



PROVIDER MANUAL

Managed Care Operations

February 2023

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INTRODUCTION

For people who receive its services to have choices, and access to an effective and broad system of care, Integral Care has developed a network of Providers. Network Providers are a valuable key to the overall success of the people Integral Care serves. We are incredibly pleased that you have become a member of Integral Care's Provider Network. In this Provider Manual, you will find information that is relevant to you as a Provider such as how to obtain an authorization and submit invoices, training requirements, links, and contact information.

IMPORTANT NOTE:

All Providers **must electronically sign the** "Integral Care Provider Manual Acknowledgement" form prior to receiving a final Agreement for Direct Care Services with Integral Care and as otherwise may be determined by Integral Care when a revised Provider Manual is issued. Doing so acknowledges that you have received and reviewed the latest version of the Provider Manual. If you have questions about any section of this Provider Manual, contact the Integral Care Contract Manager at providers@integralcare.org. You can find the most recent version of the Provider Manual online at www.IntegralCare.org under Provider Portal>Current Providers>Provider Manual.

Important process information covered in this Provider Manual includes

- Credentialing Requirements
- Documentation and Training Requirements
- Service Delivery Guidelines
- Authorization and Utilization Management Procedures
- Invoicing (Claims) and Billing and Reimbursement Guidelines and Procedures
- Contract Compliance
- Confidentiality
- Client Rights, Reporting of Abuse, Neglect and Other Incidents of a Serious Nature

Integral Care History

Founded in 1967, Integral Care prides itself on providing innovative, quality services for Covered Individuals residing in Travis County, Texas who have intellectual and/or developmental disabilities and/or brain-based disorders, such as major depression, bi-polar disorder, and schizophrenia, as well as those who have a (combined) diagnosis of chemical dependency and/or people without housing. Target populations served are determined by the State.

Integral Care's Mission

To improve the lives of individuals affected by behavioral health and developmental and/or intellectual challenges in Travis County, Texas.

INTAKE, ELIGIBILITY AND ACCESS TO COVERED SERVICES

Integral Care Divisions

Integral Care has organized services into four service divisions, each of which provides services to distinct populations. Below you will find a hyperlink for each service division for more in-depth information on programs and services offered:

ADULT BEHAVIORAL HEALTH SERVICES

[HTTPS://INTEGRALCARE.ORG/EN/ADULT-SERVICE/](https://integralcare.org/en/adult-service/)

CHILD AND FAMILY SERVICES DIVISION

[HTTPS://INTEGRALCARE.ORG/EN/CHILD-FAMILY-SERVICES/](https://integralcare.org/en/child-family-services/)

CRISIS SERVICES DIVISION

[HTTPS://INTEGRALCARE.ORG/EN/CRISIS-SERVICES/](https://integralcare.org/en/crisis-services/)

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES DIVISION

[HTTPS://INTEGRALCARE.ORG/EN/INTELLECTUAL-DEVELOPMENTAL-DISABILITIES/](https://integralcare.org/en/intellectual-developmental-disabilities/)

SERVICE DELIVERY

SERVICE DELIVERY & CONTRACTED PROVIDERS

Though Integral Care contracts with a network of trusted behavioral healthcare Providers to extend its services, Providers who deliver services to Covered Individuals on this external network must follow the same guidelines and meet the same requirements for service delivery as Integral Care's internal employees.

OUR PHILOSOPHY

To support Integral Care’s Vision of “Healthy Living for Everyone,” Providers are expected to work collaboratively with Covered Individuals, their Legally Authorized Representatives (LARs), and families to ensure Covered Services provided are client-driven, culturally relevant, and safe.

All Covered Services provided to Covered Individuals must be person-centered. Providers must consider and respect the individualized needs, strengths, and preferences of each Covered Individual during service planning and service delivery.

Service delivery of authorized services – and any corresponding or supporting activities – must also be culturally sensitive. Providers must consider and respect the Covered Individual's culture, beliefs, race, ethnicity, religion, sexual orientation, identity, and age.

Providers must ensure the health, safety, and welfare of all Covered Individuals during service delivery.

SERVICE PLANS, GOALS, & OBJECTIVES

Covered Service Plans (also referred to as “Treatment Plans,” “Plans of Care,” or “Person-Directed Plans”) guide and direct all Covered Services delivered to Covered Individuals. Designated clinicians and coordinators collaborate with the individual, their LAR, and anyone else chosen by the Covered Individual or LAR to determine unique needs and develop a personalized Plan of Care.

The service planning team recommends services that support the achievement of the Covered Individual’s goals and objectives.

Service Plans provide the following service delivery guidelines for Providers:

- The personalized needs of the Covered Individual and any family;
- Delivery schedules for authorized services (frequency and duration of service delivery);
- Specific individualized objectives or goals toward which the Provider should direct Covered Services;
- Activities beneficial and/or not approved during the delivery of the authorized Covered Services;
and
- Any other relevant service delivery guidelines.

SERVICE DELIVERY DOCUMENTATION

Providers must document each service to Covered Individuals in Integral Care’s electronic health record (EHR) or by using the appropriate form. Service documentation must include each of the following:

Name of Covered Individual (and LAR, if applicable) receiving service	Type of Service Provided (by service description, CPT code, or procedure code)	Date of Service	Begin and End time of Service	Location of Service
Title of any curriculum used	Plan objective(s) that were the focus of the Service	Narrative summary of activities that occurred during service delivery	Details of any pertinent event or behavior relating to the Covered Individual’s intervention which occurred during service delivery	A description of the Covered Individual’s progress or lack of progress in achieving Plan goals
Any Training Methods Used (e.g., instructions, modeling, role play, feedback, repetition)	Modality and Method of Service (e.g., Covered Individual vs group, face-to-face, telephone, or telehealth)	Appointment type (e.g., face to face, telephone, or collateral)	Intensity of the Service (e.g., routine, urgent, or emergent)	The name, title, and signature of the Covered Individual Provider or Group Member providing service

The Service narrative summary must match the Service authorized and its definition included in the specific service training manuals that are available on Integral Care’s website at:

<https://integralcare.org/en/provider-portal/>

Documentation of Covered Services delivered by the Provider, and the needs and goals/objectives documented by the Provider must also match the Service Plan, Provider Activity Sheet, and/or the written authorization issued by the UM/RA or the designated clinician.

DOCUMENTING SUPERVISION DURING SERVICE DELIVERY

Covered Individuals receiving Covered Services from a Provider must receive supervision consistent with the Covered Individual’s Level of Need as described in their Service Plan. Supervision is a primary and required component of services provided. While providing the appropriate respect for the Covered

Individual's privacy, Providers are always required to ensure the appropriate supervision of the Covered Individual's activities.

Providers may have additional supervisory actions based on the definition of the Covered Service or in writing by the UM/RA representative and are required to implement any additional supervisory actions.

Being aware of the Covered Individual's activities requires the Provider to direct focused attention on the Covered Individual within the same physical space. This requires the Provider to be always within sight and/or hearing range of the Covered Individual (as appropriate to the specific situation and/or Covered Individual's age).

Providers must ensure their service documentation clearly demonstrates the appropriate supervision level.

DOCUMENTING SUBSTANCE USE RECORDS

Records of a Covered Individual who has requested or is receiving treatment for substance use must be documented on a separate service delivery record and maintained separately from that Covered Individual's other records.

DOCUMENTING HIV/AIDS RECORDS

Records of a Covered Individual's diagnosis of and/or treatment for HIV and/or AIDS must be documented on a separate service delivery record and maintained separately from the Covered Individual's other records.

OUR ELECTRONIC HEALTH RECORD (EHR) SYSTEM

Integral Care uses MyAvatar, confidential and proprietary software from Netsmart, for its client data and electronic health record (EHR). Use of any EHR information including, but not limited to, on-line information and any printed reports, documents, screen prints, etc., must be limited to providing Covered Services under the Provider's agreement for direct care services. To access the EHR, if determined necessary for service delivery, the Provider must execute a confidentiality and licensing agreement form(s).

Connecting to the Integral Care Client Data/Electronic Health Record System, MyAvatar: Using MyAvatar via the Internet requires:

1. A computer workstation.
2. An Internet connection; and

3. Installation of Citrix.

Maintenance of the computers, software, and Internet connection used to access the EHR system is the responsibility of the Provider and will not be provided by Integral Care.

COMMUNICATION AND REPORTING CHANGES

Providers are required to promptly report changes in contact information to Integral Care. Providers must also report changes to any Group Members providing Covered Services under their Agreement for Direct Care Services with Integral Care.

Any address changes to the location of where Covered Services are provided to Covered Individuals must be reported and approved prior to providing Covered Services to Covered Individuals at the new location.

In addition, Providers must have and maintain a valid email address and telephone/cell number to facilitate communication between the Provider and Integral Care.

TRANSFER TO ANOTHER INTEGRAL CARE-CONTRACTED PROVIDER

Transfer of a Covered Individual to another Integral Care Provider requires authorization from the UM/RA representative. Requests by a Provider to transfer a Covered Individual to another Provider are authorized by the UM/RA when there is clear justification for the transfer. Failure to obtain approval will result in non-authorization/ non-payment for those unapproved services.

A Covered Individual may request a change of Provider at any time. The Covered Individual's UM/RA representative is responsible for determining whether the transfer will be approved, and for facilitating any authorized transfer. Providers must assist in and cooperate with any transfer of a Covered Individual to a different Provider.

AUTHORIZATIONS/UTILIZATION MANAGEMENT/RESOURCE ALLOCATION

Integral Care's staff determines if a Covered Individual is eligible for Covered Services through the Integral Care Provider Network. Providers should review the types of authorizations and the requirements for service and payment.

NON-EMERGENCY AUTHORIZATIONS

The Provider **HAS** the responsibility to obtain initial verbal and subsequent written authorization for all non-Emergency Covered Services for Covered Individuals from the appropriate Integral Care Utilization Manager (UM) or Resource Allocator (RA). The table below provides the identified staff who provide authorizations for programs and Covered Services.

Definitions

Utilization Manager: Licensed staff who approve authorization requests submitted by Providers, as defined by Texas Department of Insurance (TDI) regulations.

Care Coordinator/Service Coordinator/Coordinator/Intensive Care Manager/Resource Authorizer: Designated individual who authorizes, manages, and coordinates resources consistent with the Wraparound or Person-Directed Planning service delivery models.

Utilization Management / Resource Allocation Function Table

INTEGRAL CARE DIVISION	PROGRAM/SERVICES	UTILIZATION MANAGER/RESOURCE ALLOCATOR
Behavioral Health (“BHS”)	Texas Resilience and Recovery (TRR)	Utilization Manager
	External Contract Substance Abuse Providers (MSO and non-MSO)	Utilization Manager
	External and Internal Contract Providers (non-MSO)	Program/Contract Manager and Utilization Manager
Intellectual and Developmental Disabilities (“IDD”)	All IDD Covered Services Internal and External Contracted Providers	Service Coordinator
Child and Family Services (“CFS”)	Children’s Partnership program for youth with serious emotional disturbances (SED)	Care Coordinator
	Youth and Family Assessment Program (YFAC) -program for At-Risk youth	Care Coordinator
	External and Internal Contract Providers who serve Integral Care children/adolescents with SED	Utilization Manager

For BHS, CSD and CFS Providers, the Texas Resilience and Recovery (TRR) are available on the Department of State Health Services website at:

Guidelines for Adults

<https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-adult.pdf>

Guidelines for Children/Youth

<https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-child.pdf>

Providers who provide TRR Covered Services must receive TRR training prior to providing such services.

For CFS and IDD Providers, the Wraparound models are considered best practice and Providers are encouraged to participate in this training.

Before a Provider provides Covered Services, the designated UM/RA staff member will contact the Provider to review the Covered Individual's person-centered plan and to authorize needed services. The UM/RA staff member is limited to arranging **ONLY** the service at the rates stated in the Provider's current agreement for direct care services. After initial authorization of Covered Services by the UM/RA staff member, the Provider will receive written/electronic authorization to provide the UM/RA-approved services. The Provider should review the written authorization for accuracy as to the type of service, number of units, start and end dates and service/CPT or procedure codes to ensure consistency with the prior, initial verbal authorization or written approval given by the UM/RA.

For Substance Abuse Managed Services Organization (SAMSO) or hospital services, an organization may be able to request an authorization for an Individual that is eligible for Covered Services. In these cases, a Service Authorization Request should be submitted via Provider Connect or identified Integral Care system and completed Eligibility and Consent and Authorization Request Forms should be uploaded to the system. SAMSO or hospital services Covered Individual may or may not be existing Integral Care Covered Individual. Integral Care Covered Individuals that are currently being served under the BHS or CSD divisions will have either a Treatment Plan or a Service Plan that guides and directs their service provision.

IMPORTANT INFORMATION:

It is the Provider's responsibility to ensure that a written/electronic authorization has been received for all requested Covered Services prior to service delivery.

Integral Care IS NOT REQUIRED TO PAY FOR ANY COVERED SERVICE THAT IT DOES NOT AUTHORIZE IN WRITING PRIOR TO THE SERVICE BEING PROVIDED THROUGH THE APPROPRIATE UM/RA IDENTIFIED BELOW. THE ONLY EXCEPTION MAY BE FOR EMERGENCY AUTHORIZATIONS.

- Authorization is not a guarantee of payment (see reasons for denial or adjustment of submitted Claims / Invoices in the “Claims / Invoice Submission/Payment Process Requirements” section, below).
- The Provider must immediately notify the UM/RA when the Covered Individual’s need for Covered Services/treatment change, or when the Covered Services are discontinued for any reason during treatment or program involvement.
- The forms and information needed varies for SAMSO and Hospital Providers.

For BHS, CSD and CFS Providers:

Important Information needed by the UM/RA staff to authorize Covered Services include, but are not limited to:
<ul style="list-style-type: none"> • Identifying information concerning the Covered Individual and the Covered Services they/their will receive must be provided (name, date of birth, social security number, including that of the Covered Individual’s or primary caregiver, if applicable and the following: <ul style="list-style-type: none"> • Current diagnostic review • Current assessment • Current plan • Plan objective(s) that was the focus of the service • The progress or lack of progress in achieving treatment plan goals

For CFS and IDD Providers:

Upon accepting referrals, Providers should obtain as a minimum the following information from the UM/RA (or for IDD Service Coordinator) staff member:
<ul style="list-style-type: none"> ▪ Authorization Number ▪ Name of Covered Individual and/or service recipient (i.e., family member) ▪ Covered Individual’s date of birth ▪ Covered Individual’s needs and strengths ▪ Goals and objectives in providing Covered Services ▪ Other relevant information for service provision ▪ Diagnosis, if relevant to service provision

ONGOING REVIEW FOR AUTHORIZATIONS

Authorizations for continuing care are approved by the UM/RA after a brief review of the Covered Individual's response to Covered Services, justification for continuation of services and plan changes and/or recommendations.

EMERGENCY AUTHORIZATIONS

Emergency authorizations may be issued after the service by the UM/RA, at Integral Care's sole determination. An "emergency" requires immediate intervention and must be approved verbally by the appropriate UM/RA prior to service delivery. The Provider must request written authorization from the appropriate UM/RA no later than the following business day after the emergency.

For SAMSO and hospital Providers, the UM staff are available 24/7 by phone to discuss emergency authorizations.

If Integral Care provides crisis intervention to a Covered Individual who is currently receiving or scheduled to receive Covered Services from a Provider, Integral Care will notify the Provider of the intervention within twenty-four (24) hours of the intervention.

CLAIM/INVOICE SUBMISSION/PAYMENT PROCESS REQUIREMENTS

FEE FOR SERVICE BILLING PROCESS

Provider will obtain an authorization and bill in accordance with the fee established and found in the Provider's Agreement for Direct Care Services.

A Provider who has provided Covered Services to a Covered Individual must obtain authorization and request payment from Integral Care as specified below.

THIRD PARTY PAYER BILLING PROCESS

Third party payer billing is a situation in which a Provider bills for Covered Services funded or reimbursed by a third-party benefit plan administrator other than Integral Care including, but not limited to: Medicaid, STAR Medicaid, CHIP, private insurance, or other third-party insurance billing.

1. Providers must obtain authorization and bill designated benefit plan administrators for third party payer Covered Services by submitting claims/invoices directly to the insurance payers or benefit plan administrators for Medicaid, STAR, CHIP, or private insurance company; or
2. A claim/invoice submitted for non-third-party billing is due by the third business day of the month immediately following the month in which Covered Services were provided unless Provider's agreement for direct care services with Integral Care contains different requirements; Or-
3. For inpatient Covered Services, authorized by Integral Care the claim is due within 30 days of the Covered Individual's discharge date.

COST REIMBURSEMENT BILLING PROCESS

The process by which a Provider bills for cost incurred to operate the program and/or deliver Covered Services should be consistent with the budget submitted by the Provider and documented in the agreement for direct care services between Provider and Integral Care.

1. Providers will submit a claim/invoice on an Integral Care-approved Claim/Invoice form to the designated Integral Care office. For cost-reimbursement contracts, submission must include the Provider's general ledger for the month and Provider staff time sheets.
2. The deadline for submission is the 3rd business day of the month following the month in which Covered Services were provided.
3. Billing should be submitted to Integral Care via ProviderConnect or SharePoint. Providers will be trained accordingly on which method to use for billing submission during the contract onboarding process. Providers needing to request a reasonable accommodation related to billing submission should contact Integral Care at mso@integralcare.org.

DEADLINES FOR CLAIM/INVOICE PROCESSING FOR PAYMENT

All complete claims/invoices must be received by Integral Care by the submission deadline to be processed for payment.

Please visit the following link for detailed Claim/Invoice instructions:

<https://integralcare.org/en/provider-portal/#1499454040196-73ad739e-d8bd>

Claims submitted by encrypted email will have the date of email as the date code stamp for submissions. Integral Care will verify information before a submitted Claim/Invoice is paid.

Providers must make every attempt to provide all required form information accurately. Should questions arise, contact your Integral Care representative for answers.

Claims/Invoices submitted will be processed for payment or denied. Denial of claim will be reflected on the Explanation of Benefits (EOB).

CLAIM/INVOICE PAYMENT TERMS

All Claims/Invoices must be received by Integral Care no later than 5 pm on the third (3rd) business day of the month immediately following the month in which Covered Services were provided. For this requirement, a “business day” is defined as any calendar day in which Integral Care is open to the public for business. The agreement for direct care services between Integral Care and a Provider may specify alternate due dates for Claims/Invoices. For situations in which the Provider has chosen semi-monthly billing, the mid-month deadline specified in the Invoice Instructions must also be followed.

Failure to comply with these deadlines may result in non-payment or denial of the Claim/Invoice at Integral Care’s sole discretion.

Integral Care will date stamp all Claims/Invoices when received. Claims will be processed for payment within thirty (30) days of Integral Care’s receipt of a complete and accurate Claim/Invoice packet or as determined in Provider’s Agreement for Direct Care Services. Payment will be denied for any Claim/Invoice that is originally submitted to Integral Care either incomplete or past the due date, as specified above.

CORRECTIONS AND ADJUSTMENTS TO PAYMENTS

Within 30 days of Integral Care's receipt of a complete, timely Claim/Invoice, Provider will receive either: Payment, an Adjustment Letter/EOB indicating denials, adjustments or recoupment of the Claim/Invoice, or portions of the Claim/Invoice.

All resubmissions of original Claims/Invoices, or portions of Claims/Invoices, must be submitted by the Provider within 30 days of the date on the Provider's Adjustment Letter/EOB for the Covered Services. Integral Care will not process or pay any Claims/Invoices, or parts of Claims/Invoices, resubmitted beyond this deadline.

BILLING DENIALS, ADJUSTMENTS OR RECOUPMENT

At times, Providers may receive billing denials, adjustments, or recoupments. The reasons for such actions can include but are not limited to the following:

- UM/RA did not authorize all, or part, of the Covered Services invoiced.

- Covered Services billed exceeded authorizations for the month.
- Covered Services billed were submitted past the Claim/Invoice submission due date for the service billing month.
- Documentation on the Provider's service delivery record did not exist for each billable event.
- For CFS and IDD services only: there was no Provider service delivery record submitted with the Claim/Invoice.
- Service delivery records or Claims/Invoices forms had incorrect or blank start and stop times or dates.
- The Claim/Invoice submitted was not signed and/or dated.
- Billable time on Claim/Invoice did not correspond with start and stop time on the Service Delivery Record.
- Incorrect Claim/Invoice Forms and/or Provider Service Delivery Records were used.
- Two or more Covered Services were billed for the same Covered Individual during the same date/time period.
- According to the Covered Individual, family, Care Coordinator, or some other credible source, the Covered Individual/family did not receive the Covered Services billed.
- Provider was not authorized/credentialed/licensed/contracted to provide the Covered Services at the time they were provided.
- The person documenting the Service is not the person who provided the Service to the Covered Individual/family.
- Documentation of Covered Services did not meet required standard of accuracy and comprehensiveness.
- Covered Services delivery did not correspond with stated Outcomes, goals, and/or objectives.
- Covered Services delivered did not meet the definition of the Covered Services authorized, as per the authorization letter.
- Covered Services were not delivered as required by the Agreement for Direct Care Services between Integral Care and Provider.
- Covered Services were not delivered at the duration or frequency delineated in the Plan, authorization letter or other Integral Care staff documentation (i.e., Provider Activity Sheet for CP and YAFAC only).

If Integral Care overpays a Provider, Integral Care will either, in its sole discretion, require immediate repayment from the Provider or adjust future payments to the Provider accordingly, to the extent permitted by applicable law. If Integral Care underpays a Provider, Integral Care will either pay the

Provider immediately, or adjust future payments to the Provider accordingly, to the extent permitted by applicable law.

CREDENTIALING/RE-CREDENTIALING AND PROVIDER CHANGES

CREDENTIALING REQUIREMENTS

Providers are required to provide time-sensitive documents to Integral Care’s Credentialing Department as documents are renewed and/or requested on an ongoing basis. At the time of re-credentialing and/or renewal of Agreement for Direct Care Services, Providers will be contacted by the Credentialing Department regarding the required documents.

CREDENTIALING DOCUMENT TABLES

Credentialing On-Going Documents and Submission Timelines for Continuation of Active Provider Network Status and Renewal of Agreement for Direct Care Services

Credentialing Requirements for Re-credentialing and/or Renewal of Agreement for Direct Care Services		
SERVICES PROVIDED	DOCUMENTATION REQUIRED	REQUIRED RENEWAL SCHEDULE
Professional or licensed /certified Covered Services (regardless of location in which provided)	<ol style="list-style-type: none"> 1. Re-credentialing Application (Texas Standardized Credentialing Application) 2. License and/or Certification 3. Professional Liability Insurance in Integral Care-established amounts 	<ol style="list-style-type: none"> 1. Every 3 years which will be requested by Integral Care 2. Prior to expiration 3. Prior to expiration
Covered Services provided in the Provider’s home	<ol style="list-style-type: none"> 1. Homeowner’s or Renter’s Insurance in Integral Care-established amounts 2. Fire Inspection (if determined eligible within local fire authority guidelines.) 3. Site Review 	<ol style="list-style-type: none"> 1. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site 2. Prior to expiration annually, and, when new service site, prior to service delivery of Covered Services at new service site

Credentialing Requirements for Re-credentialing and/or Renewal of Agreement for Direct Care Services		
SERVICES PROVIDED	DOCUMENTATION REQUIRED	REQUIRED RENEWAL SCHEDULE
		3. Every 2 yrs. or for each new service site-conducted by Integral Care
Covered Services provided in a Licensed and/or Accredited Facility excluding hospitals.	<ol style="list-style-type: none"> 1. State Facility License 2. Accreditation 3. General Liability Insurance 4. Fire Inspection (if determined eligible within local fire authority guidelines.) 	<ol style="list-style-type: none"> 1. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site 2. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site 3. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site 4. Prior to expiration and, when new service site, prior to delivery of Covered Services and new service site
Covered Services provided in a Licensed and/or Accredited Hospital.	<ol style="list-style-type: none"> 1. State Facility License 2. Accreditation 3. General Liability Insurance 	<ol style="list-style-type: none"> 1. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site 2. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site 3. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site
Covered Services provided in an office, facility, or other site-based location including transitional living home with less than seven individuals living in residence.	<ol style="list-style-type: none"> 1. General Liability Insurance in Integral Care-established amounts 2. Fire Inspection (if determined eligible within local fire authority guidelines.) 3. Site Review 	<ol style="list-style-type: none"> 1. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site 2. Prior to expiration annually, and, when new service site, prior to service delivery of Covered Services at new service site 3. Every 2 years or for each new service site-conducted by Integral Care's Contract Monitor

Credentialing Requirements for Re-credentialing and/or Renewal of Agreement for Direct Care Services		
SERVICES PROVIDED	DOCUMENTATION REQUIRED	REQUIRED RENEWAL SCHEDULE
Covered Services in a transitional living home if more than six individuals living in the residence.	<ol style="list-style-type: none"> 1. Rooming/Boarding House License (as required by City of Austin.) 2. Certificate of Occupancy 3. General Liability Insurance in Integral Care-established amounts 4. Fire inspection (if determined eligible within local fire authority guidelines.) 5. Site review 	<ol style="list-style-type: none"> 1. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site. 2. Initially or as changes occur. 3. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site 4. Prior to expiration and, when new service site, prior to delivery of Covered Services at new service site 5. Every 2 years or for each new service site-conducted by Integral Care’s Contract Monitor
Transportation of Covered Individuals (or their family members) when provided as a reimbursable Covered Service, or incidental to another Covered Service being provided (such as mentoring, respite, etc.)	<ol style="list-style-type: none"> 1. Texas Driver’s License 2. Texas DPS 3-year Drivers Non-certified Record 3. Auto Liability Insurance in minimum coverage amounts as required by Integral Care in Attachment C of the Agreement for Direct Care Services, titled Insurance Requirements. 	<ol style="list-style-type: none"> 1. Prior to expiration 2. Every 2 years 3. Prior to expiration
Risk Management Checks for All Covered Services	<ol style="list-style-type: none"> 1. CANRS 2. Criminal Background 3. Employee Misconduct Registry /Nurse’s Aide Registry 4. USDHHS Office of Inspector General (OIG) 5. Texas Office of Inspector General 6. System for Award Management (formerly General Administration 	<ol style="list-style-type: none"> 1. Annually conducted by Integral Care for Group Members and Individuals 2. Annually conducted by Organization Provider for Group Members, or by Integral Care for Individual Providers 3. Annually conducted by Organization Provider for Group Members or by Integral Care for Individual Providers 4. Annually conducted by Organization Provider for Group Members or by

Credentialing Requirements for Re-credentialing and/or Renewal of Agreement for Direct Care Services		
SERVICES PROVIDED	DOCUMENTATION REQUIRED	REQUIRED RENEWAL SCHEDULE
	Services Excluded Parties List System)	<p>Integral Care for Individual Providers</p> <p>5. Annually conducted by Organization Provider for Group Members or by Integral Care for Individual Providers</p> <p>6. Annually conducted by Organization Provider for Group Members or by Integral Care for Individual Providers</p>
Risk Management All Covered Services	Changes in criminal background status, Nurse’s Aide Registry or Employee Misconduct Registry	<p>Changes in status to any of the referenced risk management checks/documents must be reported to the Credentialing Department as soon as they occur or, for an Organization Provider, as soon as the annual checks for Group Members are repeated or Organization Provider discovers the change of status, whichever is sooner.</p> <p>Persons with criminal convictions as listed in Title 25 TAC Chapter 414, Subchapter K, Section 414.504 (d), are not eligible to provide Covered Services to Covered Individuals. See link: Title 25</p>

Individual Providers and Group Member Providers

Document	Submission Timeline
Professional License or Certification	Renewal to be received prior to expiration date
Professional Liability Insurance	Renewal to be received prior to expiration date
Governmental Photo ID	Renewal to be received prior to expiration date
Auto Insurance if transporting	Renewal to be received prior to expiration date
Driver License, if transporting	Renewal to be received prior to expiration date
Driver Record, if transporting	Every 3 years or at time of contact amendment or renewal
TB Test Results	Annually prior to last completion date

Organizations Providing Covered Services in a Facility or Residence

Document	Submission Timeline
State License, if applicable	Renewal to be received prior to expiration date
General Liability Insurance*	Renewal to be received prior to expiration date
Workers Comp Insurance	Renewal to be received prior to expiration date
*Homeowners or Renters insurance if Covered Services in own residence	Renewal to be received prior to expiration date
Animal Vaccines, if Covered Services in own residence or facility	Renewal to be received prior to expiration date
Fire Inspection	Annually prior to last completion date

Hospital Facilities

Document	Submission Timeline
General Liability Insurance	Renewal to be received prior to expiration date
Professional Liability Insurance	Renewal to be received prior to expiration date
Workers Comp Insurance	Renewal to be received prior to expiration date
State Facility License	Renewal to be received prior to expiration date
Accreditation	Renewal to be received prior to expiration date

Responsibility for some informational items depends on whether Provider is an Individual Provider, or an Organization Provider containing Group Members as follows:

Organization Provider:

Organization group risk management (background) checks, verification checklists and other requirements must be met for each of its Group Members. This is on-going, as applicable, and is prior to delivery of Covered Services by new Group Member.

An approved Organization Provider is responsible for ensuring their Group Member Providers (employee or subcontractor) who will provide Covered Services must submit:

- Consistent submission of proof of required training such as Integral Care training. This link allows you to request access to our Relias training platform:
<https://www.cognitofrms.com/IntegralCare/ProviderHelpTicket>
- Submit background checks. Background checks are required prior to Integral Care credentialing approval (which must occur prior to provision of Covered Services), and annually thereafter, by submitting information on the Background Check Form for Organization Group Member Providers at this link:
<https://www.cognitofrms.com/IntegralCare/BackgroundCheckFormForOrganizationGroupMemberProviders>
- Completion of verification checklist. Verification Checklist for Organization Group Member Providers is required prior to Integral Care Credentialing approval; (which must occur prior to provision of Covered Services) and requested documents at this link:
<https://www.cognitofrms.com/IntegralCare/VerificationChecklistForOrganizationGroupMemberProviders>
- If the additional person is licensed or certified, and the license/certification is required to perform the Covered Services as indicated by selection of certain criteria on the form, providers must also submit a Texas Standardized Credentialing Application (TSCA) (Version 01/2007) to Integral Care's Credentialing Department which is available in the Verification Checklist above.

Individual Provider: Integral Care will perform all required risk management (background) checks annually.

ADDRESS CHANGE AND/ OR OTHER PROVIDER CHANGES

All Providers must immediately report changes in any Provider information such as name, address, email, phone, fax, tax ID number, etc. in writing by help ticket, mail, or email to Integral Care's Credentialing Department. Providers must immediately report any changes in licensure/certification status that affect the Provider's ability to provide Covered Services, or any investigation into licensure or arrest for or conviction of any crime, to Integral Care's Credentialing Department. All Providers must immediately report changes in Group Member information such as employment start and end dates, by help ticket, or by mail or email to Integral Care's Credentialing Department.

The employee or subcontractor to be added must be approved by Integral Care's Credentialing Department before that person provides any Covered Service.

A Provider who wishes to add to or remove any Covered Service from its Agreement for Direct Care Services must contact the Contract Manager to request an Agreement for Direct Care Services

amendment. Additional documentation as appropriate to the Covered Services requested may be required.

A Provider who wishes to change its status as either an Individual or Organization Provider must submit the appropriate application(s).

A Provider who no longer wishes to participate in Integral Care's Provider Network must submit written notification of intent to terminate the Agreement for Direct Care Services by help ticket, mail, or email to Integral Care's Credentialing Department, within the applicable timeframe required in that Provider's Agreement for Direct Care Services with Integral Care.

When an Organization Provider learns that a Group Member will no longer provide Covered Services (i.e., leaving employment or subcontracting status) the Organization Provider must immediately report that to Integral Care's Credentialing Department by help ticket and provide the Group Member's name, the Organization Provider's name, and the effective date of the Group Member's discontinuation of provision of services.

Submitting a help ticket will allow an Integral Care Representative to reach out to gather information on changes: <https://www.cognitofrms.com/IntegralCare/ProviderHelpTicket>

Email mso@integralcare.org to give Provider updates, notification to terminate, information regarding Group Members providing Covered Services, etc.

PROVIDER TRAINING

All Providers must, at their own expense, complete trainings required by their Agreement for Direct Care Services with Integral Care. Integral Care provides certain training for a fee. Providers may also need to ensure that persons providing Covered Services under the Provider's Agreement for Direct Care Services with Integral Care have completed additional specialized trainings and service modalities, as specified either in that Provider's Agreement for Direct Care Services with Integral Care, or by the assigned Contract Manager as special Covered Individual-specific disabilities, funder requirements, circumstances and/or needs dictate. For further assistance, use the Provider Help Ticket form <https://www.cognitofrms.com/IntegralCare/ProviderHelpTicket> on the Integral Care website or contact the Contract Manager.

Providers with access to Integral Care's EHR will be required to attend Integral Care's training on the use of the EHR. Additional clinical training may be required prior to the Provider being authorized to provide Covered Services. Additional trainings for Provider's using the EHR may include resiliency and disease management program, Texas Recommended Authorization Guidelines (TRAG) assessment, Texas Medication Algorithms, co-occurring psychiatric/substance use disorders competencies, cognitive behavioral therapy (as appropriate), Wraparound, Person-Directed Planning and documentation of assessments, Covered Services, and treatment planning in the EEHR.

CPR/FIRST AID

Many community programs offer CPR and Standard First Aid training, and Integral Care is happy to accept their certifications. Providers may attend any CPR/Standard First Aid course that is either an American Red Cross or American Heart Association approved course, taught by a certified instructor. Classes that are completed strictly online are not accepted. Upon completion of an approved course, email or fax a copy of the course certification card(s) front and back to the Contract Manager.

NON-VIOLENT VERBAL AND PHYSICAL DE-ESCALATION

Integral Care offers and, for some Providers, requires non-violent verbal and physical de-escalation training. Training recommended and offered by Integral Care is Safety-Care. Integral Care will accept SATORI, SAMA and will evaluate other comparable training for acceptance in lieu of Safety-Care upon request. All non-violent verbal and physical de-escalation trainings require annual refreshers unless otherwise approved in advance by Integral Care.

REFRESHER TRAINING

All Providers must complete assigned training requirements on an annual basis. Trainings assigned to Providers may be accessed by logging into Relias, Integral Care's learning management system. For technical assistance accessing Relias, submit a Provider Help Ticket form (<https://www.cognitoforms.com/IntegralCare/ProviderHelpTicket>) or contact the Contract Manager.

TABLE OF GENERAL TRAINING REQUIREMENTS

Provider Training	Type of Training	Length of Training	Required For	Must Be Completed	Renewals
Integral Care Standards of Conduct	Online	0.25 hours	All Providers	Pre-Service	Annually
Client/Patient Rights	Online	2 hours	All Providers	Pre-Service	Annually
Corporate Compliance and Ethics	Online	1 hour	All Providers	Pre-Service	Annually
Corporate Compliance: The Basics	Online	0.5 hours	All Providers	Pre-Service	Annually
CPR/AED and Basic First Aid	Online/In-Person	4 hours	All Providers	Pre-Service	Bi-Annually
Care for Culture	Online	1 hour	All Providers	Pre-Service	Annually
HIPAA/Confidentiality	Online	0.5 hours	All Providers	Pre-Service	Annually
Safety-Care Part 1: De-escalation and Physical Safety	In-Person or Online	8 hours	All Providers	Pre-Service	Annually
Infection Control	Online	0.25 hours	All Providers	Pre-Service	Annually
DADS HCS & TxHmL Behavioral Support Services Provider Policy	Online	1 hour	IDD Providers	Pre-Service	Tri-Annually
Mental Health First Aid	In-Person	8 hours	HCC Providers	Within 6 months of credentialing	Tri-Annually
Definitions/Documentation/Invoicing Training	In-Person or Online	3 hours	All Providers	Pre-Service	Initial Training
Safety-Care: Holds and Restraints	In-Person	4 hours	IDD and YES	Pre-Service	Annually
What's This Thing Called Wraparound?	Online	1 hour	CFS, FWV, and YES Providers	Within 3 months of credentialing	Initial Training Only
Team Roles in Wraparound	Online	1 hour	CFS, FWV, and YES Providers	Within 3 months of credentialing	Initial Training Only
Overview of the Youth Empowerment Services (YES) Waiver: YES Waiver 101	Online	1 hour	YES Providers	Within 3 months of credentialing	Initial Training Only
YES Waiver Orientation Training	In-Person	3 hours	YES Providers	Pre-Service	Initial Training Only
How to Implement Wraparound	Online	1 hour	FWV Providers	Within 3 months of credentialing	Initial Training Only

CONFIDENTIALITY

Providers must protect the confidentiality of the Covered Individuals they serve. Before any identifying information regarding any Covered Individual can be released, either verbally or in writing, the Covered Individual or LAR must complete and sign an Integral Care Authorization for Release of Protected Health Information which can be found at: <https://integralcare.org/en/medical-records-request/>

Verbal authorization is not sufficient. Unless calling 911 in cases of medical emergency or Imminent Danger**, or when the Covered Individual is the alleged victim of a HHSC abuse investigation, the Covered Individual or LAR must complete and sign an Authorization for Release of Protected Health Information.

***Imminent Danger - The Individual is in danger of hurting self or others within 24 hours.*

- To release Substance, Use or HIV/AIDS information, those specific items must be checked on the authorization form. These can be in addition to other items checked on the form.
- Information that identifies a Covered Individual should be shared only with Provider staff and Covered Individuals' team members on a need-to-know basis.
- The following measures should be used to avoid violating a Covered Individual's privacy:
 - Speaking with Covered Individuals about personal information in a private area away from others.
 - Storing all identifying information regarding Covered Individuals is secure and inaccessible by unauthorized persons. Avoid leaving information on desktops, chairs, unlocked cabinets, etc.
 - Ensure all telephone (including cell phone) conversations take place in a private area where conversations cannot be overheard.
- Providers should not identify Covered Individuals as service recipients when interacting with others in the community. To avoid rudeness, the Provider could introduce the Covered Individual by first name without indicating that the Covered Individual is a service recipient. The Covered Individual is allowed to give any information about themselves as they choose.
- Providers who receive access to Integral Care's EHR will be required to provide a picture ID to a representative of Integral Care's Management Information Systems (MIS) staff and sign a confidentiality agreement prior to receiving access to the EHR.
- E-mailing protected health information is permitted when using encryption that has been previously approved by Integral Care. Non-encrypted email containing protected health information is not permitted and will result in a review by the Integral Care HIPAA officer to determine any required actions.
- Additional PHI (Protected Health Information) Requirements

- When accessing PHI information in the EHR is complete. Provider must immediately log out of the HER
- Providers are not allowed to text PHI information
- Providers must not take screenshots of PHI information with cell phones
- Providers must not save client files with PHI information on public or shared computers

MEDIA PROTOCOLS

Providers who become aware of any event that may cause negative media attention to the Provider or Integral Care must immediately contact the Chief Strategy Officer. To contact Chief Strategy Officer, email providers@integralcare.org. **PROVIDERS MAY NOT COMMUNICATE DIRECTLY WITH THE PUBLIC OR THE MEDIA ON INTEGRAL CARE'S BEHALF ABOUT THIS TYPE OF EVENT. ALL COMMUNICATION TO THE PUBLIC OR THE MEDIA ON INTEGRAL CARE'S BEHALF MUST ORIGINATE FROM INTEGRAL CARE'S CHIEF STRATEGY OFFICER.**

RIGHTS OF COVERED INDIVIDUALS

Please refer to Operating Procedure(s) 10.01 Rights of Persons receiving Mental Health and Substance Abuse Services and 10.02 Rights of Clients of Intellectual and Developmental Disability (IDD) Services for detailed content and reporting requirements. You can find our policy and procedures on the Provider portal <https://integralcare.org/en/provider-portal/>.

NEGLECT, ABUSE, AND EXPLOITATION

Providers are mandated reporters; therefore, any knowledge of abuse, neglect or exploitation must be reported to the Department of Family and Protective Services at 800-252-5400 immediately or within one hour. The DFPS numeric case number provided will be entered into the Integral Care incident report that is required for all abuse, neglect, and exploitation allegations. Integral Care's Ombudsman must be notified via email or telephone at ombudsman@integralcare.org or 512 440-4086.

All Providers are required to complete the Integral Care training on Abuse, Neglect and Exploitation, or a comparable training approved by Integral Care, **PRIOR** to providing Covered Services.

Providers are encouraged to contact the Ombudsman's office with questions on client rights. Please note that when an allegation has been called into the appropriate APS/CPS department, Providers do not further investigate the incident, and will cooperate with any subsequent DFPS investigation.

INVESTIGATIONS OF ALLEGED PROVIDER ABUSE, NEGLECT OR EXPLOITATION

Investigations of abuse, neglect, or exploitation at Integral Care and/or its affiliate and Provider sites are conducted by the DFPS.

When DFPS notifies Integral Care of an allegation of Provider abuse, neglect, or exploitation, the Ombudsman will notify Integral Care's Contract Manager so that appropriate action can be taken. Law prohibits an alleged perpetrator/Provider from providing Covered Services to the alleged victim during an open investigation. A Provider may also be placed on hold from providing Covered Services during an open investigation at the sole discretion of Integral Care. Discussing the allegation with anyone other than DFPS investigatory staff during the investigation is prohibited. The alleged perpetrator/Provider will be informed of the allegation and of his/her obligation to cooperate fully with the DFPS investigation.

RECEIPT OF DFPS FINDINGS

Once DFPS completes its investigation it will provide findings to Integral Care electronically and those findings are routed internally ending with a review by Integral Care's Chief Executive Officer, who determines whether to accept the DFPS finding(s) or to request that DFPS review its finding(s); Reports of abuse, neglect or exploitation investigation reports are confidential. Integral Care's copy of the DFPS report (or the Ombudsman's report of a substance abuse investigation) is kept on file by the Ombudsman and is not released to other parties either inside or outside Integral Care (other than the Covered Individual who is the subject of the investigation or their LAR, if applicable).

Once the finding(s) is final, the Contract Manager provides written notification to the Provider of any findings that were made against the Provider. The Contract Manager may require the Provider to submit a plan of improvement based on the investigative findings. If the final finding is confirmed, the Provider may be prohibited from further interaction with Covered Individuals and/or the Provider's Agreement for Direct Care Services with Integral Care may be terminated.

CONFIDENTIALITY OF ABUSE, NEGLECT OR EXPLOITATION REPORTS

Reports of abuse, neglect, or exploitation investigation are confidential. Integral Care's copy of the DFPS report (or the Ombudsman's report of a substance abuse investigation) is kept on file by the Ombudsman only and is not released to other parties either inside or outside Integral Care (other than the Covered Individual, as described in the following paragraph). Requests for copies of a DFPS report will be referred to the regional office of the DFPS.

Copies of an investigative report of abuse, neglect or exploitation involving substance abuse services shall be released upon request to the involved Covered Individual or their LAR (if applicable). The names of other Individuals in the report shall be rendered unreadable.

RIGHTS VIOLATIONS

Rights violations include, but are not limited to, breach of confidentiality, inadequate or failure to obtain informed consent, and denial of the right to participate in Individualized services and the right to the least restrictive environment must be reported by submitting an Incident Report. No employee or affiliate of Integral Care shall engage in any retaliatory action against any Provider and/or Individual because that Provider/individual reports a possible rights violation. A full list of rights for those in service is posted in the Rights Handbook posted in the Provider section of the Integral Care website.

A Provider who knows or suspects that an Individual in Covered Services is being or has been abused, neglected, or exploited must:

1. Report such knowledge or suspicion to DFPS immediately, if possible, but in no case more than one hour after knowledge or suspicion by calling 1-800-252-5400. Preserve and protect any evidence related to the allegation in accordance with instructions from DFPS. For allegations of sexual abuse or if physical injury has occurred it is most likely DFPS will request that the Covered Individual receive a medical examination if the individual consents; and
2. Cooperate with the DFPS investigator during the investigation.

Failure to report abuse, neglect or exploitation could result in disciplinary action, for example, such as termination of the Provider's Agreement for Direct Care Services.

The Integral Care Operating Procedures for the Rights of Individuals in services can be found on the Integral Care website in the Provider Portal.

INDIVIDUAL COMPLAINT/APPEAL PROCESS

Providers have a responsibility to ensure the rights of individuals they provide Covered Services for are protected. Should a Covered Individual be dissatisfied with any aspect of Covered Services, Provider will provide that Covered individuals with contact information of the Integral Care Ombudsman for making complaints.

Providers or Covered Individuals who are dissatisfied with any aspect of Covered Services may complain to Integral Care by **contacting the Ombudsman's office, at Ombudsman@integralcare.org or 512 440-4086 for assistance.** Complaints may also be made by mail through the Ombudsman at P.O. Box 3548, Austin, TX, 78764-3548.

Providers must inform Covered Individuals of Integral Care's Complaint and Appeal processes. Providers must assist a Covered Individual with complaints or appeals at no charge to the Covered Individual, if requested. Providers must cooperate fully with Integral Care in the investigation of complaints or appeals.

Providers must display in a prominent location at the service site (unless the service site is the Provider's home) a notice ("Resolution of Concerns") informing Covered Individuals of their right to make Complaints. A copy of this notice is available on the Provider Portal. The notice is also available from the Ombudsman.

PROVIDER RESOLUTION OF COMPLAINTS AND APPEALS

PROVIDER COMPLAINT/APPEALS PROCESS

For in-depth information on Provider Appeals and Complaints the following documents are available:

- Operating Procedure 9.22 Provider Procedure for Adverse Determinations Other than Utilization Management/Resource Allocation
- Operating Procedure 09.21 Resolution of Provider Complaints except Mental Retardation Authority MRA

All Provider Complaints are routed to Integral Care's Ombudsman.

- Providers with any Complaints or suggestions are encouraged to contact the Ombudsman. Reasonable efforts will be made to resolve all Complaints informally within a short period of time.
- If a Complaint is not resolved to the Provider's satisfaction in five (5) days after the Provider notifies the Ombudsman, Integral Care will ask the Provider to submit the Complaint to the Ombudsman in writing, and the Ombudsman will give the Provider written acknowledgement upon receipt of the Complaint.
- If a written Complaint is not resolved to the Provider's satisfaction within thirty (30) days after the Ombudsman receives it, the Provider may submit a written request for an appeal of the unsatisfactory resolution to the Ombudsman within ten (10) days after either receipt of the unsatisfactory resolution or thirty (30) days after the Ombudsman receives the written Complaint, whichever is earlier.
- First level appeal is determined by the Provider Network and Authority Officer.
- If a Complaint is not resolved in the first level appeal, an Appeal Committee will be convened to rule on adverse determinations (listed in the section below) that were not informally resolved.
- The determination by the Appeal Committee is final.

Integral Care's procedure for Adverse Determinations other than those related to Utilization Management/Resource Allocation (service denials) is the mechanism for facilitating a review and reconsideration of the following types of decisions:

- Credentialing/ re-credentialing
- Privileging
- Provider Network enrollment/ disenrollment
- Billing and/or payment issues
- Other administrative issues

INCIDENT REPORT REQUIREMENTS

Providers are responsible for reporting serious incidents involving a Covered Individual that occurring during service provision, or Provider otherwise learns of events that require incident reporting. Operating Procedure 03.02 Reporting Incidents provides guidance on incident report requirements:

Providers are required to have access to the Integral Care Incident Reporting system administered by the Quality Management department.

To obtain access to the Integral Care Incident Report system, the Provider has two options: Fill out a Provider Help Ticket at <https://www.cognitofrms.com/IntegralCare/ProviderHelpTicket> OR send an email to Quality Management requesting access at incidentreport@integralcare.org.

Once the request has been received, the QM (Quality Management) representative will respond with an assignment of a user id and a password for system access and provide any technical assistance that may be needed. All incident reports are required to be submitted within 24 business hours of the event or knowledge of the event. Any other actions or paperwork that is required due to the nature of the event must be filed at that time including other entities, departments required by law or specified in the Incident Report Manual.

The Incident Report Manual contains guidance on what to report and how to report incidents within the required 24 business hours. The Incident Report manual can be found on the Integral Care website in the Current Providers Section: <https://integralcare.org/en/provider-portal/#1499454040196-73ad739e-d8bd>

INJURY TO, OR DEATH OF COVERED INDIVIDUAL

In the event of an injury to a Covered Individual, appropriate medical intervention must be obtained immediately. Upon ensuring the Covered Individual's safety, initiate incident reporting protocols as described above.

In the event of a Covered Individual's death while receiving Covered Services, an Incident Report must be completed within 24 business hours. Death Review and subsequent Administrative Review, as appropriate, will be initiated. The Provider will continue to forward any new information and appropriate documentation to Integral Care's Quality Management. The Death Review will be completed only after the Medical Examiner's determination of all the facts and cause of death.

CONTRACT COMPLIANCE

CONTRACT MONITORING

Integral Care conducts contract monitoring activities on a routine basis. Advance notice will typically be given to the Provider; however unannounced monitoring reviews may occur at any time in response to a complaint or a concern.

An Agreement for Direct Care Services may be monitored through one or more of the following:

- Site visit
- Record review
- Billing desk review
- Incident Reports are completed when serious or non-routine events occur.
- Covered Individual/family interviews
- Provider staff interviews
- Interviews with UM/RAs

All contract monitoring must sufficiently determine:

- Provider's compliance with the Agreement for Direct Care Services terms for service delivery.
- Whether Covered Individual health/safety is being adequately protected as per TAC Title 23, Section 414.554 Responsibilities of Local Authorities, Community Centers, and Contractors and relevant Integral Care policies.
- Provider's qualifications.
- Whether administrative requirements (such as billing compliance, program certifications/licensures and insurance requirements) have been met; and
- Satisfaction of Covered Individuals served and their family members with the Covered Services received from the Provider.

Providers will be notified in writing of the results of all formal contract monitoring activities. A Provider may be required to submit a written plan of correction to address non-compliance and/or quality improvement issues. Written plans of correction must be approved by the Contract Manager/ Monitor or his/her designee. The Contract Manager will provide a reasonable amount of technical assistance in an effort to bring the Provider into compliance.

Provider sanctions, up to and including Agreement for Direct Care Services termination may occur if the Provider does not respond to technical assistance provided or fails to implement the approved plan of correction to the satisfaction of the Contract Manager/ Monitor, or if Provider's performance is significantly below Integral Care's standards, as determined by Integral Care.

PROVIDER SANCTIONS

Integral Care may impose, upon the recommendation of the Provider Network and Authority Officer with the approval of Integral Care's General Counsel, sanctions upon a Provider as a result of activities or events, which constitute a default of the conditions of the Provider's Agreement for Direct Care Services.

The Provider Network and Authority Officer or designee will investigate any allegation of actions which could constitute an event of default under an Agreement for Direct Care Services and will discuss the activity in question with the Provider, giving the Provider an opportunity to correct the default and respond in writing within an appropriate time frame depending upon the severity of the finding. The Provider Network and Authority Officer will review the written response offered by the Provider. A joint decision will be made by the Provider Network and Authority Officer and the General Counsel about whether the imposition of sanctions is appropriate and what sanctions will be imposed.

Possible sanctions include but are not limited to:

- Sanctions included within the terms of a Provider's Agreement for Direct Care Services.
- Suspension of authorizations or withdrawal of previously issued authorizations for Covered Services.
- Suspension of outstanding payments, in whole or part.
- Recoupment of funds paid to Provider for Covered Services.
- Suspension of Agreement for Direct Care Services and transfer of Covered Individuals to other Providers, pending additional review.
- Offsets against future payments.
- Additional training; and
- Other sanctions as jointly determined by the Provider Network and Authority Officer and General Counsel.

The Provider Network and Authority Officer or, in appropriate situations, the General Counsel, will notify the Provider in writing of Integral Care's decision to impose sanctions and of the type of sanctions to be imposed, including instructions on how to appeal the decision to impose sanctions.

The Contract Monitor/ Manager will consult with the Provider in the development of any required Plan of Correction to address the area of concern, subject to the terms of the Provider's Agreement for Direct Care Services. The Plan of Correction will include timelines for ensuring that the problem is resolved in a timely manner.

HEALTH, SAFETY AND RIGHTS OF COVERED INDIVIDUALS

The Contract Monitor/ Manager will review for compliance in the following areas:

- Knowledge of allegations or suspicions of abuse, neglect, or exploitation of Covered Individuals and how they are reported to DFPS, as directed by law. All Provider staff must have knowledge of what constitutes abuse, neglect, or exploitation.
- Environmental safety and use of universal precautions at site-based programs.
- Medication administration and storage.
- Covered Individuals are informed of their rights and any rights violations are reported in a timely manner to Integral Care's Ombudsman.
- Covered Individuals are properly notified of Integral Care's Complaint process.
- Providers protect confidentiality and privacy.

SATISFACTION SURVEYS

Providers must participate with Integral Care in evaluating satisfaction of Covered Individuals and Providers. Integral Care uses Qualtrics, a web-based system, to collect satisfaction data. Providers receive survey links from Quality Management. Three Provider survey types exist:

- Client Satisfaction Survey: Can be collected at any time during the Covered Individual's inpatient hospital or at the end of a Covered Services provision to a Covered Individual. Can be completed multiple times such as at the beginning of treatment and end.
- Provider Experience Survey: Occurs at minimum annually where Covered Individuals provide feedback on the Provider.
- System of Care Provider Survey: Occurs annually and allows Providers to provide insights on experience with Integral Care.

Information received will be available to Providers for discussion and feedback from the Contract Monitors. SAMSO Providers will have data reviewed at quarterly SAMSO meetings.