Services Commission (HHSC). Funding for this project is made available from the Texas Health and Human Services Commission (hereinafter “system agency”) under HHS001646500001.

- 1. Term of Performance.** This Agreement term is from September 1, 2025 through August 31, 2026, with eligible expenditures allowed from September 1, 2025 through August 31, 2026.
- 2. Statement of Work.** Provider will be providing all the necessary qualified personnel, equipment, materials and facilities to accomplish the services as set forth attached hereto and incorporated herein with the Statement of Work (Attachment A).
- 3. Termination.** This Agreement may be terminated in whole or in part in any of the following cases: a) by either party upon thirty (30) days prior written notice; b) by either party if the other party materially fails to comply with the terms and conditions of this Agreement; or c) by either party without prior notice when such action is necessary to protect the safety of patients.
- 4. Consideration and Payment.** Provider shall submit billable medication service notes and/or billable progress notes through the Clinical Management for Behavioral Health Services (CMBHS) System after services are rendered. Monthly claims shall be generated by the 5th calendar day in CMBHS. Provider will be reimbursed for services provided utilizing the established unit rates. Final deadline to submit billable medication service notes and/or billable progress notes through CMBHS will be no later than September 5, 2026. Additional information regarding Consideration and Payment is outlined in Attachment B, Program Services and Unit Rates.

5. **Reports.** Provider shall submit reports as specified in the Statement of Work (Attachment A), attached hereto and incorporated herein. In addition, Provider may be asked to furnish other reports, at such time and in such form, as reasonably requested by UTHSA during the term of this Agreement.
6. **Right to Access.** Provider shall allow UT Health, Texas Health and Human Services, State Auditor's Office (SAO), Office of Inspector General (OIG), and the Comptroller General of the United States, and any of their representatives, the right of access to inspect the work and the premises on which any work is performed and the right to audit the Provider in accordance with §200.300 of the OMB Uniform Guidance.
7. **Publications, Copyrights, and Confidentiality.** No party shall, without the prior written consent of the other party, use in advertising, publicity, or otherwise, the name, trademark, logo, symbol, or other image of the other party, its employees or agents, including without limitation, any of such relating to UTHSA and Provider. Provider (including its employees, agents, and representatives) shall not issue or disseminate any press release or statement, nor initiate any communication of information regarding this initiative (written or oral) to the communications media without the prior written consent of UTHSA.

Disclosure of information the parties wish to remain confidential and proprietary information (hereinafter collectively, "Confidential Information") directly pertaining to the project is in confidence and thus the Parties agree to:

- a. (1) Not disclose the Confidential Information, as defined above, to any other person and (2) use at least the same degree of care to maintain the Confidential Information as the Receiving Party uses in maintaining its own confidential information, but always at least a reasonable degree of care;
- b. Use the Confidential Information only for the Purpose;
- c. Restrict disclosure of the Confidential Information solely to those employees of the Receiving Party having a need to know such Confidential Information in order to accomplish the Purpose;
- d. Advise each such employee, before he or she receives access to the Confidential Information, of the obligations of the Parties under this Agreement, and require each such employee to maintain those obligations. The Confidential Information may be communicated to the University's scientific and/or institutional review committee(s) under a similar, appropriate understanding of the confidential and/or proprietary nature of the Confidential Information supplied and to further the Purpose.
- e. Within fifteen (15) days following written request of the Disclosing Party return to the Disclosing Party all documentation, copies, notes, diagrams, computer memory media and other materials containing any portion of the Confidential Information which was provided by the Disclosing Party, or confirm to Disclosing Party, in writing, the destruction of such materials. The Parties shall have the right to retain one (1) copy in a secure location for the sole purpose of determining any continuing obligations of confidentiality under this Agreement. This Agreement imposes no obligation on the Receiving Party with respect to any portion of the Confidential Information received from the Disclosing Party which (a) was known to Receiving Party prior to disclosure by Disclosing Party, (b) is lawfully obtained by Receiving Party from a third party under no obligation of confidentiality, (c) is or becomes generally known or publicly available other than by unauthorized disclosure, (d) is independently developed by Receiving Party, (e) is disclosed by Disclosing Party to a third party without a duty of confidentiality on the third party, or (f) is not disclosed in writing or

reduced to writing and marked with an appropriate confidentiality legend within thirty (30) days after disclosure. In addition, a Party may disclose to third parties Confidential Information of the other Party to the minimal extent such disclosure is required to comply with law or regulation, provided that to the extent possible the Party required to make such disclosure shall notify disclosing Party and assert or allow disclosing Party to assert any exclusions or exemptions that may be available to it and/or seek a protective order with respect thereto. The Confidential Information provided by the Disclosing Party shall remain the sole property of Disclosing Party.

- 8. Patents and Intellectual Property.** Ideas, know-how, data (including initiative results), and other intellectual property generated under this Agreement shall be the sole and exclusive property of UTHSA and inventorship shall be determined in accordance with U.S. Patent laws. Provider shall also grant to UTHSA an irrevocable, royalty-free, worldwide, non-exclusive license to each invention for which it is unable to assign rights to UTHSA.
- 9. HIPAA.** Provider shall be responsible for full compliance with all applicable HIPAA regulations. Provider shall collect, use, and disclose Protected Health Information, as defined in the HIPAA regulations. The Business Associate Agreement (BAA) agreement terms and conditions attached hereto as Attachment D are incorporated herein and must be signed and executed for non-covered entities. Covered entities are not required to execute Attachment D, but must mark they are a HIPAA covered entity in Attachment D. In the event of conflict between this agreement and Attachment D, Attachment D supersedes for all issues regarding Protected Health Information as defined in the BAA.
- 10. Liability and Insurance.** Each party shall be responsible for its own negligent acts or omissions and the negligent acts or omissions of its employees, agents, officers, or directors, to the extent allowed by law. Provider represents and certifies that it and its employees are covered by sufficient malpractice and general liability insurance, or program of self-insurance to fully perform their responsibilities hereunder.
- 11. Debarment.** Provider certifies that it has not been debarred under the provisions of the Generic Drug Enforcement Act of 1992, or other applicable government regulations and Provider represents that, to the best of its knowledge after reasonable inquiry, its employees are not and have never been so debarred and that it will not use in any capacity, in connection with the services to be performed under this Agreement, any individual who has been so debarred.
- 12. Federal Funding.** This Agreement is made with federal funds awarded to Provider, the following provisions are made a part of this Agreement, as applicable:
 - a. Equal Employment Opportunity. Provider agrees to comply with E.O. 11246, "Equal Employment Opportunity," as amended by E.E. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."
 - b. Copeland "Anti-kickback" Act (18 U.S.C. 874 and U.S.C. 276c). Provider will comply with Copeland "Anti-Kickback" Act (18 U.S.C. 874), as supplemented by Department of Labor regulations (29 CFR Par 3, "Contractors and Sub-contractors on Public Buildings or Public Works Financed in Whole or in Part by Loans or Grants from the United States"). The Act provides that each contractor or sub-recipient will be prohibited from inducing, by any means, any person employed in the construction,

completion or repair of public work, to give up any part of the compensation to which he is otherwise entitled. Provider is bound to report all suspected or reported violations to the federal awarding agency.

- c. Davis-Bacon Act, as amended (40 U.S.C. 276a to a-7). Provider will comply with the Davis-Bacon Act (40 U.S.C. 276a- to a-7) as supplemented by Department of Labor regulations (29 CFR part 5, “Labor Standards Provisions Applicable to Contracts Governing Federally Financed and Assisted Construction”). Under this Act, contractors will be required to pay wages to laborers and mechanics at a rate not less than the minimum wages specified in a wage determination made by the Secretary of Labor. In addition, contractors will be required to pay wages not less than once a week. Should the Davis-Bacon Act apply to this Agreement, this Contract is conditioned upon the acceptance by Provider of the wage determination. Provider is bound to report all suspected or reported violations to the federal awarding agency.
- d. Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended. Provider agrees to comply with all applicable standards, orders, or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 et seq.). University is bound to report violations to the federal awarding agency and the Regional Office of the Environmental Protection Agency.
- e. Byrd Anti-Lobbying Amendment (31 U.S.C. 1352). Provider is required to file the required Anti-Lobbying Certification certifying that it will not and has not used federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of a member of Congress in connection with obtaining any federal contract, grant, or any other award covered by 31 U.S.C. 1352.
- f. EEOC and Veterans. Provider shall abide by the requirements of 41 CFR §§ 60- 1.4(a), 60-300.5(a) and 60-741.5(a). These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities and prohibit discrimination against all individuals based on their race, color, religion, sex, or national origin. Moreover, these regulations require that covered prime contractors and Provider’s take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, national origin, protected veteran status or disability.

13. Independent Contractor. Provider’s relationship to UTHSA under this Agreement shall be that of an independent contractor and not an agent, joint venture, or partner of UTHSA and, as such, no employees, staff, or agents of Provider shall be entitled to any benefits applicable to employees of UTHSA.

14. Boycotting Israel. Pursuant to Chapter 2271, *Texas Government Code*, Provider certifies it (1) does not currently boycott Israel; and (2) will not boycott Israel during the Term of this Agreement. Provider acknowledges this Agreement may be terminated and payment withheld if this certification is inaccurate.

15. Ethics Matters, No Financial Interest. Provider and its employees, agents, representatives and subcontractors have read and understand UTHSA Conflicts of Interest Policy, UTHSA’s Standards of Conduct Guide at <https://www.utsystem.edu/documents/docs/policies-rules/ut-system-administration-standards-conduct-guide>, and applicable state ethics laws and rules available at <https://www.utsystem.edu/offices/systemwide-compliance/ethics>. Neither Provider nor its employees, agents, representatives or subcontractors will assist or cause

UTHSA employees to violate UTHSA's Conflicts of Interest Policy, provisions described by UTHSA's Standards of Conduct Guide, or applicable state ethics laws or rules. Provider represents and warrants that no member of the Board has a direct or indirect financial interest in the transaction that is the subject of this Agreement.

16. Subcontracting and Assignment. This Agreement may not be subcontracted, assigned or transferred by either party without the prior written consent of the other.

17. Entire Agreement. This Agreement constitutes the entire agreement between the parties. Any alterations, modification, or amendment to this Agreement must be in writing and signed by authorized officials of both parties. No changes in the Statement of Work will be made unless agreed upon by UTHSA and Provider.

18. Notices. Any notices to be given under these terms and conditions unless otherwise stated shall be submitted as follows:

To UTHSA:

For Technical Matters:

Cynthia Blaylock
The University of Texas Health
Science Center at San Antonio
5109 Medical Drive
San Antonio, TX 78229
210-450-7119
blaylockc@uthscsa.edu

For Business Matters:

Chris G. Green, CPA
AVP Sponsored Programs
The University of Texas Health
Science Center at San Antonio
7703 Floyd Curl Drive, MSC 7828
San Antonio, TX 78229
210-567-2340
grants@uthscsa.edu

To Provider:

For Technical Matters:

Name: _____
Title: _____
North Texas Behavioral Health
Authority
8111 LBJ Fwy., Ste. 900
Dallas, TX 75251
Phone: _____
Email: _____

For Business Matters:

Name: Carol Lucky
Title: Chief Executive Officer
North Texas Behavioral Health
Authority
8111 LBJ Fwy., Ste. 900
Dallas, TX 75251
Phone: 214-366-9407
Email: clucky@ntbha.org

The parties hereby accept and agree to this Agreement.

By: _____
Chris G. Green, CPA
Assistant Vice President, Sponsored
Programs
Date: _____

By: _____
Name: Carol Lucky
Title: Chief Executive Officer
Date: _____

Attachments:

- A. Statement of Work (SOW)**
- B. Program Services and Unit Rates**
- C. Data Use Agreement (DUA)**
- D. Business Associate Agreement (BAA)**
- E. Qualified Services Organization Agreement (QSOA)**
- F. Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder**

ATTACHMENT A
SCOPE OF GRANT PROJECT – OBT

I. PURPOSE

To ensure the provision of office-based treatment (OBT) services to alleviate the adverse physiological effects of withdrawal from the use of opioids as required to meet the individualized needs of the client with opioid use disorders (OUD) through the provision of buprenorphine and extended-release injectable naltrexone in combination with counseling and behavioral therapies.

II. TARGET POPULATION

Texas residents who meet financial criteria for Health and Human Services Commission (HHSC)-funded substance use disorder (SUD) services and have met the Diagnostic and Statistical Manual of Mental Disorders criteria for opioid use disorder.

III. GOALS

The program goals are to:

- A. Implement service delivery models that enable the full spectrum of treatment that facilitates long-term recovery from opioid use disorders.
- B. Increase access to FDA-approved medications for the treatment of opioid use disorder (OUD) for individuals in Office-Based Treatment (OBT) services.

IV. SERVICE AREA

Provider shall provide services to the SECTION II, TARGET POPULATION, in the HHS health region and counties documented, as follows:

Region: Statewide

To review counties within an HHS health region, refer to the below link for a list of counties within a region:

<https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/hhs-regional-map.pdf>

V. PROVIDER RESPONSIBILITIES

Providers shall:

- A. Use the funds and associated billing codes provided through this Contract to subcontract adult outpatient, physician and pharmacy services.
- B. Provide medications approved for office-based treatment of opioid use disorders along with providing counseling and behavioral therapy.
- C. Maintain, throughout the duration of the Contract, of the provider organizations' certification and licensure compliance with applicable statutes, guidelines, and regulations related to outpatient treatment services and office-based treatment as adopted by HHSC, the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT), and the Drug Enforcement Agency (DEA).
- D. Utilize and adhere to the most current Texas Health and Human Psychiatric Drug Formulary, including Reserve Drug Criteria and Audit Criteria, which can be found at:

<https://www.hhs.texas.gov/providers/health-care-facilities-regulation/psychiatric-drug-formulary>

- E. Utilize the HHSC ATTACHMENT F, GUIDELINES FOR THE USE OF THE EXTENDED-RELEASE INJECTABLE NALTREXONE, as applicable.
- F. Ensure Physician(s), Physician's Assistant(s) and Nurse Practitioner(s) providing OBT services:
 - a. Maintain their licenses to practice medicine in good standing for the duration of the Contract; and
 - b. Meet the Medication Access and Training Expansion (MATE) Act training Requirements as delineated in Public Law 117-328, Section 1263, Consolidated Appropriations Act, 2023.
- G. Ensure that medical and clinical staff providing OBT services maintain compliance with rules adopted by HHSC related to medication and counseling treatment, and records management as required by SAMHSA and the Code of Federal Regulations (CFR).
- H. Ensure that clinical staff providing direct OBT services maintain their professional license and are in compliance with professional rules adopted by HHSC as stated in Title 25 of the Texas Administrative Code (TAC), Chapter 562, Health Professions Regulation, Licensed Chemical Dependency Counselors (LCDCs) throughout the duration of the Contract.
- I. Adhere to the Texas Targeted Opioid Response (TTOR) Brand Guidelines, ATTACHMENT A-6, TTOR BRAND GUIDELINES, V.3.0, for all communications. The TTOR Brand Guidelines provide a guide for the TTOR team and all TTOR-funded projects to ensure brand consistency. Provider may apply for an exception to be approved by Be Well Texas (BWTX), but at a minimum Provider shall utilize the approved voice, tone and logo described in the TTOR Brand Guidelines.
- J. Ensure all project materials include the following attribution statement: "This project is supported by Texas Targeted Opioid Response, a public health initiative operated by the Texas Health and Human Services Commission through federal funding from the Substance Abuse and Mental Health Services Administration grant award number HHS001646500001."
- K. Ensure all presentation and training materials include the following disclaimer: "The views expressed do not necessarily reflect the official policies of the Department of Health and Human Services or Texas Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. or Texas Government."
- L. Ensure all public-facing project materials have been submitted to the Provider and submitted and approved by BWTX at least two weeks prior to publication. Public-facing materials include but are not limited to press releases, publications, reports, fact sheets, and advertisements. BWTX will provide guidance on the approval process and timeline.
- M. Ensure that appropriate staff and subcontractors participate in HHSC & BWTX webinars, conference calls, and trainings at the specified dates, times, and locations as required by BWTX.
- N. Ensure the establishment of a comprehensive resource network made up of community, health, and social service agencies serving or having interest in the target population.

Provider and subcontractors must engage and collaborate with community resources through written agreements defining the collaborative relationships, including:

- a. HHSC-funded Treatment:
 - i. Prevention
 - ii. Recovery
 - iii. Intervention
 - iv. Mental Health
 - v. Co-occurring psychiatric substance use disorders (COPSD) providers
- b. Local Mental Health Authorities (LMHAs), and/or Local Behavioral Health Authorities (LBHAs) within Provider's Health & Human Services (HHS) Region and service area (<https://resources.hhs.texas.gov/pages/find-services>) including HHSC-funded providers or HHSC-funded Outreach, Screening, Assessment, and Referral (OSR) providers; and Local and regional health departments, local Federally Qualified Health Centers (FQHCs) and other primary care centers.
- c. At BWTX discretion, Provider shall coordinate services with BWTX identified stakeholders to improve access to the continuum of services offered by the BWTX. Coordination may include, but is not limited to, scheduled meetings, collaboration on related initiatives, and service referrals.

O. Service Delivery

- a. Ensure that screening, assessment, and admission occurs in the following manner:
 - i. If the client first presents either by phone or in person onsite, financial eligibility and screening must be documented. Screening must be conducted in a confidential, face-to-face interview unless there is documented justification for an interview by phone. The screening process in CMBHS must be used to determine the individual's needs and documentation of referral(s) to appropriate resources based on the screening.
 - ii. A CMBHS Substance Use Disorder Update Assessment with the Client must be conducted and documented, six months after admission and then annually thereafter.
 - iii. Individuals must be admitted based on the following: federal priority populations established for entering state-funded substance use disorder services, in accordance with 45 Code of Federal Regulations (CFR) §96.131:
 - 1. Pregnant injecting individuals must be admitted immediately;
 - 2. Pregnant individuals must be admitted immediately; and
 - 3. Injecting drug users must be admitted within 14 days.
 - iv. Admit individuals based on state priority populations established for entering state-funded substance use disorder services:
 - 1. Individuals identified as being at high risk of overdose must be admitted within 72 hours.
 - 2. Individuals referred by the Department of Family and Protective Services (DFPS) must be admitted within 72 hours;

3. Individuals experiencing housing instability or homelessness will be admitted to requested services within 72 hours: and
 4. All other populations.
- v. Ensure the following if subcontractor is unable to provide admission to individuals within these priority populations according to guidelines:
1. Provider will coordinate with an alternate provider, such as OSAR and/or directly to funded providers (<https://resources.hhs.texas.gov/pages/find-services>) for immediate admission; and
 2. Provider will notify program services unit staff at TTOR@hhsc.state.tx.us immediately if unable to admit in the 72 hours timeframe, so that assistance can be provided that ensures immediate admission to other appropriate services and proper coordination with the Department of Family and Protective Services (DFPS) staff when appropriate.
- P. Ensure compliance with the following throughout the duration of this Contract:
- a. A physician, physician assistant, or nurse practitioner that meets the MATE Act Training Requirements as delineated in Section 1263 of the Consolidated Appropriations Act, 2023, to provide patient evaluation and prescribing of buprenorphine. The agreement will include the following:
 - i. Referral process to and from LMHAs/LBHAs and prescribing physician;
 - b. Communication and transfer of records to and from the physician to the licensed outpatient staff. Records may include, but are not limited to, the following:
 - i. Admission notes from the physician with criteria met for office-based treatment (OBT);
 - ii. Urinalysis test/results;
 - iii. Medication orders to include milligrams, frequency, and duration; and
 - iv. Level of care determinations and frequency of outpatient counseling services.
 - c. Clinical data entry in CMBHS electronic medical record; and
 - d. Diversion control.
 - i. Physician, Physician Assistant, and Nurse Practitioner ensure OBT-approved client(s) receive evaluations and prescribe and administer extended-release injectable Naltrexone. The agreement shall include the following:
 1. Referral process to and from LMHAs/LBHAs and administering physician;
 2. Communication and transfer of records to and from the physician to the licensed outpatient staff. Records may include, but are not limited to, the following:
 - a. Admission notes from the physician with criteria met for office-based treatment (OBT);
 - b. Urinalysis test/results;
 - c. Medication orders;

- d. Level of care determination and frequency of outpatient counseling services.
 - e. Clinical data entry in CMBHS electronic medical record; and
 - f. A pharmacy that details the process of reimbursement for buprenorphine provision.
- Q. Ensure the provision of Medication and Counseling Treatment which shall include individual and group counseling services, specialized female services when applicable, and behavioral therapies as well as medication, to include buprenorphine and/or extended- release injectable naltrexone, to treat moderate to severe opioid use disorder. Provider will refer all OBT clients to the prescribing and administering physician and if applicable, referrals to the contracted pharmacy for the provision of buprenorphine.
- R. Ensure the provision of Overdose Prevention and Reversal Education in the following manner:
 - a. Overdose prevention education to clients on the waiting list.
 - b. Overdose prevention education to all clients prior to discharge, including clients who received the overdose prevention education prior to admission;
 - c. General overdose prevention and reversal education to all clients as a part of treatment education requirements to include education on how to access and administer naloxone;
 - d. Overdose prevention activities with clients with opioid use disorders and those clients who use drugs intravenously to include:
 - i. Education on overdose prevention and risk reduction strategies;
 - e. Education about and referral to HHSC-funded HIV Outreach services for clients with IV drug use history;
 - f. Education about and referral to HHSC-funded Pregnant Postpartum Intervention (PPI) services for pregnant clients, postpartum clients, and clients involved with Child Protective Services (CPS);
 - g. Referral to local community resources that work to reduce harm associated with high-risk behaviors associated with drug use; and
 - h. For detailed guidance, please refer to SAMHSA's Opioid Overdose Prevention Tool Kit found at: Overdose Prevention and Response Toolkit | SAMHSA.
- S. Ensure the following for pregnant women, injecting drug users, individuals at high risk for overdose, and individuals referred by the DFPS presenting for treatment:
 - a. Immediate admission (within 72 hours);
 - b. If unable to provide immediate admission to these populations, the notification must immediately be provided by Provider to the BWTX program services staff at TTOR@hhsc.state.tx.us & BeWellTx@uthscsa.edu so that assistance can be provided that ensures referral to an alternate provider for immediate admission.
 - c. Implementation of policies and procedures that conform with HHSC's definition for waitlist and interim services.
 - d. Report availability of capacity and waiting list information Monday through Friday through CMBHS and comply with procedures specified by BWTX.
- T. Ensure authorizations for OBT Services:
 - a. Occur in CMBHS prior to providing OBT services;

- b. Are not provided until the service has been authorized; and
 - c. Are compliant with the HHSC approved policies and procedures.
- U. Ensure interim services are provided or arranged for, including screening for tuberculosis, hepatitis B and C, sexually transmitted diseases (STDs), and Human Immunodeficiency Virus (HIV) and document in CMBHS.
- V. Ensure documentation in CMBHS for medication and counseling services, including, but not limited to:
 - a. OBT-related activities and services in CMBHS. This information will assist BWTX in determining the number of clients served and the OBT-related services and activities provided by Provider;
 - b. Informed consent form completion and upload to an administrative note and record clinical documentation in the client's CMBHS record, e.g. diagnostic tests such as the Clinical Institute Withdrawal Assessment or Beck Depression Inventory, physician orders, etc.
 - c. Counseling services, medication provision, and overdose prevention education within seven business days of service delivery. Physician orders and medication provision;
 - d. Outpatient SUD counseling services including individual, group, and psychoeducation;
 - e. The needs of the client using the CMBHS assessment tool;
 - f. The treatment plan including discharge criteria, and discharge plan; and
 - g. If a client is discharged, Provider will identify a specific physician or authorized healthcare professional, as appropriate, to whom the client is being discharged. The name, address, and telephone number of the provider caring for the client after discharge are to be recorded in the client's CMBHS record.
- W. Ensure staff providing OBT and/or counseling services maintain privacy and security controls related to confidential client information.
- X. Ensure that clinical staff providing direct services have the training and expertise in:
 - a. Motivational Enhancement Therapy (MET) or Motivational Interviewing (MI) techniques;
 - b. Overdose prevention;
 - c. Medication Assisted Treatment (MAT) Advocacy;
 - d. Co-Occurring Psychiatric & Substance Use Disorders (COPSD);
 - e. Trauma, abuse and neglect, violence, Post-Traumatic Stress Disorder (PTSD), and related conditions;
 - f. Medicaid, Temporary Aid to Needy Families (TANF), and Children's Health Insurance Plan (CHIP) eligibility.
 - g. Seeking Safety curriculum;
 - h. Fetal Alcohol Spectrum Disorders (FASD);
 - i. Cultural Competency, specifically including but not limited to gender and sexual identity and orientation; and
 - j. Substance Use and Child Welfare by the National Center for Substance Abuse and Child Welfare, Tutorial 1: Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals.

- Y. Ensure program directors and/or medical directors participate in monthly conference calls as scheduled by Be Well Texas and/or HHSC to address programmatic, documentation, or testing issues.
- Z. Ensure the following related to the Annual Survey:
 - a. Completion of the Medications for Opioid Use Disorder (MOUD) Programs Opioid Treatment Services (OTS) annual survey.
 - b. Use of the HHSC approved client satisfaction OTS annual survey template for collecting information from clients who have received MOUD Program services.
 - c. Development and coordination of a process for collecting client survey data.
 - d. Submission of results of client survey

VI. CONFERENCE CALLS

Provider shall:

- A. Ensure essential staff (e.g. program directors, program administrators, clinicians, contract manager, and/or medical directors) participate in monthly Provider conference calls as scheduled by BWTX to address programmatic, documentation, or testing issues.
- B. Additionally, BWTX may facilitate weekly and/or monthly conference calls with the Provider to review the Monthly Activity Report deliverables and to discuss all issues and/or concerns with implementing the scope of work.
- C. Provider may be requested to participate in quarterly interviews with the BWTX evaluation and quality assurance department to discuss program implementation and process improvement.

VII. BWTX TRAINING AND TECHNICAL ASSISTANCE

- A. Provider shall participate in a minimum of one (1) BWTX TxRx (Medications for Substance Use Disorder) Extension for Community Healthcare Outcomes (ECHO) per month-Online.
- B. TxRx ECHO sessions are held on the second and fourth Thursday of each month, from 12:00-1:00 PM Central Time. Provider shall attend the TxRx ECHO as members of the learning network.
- C. Participating staff members should include clinical care team members.
- D. Provider will lead at least one (1) case presentation during the term of this Agreement. BWTX will ensure appropriate technical assistance in presenting this case presentation.
- E. Provider will not be held responsible for attending any ECHO sessions cancelled by BWTX throughout the grant period or those that occur prior to the Provider's contract execution date.

VIII. PROGRAM AND QUALITY IMPROVEMENT EVALUATIONS

- A. Provider shall complete evaluations for all training and technical assistance programs completed, including the TxRx ECHO, Texas Substance Use Symposium, and technical assistance. Provider will complete evaluations on or before the date indicated on individual evaluation forms and surveys.
- B. BWTX Event Attendance
 - i. Provider shall attend BWTX custom technical assistance or training events when determined by BWTX to be directly relevant for the provider

and staff providing MOUD or related services. If it is not possible for the provider to attend, a video/audio recording will be made available.

IX. QUALITY MANAGEMENT REQUIREMENTS

Provider shall:

- A. Provider shall comply with all applicable rules published in the Texas Administrative Code (TAC). Provider shall also comply with all applicable Texas Health and Safety Codes, including laws related to drug paraphernalia under Health & Safety Code Chapter 481.
- B. BWTX will provide Quality Management (QM) and oversight as outlined in Texas Administrative Code Chapter 564 Quality Management, for all subcontractors performing activities required within Attachment A.
- C. Providers shall be reviewed on their compliance with contract and regulatory requirements and delivery of client care at least once per Fiscal Year during the term of the contract.
- D. Provider shall participate in onsite and/or desk reviews and continuous quality improvement (CQI) activities as defined and scheduled by BWTX which includes but not limited to data verification, performing reviews; and submitting supporting documentation and client records for review. Reviews may be conducted either announced or unannounced, as determined by BWTX.
- E. Providers found to be underperforming or noncompliant as a result of the quality monitoring performed shall submit a Performance Improvement Plan (PIP) or Corrective Action Plan (CAP) with supporting documentation for every audit finding, as requested by BWTX. These PIPs are to be monitored for completion and effectiveness at a future date to be determined by BWTX.
- F. Provider shall participate in and actively pursue CQI activities that support performance and outcomes improvement.
- G. Provider shall respond to consultation recommendations by BWTX, which may include, but are not limited to the following:
 - i. Staffing training;
 - ii. Self-monitoring activities guided by BWTX, including use of quality management tools by BWTX to identify compliance to contract and regulatory requirements and measure quality of the delivery of client care. A walkthrough of these audit tools is part of the Entrance Conference scheduled by BWTX at the beginning of the audit process for the Fiscal Year.
 - iii. Monitoring of performance reports in HHSC's electronic clinical management system.
- H. Provider shall maintain financial and programmatic performance records pertaining to but not limited to Spend Down: Expenses vs. Fiscal Year budget; Capacity vs. Allocated Census that is made available for inspection by BWTX, upon request.
- I. Failure to comply with the terms and conditions of the agreement may result in termination of the agreement with or without prior notice. Please reference section 3 Termination Clause.
- J. Provider shall maintain receipts for purchases for 7 years and will be subject to audit by BWTX. Failure to provide proof can result in refunding the monies to BWTX and a PIP.

- K. Right to Access- The Provider shall allow UT Health, Texas Health and Human Services, State Auditor's Office (SAO), Office of Inspector General (OIG), and the Comptroller General of the United States, and any of their representatives, the right to access to inspect the work and the premises on which any work is performed and the right to audit the Provider in accordance with §200.300 of the OMB Uniform Guidance.
- L. BWTX will develop a quarterly review schedule, and ensure all providers are reviewed at least once per fiscal year. BWTX shall document the Quality Management (QM) activities performed in the period being reported and include them in a section of the Quarterly Report. At a minimum, the QM activities section of the Quarterly Report should include the following: Date of review;
 - i. Name of contractor;
 - ii. Unique subcontractor's Identifier for the review;
 - iii. Type of review;
 - iv. Name of staff conducted review;
 - v. List of findings;
 - vi. Number of monitoring reviews conducted;
 - vii. Types of monitoring reviews conducted;
 - viii. Summary evaluation of findings and plan of oversight to facilitate compliance, if applicable;
 - ix. Number and nature of complaints received with resolutions for the complaints; and
 - x. List of significant findings that must, at a minimum, include the following:
 - 1. Immediate risk to health or safety;
 - 2. Participant abuse, neglect, or exploitation;
 - 3. Fraud, waste, or abuse reports; and
 - 4. Report criminal activity of any subcontractor's staff.
 - xi. BWTX will develop and utilize a quality management monitoring tool that must be completed to document all quality reviews. All completed tools with corrective actions documentation must be stored and made available to BWTX upon request.
 - xii. BWTX will monitor all subcontracts to ensure compliance. The required Quality Management report will include activities to support the QM activities for this project.

X. SUBMISSION SCHEDULE AND REPORTING REQUIREMENTS

Provider shall:

- A. Submit all deliverables to Clinical Management Behavioral Health Services (CMBHS) and/or any alternative method required by BWTX for documenting OBT-related activities, services, and testing. Provider is required to maintain access to required systems or platforms for the term of this Grant Agreement.
- B. Submit additional required deliverables for this contract upon request.
- C. Ensure the use of CMBHS components and/or functionality, in accordance with BWTX instructions. Subcontractor will use the updated components and/or functionality as

directed by Provider. Subcontractor's duty to submit documents survives the termination or expiration of this Contract.

- D. Ensure that the required number of clients are served per year based on funded amount.
- E. Ensure the performance and submission of Governmental Performance and Results Act (GPRA) assessments in compliance with 107 Stat. 285 – Public Law No. 103-62 (08/03/1993) for all participants who are engaged in treatment services in the following manner:
 - i. Assessments must be conducted face to face, unless a waiver is granted by the BWTX
 - ii. Conduct the GPRA assessment immediately after the client is stabilized on medication or within four weeks after admission, whichever is sooner;
 - iii. The GPRA assessments must be completed at intake, six-month follow-up, and discharge. Additionally, the six-month follow-up must be conducted between months five through seven, depending on the client's availability. Subcontractor will use CMBHS to conduct, document and enter assessments as close to real time as possible. Provider will aim to upload their data into CMBHS within 1 day, but it must be entered into CMBHS no later than 7 days after the GPRA assessment is conducted;
 - iv. Maintenance of a minimum of 80% follow-up rate for the six-month assessment, regardless of discharge status (including closed cases, administrative discharges, and participants who have left the program); and,
 - v. When directed by BWTX, ensure a new initial GPRA assessments is performed for all clients in services at the beginning of each fiscal year.
- F. Note that if the due date is on a weekend or holiday, the due date is the following business day.
- G. Submitted documents will survive the termination or expiration of this Contract.
- H. Respond to requests and provide information and/or data meeting federal and state legislative requirements as requested and within the timelines specified.
- I. Monitor performance of the requirements in this Attachment and comply with the Contract's terms and conditions.
- J. Submit all documents listed in the table displayed in this section using the naming conventions provided by the stated due date.

Report Name	Due Date	Submission
CMBHS Security Attestation Form and List of Authorized Users	Biannually, Each Fiscal Year: September 15 th and March 15 th	BeWellTXHelpDesk@uthscsa.edu
Monthly Capacity Report	10 th day of the following month	Monthly in CMBHS
Wait List	Daily, update as needed	CMBHS daily, as needed
GPRA Assessments	Ongoing	CMBHS
Closeout Documents	9/5/2026	Claims and GPRA Assessment final deadline entered in CMBHS
Claims	5 th calendar day for services rendered from previous month.	CMBHS
Quality Audit	TBD	BeWellTXQuality@uthscsa.edu
Monthly Conference Calls	Third Friday of each Month, from 10:00-11:00 AM Central Time	Attendance required
TxRx ECHO Sessions	Second and fourth Thursday of each month, from 12:00-1:00 PM Central Time	Attendance required (1 session per month)
MATE Act Training Requirements (for Physician(s), Physician's Assistant(s), and Nurse Practitioner(s))	Upon request.	Provider will maintain documentation and provide to BWTX Quality upon request.
Memorandum of Understanding (MOU)		
Executed MOU with FQHC (Federally Qualified Health Center)	Upon request.	BeWellTXQuality@uthscsa.edu
Executed MOU(s) with HHSC Funded Treatment, Prevention, Recovery, Intervention, Mental Health, Co-occurring psychiatric substance use disorders (COPSD) Providers.	Upon request.	BeWellTXQuality@uthscsa.edu
Executed MOU with OSAR (Outreach, Screening, Assessment, Referral)	Upon request.	Provider will maintain documentation and provide to BWTX Quality upon request.
Executed MOU with LMHA/LBHA (Local Mental/Behavioral Health Authority)	Upon request.	Provider will maintain documentation and provide to BWTX Quality upon request.
Policies & Procedures		
Waitlist Policy & Procedure	Upon request.	BWTX Quality upon request.

**ATTACHMENT B
PROGRAM SERVICES AND UNIT RATES**

- I.** Provider will generate all service claims through CMBHS monthly. Services claims generated through CMBHS by Provider will be utilized by UTHSA to generate reimbursement to Provider. By execution of this agreement, Provider certifies and attests that all service claims generated through CMBHS are true, complete and accurate. Provider is aware that any false, fictitious, or fraudulent submission may subject Provider to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise in accordance with U.S. Code Title 18, Section 1001 and Title 31, Sections 3729-3730 and 3801-3812. In addition, all services entered into CMBHS by Provider will be made in accordance with the conditions of this agreement and will be subject to audit by UTHSA, Texas Health and Human Services or a third party.
- II.** Provider shall maintain receipts for purchases for 7 years and will be subject to audit by BWTX. Failure to provide proof can result in refunding the monies to BWTX and a PIP.

III. Funded Capacity

Funded capacity is defined as the stated number of clients who will be concurrently served as determined by this Contract.

Funded Capacity*	Budget*
55	\$721,603.14
<i>*Subject to change</i>	

IV. Service Unit Rates

The Treatment Rate Sheet link below is subject to change and contingent on available funding.

<https://www.hhs.texas.gov/providers/behavioral-health-services-providers/substance-use-service-providers>

V. Invoice and Payment

Provider shall generate billable medication service notes and/or billable progress notes to BWTX through the Clinical Management for Behavioral Health Services (CMBHS) System after services are rendered. Monthly claims shall be generated by the 5th calendar day in CMBHS. Provider will be reimbursed for services provided under this Contract utilizing the established unit rates. The final deadline to generate billable medication service notes and/or billable progress notes to BWTX through CMBHS for the grant term will be no later than 9/15/2026.

VI. Recapture of Funds

At its sole discretion, BWTX may withhold all or part of any payment to the Provider to offset overpayments, unallowable or ineligible costs made to the Provider, or require Provider to promptly refund or credit within (30) calendar days of written notice any funds erroneously paid by BWTX which are not expressly authorized under the Contract.

VII. Claims and Payment Requirements

- a. Provider will demonstrate their capacity to bill insurance and Medicaid for those clients with insurance coverage. Funds under the Contract can only be used as payment of last

resort, which means that other applicable reimbursement resources such as Medicaid or other third-party payors will be billed first.

- b. If the client has Medicaid or other third-party payors and does cover Medication Assisted Treatment, the client will not qualify for funding under this grant.
- c. If the client has Medicaid or other third-party payors' insurance, but does not cover Medication Assisted Treatment, the client may still qualify for funding under this grant but will need to provide documentation Medication Assisted Treatment is not covered under their Medicaid or other third-party payor insurance.
- d. Provider shall operate within the funded capacity and awarded budget amount indicated in this Contract for the duration of the contract term.
- e. Submitted claims in excess of the Provider's stated funded capacity will be approved for payment based on availability of funds, and contingent upon approval of a subsequent amendment.
- f. BWTX, at its sole discretion, will adjust the funded capacity of this Contract based on Provider's performance and/or other criteria determined by BWTX, and contingent on availability of funds.
- g. Provider shall not exceed the awarded budget as indicated in this Contract for the duration of the contract term unless approved by the BWTX team.
- h. Except as indicated by the CMBHS financial eligibility assessment, Provider will accept reimbursement or payment from BWTX as payment in full for services or goods provided to clients or participants, and Provider will not seek additional reimbursement or payment for services or goods, to include benefits received from federal, state, or local sources, from clients or participants.
- i. Document all specified required activities and services in the Clinical Management for Behavioral Health Services (CMBHS) system.
- j. Document Financial Eligibility appropriately in CMBHS before charging any individuals for screening and assessment. Provider will not require payments from individuals determined by the Financial Eligibility function of CMBHS to be eligible for state-funded services for screening and assessments.
- k. Ensure requirements of Texas residency eligibility, Financial Eligibility, and clinical eligibility are met, as determined by CMBHS client profile, CMBHS SUD assessment, and financial eligibility documentation in CMBHS.
- l. If the client is eligible for state-funded services determined by the Financial Eligibility documented by the Provider in CMBHS;
- m. Provider shall upload proof of income and proof of residency in CMBHS under Financial Eligibility.
- n. Provider shall run the MEV every 30 days and prior to the 5th calendar day of each month. It is the provider's responsibility to ensure that claims entered into CMBHS are not eligible for Medicaid, Medicare, or any third party insurance.
- o. Please note, the client is not eligible for BWTX-funded services until all required documentation is submitted as referenced above.
- p. Failure to comply with the financial eligibility documentation, and MEV requirements will result in an audit finding. A PIP will follow to provide additional training and assistance.

VIII. Third-Party Payors

- a. Provider shall not seek reimbursement from BWTX if the individual is covered by a third-party payor.
- b. Demonstrate the capacity to bill insurance, Medicaid, and/or Medicare for individuals with health insurance coverage.
- c. Contract with Medicaid and the identified Managed Care Organizations in service delivery Region.
- d. Contract with Medicare in the service delivery region.
- e. Refer individuals to a treatment Program that is approved by the individual's third-party payor if Provider is not eligible for reimbursement.
- f. If the approved treatment Program refuses treatment services to the Client and documents that refusal, Provider may provide treatment services and bill BWTX; The refusal, including third-party payor and approved treatment Program, shall be documented in the Client file;
- g. The Client meets the diagnostic criteria for substance use disorder; and
- h. If Client's third-party payor would cover or approves partial or full payment for treatment services, Provider may bill BWTX for the non-reimbursed costs, including the deductible, provided:
 - i. The Client's parent/guardian refuses to file a claim with the third party payor, or refuses to pay either the deductible or the non-reimbursed portion of the cost of treatment, and Provider has obtained a signed statement from the parent/guardian of refusal to pay, and Provider has received written approval from the BWTX substance use disorder treatment Program services clinical coordinator to bill for the deductible or non-reimbursed portion of the cost;
 - j. The Client or parent/guardian cannot afford to pay the deductible or the non-reimbursed portion of the cost of treatment; or
 - k. The Client or parent/guardian has an adjusted income at or below 200% of the Federal poverty guidelines.
- l. If a Client has exhausted all insurance coverage and requires continued treatment, Provider may provide the continued treatment services and bill BWTX if the Client meets the priority population mentioned under Service Delivery in the statement of work.

**ATTACHMENT C
DATA USE AGREEMENT**

The University of Texas Health Science Center at San Antonio (“UTHSA”) has contracted with North Texas Behavioral Health Authority (“Provider”) for performance of services on behalf of UT Health San Antonio which are subject to the Data Use Agreement (“DUA”). Provider acknowledges, understands and agrees to be bound by the identical terms and conditions applicable to UT Health San Antonio under the DUA, incorporated by reference in this Agreement, with respect to Texas Department of Health and Human Services (“HHSC”) Confidential Information. UTHSA and Provider agree that HHSC is a third-party beneficiary to applicable provisions of the subcontract.

HHSC has the right but not the obligation to review or approve the terms and conditions of the services agreement by virtue of this Data Use Agreement.

UT Health San Antonio and Provider assure HHSC that any Breach or Event as defined by the DUA that Provider discovers will be reported to HHSC by UTHSA in the time, manner and content required by its DUA with HHSC.

If UTHSA knows or should have known in the exercise of reasonable diligence of a pattern of activity or practice by Provider that constitutes a material breach or violation of the DUA or the Provider’s obligations UTHSA will:

1. Take reasonable steps to cure the violation or end the violation, as applicable;
2. If the steps are unsuccessful, terminate the service agreement with Provider, if feasible;
3. Notify HHSC immediately upon reasonably discovery of the pattern of activity or practice of Provider that constitutes a material breach or violation of the DUA and keep HHSC reasonably and regularly informed about steps UTHSA is taking to cure or end the violation or terminate Provider agreement or arrangement.

**The University of Texas Health
Science Center at San Antonio**

By: _____

Name: _____

Title: _____

Date: _____

North Texas Behavioral Health Authority

By: _____

Name: **Carol Lucky**

Title: **Chief Executive Officer**

Date: _____

ATTACHMENT D
BUSINESS ASSOCIATE AGREEMENT

Provider certifies that it is a HIPAA Covered Entity: Yes ☐ No ☐

(If yes, skip section below entitled, Business Associate Agreement)

Business Associate Agreement

This Business Associate Agreement (the “Agreement”) by and between Business Associate and Covered Entity (collectively the “Parties”) to comply with privacy standards adopted by the U.S. Department of Health and Human Services as they may be amended from time to time, 45 C.F.R. parts 160 and 164 (“the Privacy Rule”) and security standards adopted by the U.S. Department of Health and Human Services as they may be amended from time to time, 45 C.F.R. parts 160, 162 and 164, subpart C (“the Security Rule”), and the Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and regulations promulgated there under and any applicable state confidentiality laws.

RECITALS

WHEREAS, Business Associate provides services to or on behalf of Covered Entity;

WHEREAS, in connection with these services, Covered Entity discloses to Business Associate certain protected health information that is subject to protection under the HIPAA Rules; and

WHEREAS, the HIPAA Rules require that Covered Entity receive adequate assurances that Business Associate will comply with certain obligations with respect to the PHI received in the course of providing services to or on behalf of Covered Entity.

NOW THEREFORE, in consideration of the mutual promises and covenants herein, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree as follows:

- A. **Definitions.** Terms used herein, but not otherwise defined, shall have meaning ascribed by the Privacy Rule and the Security Rule.
1. **Breach.** “Breach” shall have the same meaning as the term “breach” in 45 C.F.R. §164.502.
 2. **Business Associate.** “Business Associate” shall mean **North Texas Behavioral Health Authority.**
 3. **Covered Entity.** “Covered Entity” shall mean **The University of Texas Health Science Center at San Antonio.**
 4. **Designated Record Set.** “Designated Record Set” shall mean a group of records maintained by or for a Covered Entity that is: (i) the medical records and billing records about Individuals maintained by or for a covered health care provider; (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) used, in whole or in part, by or for the covered entity to make decisions about Individuals. For purposes of this definition, the term “record” means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

5. HIPAA Rules. The Privacy Rule and the Security Rule and amendments codified and promulgated by the HITECH Act are referred to collectively herein as “HIPAA Rules.”
 6. Individual. “Individual” shall mean the person who is the subject of the protected health information.
 7. Protected Health Information (“PHI”). “Protected Health Information” or PHI shall have the same meaning as the term “protected health information” in 45 C.F.R. §160.103, limited to the information created, received, maintained or transmitted by Business Associate from or on behalf of covered entity pursuant to this Agreement.
 8. Required by Law. “Required by Law” shall mean a mandate contained in law that compels a use or disclosure of PHI.
 9. Secretary. “Secretary” shall mean the Secretary of the Department of Health and Human Services or his or her Designee.
 10. Sensitive Personal Information. “Sensitive Personal Information” shall mean an individual’s first name or first initial and last name in combination with any one or more of the following items, if the name and the items are not encrypted: a) social security number; driver’s license number or government-issued identification number; or account number or credit or debit card number in combination with any required security code, access code, or password that would permit access to an individual’s financial account; or b) information that identifies an individual and relates to: the physical or mental health or condition of the individual; the provision of health care to the individual; or payment for the provision of health care to the individual.
 11. Provider. “Provider” shall have the same meaning as the term “Contractor” in 45 C.F.R. §160.103.
 12. Unsecured PHI. “Unsecured PHI” shall mean PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
- B. Purposes for which PHI May Be Disclosed to Business Associate. In connection with the services provided by Business Associate to or on behalf of Covered Entity described in this Agreement, Covered Entity may disclose PHI to Business Associate for the purposes of providing services to alleviate the adverse physiological effects withdrawal from the use of opioids as required to meet the needs of the patient.
- C. Obligations of Covered Entity. If deemed applicable by Covered Entity, Covered Entity shall:
1. provide Business Associate a copy of its Notice of Privacy Practices (“Notice”) produced by Covered Entity in accordance with 45 C.F.R. 164.520 as well as any changes to such Notice;
 2. provide Business Associate with any changes in, or revocation of, authorizations by Individuals relating to the use and/or disclosure of PHI, if such changes affect Business Associate’s permitted or required uses and/or disclosures;
 3. notify Business Associate of any restriction to the use and/or disclosure of PHI to which Covered Entity has agreed in accordance with 45 C.F.R. 164.522, to the extent that such restriction may affect Business Associate’s use or disclosure of PHI;
 4. not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy rule if done by the Covered entity;

5. notify Business Associate of any amendment to PHI to which Covered Entity has agreed that affects a Designated Record Set maintained by Business Associate;
6. if Business Associate maintains a Designated Record Set, provide Business Associate with a copy of its policies and procedures related to an Individual's right to: access PHI; request an amendment to PHI; request confidential communications of PHI; or request an accounting of disclosures of PHI; and, notify individuals of breach of their Unsecured PHI in accordance with the requirements set forth in 45 C.F.R. §164.404.

D. Obligations of Business Associate. Business Associate agrees to comply with applicable federal and state confidentiality and security laws, specifically the provisions of the HIPAA Rules applicable to business associates, including:

1. Use and Disclosure of PHI. Except as otherwise permitted by this Agreement or applicable law, Business Associate shall not use or disclose PHI except as necessary to provide Services described above to or on behalf of Covered Entity, and shall not use or disclose PHI that would violate the HIPAA Rules if used or disclosed by Covered Entity. Also, knowing that there are certain restrictions on disclosure of PHI. Provided, however, Business Associate may use and disclose PHI as necessary for the proper management and administration of Business Associate, or to carry out its legal responsibilities. Business Associate shall in such cases:
 - (a) provide information and training to members of its workforce using or disclosing PHI regarding the confidentiality requirements of the HIPAA Rules and this Agreement;
 - (b) obtain reasonable assurances from the person or entity to whom the PHI is disclosed that: (a) the PHI will be held confidential and further used and disclosed only as Required by Law or for the purpose for which it was disclosed to the person or entity; and (b) the person or entity will notify Business Associate of any instances of which it is aware in which confidentiality of the PHI has been breached; and
 - (c) agree to notify the designated Privacy Officer of Covered Entity of any instances of which it is aware in which the PHI is used or disclosed for a purpose that is not otherwise provided for in this Agreement or for a purpose not expressly permitted by the HIPAA Rules.
2. Data Aggregation. In the event that Business Associate works for more than one Covered Entity, Business Associate is permitted to use and disclose PHI for data aggregation purposes, however, only in order to analyze data for permitted health care operations, and only to the extent that such use is permitted under the HIPAA Rules.
3. De-identified Information. Business Associate may use and disclose de-identified health information if written approval from the Covered Entity is obtained, and the PHI is de-identified in compliance with the HIPAA Rules. Moreover, Business Associate shall review and comply with the requirements defined under Section E. of this Agreement.
4. Safeguards.
 - (a) Business Associate shall maintain appropriate safeguards to ensure that PHI is not used or disclosed other than as provided by this Agreement or as Required by Law. Business Associate shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any paper or electronic PHI it creates, receives, maintains, or transmits on behalf of Covered Entity.

- (b) Business Associate shall assure that all PHI be secured when accessed by Business Associate's employees, agents or Provider. Any access to PHI by Business Associate's employees, agents or Provider's shall be limited to legitimate business needs while working with PHI. Any personnel changes by Business Associate, eliminating the legitimate business needs for employees, agents or contractors access to PHI – either by revision of duties or termination – shall be immediately reported to Covered Entity. Such reporting shall be made no later than the third business day after the personnel change becomes effective.
- 5. Minimum Necessary. Business Associate shall ensure that all uses and disclosures of PHI are subject to the principle of “minimum necessary use and disclosure,” i.e., that only PHI that is the minimum necessary to accomplish the intended purpose of the use, disclosure, or request is used or disclosed; and, the use of limited data sets when possible.
- 6. Disclosure to Agents and Provider's. If Business Associate discloses PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, to agents, including a Contractor, Business Associate shall require the agent or Contractor to agree to the same restrictions and conditions as apply to Business Associate under this Agreement. Business Associate shall ensure that any agent, including a Contractor, agrees to implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of the paper or electronic PHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity. Business Associate shall be liable to Covered Entity for any acts, failures or omissions of the agent or Contractor in providing the services as if they were Business Associate's own acts, failures or omissions, to the extent permitted by law. Business Associate further expressly warrants that its agents or Provider's will be specifically advised of, and will comply in all respects with, the terms of this Agreement.
- 7. Individual Rights Regarding Designated Record Sets. If Business Associate maintains a Designated Record Set on behalf of Covered Entity Business Associate agrees as follows:
 - (a) Individual Right to Copy or Inspection. Business Associate agrees that if it maintains a Designated Record Set for Covered Entity that is not maintained by Covered Entity, it will permit an Individual to inspect or copy PHI about the Individual in that set as directed by Covered Entity to meet the requirements of 45 C.F.R. § 164.524. If the PHI is in electronic form, the Individual shall have a right to obtain a copy of such information in electronic form and, if the Individual chooses, to direct that an electronic copy be transmitted directly to an entity or person designated by the individual in accordance with HITECH section 13405 (c). Under the Privacy Rule, Covered Entity is required to take action on such requests as soon as possible, but not later than 30 days following receipt of the request. Business Associate agrees to make reasonable efforts to assist Covered Entity in meeting this deadline. The information shall be provided in the form or form requested if it is readily producible in such form or form; or in summary, if the Individual has agreed in advance to accept the information in summary form. A reasonable, cost-based fee for copying health information may be charged. If Covered Entity maintains the requested records, Covered Entity, rather than Business Associate shall permit access according to its policies and procedures implementing the Privacy Rule.
 - (b) Individual Right to Amendment. Business Associate agrees, if it maintains PHI in a Designated Record Set, to make amendments to PHI at the request and direction of Covered Entity pursuant to 45 C.F.R. §164.526. If Business Associate maintains a record in a Designated Record Set that is not also maintained by Covered Entity, Business Associate agrees that it will accommodate an Individual's request to amend PHI only in conjunction

with a determination by Covered Entity that the amendment is appropriate according to 45 C.F.R. §164.526.

- (c) Accounting of Disclosures. Business Associate agrees to maintain documentation of the information required to provide an accounting of disclosures of PHI, whether PHI is paper or electronic for, in accordance with 45 C.F.R. §164.528 and HITECH Sub Title D Title VI Section 13405 (c), and to make this information available to Covered Entity upon Covered Entity's request, in order to allow Covered Entity to respond to an Individual's request for accounting of disclosures. Under the Privacy Rule, Covered Entity is required to take action on such requests as soon as possible but not later than 60 days following receipt of the request. Business Associate agrees to use its best efforts to assist Covered Entity in meeting this deadline but not later than 45 days following receipt of the request. Such accounting must be provided without cost to the individual or Covered Entity if it is the first accounting requested by an individual within any 12 month period; however, a reasonable, cost-based fee may be charged for subsequent accountings if Business Associate informs the individual in advance of the fee and is afforded an opportunity to withdraw or modify the request. Such accounting is limited to disclosures that were made in the six (6) years prior to the request (not including disclosures prior to the compliance date of the Privacy Rule) and shall be provided for as long as Business Associate maintains the PHI.
8. Internal Practices, Policies and Procedures. Except as otherwise specified herein, Business Associate shall make available its internal practices, policies and procedures relating to the use and disclosure of PHI, received from or on behalf of Covered Entity to the Secretary or his or her agents for the purpose of determining Covered Entity's compliance with the HIPAA Rules, or any other health oversight agency, or to Covered Entity. Records requested that are not protected by an applicable legal privilege will be made available in the time and manner specified by Covered Entity or the Secretary.
9. Notice of Privacy Practices. Business Associate shall abide by the limitations of Covered Entity's Notice of which it has knowledge. Any use or disclosure permitted by this Agreement may be amended by changes to Covered Entity's Notice; provided, however, that the amended Notice shall not affect permitted uses and disclosures on which Business Associate relied prior to receiving notice of such amended Notice.
10. Withdrawal of Authorization. If the use or disclosure of PHI in this Agreement is based upon an Individual's specific authorization for the use or disclosure of his or her PHI, and the Individual revokes such authorization, the effective date of such authorization has expired, or such authorization is found to be defective in any manner that renders it invalid, Business Associate shall, if it has notice of such revocation, expiration, or invalidity, cease the use and disclosure of the Individual's PHI except to the extent it has relied on such use or disclosure, or if an exception under the Privacy Rule expressly applies.
11. Knowledge of HIPAA Rules. Business Associate agrees to review and understand the HIPAA Rules as it applies to Business Associate, and to comply with the applicable requirements of the HIPAA Rule, as well as any applicable amendments.
12. Information Breach Notification for PHI. Business Associate expressly recognizes that Covered Entity has certain reporting and disclosure obligations to the Secretary and the Individual in case of a security breach of unsecured PHI. Where Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses or discloses unsecured paper or electronic PHI, Business Associate immediately following the "discovery" (within the meaning of 45 C.F.R.

§164.410(a)) of a breach of such information, shall notify Covered Entity of such breach. Initial notification of the breach does not need to be in compliance with 45 C.F.R. §164.404(c); however, Business Associate must provide Covered Entity with all information necessary for Covered Entity to comply with 45 C.F.R. §164.404(c) without reasonable delay, and in no case later than 30 days following the discovery of the breach. Business Associate shall be liable for the costs associated with such breach if caused by the Business Associate's negligent or willful acts or omissions, or the negligent or willful acts or omissions of Business Associate's agents, officers, employees or Provider's.

13. Breach Notification to Individuals. Business Associate's duty to notify Covered Entity of any breach does not permit Business Associate to notify those individuals whose PHI has been breached by Business Associate without the express written permission of Covered Entity to do so. Any and all notification to those individuals whose PHI has been breached shall be made under the direction, review and control of Covered Entity. The Business Associate will notify the Privacy Officer via telephone with follow-up in writing to include; name of individuals whose PHI was breached, information breached, date of breach, form of breach, etc. The cost of the notification will be paid by the Business Associate.
14. Information Breach Notification for Other Sensitive Personal Information. In addition to the reporting under Section D.12, Business Associate shall notify Covered Entity of any breach of computerized Sensitive Personal Information (as determined pursuant to Title 11, subtitle B, chapter 521, Subchapter A, Section 521.053. Texas Business & Commerce Code) to assure Covered Entity's compliance with the notification requirements of Title 11, Subtitle B, Chapter 521, Subchapter A, Section 521.053, Texas Business & Commerce Code. Accordingly, Business Associate shall be liable for all costs associated with any breach caused by Business Associate's negligent or willful acts or omissions, or those negligent or willful acts or omissions of Business Associate's agents, officers, employees or Provider's.

E. Permitted Uses and Disclosures by Business Associates. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Business Associates Agreement or in a Master Services Agreement, provided that such use or disclosure would not violate the HIPAA Rules if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity. Also, Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with the HIPAA Rules.

1. Use. Business Associate will not, and will ensure that its directors, officers, employees, contractors and other agents do not, use PHI other than as permitted or required by Business Associate to perform the Services or as required by law, but in no event in any manner that would constitute a violation of the Privacy Standards or Security standards if used by Covered Entity.
2. Disclosure. Business Associate will not, and will ensure that its directors, officers, employees, contractors, and other agents do not, disclose PHI other than as permitted pursuant to this arrangement or as required by law, but in no event disclose PHI in any manner that would constitute a violation of the Privacy Standards or Security Standards if disclosed by Covered Entity.
3. Business Associate acknowledges and agrees that Covered Entity owns all right, title, and interest in and to all PHI, and that such right, title, and interest will be vested in Covered Entity. Neither Business Associate nor any of its employees, agents, consultants or assigns will have any rights in any of the PHI, except as expressly set forth above. Business Associate represents, warrants, and covenants that it will not compile and/or distribute analyses to third parties using any PHI without Covered Entity's express written consent.

F. Application of Security and Privacy Provisions to Business Associate.

1. Security Measures. Sections 164.308, 164.310, 164.312 and 164.316 of Title 45 of the Code of Federal Regulations dealing with the administrative, physical and technical safeguards as well as policies, procedures and documentation requirements that apply to Covered Entity shall in the same manner apply to Business Associate. Any additional security requirements contained in Sub Title D of Title IV of the HITECH Act that apply to Covered Entity shall also apply to Business Associate. Pursuant to the foregoing requirements in this section, the Business Associate will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the paper or electronic PHI that it creates, has access to, or transmits. Business Associate will also ensure that any agent, including a Provider, to whom it provides such information, agrees to implement reasonable and appropriate safeguards to protect such information. Business Associate will ensure that PHI contained in portable devices or removable media is encrypted.
2. Annual Guidance. For the first year beginning after the date of the enactment of the HITECH Act and annually thereafter, the secretary shall annually issue guidance on the most effective and appropriate technical safeguards for use in carrying out the sections referred to in subsection (a) and the security standards in subpart C of part 164 of title 45, Code of Federal Regulations. Business Associate shall, at their own cost and effort, monitor the issuance of such guidance and comply accordingly.
3. Privacy Provisions. The enhanced HIPAA privacy requirements including but not necessarily limited to accounting for certain PHI disclosures for treatment, restrictions on the sale of PHI, restrictions on marketing and fundraising communications, payment and health care operations contained Subtitle D of the HITECH Act that apply to the Covered entity shall equally apply to the Business Associate.
4. Application of Civil and Criminal Penalties. If Business Associate violates any security or privacy provision specified in subparagraphs (1) and (2) above, sections 1176 and 1177 of the Social Security Act (42 U.S.C. 1320d-5, 1320d-6) shall apply to Business Associate with respect to such violation in the same manner that such sections apply to Covered Entity if it violates such provisions.

G. Term and Termination.

1. Term. This Agreement shall be effective as of the Effective Date and shall be terminated when all PHI provided to Business Associate by Covered Entity, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity.
2. Termination for Cause. Upon Covered entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
 - a. Provide an opportunity for Business associate to cure the breach or end the violation and terminate this Agreement, whether it is in the form of a standalone agreement or an addendum to a Master Services Agreement, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or
 - b. Immediately terminate this Agreement whether it is in the form of a standalone agreement or an addendum to a Master Services Agreement if Business associate has breached a material term of this Agreement and cure is not possible.
3. Effect of Termination. Upon termination of this Agreement for any reason, Business Associate agrees to return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, maintained by Business Associate in any form. If Business Associate determines that the return or destruction of PHI is not feasible, Business Associate shall inform Covered Entity in writing of the reason thereof, and shall agree to extend the protections of this Agreement to such PHI and limit

further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI not feasible for so long as Business Associate retains the PHI.

H. Miscellaneous.

1. Indemnification. To the extent permitted by law, Business Associate agrees to indemnify and hold harmless Covered Entity from and against all claims, demands, liabilities, judgments or causes of action of any nature for any relief, elements of recovery or damages recognized by law (including, without limitation, attorney's fees, defense costs, and equitable relief), for any damage or loss incurred by Covered Entity arising out of, resulting from, or attributable to any acts or omissions or other conduct of Business Associate or its agents in connection with the performance of Business Associate's or its agents' duties under this Agreement. This indemnity shall apply even if Covered Entity is alleged to be solely or jointly negligent or otherwise solely or jointly at fault; provided, however, that a trier of fact finds Covered Entity not to be solely or jointly negligent or otherwise solely or jointly at fault. This indemnity shall not be construed to limit Covered Entity's rights, if any, to common law indemnity.

Covered Entity shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of Business Associate. Covered Entity shall provide Business Associate with timely notice of the existence of such proceedings and such information, documents and other cooperation as reasonably necessary to assist Business Associate in establishing a defense to such action.

These indemnities shall survive termination of this Agreement, and Covered Entity reserves the right, at its option and expense, to participate in the defense of any suit or proceeding through counsel of its own choosing.

2. Mitigation. If Business Associate violates this Agreement or either of the HIPAA Rules, Business Associate agrees to mitigate any damage caused by such breach.
3. Rights of Proprietary Information. Covered Entity retains any and all rights to the proprietary information, confidential information, and PHI it releases to Business Associate.
4. Survival. The respective rights and obligations of Business Associate under Section E.3 of this Agreement shall survive the termination of this Agreement.
5. Notices. Any notices pertaining to this Agreement shall be given in writing and shall be deemed duly given when personally delivered to a Party or a Party's authorized representative as listed below or sent by means of a reputable overnight carrier, or sent by means of certified mail, return receipt requested, postage prepaid. A notice sent by certified mail shall be deemed given on the date of receipt or refusal of receipt. All notices shall be addressed to the appropriate Party as follows: If to Covered Entity:

The University of Texas Health
Science Center at San Antonio
Office of Sponsored Programs
Attention: AVP, Sponsored
Programs 7703 Floyd Curl
Drive, MSC 7828 San Antonio,
Texas 78229-3900 Phone
Number: 210-567-2340
Email: grants@uthscsa.edu

If to Business Associate:

North Texas Behavioral Health Authority

8111 LBJ Freeway, Ste. 900

Dallas, TX 75251

Attn: Carol Lucky

Phone Number: 214-366-9407

Email: clucky@ntbha.org

6. Amendments. This Agreement may not be changed or modified in any manner except by an instrument in writing signed by a duly authorized officer of each of the Parties hereto. The Parties, however, agree to amend this Agreement from time to time as necessary, in order to allow Covered Entity's to comply with the requirements of the HIPAA Rules.
7. Choice of Law. This Agreement and the rights and the obligations of the Parties hereunder shall be governed by and construed under the laws of the State of Texas, without regard to applicable conflict of laws principles.
8. Assignment of Rights and Delegation of Duties. This Agreement is binding upon and inures to the benefit of the Parties hereto and their respective successors and permitted assigns. However, neither Party may assign any of its rights or delegate any of its obligations under this Agreement without the prior written consent of the other Party, which consent shall not be unreasonably withheld or delayed. Notwithstanding any provisions to the contrary, however, Covered Entity retains the right to assign or delegate any of its rights or obligations hereunder to any of its wholly owned subsidiaries, affiliates or successor companies. Assignments made in violation of this provision are null and void.
9. Nature of Agreement. Nothing in this Agreement shall be construed to create (i) a partnership, joint venture or other joint business relationship between the Parties or any of their affiliates, (ii) any fiduciary duty owed by one Party to another Party or any of its affiliates, or (iii) a relationship of employer and employee between the Parties.
10. No Waiver. Failure or delay on the part of either Party to exercise any right, power, privilege or remedy hereunder shall not constitute a waiver thereof. No provision of this Agreement may be waived by either Party except by a writing signed by an authorized representative of the Party making the waiver.
11. Equitable Relief. Any disclosure of misappropriation of PHI by Business Associate in violation of this Agreement will cause Covered Entity irreparable harm, the amount of which may be difficult to ascertain. Business Associate therefore agrees that Covered Entity shall have the right to apply to a court of competent jurisdiction for specific performance and/or an order restraining and enjoining Business Associate from any such further disclosure or breach, and for such other relief as Covered Entity shall deem appropriate. Such rights are in addition to any other remedies available to Covered Entity at law or in equity. Business Associate expressly waives the defense that a remedy in damages will be adequate, and further waives any requirement in an action for specific performance or injunction for the posting of a bond by Covered Entity.

12. Severability. The provisions of this Agreement shall be severable, and if any provision of this Agreement shall be held or declared to be illegal, invalid or unenforceable, the remainder of this Agreement shall continue in full force and effect as though such illegal, invalid or unenforceable provision had not been contained herein.
13. No Third Party Beneficiaries. Nothing in this Agreement shall be considered or construed as conferring any right or benefit on a person not party to this Agreement nor imposing any obligations on either Party hereto to persons not a party to this Agreement.
14. Headings. The descriptive headings of the articles, sections, subsections, exhibits and schedules of this Agreement are inserted for convenience only, do not constitute a part of this Agreement and shall not affect in any way the meaning or interpretation of this Agreement.
15. Entire Agreement. This Agreement, together with all Exhibits, Riders and amendments, if applicable, which are fully completed and signed by authorized persons on behalf of both Parties from time to time while this Agreement is in effect, constitutes the entire Agreement between the Parties hereto with respect to the subject thereof and supersedes all previous written or oral understandings, agreements, negotiations, commitments, and any other writing and communication by or between the Parties with respect to the subject thereof. In the event of any inconsistencies between any provisions of this Agreement in any provisions of the Exhibits, Riders, or amendments, the provisions of this Agreement shall control.
16. Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Rules and any applicable state confidentiality laws. The provisions of this Agreement shall prevail over the provisions of any other agreement that exists between the Parties that may conflict with, or appear inconsistent with, any provision of this Agreement or the HIPAA Rules.
17. Regulatory References. A citation in this Agreement to the Code of Federal Regulations shall mean the cited section as that section may be amended from time to time.

Agreed to:

COVERED ENTITY

By: _____
(Authorized Signature)

Name: Chris G. Green, CPA
(Type or Print)

Title: AVP, Sponsored Programs

Date: _____

BUSINESS ASSOCIATE

By: _____
(Authorized Signature)

Name: Carol Lucky
(Type or Print)

Title: Chief Executive Officer

Date: _____

ATTACHMENT E
QUALIFIED SERVICE ORGANIZATION AGREEMENT (QSOA)

The University of Texas Health Science Center at San Antonio (“UTHSA”) on behalf of the Be Well Texas Clinic and North Texas Behavioral Health Authority (“Provider”) agree that this Agreement constitutes a Qualified Service Organization Agreement (“QSOA”) as required by 42 C.F.R. Part 2.

Accordingly, Provider agrees to provide the services outlined in the Services Agreement (“Agreement”) between such Parties. Information obtained by Provider relating to individuals who may have been diagnosed as needing, or who have received substance use disorder treatment services shall be maintained and used only for the purposes intended under this QSOA and in conformity with all applicable provisions of 42 USC 290dd-2 and the underlying federal regulations, 42 C.F.R. Part 2.

Furthermore, Provider:

- (1) Acknowledges that in receiving, storing, processing and otherwise dealing with any information from the UTHSA Part 2 Program about the patients in the Part 2 Program, it is fully bound by the provisions of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; and
- (2) Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for the Federal Confidentiality Regulations, 42 C.F.R. Part 2.

IN WITNESS WHEREOF, an authorized officer of each Party has duly executed and delivered this QSOA effective as of the date set forth below:

**The University of Texas Health
Science Center at San Antonio**

North Texas Behavioral Health Authority

By: _____

By: _____

Name: _____

Name: Carol Lucky

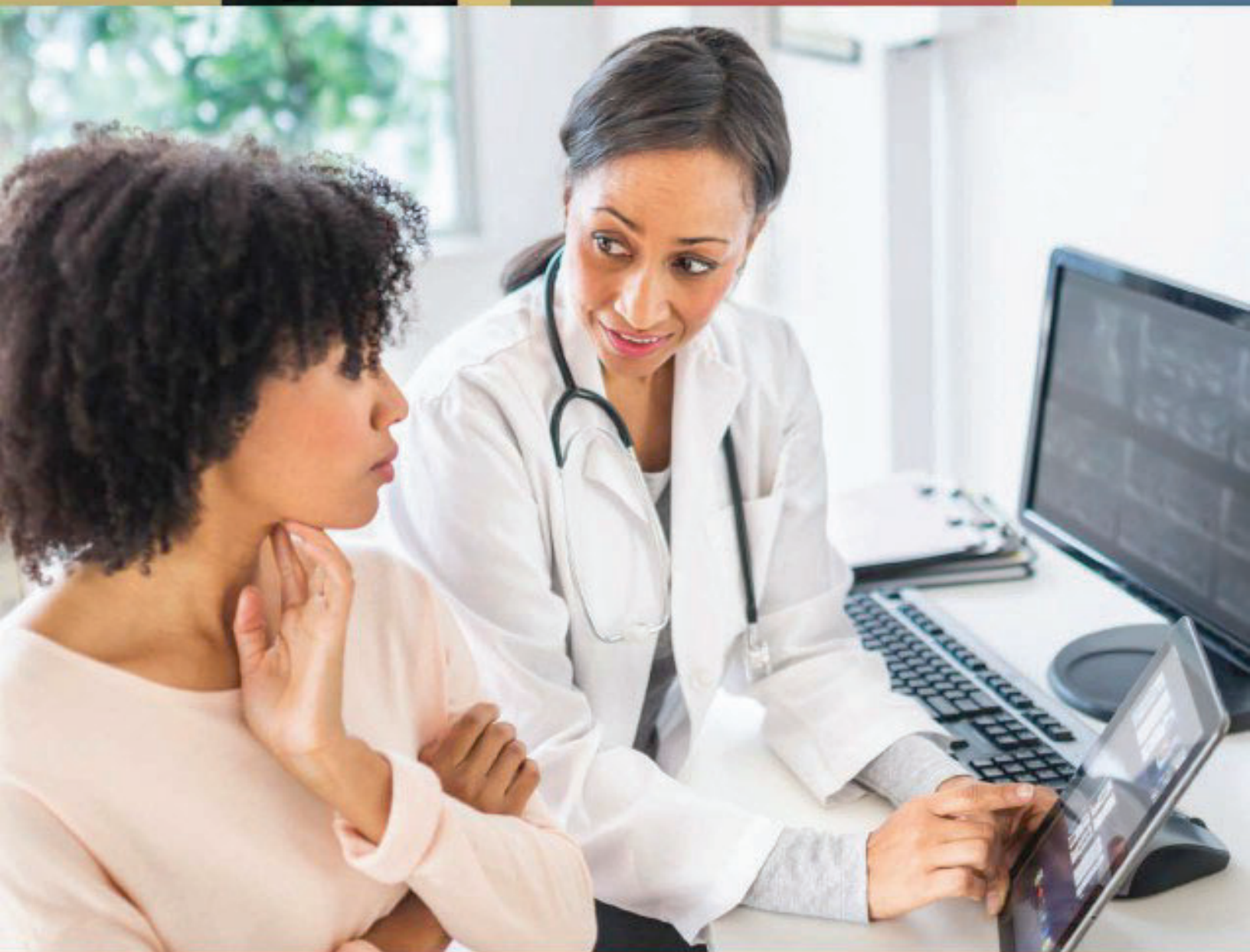
Title: _____

Title: Chief Executive Officer

Date: _____

Date: _____

Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide



Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide

Revised February 2, 2015

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Division of Pharmacologic Therapies

1 Choke Cherry Road
Rockville, MD 20857

Acknowledgments

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Disclaimer

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Originating Office

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INTRODUCTION

The profile of opioid misuse and opioid use disorder in the United States is changing, in that nonmedical use of prescription opioids has become as significant a problem as the use of heroin.¹ Federal data for 2013 indicate that approximately 4.5 million people in the United States reported nonmedical use of prescription pain relievers in the past month and 289,000 reported use of heroin in the past month.² Despite the dimensions of the problem, nearly 80 percent of people with an opioid use disorder do not receive treatment because of limited treatment capacity, financial obstacles, social bias, and other barriers to care.³

A diagnosis of opioid use disorder continues to carry significant social bias, which affects both the individuals who receive the diagnosis and the health care professionals to whom such individuals may turn for care.

Researchers, federal health agencies, and pharmaceutical manufacturers have focused on developing medications that can be used to expand access to treatment of an opioid use disorder in medical office settings, rather than limiting use to specialized opioid treatment programs (OTPs).⁴ This effort has yielded two important products that the Food and Drug Administration (FDA) has approved for use in treating an opioid use disorder and/or preventing relapse: buprenorphine (alone and in combination with naloxone) and naltrexone (in an oral formulation and an extended-release injectable formulation). These medications differ in mechanism of action, route and frequency of administration, and certain regulatory restrictions on their use as shown in Table 1 on page 4.

After reviewing multiple studies, many experts in addiction have concluded that patients who have an opioid use disorder should be offered medication-assisted treatments on a routine basis.⁵ However, considerable resistance to the use of such treatments persists. A diagnosis of opioid use disorder continues to carry significant social bias, which affects both the individuals who receive the diagnosis and the health care professionals to whom such individuals may turn for care.^{*6}

With practical resources, the unmet need for treatment and the largely untapped resource of primary care medicine can be brought together to yield healthier patients who are treated in safer environments and an expanded repertoire of effective professional practices for primary care providers. In fact, many studies show that the treatment of an opioid use disorder can be successfully integrated into general office practice by physicians and health providers who are not addiction specialists.^{7–15}

To review the options available for the treatment of opioid use disorder, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute on Drug Abuse (NIDA) jointly convened the Consensus Panel on New Pharmacotherapies for Opioid Use Disorders and Related Comorbidities (see Appendix A). Composed of experts in research, clinical care, medical education, and public policy, the panel reviewed current evidence on the effectiveness of available medications for the treatment of an opioid use disorder and developed a guidance for clinical practice.⁵ The panel's guidance is presented in this document.

* The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013)⁶ uses the term *opioid use disorder* to include abuse of or dependence on opioids. The specific indication for which extended-release injectable naltrexone was approved by FDA is prevention of relapse to opioid dependence, following opioid detoxification, which is subsumed by the DSM-5 term *opioid use disorder*.

ASSESSING THE NEED FOR TREATMENT

Patient Assessment

A patient who is identified with a potential opioid use disorder should undergo a thorough assessment to confirm the diagnosis.¹⁶ The objectives of the assessment are to determine the patient's need for treatment, to develop a treatment plan, and to establish a baseline measure for evaluating the patient's progress. Accordingly, the patient assessment should:

- Confirm the opioid use disorder diagnosis
- Establish current opioid use—when, what, and how much opioid the patient used most recently
- Document the patient's substance use history, including alcohol and other drugs of abuse
- Identify patients who require medically supervised detoxification from alcohol, benzodiazepines, or other sedatives, in addition to opioids
- Determine where and when such detoxification should be accomplished
- Identify comorbid medical and psychiatric conditions and disorders and prioritize and coordinate their management
- Screen for infectious diseases for which people who misuse opioids are at elevated risk, such as hepatitis B, hepatitis C and HIV/AIDS
- Assess the patient's access to social supports, family, friends, employment, housing, finances, and assistance with legal problems
- Evaluate the patient's degree of motivation for behavior change and readiness to participate in treatment

The physical examination should focus on problems the patient is experiencing and include screening for common consequences or co-occurring problems associated with the patient's current and past substance use.

Substance Use History. A complete substance use history is essential to development of a safe and appropriate treatment plan.¹⁷ In-depth interviews, combined with the use of standardized assessment instruments, are effective methods of gathering this information. Ideally, the substance use history should include

the nature of the patient's substance use disorders, underlying or co-occurring diseases or conditions, the effect of opioid use on the patient's physical and psychological functioning, and the outcomes of past treatment episodes.

It is essential to find out whether the patient is currently taking (or recently took) methadone or other long-acting opioids.^{18,19} Urine toxicology screens must also be completed. It also is advisable to access the patient's prescription drug use history through the state's prescription drug monitoring program (PDMP)²⁰ where available, both to confirm compliance in taking prescribed medications and to detect unreported use of other prescription medications.¹⁷ Information about PDMPs and how to access them is available from state boards of medicine and pharmacy.

Information about PDMPs and how to access them is available from state boards of medicine and pharmacy.

In addition to securing the patient's PDMP record, obtaining information from family members and significant others can provide useful perspectives on the patient's behavior and level of function, so consent to speak with family members and other providers must be obtained. Contact with or records from clinicians who have treated the patient in the past and information from the prescription benefit provider should also be sought out.¹⁰

Physical Examination. The physical examination of a patient who is being evaluated for a substance use disorder should focus on physical findings related to addiction and its complications. For example, examination of skin injection sites can provide useful information about the duration of injection drug use. Recent injection marks are small and red and sometimes are inflamed or surrounded by slight bruising. Older injection sites typically are not inflamed but sometimes show pigmentation changes (either lighter or darker), and the skin may have an atrophied or sunken appearance. A combination of recent and old injection sites suggests that the

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patient may be currently using opioids and may have a complex opioid use disorder.²¹

The physical examination should address body systems related to reported symptoms. In asymptomatic people, height, weight, and blood pressure should be recorded, and a cardiac examination (listening for murmurs or cardiac rhythm abnormalities) should be performed.²²

Laboratory Tests. A urine drug screen or other toxicology screen should be part of the patient assessment to confirm recent opioid use and to screen for use of other drugs. A urine test for alcohol (ethyl glucuronide) also needs to be included. Ideally, a drug screen should test for all opioids commonly prescribed and/or misused in the local community, as well as illicit drugs that are available locally.²³

Other useful tests include those of liver enzymes and serum bilirubin, as well as tests for hepatitis B and C and HIV, particularly in patients who have engaged in injection drug use. For those patients who inject drugs, serum creatinine levels should be tested for the presence of silent renal disease.²²

Developing a Treatment Plan

Treatment of an opioid use disorder should be guided by an individualized plan that is developed in consultation with the patient.²⁴ Elements of such a plan include the following:

- The role of medications in the patient’s treatment and the rationale for their selection
- Referral and follow-up plans for specialty addiction treatment, psychosocial treatment, and/or family therapy, if clinically indicated
- Motivation for participating in mutual-help groups
- A discussion of the involvement of family or significant others in treatment
- A plan for treating co-occurring medical or psychiatric disorders
- Schedules for follow-up office visits and laboratory testing to monitor the patient’s progress and health status
- Criteria for discontinuing use of the medication

The plan should be written to measure progress during the monitoring process.^{22,25} The plan and the steps taken to implement it should be documented in the patient’s medical record.¹⁷

Use of Medications. Whenever a medication is to be used, the treatment plan should give attention to steps that will promote medication adherence.²⁶ Depending on the needs of the patient, these steps might include specific strategies for remembering to take medications, use of blister-card packs or pill boxes, a schedule for monitoring medication adherence that reflects the patient’s history of adherence to other medication regimens, and steps to involve the patient’s family members in monitoring adherence.

Naltrexone functions as an opioid antagonist, whereas methadone is an opioid agonist and buprenorphine is an opioid partial agonist. Patients should abstain from using any opioids, including opioid-containing medicines, for a minimum of 7 to 10 days before starting extended-release injectable naltrexone to avoid precipitation of opioid withdrawal. Patients transitioning from buprenorphine or methadone may be vulnerable to precipitation of withdrawal symptoms for as long as 2 weeks.^{26,27}

All medications for the treatment of the opioid use disorder should be prescribed as part of a comprehensive treatment approach that includes counseling and other psychosocial therapies delivered by a psychiatrist, psychologist, or professional counselor, as well as social support through participation in Narcotics Anonymous (NA) and other mutual-help programs.^{1,5} Health care providers who choose to offer medication-assisted treatment in their office practices need to understand the nature of the underlying disorder, the specific actions of each available medication (and the associated contraindications or cautions), and the importance of careful patient selection and monitoring.⁸

Table 1 summarizes key information about three medications currently approved to treat opioid use disorders (extended-release injectable naltrexone, methadone, and buprenorphine). Only one column in the table is devoted to naltrexone because the prescribing considerations for extended-release injectable naltrexone and oral naltrexone are similar.²⁶

**TABLE 1: KEY FEATURES OF MEDICATIONS APPROVED FOR TREATING
OPIOID USE DISORDER***

Prescribing Considerations	Extended-Release Injectable Naltrexone	Methadone	Buprenorphine
Frequency of Administration	Monthly [†]	Daily	Daily (also alternative dosing regimens)
Route of Administration	Intramuscular (IM) injection into the gluteal muscle by a physician or other health care professional. [†]	Orally as liquid concentrate, tablet or oral solution of diskette or powder.	Oral tablet or film is dissolved under the tongue.
Who May Prescribe or Dispense	Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.	SAMHSA-certified OTPs dispense methadone for daily administration either on site or, for stable patients, at home.	Physicians must have board certification in addiction medicine or addiction psychiatry and/or complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waived physician.
Pharmacologic Category	Opioid antagonist	Opioid agonist	Opioid partial agonist Buprenorphine's partial agonist effect relieves withdrawal symptoms resulting from cessation of opioids. This same property will induce a syndrome of acute withdrawal in the presence of long-acting opioids or sufficient amounts of receptor-bound full agonists. Naloxone, an opioid antagonist, is sometimes added to buprenorphine to make the product less likely to be abused by injection.

* Table 1 highlights some properties of each medication. It does not provide complete information and is not intended as a substitute for the package inserts or other drug reference sources used by clinicians (see <http://www.dailymed.nlm.nih.gov> for current package inserts). For patient information about these and other drugs, visit the National Library of Medicine's MedlinePlus (<http://www.medlineplus.gov>). Whether a medication should be prescribed and in what amount are matters to be discussed between an individual and his or her health care provider. The prescribing information provided here is not a substitute for the clinician's judgment, and the National Institutes of Health and SAMHSA accept no liability or responsibility for use of the information in the care of individual patients.

[†] Naltrexone hydrochloride tablets (50 mg each) are also available for daily dosing.

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Prescribing Considerations	Extended-Release Injectable Naltrexone	Methadone	Buprenorphine
Clinical Uses/Ideal Candidates	Prevention of relapse to opioid use disorder following opioid detoxification; studies suggest benefits for patients who are experiencing increased stress or other relapse risks (e.g., visiting places of previous drug use, loss of spouse, loss of job). Appropriate for patients who have been detoxified from opioids and who are being treated for a co-occurring alcohol use disorder. Extended-release naltrexone should be part of a comprehensive management program that includes psychosocial support. Other good candidates include persons with a short or less severe addiction history or who must demonstrate to professional licensing boards or criminal justice officials that their risk of opioid use is low.	Detoxification and maintenance treatment of opioid addiction. Patients who are motivated to adhere to the treatment plan and who have no contraindications to methadone therapy. Methadone should be part of a comprehensive management program that includes psychosocial support.	Treatment of opioid dependence. Patients who are motivated to adhere to the treatment plan and who have no contraindications to buprenorphine therapy. Buprenorphine should be part of a comprehensive management program that includes psychosocial support.
Contraindications	Contraindicated in patients receiving long-term opioid therapy. Contraindicated in patients who are engaged in current opioid use (as indicated by self-report or a positive urine drug screen) or who are on buprenorphine or methadone maintenance therapy, as well as in those currently undergoing opioid withdrawal. Contraindicated in patients with a history of sensitivity to polylactide-co-glycolide, carboxymethylcellulose, or any components of the diluent. Should not be given to patients whose body mass precludes IM injection with the 2-inch needle provided; inadvertent subcutaneous injection may cause a severe injection site reaction. Should not be given to anyone allergic to naltrexone.	Contraindicated in patients who are hypersensitive to methadone hydrochloride or any other ingredient in methadone hydrochloride tablets, diskettes, powder or liquid concentrate. Contraindicated in patients with respiratory depression (in the absence of resuscitative equipment or in unmonitored settings) and in patients with acute bronchial asthma or hypercarbia. Contraindicated in any patient who has or is suspected of having a paralytic ileus.	Contraindicated in patients who are hypersensitive to buprenorphine or naloxone.

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Prescribing Considerations	Extended-Release Injectable Naltrexone	Methadone	Buprenorphine
Warnings	Use with caution in patients with active liver disease, moderate to severe renal impairment, and women of childbearing age. Discontinue in the event of symptoms or signs of acute hepatitis. As with any IM injection, extended-release injectable naltrexone should be used with caution in patients with thrombocytopenia or any coagulation disorder (e.g., hemophilia, severe hepatic failure); such patients should be closely monitored for 24 hours after naltrexone is administered. Patients may become sensitive to lower doses of opioids after treatment with extended-release injectable naltrexone. This could result in potentially life-threatening opioid intoxication and overdose if previously tolerated larger doses are administered. Clinicians should warn patients that overdose may result from trying to overcome the opioid blockade effects of naltrexone.	Methadone should be used with caution in elderly and debilitated patients; patients with head injury or increased intracranial pressure; patients who are known to be sensitive to central nervous system depressants, such as those with cardiovascular, pulmonary, renal, or hepatic disease; and patients with comorbid conditions or concomitant medications that may predispose to dysrhythmia or reduced ventilatory drive. Methadone should be administered with caution to patients already at risk for development of prolonged QT interval or serious arrhythmia. The label includes a warning about somnolence that may preclude driving or operating equipment.	Caution is required in prescribing buprenorphine to patients with polysubstance use and those who have severe hepatic impairment, compromised respiratory function, or head injury. Significant respiratory depression and death have occurred in association with buprenorphine, particularly administered intravenously or in combination with benzodiazepines or other central nervous system depressants (including alcohol). Buprenorphine may precipitate withdrawal if initiated before patient is in opioid withdrawal, particularly in patients being transferred from methadone. The label includes a warning about somnolence that may preclude driving or operating equipment.
Use in Pregnant and Postpartum Women	Pregnancy: FDA pregnancy category C[†] Nursing: Transfer of naltrexone and 6β-naltrexol into human milk has been reported with oral naltrexone. Because animal studies have shown that naltrexone has a potential for tumorigenicity and other serious adverse reactions in nursing infants, an individualized treatment decision should be made whether a nursing mother will need to discontinue breast feeding or discontinue naltrexone.	Pregnancy: FDA pregnancy category C[†] Methadone has been used during pregnancy to promote healthy pregnancy outcomes for more than 40 years. Neonatal abstinence syndrome may occur in newborn infants of mothers who received medication-assisted treatment with methadone during pregnancy. No lasting harm to the fetus has been recognized as a result of this therapy but individualized treatment decisions balancing the risk and benefits of therapy should be made with each pregnant patient. Nursing: Mothers maintained on methadone can breastfeed if they are not HIV positive, are not abusing substances, and do not have a disease or infection in which breastfeeding is otherwise contraindicated.	Pregnancy: FDA pregnancy category C[†] Neonatal abstinence syndrome may occur in newborn infants of mothers who received medication-assisted treatment with buprenorphine during pregnancy. No lasting harm to the fetus has been recognized as a result of this therapy but individualized treatment decisions balancing the risk and benefits of therapy should be made with each pregnant patient. Nursing: Buprenorphine and its metabolite norbuprenorphine are present in low levels in human milk and infant urine. Available data are limited but have not shown adverse reactions in breastfed infants.
Potential for Abuse and Diversion	No	Yes	Yes

SOURCES:^{1,26– 44}

[†] Animal studies have shown an adverse effect on the fetus and there are no adequate, well-controlled studies in humans, but potential benefits may warrant use of the drug in some pregnant women despite potential risks.

Extended-Release Injectable Naltrexone

The extended-release injectable formulation of naltrexone (Vivitrol®) was approved by the FDA in 2010 for the prevention of relapse to opioid dependence following opioid detoxification.¹ It is supplied as a 380 mg IM injection to be administered in the gluteal muscle every 28 to 30 days, alternating buttocks for each subsequent injection.

Packaging. The drug is packaged in a kit containing a vial of naltrexone microspheres as a dry powder, which must be suspended in a liquid diluent immediately before use. Kits must be refrigerated during storage but should be brought to room temperature approximately 45 minutes before an injection is given. The microspheres suspended in solution must be mixed vigorously to prevent clumping, which can clog the needle during injection.²⁷

Each kit also contains a syringe and five needles—one for mixing the microspheres with the diluent and four needles (two 1.5-inch needles and two 2-inch needles) for injecting the suspension into the upper outer quadrant of the gluteal muscle.²⁷

Formulation. Extended-release injectable naltrexone was developed by embedding the drug molecule in microspheres composed of a biodegradable copolymer, resulting in release of the active ingredient over a predetermined period. Upon injection, the microspheres begin to absorb water almost immediately, leading to a swelling of the microspheres. This process begins an initial release of the drug.

As water absorption continues, the polymer begins to undergo hydrolysis. Later, physical erosion of the polymer occurs. The drug diffuses into the surrounding media as the polymer continues to undergo hydrolysis and erosion, resulting in a sustained release of the drug from the microspheres. The polymer matrix eventually breaks down into lactic acid and glycolic acid, which are completely metabolized by the body and eliminated as carbon dioxide and water.

Pharmacodynamics and

Pharmacokinetics. Naltrexone is a competitive antagonist at the opioid receptors in the brain. It is

metabolized in the liver to the opioid antagonist 6- β -naltrexol. The absorption of extended-release naltrexone is mediated by its gradual and prolonged release for 2 to 4 weeks after injection through hydrolysis of the copolymer microspheres.^{27,45} Two peak blood levels occur after injection of the extended-release formulation: a transient initial peak occurs approximately 2 hours later and a second peak occurs about 2 to 3 days later. About 14 days after injection, the blood level slowly begins to decline in a linear fashion.

Efficacy. The phase 3 clinical trials of extended-release injectable naltrexone showed a consistent pattern of clinical efficacy for maintaining abstinence, achieving medication adherence, maintaining retention, protecting against reestablishment of opioid physical dependence, and may reduce craving for opioids for some individuals, while showing good safety and tolerability.^{27,29}

Indications, Contraindications, and

Cautions. The FDA-approved indication for extended-release injectable naltrexone is the prevention of relapse to an opioid use disorder following opioid detoxification.²⁷ Other information on indications, contraindications, and cautions appears in Table 1. It is advisable to download a copy of the full prescribing information from the FDA (available at <http://www.fda.gov/safety/medwatch/safetyinformation/ucm208449.htm>).

Safety. Based on its use in the treatment of alcohol dependence (an indication approved by the FDA in 2006), extended-release injectable naltrexone appears to be reasonably well tolerated. Its side effect profile is similar to that of oral naltrexone, with the addition of possible injection site reactions (ISRs).^{1,46}

Side effects reported in clinical trials include nasopharyngitis, influenza, upper respiratory tract infection, sinusitis, insomnia, headache, dizziness, upper abdomen pain, diarrhea, fatigue, and back pain.^{46–50} Muscle cramps, dizziness, sedation, decreased appetite, and an allergic form of pneumonia also have occurred in patients treated with extended-release injectable naltrexone, as have common cold symptoms, and toothaches.^{1,27,28}

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More serious adverse reactions, with advice on their management, include the following:

- **ISRs:** Extended-release injectable naltrexone injections may cause pain or tenderness at the injection site, which usually resolves in 2 to 5 days. However, more serious reactions such as swelling, erythema, bruising, and pruritus may occur, generally as the result of an inadvertent subcutaneous injection. Providers should be trained in proper techniques for IM injections to prevent problems.⁴⁵ The FDA issued an alert on this subject following phase 3 clinical trials because of reports of severe ISRs requiring surgical intervention.⁴⁶
- **Vulnerability to opioid overdose:** Following a person's treatment with extended-release injectable naltrexone, his or her opioid tolerance is reduced from pretreatment baseline, and patients are vulnerable to potentially fatal overdose at the end of a dosing interval, after missing a dose, or after discontinuing treatment. Attempts to overcome the blockade may also lead to fatal overdose.
- **Hypersensitivity reactions, including anaphylaxis:** Trial results included reactions such as urticaria and angioedema. Patients should be warned of these risks and advised to seek immediate medical attention should any symptoms of hypersensitivity reactions arise.²⁷
- **Hepatotoxicity:** Cases of hepatitis and clinically significant liver dysfunction were observed in association with extended-release injectable naltrexone treatment. Patients should be warned of the risk of such injury.^{27,45}
- **Depression and suicidality:** Depression-related adverse events and events of a suicidal nature were observed in clinical trials of extended-release injectable naltrexone. Patients should be monitored for development of depression, suicidal thinking, or mood or anxiety disorders and treated appropriately, and families and caregivers should be alerted to the need to monitor patients for the emergence of depression or suicidality.^{27,45}
- **Precipitated opioid withdrawal:** When withdrawal is precipitated abruptly by the administration of an opioid antagonist to a patient dependent on opioids, the resulting

withdrawal syndrome can be severe enough to require hospitalization. An opioid-free interval is recommended for patients previously dependent on opioids. This interval should be guided by the type of opioid that the patient had been taking previously—that is, short- or long-acting opioids. Health care providers should always be prepared to manage withdrawal symptomatically. Patients should receive supportive treatments (i.e., hydration and antispasmodic and antidiarrheal medications) until opioid withdrawal symptoms resolve. Benzodiazepines or β 2-agonists such as clonidine should mitigate some withdrawal symptoms (watch for side effects of clonidine, including dizziness, hypotension, fatigue, and headache).

Drug Interactions. Patients taking naltrexone may not experience pain relief from opioid-containing medications because naltrexone antagonizes the opioid effects.²⁷

Clinical Recommendations. Although no definitive research supports which patients benefit most from extended-release injectable naltrexone, patients in the following categories may be good candidates for such treatment.¹

- **Patients who have not had treatment success with methadone or buprenorphine:** Depending on the reasons for treatment failure, individuals with an opioid use disorder who have not been successfully treated with methadone or buprenorphine may benefit from medically supervised withdrawal followed by a trial of extended-release injectable naltrexone.⁵¹
- **Patients who have a high degree of motivation for abstinence:** Individuals who are highly motivated to achieve and maintain abstinence from opioids may be good candidates for treatment with extended-release injectable naltrexone.⁵⁰ This category includes people who are required to demonstrate abstinence on urine drug screens, such as individuals in programs for impaired health care professionals, parolees, probationers, and airline pilots.⁵²
- **Patients who have been successful on opioid agonists who wish to discontinue agonist therapy or patients who are not interested in**

agonist therapy to treat their opioid use disorder: Some patients may be successful on agonist treatment and want continued pharmacologic help to prevent relapse but prefer another type of treatment.⁵¹ Other patients may not be interested in agonist therapy.¹ The latter group typically includes individuals who (1) feel they are discriminated against (or are embarrassed or ashamed) because they are on agonist therapy⁵³ or (2) would like to reduce the time devoted to daily or multiple OTP visits per week, as is frequently required for methadone treatment.¹

Patients may be suitable candidates for treatment with extended-release injectable naltrexone even if past episodes of medication-assisted treatment were not successful.⁵⁴ However, experts agree that the following patients are unlikely to do well on extended-release injectable naltrexone:¹

- Patients who do not tolerate extended opioid-free periods. For example, a patient who is not tolerating withdrawal is better managed with a partial agonist (buprenorphine) or an agonist (methadone) than with an antagonist medication.
- Patients who are unable to complete withdrawal.
- Patients who experience protracted abstinence symptoms following withdrawal.
- Patients whose psychiatric symptoms worsen during withdrawal.
- Patients whose chronic pain requires treatment with opioid analgesics. Treatment with extended-release injectable naltrexone is not a viable option if pain requires chronic opioid therapy.
- Patients who have advanced liver disease, impending liver failure, or acute hepatitis. Use of extended-release injectable naltrexone probably is safe in patients with chronic hepatitis B or C provided that the patient is not at the end stage and starting to go into liver failure. Patients with routine elevated liver enzymes usually tolerate naltrexone

Integrating Pharmacologic and Nonpharmacologic Therapies

Some patients respond to psychosocial interventions or medication therapy alone, but most patients need both. The different

approaches (medication-assisted treatment, professional counseling, and mutual-help groups) are complementary. They support the same goals while addressing different aspects of opioid use disorder: neurobiological, psychological, and social.

Offering the full range of effective treatments maximizes patient choice and outcomes, because no single approach is universally successful. Many studies show that the combination of pharmacologic and nonpharmacologic interventions may be more effective than either approach used alone.⁵⁵

Sources of information on psychosocial therapies suitable for patients being treated in medical office settings are shown in Appendix B.

Encouraging Participation in Mutual-Help Programs.

The support of a mutual-help group can be critical to long-term recovery. The oldest, best-known, and most accessible mutual-help program for people with an opioid use disorder is offered by NA. Patients may resist attending NA meetings and may fear that disclosure of medication use will make them unwelcome.²⁶ Although some NA members may have negative attitudes toward medication, the organization itself supports appropriate medication use. Providers should encourage patients to try meetings of different groups until they find one that is a good fit. Lists of local meetings to give to patients can be obtained from the Narcotics Anonymous World Services Web site (<http://www.na.org>).

Other mutual-help groups, although not as universally available as NA, have a strong presence in many communities. Contact information for several groups that may be helpful to patients and their families is provided in Appendix B.

The support of a mutual-help group can be critical. The oldest, best known, and most accessible mutual-help program for people with an opioid use disorder is offered by Narcotics Anonymous.

Special Considerations in Treatment Planning

Some patients present with specific conditions or at life stages that require special consideration in formulating a treatment plan.

Patients With Psychiatric Comorbidities.

Studies of treatment populations have shown that co-occurring psychiatric disorders are present in 20 percent to 60 percent of people entering treatment, depending on the treatment group of the study and its methodology.⁵⁶ Even higher rates have been reported among older adults, people with low socioeconomic status, and those who reside in urban areas,^{57,58} as well as those who are homeless⁵⁹ or incarcerated.⁶⁰

When psychiatric and substance use disorders co-occur, the two disorders typically become intertwined, thus complicating the treatment plan and process. Therefore, whenever a patient enters treatment for either a substance use disorder or a psychiatric disorder, he or she should be assessed for the co-occurrence of the other.²⁴ To establish how a patient's substance use and a psychiatric disorder are linked, the order of onset of their psychiatric disorder and substance use, family history, and effect of previous treatments of the co-occurring psychiatric disorder should be determined.⁵⁴

Patients With Co-Occurring Medical Disorders.

Individuals with substance use disorders almost always are at higher risk for disease and other medical disorders than are those without addiction disorders. Furthermore, people with substance use disorders typically miss opportunities to receive preventive health care.^{22,61}

Like individuals with other chronic medical conditions, those who misuse opioids exist on a continuum ranging from less to more medically complicated.^{52,62,63} Moreover, the management of unrelated medical illnesses is complicated by addiction, its effect on adherence to the treatment regimen, and the direct consequences of the misused substances. This complication warrants a targeted approach to the conditions for which a patient is at risk.²²

Hepatic disorders: Hepatic monitoring is important because HCV seroprevalence is high among people with opioid use disorder. The U.S.

Departments of Veterans Affairs and Defense guidelines for the use of naltrexone recommend measuring baseline transaminase levels, followed by periodic monitoring at 6- or 12-month intervals.⁶⁴

HIV/AIDS: Methadone interacts with several antiretroviral treatments for HIV, buprenorphine causes fewer concerns, and extended-release injectable naltrexone causes almost none.⁶⁵ However, treatment is worth considering because of the prevalence of HIV infection among people who inject drugs.

Pain: Because of their opioid agonist activity, methadone and buprenorphine offer advantages in treating patients who have chronic pain. Naltrexone is not a good choice for people whose pain needs to be treated with opioid analgesics, but it can be used in patients whose pain is treated with non-opioid analgesics.

Obesity: In obese patients, a longer needle is needed to reach the muscle with injections. The risk of rare aseptic abscesses and other severe ISRs may increase when the injection goes subcutaneously into fatty tissue instead of the muscle.

Renal disorders: Renal problems do not require dose adjustments with naltrexone or buprenorphine.

Hospitalization: If a patient who is taking extended-release injectable naltrexone is hospitalized for medical reasons, special attention must be directed to the provision of adequate pain control.²²

Alcohol dependence: Extended-release injectable naltrexone has dual activity for the prevention of relapse to both high-risk drinking and opioid use.

Marijuana use: Patients who use marijuana or other substances containing tetrahydrocannabinol may need other types of pharmacotherapy until research studies clearly show whether extended-release injectable naltrexone increases the cardiovascular risks of cannabinoids.⁶⁶

Adolescents. The lack of treatment resources geared specifically to young people, coupled with the epidemic of prescription opioid and heroin abuse in this population, has left many young people with few effective treatment options.⁶⁷

Ample evidence demonstrates the failure of detoxification-only treatments and the high rates of dropout from psychosocial-only treatments on the part of adolescents and young adults. Yet, despite an increasing body of evidence that medications such as buprenorphine, methadone, and naltrexone are effective and easily combined with psychosocial treatments, only buprenorphine is approved by the FDA for the treatment of patients younger than 18, and the safety and effectiveness of buprenorphine hydrochloride sublingual tablets in patients younger than 16 have not been established. Therefore, the best course of action is to refer young patients to an addiction specialist or program with experience in treating adolescents.⁵

Pregnant and Postpartum Women. Opioid use disorder is associated with increased maternal and neonatal complications.⁵⁴ Currently, no medications have been approved by the FDA for treatment of opioid use disorder during pregnancy. Treatment with methadone or buprenorphine has been used, but the risks are not known.^{68–70} Although there is some interest in the potential for extended-release injectable naltrexone in this population, no research to evaluate its safety or efficacy has been conducted to date.⁷¹

FDA-approved prescribing information for extended-release injectable naltrexone states that “there are no adequate and well-controlled studies of either naltrexone or extended-release injectable naltrexone (Vivitrol®) in pregnant women. This product should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.”²⁷ Accordingly, patients dependent on opioids who are pregnant or nursing should be referred to an addiction specialist or program with experience in treating this population.

Older Adults. Members of the baby boom generation had more experience with nonmedical drug use than members of prior generations, and this continues to be true as members of this population reach retirement age and experience consequences of aging such as chronic pain. Furthermore, substance use disorders in older adults often are misdiagnosed, as are the consequences of such disorders.⁵⁴ For example,

dementia, malnutrition, self-neglect, functional decline, sleep problems, and anxiety or depression all may be attributed to “normal” aging when the true cause is substance misuse or a substance use disorder.²²

Studies show that older adults can and do benefit from treatment and in some cases have better outcomes than do younger adults.⁷² However, there are few studies of extended-release injectable naltrexone in this population.

In the absence of a specific evidence base for naltrexone in older adults, pharmacologic treatments should follow the evidence base for the general adult population. Health care providers may need to consider using oral naltrexone if the fixed dose extended-release injectable naltrexone is not appropriate in elderly patients with age-related pharmacokinetic and pharmacodynamic changes, as well as any mental or physical comorbidities.⁵⁴

Studies show that older adults can and do benefit from treatment and, in some cases, have better outcomes than do younger adults.

Other Populations. Certain highly motivated licensed individuals, such as health care professionals, attorneys, and pilots, may be ideal candidates to accept and persist with treatment with extended-release injectable naltrexone.^{52,73} Many professional groups have specialized programs that promote treatment, monitor recovery, and provide advocacy to maintain licensure. It has been suggested that professional advocacy might be the “voucher” or “contingency” that makes compliance with extended-release injectable naltrexone worthwhile for licensed professionals with opioid use disorder.⁷⁴ For example, some clinical evidence suggests that this may be the case with anesthesiologists.⁷⁵

In contrast, some individuals who are relatively less motivated or at an early stage in the addiction process may need specific counseling approaches to addressing their motivational issues before treatment with extended-release injectable naltrexone is initiated.⁷⁶

INITIATING MEDICATION-ASSISTED TREATMENT

Educating the Patient and Obtaining Informed Consent

The clinician should discuss with the patient the risks and benefits of medication-assisted treatment as compared with the risks associated with no treatment or treatment without medication.^{4,77–80} In addition, certain topics should be reviewed with every patient who is a candidate for medication-assisted treatment.⁸¹ Face-to-face conversations, supplemented by written fact sheets, are helpful in answering the following questions:

- Which medication is to be used? How is it administered? How does it work? What are its advantages and disadvantages?
- What is the duration of treatment, its cost, and associated routines?
- What are the known side effects?
- What are the contraindications?
- What are the issues related to pregnancy, lactation, and contraception?
- What are the dangers of concurrent use of nonprescribed drugs?
- What are the potential interactions between extended-release injectable naltrexone and other therapeutic medications?
- What is the potential impact of treatment with extended-release injectable naltrexone on driving, other activities of daily living, and employment?

Because methadone normalizes endocrine functions, it is not unusual for women in the early phases of medication-assisted treatment to become pregnant unintentionally, especially if they do not receive counseling for this possibility.⁸²

Patients should be educated about the effects of using opioids and other drugs while taking the prescribed medication and the potential for overdose if opioid use is resumed after tolerance is lost.^{83,84} Some health care providers supply a laminated card that identifies the individual as a patient of their practice. This is helpful to other health care providers who may see the patient in an emergency department.²⁴

Informed Consent. The patient's informed consent to treatment should be documented in a

written form that is discussed with and signed by the patient. Such a form can be helpful in reinforcing the information provided and establishing a set of ground rules. Typical provisions of an informed consent document include:¹⁷

- The medication and other therapies to be employed, with a rationale for their use
- Schedules for follow-up office visits and laboratory testing to monitor the patient's progress and health status
- Goals for attendance at meetings of mutual-help groups
- Involvement of family or significant others in treatment
- Symptoms that should be reported to the prescribing physician
- A plan for treating any co-occurring medical or psychiatric conditions, as well as other substance use disorders, including smoking
- Criteria for discontinuing the use of medication or other therapies and referral to specialty addiction treatment, if indicated

The patient should be advised to carry a medical alert card identifying the use of extended-release naltrexone, describing any potential adverse effects, and providing contact information for the treating clinician or institution in an emergency.¹⁷

The patient should be advised to carry a medical alert card identifying the use of extended-release naltrexone, describing any potential adverse effects, and providing contact information in an emergency.

The fact that a patient has received and understands this information should be documented in a written informed consent agreement, which should be signed before treatment is initiated and filed in the patient's medical record.¹⁷

Withdrawing the Patient From Opioids

Naltrexone displaces heroin or prescribed opioids from receptors to which they have bound, so it can precipitate significant withdrawal symptoms. Therefore, it is important that detoxification from

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opioids be completed at least 7 to 10 days before extended-release injectable naltrexone is initiated or resumed. A urine drug screen to confirm abstinence should be conducted before naltrexone is started.²⁷ Patients who are transitioning from buprenorphine or methadone to naltrexone may be vulnerable to precipitation of withdrawal symptoms for as long as 2 weeks. Clinicians should be prepared to manage withdrawal symptomatically with non-opioid medications.²⁷

The withdrawal syndrome that occurs spontaneously is marked by a predictable constellation of signs and symptoms that follow a rapid decrease in, or abrupt discontinuation of, intake of an opioid that has been used consistently for a period of time.

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Some patients experience prolonged withdrawal signs or symptoms, known as *protracted abstinence syndrome*. Symptoms of the syndrome include sleep disturbances, anxiety, irritability, and mood instability.¹ Suggested nonpharmacologic approaches include educating patients about expected symptoms, offering support and understanding, monitoring the patient for sleep disturbances or co-occurring disorders, encouraging physical and mental activities, and promoting the use of mutual-help groups. For some patients with protracted withdrawal, additional psychosocial interventions (such as cognitive behavioral therapy) or pharmacotherapy may be necessary to avoid relapse.⁸⁶

Precipitated withdrawal is much more severe than spontaneous withdrawal, and patients undergoing precipitated withdrawal can become very ill. Patients must understand that withdrawal precipitated by administration of an opioid antagonist may be severe enough to require hospitalization if they have not been opioid free for an adequate period and is different from the experience of spontaneous withdrawal that occurs

with discontinuation of opioid in an individual with an opioid use disorder.

Bell and colleagues⁸⁷ suggested that following one of the following two approaches to induction into naltrexone treatment can help avoid precipitated withdrawal:

1. The conventional approach is to undertake detoxification and, when patients have been free of opioids for 7 to 10 days or free of methadone for 10 days, begin treatment with naltrexone. Patient histories can be unreliable, so it is advisable to perform a naloxone challenge test before giving the first dose of naltrexone to avoid inadvertently precipitating a significant or prolonged withdrawal reaction. Patients may experience precipitated withdrawal despite tolerating a naloxone challenge test.
2. Antagonist-accelerated induction (rapid detoxification^{*88}) involves administration of naltrexone or naloxone, while providing symptomatic relief to make the ensuing precipitated withdrawal tolerable. See footnote for cautions on this procedure issued by the Centers for Disease Control and Prevention (CDC)⁸⁸

Health care providers should always be prepared to manage precipitated withdrawal, even if the steps identified above are taken.

Reported cases of precipitated withdrawal have frequently involved patients transitioning from buprenorphine.

Successful management of withdrawal can facilitate entry into addiction treatment by reducing uncomfortable withdrawal symptoms that negatively reinforce drug taking. This is best managed by a specialized practitioner or treatment program.⁵

Many individuals undergo withdrawal more than once, and some do so many times. When people who were recently dependent return for repeat detoxification they do so generally with a more

* Anesthesia-assisted rapid opioid detoxification (AAROD) for the purpose of induction onto naltrexone carries additional risks, including death. The CDC advises against the use of AAROD because of these risks and the fact that less risky yet effective protocols are available for detoxification and maintenance pharmacotherapy.⁸⁸

realistic expectation of what is needed to remain free from alcohol and drugs.⁸⁹

People in the early stages of treatment often relapse to substance use and get caught up in a revolving door of repeated detoxification. Therefore, it is important to educate patients that short-term treatment of withdrawal does not eliminate the need for long-term treatment of addiction.^{5,77,90}

Induction Onto Extended-Release Injectable Naltrexone Treatment

The clinician should consider how best to induct a patient into treatment with extended-release injectable naltrexone. Product labeling and standard practice call for 7 to 10 days of abstinence from short-acting opioids before starting naltrexone.⁹¹ A urine drug screen should be conducted to verify abstinence before beginning induction.⁵¹

Dosing and Administration. For patients who are appropriate candidates, the recommended dose of extended-release injectable naltrexone is 380 mg, delivered intramuscularly approximately every 30 days, alternating buttocks for each subsequent injection. The following cautions should be observed:^{1,83,92}

- Injectable naltrexone should be administered only by a medical professional (a physician, nurse, or physician assistant) who knows how to administer IM gluteal injections.
- Injectable naltrexone is packaged in a kit containing a vial of naltrexone microspheres as a dry powder that must be suspended in a liquid diluent immediately before use. Kits must be refrigerated during storage but should be brought to room temperature approximately 45 minutes before an injection is given. The powder and diluent must be mixed vigorously to prevent clumping, which can clog the needle during injection.
- A syringe and five needles are provided—one for mixing the microspheres with the diluent and four (two 1.5-inch needles and two 2-inch needles) for injecting the suspension into the upper outer quadrant of the gluteal muscle. Body habitus should be assessed before each injection for each patient to ensure that needle length is adequate for IM

administration. Injectable naltrexone must be administered only with one of the administration needles supplied in the carton. A spare administration needle of each size is provided in case of clogging.

- Proper IM injection technique is essential. Serious ISRs, some requiring extensive surgical debridement, have been observed with extended-release injectable naltrexone. It has been reported that likelihood of these severe reactions may increase if the product is inadvertently administered subcutaneously rather than intramuscularly.
- The medication should be administered every 4 weeks. If a dose is delayed or missed, the next injection should be administered as soon as possible. However, it is not recommended that medication be readministered at less than 4-week intervals.
- It is not recommended that the medication be administered at a dose higher than 380 mg.

Following IM injection, the plasma concentration time profile is characterized by a transient initial peak at about 2 hours after injection, followed by a second peak approximately 2 to 3 days later. At approximately 14 days after administration, concentrations begin to slowly decline, with measurable levels detectable for more than 30 days after administration. However, the therapeutic benefit of a single dose has not been established for periods longer than 4 weeks.²⁷

Supportive Care Following Induction.

Careful follow-up is a critical element in optimizing the benefits of naltrexone treatment. The practitioner performing induction onto naltrexone treatment should schedule two office visits in the first week of induction to assess the patient. Weekly clinical reviews should be conducted in the first month of treatment. Other elements of supportive care include the following:⁸⁷

- Medical monitoring such as a regular review by the prescribing physician, with monitoring of compliance, review of drug use, and sometimes urine drug screens to confirm self-report
- Counseling in regularly scheduled sessions with a professional counselor
- Mutual-help groups and family involvement

Transfer to Extended-Release Injectable Naltrexone. If a patient is being transferred to extended-release injectable naltrexone from methadone or buprenorphine, the taper should be completed 7 to 10 days before naltrexone induction begins.²⁷

Special Considerations in Pain

Management. Extended-release naltrexone blocks the effects of opioid analgesics. For acute pain (e.g., that associated with dental work, surgery, traumatic injury), regional analgesia, conscious sedation, use of non-opioid analgesics, or general anesthesia may be needed for pain management.^{24,83}

If regional anesthesia is not used, then a larger amount of opioid analgesic may be needed to override the opioid blockade, but this should be done in a hospital setting because it may result in respiratory depression that is deeper and more

prolonged than usual. For this reason, a rapid-acting opioid analgesic that minimizes the duration of respiratory depression is preferred. The amount administered should be titrated to the needs of the patient. In such cases, the patient should be monitored closely by trained medical personnel.^{5,24}

Careful follow-up is a critical element in optimizing the benefits of naltrexone treatment. The practitioner performing induction onto naltrexone treatment should schedule two office visits in the first week of induction to assess the patient. Weekly clinical reviews should be conducted in the first month of treatment.

MONITORING PATIENT PROGRESS AND ADJUSTING THE TREATMENT PLAN

As with patients with other chronic relapsing disorders, patients diagnosed with opioid use disorder require long-term monitoring and support, as well as periodic adjustment of the treatment regimen.

Monitoring Patient Progress

Use of medication-assisted treatment requires careful monitoring throughout treatment, with special attention to problems that may arise at the time of induction.

Monitoring patient progress is an ongoing process that assesses the patient on four dimensions:⁵ (1) adherence to the treatment plan, (2) ability to maintain abstinence, (3) levels of craving, and (4) overall health status and social functioning. Toxicology screening is an important part of monitoring patient compliance and progress. At each visit, the health care provider should:

- Assess the patient for continued use of any illicit or nonprescribed drug
- Assess the patient's adherence to the treatment regimen

- Assess changes in the patient's social functioning and relationships
- Review whether the patient is involved in counseling
- Monitor for side effects of the extended-release injectable naltrexone and other prescription medications

With this information, the clinician can decide whether to continue pharmacotherapy, modify the treatment plan as indicated, and address any co-occurring medical, psychiatric, and substance use issues.

Sources of Information. Patient self-reports can be useful indicators of treatment progress. In eliciting such information, it is important to avoid conveying a judgmental attitude toward the patient's behavior. The clinician should ask about the quantity and frequency of alcohol and drug use, especially during stressful periods (e.g., holidays, celebrations, major life changes). The patient also should be asked about current craving and how he or she felt over the preceding week (by assigning a rating between 1 and 10, with 1 indicating no craving and 10 the most

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intense craving the patient has ever experienced). In addition, the patient may be asked whether any episodes have caused particular problems. Identifying patterns of craving over time allows both the clinician and the patient to see that the patient's patterns of craving may fluctuate throughout the day and over longer periods, indicating the need to continue, adjust, supplement, or discontinue use of a particular medication.

Other sources and types of information that are useful in patient monitoring include the following:^{5,17}

- Laboratory tests, such as the ALT, AST, GGT, CDT, and random urine drug screens, including ethyl glucuronide, to detect recent alcohol use
- The patient's history of keeping (or not keeping) appointments for office visits, following-up on referrals, or attending mutual-help groups
- Data from the state PDMP (if available) on the patient's use of prescribed opioids or other prescribed medications
- Information about other nonprescribed drugs being used
- Reports from family members (obtained with a signed release from the patient)
- Periodic status reports from consultants on the patient's use of psychosocial therapies or other supports

Opioid use disorder is a chronic illness that, despite treatment, may wax and wane in intensity over time.

Documenting Patient Progress. In the event of a legal, regulatory, or civil (malpractice-related) challenge, detailed medical records documenting what was done and why are the foundations of the practitioner's defense. Every clinician needs to be aware of and understand the federal requirements for recordkeeping, as well as the laws and regulatory requirements of the state in which he or she practices.¹⁷ State laws and medical board rules may differ substantially from federal requirements and from one state to another. The board of medical licensure or board of pharmacy in each state can provide information about relevant requirements. At a minimum,

patient records should contain the following information:^{93,94}

- **Patient history and physical examination:** The patient's record must include a history of all controlled drugs used to treat the patient, a history of illicit substances used, and patient allergies. Past treatment attempts also should be documented. Medical records obtained from clinicians who have treated the patient in the past should be included. (Caution should be exercised in accepting records supplied by patients, because these occasionally are fraudulent.) The medical record also should include information about the patient's personal and family history of alcohol, tobacco, and other substance use as well as a personal history of major depression or other psychiatric disorder.
- **Treatment plan:** The treatment plan and goals should be documented in the record so that there is evidence of clear-cut, individualized objectives to guide the choice of therapy. Patient improvements after a brief trial should be documented in the record, as should all regimens that were tried but failed.
- **Consultants' reports:** Whenever the best clinical course is not clear or the patient's response is not as expected, consultation with an appropriate specialist should be obtained. Generally, the results of the consultation should be discussed with the consultant and a written consultation report should be added to the patient's medical record.
- **Prescription orders:** The patient record must include all prescription orders, whether written or telephoned. Written instructions for the use of all medications should be given to the patient and documented in the record. The prescription order should list medication name, formulation, route of administration, and amount.
- **Informed consent:** A written informed consent or treatment agreement signed by both patient and practitioner can be helpful in establishing a set of ground rules and appropriate expectations.
- **Monitoring visits:** Medication monitoring visits are billable and can be performed by a nurse. They should be carefully documented in the medical record, in the same manner as a visit with the physician.

- **Treatment progress/outcomes:** The patient's record should clearly reflect the decision-making process that led to a medical, psychiatric, or behavioral outcome.

A patient's goals may change over time, requiring the clinician to adapt to new objectives.

Good records demonstrate that a service was provided to the patient, and that the service was medically necessary. Even if the outcome is less than optimal, thorough records protect the clinician as well as the patient.⁹⁴

Adjusting the Treatment Plan

Opioid use disorder is a chronic illness that, despite treatment, may wax and wane in intensity over time.⁵ If a patient begins to experience problems with adherence, the clinician should revisit the treatment plan to determine whether different strategies or treatment modalities (pharmacologic and nonpharmacologic) might be useful. For example, switching the patient from oral naltrexone to extended-release injectable naltrexone may enhance compliance with medication use.

A patient's goals also may change over time, requiring the clinician to adapt to new objectives. Also, as with patients who receive treatment for other chronic diseases, patients receiving treatment for an opioid use disorder may relapse.

Responding to Changes in Treatment Progress.

Individuals receiving medication-assisted treatment often demonstrate dramatic improvement in addiction-related behaviors and psychosocial functioning. Such positive changes should be acknowledged and reinforced by the prescribing physician whenever possible.^{10,95}

However, lack of adherence to pharmacologic regimens occurs in a substantial proportion of patients, with some studies reporting that as many as 7 out of 10 patients fail to follow the treatment plan.⁵ If a patient experiences problems with adherence, the clinician should revisit the treatment plan to determine whether different strategies or treatment modalities (pharmacologic or nonpharmacologic) might be useful. Other strategies to improve adherence and reduce the risk of relapse during treatment include providing

incentives to take the monthly injections (i.e., contingency management); involving significant others in monitoring the patient to ensure adherence to the medication plan, in a manner consistent with patient privacy requirements; offering relapse prevention counseling; and using motivational interviewing techniques.^{44,47,96}

Behaviors that violate the treatment agreement or that indicate limited progress in treatment may not constitute grounds for automatic termination of medication-assisted treatment. Such behaviors should trigger a reassessment of the patient's needs and goals and a corresponding revision of the treatment plan. Aberrant or dysfunctional behaviors may indicate the need for more vigorous engagement in peer support, counseling, or psychotherapies or possibly referral to a more structured treatment setting.⁵⁵

Alternative pharmacologic therapies such as methadone or buprenorphine maintenance therapy also should be considered for these patients.^{27,84} Such changes should be documented in the patient's medical record.¹⁰

Relapse rarely is caused by a single factor and often is the result of an interaction of physiologic and environmental factors. It is best conceptualized as a dynamic process in which the patient's readiness to change interacts with other external and internal factors.

Preventing and Responding to Relapse. As with patients who receive treatment for other chronic disorders, patients receiving treatment for an opioid use disorder may experience relapses. Relapse rarely is caused by a single factor and often is the result of an interaction of physiologic and environmental factors.⁹⁷ It is best conceptualized as a dynamic process in which the patient's readiness to change interacts with other external and internal factors.⁹⁸

If relapse occurs, the clinician should consider several options:

- Examine social, medical, or behavioral factors that contribute to the patient's substance use
- Increase monitoring
- Change the medication

- Increase or change the intensity of psychosocial services
- Refer the patient for specialty care

Relapse risk is highest in the first 6 to 12 months after achieving abstinence and then diminishes gradually over the years. It may be necessary to escalate other treatment or to resume therapy with extended-release injectable naltrexone services if relapse appears imminent. Patients should be cautioned that they will be more sensitive to lower doses of opioids after treatment with extended-release injectable naltrexone is discontinued.²⁴

Reinduction Onto Naltrexone Treatment.

Many patients who have relapsed express a desire to resume naltrexone treatment. If a patient experiences multiple relapses, the clinician should consider whether to continue treatment with naltrexone or whether to offer a different treatment modality.

Patients may benefit from referral to a specialist for additional evaluation and treatment. For example, the treatment of addiction for a patient with a comorbid psychiatric disorder may be best managed through consultation with or referral to a specialist in psychiatry or addiction psychiatry.⁹⁹

DECIDING WHETHER AND WHEN TO END MEDICATION-ASSISTED TREATMENT

Long-term treatment, which is common to many chronic medical conditions, should not be seen as a failure. In fact, it is a cost-effective way of prolonging life and improving the patient's quality of life by supporting the natural and ongoing process of change and recovery.²⁴ Nevertheless, the physician and patient may wish to weigh the potential benefits and risks of continuing medication-assisted treatment and discuss whether such therapy remains appropriate.

Factors to consider in determining a patient's suitability for long-term, medication-free status include the presence of stable housing and income, availability of adequate psychosocial supports, and the absence of legal problems. For patients who have not achieved these indices of stabilization, a period of maintenance to address these barriers usually is advised.⁵⁵

Ideally, the patient and practitioner will reach a decision about whether and when medication-assisted treatment should be discontinued, usually for one of the following reasons:²⁴

- The patient reports substantially diminished craving.
- The patient has maintained stable abstinence over a sustained period.
- The patient feels ready to discontinue the medication.

- The patient is engaged in ongoing recovery, including community supports (such as attendance at mutual-help group meetings).

Less than ideally, some patients simply stop taking their medication without consulting the prescriber. Alternatively, a patient may ask to discontinue medication use because of side effects or other reasons. Still other patients must discontinue medication use because of a significant negative laboratory finding or problem with their physical health status.^{5,24}

The clinician should help the patient withdraw from the medication at an appropriate pace and encourage the patient to continue with psychosocial therapies and participation in mutual-help groups. In the case of extended-release injectable naltrexone, withdrawal is termination of the monthly injection. Patients who resist treatment should be reassessed for co-occurring disorders.

If the patient wishes to continue treatment, his or her engagement in counseling and other psychosocial services should be intensified.¹⁰⁰ However, if the patient does not want to continue treatment, the physician may consider referring him or her to an addiction specialist or treatment program.¹⁷

Relapse can be fatal. Patients who relapse to opioid use after being treated with extended-release injectable naltrexone or other medications

are at risk for accidental overdose and overdose-related death.¹⁰¹ If a patient reverts to pretreatment opioid use, as the blockade wanes, he or she may experience overdose and life-threatening consequences, including respiratory arrest and circulatory collapse.²⁷ Therefore, it is recommended that clinicians and patients jointly develop a relapse prevention plan.⁸⁴ SAMHSA's Opioid Overdose Toolkit¹⁰² includes strategies for developing such a plan that includes ways to address emergency reversal of actual or suspected opioid overdose (see Appendix B for more information).

Relapse to drug use often is preceded by emotional and cognitive relapse. Negative mood states may be warning signs of impending relapse, as are behaviors such as isolating or overcommitting oneself or failing to maintain healthful sleeping and eating habits. People in recovery may need to plan how to respond to disappointments and celebrations without relapsing to drug use.

Cognitive patterns that may predict relapse include thinking that others are having more fun, glamorizing past drug use, and seeing opportunities to relapse without getting caught when others are otherwise occupied or away. The relapse prevention plan should include strategies for managing these thoughts when they arise, such as contacting a supportive person, imposing a specific waiting period before acting, distracting oneself with physical or enjoyable activities, making a list of the pros and cons of drug use, and deciding not to use drugs "just for today."

Although relapse may be seen as a normal part of a chronic medical disorder, relapse to using opioids after a period of abstinence is strongly associated with overdose. Patients should understand that medication treatment can be resumed if they find themselves unable to cope with negative moods or thoughts.

Every effort should be made to avoid secretiveness and shame about relapse. Providers may wish to consider providing newly medication-free patients with naloxone and supporting their family and friends in learning how to use it. This effort conveys the message that relapse may occur but that the patient has the opportunity to reenter treatment alive and well.

Voluntary Termination of Medication-Assisted Treatment

When the patient and physician agree to discontinue medication-assisted treatment, medically supervised withdrawal should be followed by long-term, drug-free treatment to minimize the risk of relapse.

Both the physician and the patient should accept that the patient may need or want to resume medication-assisted treatment, either with extended-release naltrexone or with another medication.¹⁰⁰ Patients also should be assured that relapse need not occur for them to be reinstated on medication-assisted treatment.¹⁰

If the best clinical course is not clear, consultation with a specialist may be helpful. The results of the consultation should be discussed with the patient and added to the patient's record.²⁵

Referring a Patient for More Intensive Care

If office-based interventions are not effective for a given patient or if the clinician does not have the resources to offer needed care, the patient should be referred for more intensive or specialized services. Many specialty treatment programs provide services that address withdrawal and craving; management of long-term abstinence through pharmacotherapy; case monitoring; individual, group, and family/couples counseling and therapy; other psychosocial services such as vocational counseling; and referral to mutual-help groups.⁵

Specialized treatment programs anywhere in the United States can be identified through use of the Substance Abuse Behavioral Health Treatment Services Locator on the SAMHSA Web site at <http://www.findtreatment.samhsa.gov>.

A physician who is planning to treat a patient for opioid use disorder should become familiar with local treatment resources. Developing relationships with such specialized practitioners and programs facilitates the process of consultation and referral. In addition, understanding a program's treatment duration, modality, philosophy, and continuing-care options helps the physician identify appropriate placements for patients who no longer are

candidates for treatment in the general medical office.

A patient may become a candidate for referral to a more structured treatment environment (such as an OTP) for the following reasons:

- **Noncompliance with the treatment plan:** For example, a patient may continue to misuse opioids or fail to appear for scheduled monthly doses of extended-release injectable naltrexone. In such a situation, it may be advisable to transfer the patient to another medication or to refer him or her to a specialized practitioner or treatment setting for more intensive care.
- **Noncompliance with agreed-on activities:** A patient who refuses to participate in counseling or mutual-help groups may need more structure than can be provided in a general medical office and may be better served by an addiction specialist or in an OTP.
- **Threats or verbal abuse:** The patient who verbally abuses office staff, exhibits out-of-control behavior, or otherwise threatens the safety and well-being of office personnel or other patients is a special concern. Such a patient requires more structure than can be provided in a general medical office and should be referred to an addiction specialist or OTP.
- **Nonpayment for services:** If payment is owed for a backlog of bills and the patient has made no effort to arrange a payment plan or to access resources for payment, treatment termination may be necessary but should be done with care to ensure the patient does not leave without treatment options (i.e., patient abandonment).

Conditions that result in termination of treatment in a general medical office setting should be outlined in the treatment agreement or informed consent.⁹⁹

Special Considerations

Situations that may require additional arrangements or a delay in referring or discharging a patient include the following:⁹⁹

- If the patient is in an acute phase of treatment, termination must be delayed until the acute phase has passed. If the practitioner is the only source of treatment for the patient's opioid use disorder in a reasonable driving distance, the practitioner may need to continue care until other arrangements can be made.
- If the practitioner is the only source of a particular type of specialized medical care, he or she may need to continue care until the patient can be safely transferred to another practitioner who can provide such care.
- If the patient is a member of a prepaid health plan, the patient cannot be discharged until the practitioner has communicated with the third-party payer to ask that the patient be transferred to another practitioner.

It may become necessary to reinstate pharmacotherapy with extended-release injectable naltrexone or another medication or to provide other treatment services if relapse appears imminent or occurs.²⁵

Documenting the Decision and Notifying the Patient

When terminating the physician–patient relationship (and no special considerations are present), the reasons for such termination should be formally documented in the patient record.

The patient also should be given a written notice that he or she must find another health care provider within a stipulated period. The notice should be mailed to the patient by certified mail, return receipt requested. Copies of the letter should be filed in the patient's medical record, along with the original certified mail receipt and the original certified mail return receipt (even if the patient refuses to sign for the certified letter).^{10,25}

SUMMARY

Medication-assisted treatment has shown much promise in reducing nonmedical use of opioids and restoring patients to a healthier life. Considerable research evidence and consensus among experts support the use of pharmacologic treatments for an opioid use disorder in primary care settings. In fact, primary care physicians and members of their health care provider teams are ideally situated to employ these medications to help their patients—particularly those who have been unwilling or unable to access treatment in specialized settings—achieve and sustain a robust recovery from drug use and a safer, healthier life.

A number of FDA-approved medications have been shown to be important elements of such treatment. Although some patients do not benefit from medication-assisted treatment, most do. For each patient deemed an appropriate candidate for

such treatment, multiple pharmacologic agents offer a variety of options so that treatment can be tailored to each patient's needs and circumstances.

Medication-assisted treatment has shown much promise in reducing nonmedical use of opioids and restoring patients to a healthier life.

In addition, new patient care models and improvements in the quality and quantity of treatment options are being encouraged through implementation of the Affordable Care Act. These new developments reveal the considerable potential for expanding the use of medication-assisted treatment as clinicians recognize their safety, efficacy, and cost-effectiveness.

APPENDIX A: MEMBERS OF THE CONSENSUS PANEL, STAFF, AND CONSULTANTS[§]

PANEL CHAIR

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APPENDIX B: SOURCES OF INFORMATION

SAMHSA Publications and Web sites

National Registry of Evidence-based Programs and Practices

<http://www.nrepp.samhsa.gov/Index.aspx>

Treatment Improvement Protocol 45.

Detoxification and Substance Abuse Treatment.

HHS Publication No. (SMA) 08-4131

<http://www.kap.samhsa.gov/products/manuals/tips/pdf/TIP45.pdf>

SAMHSA Treatment Locator

<http://www.samhsa.gov/treatment/index.aspx>

SAMHSA Advisory: *The Role of Biomarkers in the Treatment of Alcohol Use Disorders*, 2012 Revision

http://www.kap.samhsa.gov/products/manuals/advisory/pdfs/Advisory_Biomarkers_Revision.pdf

Coding for Screening and Brief Intervention Reimbursement

<http://www.samhsa.gov/sbirt/coding-reimbursement>

General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occurring Mental and Substance Use Disorders

http://www.samhsa.gov/co-occurring/docs/Pharm_Principles_508.pdf

Opioid Overdose Toolkit

<http://www.store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742>

NIDA Publications and Web Sites

Comorbidity: Addiction and Other Mental Illness (Research Report Series; Publication Number 10-5771). Rockville, MD: National Institutes of Health, 2010.

Principles of Drug Addiction Treatment: A Research-Based Guide, Third Edition. Rockville, MD: National Institutes of Health, 2012.

Mentoring Network

Physician Clinical Support System for Medication-Assisted Treatment

<http://www.pcssmat.org>

Information About Mutual Support Groups

Narcotics Anonymous (NA)

<http://www.na.org>

Dual Recovery Anonymous (for patients with co-occurring psychiatric disorders)

<http://www.draonline.org>

Self-Management and Recovery Training

<http://www.smartrecovery.org>

Web-Based Courses

American Society of Addiction Medicine (ASAM) *SBIRT Core Training Program*

<http://www.sbirtraining.com/>

ASAM e-Live Learning Center

<http://www.softconference.com/asam/default.asp>

ASAM *From Assessment to Service Planning and Level of Care Course*

<http://www.changecompanies.net/asamcriteria/learning.php>

Other Web Sites, Articles, and Texts

Alliance of States with Prescription Monitoring Programs

<http://www.pmpalliance.org/>

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Fact Sheet: Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services.*

<http://www.prescribetoprevent.files.wordpress.com/2012/01/sbirt-guidance-document.pdf>

Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide

U.S. Departments of Veterans Affairs and Defense.
*VA/DoD Clinical Practice Guideline for
Management of Substance Use Disorders in the
Primary Care Setting.*

http://www.healthquality.va.gov/sud/sud_fulltext.pdf

The ASAM Criteria, Third Edition (PPC-3), 2013

[http://www.asam.org/publications/patient-
placement-criteria](http://www.asam.org/publications/patient-placement-criteria)

British Association for Psychopharmacology.
*Evidence-based guidelines for the pharmacological
management of substance abuse, harmful use,
addiction and comorbidity: Recommendations from
BAP.* London: June 2012.

[http://www.bap.org.uk/pdfs/BAPaddictionEBG_201
2.pdf](http://www.bap.org.uk/pdfs/BAPaddictionEBG_2012.pdf)

Principles of Addiction Medicine, Fifth Edition, 2014

[http://www.asam.org/publications/principles-of-
addiction-medicine](http://www.asam.org/publications/principles-of-addiction-medicine)

Principles of Addiction Medicine: The Essentials

[http://www.asam.org/publications/principles-the-
essentials](http://www.asam.org/publications/principles-the-essentials)

*Diagnostic and Statistical Manual of Mental
Disorders*, Fifth Edition (DSM-5), 2013

<http://www.psych.org/>

APPENDIX C: ACKNOWLEDGMENTS

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