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

Audit Committee Meeting
July 15, 2025
8:30 am

I. **DECLARATION OF QUORUM**

II. **PUBLIC COMMENTS**

III. **MINUTES**

A. Approval of the Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, April 15, 2024
(EXHIBIT A-1)

IV. **REVIEW AND TAKE ACTION**

A. FY26 Compliance Work Plan
(EXHIBIT A-2 Demetria Luckett)

B. FY26 Internal Audit Work Plan
(EXHIBIT A-3 David Fojtik)

V. **REVIEW AND COMMENT**

A. Compliance FY2025 Quarter 3 Activities
(EXHIBIT A-4 Demetria Luckett)

B. Internal Audit Q3-Q4 Reports
(EXHIBIT A-5 David Fojtik)

VI. **EXECUTIVE SESSION**

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

VII. **RECONVENE INTO OPEN SESSION**

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

IX. **INFORMATION ONLY**

A. FY2025 Q3 Compliance Department Binder
(EXHIBIT A-6)

B. Internal Audit Q3-Q4 Binder
(EXHIBIT A-7)

X. **ADJOURN**

Veronica Franco, Board Liaison
Jim Lykes
Chairperson, Audit Committee
The Harris Center for Mental Health and IDD

EXHIBIT A-1

BOARD OF TRUSTEES
THE HARRIS CENTER *for*
MENTAL HEALTH AND IDD
AUDIT COMMITTEE MEETING
TUESDAY, APRIL 15, 2025
MINUTES

Mr. J. Lykes, Committee Chair, called the meeting to order at 8:32 a.m. in Room 109, 9401 Southwest Freeway, noting a quorum of the Committee was present.

Committee Members in Attendance: Mr. J. Lykes, Mr. G. Womack, Dr. J. Lankford, Dr. K. Bacon-videoconference

Committee Member in Absence: Dr. L. Fernandez-Wische

Other Board Member Present: Dr. R. Gearing, Resha Thomas-videoconference, Dr. M. Miller, Jr.

I. **DECLARATION OF QUORUM**

Dr. Gearing called the meeting to order at 8:32 a.m. noting that a quorum was present.

II. DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS

III. PUBLIC COMMENTS

There were no requests for Public Comment.

IV. MINUTES

Approval of Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, October 15, 2024.

MOTION: LANKFORD SECOND: WOMACK

THEREFORE, BE IT RESOLVED that the Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, October 15, 2024 as presented under Exhibit A-1, is approved, and recommended to the Full Board for acceptance.

V. REVIEW AND COMMENT

A. **Compliance FY 2025 Qtr. 1&2 Audit Activities-** Demetria Luckett presented the Compliance FY 2025 Qtr. 1&2 Audit Activities to the Audit Committee.

B. Internal Audit FY2025 Q2 Reports-David Fotjik presented the Internal Audit FY2025 Q2 Reports to the Audit Committee.

VI. EXECUTIVE SESSION

There was no Executive Session during the Audit Committee Meeting.

VII. ADJOURN-

MOTION: GEARING **SECOND: MILLER, JR.**
With unanimous affirmative vote
BE IT RESOLVED The meeting was adjourned at 9:04 a.m.

_____

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

EXHIBIT A-2

The Harris Center for Mental Health and IDD
Compliance Department FY 2026 Work Plan

Presenter: Demetria Luckett, Compliance Director

Work Plan Description: This work plan outlines the department's strategic activities and highlights areas that are critical to support The Harris Center's overall mission. The initiatives below are focused on strengthening regulatory compliance and creating consistency across programs.

Comprehensive Reviews (Expanded Scope)

For Fiscal year 2026, Compliance is implementing a more efficient and strategic approach to comprehensive reviews by expanding the scope of each audit while also working to reduce the frequency of disruptions to programs. The expanded reviews will now include policy acknowledgement checks, operational walkthroughs at the time of audit, and staff interviews. For select programs, a billing and coding component will also be incorporated, which will allow us to assess documentation accuracy alongside billing compliance within a single audit timeline.

Additionally, comprehensive reviews will be consolidated across multiple sites (when appropriate) within a program, using representative samples from different program locations. This will allow for broader compliance coverage and will allow the compliance team to reach more programs while still maintaining a quality review process.

Thirty-three (33) comprehensive reviews to be completed:

1. Step Down State Hospital Transition Program
2. Early Onset Psychosis Program (EEOP)
3. Individualized Skills and Socialization Services (ISS – All locations)
4. Competency and Sanity Evaluation Unit
5. Chronic Consumer Stabilization Initiative (CCSI)
6. Crisis Access Line/988
7. Intermediate Care Facilities (ICF - All locations)
8. Forensic Single Portal
9. Hospital to Home
10. Crisis Call Diversion
11. Substance Use Recovery Services
12. Service Coordination GR/SAM
13. Forensic Court Clinical Interview Unit
14. Independent Living
15. Child and Adolescent Clinics (all locations)
16. Service Coordination (HCS/TxHmL)

17. Youth Diversion Center
18. Project for Assistance in Transition from Homelessness (PATH)
19. Jail Re-Entry
20. Adult Mental Health Clinics (all locations)
21. Community Based Supports (CCBS)
22. Mental Health First Aid
23. Jail Diversion Center
24. Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT)
25. Service Coordination - PASRR
26. Jail Based Competency Restoration
27. Homeless Outreach Team (HOT)
28. Service Coordination – CFC
29. Crisis Stabilization Unit (CSU)
30. Response Intervention for Change
31. IDD Eligibility Center
32. Jail Diversion Desk
33. Substance Use Disorder Outreach

Focus Reviews

Focus reviews are targeted audits that will be conducted to assess specific operational or clinical processes across programs. These reviews are narrow in scope and will review a single topic such as adherence to a specific policy or billing practices. Focus reviews may be based on trends or prior findings.

Four (4) Agency wide focus reviews: These reviews will examine compliance requirements in a sample of programs across all divisions (Forensics, IDD, Behavioral Health, CPEP).

1. Agency required training
2. Agency required consents
3. Incident Reporting Compliance
4. Policy Acknowledgements

Four (4) Billing and Coding focus reviews: These reviews assess documentation and billing alignment across all applicable divisions. They are designed to review coding accuracy and documentation support for billing.

1. Telehealth Services
2. Procedure Codes
3. Minimum Time Requirements
4. Skills Training and Development Services (adult and adolescent)

Follow Up Reviews: Audits are conducted after a prior review to assess whether identified deficiencies have been corrected. Follow Up reviews verify the implementation of corrective action plans.

16 Follow Up Reviews:

1. Youth Empowerment Services (YES) Waiver
2. Permanency Plans (IDD)
3. Dual Diagnosis Residential Program (DDRP)
4. Co-Locations Child and Adolescent Services
5. Mobile Crisis Outreach Team (MCOT)
6. Juvenile Justice Alternative Education Program (JJAEP)
7. Intermediate Care Facilities
8. Individualized Skills and Socialization Services (ISS)
9. Eight (8) audit slots will be reserved for open Follow up reviews in FY26. These slots will allow flexibility for revisiting programs with significant findings from the current year's audit schedule. If follow up reviews are not needed for all eight slots, they may be repurposed for Focus reviews based on external audit findings or agency priorities.

Self-monitoring reviews: These reviews assess whether programs are actively reviewing their own documentation and processes in alignment with agency expectations. In FY26, Compliance will also conduct more frequent follow ups on corrective actions plans tied to self-monitoring findings. Four programs will be monitored: Forensics, Behavioral Health, IDD, and CPEP.

External Audits: Compliance will oversee external audit activity which includes response tracking and monitoring of corrective action plans resulting from the state or third-party reviews.

Other compliance activities: Additional compliance activities include deficiency tracking in EPIC, Policy and Procedure overview, and staff education initiatives such as Compliance Week awareness campaigns.

EXHIBIT A-3

FY2026 Audit Plan

Internal Audit Department

David W. Fojtik, CPA, MBA, CIA, CFE
July 15, 2025

Approve FY2026 Audit Plan

Proposed FY 26 Audit Projects

1. IT Risk and Compliance – (120 Hours Scheduled)
2. Pharmacy Inventory Audit – (100 Hours Scheduled)
3. Construction Auditing – (130 Hours Scheduled)
4. Budget Department Procedures and Processes Audit – (100 Hours Scheduled)
5. Expense Accounts/Travel/Credit Care – (120 Hours Scheduled)
6. Grant (Federal, State, and Local) Contract Review – (120 Hours Scheduled)
7. Overtime Usage and Premium Holidays – (100 Hours Scheduled)
8. Organizational Budget Control Review – (100 Hours Scheduled)
9. Third-Party Providers' Risk – (120 Hours Scheduled)

Plus:

10. Audit Follow-Up/Special Audit Requests – (350 Hours Scheduled)
11. Consulting Activities – (80 Hours Scheduled)
12. Provide Assistance to External Auditors – (40 Hours Scheduled)

Total Auditing Hours: 1,480

Questions

EXHIBIT A-4

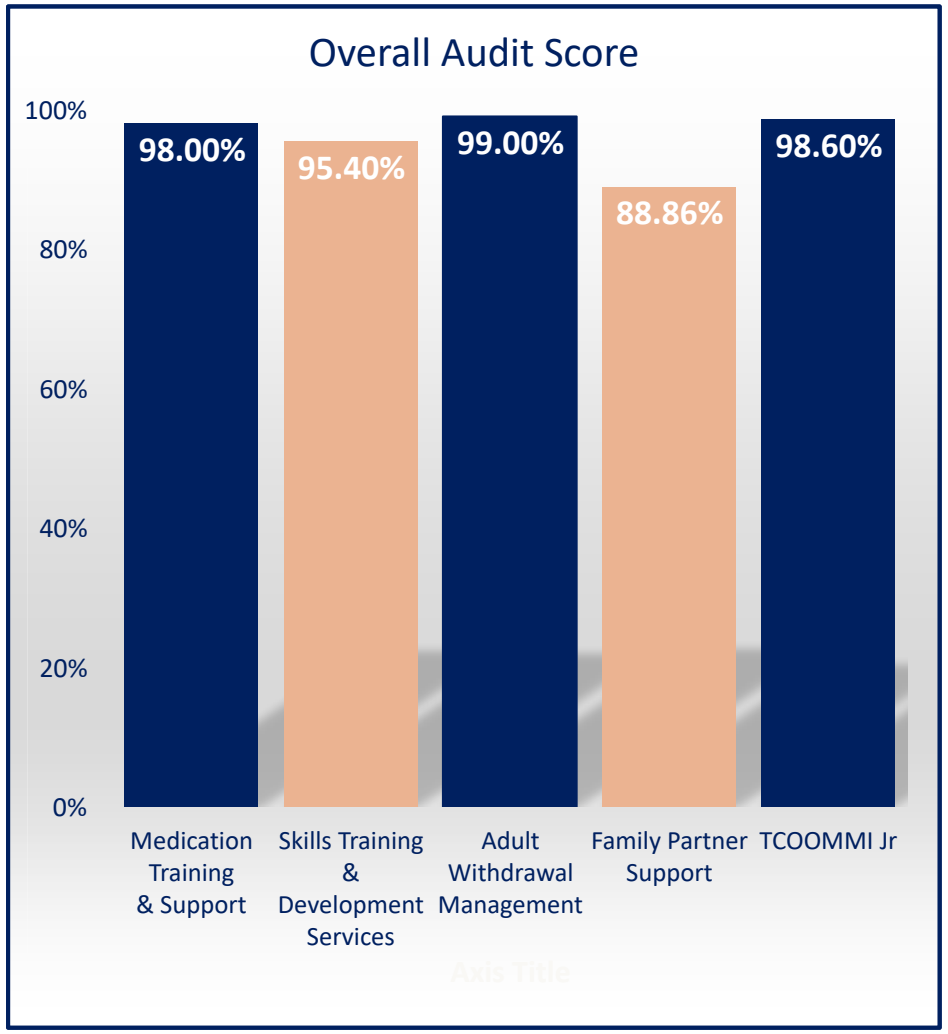
COMPLIANCE DEPARTMENT

FY 2025 AUDIT REPORTS

Presented by: Demetria Luckett, Compliance Director

July 2025

Billing and Coding Focus Reviews

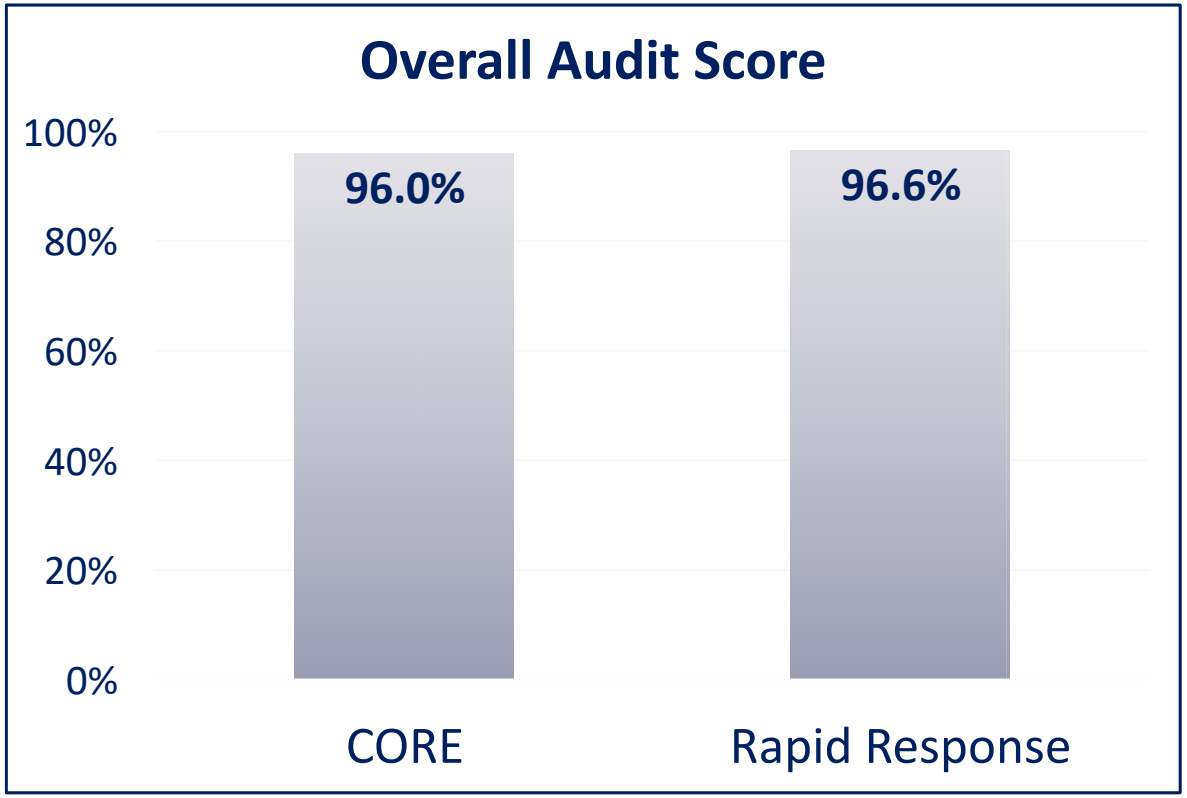


Review	Client records (coding & documentation)	Operations (billing & claims processes)	Overall Score	Action Items/Trends
AMH Medication training and support services	97.3%	98.8%	98%	Identified findings included notes were not signed within required timeframes Missing plan of care documentation. The programs assigned training for staff on documentation practices and retraining on recovery plans. There is also going to be monthly self-monitoring.
AMH Skills Training and Development Services	92.77%	98.02%	95.40%	
Adult Withdrawal Management Services	99%	NA	99%	*Discontinued program effective March 2025
Family Partner Support Services	88.86%	NA	88.86%	Across the review, there was evidence of incomplete or inaccurate CANS summaries. Program is implementing re-education on plan of cares and accurate documentation.
TCOOMMI Jr	98.60%	NA	98.60%	There was a small sample size of encounters where the modality of service was not congruent with the progress note.

*AMH – Adult Mental Health
*TCOOMMI – Texas Correctional Office on Offenders with Medical or Mental impairments

CPEP Division

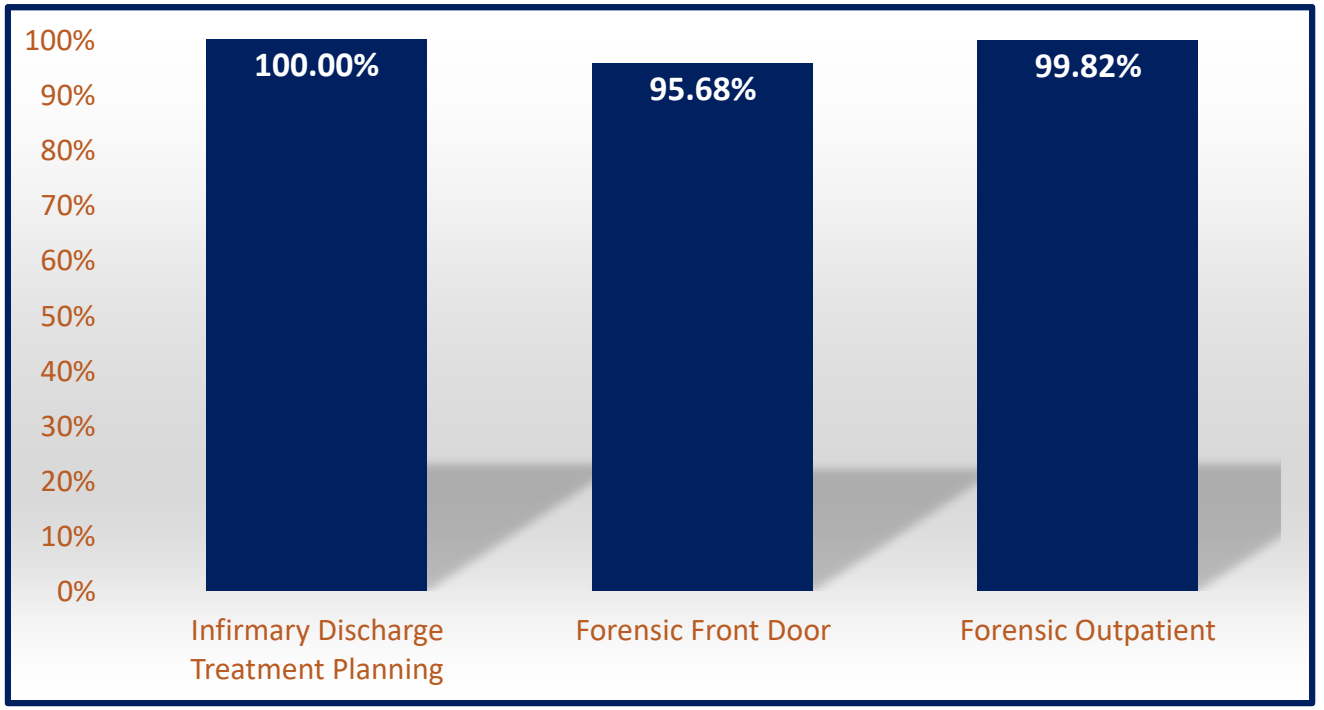
	Operations	Medical	Environment	Clinical Records	Personnel	Overall
Clinician Officer remote Evaluation	100%	100%	NA	97%	87%	96%
Rapid Response	100%	100%	100%	99%	84%	96.6%



Clinical records was strong across both comprehensive reviews. Personnel gaps were linked to training timelines. The program is coordinating with our Education department and reinforcing compliance through self monitoring and staff reminders.

FORENSICS DIVISION

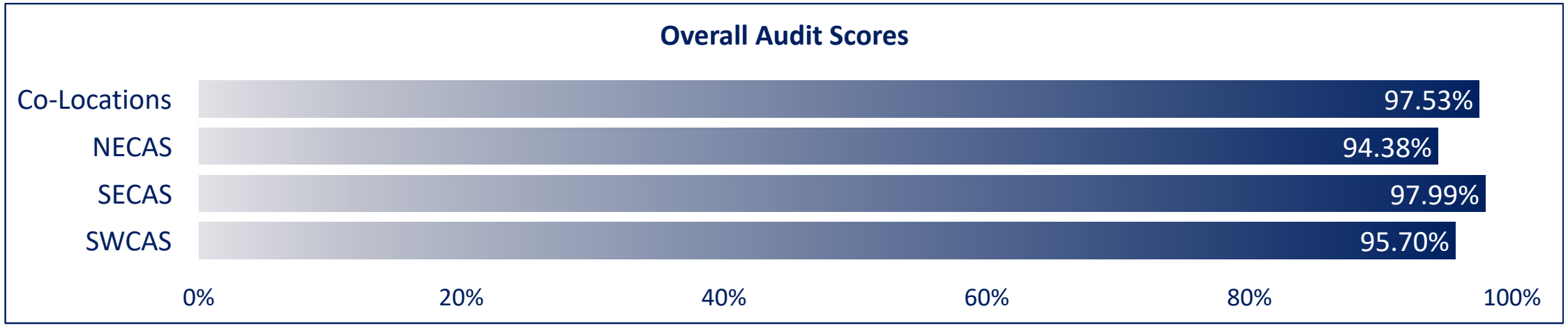
	OPERATIONS	MEDICAL	ENVIRONMENT	CLINICAL RECORDS	PERSONNEL	OVERALL
INFIRMARY DISCHARGE TREATMENT PLANNING	100%	100%	NA	100%	100%	100%
FORENSIC FRONT DOOR	100%	100%	NA	100%	82.72%	95.68%
FORENSIC OUTPATIENT	100%	100%	100%	100%	99.09%	99.82%



Behavioral Health Division

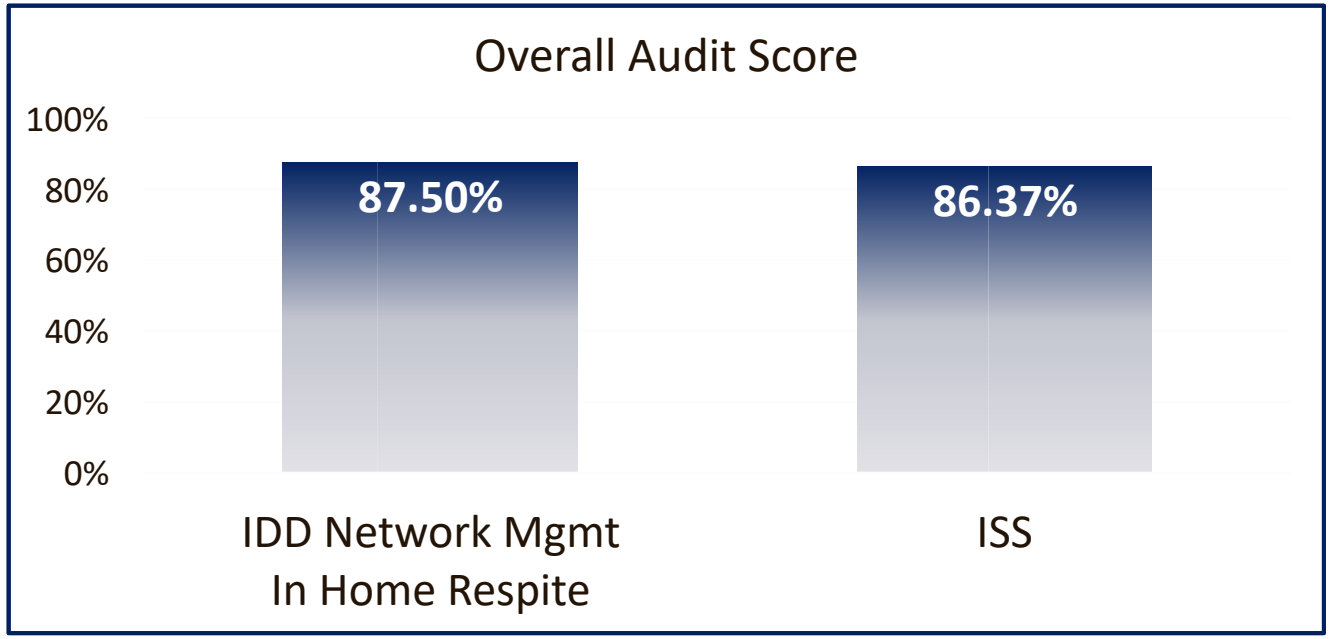
	Operations	Medical	Environment	Clinical Records	Personnel	Overall	Identified areas of improvement	Program Response
SWCAS	100%	100%	100%	83.08%	95.43%	95.70%	Medication Monitoring, Recovery Plans, and documentation of medication related support were common areas of improvement. Services were listed on the client plan but not documented as provided.	In January, the division revamped mental health treatment plans. Final implementation is still underway, with expected improvements in documentation.
SECAS	100%	100%	100%	90.36%	99.59%	97.99%		
NECAS	100%	100%	100%	84.82%	87.07%	94.38%		
Co-Locations	100%	100%	100%	88.10%	99.55%	97.53%		

*SW/SE/NE – Southwest/Southeast/Northeast *CAS – Child and Adolescent Services



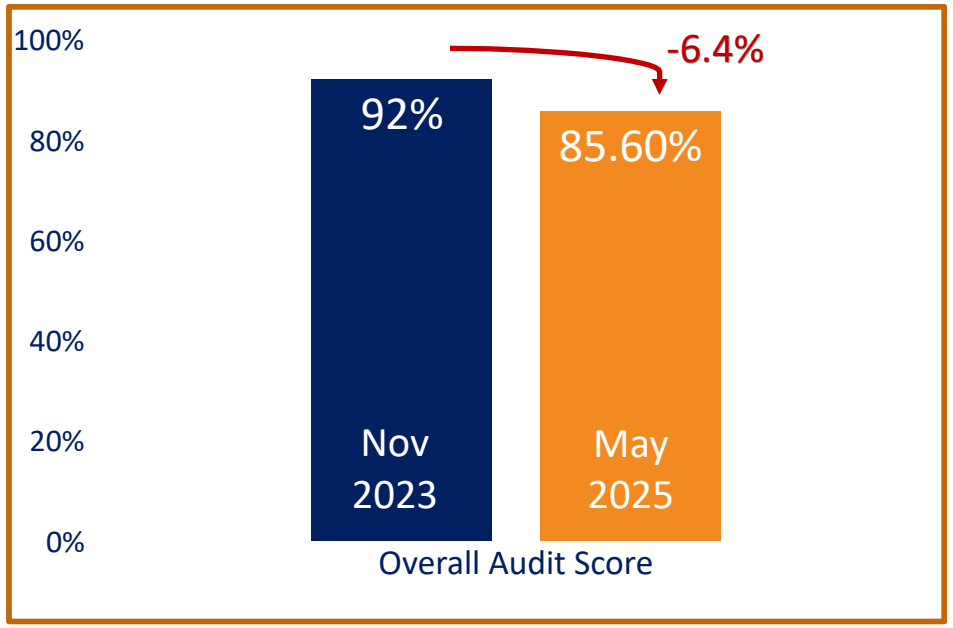
IDD Division

	Operations	Medical	Environment	Clinical Records	Personnel	Overall	comments
IDD Network mgmt. & in home respite	NA	NA	NA	100%	75%	87.5%	Annual training requirements were an identified area of improvement. The program is now current on trainings.
ISS/Day Hab Locations	100%	NA	97%	66.67%	81.25%	86.37%	The clinical record is an area of improvement due to missing documentation. Currently, the program utilizes paper documentation.

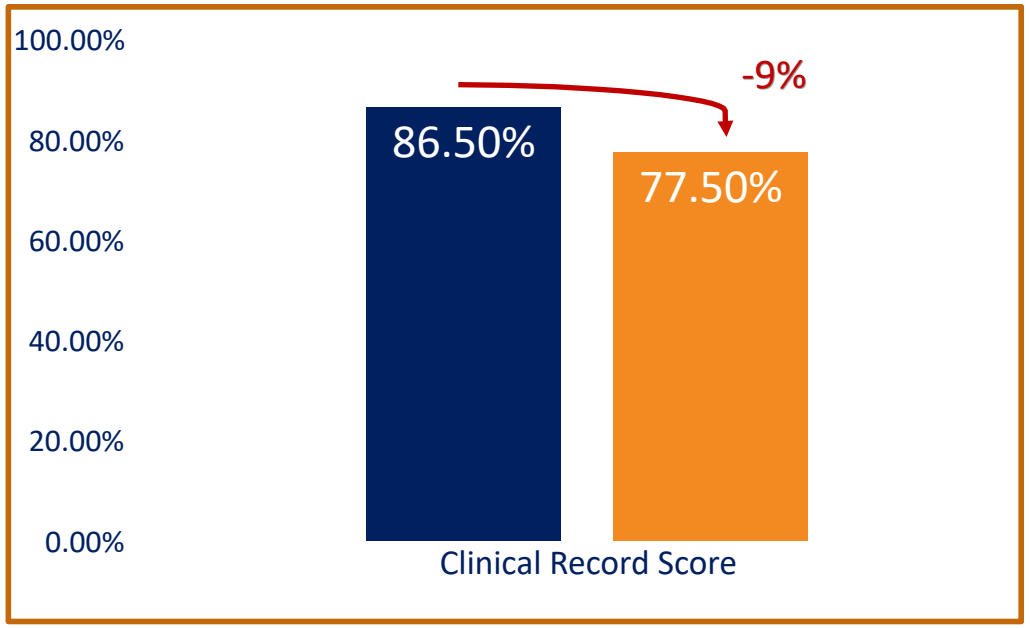


Follow Up Audits

Clinical High Risk Psychosis (CHRP Follow Up)



Project for Assistance in Transition from Homelessness (PATH Follow Up)



CHRP Highlights

Only two domains were audited for this follow up: Client Records and Medical. Client Records score increased from 93.17% to 100%. The medical score decreased due to a metric regarding an assessment being initiated prior to initiation of medication.

PATH Highlights

The clinical record domain was re-audited and nursing documentation was at 100%. Case management service encounters scored 55%. The program is being referred to our Performance Improvement department to develop a plan on case management.

AGENCY TREND

Key Finding

ANNUAL TRAINING REQUIREMENTS WERE THE MOST COMMON DEFICIENCY ACROSS PROGRAMS AND DIVISIONS

Targeted Support

COMPLIANCE WILL BEGIN DEVELOPING A GUIDANCE DOCUMENT OVER TRAINING REQUIREMENTS FOR AUDITED PROGRAMS.

External Reviews FY 2025 - Q3: March 2025—May 2025

59 External audits monitoring by Compliance over Quarter 3	
On February 6, 2025, Texas Health and Human Services completed the 2025 Quality Assurance review for the IDD division. While the overall score was 92.04%, HCS (82.70%) and TxHmL (89.58%) fell below 90%, triggering intermittent monitoring for the next year. Action plans were submitted from the program.	Texas Health and Human Services completed a quality management review of the YES Waiver program on April 11, 2025. The review resulted in a 90% compliance score. Areas of non-compliance require a Corrective Action Plan (CAP) and Evidence of Correction (EOC) by 5/26/25. The program submitted the CAP on 5/13/25. On 5/14/25 HHSC determined that the CAP and EOC addressed all required elements and concluded the audit.
The Health and Human Services Commission Provider Finance Department conducted a desk review of the MEI cost report to verify compliance with financial reporting requirements. HHSC requested documentation including payroll summaries, expense categories, and general ledgers for contracted services. The required documents were submitted by the Cost Accounting department on April 15, 2025. At this time, no response has been received from the surveyor.	A comprehensive audit was performed by the HHSC substance use compliance unit on 3/4/25 and the following findings were noted: incomplete training records, consents forms not including all Texas administrative code (TAC) requirements, individualized discharge planning, and not fulfilling required TAC specific education of clients. The program has since submitted a corrective action plan outlining details to update consent and postings, implementing a plan for client education and discharge planning, and to ensure compliance for all required staff training. The surveyor accepted the plan of action on 5/6/25 and the audit was concluded.
Express Scripts conducted three onsite audits for Southwest and Northwest pharmacies.	Harris County Housing and Community Development conducted an audit of TMC Residence Hall located in 1104 Alabama and Hope Harbour focusing on compliance with the HOME program. At this time, the audit has not received a formal closure response.
17 Datavant record requests received between March and May 2025 from Aetna, Ambetter, Optum, Cigna, and Medicare Advantage plans.	29 Optum pharmacy audits conducted across multiple regions.
HHSC conducted a performance review under the FY25 performance contract, requiring 95% of permanency plans to be completed within the required timeframes. On May 5, 2025, HHSC provided notification that for Q2, the Local Intellectual and developmental disability achieved only 77%, falling below the target. As a result, HHSC issued a Notice of non-compliance and imposed a sanction of $4,768.45, per contractual guidelines.	HHSC reviewed the FY25 performance data and found that the Local IDD Authority achieved 84% of TxHmL enrollments within required timeframes, falling short of the 95% contractual target. As a result, HHSC issued a Notice of non-compliance and imposed a sanction of $2,384.22, as outlined in the performance contract.
Vitrix Health (on behalf of Texas Children's Health Plan) requested records on 3/26/25 for HEDIS data abstraction for the 2024 measurement year. The request was for a Texas Children's Health Plan member.	Community Health Choice requested medical records on 5/30/25 as part of a compliance review related to risk adjustment. Release of Information Department submitted records to managed care organization. Audit results are pending.

Thank you.

EXHIBIT A-5

FY2025 Q3/Q4 Audits

Internal Audit Department

David W. Fojtik, CPA, MBA, CIA, CFE
July 15, 2025

FY2025 Q3 and Q4 Reports

Agenda:

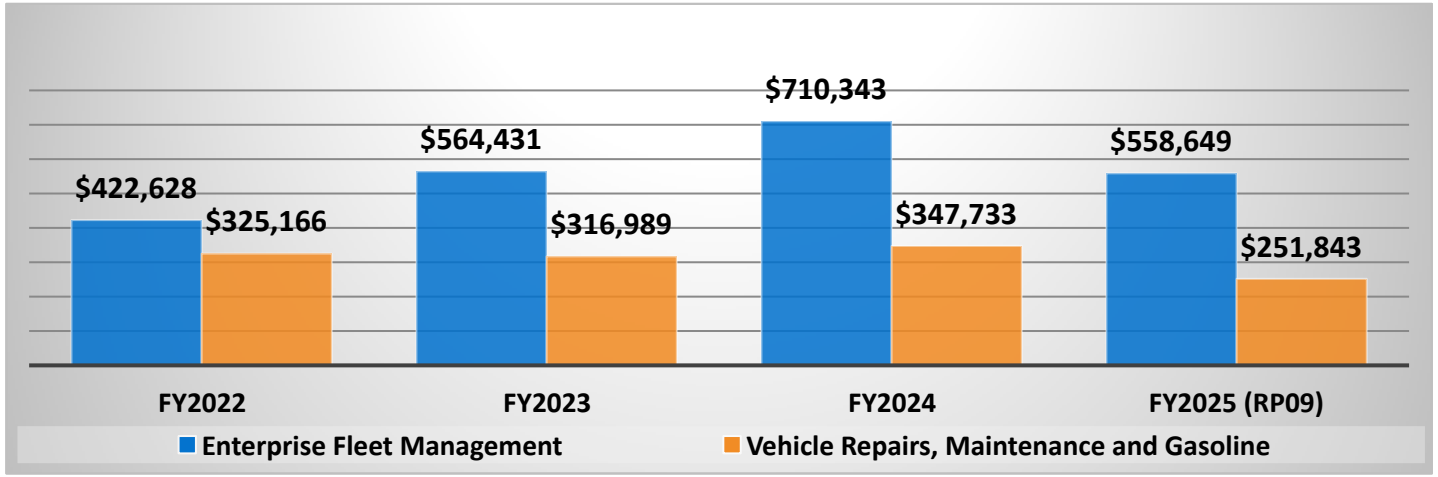
Projects to be presented:

- Follow-Up: Fleet Management Audit
- Follow-Up: Harm Reduction Program Review
- Follow-Up: Late Grant Contract Billing Review
- Follow-Up: Recenter Integration Review
- Follow-Up: RM Third-Party Billing Review
- FY2025 Summary of Wins and Accomplishments

FY2025 Q3 and Q4 Reports

Follow-Up: Fleet Management Audit

Observation #1 – Internal Audit found costs for operating both the leased and agency-owned vehicles in FY 2024 totaled $1,058,076 compared to $881,420 in FY 2023. The Enterprise Lease program represents the larger share of the Center's vehicle operating costs and includes 97 vehicles. Internal Audit found total operating costs (both Enterprise and Agency-owned) were $810,491 through May 31, 2025. The total fleet management costs for FY 2025 are projected to be $1,080,654.



Source: Actual *Agency-Owned and Leased Vehicle Costs, from Trending Reports 2022 to May 2025.*

Management Response: (Fleet Transportation Administrator-Senior): Agreed.

FY2025 Q3 and Q4 Reports

Follow-Up: Fleet Management Audit

Observation #2 – Internal Audit found seven (7) agency-owned vehicles in inventory as of April 30, 2025 in the fixed asset reports. The five (5) Ford Escapes are contractually retained to comply with the Substance Abuse Disorder Outreach Program (SUDOP) program grant requirements. Based on the scan date, the average age of the 7 vehicles is 3.6 years, as of April 30, 2025.

The Harris Center remaining inventory of agency-owned vehicles, as of April 30, 2025

Serial #	Scan Date	Description	Model	Location Code
1GAWGEFP01175220	1/17/2020	2020 White Chevrolet Express Van *	Express Van	185801PRKLT
1FDEE3FN2PDD14923	6/30/2023	2023 24FT MOBILE MED. CLINIC CHASSIS	E450	1817
1FMCU0F61LUB44081	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^
1FMCU0F62LUB78451	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^
1FMCU0F63LUA84756	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^
1FMCU0F63LUB44079	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^
1FMCU0F6XLUB44080	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^

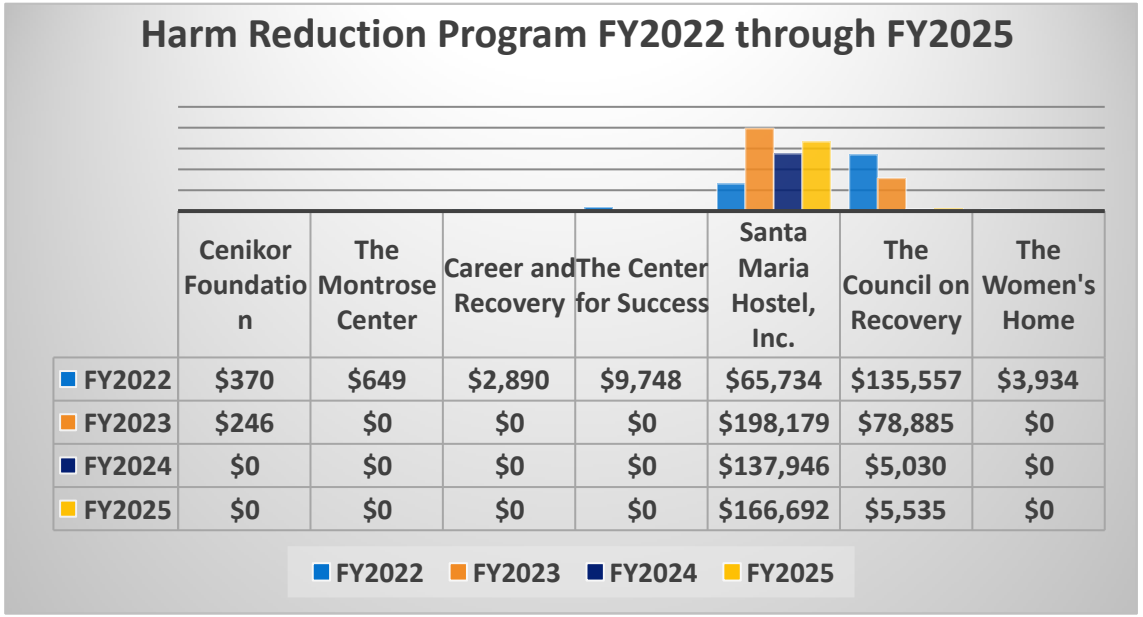
*Source: Agency-Owned and Leased Vehicle Costs trending reports 2022 to 2025, April 30, 2025 (* = Gordon's van; ^ = SUDUP program grant location)*

Management Response: (Fleet Transportation Administrator-Senior): "The agency-owned 2020 White Chevrolet Express Van VIN#1GAWGEFP01175220 was recently picked up on May 7th to be auctioned off on behalf of Enterprise."

FY2025 Q3 and Q4 Reports

Follow-Up: Harm Reduction Program Review

Observation #1 – Internal Audit assessed the reimbursements provided to OSAR provider organizations. Over the past four years, we found that the Santa Maria Hostel received $568,550, or 70.1% of all Harm Reduction funds, while The Council on Recovery received $225,007, or 27.7% of Harm Reduction Program funds. In April 2025, Internal Audit learned that the 2025 grant program funding was no longer available.



	Cenikor Foundation	The Montrose Center	Career and Recovery	The Center for Success	Santa Maria Hostel, Inc.	The Council on Recovery	The Women's Home
FY2022	$370	$649	$2,890	$9,748	$65,734	$135,557	$3,934
FY2023	$246	$0	$0	$0	$198,179	$78,885	$0
FY2024	$0	$0	$0	$0	$137,946	$5,030	$0
FY2025	$0	$0	$0	$0	$166,692	$5,535	$0

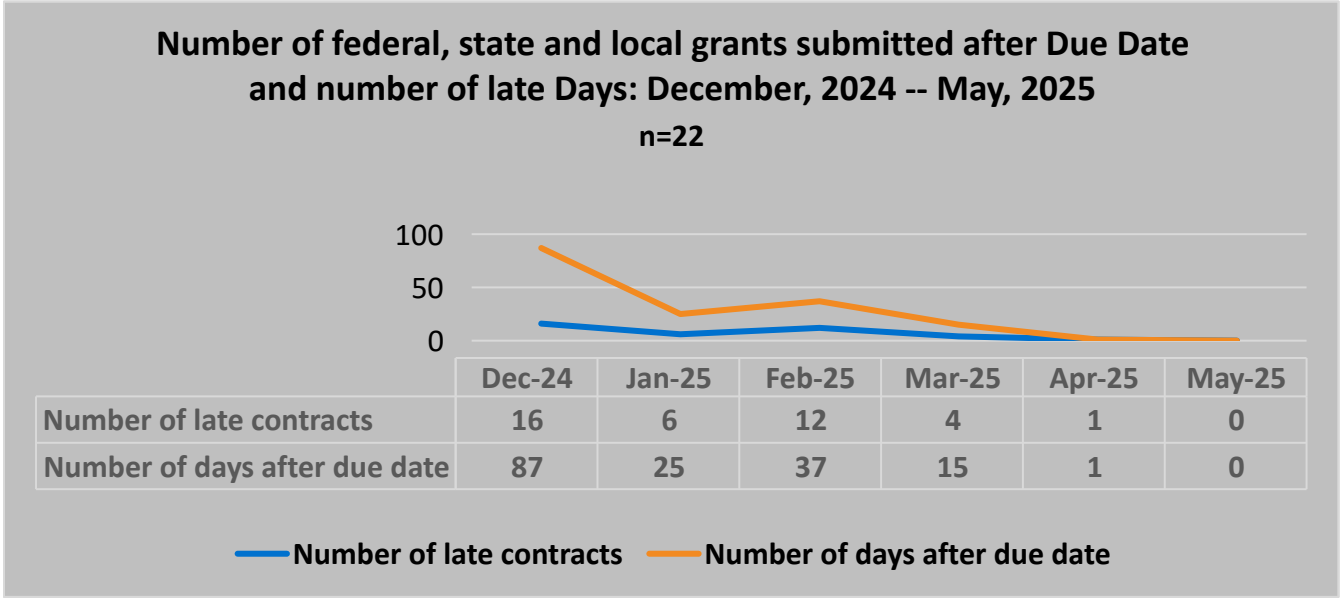
Source: Internal Audit reports on COVID-19/Harm Reduction grants FY2022 thru FY2025

Management Response #1 (Program Director of Substance Use Recovery Services): "We acknowledge the funding distribution trends. The higher reimbursement amounts to Santa Maria Hostel are a result of their consistency with reimbursement requests during grant period and the lack of requests from others within the region. We will review outreach and engagement practices with other OSAR providers in Region 6 to encourage broader participation in future funding cycles, should funding be reinstated."

FY2025 Q3 and Q4 Reports

Follow-Up: Late Grant Contract Billing Review

Observation #1 – Internal Audit tracked 22 federal, state and local grant contracts for late submission. We found that sixteen (16) were submitted late in December, 2024. We found six (6) invoices submitted late in January, twelve (12) in February, four (4) in March, one (1) in April, and none in May, 2025.



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number of late contracts	16	6	12	4	1	0
Number of days after due date	87	25	37	15	1	0

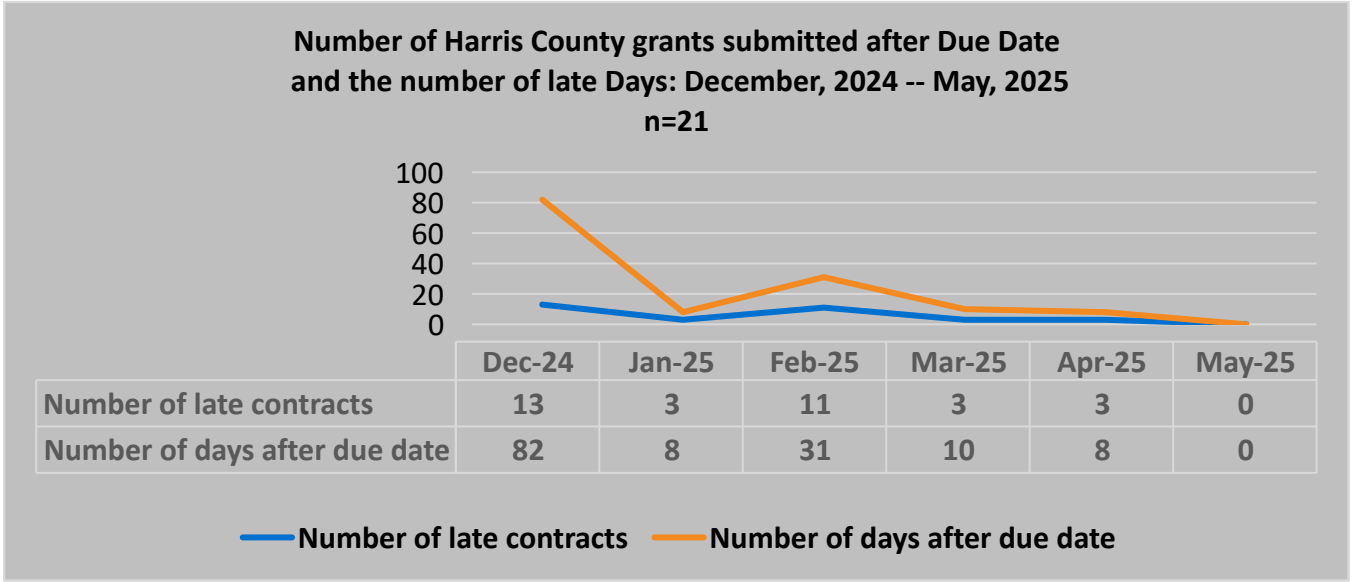
Source: Internal Audit review of grant invoices for sample of FY2025 reimbursable services contracts

Management Response #1 (Chief Financial Officer): No response required.

FY2025 Q3 and Q4 Reports

Follow-Up: Late Grant Contract Billing Review

Observation #2 – Internal Audit tracked 21 Harris County contracts for late submission. We found that thirteen (13) submitted late in December, 2024. We found three (3) late invoices in January, eleven (11) in February, three (3) in March and April, and none in May, 2025.



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number of late contracts	13	3	11	3	3	0
Number of days after due date	82	8	31	10	8	0

Source: Internal Audit review of grant invoices for sample of FY2025 reimbursable services contracts

Management Response #2 (Chief Financial Officer): No response required.

FY2025 Q3 and Q4 Reports

Follow-Up: Late Grant Contract Billing Review

Observation #3 – We noted that the HR133 program invoice includes three (3) component programs (see below) that are billed on the same invoice and is due on the 15th of each month. The current invoice for May has not been submitted to HHSC as of June 26, 2025.

- **HR133 Outpatient Capacity Expansion (A01)**
- **HR133 Housing and Homelessness (A02)**
- **HR133 Crisis Hotline and Mobile Crisis Outreach Team (A06)**

Management Response #3 (Chief Financial Officer: "The HR133 contract was terminated by HHSC due to the cancellation of ARPA funding. We received a letter from HHSC dated April 15 that we have 45 days from the date of the letter to submit final invoices". We spoke with our state representative, Rhonda Dieterich, who laid out the framework of our invoice submissions which we observed. The last invoice was submitted on May 29, 1 day before its due date.

FY2025 Q3 and Q4 Reports

Follow-Up: Recenter Integration Audit

Observation #1 – Internal Audit has reviewed Recenter consumer payroll deductions for rent, laundry, etc., from bi-weekly payrolls but the revenue(deductions) is not reflected on the books of the Harris Center. Funds amounting to $60,381 have accumulated since December 20, 2024.

Management Response #1 (Recenter Director of Operations): "Since December 20, 2024 we placed these revenues in a non-interest-bearing account at the bank. These revenues are mostly from the residents here. There have been no directives on how funds are to be reported."

Management Response #2 (Chief Financial Officer): "The Harris Center invoiced ReCenter on June 24th for the $60,381 payment. We will accrue that revenue in June if we have not yet received the payment for it."

FY2025 Q3 and Q4 Reports

Follow-Up: RM Third-Party Billing and Refunds Audit

Observation #1 – Internal Audit compared general ledger revenues data in the external auditor's FY 2024 *Annual Comprehensive Financial Report (ACFR)*, which showed Miscellaneous Revenues decreased $993,095, from $4.3 million in FY 2023 to $3.3 million in FY 2024.

THE HARRIS CENTER FOR MENTAL HEALTH AND IDD
STATEMENT OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCES - GOVERNMENTAL FUNDS
For the Years Ended August 31, 2024 and 2023

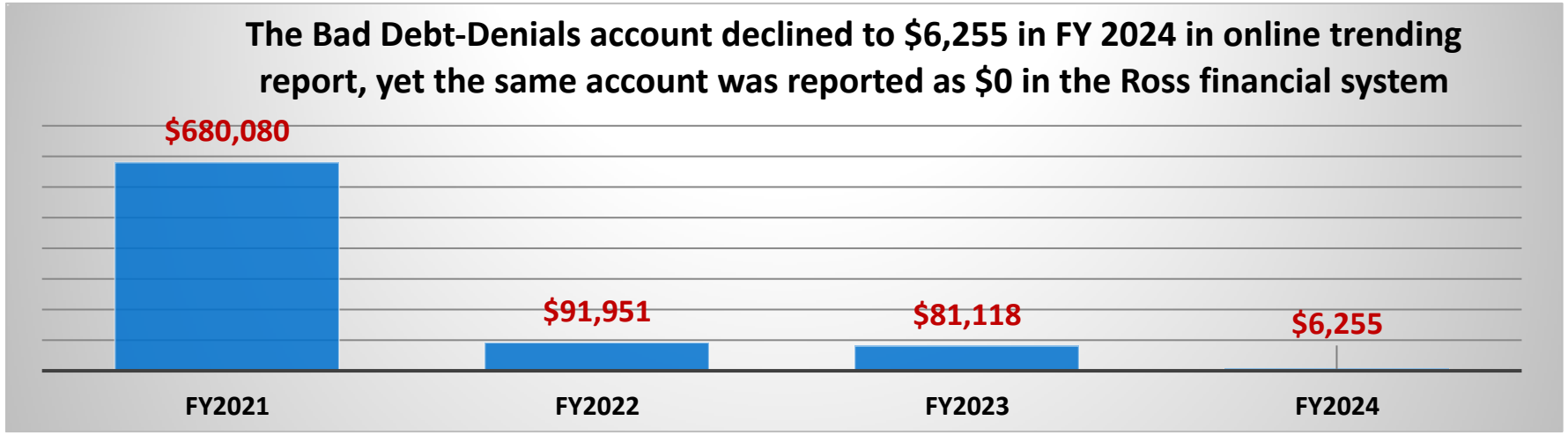
	General Fund	
	2024	2023
Revenues		
State grants & programs	$ 151,910,634	$ 124,573,917
Federal grants	107,101,684	103,993,065
Harris County allocation and other contracts	46,339,437	52,635,562
Local billings	36,383,805	29,083,609
Investment earnings	3,662,619	2,941,559
Miscellaneous	3,294,681	4,287,776
Total Revenues	348,692,860	317,515,488

Source: Annual Comprehensive Financial Report, The Harris Center for Mental Health, January 28, 2025, page 22.

FY2025 Q3 and Q4 Reports

Follow-Up: RM Third-Party Billing and Refunds Audit

Observation #2 – Internal Audit found the year-end balance of the bad debt-denials account was reflected as $6,255 on the Financial Services Trending Report yet the ROSS Financial System reported this account's balance as $0 at the FY 2024 fiscal year-end. Why?



Online Trending Report showing year-end actual balances for bad debt-denials account, The Harris Center for Mental Health

Management Response #2 (Controller): "Financial Services has changed the accounting breakdown for Net Patient Revenue account in order to meet new requirements in the pending GASB 606 standard." This change was not reflected on the Financial Services Trending Report.

FY2025 Q3 and Q4 Reports

FY2025 Key Activities and Accomplishments

- Completed all eight (8) Board-approved FY 2025 internal audit projects.
- Completed one (1) special audit request (SAR) and four (4) special management requests (SMRs).
- Completed six (6) follow-up audits based on prior year special audit requests to assure the business unit was making meaningful changes to change operationally to gain greater compliance and greater consistency with the Center’s expected norms.
- Internal Audit successfully project-managed installation of a continuous monitoring module of business data for accounts payable and in-county travel reporting.

FY2025 Q3 and Q4 Reports

FY2025 Key Activities and Accomplishments (cont'd)

- Internal Audit completed the installation of the AutoAudit software system (version 7.6.1) that provides an independent and protected repository of audit reports. We added an issue tracking feature that facilitates responses between Internal Audit and the auditee contacts.
- Internal Audit took special steps to review the integration of the ReCenter (aka The Men's Center) organization into a greater portfolio of respite and substance abuse programs that are already in place at The Harris Center. Internal Audit performed several due diligence steps to review preparing payroll on QuickBooks, the intricacy of preparing payments for employee payroll taxes and federal income taxes, and tracing payments from vendor invoices to final debit transactions on the ReCenter's bank statements.

FY2025 Q3 and Q4 Reports

FY2025 Key Activities and Accomplishments (cont'd)

- Internal Audit reviewed the FY2025 OSAR Harm Reduction Program provider's requests for purchases of PPE and for client transportation (Metro and taxi), and we worked with The Harris Center's Director of Mental Health Projects on the standardized review process which included making improved reporting for the HHSC RedCap system.
- In June 2024, Internal Audit had entered an agreement with FraudHotline (www.fraudhl.com) which provides a confidential and anonymous site for employees, contractors and any others to report issues or behaviors that seem unusual or peculiar, and worthy of further investigation.
- In October 2024, Internal Audit asked the Communications Department to announce International Fraud Awareness Week in mid-November of 2024. The event is the annual outreach to educate the fraud examiner community and general public to recognize typical examples of fraud, waste and abuse and provide an opportunity to show employees how to report observations to Internal Audit using FraudHotline to start an investigation or analysis.

Questions

EXHIBIT A-6

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

Report Description: This report provides a summary of compliance activities for quarter three of FY25, including internal audit findings, external audit involvement, and ongoing department responsibilities.

Presenter: Demetria Luckett, Compliance Director

Explanation of Auditing Format:

The Compliance department has continued their new auditing format that was introduced earlier this fiscal year. The reviews are grouped into five core areas: Personnel, Operations, Environment, Client Records, and Medical. These areas help us pinpoint risks and improvement areas across our programs and service lines.

This report covers all audits completed between March 1st, 2025, and May 31st, 2025, and includes a breakdown by division and type of review: Comprehensive, Focus, and Follow-Up. There will be an overview of each audit completed and corrective action if applicable.

Audit Format Refresher:

- **Personnel:** Training, licensing, certifications, and adherence to staffing requirements.
- **Operations:** Internal processes, documentation practices, and regulatory compliance.
- **Environment:** Safety protocols, emergency preparedness, vehicle compliance, and rights protections.
- **Client Records:** Documentation accuracy, timeliness, integrity, Medical Necessity, and clinical recordkeeping.
- **Medical:** Medication management practices, consents, clinical services, and patient safety standards.

This structure promotes consistency and allows us to identify strengths and recurring issues across all program areas.

There were a total of 5 Billing and Coding Focus Reviews completed for the third quarter of FY25. Each billing and coding focus audit consists of two core areas: Operations (billing) and Client Records (coding/clinical documentation).

1. Behavioral Health Division: Adult Mental Health Medication Treatment Services Focused Billing and Coding Audit:
    a. This audit reviewed the period of April 2024 to assess medication training and support service clinical documentation, coding, and billing claim practices. The program had an overall audit score of 98%. The operations score was 98.8%, and the client record score was 97.3%. Documentation issues identified included progress notes entered prior to patient encounter, late documentation beyond the allowed timeframe, missing plan of care, and copy-paste documentation lacking patient-specific updates. Additionally, there were minor incorrect billings due to miscoding and unauthorized service. The program received the findings, and a follow-up review will be conducted in 180 days for specific metrics under 95%.

2. Behavioral Health Division: Adult Mental Health Skills Training and Development Services Medical Billing and Coding Review.
    a. This audit reviewed the period of July 2024 to assess skills training, development service documentation, coding, and billing practices. There was an overall audit score of 95.4%. The operations score was 98.02%, and the client's record score was 92.77%. Documentation issues consisted of a missing plan of care, which justified service provision and late documentation beyond the required timeframe. The program initiated a documentation refresher training and is implementing an in-person ANSA/plan of care training session in August 2025. The team is also self-monitoring through chart audits.
3. CPEP Division: Substance Use Detoxification Recovery Services Program – Adult Withdrawal Management Service Coding Review:
    a. This review covers a period of February - March 2025 and assesses documentation related to adult withdrawal management services to maintain compliance with regulatory requirements. This review consisted of one main domain of clinical documentation requirements (client records) and had an overall score of 99%. Minor findings included missing or inaccurate provider notes for crisis services and a duplicate intake assessment on the same date of service. Audit was reviewed with program leadership.
4. CPEP Division: Peer Support Services Program – Family Partner Support Service Focused Coding Review.
    a. This review covers a period of March 2025 to assess compliance in coding of client records and documentation for Family Partner Support Services. There was one domain of client records, and the overall audit score was 88.86%. Discrepancies in documentation included missing, incomplete, or inaccurate CANS assessment summaries, encounters with an overlapping appointment time or encounters with invalid plans of care. Peer Support Leadership team educated and followed up with Family partners regarding timeliness and accuracy of documentation submissions.
5. Forensics Division: TCOOMMI (Texas Correctional Office on offenders with Medical or Mental Impairments) Focused Billing and Coding Review for Telehealth.
    a. This review covers the period of March 2025 and assesses client records and documentation related to telehealth and telemedicine practices for compliance with regulatory requirements. The discrepancies included inaccurate provider documentation, specifically service documentation did not match service delivery method. To address the findings, leadership will conduct targeted training with service providers.

There was a total of eleven (11) Comprehensive and two (2) Follow-up Reviews. Comprehensive reviews cover the five domains applicable to the program, and Follow-up Reviews cover the domains which previously needed a plan of improvement.

CPEP Division

1. Clinician Officer Remote Evaluation (CORE) Comprehensive Review
    a. This review covers the period from December 1, 2024, through February 28, 2025. The overall program review score was 94%. There were strengths in operational, medical, and clinical requirements. Areas of improvement were within the personnel domain with a score of 80% and deficiencies were within the annual training requirements. There were minor deficiencies within the clinical domain related to individualized safety plans and telehealth consents.

The HARRIS CENTER for Mental Health and IDD

2. Rapid Response Comprehensive Review
    a. This review covers the period of December 1st, 2024 – February 28, 2025, and assessed operational, medical, environmental, personnel, and clinical requirements according to regulatory and internal agency policies and procedures. The overall score for this audit was 97%. Areas of strength were in operations, medical, environmental, and clinical domains with a score of 99% or above. The main area of improvement was in the personnel domain relating to annual training requirements and had a score of 84%.
3. Project for Assistance in Transition from Homelessness (PATH) Follow Up Review
    a. A follow-up review assessed nursing and case management documentation from December 1, 2024, through February 28, 2025. The overall score was 78%, with nursing encounter documentation at 100% for the required standard. Case management scored 55% due to insufficient documentation of referrals, linkage, advocacy, and developing a plan of care. The program was referred to our performance improvement department to improve consistency in capturing case management activities.

Forensics Division

1. Infirmary Discharge Treatment Planning Comprehensive Review
    a. The program had an overall score of 100% compliance in all five domains.
2. Forensic Front Door Comprehensive Review
    a. The program had an overall audit score of 95.68%. Operational, medical, and clinical domains were at 100% compliance. The Personnel requirements had a score of 82.72% which included deficiencies related to annual training and Human Resource required files.
3. Forensic Outpatient Comprehensive Review
    a. The program had an overall score of 99.82% with compliance in all domains. There were minor deficiencies within the personnel domain for annual training requirements. A plan of improvement will be completed by the program.

Behavioral Health Division

1. Southwest Child and Adolescent Services Comprehensive Review
    a. This review had an overall score of 95.70% with compliance noted in operations, medical, environmental, and personnel domains. One area of improvement was identified in the personnel domain regarding agency-mandated training courses. Client records scored an 83.08%. Compliance concerns include incomplete consents and client rights documentation, missing elements in plans of care, incomplete progress or case management notes, and failure to deliver all services outlined in the plan of care. The program has implemented training for clinical staff and will begin self-monitoring a sample chart quarterly.
2. Southeast Child and Adolescent Services (SECAS) Comprehensive Review
    a. This review had an overall score of 98%, with 100% compliance in operations, medical, and environment, and 99% in personnel. The area for improvement was within the client records domain, which scored 90%. The program reviewed and implemented monthly training tracking, retraining documentation for plans of care and medication consents, as well as updates to agency policies.
3. Northeast Child and Adolescent Services (NECAS) Comprehensive Review

The HARRIS CENTER for Mental Health and IDD

   a. This review had an overall score of 94.38%. The operations, medical, and environment domains had a score of 100%. The personnel domain had a score of 87.07% and the clinical domain was 84.82%. Areas of improvement were identified for missing agency-mandated training courses, missing consents, completing plan of care updates within required timeframes, and missing documentation for case management and medication training and support. The program is completing a plan of improvement to self-monitor, and the compliance department will perform a follow-up review.
4. Co-locations Child and Adolescent Services (Co-locations) Comprehensive Review
   a. This review had an overall score of 97.53%. The operations, medical, and environment domains scored 100%, and personnel scored 99.55%. The client records domain scored 88.10% and identified areas of improvement were within recovery plan completion, documentation of services for treatment plan goals or activities, medication monitoring, and documentation of medication training and support. This was the first comprehensive review for the Co-locations program. The program is working on a corrective action plan to meet compliance.
5. Clinical High-Risk Psychosis (CHR-P) Follow Up Review
   a. The follow-up review consisted of an audit of informed medication consent, client rights, plans of care, and AIMS assessments. The overall score was 86% with 100% in medication consents and client rights. The AIMS score was 57% due to missing AIMS completed prior to the initiation of a psychoactive medication. The program is coordinating with the appropriate department regarding this regulation.

IDD Division

1. IDD Network Management In-Home Respite Comprehensive Review
   a. This review focused on compliance with the FY25 In-Home Respite contract and the IDD Service Definition manual. Two domains were audited: Clinical Records and Personnel. The program had an overall score of 88%, with 100% compliance with Clinical records. The Personnel domain scored 75% due to missing annual training. The deficiencies were linked to limited access during a software transition, and all training is now current.
2. ISS/Day Hab Comprehensive Review
   a. This review had an overall score of 78.56%. Key findings included missing PDP, IPC, DID, consents, rights acknowledgement, documentation of complaint procedures, and progress notes lacked measurable outcomes. Program indicated missing documents would be provided by the service coordinator, but no follow up was documented. This was the first review for this program, and another focus review will be scheduled within 90 days.

Other Compliance Activities

1. Epic Deficiency Monitoring: Track and communicate ongoing Epic documentation deficiencies to ensure timely resolution.
2. Policy and Procedure Oversight: Facilitate and maintain the agency's policy and procedure process using the PolicyTech platform, which includes approvals, updates, and staff communication (ongoing).
3. Corrective Action Monitoring: Track and follow up on corrective action plans related to audit findings, including timelines and status updates.

The HARRIS CENTER for Mental Health and IDD

4. Complaint and Grievance Review: Support the Rights Office by conducting clinical record reviews related to complaints and grievances.

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

Datavant Record Requests:

1. Datavant (on behalf of Aetna) requested records on 3/25/25 for risk adjustment data reporting to HHS. Request includes complete medical records for identified Aetna members. Records will be used solely for annual federal risk adjustment purposes. Records were submitted by our Release of Information Department.
2. Datavant (on behalf of Ambetter from Superior HealthPlan) requested records on 3/26/25 to support federal risk adjustment reporting. Request included full medical record on an Ambetter member for review by Ambetter's coding team. Records were submitted by our ROI department.
3. Datavant (on behalf of Aetna) requested records on 3/28/2025 for risk adjustment data reporting to HHS. Request includes complete medical records for identified Aetna members. Records will be used solely for annual federal risk adjustment purposes. Records were submitted by our ROI department.
4. Datavant (on behalf of United Healthcare) requested records on 4/7/25 for 2024 HEDIS medical record collection. Records were submitted by our ROI department.
5. Datavant (on behalf of Cigna) requested records on 4/14/25 for Medicare Advantage risk adjustment chart reviews. Requested documentation included a full range of records from 1/1/24 to present to support accurate diagnostic coding. Records were submitted for multiple requested members by the ROI department.
6. Datavant (on behalf of Aetna Medicare Advantage) submitted two different requests on 4/21/25 for different patients. Records were requested to support Medicare risk adjustment data submission to CMS. Records were submitted by the Release of Information Department.
7. Datavant (on behalf of Aetna Medicare Advantage) submitted a request on 4/29/25 for multiple patients. Records were requested to support Medicare risk adjustment data submission to CMS. Records were submitted by the ROI department.
8. Datavant submitted seven chart review requests on 5/20/25 for multiple patients. The request included a requirement to submit a provider signature log to validate documentation. Records were submitted by the ROI department.
9. Datavant submitted two chart review requests on 5/21/25 for multiple patients. The request included a requirement to submit a provider signature log to validate documentation. Records were submitted by the ROI department.

Pharmacy Audits:

1. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 3/3/25 to validate claims associated with Invega Trinz INJ 819 mg. The requested documentation was submitted by the pharmacy representative on 3/3/25. On 3/20/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
2. Optum Rx conducted a chart review audit for Southwest Clinic Pharmacy on 3/3/25 to validate claims associated with Invega Trinz INJ 819 mg. The requested documentation was submitted by the pharmacy

representative on 3/3/25. On 3/26/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.

3. Optum Rx conducted a chart review audit for Southwest Clinic Pharmacy on 3/4/25 to validate claims associated with Invega Trinz INJ 819 mg. The requested documentation was submitted by the pharmacy representative on 3/4/25. On 3/20/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
4. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 3/10/25 to validate claims associated with Invega Trinz INJ 819 mg. The requested documentation was submitted by the pharmacy representative on 3/11/25. On 3/28/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
5. Optum Rx conducted a chart review audit for Northeast Clinic Pharmacy on 3/12/25 to validate claims associated with Invega Sust INJ 234 mg. The requested documentation was submitted by the pharmacy representative on 3/12/25. On 3/27/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
6. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 3/13/25 to validate claims associated with Loxapine Cap 25 mg. The requested documentation was submitted by the pharmacy representative on 3/14/25. On 4/3/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
7. Optum Rx conducted a chart review audit for Northeast Clinic Pharmacy on 3/14/25 to validate claims associated with Invega Sust INJ 234 mg. The requested documentation was submitted by the pharmacy representative on 3/14/25. On 4/3/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
8. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 3/18/25 to validate claims associated with Invega Hayfe INJ 1560 mg. The requested documentation was submitted by the pharmacy representative on 3/21/25. On 4/9/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
9. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 3/19/25 to validate claims associated with Invega Sust INJ 234 mg. The requested documentation was submitted by the pharmacy representative on 3/21/25. On 4/10/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
10. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 3/28/25 to validate claims associated with Invega Trinz INJ 546 mg. The requested documentation was submitted by the pharmacy representative on 3/31/25. On 4/28/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
11. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 4/1/25 to validate claims associated with Invega Sust INJ 546 mg. The requested documentation was submitted by the pharmacy representative on 4/15/25. Audit results are still pending at this time.
12. Optum Rx conducted a chart review audit for Northeast Clinic Pharmacy on 4/2/25 to validate claims associated with Invega Sust INJ 156 mg. The requested documentation was submitted by the pharmacy representative on 4/2/25. On 4/24/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
13. Optum Rx conducted a chart review audit for Southwest Clinic Pharmacy on 4/4/25 to validate claims associated with Vyvanse Cap 30mg. The requested documentation was submitted by the pharmacy representative on 4/14/25. On 4/24/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.

The HARRIS CENTER for Mental Health and IDD

14. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 4/15/25 to validate claims associated with Invega Sust INJ 234 mg. The requested documentation was submitted by the pharmacy representative on 4/15/25. Audit results are still pending at this time.
15. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 4/15/25 to validate claims associated with Uzedy INJ 200 mg. The requested documentation was submitted by the pharmacy representative on 4/15/25. On 5/9/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
16. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 4/17/25 to validate claims associated with Uzedy INJ 200 mg. The requested documentation was submitted by the pharmacy representative on 4/25/25. On 5/12/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
17. On 4/29/25 Express Scripts conducted an onsite audit at Northwest Clinic Pharmacy of submitted claims. A discrepancy was identified related to incorrect days' supply and a difference in copayment amounts. The audit resulted in a recoupment of $123.82.
18. Optum Rx conducted a chart review audit for Northeast Clinic Pharmacy on 4/30/25 to validate claims associated with Invega Trinz INJ 819 mg. The requested documentation was submitted by the pharmacy representative on 5/5/25. On 5/23/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
19. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 5/2/25 to validate claims associated with Invega Sust INJ 234 mg. The requested documentation was submitted by the pharmacy representative on 5/2/25. On 5/23/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
20. Optum Rx conducted a chart review audit for Northeast Clinic Pharmacy on 4/25/25 to validate claims associated with Abilify ASIM INJ 960 mg. The requested documentation was submitted by the pharmacy representative on 5/6/25. On 5/23/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
21. Optum Rx conducted a chart review audit for Northeast Clinic Pharmacy on 5/7/25 to validate claims associated with Invega Sust INJ 234 mg. The requested documentation was submitted by the pharmacy representative on 5/7/25. On 5/23/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
22. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 5/7/25 to validate claims associated with Abilify ASIM INJ 960 mg. The requested documentation was submitted by the pharmacy representative on 5/7/25. On 5/23/25, Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
23. Optum Rx conducted a chart review audit for Southwest Clinic Pharmacy on 5/8/25 to validate claims associated with Invega Trinz INJ 546 mg. The requested documentation was submitted by the pharmacy representative on 5/14/25. Audit is still pending results.
24. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 5/13/25 to validate claims associated with Invega Sust INJ 234 mg. The requested documentation was submitted by the pharmacy representative on 5/14/25. Audit is still pending results.
25. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 5/16/25 to validate claims associated with Invega Trinz INJ 546 mg. The requested documentation was submitted by the pharmacy representative on 5/19/25. Audit is still pending results.
26. On 5/8/25 Express Scripts conducted an onsite audit of submitted claims at Southwest Clinic Pharmacy. The audit resulted in no discrepancies identified and no recoupment due.

The HARRIS CENTER for Mental Health and IDD

27. An onsite audit was conducted on 5/8/25 at Northwest Clinic Pharmacy for a review of submitted claims. The results of the audit are still pending.
28. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 5/19/25 to validate claims associated with Invega Sust INJ 156 mg. The requested documentation was submitted by the pharmacy representative on 5/19/25. Audit is still pending results.
29. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 5/19/25 to validate claims associated with Loxapine Cap 25 mg. The requested documentation was submitted by the pharmacy representative on 5/19/25. Audit is still pending results.
30. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 5/23/25 to validate claims associated with Invega Trinz INJ 410 mg. The requested documentation was submitted by the pharmacy representative on 5/27/25. Audit is still pending results.
31. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 5/27/25 to validate claims associated with Invega Trinz INJ 546 mg. The requested documentation was submitted by the pharmacy representative on 5/27/25. Audit is still pending results.
32. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 5/27/25 to validate claims associated with Invega Trinz INJ 546 mg. The requested documentation was submitted by the pharmacy representative on 5/27/25. Audit is still pending results.

Program Specific Audits

1. Texas Health and Human Services Fiscal Year 2025 Quality Assurance Review
    a. On February 6, 2025, Texas Health and Human Services completed the 2025 Quality Assurance review for the IDD division. While the overall score was 92.04%, HCS (82.70%) and TxHmL (89.58%) fell below 90%, triggering intermittent monitoring for the next year. Action plans were submitted from the program.
2. Youth Empowerment Services (YES) Waiver Program Audit
    a. Texas Health and Human Services completed a quality management review of the YES Waiver program on April 11, 2025. The review resulted in a 90% compliance score. Areas of non-compliance require a Corrective Action Plan (CAP) and Evidence of Correction (EOC) by 5/26/25. The program submitted the CAP on 5/13/25. On 5/14/25 HHSC determined that the CAP and EOC addressed all required elements and concluded the audit.
3. Substance Use Recovery Services Program Audit
    a. A comprehensive audit was performed by the HHSC substance use compliance unit on 3/4/25 and the following findings were noted: incomplete training records, consents forms not including all Texas administrative code (TAC) requirements, individualized discharge planning, and not fulfilling required TAC specific education of clients. The program has since submitted a corrective action plan outlining actions to update consent and postings, implementing a plan for client education and discharge planning compliance, and a plan to ensure trainings are up to date. The surveyor accepted the plan of action on 5/6/25 and the audit was concluded.
4. MEI Cost Report Desk Review
    a. The Health and Human Services Commission Provider Finance Department conducted a desk review of the MEI cost report to verify compliance with financial reporting requirements. HHSC requested documentation including payroll summaries, expense categories, and general ledgers for contracted services. The required documents were submitted by the Cost Accounting department on April 15, 2025. At this time, no response has been received from the surveyor.

5. Harris County Housing and Community Development Audit of TMC Residence Hall
    a. Harris County Housing and Community Development conducted an audit of TMC Residence Hall located in 1104 Alabama. It was focused on compliance with the HOME program. The review included onsite evaluation of resident records as well as documentation of lease terminations, denied applicants, accommodation requests, financial statements, rent roll, and property tax statements. All required documents were submitted as requested during the audit. In the exit conference, there were documents requested, and they were submitted in a timely manner by the program manager. Currently, the audit has not received a formal closure response.
6. Harris County Housing and Community Development Audit of Hope Harbor
    a. Harris County Housing and Community Development conducted an audit of Hope Harbor focused on compliance with the HOME program. The review included onsite evaluation of resident records as well as documentation of lease terminations, denied applicants, accommodation requests, financial statements, rent roll, and property tax statements. All required documents were submitted as requested during the audit. In the exit conference, there were documents requested, and they were submitted in a timely manner by the program manager. At this time, the audit has not received a formal closure response.
7. Permanency Plan Compliance Audit– IDD Division
    a. HHSC conducted a performance review under the FY25 performance contract, requiring 95% of permanency plans to be completed within the required timeframes. On May 5, 2025, HHSC provided notification that for Q2, the Local Intellectual and developmental disability achieved only 77%, falling below the target. As a result, HHSC issued a Notice of non-compliance and imposed a sanction of $4,768.45, per contractual guidelines.
8. Texas Home Living (TxHmL) Enrollment Compliance Audit – IDD Division
    a. HHSC reviewed the FY25 performance data and found that the Local IDD Authority achieved 84% of TxHmL enrollments within required timeframes, falling short of the 95% contractual target. As a result, HHSC issued a Notice of non-compliance and imposed a sanction of $2,384.22, as outlined in the performance contract.

Miscellaneous Requests

1. Vitrix Health (on behalf of Texas Children's Health Plan) requested records on 3/26/25 for HEDIS data abstraction for the 2024 measurement year. The request was for a Texas Children's Health Plan member.
2. Community Health Choice requested medical records on 5/30/25 as part of a compliance review related to risk adjustment. Release of Information Department submitted records to managed care organization. Audit results are pending.

COMPREHENSIVE AND FOLLOW UP REVIEWS BY DIVISION

The HARRIS CENTER for Mental Health and IDD
Transforming Lives

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Adult Mental Health (AMH) Medication Training & Support Services
Focused Billing & Coding Review
Review Dates: March 5, 2025 – March 31, 2025

I. Audit Type:
Focused

II. Purpose:
This review was conducted to assist the Adult Mental Health (AMH) program and Revenue Management division in assessing Medication Training & Support Service clinical documentation, coding, and billing claim practices for Compliance with the 2024 Center for Medicare and Medicaid Services (CMS) Regulations and Guidance, the 2024 Current Procedural Terminology (CPT) guidelines; the Texas Administrative Code (TEX. ADMIN. CODE) Medication Training & Support Services 1 TEX. ADMIN. CODE §306.315; MH Case Management Medicaid Reimbursement 26 TEX. ADMIN. CODE §306.277; Telemedicine and Telehealth Benefits and Limitations; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361; *HIM.EHR.A.6; Telehealth & Telemedicine Procedure MED.B.6; Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Financial Assessment ACC.A.11, Writing Off Self Pay Balances FM.B.10, Charity Care Procedures FM.B.11, Telehealth & Telemedicine Procedure MED.B.6.*

III. Audit Method:
Active records were randomly selected by generating the *Compliance PB Transaction Report* in the EPIC (EHR) system for people served during the 3rd Qtr. Of FY 2024 (April 1 – April 31, 2024). Compliance reviewed Thirty (34) client encounters containing qualified mental health care provider documentation for Adult Medication Training & Support service code H0034. The above-mentioned sample size was obtained on 03/07/2025 *Compliance Coding & Billing Audit Review Tool. It consisted of 2 (Two) components: Medical Billing & Coding requirements (Operations) and Clinical Documentation requirements (Client records).*

IV. Audit Findings/History:
Overall Audit Score (AMH Program) – 98%
Compliance has identified multiple documentation issues that may impact regulatory adherence, service authorization, and clinical record accuracy for the Medication Training and Support (MTS) services. Progress notes were not submitted within the required 42-hour timeframe, and in several cases, the plan of care and service frequency were not documented to support the service rendered. Additionally, some notes contained identical content across sessions without patient-specific updates, and there were instances where documentation was entered before the patient's arrival, raising concerns about accuracy and Compliance.

V. Recommendations:
It is recommended that the Vice President (VP) of the Mental Health (MH) Division and the VP of Revenue Cycle and Grants review the findings and collaborate with the appropriate personnel to assess and ensure physician and other QMHP services are billed, and claims are filed and collected in a timely and accurate manner by Information in TAC, CPT, CMS guidelines and Agency P&P. A Plan of Improvement (POI) is required to address the deficiencies noted in this report, we will reevaluate in 180 days to do so. Compliance will continue to provide essential support to the MH Division and Revenue Management team regarding their documentation of services, including review of clinical documentation from a credentialed professional coder. The VP of both MH Division and Revenue Cycle and Grants must return a signed copy acknowledging receipt of this report to Compliance within three (3) business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Mental Health (MH) Division
Adult Mental Health Program
Medication Training & Support (MTS) Services Medical Billing & Coding Review

Compliance Auditor(s): Prakash Thomas & Obiageri Pickens

Compliance Review: 03/05/2025-03/31/2025

Purpose

This review was conducted to assist Adult Mental health (AMH) program and Revenue Management division assess Medication Training & Support Service clinical documentation, coding and billing claim practices for compliance with the 2024 Center for Medicare and Medicaid Services (CMS) Regulations and Guidance, the 2024 Current Procedural Terminology (CPT) guidelines, Behavioral Health & Case Management Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 December 2024; the Texas Administrative Code (TEX. ADMIN. CODE) Medication Training & Support Services 1 TEX. ADMIN. CODE §306.315; MH Case Management Medicaid Reimbursement 26 TEX. ADMIN. CODE §306.277; Telemedicine and Telehealth Benefits and Limitations; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361;*HIM.EHR.A.6; Telehealth & Telemedicine Procedure MED.B.6; Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Financial Assessment ACC.A.11, Writing Off Self Pay Balances FM.B.10, Charity Care Procedures FM.B.11, Telehealth & Telemedicine Procedure MED.B.6.*

Method

Active records were randomly selected by generating the *Compliance PB Transaction Report* in the EPIC (EHR) system for persons served during the 3rd Qtr. of FY 2024 (April 1, 2024 – April 31, 2024). Compliance reviewed Thirty (34) client encounters containing qualified mental health care provider documentation for Adult Medication Training & Support service code H0034. Above mentioned sample size was obtained on 03/07/2025. This desk review was conducted using the *Compliance Coding & Billing Audit Review Tool. It consisted of 2 (Two) components: Medical Billing & Coding requirements (Operations) and Clinical Documentation requirements (Client records).*

The HARRIS CENTER for Mental Health and IDD

Findings

Overall Audit Score (MTS Program) – 98%
Detailed findings below:

Strengths:

- **Operations - (98.8%)**
  - Services provided correspond to verified CPT code 97%
    1 TEX. ADMIN. CODE §354.2709
  - Services provided correspond to verified Modifier codes 100%
    CMS Regulations and Guidance, CPT Guidelines
  - Services provided correspond to verified *Add-on codes* 100%
    CMS Regulations and Guidance, CPT Guidelines
  - Claim contains appropriate demographics set as detailed in EMR 100%
    HIM.EHR. B.5
  - Appropriate Payor approved codes documented within claim 100%
    1 TEX. ADMIN. CODE §355.8085
  - Appropriate billing provider details listed within claim 100%
    1 TEX. ADMIN. CODE §355.8085
  - Appropriate billing Units documented 97%
    Agency P&P EM.P.4, LD.A.13
  - Services provided are not billed as Duplicate 100%
    Agency P&P EM.P.4, LD.A.13
  - Services provided are not billed as a Bundle 100%
    Agency P&P EM.P.4, LD.A.13
  - Appropriate and verified Copay amount for billed service 100%
    1 TEX. ADMIN. CODE §355.8085
  - Appropriate and verified original charges on claim 94%
    1 TEX. ADMIN. CODE §355.8085
  - Appropriate and verified Adjustments on claim 97%
    Agency P&P ACC.A.11, FM.B.10, FM.B.11
  - Appropriate and verified Reimbursement collected N/A
    Agency P&P ACC.A.11, FM.B.10, FM.B.11
  - Collections resolution, overpayment verification completed 100%
    Agency P&P ACC.A.13

- **Client Records – (97.3%)**
  - Evidence of Incorrect / Overlap / Duplicate Appointment Times 100%
    Agency P&P EM.P.4, LD.A.13
  - Evidence of Copy & Pasting / Cloning within Documentation 97%
    Agency P&P EM.P.4, LD.A.13, HIM.EHR. B.5
  - Evidence of Medically Appropriate History / Assessments 94%
    Behavioral Health & Case Management Services Handbook
  - Evidence of Medically Appropriate Examination 97%
    Behavioral Health & Case Management Services Handbook

- Appropriate Total Time-Based Code for service 100%
  1 TEX. ADMIN. CODE §355.8085
- Service Authorization & Medical Necessity from Treatment plan 97%
  26 TEX. ADMIN. CODE §301.353
- Documentation of Face to Face / Telehealth (TH) on date of service 100%
  Agency P&P MED.B.6, 1 TEX. ADMIN. CODE §306.369
- Consent documented and received for services and POC by QMHP 100%
  26 Agency P&P HIM.EHR. B.4
- Appropriate person specific Goals documented / Assessment & Plan 100%
  26 TEX. ADMIN. CODE §306.315
- Evidence of timely service completion with approved/certified QMHP 88%
  26 TEX. ADMIN. CODE §301.361

Detail Findings:

Compliance has identified multiple documentation issues that may impact regulatory adherence, service authorization, and clinical record accuracy for the Medication Training and Support (MTS) service. These include:

- Pre-Encounter Note Entry: The progress note was entered before the Patient's arrival, which may compromise the accuracy and validity of the clinical record. To mitigate this compliance recommends that providers finalize and sign off on documentation only after the appointment has been completed and not prior to the scheduled end time,
- Late Documentation: Progress notes were submitted beyond the required 42-hours timeframe, failing to meet documentation timeliness standards.
- Missing Plan of Care and Frequency: No plan of care was on file specifying the MTS service or its frequency, which is required to justify service provision and support coding and billing compliance.
- Copy-Paste Documentation: identical note content was used across multiple entries without patient-specific updates, raising concerns about documentation integrity.

Compliance also notes evidence of incorrect original charges due to (1) provider miscoding for rendered service and (2) unauthorized service from plan of care document.

Observations

Providers in multiple encounters documented verbal consent rather than obtaining written (wet) signatures, as expected for MTS services; however, current program expectations require a written (wet) signature to confirm consent. Obtaining written consent is the standard followed to ensure clear authorization and minimize risk.

Recommendations

It is recommended that the Vice President (VP) of Mental Health (MH) Division and the VP of Revenue Cycle and Grants review the findings and collaborate with the appropriate personnel to assess and ensure physician and other QMHP services are billed, and claims are filed and collected in a timely and accurate manner in accordance with Information in TAC, CPT, CMS guidelines and Agency P&P. Compliance will review provider documentation and coding in the next one hundred eighty (180) days to ensure the program has implemented its plan of improvement (POI) pertaining to documentation integrity and service authorization requirements for AMH MTS services. Compliance will continue to provide essential support to the MH Division and Revenue Management team regarding their documentation of services, including review of clinical documentation from a credentialed professional coder. The VP of both MH Division and Revenue Cycle and Grants must return a signed copy acknowledging receipt of this report to Compliance within three (3) business days.

Management Response

Revenue Management is in process of setting up a Medical Coding department who will be reviewing charges prior to claim submission.

The HARRIS CENTER for Mental Health and IDD

X Signed by: Obiageri Pickens
76D92C4BD2D340B...

Compliance Auditor

X Signed by: Rachel Beasley
D7108AF937F640D...

VP of Revenue Cycle & Grants

X Signed by: Lance Britt
BAB06A90B5FE4AC...

VP of Behavioral Health Services

X DocuSigned by: Eva Honeycutt
0D0E701484E5478...

Director - Revenue Management

X DocuSigned by: Jennifer Boswell
7DB69DBAB68D488...

Director - Adult Mental Health Services

X Signed by: Demetria Luckett
B4ED8213F5ED41A...

Compliance Director/Manager

X Signed by: Lisa Walker
3B912FA02715458...

Compliance manager

The HARRIS CENTER for Mental Health and IDD
Transforming Lives

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Adult Mental Health (AMH) Skills Training & Development
Focused Billing & Coding Review
Review Dates: April 9, 2025 – May 06, 2025

I. Audit Type: Focused

II. Purpose: This review was conducted to assist Adult Mental health (AMH) program and Revenue Management division assess Skills Training & Development (ST&D) Service clinical documentation, coding and billing claim practices for compliance with the 2024 Center for Medicare and Medicaid Services (CMS) Regulations and Guidance, the 2024 Current Procedural Terminology (CPT) guidelines, Behavioral Health & Case Management Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 December 2024; the Texas Administrative Code (TEX. ADMIN. CODE) Skills Training & Development Services 1 TEX. ADMIN. CODE §306.319; MH Case Management Medicaid Reimbursement 26 TEX. ADMIN. CODE §306.277; Telemedicine and Telehealth Benefits and Limitations; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361;*HIM.EHR.A.6; Telehealth & Telemedicine Procedure MED.B.6; Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Financial Assessment ACC.A.11, Writing Off Self Pay Balances FM.B.10, Charity Care Procedures FM.B.11, Telehealth & Telemedicine Procedure MED.B.6.*

III. Audit Method:
Active records were randomly selected by generating the *Compliance PB Transaction Report* in the EPIC (EHR) system for persons served during the 3rd Qtr. of FY 2024 (July 1, 2025 – July 31, 2025). Compliance reviewed Thirty six (36) client encounters containing qualified mental health care provider documentation for Adult Skills Training & Development service code H2014. The above-mentioned sample size was obtained on 04/09/2025. This desk review was conducted using the *Compliance Coding & Billing Audit Review Tool. It consisted of 2 (Two) components: Medical Billing & Coding requirements (Operations) and Clinical Documentation requirements (Client records).*

IV. Audit Findings/History:
Overall Audit Score (AMH Program) – 95.4%
Compliance has identified client record discrepancies that include provider documentation deficiencies for the Skills Training & Development services. These include: (1) Missing valid Plan of Care documentation on file specifying the Skills Training & Development service or its frequency, which is required to justify service provision and support coding and billing compliance. (2) Late Documentation: was identified as Service progress notes were submitted beyond the required 42-hours timeframe, failing to meet documentation timeliness standards.

V. Recommendations:
It is recommended that the Vice President (VP) of Mental Health (MH) Division and the VP of Revenue Cycle and Grants review the findings and collaborate with the appropriate personnel to assess and ensure QMHP services are billed, and claims are filed and collected in a timely and accurate manner in accordance with Information in TAC, CPT, CMS guidelines and Agency P&P. Compliance will review provider documentation and coding in the next one hundred eighty (180) days to ensure the program has implemented its plan of improvement (POI) pertaining to documentation integrity and service authorization requirements for AMH Skills Training & Development services. Compliance will continue to provide essential support to the MH Division documentation from a credentialed professional coder. The VP of both MH Division and Revenue and Revenue Management team regarding their documentation of services, including review of clinical Cycle and Grants, must return a signed copy acknowledging receipt of this report to Compliance within three (3) business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Mental Health (MH) Division
Adult Mental Health Program
Skills Training & Development Services Medical Billing & Coding Review

Compliance Auditor(s): Prakash Thomas & Obiageri Pickens

Compliance Review: 04/09/2025-05/06/2025

Purpose

This review was conducted to assist Adult Mental health (AMH) program and Revenue Management division assess Skills Training & Development (ST&D) Service clinical documentation, coding and billing claim practices for compliance with the 2024 Center for Medicare and Medicaid Services (CMS) Regulations and Guidance, the 2024 Current Procedural Terminology (CPT) guidelines, Behavioral Health & Case Management Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 December 2024; the Texas Administrative Code (TEX. ADMIN. CODE) Skills Training & Development Services 1 TEX. ADMIN. CODE §306.319; MH Case Management Medicaid Reimbursement 26 TEX. ADMIN. CODE §306.277; Telemedicine and Telehealth Benefits and Limitations; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361;*HIM.EHR.A.6; Telehealth & Telemedicine Procedure MED.B.6; Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Financial Assessment ACC.A.11, Writing Off Self Pay Balances FM.B.10, Charity Care Procedures FM.B.11, Telehealth & Telemedicine Procedure MED.B.6.*

Method

Active records were randomly selected by generating the *Compliance PB Transaction Report* in the EPIC (EHR) system for persons served during the 3rd Qtr. of FY 2024 (July 1, 2025 – July 31, 2025). Compliance reviewed Thirty (36) client encounters containing qualified mental health care provider documentation for Adult Skills Training & Development service code H2014. The above-mentioned sample size was obtained on 04/09/2025. This desk review was conducted using the *Compliance Coding & Billing Audit Review Tool. It consisted of 2 (Two) components: Medical Billing & Coding requirements (Operations) and Clinical Documentation requirements (Client records).*

The HARRIS CENTER for Mental Health and IDD

Findings

Overall Audit Score (Skills Training and Development) – 95.4%
Detailed findings below:

Strengths:

- **Operations - (98.02%)**
  - Services provided correspond to verified CPT code 100%
    1 TEX. ADMIN. CODE §354.2709
  - Services provided correspond to verified Modifier codes 100%
    CMS Regulations and Guidance, CPT Guidelines
  - Services provided correspond to verified *Add-on codes* 100%
    CMS Regulations and Guidance, CPT Guidelines
  - Claim contains appropriate demographics set as detailed in EMR 100%
    HIM.EHR. B.5
  - Appropriate Payor approved codes documented within claim 100%
    1 TEX. ADMIN. CODE §355.8085
  - Appropriate billing provider details listed within claim 100%
    1 TEX. ADMIN. CODE §355.8085
  - Appropriate billing Units documented 100%
    Agency P&P EM.P.4, LD.A.13
  - Services provided are not billed as Duplicate 100%
    Agency P&P EM.P.4, LD.A.13
  - Services provided are not billed as a Bundle 100%
    Agency P&P EM.P.4, LD.A.13
  - Appropriate and verified Copay amount for billed service 100%
    1 TEX. ADMIN. CODE §355.8085
  - Appropriate and verified original charges on claim 100%
    1 TEX. ADMIN. CODE §355.8085
  - Appropriate and verified Adjustments on claim 100%
    Agency P&P ACC.A.11, FM.B.10, FM.B.11
  - Appropriate and verified Reimbursement collected 100%
    Agency P&P ACC.A.11, FM.B.10, FM.B.11
  - Collections resolution, overpayment verification completed 72.22%
    Agency P&P ACC.A.13

- **Client Records – (92.77%)**
  - Evidence of Incorrect / Overlap / Duplicate Appointment Times 100%
    Agency P&P EM.P.4, LD.A.13
  - Evidence of Copy & Pasting / Cloning within Documentation 100%
    Agency P&P EM.P.4, LD.A.13, HIM.EHR. B.5
  - Evidence of Medically Appropriate History / Assessments 97.2%
    Behavioral Health & Case Management Services Handbook
  - Evidence of Medically Appropriate Examination 100%
    Behavioral Health & Case Management Services Handbook

- Appropriate Total Time-Based Code for service 100%
  1 TEX. ADMIN. CODE §355.8085
- Service Authorization & Medical Necessity from Treatment plan 72.2%
  26 TEX. ADMIN. CODE §301.353
- Documentation of Face to Face / Telehealth (TH) on date of service 100%
  Agency P&P MED.B.6, 1 TEX. ADMIN. CODE §306.369
- Consent documented and received for services and POC by QMHP 100%
  26 Agency P&P HIM.EHR. B.4
- Appropriate person specific Goals documented / Assessment & Plan 100%
  26 TEX. ADMIN. CODE §306.315
- Evidence of timely service completion with approved/certified QMHP 58.3%
  26 TEX. ADMIN. CODE §301.361

Detail Findings:

Compliance has identified client record discrepancies that include provider documentation deficiencies for the Skills Training & Development services. These include:

- Missing valid Plan of Care documentation: No plan of care was on file specifying the ST&D service or its frequency, which is required to justify service provision (Medical Necessity) and support coding and billing compliance.
- Based on the above finding, Compliance has identified the need to establish a clear line of communication between the program and the revenue management team. This will help mitigate the billing of unauthorized services and reduce the need for future claims reconciliation.
- Late Documentation: Service progress notes were submitted beyond the required 42-hours timeframe, failing to meet documentation timeliness standards.

Observations

Providers have documented verbal consent in multiple encounters instead of obtaining written (wet) signatures, which are required for Skills Training & Development services. However, current program expectations mandate a written (wet) signature to confirm consent. Obtaining written consent is the standard practice to ensure clear authorization and minimize risk.

Recommendations

It is recommended that the Vice President (VP) of Mental Health (MH) Division and the VP of Revenue Cycle and Grants review the findings and collaborate with the appropriate personnel to assess and ensure QMHP services are billed, and claims are filed and collected in a timely and accurate manner in accordance with Information in TAC, CPT, CMS guidelines and Agency P&P. Compliance will review provider documentation and coding in the next one hundred eighty (180) days to ensure the program has implemented its plan of improvement (POI) pertaining to documentation integrity and service authorization requirements for AMH Skills Training & Development services. Compliance will continue to provide essential support to the MH Division and Revenue Management team regarding their documentation of services, including review of clinical documentation from a credentialed professional coder. The VP of both MH Division and Revenue Cycle and Grants must return a signed copy acknowledging receipt of this report to Compliance within three (3) business days.

Management Response

.

Revenue Management is in process of setting up a Medical Coding department who will be reviewing charges prior to claim submission.

The HARRIS CENTER for Mental Health and IDD

X Signed by: Obiageri Pickens
76D92C4BD2D340B...

Compliance Auditor

X Signed by: Prakash Thomas
C33696334A5647E...

Compliance Auditor

X Signed by: Rachel Beasley
D7108AF937F640D...

VP of Revenue Cycle & Grants

X Signed by: Lance Britt
BAB66A90B5FE4AC...

VP of Behavioral Health Services

X DocuSigned by: Eva Honeycutt
9B9E7614484E5478...

Director - Revenue Management

X DocuSigned by: Jennifer Boswell
7DB69DBAB68D466...

Director - Adult Mental Health Services

The HARRIS CENTER for Mental Health and IDD

X Signed by: Demetria Luckett B4ED8213F5ED41A...

Compliance Director/Manager

X Signed by: Lisa Walker 3B912FA02715458...

Compliance Manager

The Harris Center for Mental Health and IDD
Transforming Lives

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Substance Use Detoxification (DETOX) Recovery Services Program
Adult Withdrawal Management Service Focused Coding Review
Review Dates: April 29, 2025 – May 19, 2025

I. Audit Type: Focused

II. Purpose:
This review was conducted to assist the Substance use Detoxification (DETOX) Recovery Services program assess client records and documentation related to Adult Withdrawal Management services for compliance with the 2024 Center for Medicare and Medicaid Services (CMS) Regulations and Guidance, the 2024 Current Procedural Terminology (CPT) guidelines, 2024 American Medical Association (AMA) E/M Service Guidelines, Behavioral Health & Case Management Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 December 2024; the Texas Administrative Code (TEX. ADMIN. CODE) Skills Training & Development Services 1 TEX. ADMIN. CODE §306.319; MH Case Management Medicaid Reimbursement 26 TEX. ADMIN. CODE §306.277; Telemedicine and Telehealth Benefits and Limitations; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.359; *Correcting Documentation and Coding Errors HIM.EHR.A.6; Telehealth & Telemedicine Procedure MED.B.6; Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Telehealth & Telemedicine Procedure MED.B.6*

III. Audit Method:
Active records were randomly selected by generating the Compliance C&B Transaction Search Report in the EPIC (EHR) system for persons served during the 2nd & 3rd Qtr. of FY 2025 (February 1, 2025 – March 31, 2025). Compliance reviewed Forty (40) client encounters containing qualified mental health care provider documentation for various intake and follow up medical management service lines (90792, 99213-99215) Above mentioned sample size was obtained on 04/29/2025. This desk review was conducted using the Compliance Coding & Billing Audit Review Tool. Current audit review consists of one main domain: Clinical Documentation requirements (Client records).

IV. Audit Findings/History:
Overall Audit Score (DETOX Program) – 99.00%
Compliance has identified discrepancies in client records, including missing and/or inaccurate provider documentation for crisis services delivered through the DETOX program. These include: (1) As per CMS regulations and AMA E/M (Evaluation & Management) guidelines, Compliance identified service encounters with inaccurate primary codes based on "Medical Decision Making" (MDM) selection criteria for follow-up E/M services. (2) Compliance identified inaccurate primary codes for service due to evidence of duplicate intake assessment for the same date of service.

V. Recommendations:
Compliance will review provider documentation and coding in the next one hundred eighty (180) days to ensure the program has implemented its plan of improvement (POI) pertaining to appropriate primary coding of medical services for DETOX program service lines.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Crisis Services Division
Substance Use Detoxification (DETOX) Recovery Services Program
Adult Withdrawal Management Service Coding Review

Compliance Auditor(s): Prakash Thomas

Compliance Review: 04/29/2025 – 05/19/2025

Purpose

This review was conducted to assist the Substance use Detoxification (DETOX) Recovery Services program assess client records and documentation related to Adult Withdrawal Management services for compliance with the 2024 Center for Medicare and Medicaid Services (CMS) Regulations and Guidance, the 2024 Current Procedural Terminology (CPT) guidelines, 2024 American Medical Association (AMA) E/M Service Guidelines, Behavioral Health & Case Management Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 December 2024; the Texas Administrative Code (TEX. ADMIN. CODE) Skills Training & Development Services 1 TEX. ADMIN. CODE §306.319; MH Case Management Medicaid Reimbursement 26 TEX. ADMIN. CODE §306.277; Telemedicine and Telehealth Benefits and Limitations; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.359; *Correcting Documentation and Coding Errors HIM.EHR.A.6; Telehealth & Telemedicine Procedure MED.B.6; Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Telehealth & Telemedicine Procedure MED.B.6.*

Method

Active records were randomly selected by generating the *Compliance C&B Transaction Search Report* in the EPIC (EHR) system for persons served during the 2nd & 3rd Qtr. of FY 2025 (February 1, 2025 – March 31, 2025). Compliance reviewed Forty (40) client encounters containing qualified mental health care provider documentation for various intake and follow up medical management service lines (90792, 99213-99215) Above mentioned sample size was obtained on 04/29/2025. This desk review was conducted using the *Compliance Coding & Billing Audit Review Tool. Current audit review consists of one main domain: Clinical Documentation requirements (Client records).*

The HARRIS CENTER for Mental Health and IDD

Findings

Overall Audit Score (DETOX Program) – 99.00%
Detailed findings below:

Strengths:

- **Client Records – (99.00%)**
  - Evidence of Incorrect / Overlap / Duplicate Appointment Times 100%
    Agency P&P EM.P.4, LD.A.13
  - Evidence of Copy & Pasting / Cloning within Documentation 100%
    Agency P&P EM.P.4, LD.A.13, HIM.EHR.B.5
  - Evidence of Medically Appropriate History / Assessments (MAH) 100%
    Behavioral Health & Case Management Services Handbook
  - Evidence of Medically Appropriate Examination (MAE) 100%
    Behavioral Health & Case Management Services Handbook
  - Appropriate Total Time-based code for service 100%
    1 TEX. ADMIN. CODE §301.353
  - Appropriate Medical-Decision-Making (MDM) code for service 95%
    26 TEX. ADMIN. CODE §301.353, AMA E/M Guidelines
  - Documentation of Face to Face / Telehealth (TH) on date of service 100%
    Agency P&P MED.B.6, 1 TEX. ADMIN. CODE §306.369
  - Consent documented and received for services and POC by QMHP 100%
    Agency P&P HIM.EHR.B.4
  - Appropriate services documented/billed as per Assessment & Plan 95%
    Agency P&P HIM.EHR.B.4, 2024 CPT Guidelines
  - Evidence of timely service completion with approved/certified QMHP 100%
    26 TEX. ADMIN. CODE §301.361

Detail Findings:

Compliance has identified discrepancies in client records, including missing and/or inaccurate provider documentation for crisis services delivered through the DETOX program. These include:

- As per CMS regulations and AMA E/M (Evaluation & Management) guidelines, Compliance identified service encounters (2) with inaccurate primary codes based on "Medical Decision Making" (MDM) selection criteria for follow-up E/M services. (95%)
- Compliance identified inaccurate primary codes for service (2) due to evidence of duplicate intake assessment for the same date of service. (95%)

The HARRIS CENTER for Mental Health and IDD

Recommendations

It is recommended that the Vice President (VP) of Crisis Medical Services Division review the findings and collaborate with the appropriate personnel to assess and ensure QMHP services are billed (when applicable) and claims are filed and collected in a timely and accurate manner in accordance with Information in TAC, CPT, AMA, CMS guidelines and Agency P&P. Compliance will review provider documentation and coding in the next one hundred eighty (180) days to ensure the program has implemented its plan of improvement (POI) pertaining to appropriate primary coding of medical services for DETOX program service lines. Compliance will continue to provide essential support to the Crisis Services Division regarding their documentation of services, including review of clinical documentation from a credentialed professional coder. The VP of Crisis Medical Services Division must return a signed copy acknowledging receipt of this report to Compliance within three (3) business days.

Management Response

Management acknowledges the findings and is in agreeance. Management thanks Compliance for their diligence and support throughout the review process. It's imperative to note that the DETOX program ended effective March 2025

The HARRIS CENTER for Mental Health and IDD

X Signed by: Prakash Thomas C33696334A5647E...

Compliance Auditor

X DocuSigned by: Vinay Kapoor 4E068B35992348C...

VP of Crisis Medical Service

X Signed by: Byanca Hernandez BCE3DE376D9242B...

Program Manager / Director

X Signed by: Lisa Walker 3B912FA02715458...

Compliance Manager

X Signed by: Demetria Luckett B4ED8213F5ED41A...

Compliance Director

The Harris Center for Mental Health and IDD
Transforming Lives

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Peers Support Services Program
Family Partner Support Services Focused Coding Review
Review Dates: April 16, 2025 – April 29, 2025

I. Audit Type: Focused

II. Purpose:
This review was conducted to assist the Peers Services program assess client records and documentation related to Family Partner Support services for compliance with the 2024 Center for Medicare and Medicaid Services (CMS) Regulations and Guidance, the 2024 Current Procedural Terminology (CPT) guidelines, 2024 American Medical Association (AMA) E/M Service Guidelines, Behavioral Health & Case Management Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 December 2024; the Texas Administrative Code (TEX. ADMIN. CODE) Skills Training & Development Services 1 TEX. ADMIN. CODE §306.319; MH Case Management Medicaid Reimbursement 26 TEX. ADMIN. CODE §306.277; Telemedicine and Telehealth Benefits and Limitations; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.359; *Correcting Documentation and Coding Errors HIM.EHR.A.6; Telehealth & Telemedicine Procedure MED.B.6; Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Telehealth & Telemedicine Procedure MED.B.6.*

III. Audit Method:
Active records were randomly selected by generating the Compliance C&B Transaction Search Report in the EPIC (EHR) system for persons served during the 3rd Qtr. of FY 2025 (March 1, 2025 – March 31, 2025). Compliance reviewed Forty (40) client encounters containing certified family partner (CFP) documentation for caregiver support services related to CFP procedural code S9482. Above mentioned sample size was obtained on 04/16/2025. This desk review was conducted using the Compliance Coding & Billing Audit Review Tool. Current audit review consists of one main domain: Clinical Documentation requirements (Client records).

IV. Audit Findings/History:
Overall Audit Score (Family Partner Support Services) – 88.86%
Compliance has identified discrepancies in client records, including missing and/or inaccurate provider documentation for crisis services delivered through the Family Partner Support service line. These include: (1) All reviewed encounters showed evidence of missing, incomplete, or inaccurate CANS assessment summaries within the client's CFP note. (2) Compliance identified CFP encounters with incorrect or overlapping appointment times. (3) Compliance identified CFP encounters with missing and/or invalid Plan of Care (POC) documentation.

V. Recommendations:
Compliance will review provider documentation and coding in the next one hundred eighty (180) days to ensure the program has implemented its plan of improvement (POI) pertaining to appropriate clinical documentation and primary coding of CFP services.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Crisis Services (CPEP) Division
Peers Support Services Program – Family Partner Support Service
Focused Coding Review

Compliance Auditor(s): Prakash Thomas

Compliance Review: 04/16/2025 – 04/29/2025

Purpose

This review was conducted to assist the Peers Services program assess client records and documentation related to Family Partner Support services for compliance with the 2024 Center for Medicare and Medicaid Services (CMS) Regulations and Guidance, the 2024 Current Procedural Terminology (CPT) guidelines, 2024 American Medical Association (AMA) E/M Service Guidelines, Behavioral Health & Case Management Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 December 2024; the Texas Administrative Code (TEX. ADMIN. CODE) Skills Training & Development Services 1 TEX. ADMIN. CODE §306.319; MH Case Management Medicaid Reimbursement 26 TEX. ADMIN. CODE §306.277; Telemedicine and Telehealth Benefits and Limitations; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.359; *Correcting Documentation and Coding Errors HIM.EHR.A.6; Telehealth & Telemedicine Procedure MED.B.6; Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Telehealth & Telemedicine Procedure MED.B.6.*

Method

Active records were randomly selected by generating the *Compliance C&B Transaction Search Report* in the EPIC (EHR) system for persons served during the 3rd Qtr. of FY 2025 (March 1, 2025 – March 31, 2025). Compliance reviewed Forty (40) client encounters containing certified family partner (CFP) documentation for caregiver support services related to CFP procedural code S9482. Above mentioned sample size was obtained on 04/16/2025. This desk review was conducted using the *Compliance Coding & Billing Audit Review Tool. Current audit review consists of one main domain: Clinical Documentation requirements (Client records).*

The HARRIS CENTER for Mental Health and IDD

Findings

Overall Audit Score (Family Partner Support services – 88.86%)
Detailed findings below:

Strengths:

- **Client Records – (88.86%)**
  - Evidence of Incorrect / Overlap / Duplicate Appointment Times 92.5%
    Agency P&P EM.P.4, LD.A.13
  - Evidence of Copy & Pasting / Cloning within Documentation 100%
    Agency P&P EM.P.4, LD.A.13, HIM.EHR.B.5
  - Evidence of Medically Appropriate History / Assessments (MAH) 0%
    Behavioral Health & Case Management Services Handbook
  - Evidence of Medically Appropriate Examination (MAE) 97.5%
    Behavioral Health & Case Management Services Handbook
  - Appropriate Total Time-based code for service 97.5%
    1 TEX. ADMIN. CODE §301.353
  - Appropriate Medical-Decision-Making (MDM) code for service 100%
    26 TEX. ADMIN. CODE §301.353, AMA E/M Guidelines
  - Documentation of Face to Face / Telehealth (TH) on date of service 100%
    Agency P&P MED.B.6, 1 TEX. ADMIN. CODE §306.369
  - Consent documented and received for services and POC by QMHP 95%
    Agency P&P HIM.EHR.B.4
  - Appropriate services documented/billed as per Assessment & Plan 97.5%
    Agency P&P HIM.EHR.B.4, 2024 CPT Guidelines
  - Evidence of timely service completion with approved/certified QMHP 100%
    26 TEX. ADMIN. CODE §301.361
  - Evidence of completed training / background checks / certifications 97.5%
    Agency P&P HR.B.14

Detail Findings:

Compliance has identified discrepancies in client records, including missing and/or inaccurate provider documentation for crisis services delivered through the Family Partner Support service line. These include:

- All reviewed encounters (40) showed evidence of missing, incomplete, or inaccurate CANS assessment summaries within the client's CFP note. (0%)
- Compliance identified CFP encounters (3) with incorrect or overlapping appointment times. (95%)
- Compliance identified CFP encounters (2) with missing and/or invalid Plan of Care (POC) documentation (95%)

The HARRIS CENTER for Mental Health and IDD

Recommendations

It is recommended that the Vice President (VP) of Crisis Services (CPEP) Division review the findings and collaborate with the appropriate personnel to assess and ensure Family Partner services are billed (when applicable) and claims are filed and collected in a timely and accurate manner in accordance with Information in TAC, CPT, AMA, CMS guidelines and Agency P&P. Compliance will review provider documentation and coding in the next one hundred eighty (180) days to ensure the program has implemented its plan of improvement (POI) pertaining to appropriate clinical documentation and primary coding of CFP services. Compliance will continue to provide essential support to the Crisis Services Division regarding their documentation of services, including review of clinical documentation from a credentialed professional coder. The VP of Crisis Services (CPEP) Division must return a signed copy acknowledging receipt of this report to Compliance within three (3) business days.

Management Response

Peer Support Services Management Team will educate and follow-up with the Family Partners regarding the timeliness of documentation submission, accuracy of the session documentation, and review the Plan of Care and CANS assessment domains to ensure accuracy and connectivity with individual sessions. The Peer Support Services Management will assist with appropriate, accurate, and concise billing of services provided to clients.

The HARRIS CENTER for Mental Health and IDD

X Signed by: Prakash Thomas C33696334A5647E...

Compliance Auditor

X Signed by: kim kornmayer 705073BD206644E...

VP of Crisis Service CPEP

X Signed by: Pansy Wade 7F33ABDCE400423...

Program Manager / Director

X Signed by: Lisa Walker 3B912FA02715458...

Compliance Manager

X Signed by: Demetria Luckett B4ED8213F5ED41A...

Compliance Director

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI Jr) Program
Focused Coding Review
Review Dates: May 19, 2025 – May 27, 2025

I. Audit Type: Focused

II. Purpose:
This review was conducted to assist the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOMMI Jr.) program assess client records and documentation related to Telehealth and Telemedicine practices for compliance with the 2024 Center for Medicare and Medicaid Services (CMS) Regulations and Guidance, the 2024 Current Procedural Terminology (CPT) guidelines, Telecommunication Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 January 2024, Behavioral Health & Case Management Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 December 2024; the Texas Administrative Code (TEX. ADMIN. CODE) Skills Training & Development Services 1 TEX. ADMIN. CODE §306.319; MH Case Management Medicaid Reimbursement 26 TEX. ADMIN. CODE §306.277; Telemedicine and Telehealth Benefits and Limitations; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.359; *Correcting Documentation and Coding Errors HIM.EHR.A.6; Telehealth & Telemedicine Procedure MED.B.6; Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Telehealth & Telemedicine Procedure MED.B.6.*

III. Audit Method:
Active records were randomly selected by generating the *Compliance C&B Transaction Search Report* in the EPIC (EHR) system for persons served during the 4th Qtr. of FY 2025 (March 1, 2025 – March 31, 2025). Compliance reviewed Fifty (50) client encounters containing qualified mental health care provider documentation for various service lines (H2014, T1017, 99213-99215) that utilized Telehealth and Telemedicine equipment and documentation. Above mentioned sample size was obtained on 05/12/2025. This desk review was conducted using the *Compliance Coding & Billing Audit Review Tool. Current audit review consists of one main domain: Clinical Documentation requirements (Client records).*

IV. Audit Findings/History:
Overall Audit Score (TCOOMMI Jr. Program) – 98.60%
Compliance has identified discrepancies in client records, including missing and/or inaccurate provider documentation for forensic services delivered via Telehealth and Telemedicine. These include: (1) Service documentation and coding indicate certain services were provided via telephone interview while clinical notes were found to be incongruent containing statements that would indicate an in-person encounter (2) One service note was documented to be an electronic visit (contact Type “E”) but was also documented to be completed with client and LAR at client’s home.

V. Recommendations:
Compliance will review provider documentation and coding in the next one hundred eighty (180) days to ensure the program has implemented its plan of improvement (POI) pertaining to documentation integrity of telehealth / telemedicine services for Forensic program service lines

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Forensic Services Division
Texas Correctional Office on Offenders with
Medical or Mental Impairments (TCOOMMI Jr) Program
Telehealth & Telemedicine Coding Review

Compliance Auditor(s): Prakash Thomas

Compliance Review: 05/19/2025 – 05/27/2027

Purpose

This review was conducted to assist the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOMMI Jr.) program assess client records and documentation related to Telehealth and Telemedicine practices for compliance with the 2024 Center for Medicare and Medicaid Services (CMS) Regulations and Guidance, the 2024 Current Procedural Terminology (CPT) guidelines, Telecommunication Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 January 2024, Behavioral Health & Case Management Services Handbook - Texas Medicaid Provider Procedures Manual: Vol. 2 December 2024; the Texas Administrative Code (TEX. ADMIN. CODE) Skills Training & Development Services 1 TEX. ADMIN. CODE §306.319; MH Case Management Medicaid Reimbursement 26 TEX. ADMIN. CODE §306.277; Telemedicine and Telehealth Benefits and Limitations; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.359; *Correcting Documentation and Coding Errors HIM.EHR.A.6; Telehealth & Telemedicine Procedure MED.B.6; Corporate Compliance Documentation and Claims Integrity Plan EM.P.4, Code of Ethics LD.A.13, State Service Contract Monitoring and Performance Reporting ACC.A.13, Telehealth & Telemedicine Procedure MED.B.6.*

Method

Active records were randomly selected by generating the *Compliance C&B Transaction Search Report* in the EPIC (EHR) system for persons served during the 3rd Qtr. of FY 2025 (March 1, 2025 – March 31, 2025). Compliance reviewed Fifty (50) client encounters containing qualified mental health care provider documentation for various service lines (H2014, T1017, 99213-99215) that utilized Telehealth and Telemedicine equipment and documentation. Above mentioned sample size was obtained on 05/12/2025. This desk review was conducted using the *Compliance Coding & Billing Audit Review Tool. Current audit review consists of one main domain: Clinical Documentation requirements (Client records).*

The HARRIS CENTER for Mental Health and IDD

Findings

Overall Audit Score (TCOOMMI Jr. Program) – 98.60%
Detailed findings below:

Strengths:

- **Client Records – (98.60%)**
  - Evidence of Incorrect / Overlap / Duplicate Appointment Times 100%
    Agency P&P EM.P.4, LD.A.13
  - Evidence of Copy & Pasting / Cloning within Documentation 100%
    Agency P&P EM.P.4, LD.A.13, HIM.EHR.B.5
  - Evidence of Medically Appropriate History / Assessments (MAH) 100%
    Behavioral Health & Case Management Services Handbook
  - Evidence of Medically Appropriate Examination (MAE) 88%
    Behavioral Health & Case Management Services Handbook
  - Appropriate Telehealth Modifier / Code for service 100%
    1 TEX. ADMIN. CODE §301.359
  - Service Authorization & Medical Necessity from Treatment plan 100%
    26 TEX. ADMIN. CODE §301.353
  - Documentation of Face to Face / Telehealth (TH) on date of service 98%
    Agency P&P MED.B.6, 1 TEX. ADMIN. CODE §306.369
  - Consent documented and received for services and POC by QMHP 100%
    26 Agency P&P HIM.EHR.B.4
  - Appropriate person specific Goals documented / Assessment & Plan 100%
    26 TEX. ADMIN. CODE §306.315
  - Evidence of timely service completion with approved/certified QMHP 100%
    26 TEX. ADMIN. CODE §301.361

Detail Findings:

Compliance has identified discrepancies in client records, including missing and/or inaccurate provider documentation for forensic services delivered via Telehealth and Telemedicine. These include:

- Service documentation and coding indicate certain services were provided via telephone interview. Both Contact Type "T" for telephone use and telephone modifiers "FQ" were linked to note within client's EHR. Based on the above finding, clinical notes were found to be incongruent (MAE score of 88%) containing statements that would indicate an in-person encounter.
- One service note was documented to be an electronic visit (contact Type "E") but was also documented to be completed with client and LAR at client's home. (98%)

Observations

- Compliance identified one encounter that was miscoded for the primary service rendered. This finding, however, is outside the scope of current audit review.

Recommendations

It is recommended that the Vice President (VP) of Forensic Services Division review the findings and collaborate with the appropriate personnel to assess and ensure QMHP services are billed (when applicable) and claims are filed and collected in a timely and accurate manner in accordance with Information in TAC, CPT, CMS guidelines and Agency P&P. Compliance will review provider documentation and coding in the next one hundred eighty (180) days to ensure the program has implemented its plan of improvement (POI) pertaining to documentation integrity of telehealth/telemedicine services for Forensic program service lines. Compliance will continue to provide essential support to the Forensic Services Division regarding their documentation of services, including review of clinical documentation from a credentialed professional coder. The VP of Forensic Services Division must return a signed copy acknowledging receipt of this report to Compliance within three (3) business days.

Management Response

The HARRIS CENTER for Mental Health and IDD

X Signed by: Prakash Thomas C33696334A5647E...

Compliance Auditor

X Signed by: Jasper York B9DFE4D8B9AC436...

Assistant Program Manager

X DocuSigned by: MONIQUE JILES CBB9E31912AD4EE...

VP of Forensic Divsion

X Signed by: Anselm Khoo F9751FBC854C4C9...

Program Manager / Director

X Signed by: Lisa Walker 3B912EA02715458...

Compliance Manager

X

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
2nd Quarter (Qtr.) of Fiscal Year (FY) 2025
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
Clinician Officer Remote Evaluation (CORE)
Comprehensive Review
Review Date: April 29, 2025, to May 22, 2025

I. Audit Type:
Comprehensive Review.

II. Purpose:
The purpose of this review was to assess Rapid Response Operation Guidelines, Medical Requirements, Environmental Requirements, Personnel Requirements, and Clinical Record Requirements for compliance with Texas Administrative Code (TEX. ADMIN. CODE) *26 §301.355 Utilization Management, TEX. ADMIN. CODE 26 §320.75 Monitoring Compliance with Policies and Procedures, TEX. ADMIN. CODE 26 §301.323 Environment of Care and Safety, TEX. ADMIN. CODE 26 §301.359 Telemedicine Services, TEX. ADMIN. CODE 26 §301.351 Crisis Services, TEX. ADMIN. CODE 26 §301.329 Medical Records System, TEX. ADMIN. CODE 25 §320.25 Communication of Rights to Individuals Receiving Mental Health Services, TEX. ADMIN. CODE 25 §320.59 Documentation of Informed Consent, TEX. ADMIN. CODE 25 §320.113 Staff Member Training, CORE Organizational Guidelines, and The Harris Center Policy and Procedure MED.B.6 Telehealth and Telemedicine Procedure.*

III. Audit Method:
Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for person's served during the 2nd Qtr. of FY 2025 (December 1, 2024, to February 28, 2025), and the *Organizational Development Staff Training Roster Report*. Compliance conducted a desk review, sampling Fifteen (15) consumer records and twelve (12) personnel records using a modified version of the STATE Review Tool. Detailed data for this review is presented below.

IV. Audit Findings and History:
Overall Program Score: 96%
Detailed finding(s) is presented below.
The program's strength was Operation Requirements 100%, Medical Requirements 100%, Personnel Requirements 87%, and Clinical Record Requirements 97%

The program has elements within the Personnel Requirements and the Clinical Record Requirements that fail below the threshold score of 95% which requires a POI: Staff job duties that involve direct care responsibilities must be current with annual trainings *TAC 320.29 (1) (3) 33%,* Before providing a telehealth or a telemedicine service, the person served will be oriented to the process and will be asked to consent to the service *THC P&P MED,MH. B.1 and CORE Operational Guidelines 93%,* The individual and the provider will work together to develop an effective individualized safety plan *THC P&P MED.MH. B.1 27%.*

History

A comprehensive audit was conducted 3rd Qtr. FY 2020, and a POI follow up was conducted 4th Qtr. 2022.

V. Recommendations:
Compliance recommends that the CORE program review the findings and continue to assess its processes to ensure all required standards are completed in accordance with *TEX. ADMIN. CODE Staff Member Training Requirements, THC P&P and CORE Organizational Guidelines Completion of an Individualized Safety Plan and Obtaining Telehealth and Telemedicine Consent.* The CORE program is required to submit a Plan of Improvement (POI) focusing on the elements in Personnel Requirements and the Clinical Record Requirements. The Vice President (VP) of CPEP Division and the Program Manager/Director must sign and return the report with management response along with the POI to Compliance within seven business days.

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Comprehensive Psychiatric Emergency Program (CPEP) Division
Clinician Officer Remote Evaluation (CORE)
Comprehensive Review

Compliance Auditor(s): Marvin Williams

Review Date: April 29, 2025, to May 22, 2025

Purpose

The purpose of this review was to assess Clinician Officer Remote Evaluation (CORE) Operation Guidelines, Medical Requirements, Environmental Requirements, Personnel Requirements, and Clinical Record Requirements for compliance with Texas Administrative Code (TEX. ADMIN. CODE) *26 §301.355 Utilization Management, TEX. ADMIN. CODE 26 §320.75 Monitoring Compliance with Policies and Procedures, TEX. ADMIN. CODE 26 §301.323 Environment of Care and Safety, TEX. ADMIN. CODE 26 §301.359 Telemedicine Services, TEX. ADMIN. CODE 26 §301.351 Crisis Services, TEX. ADMIN. CODE 26 §301.329 Medical Records System, TEX. ADMIN. CODE 25 §320.25 Communication of Rights to Individuals Receiving Mental Health Services, TEX. ADMIN. CODE 25 §320.59 Documentation of Informed Consent, TEX. ADMIN. CODE 25 §320.113 Staff Member Training, CORE Organizational Guidelines, and The Harris Center Policy and Procedure MED.B.6 Telehealth and Telemedicine Procedure.*

Method

Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for person's served during the 2nd Qtr. of FY 2025 (December 1, 2024, to February 28, 2025), and the *Organizational Development Staff Training Roster Report*. Compliance conducted a desk review, sampling Fifteen (15) consumer records and twelve (12) personnel records using a modified version of the STATE Review Tool. Detailed data for this review is presented below.

Findings

Overall Program Score: 96%
Detailed findings are presented below.

Strengths:

- Operation Requirements (*Health and Safety Code, Title 7 Subtitle A §534.006 (a)(1), §534.010 (b) (1-2), §534.014 (a) (1-3), TEX. ADMIN. CODE 26 §301.335 (a) (1-6).* **100%**
- Medical Requirements *TEX. ADMIN. CODE 25 §414.413(a)(b) (1-3), §415.5) (i) (1-4) (2), §415.10 (a) (1-3), §415.5(i) (1-4), TEX. ADMIN. CODE 26 §301.355 (b) (1-2) (A-H), (5)(6) (A-H)* **100%**
- Clinical Requirements *HHSC TEX. ADMIN. CODE 26 §301.353 (e), (e) (2) (D), (e) (2) (e), TEX. ADMIN. CODE 26 §301.361 (b), THC P&P MED.MH. B.1* **97%**

Areas of Improvement:

Below are the elements within the Personnel and Clinical Record Requirements that fall below the threshold score of 95%.

- Personnel Requirements *TEX. ADMIN. CODE 25 §404.165(1) (3), §415.257(c) (2), TEX. ADMIN. CODE 26 §301.331 (h) (1-4).* **87%**
    - Staff job duties that involve direct care responsibilities must be current with annual training(s), *TEX. ADMIN. CODE 26 §320.29 (1) (3) 33%.*
- Clinical Record Elements
    - Before providing a telemedicine or a telehealth service, the person served will be oriented to the process and will be asked to consent to the service. *CORE Organizational Guidelines and THC P&P MED.MH. B.1 93%.*
    - The individual and the provider will work together to develop an effective individualized safety plan. *THC P&P MED.MH. B.1 27%.*

History

A comprehensive audit was conducted 3rd Qtr. FY 2020, and a POI follow-up was conducted 4th Qtr. FY 2022.

Recommendations

Compliance recommends that the CORE program review the findings and continue to assess its processes to ensure all required standards are completed in accordance with *TEX. ADMIN. CODE Staff Member Training Requirements, THC P&P and CORE Organizational Guidelines Completion of an Individualized Safety Plan and Obtaining Telehealth and Telemedicine Consent.* The CORE program is required to submit a Plan of Improvement (POI) focusing on the elements in Personnel Requirements and the Clinical Record Requirements. The Vice President (VP) of CPEP Division and the Program Manager/Director must sign and return the report with management response along with the POI to Compliance by the close of business on June 13, 2025.

Management Response

With the newer Absorb training, CORE CTLs have been working with Education and Development to determine correct due dates for CORE team members trainings, and this has been ongoing for a few months now. CTLs will continue to confirm when trainings are due and monitor Absorb to assist team members as they get up to date with CPR/Handle with Care II. Team members have been informed to complete the Understanding CLAS, Cultural Competency and Cultural Humility.

CORE team members when taking CORE calls from law enforcement officers do get consent to treatment to have CORE assessments via telehealth. CORE team members also serve as backup to MCOT and assist the crisis line where patient call in themselves voluntarily and are connected to CORE. Consent not required for these connections.

Program Director is currently working with IT to update CORE progress note to include a section for Safety Planning on the progress note and currently scheduled to go into testing. Go live expected in Epic 6-13-2025. Team members have also been provided educational materials on completing the Stanley Brown Safety Plan. Currently as of 5-29-2025, team members have been instructed to manually type in a Safety Plan section and add Safety Planning information discussed with the patient.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Marvin Williams
98E4DFCC55AF49A...

Regulatory Compliance Auditor

X Signed by: Keisha Lorio
D1D0B4878D9E451...

Program Manager / Director

X Signed by: Kim Kornmeyer
705073BD206644F...

Vice President of CPEP Division

X Signed by: Lisa Walker
3B912EA02715458...

Compliance Manager

X Signed by: Demetria Luckett
B4ED8213F5ED41A...

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
2nd Quarter (Qtr.) of Fiscal Year (FY) 2025
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
Rapid Response
Comprehensive Review
Review Date: April 21, 2025, to May 5, 2025

I. Audit Type:
Comprehensive Review.

II. Purpose:
The purpose of this review was to assess Rapid Response Operation Guidelines, Medical Requirements, Environmental Requirements, Personnel Requirements, and Clinical Record Requirements for compliance with Texas Administrative Code (TEX. ADMIN. CODE) *26 §301.355 Utilization Management, TEX. ADMIN. CODE 26 §320.75 Monitoring Compliance with Policies and Procedures, TEX. ADMIN. CODE 26 §301.323 Environment of Care and Safety, TEX. ADMIN. CODE 26 §301.359 Telemedicine Services, TEX. ADMIN. CODE 26 §301.351 Crisis Services, TEX. ADMIN. CODE 26 §301.329 Medical Records System, TEX. ADMIN. CODE 25 §320.25 Communication of Rights to Individuals Receiving Mental Health Services, TEX. ADMIN. CODE 25 §320.59 Documentation of Informed Consent, TEX. ADMIN. CODE 25 §320.113 Staff Member Training, Interlocal Subrecipient Agreement between The City of Houston and The Harris Center for Mental Health and Intellectual Development Disabilities (IDD) (THC), and THC Policy and Procedure HIM.EHR.B.9 Patient/Individual Records Administration.*

III. Audit Method:
Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for person's served during the 2nd Qtr. of FY 2025 (December 1, 2024, to February 28, 2025), and the *Organizational Development Staff Training Roster Report*. Compliance conducted a desk review, sampling Fifteen (15) consumer records and ten (10) personnel records using a modified version of the STATE Review Tool. Detailed data for this review is presented below.

IV. Audit Findings and History:
Overall Program Score: 99%
Detailed finding(s) is presented below.
The program's strength was Operation Requirements 100%, Medical Requirements 100%, Environmental Requirements 100%, and Clinical Record Requirements 99%

The program has elements within the Personnel Requirements and the Clinical Record Requirements that fail below the threshold score of 95% which requires a POI: Staff must be current with the training identifying the causes of aggressive or threatening behaviors of individuals who need mental health services *TAC 320.29 (1) (3) 80%,* All employees shall receive instruction for maintaining annual rights training *TAC §320.113 (b) (1-2) (c) (2) 40%,* Service encounter documentation provided away from the program location will be entered into the record within seventy-two (72) hours *THC P&P HIM.EHR. B.9 93%,* A sign and dated form that states the person served has been informed of their rights and has received a client rights handbook *TEX. ADMIN. CODE 26 §*404.163 (a) (b) 40%, and the individual and the provider will work together to develop an effective individualized safety plan *THC P&P MED.MH. B.1 86%.*

History

No previous review of this type has been conducted.

V. Recommendations:
Compliance recommends that the Rapid Response program review the findings and continue to assess its processes to ensure all required standards are completed in accordance with *TEX. ADMIN. CODE Staff Member Training Requirements, Communication of Rights to Individuals Receiving Mental Health Services, and THC P&P Suicide/Violence Behavioral Crisis Intervention.* The Rapid Response program is required to submit a Plan of Improvement (POI) focusing on the elements in Personnel Requirements and the Clinical Record Requirements. The Vice President (VP) of CPEP Division and the Program Manager/Director must sign and return the report with management response along with the POI to Compliance with seven business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2025
Comprehensive Psychiatric Emergency Program (CPEP) Division
Rapid Response
Comprehensive Review

Compliance Auditor(s): Marvin Williams

Review Date: April 21, 2025, to May 5, 2025

Purpose

The purpose of this review was to assess Rapid Response Operation Guidelines, Medical Requirements, Environmental Requirements, Personnel Requirements, and Clinical Record Requirements for compliance with Texas Administrative Code (TEX. ADMIN. CODE) *26 §301.355 Utilization Management, TEX. ADMIN. CODE 26 §320.75 Monitoring Compliance with Policies and Procedures, TEX. ADMIN. CODE 26 §301.323 Environment of Care and Safety, TEX. ADMIN. CODE 26 §301.359 Telemedicine Services, TEX. ADMIN. CODE 26 §301.351 Crisis Services, TEX. ADMIN. CODE 26 §301.329 Medical Records System, TEX. ADMIN. CODE 25 §320.25 Communication of Rights to Individuals Receiving Mental Health Services, TEX. ADMIN. CODE 25 §320.59 Documentation of Informed Consent, TEX. ADMIN. CODE 25 §320.113 Staff Member Training, Interlocal Subrecipient Agreement between The City of Houston and The Harris Center for Mental Health and Intellectual Development Disabilities (IDD) (THC), and THC Policy and Procedure HIM.EHR.B.9 Patient/Individual Records Administration.*

Method

Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for person's served during the 2nd Qtr. of FY 2025 (December 1, 2024, to February 28, 2025), and the *Organizational Development Staff Training Roster Report*. Compliance conducted a desk review, sampling Fifteen (15) consumer records and ten (10) personnel records using a modified version of the STATE Review Tool. Detailed data for this review is presented below.

Findings

Overall Program Score: 97%
Detailed findings are presented below.

Strengths:

- Operation Requirements (*Health and Safety Code, Title 7 Subtitle A §534.006 (a)(1), §534.010 (b) (1-2), §534.014 (a) (1-3), TEX. ADMIN. CODE 26 §301.335 (a) (1-6).* **100%**
- Medical Requirements *TEX. ADMIN. CODE 25 §414.413(a)(b) (1-3), §415.5) (i) (1-4) (2), §415.10 (a) (1-3), §415.5(i) (1-4), TEX. ADMIN. CODE 26 §301.355 (b) (1-2) (A-H), (5)(6) (A-H)* **100%**
- Environmental Requirements *TEX. ADMIN. CODE 26 §301.323 (a)(1), §301.323* **100%**
- Clinical Requirements *HHSC TEX. ADMIN. CODE 26 §301.353 (e), (e) (2) (D), (e) (2) (e), TEX. ADMIN. CODE 26 §301.361 (b), THC P&P MED.MH. B.1* **99%**

Areas of Improvement:
Below are the elements within the Personnel and Clinical Record Requirements that fall below the threshold score of 95%.

- Personnel Requirements *TEX. ADMIN. CODE 25 §404.165(1) (3), §415.257(c) (2), TEX. ADMIN. CODE 26 §301.331 (h) (1-4).* **84%**
    - Staff job duties that involve direct care responsibilities must be current with annual training(s), and the training identifying the causes of aggressive or threatening behaviors of individuals who need mental health services. *TEX. ADMIN. CODE 26 §320.29 (1) (3) 80%.*
    - All employees shall receive instruction for maintaining annual rights training *TEX. ADMIN. CODE 26 §320.113 (b) (1-2) (c) (2) 40%*
- Clinical Record Requirements (Elements)
    - Service encounter documentation provided away from clinics/program locations will be entered into the record within seventy-two (72) hours. *THC P&P HIM.EHR. B.9 93%.*
    - A sign and dated form that states the person served has been informed of their rights and has received a client rights handbook. *TEX. ADMIN. CODE 26 §*404.163 (a) (b) 40%,
    - The individual and the provider will work together to develop an effective individualized safety plan. *THC P&P MED.MH. B.1 86%.*

History

No previous review of this type has been conducted.

Recommendations

Compliance recommends that the Rapid Response program review the findings and continue to assess its processes to ensure all required standards are completed in accordance with *TEX. ADMIN. CODE Staff Member Training Requirements, Communication of Rights to Individuals Receiving Mental Health Services, and THC P&P Suicide/Violence Behavioral Crisis Intervention.* The Rapid Response program is required to submit a Plan of Improvement (POI) focusing on the elements in Personnel Requirements and the Clinical Record Requirements. The Vice President (VP) of CPEP Division and the Program Manager/Director must sign and return the report with management response along with the POI to Compliance by the close of business on June 9, 2025.

Management Response

Received and Plan of Improvement has been submitted.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Marvin Williams
38E4BF0C55AF49A...

Regulatory Compliance Auditor

X Signed by: Jami Mack
07524706D4EE403...

Program Director / Manager

X Signed by: kim kornmeyer
705973BD2066441F...

Vice President of CPEP Division

X Signed by: Lisa Walker
3B912FA027153438...

Compliance Manager

X Signed by: Demetria Luckett
B4ED8213F5ED41A...

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
2nd Quarter (Qtr.) of Fiscal Year (FY) 2025
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
Project for Assistance in Transition from Homelessness (PATH)
Plan of Improvement (POI) Follow-Up
Review Date: March 12, 2025, to April 1, 2025

I. Audit Type:
POI Follow-up Review.

II. Purpose:
The purpose of this review was to assess the PATH program for collaboration with Performance Improvement (PI) to ensure compliance with the Texas Administrative Code (TEX. ADMIN. CODE) *26 §306.275 Documenting MH Case Management Services, 26 §306.263 MH Case Management Services Standards, and TEX. ADMIN. CODE 22 §217.11 Standards of Nursing Practice.*

III. Audit Method:
Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for person's served during the 2nd Qtr. of FY 2025 (December 1, 2024, to February 28, 2025), Compliance conducted a desk review, sampling fifteen (15) consumer records and reviewed forty-seven (47) service encounter documentation using the Compliance Service Encounter Review Tool. Detailed data for this review is presented below.

IV. Audit Findings and History:
Overall Program Score: 78%
Detailed finding(s) is presented below.
The program's strength was the Clinical Record Requirements for nurse services with a score of 100%, the record included nurse service encounter documentation that clear, concise, and gave an accurate description of the encounter.

The program had other Clinical Record Requirements that fail below the threshold score of 95%, case management activities that did not include the steps that are necessary to accomplish the goals to meet the individual's needs by using referral, linking, advocacy, monitoring in gaining access to community resources or developing a plan of care with assessment, the score was 55%.

History

A previous review was conducted 2nd Qtr. FY 2024.

V. Recommendations:
The Program should continue to monitor its processes to ensure all required standards are completed in accordance with *TEX. ADMIN. CODE Documenting MH Case Management Services and MH Case Management Services Standards.* The PATH program is not required to submit a plan of improvement; however, is required to continue its collaboration with Performance Improvement (PI) for essential support. The Vice President (VP) of CPEP Division and the Program Manager/Director must sign and return this report with management response to Compliance within seven business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2025
Comprehensive Psychiatric Emergency Program (CPEP) Division
Project for Assistance in Transition from Homelessness (PATH)
Performance Improvement (PI) Follow-Up Review

Compliance Auditor(s): Marvin Williams

Review Date: March 12, 2025, to April 1, 2025

Purpose

The purpose of this review was to assess the PATH program for collaboration with Performance Improvement (PI) to ensure compliance with the Texas Administrative Code (TEX. ADMIN. CODE) *26 §306.275 Documenting MH Case Management Services, 26 §306.263 MH Case Management Services Standards, and TEX. ADMIN. CODE 22 §217.11 Standards of Nursing Practice.*

Method

Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for person's served during the 2nd Qtr. of FY 2025 (December 1, 2024, to February 28, 2025), Compliance conducted a desk review, sampling fifteen (15) consumer records and reviewed forty-seven (47) service encounter documentation using the Compliance Service Encounter Review Tool. Detailed data for this review is presented below.

Findings

Overall Program Score: 78%
Detailed findings are presented below.

Strengths:
Clinical Record Requirements

- Standards for all nurses: vocational nurses, registered nurses and nurses with advanced practice authorization documentation shall be clear, concise, and give an accurate description of the encounter. *TEX. ADMIN CODE 22 §217.11 (d) (i-vi).* **100%**

Areas of Improvement:
Clinical Record Requirements

- Case management activities include taking the steps that are necessary to accomplish the goals to meet the individual's identified needs by using referral, linking, advocacy, monitoring in gaining access to community resources and or developing the plan of care (POC) with assessment (POC). *TEX. ADMIN. CODE 26 §306.263 (b) (1-13), §306.275 (c) (1-11).* **55%**

The HARRIS CENTER for Mental Health and IDD

History

The previous review was conducted 2nd Qtr. FY. 2024.

Recommendations

The Program should continue to monitor its processes to ensure all required standards are completed in accordance with *TEX. ADMIN. CODE Documenting MH Case Management Services and MH Case Management Services Standards.* The PATH program is not required to submit a plan of improvement; however, is required to continue its collaboration with Performance Improvement (PI) for essential support. The Vice President (VP) of CPEP Division and the Program Manager/Director must sign and return this report with management response to Compliance by the close of business on April 21, 2025.

Management Response

Management reviewed the findings with all clinical staff during clinical meeting on 4/1/25 and provided redirection to use the Recovery Treatment Plan Note template to support services provided. Management also provided redirection to use the Crisis Follow-up and Relapse Prevention note template after clients' visit with the NP unless a case management service(s) is being provided. Last, management reviewed with clinician staff the Buzz Words for case management.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Marvin Williams
98E4DECC55AE49A...

Regulatory Compliance Auditor

X Signed by: omar sesay
D2E29F8798764C5...

Vice President of CPEP Division

X Signed by: kim kornmeyer
705073BD206644E...

Program Director/Manager

X Signed by: Demetria Luckett
B4ED8213E5ED41A...

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Infirmary Discharge Treatment Planning Comprehensive Review
Review Date: February 12, 2025, to February 25, 2025

I. Audit Type:
Comprehensive Review

II. Purpose:
This review was conducted to determine if the Infirmary Discharge Treatment Planning Program complies with the Texas Administrative *Code (TEX. ADMIN. CODE) Documentation of Service Provision 26 TEX. ADMIN. CODE §§ 301.361(a)(1-14), (b), and The Adult Forensic Operational Guidelines Manual.*

III. **Audit Method:**
A client roster for persons served during the 1st Qtr. FY 2025 (September 1, 2024-November 30, 2024) was obtained through the function of the Electronic Health Record database (i.e., Epic). Ten (10) clients from the Infirmary Discharge Treatment Planning Program and seven (7) clinical staff were selected from the roster provided by the program leadership. The review used an audit tool developed by Compliance.

IV. Audit Findings and History:
The overall score is 100%. The program's strengths were 100% operational requirements, 100% Medical requirements, 100% Clinical Records requirements, and 100% personnel requirements. There are no areas in which the program did not meet the criteria. However, three (3) staff members were missing drug screenings due to the HR department switching vendors. Human Resources (HR) no longer has access to the previous vendor's repository for more tenured employees. HR has already contacted the external vendors regarding screening done before 2022. Compliance will follow up with HR to ensure the screenings are filed in the program's records.

V. Recommendations:
The Infirmary Discharge and Treatment Planning program should continue to review client documentation for compliance with regulatory standards and the Adult Forensic Operational Guidelines Manual. A Plan of Improvement (POI) is not required. The Vice President of the Forensic Division and the Infirmary Discharge Treatment Planning Program Director must sign and return this report to Compliance within seven (7) business days

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report

2nd Quarter (Qtr.) of Fiscal Year (FY) 2025

Forensic Division

Infirmary Discharge Treatment Planning Comprehensive Review

Compliance Auditor(s): Emmanuel Golakai

Review Dates: February 12, 2025-February 25, 2025

Purpose

This review was conducted to determine if the Infirmary Discharge Treatment Planning Program complies with the Texas Administrative *Code (TEX. ADMIN. CODE) Documentation of Service Provision 26 TEX. ADMIN. CODE §§ 301.361(a)(1-14), (b), and The Adult Forensic Operational Guidelines Manual.*

Methods

A client roster for persons served during the 1st Qtr. FY 2025 (September 1, 2024-November 30, 2024) was obtained through the function of the Electronic Health Record database (i.e., Epic). Ten (10) clients from the Infirmary Discharge Treatment Planning Program and seven (7) clinical staff were selected from the roster provided by the program leadership. The review used an audit tool developed by Compliance.

Findings

Overall Score: 100 %

Detailed findings are presented below:

Strengths:

- Operations (*Interlocal Agreement)* **100%**
- Medical (*Adult Forensic Operational Guidelines Manual*) **100%**
- Clinical Records (*26 TEX. ADMIN. CODE §301.361)* **100%**
- Personnel Requirements (26 TEX. ADMIN. CODE *§ 301.331, Interlocal Agreement, Adult Forensic Operational Guidelines Manual)* **100%**

Areas of Improvement:

There were no areas of improvement

The HARRIS CENTER for Mental Health and IDD

Observation

- Three (3) staff members were missing drug screenings due to the HR department switching vendors. Human Resources (HR) no longer has access to the previous vendor's repository for more tenured employees. HR has already contacted the external vendors regarding screening done before 2022. Compliance will follow up with HR to ensure the screenings are filed in the program's records.

History

Compliance has not previously reviewed the Infirmary Discharge Treatment Planning Program.

Recommendations

The Infirmary Discharge and Treatment Planning program should continue to review client documentation for compliance with regulatory standards and the Adult Forensic Operational Guidelines Manual. A Plan of Improvement (POI) is not required. The Vice President of the Forensic Division and the Infirmary Discharge Treatment Planning Program Director must sign and return this report to Compliance within seven (7) business days (April 17, 2025).

Management Response

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Emmanuel Golakai
9AC7A40B9B0C493...

Regulatory Compliance Auditor

X DocuSigned by: MONALISA JILES
CBB8E81812AB4EF...

Vice President of Forensic Division

X Signed by:
8C6001F823134E6...

Infirmary Discharge Treatment Planning Pro...

X Signed by: Demetria Luckett
B4ED8213F5ED41A...

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Forensic Front Door Comprehensive Review
Review Date: April 11, 2025, to April 29, 2025

I. Audit Type:
Comprehensive Review

II. Purpose:
This review was conducted to determine if the Forensic Front Door Program complies with the Texas Administrative Code (TEX. ADMIN. CODE), Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. CODE § 320.75(a)(1-3); Medication Services 26 TEX. ADMIN. CODE § 301.355(b)8)(A)(B)(C)(D)(E); General Principles 26 TEX. ADMIN. CODE § 320.207(i)(1-4); Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323(a)(4)(A-E); Community Centers: Actions Taken Upon the Death of an Individual Served 26 TEX. ADMIN. CODE § 301.407 (b)(c); Community Centers: Administrative Death Review Determination 26 TEX. ADMIN. CODE § 301.411(a)(1-4)(b)(c); Community Centers: Clinical Death Review Determination 26 TEX. ADMIN. CODE § 301.413(b)(1-3)(c(1-5); Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331(h)(1-4), § 301.331(a)(3(iv),§ 301.331(C)(viii); Staff Member Training 26 TEX. ADMIN. CODE § 320.113(c)(2); Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353; Documentation of Service Provision §301.361; Interlocal Agreement; Forensic Front Door Program Description; and Adult Forensic Operational Guidelines Manual.

III. Audit Method:
A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024- February 28, 2025) was obtained through the function of the Electronic Health Record database (i.e., Epic). Ten (10) clients from the Forensic Front Door and ten (10) clinical staff were selected from the roster provided by the program leadership. The review used an audit tool developed by Compliance.

IV. Audit Findings and History:

- The overall score is 95.68%. The program's strengths were 100% Medical requirements, 100% Clinical Records requirements, and 100% Operations Requirements. The area of improvement was Personnel Requirements 82.72%: Identifying, preventing, and reporting abuse, neglect, and exploitation(56%);); Handle with Care II (identifying the causes of aggressive or threatening behaviors of individuals who need mental health services, including behavior that may be related to an individual's non-psychiatric medical condition (11%); Copies of Agency mandated training (89%); Maintaining a documented, current, signed job description (89%); The program description lacked clarity. According to the Program Director, this was intentional as the program's structure changes daily at the jail. To avoid constant updates, the description was written in a more general format. During the compliance review, it was observed that certain employees' mandatory training fell outside of the review period, which had expired. The affected staff members were discussed directly with their manager to ensure appropriate follow-up and corrective action. Compliance has not previously reviewed the Forensic Front Door Program. Ten 10) Provider staff did not have co-occurring psychiatric and substance use disorders (COPSD) on the training tracks. The training tracks were not completed. Three (3) provider staff did not complete the Drug testing. Human Resources was not able to provide evidence at the end of the review. Compliance will follow up with Human Resources to ensure the missing drug tests are filed in the staff record

V. Recommendations
The Forensic Front Door program should continue to review client documentation and staff records for compliance with regulatory standards and the Interlocal Adult Forensic Operational Guidelines Manual, and collaborate with Human Resources to ensure staff records are updated as required. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the Forensic Division and the Forensic Front Door Program Director must sign and return this report to Compliance within seven (7) business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Forensic Division
Forensic Front Door Comprehensive Review

Compliance Auditor(s): Emmanuel Golakai

Review Dates: April 11, 2025- April 29, 2025

Purpose

This review was conducted to determine if the Forensic Front Door Program complies with the Texas Administrative *Code (TEX. ADMIN. CODE), Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. CODE § 320.75(a)(1-3); Medication Services 26 TEX. ADMIN. CODE § 301.355(b)8)(A)(B)(C)(D)(E); General Principles 26 TEX. ADMIN. CODE § 320.207(i)(1-4); Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323(a)(4)(A-E); Community Centers: Actions Taken Upon the Death of an Individual Served 26 TEX. ADMIN. CODE § 301.407 (b)(c); Community Centers: Administrative Death Review Determination 26 TEX. ADMIN. CODE § 301.411(a)(1-4)(b)(c); Community Centers: Clinical Death Review Determination 26 TEX. ADMIN. CODE § 301.413(b)(1-3)(c(1-5); Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331(h)(1-4), § 301.331(a)(3(iv),§ 301.331(C)(viii); Staff Member Training 26 TEX. ADMIN. CODE § 320.113(c)(2); Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353; Documentation of Service Provision §301.361; Interlocal Agreement; Forensic Front Door Program Description; and Adult Forensic Operational Guidelines Manual.*

Methods

A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024- February 28, 2025) was obtained through the function of the Electronic Health Record database (i.e., Epic). Ten (10) clients from the Forensic Front Door and ten (10) clinical staff were selected from the roster provided by the program leadership. The review used an audit tool developed by Compliance.

Findings

Comprehensive Audit
Overall Score: 95.68%
Detailed findings are presented below:

Strengths:

- Operations (*Interlocal Agreement)* **100%**
- Medical (*Adult Forensic Operational Guidelines Manual*) **100%**
- Clinical Records (*26 TEX. ADMIN. CODE §301.361)* **100%**
- Drug Testing *(Interlocal Agreement)* **100%**

Areas of Improvement:

- Personnel Requirement (*Interlocal Agreement, 26 TEX. ADMIN. CODE §301.331, 26 TEX. ADMIN. CODE §320.113(c)(2))* **82.72%**
  - Identifying, preventing, and reporting abuse, neglect, and exploitation training (*26 TEX. ADMIN.CODE §301.331(a)(3)(iv))* **56%**
  - Handle with Care II (identifying the causes of aggressive or threatening behaviors of individuals who need mental health services, including behavior that may be related to an individual's non-psychiatric medical condition) *TEX. ADMIN. CODE §320.113(c)(2)* **11%**

- Copies of Current Agency Mandated training (*26 TEX. ADMIN. CODE §301.331(h)(3); Interlocal Agreement)* **89%**

- Maintaining a documented, current, signed job description (*26 TEX. ADMIN. CO§301.331(h)(1)* **89%**

Observation

- The program description lacked clarity. According to the Program Director, this was intentional as the program's structure changes daily at the jail. To avoid constant updates, the description was written in a more general format.
- During the compliance review, it was observed that certain employees' mandatory training fell outside of the review period, which had expired. The affected staff members were discussed directly with their manager to ensure appropriate follow-up and corrective action.
- Ten 10) Provider staff did not have co-occurring psychiatric and substance use disorders (COPSD) on the training tracks. The training tracks were not completed.
- Three (3) provider staff did not complete the Drug testing. Human Resources was not able to provide evidence at the end of the review. Compliance will follow up with Human Resources to ensure the missing drug tests are filed in the provider staff record

History

Compliance has not previously reviewed the Forensic Front Door Program.

Recommendations

The Forensic Front Door program should continue to review client documentation and staff records for compliance with regulatory standards and the Interlocal Adult Forensic Operational Guidelines Manual, and collaborate with Human Resources to ensure staff records are updated as required. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the Forensic Division and the Forensic Front Door Program Director must sign and return this report to Compliance within three (3) business days (June 13, 2025).

Management Response

Employees will be notified monthly by the supervisor (Medical Director) in the Provider's meeting about completing trainings. The supervisor will discussed trainings during performance reviews. The supervisor will routinely review trainings in absorb. All employee trainings that are out of compliance will be completed within the next 30 days. The unit is requesting that compliance recommend t

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Emmanuel Golakai 3AC7A46D9D6C439...

Regulatory Compliance Auditor

X DocuSigned by: MONALISA MILES CBB9E34042AB4EF...

Vice President of Forensic Division

X Signed by: 8C6001F823134E6...

Forensic Front Door/Program Director/Man...

X Signed by: Lisa Walker 3B942FA02745458...

Compliance Manager

X

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Forensic Outpatient Comprehensive Review
Review Date: May 27, 2025, to May 30, 2025

I. Audit Type:
Comprehensive Review

II. Purpose:
This review was conducted to determine if the Forensic Outpatient Program complies with the Texas Administrative Code (TEX. ADMIN. CODE), Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. CODE § 320.75(a)(1-3); Medication Services 26 TEX. ADMIN. CODE § 301.355(b)8)(A)(B)(C)(D)(E); General Principles 26 TEX. ADMIN. CODE § 320.207(i)(1-4); Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323(a)(4)(A-E); Community Centers: Actions Taken Upon the Death of an Individual Served 26 TEX. ADMIN. CODE § 301.407 (b)(c); Community Centers: Administrative Death Review Determination 26 TEX. ADMIN. CODE § 301.411(a)(1-4)(b)(c); Community Centers: Clinical Death Review Determination 26 TEX. ADMIN. CODE § 301.413(b)(1-3)(c(1-5); Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331(h)(1-4), § 301.331(a)(3(iv),§ 301.331(C)(viii); Staff Member Training 26 TEX. ADMIN. CODE § 320.113(c)(2); Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353; Documentation of Service Provision §301.361; Interlocal Agreement; Forensic Outpatient Program Description; and Adult Forensic Operational Guidelines Manual.

III. Audit Method:
A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024- February 28, 2025) was obtained through the function of the Electronic Health Record database (i.e., Epic). Ten (10) clients from the Forensic Outpatient and ten (10) clinical staff were selected from the roster provided by the program leadership. The review used an audit tool developed by Compliance.

IV. Audit Findings and History:
The overall score is 99.82%. The program's strengths were 100% Medical requirements, 100% Clinical Records requirements, and 100% Operations Requirements, and 100% Environment. The area of improvement was Personnel Requirements 99.09%: Identifying, preventing, and reporting abuse, neglect, and exploitation (90%). The program description lacked clarity. According to the Program Director, this was intentional as the program's structure changes daily at the jail. To avoid constant updates, the description was written in a more general format. Compliance has not previously reviewed the Forensic Outpatient Program. One (1) Provider staff did not have co-occurring psychiatric and substance use disorders (COPSD) on the training track. The training track was not completed.

V. Recommendations
The Forensic Outpatient program should continue to review client documentation and staff records for compliance with regulatory standards, Interlocal Agreement, and the Adult Forensic Operational Guidelines Manual, and collaborate with Human Resources to ensure staff records are updated. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the Forensic Division and the Forensic Outpatient Program Director must sign and return this report to Compliance within three (3) business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Forensic Division
Forensic Outpatient Comprehensive Review

Compliance Auditor(s): Emmanuel Golakai

Review Dates: May 27, 2025- May 30, 2025

Purpose

This review was conducted to determine if the Forensic Outpatient Program complies with the Texas Administrative *Code (TEX. ADMIN. CODE), Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. CODE § 320.75(a)(1-3); Medication Services 26 TEX. ADMIN. CODE § 301.355(b)8)(A)(B)(C)(D)(E); General Principles 26 TEX. ADMIN. CODE § 320.207(i)(1-4); Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323(a)(4)(A-E); Community Centers: Actions Taken Upon the Death of an Individual Served 26 TEX. ADMIN. CODE § 301.407 (b)(c); Community Centers: Administrative Death Review Determination 26 TEX. ADMIN. CODE § 301.411(a)(1-4)(b)(c); Community Centers: Clinical Death Review Determination 26 TEX. ADMIN. CODE § 301.413(b)(1-3)(c(1-5); Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331(h)(1-4), § 301.331(a)(3(iv),§ 301.331(C)(viii); Staff Member Training 26 TEX. ADMIN. CODE § 320.113(c)(2); Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353; Documentation of Service Provision §301.361; Interlocal Agreement; Forensic Outpatient Program Description; and Adult Forensic Operational Guidelines Manual.*

Methods

A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024- February 28, 2025) was obtained through the function of the Electronic Health Record database (i.e., Epic). Ten (10) clients from the Forensic Specialty and ten (10) clinical staff were selected from the roster provided by the program leadership. The review used an audit tool developed by Compliance.

Findings

Comprehensive Audit
Overall Score: 99.82 %
Detailed findings are presented below:

Strengths:

- Operations (*Interlocal Agreement)* **100%**
- Medical (*26 TEX.ADMIN. CODE § 320.75, Adult Forensic Operational Guidelines Manual)* **100%**
- Clinical Records (*26 TEX. ADMIN. CODE §301.361)* **100%**
- Environment (26 TEX. ADMIN.CODE *§320.21, §301.323)* **100%**

Areas of Improvement:

- Personnel Requirement (*Interlocal Agreement, 26 TEX. ADMIN. CODE §301.331, 26 TEX. ADMIN. CODE §320.113(c)(2))* **99.09%**

- Identifying, preventing, and reporting abuse, neglect, and exploitation (*26 TEX. ADMIN.CODE §301.331(a)(3)(iv)*) **90%**

Observation

- The program description lacked clarity. According to the Program Director, this was intentional as the program's structure changes daily at the jail. To avoid constant updates, the description was written in a more general format.
- One (1) Provider staff did not have co-occurring psychiatric and substance use disorders (COPSD) on the training track. The training track was not completed.

History

Compliance has not previously reviewed the Forensic Outpatient Program.

Recommendations

The Forensic Outpatient program should continue to review client documentation and staff records for compliance with regulatory standards, Interlocal Agreement, and the Adult Forensic Operational Guidelines Manual, and collaborate with Human Resources to ensure staff records are updated. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the Forensic Division and the Forensic Outpatient Program Director must sign and return this report to Compliance within three (3) business days (June 13, 2025).

Management Response

Employees will be notified monthly by the supervisor in the Provider's meeting about completing trainings. The supervisor will discussed trainings during performance reviews. The supervisor will routinely review trainings in absorb. All employee trainings that are out of compliance will be completed within the next 30 days. The unit is requesting that compliance recommend to Education & Development to provide email notifications for delinquent trainings.
The unit is requesting that compliance recommend to Education & Development to provide transcripts for staff prior to switching from on training software system.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Emmanuel Golakai 3AC7A40D9D6C439...

Regulatory Compliance Auditor

X DocuSigned by: MONALISA JILES CBB9E31912AD4EF...

Vice President of Forensic Division

X Signed by: 8C6001F823134E6...

Forensic Specialty/Program Director/Manager

X Signed by: Lisa Walker 3B912EA02715458...

Compliance Manager

X

Director of Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Mental Health (MH) Division Southwest Child and Adolescent Services (SWCAS)
Comprehensive Review
Review Dates: April 10, 2025-April 28, 2025

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if the SWCAS program was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Responsibilities of Local Authorities, Community Centers, and Contractors 25 TEX. ADMIN CODE § 414.554*; *Environment of Care and Safety 26 TEX. ADMIN. Code § 301.323*; *Medical Records System 26 TEX. ADMIN. CODE § 301.329*; *Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331*; *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353*; *Medication Services § 301.355*; *Telemedicine 26 TEX. ADMIN. CODE § 301.359*; *Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361*; *Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275*; *Medication Training and Support Services § 306.315*; *Rights Handbooks for Individuals Receiving Mental Health Services at Health and Human Services Commission Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 26 TEX. ADMIN. CODE § 320.21*; *Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals Not Operated by a Community Center 26 TEX. ADMIN. CODE § 320.23*; *Communication of Rights to Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE §320.25*; *Rights Protection Officer at Health and Human Services Commission Facilities and Community Centers 26 TEX. ADMIN. CODE § 320.27*; *Staff Training in Rights of Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE § 320.29*; *Documentation of Informed Consent 26 TEX. ADMIN. CODE § 320.59*; *Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. Code § 320.75*; *General Principles 26 TEX. ADMIN. CODE § 320.207*; *Medication Monitoring 26 TEX. ADMIN. CODE § 320.217*; the Texas Health and Human Services Commission's (HHSC) *Performance Contract Notebook (PCN) FY 24-25*; the Harris Center's MH Division's *CAS Mental Health Clinics Program Manual*; and Harris Center policies and procedures *ACC.B.8 Referral, Transfer, and Discharge*; *ACC.B.14 Declaration of Mental Health Treatment*; *HIM.EHR.B.5 Content of Patient/Individual Records*; *HIM.EHR.B.9 Patient/Individual Records Administration*; *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure*; *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*; and *RR.B.2 Assurance of Individual Rights*.

III. Audit Method:
A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024-February 28, 2025) was obtained through the Encounter Data Service Details report of the Electronic Health Record database (i.e., Epic) and an employee roster was provided by program leadership. Twenty (20) clients and five (5) employees from the Child and Adolescent Services (CAS) Program were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance.

IV. Audit Findings/History:
Compliance noted that agency staff are not accurately completing consent and client rights documentation; are not including all required elements of plans of care or completing the required uniform assessment and plan of care updates within designated timeframes; are not including all required elements of progress note and case management note documentation; are not providing all services listed within the plan of care (e.g., medication training and support services); and are not including all required elements of discharge summaries. Compliance has not previously conducted a comprehensive review of the SWCAS Program.

V. Recommendations:
The SWCSC CAS program should continue to review client and employee documentation for compliance with regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this review.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Mental Health (MH) Division
Southwest Child and Adolescent Services (SWCAS) Comprehensive Review

Compliance Auditor(s): Christopher Beard

Review Dates: April 10, 2025-April 28, 2025

Purpose

This review was conducted to determine if the SWCAS program was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Responsibilities of Local Authorities, Community Centers, and Contractors 25 TEX. ADMIN CODE § 414.554*; *Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323*; *Medical Records System 26 TEX. ADMIN. CODE § 301.329*; *Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331*; *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353*; *Medication Services § 301.355*; *Telemedicine 26 TEX. ADMIN. CODE § 301.359*; *Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361*; *Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275*; *Medication Training and Support Services § 306.315*; *Rights Handbooks for Individuals Receiving Mental Health Services at Health and Human Services Commission Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 26 TEX. ADMIN. CODE § 320.21*; *Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals Not Operated by a Community Center 26 TEX. ADMIN. CODE § 320.23*; *Communication of Rights to Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE §320.25*; *Rights Protection Officer at Health and Human Services Commission Facilities and Community Centers 26 TEX. ADMIN. CODE § 320.27*; *Staff Training in Rights of Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE § 320.29*; *Documentation of Informed Consent 26 TEX. ADMIN. CODE § 320.59*; *Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. Code § 320.75*; *General Principles 26 TEX. ADMIN. CODE § 320.207*; *Medication Monitoring 26 TEX. ADMIN. CODE § 320.217*; the Texas Health and Human Services Commission's (HHSC) *Performance Contract Notebook (PCN) FY 24-25*; the Harris Center's MH Division's *CAS Mental Health Clinics Program Manual*; and Harris Center policies and procedures *ACC.B.8 Referral, Transfer, and Discharge*; *HIM.EHR.B.5 Content of Patient/Individual Records*; *HIM.EHR.B.9 Patient/Individual Records Administration*; *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure*; *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*; and *RR.B.2 Assurance of Individual Rights*.

Methods

A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024-February 28, 2025) was obtained through the Encounter Data Service Details report of the Electronic Health Record database (i.e., Epic) and an employee roster was provided by program leadership. Twenty (20) clients and five (5) employees from the SWCAS Program were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance.

The HARRIS CENTER for Mental Health and IDD

Findings

Audit

Overall Score: 95.70%

Detailed findings are presented below:

Strengths

- **Operations** (*§§ 301.359 (1)-(4);* and *§§ 301.323 (a)(2)(A)* and *(C)*) **100%**
- **Medical** (*§ 301.323 (a)(4); §§ 301.355 (b)(1)-(4)* and *(8); § 320.207 (i)(1)-(4);* and *§320.75 (a)-(b)*) **100%**
- **Environment** (*§ 301.323 (a)(1); § 320.21 (f); § 320.27 (b); § 414.554 (c)(1);* and *PCN FY 25-25 I.A.6.j. (1)-(3)*) **100%**
- **Personnel** (*§§ 301.331 (a)(3)(A)(iii), (v), (viii), (x); §§ 301.331 (a)(3)(B)(i)-(iii)* and *(v); § 301.331 (h)(1)-(4); §§ 320.29 (1)* and *(3); PCN FY 24-25 I.B.2.g.3* and *I.C.2.g.3; HR.B.35;* and *MED.MH.B.1*) **95.43%**

Areas of Improvement:

- **Personnel**
  - Agency-mandated Employee Training (*§301.331 (a)(3)(B)(iii)* and *MED.MH.B.1*) 92.65%
- **Client Records** (*§ 301.329 (a)(3)*; *§ 301.353 (a)(1)-(a10)*, *(d)(1)(C)*, *(e)(1)-(3)*, *(f)(1)*, and *(h)*; *§ 301.361 (a)-(b)*; *§§ 320.25 (a)* and *(b)*; *§ 306.275 (c)*; *§§ 306.315 (a)* and *(c)*; *§§ 320.59 (a)* and *(b)(2)*; *§ 320.207 (e)*; *§§ 320.217 (a)(1)-(3)*, *(e)*, and *(g)*; *CAS Mental Health Clinics Program Manual*; *ACC.B.8*; *HIM.EHR.B.5*; *HIM.EHR.B.9*; and *RR.B.2*) **83.08%**
  - Eligibility and Admission (*§ 301.353 (a)(1)-(10); HIM.EHR.B.5.D.1.;* and *CAS MH Clinics Program Manual 4.2 (p. 3), 5.2 (p. 26),* and *5.3 (pp. 26-27* and *28)*) 86.18%
  - Client Rights (*§ 320.21 (e); § 320.25 (a)-(b); RR.B.2;* and *HIM.EHR.B.5; HIM.EHR.B.9;* and *ACC.B.14*) 76.78%
  - Medication Monitoring (*§§ 320.217 (a)(1)-(3), (e),* and *(g)*) 76.11%
  - Recovery Plan (*§§ 301.353 (d)(1)(C)* and *(e)(1)-(3); § 415.5 (e);* and *CAS MH Clinics Program Manual 5.4 (pp. 37-38)*) 77.95%
  - Recovery Plan Review (*§ 301.353 (f)(1)(A)-(D); CAS MH Clinics Program Manual 5.4 (p. 38)*) 86.17%
  - Documentation of Services (*§ 301.361 (a)-(b); HIM.EHR.B.9*) 97.13%
    - Each service encounter will include the method of service provision (*§ 301.361 (a)(8)*) 94.44%
    - Each service encounter documented the treatment plan objective that was the focus of the service (*§ 301.361 (a)(11)*) 94.44%
    - The documentation of service provision was made within two business days after the service was provided (*§ 301.361 (b)*) 70.00%
  - Routine and Intensive Case Management Documentation (*§ 306.275 (c)(1)-(9)*) 87.46%

- Documentation Medication Training and Support (*§§ 306.315 (a)* and *(c)*) 10.24%

History

Compliance has not previously conducted a comprehensive review of the SWCAS Program.

Recommendations

The program should continue to review client documentation for compliance with regulatory standards, provide periodic targeted training based on self-monitoring results, and ensure employees remain current on all training courses. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the MH Division and the SWCAS Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days (May 12, 2025).

Management Response

Outstanding Trainings: All remaining trainings will be completed by June 2025.

Other Findings: Items identified in the preliminary review will be addressed during the upcoming quarterly meeting scheduled for May 16, 2025.

Staff Retraining on POC/CANS: Staff will undergo retraining on POC and CANS in August 2025 to ensure continued compliance and competency.

Chart Monitoring: A sample of 10 charts will be monitored by June 2025, with ongoing reviews maintained at least on a quarterly basis thereafter.

Sections Related to MDs: All matters related to medical directors will be discussed and addressed during the MD meeting scheduled for May 21, 2025.

Epic Team Intervention Update: The Epic team has indicated they will update the intervention section accordingly to ensure accuracy and compliance.

PHQA findings: The PHAQ findings were discussed and reviewed during the CTLs meetings with their teams held on May 5, 2025. Additionally, a PHQA cheat sheet was provided to each team member in attendance to support ongoing compliance and understanding.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Christopher Beard 478D54B5E9104BB...

Regulatory Compliance Auditor

X Signed by: Lance Britt BAB00A90B5FE4AC...

Vice President of MH Division

X DocuSigned by: Raul Ureste A1E76C42C9154E6...

SWCAS Program Director/Manager

X Signed by: Demetria Luckett B4ED8213F5ED41A...

Director of Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Mental Health (MH) Division Southeast Community Service Center (CSC) Child and Adolescent Services (CAS) Comprehensive Review
Review Dates: February 27, 2025-April 2, 2025

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if the SECSC CAS program was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Responsibilities of Local Authorities, Community Centers, and Contractors 25 TEX. ADMIN CODE § 414.554*; *Environment of Care and Safety 26 TEX. ADMIN. Code § 301.323*; *Medical Records System 26 TEX. ADMIN. CODE § 301.329*; *Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331*; *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353*; *Medication Services § 301.355*; *Telemedicine 26 TEX. ADMIN. CODE § 301.359*; *Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361*; *Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275*; *Medication Training and Support Services § 306.315*; *Rights Handbooks for Individuals Receiving Mental Health Services at Health and Human Services Commission Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 26 TEX. ADMIN. CODE § 320.21*; *Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals Not Operated by a Community Center 26 TEX. ADMIN. CODE § 320.23*; *Communication of Rights to Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE §320.25*; *Rights Protection Officer at Health and Human Services Commission Facilities and Community Centers 26 TEX. ADMIN. CODE § 320.27*; *Staff Training in Rights of Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE § 320.29*; *Documentation of Informed Consent 26 TEX. ADMIN. CODE § 320.59*; *Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. Code § 320.75*; *General Principles 26 TEX. ADMIN. CODE § 320.207*; *Medication Monitoring 26 TEX. ADMIN. CODE § 320.217*; the Texas Health and Human Services Commission's (HHSC) *Performance Contract Notebook (PCN) FY 24-25*; the Harris Center's MH Division's *CAS Mental Health Clinics Program Manual*; and Harris Center policies and procedures *ACC.B.8 Referral, Transfer, and Discharge*; *ACC.B.14 Declaration of Mental Health Treatment*; *HIM.EHR.B.5 Content of Patient/Individual Records*; *HIM.EHR.B.9 Patient/Individual Records Administration*; *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure*; *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*; and *RR.B.2 Assurance of Individual Rights*.

III. Audit Method:
A client roster for persons served during the 1st Qtr. FY 2025 (September 1, 2024-November 30, 2024) was obtained through the Encounter Data Service Details report of the Electronic Health Record database (i.e., Epic) and an employee roster was provided by program leadership. Twenty (20) clients and five (5) employees from the Child and Adolescent Services (CAS) Program were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance.

IV. Audit Findings/History:
Compliance noted that agency staff are not accurately completing consent and client rights documentation; are not including all required elements of plans of care or completing the required uniform assessment and plan of care updates within designated timeframes; are not including all required elements of progress note and case management note documentation; are not providing all services listed within the plan of care (e.g., medication training and support services); and are not including all required elements of discharge summaries. Compliance previously conducted a comprehensive review of the SECSC CAS Program during the first quarter of FY 2020.

V. Recommendations:
The SECSC CAS program should continue to review client and employee documentation for compliance with regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this review.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2025
Mental Health (MH) Division
Southeast Child and Adolescent Services (SECAS) Comprehensive Review

Compliance Auditor(s): Christopher Beard

Review Dates: February 27, 2025-April 2, 2025

Purpose

This review was conducted to determine if the SECSC CAS program was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Responsibilities of Local Authorities, Community Centers, and Contractors 25 TEX. ADMIN CODE § 414.554*; *Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323*; *Medical Records System 26 TEX. ADMIN. CODE § 301.329*; *Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331*; *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353*; *Medication Services § 301.355*; *Telemedicine 26 TEX. ADMIN. CODE § 301.359*; *Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361*; *Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275*; *Medication Training and Support Services § 306.315*; *Rights Handbooks for Individuals Receiving Mental Health Services at Health and Human Services Commission Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 26 TEX. ADMIN. CODE § 320.21*; *Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals Not Operated by a Community Center 26 TEX. ADMIN. CODE § 320.23*; *Communication of Rights to Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE §320.25*; *Rights Protection Officer at Health and Human Services Commission Facilities and Community Centers 26 TEX. ADMIN. CODE § 320.27*; *Staff Training in Rights of Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE § 320.29*; *Documentation of Informed Consent 26 TEX. ADMIN. CODE § 320.59*; *Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. Code § 320.75*; *General Principles 26 TEX. ADMIN. CODE § 320.207*; *Medication Monitoring 26 TEX. ADMIN. CODE § 320.217*; the Texas Health and Human Services Commission's (HHSC) *Performance Contract Notebook (PCN) FY 24-25*; the Harris Center's MH Division's *CAS Mental Health Clinics Program Manual*; and Harris Center policies and procedures *ACC.B.8 Referral, Transfer, and Discharge*; *HIM.EHR.B.5 Content of Patient/Individual Records*; *HIM.EHR.B.9 Patient/Individual Records Administration*; *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure*; *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*; and *RR.B.2 Assurance of Individual Rights*.

Methods

A client roster for persons served during the 1st Qtr. FY 2025 (September 1, 2024-November 30, 2024) was obtained through the Encounter Data Service Details report of the Electronic Health Record database (i.e., Epic) and an employee roster was provided by program leadership. Twenty (20) clients and five (5) employees from the SECAS Program were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance.

The HARRIS CENTER for Mental Health and IDD

Findings

Audit

Overall Score: 98%

Detailed findings are presented below:

Strengths

- **Operations** (*§§ 301.359 (1)-(4);* and *§§ 301.323 (a)(2)(A)* and *(C)*) **100%**
- **Medical** (*§ 301.323 (a)(4); §§ 301.355 (b)(1)-(4)* and *(8); § 320.207 (i)(1)-(4);* and *§320.75 (a)-(b)*) **100%**
- **Environment** (*§ 301.323 (a)(1); § 320.21 (f); § 320.27 (b); § 414.554 (c)(1);* and *PCN FY 25-25 I.A.6.j. (1)-(3)*) **100%**
- **Personnel** (*§§ 301.331 (a)(3)(A)(iii), (v), (viii), (x); §§ 301.331 (a)(3)(B)(i)-(iii)* and *(v); § 301.331 (h)(1)-(4); §§ 320.29 (1)* and *(3); PCN FY 24-25 I.B.2.g.3* and *I.C.2.g.3; HR.B.35;* and *MED.MH.B.1*) **99%**

Areas of Improvement:

- **Personnel**
  - Agency-mandated Employee Training (*§301.331 (a)(3)(B)(iii)* and *MED.MH.B.1*) 98%
- **Client Records** (*§ 301.329 (a)(3)*; *§ 301.353 (a)(1)-(a10)*, *(d)(1)(C)*, *(e)(1)-(3)*, *(f)(1)*, and *(h)*; *§ 301.361 (a)-(b)*; *§§ 320.25 (a)* and *(b)*; *§ 306.275 (c)*; *§§ 306.315 (a)* and *(c)*; *§§ 320.59 (a)* and *(b)(2)*; *§ 320.207 (e)*; *§§ 320.217 (a)(1)-(3)*, *(e)*, and *(g)*; *CAS Mental Health Clinics Program Manual*; *ACC.B.8*; *HIM.EHR.B.5*; *HIM.EHR.B.9*; and *RR.B.2*) **90%**
  - Eligibility and Admission (*§ 301.353 (a)(1)-(10); HIM.EHR.B.5.D.1.;* and *CAS MH Clinics Program Manual 4.2 (p. 3), 5.2 (p. 26),* and *5.3 (pp. 26-27* and *28)*) 95%
  - Client Rights (*§ 320.21 (e); § 320.25 (a)-(b); RR.B.2;* and *HIM.EHR.B.5; HIM.EHR.B.9;* and *ACC.B.14*) 87%
  - Medication Monitoring (*§§ 320.217 (a)(1)-(3), (e),* and *(g)*) 90%
  - Medication Consents (*§ 320.59 (a)* and *(b)(2)*) 78%
  - Recovery Plan (*§§ 301.353 (d)(1)(C)* and *(e)(1)-(3); § 415.5 (e);* and *CAS MH Clinics Program Manual 5.4 (pp. 37-38)*) 86%
  - Recovery Plan Review (*§ 301.353 (f)(1)(A)-(D); CAS MH Clinics Program Manual 5.4 (p. 38)*) 86%
  - Documentation of Services (*§ 301.361 (a)-(b); HIM.EHR.B.9*) 99%
  - Routine and Intensive Case Management Documentation (*§ 306.275 (c)(1)-(9)*) 93%
  - Documentation Medication Training and Support (*§§ 306.315 (a)* and *(c)*) 26%
  - Discharge Summary (*§ 301.353 (h)(1)-(3); ACC.B.8.5.D.1*) 88%

The HARRIS CENTER for Mental Health and IDD

History

Compliance previously conducted a comprehensive review of the SECAS Program during the 1st Qtr. of FY 2020.

Recommendations

The program should continue to review client documentation for compliance with regulatory standards, provide periodic targeted training based on self-monitoring results, and ensure employees remain current on all training courses. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the MH Division and the SECAS Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days (April 15, 2025).

Management Response

The following areas require a POI-
1. Agency mandated employee training will be reviewed by the direct supervisor during monthly supervision for clinical staff. PM will request the unit clinical trainer complete a monthly spreadsheet similar to other clinical trainers that gives training status for the entire unit.
2. Client Records- 1. PM unsure why TAC code 301.329 (a) (3) -(a) Maintenance of medical records (3) a current, organized, legible and comprehensive records system as the Harris Center uses an electronic health record (Epic). 2. 301.353 (a) (1)-(10), (d) (1) (C) (e) (1)-(3), (f) (1) and (h)- PM unsure why the codes listed above for 301.353 are all listed as areas of improvement. The codes listed on the audit are: 301.353 (e,1, F), (e,1, H, ii), (e, 2, C), (e, 2, D) (f, 1, C) and (f, 1, D)- PM and CTLs will work training dept to re-train staff on proper documentation of POCs. 3. 301.361 (a)- (b)- Staff POC re-training. 4. 320.25 (a)-(b)- this was directive from BO director. BO director working a process to attain physical signatures when completing annual financials and consent to services. 5. 306.275 (c)- PM will work with the CTLs and training dept on the proper documentation of case management notes. 6. 306.315 (a) and (c)-staff will be re-educated only using MTS when clinically indicated. 7. 320.59 (a) and (b) (2)- The VP of MH medical services will train physicians on the annual review of medication consents and the completion of consents for each medication prescribed. 8. 320.207 (e) PM unsure why 320.207 € listed as this was “the patient's plan of care will reflect any use of psychoactive medication as part of an integrated treatment approach aimed at increasing the patient's functioning and quality of life” was not cited on the audit. 9. 320.217 (a) (1)-(3), (e) and (g)- The VP of MH medical services and medical leadership are in the process of updating agency policies to reflect

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Christopher Beard
478D54B5E9104BB...

Regulatory Compliance Auditor

X Signed by: Lance Britt
BAB06A90B5FE4AC...

Vice President of MH Division

X Signed by: Dana Brown
E555066E02E5425...

SECAS Program Director/Manager

X Signed by: Demetria Luckett
B4ED8213F5ED41A...

Director of Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Mental Health (MH) Division Northeast Child and Adolescent Services (NECAS)
Comprehensive Review
Review Dates: April 23, 2025-May 13, 2025

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if the NECAS program was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Responsibilities of Local Authorities, Community Centers, and Contractors 25 TEX. ADMIN CODE § 414.554*; *Environment of Care and Safety 26 TEX. ADMIN. Code § 301.323*; *Medical Records System 26 TEX. ADMIN. CODE § 301.329*; *Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331*; *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353*; *Medication Services § 301.355*; *Telemedicine 26 TEX. ADMIN. CODE § 301.359*; *Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361*; *Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275*; *Medication Training and Support Services § 306.315*; *Rights Handbooks for Individuals Receiving Mental Health Services at Health and Human Services Commission Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 26 TEX. ADMIN. CODE § 320.21*; *Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals Not Operated by a Community Center 26 TEX. ADMIN. CODE § 320.23*; *Communication of Rights to Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE §320.25*; *Rights Protection Officer at Health and Human Services Commission Facilities and Community Centers 26 TEX. ADMIN. CODE § 320.27*; *Staff Training in Rights of Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE § 320.29*; *Documentation of Informed Consent 26 TEX. ADMIN. CODE § 320.59*; *Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. Code § 320.75*; *General Principles 26 TEX. ADMIN. CODE § 320.207*; *Medication Monitoring 26 TEX. ADMIN. CODE § 320.217*; the Texas Health and Human Services Commission's (HHSC) *Performance Contract Notebook (PCN) FY 24-25*; the Harris Center's MH Division's *CAS Mental Health Clinics Program Manual*; and Harris Center policies and procedures *ACC.B.8 Referral, Transfer, and Discharge*; *ACC.B.14 Declaration of Mental Health Treatment*; *HIM.EHR.B.5 Content of Patient/Individual Records*; *HIM.EHR.B.9 Patient/Individual Records Administration*; *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure*; *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*; and *RR.B.2 Assurance of Individual Rights*.

III. Audit Method:
A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024-February 28, 2025) was obtained through the Encounter Data Service Details report of the Electronic Health Record database (i.e., Epic) and an employee roster was provided by program leadership. Twenty (20) clients and five (5) employees from the NECAS Program were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance.

IV. Audit Findings/History:
Compliance noted that agency staff are not fulfilling annual training requirements; are not accurately completing consent and client rights documentation; are not including all required elements of plans of care; completing plan of care updates within designated timeframes; are not including all required elements of case management note documentation; and are not providing all services listed within the plan of care (e.g., medication training and support services). Compliance has not previously conducted a comprehensive review of the NECAS Program.

V. Recommendations:
The NECAS program should continue to review client and employee documentation, and employee training requirements for compliance with regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this review.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Mental Health (MH) Division
Northeast Child and Adolescent Services (NECAS) Comprehensive Review

Compliance Auditor(s): Christopher Beard

Review Dates: April 23, 2025-May 13, 2025

Purpose

This review was conducted to determine if the NECAS program was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Responsibilities of Local Authorities, Community Centers, and Contractors 25 TEX. ADMIN CODE § 414.554*; *Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323*; *Medical Records System 26 TEX. ADMIN. CODE § 301.329*; *Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331*; *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353*; *Medication Services § 301.355*; *Telemedicine 26 TEX. ADMIN. CODE § 301.359*; *Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361*; *Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275*; *Medication Training and Support Services § 306.315*; *Rights Handbooks for Individuals Receiving Mental Health Services at Health and Human Services Commission Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 26 TEX. ADMIN. CODE § 320.21*; *Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals Not Operated by a Community Center 26 TEX. ADMIN. CODE § 320.23*; *Communication of Rights to Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE §320.25*; *Rights Protection Officer at Health and Human Services Commission Facilities and Community Centers 26 TEX. ADMIN. CODE § 320.27*; *Staff Training in Rights of Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE § 320.29*; *Documentation of Informed Consent 26 TEX. ADMIN. CODE § 320.59*; *Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. Code § 320.75*; *General Principles 26 TEX. ADMIN. CODE § 320.207*; *Medication Monitoring 26 TEX. ADMIN. CODE § 320.217*; the Texas Health and Human Services Commission's (HHSC) *Performance Contract Notebook (PCN) FY 24-25*; the Harris Center's MH Division's *CAS Mental Health Clinics Program Manual*; and Harris Center policies and procedures *ACC.B.8 Referral, Transfer, and Discharge*; *HIM.EHR.B.5 Content of Patient/Individual Records*; *HIM.EHR.B.9 Patient/Individual Records Administration*; *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure*; *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*; and *RR.B.2 Assurance of Individual Rights*.

Methods

A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024-February 28, 2025) was obtained through the Encounter Data Service Details report of the Electronic Health Record database (i.e., Epic) and an employee roster was provided by program leadership. Twenty (20) clients and five (5) employees from the NECAS Program were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance.

The HARRIS CENTER for Mental Health and IDD

Findings

Comprehensive Audit
Overall Score: 94.38%
Detailed findings are presented below:

Strengths

• **Operations** (*§§ 301.359 (1)-(4);* and *§§ 301.323 (a)(2)(A)* and *(C)*)	**100%**
• **Medical** (*§ 301.323 (a)(4); §§ 301.355 (b)(1)-(4)* and *(8); § 320.207 (i)(1)-(4);* and *§320.75 (a)-(b)*)	**100%**
• **Environment** (*§ 301.323 (a)(1); § 320.21 (f); § 320.27 (b); § 414.554 (c)(1);* and *PCN FY 25-25 I.A.6.j. (1)-(3)*)	**100%**

Areas of Improvement:

• **Personnel** (*§§ 301.331 (a)(3)(A)(iii), (v), (viii), (x); §§ 301.331 (a)(3)(B)(i)-(iii)* and *(v); § 301.331 (h)(1)-(4); §§ 320.29 (1)* and *(3); PCN FY 24-25 I.B.2.g.3* and *I.C.2.g.3; HR.B.35;* and *MED.MH.B.1*)	**87.07%**
• Agency-mandated Employee Training	72.00%
• **Client Records** (*§ 301.329 (a)(3)*; *§ 301.353 (a)(1)-(a10)*, *(d)(1)(C)*, *(e)(1)-(3)*, *(f)(1)*, and *(h)*; *§ 301.361 (a)-(b)*; *§§ 320.25 (a)* and *(b)*; *§ 306.275 (c)*; *§§ 306.315 (a)* and *(c)*; *§§ 320.59 (a)* and *(b)(2)*; *§ 320.207 (e)*; *§§ 320.217 (a)(1)-(3)*, *(e)*, and *(g)*; *CAS Mental Health Clinics Program Manual*; *ACC.B.8*; *HIM.EHR.B.5*; *HIM.EHR.B.9*; and *RR.B.2*)	**84.82%**
• Eligibility and Admission (*§ 301.353 (a)(1)-(10); HIM.EHR.B.5.D.1.;* and *CAS MH Clinics Program Manual 4.2 (p. 3), 5.2 (p. 26),* and *5.3 (pp. 26-27* and *28)*)	87.46%
• Client Rights (*§ 320.21 (e); § 320.25 (a)-(b); RR.B.2;* and *HIM.EHR.B.5; HIM.EHR.B.9;* and *ACC.B.14*)	85.89%
• Medication Monitoring (*§§ 320.217 (a)(1)-(3), (e),* and *(g)*)	60.42%
• Medication Consents (*§§ 320.59 (a)* and *(b)(2)*)	69.47%
• Recovery Plan (*§§ 301.353 (d)(1)(C)* and *(e)(1)-(3); § 415.5 (e);* and *CAS MH Clinics Program Manual 5.4 (pp. 37-38)*)	88.41%
• Recovery Plan Review (*§ 301.353 (f)(1)(A)-(D); CAS MH Clinics Program Manual 5.4 (p. 38)*)	90.67%
• Routine and Intensive Case Management Documentation (*§ 306.275 (c)(1)-(9)*)	80.45%
• Documentation Medication Training and Support (*§§ 306.315 (a)* and *(c)*)	0%

History

Compliance has not previously conducted a comprehensive review of the NECAS Program.

Recommendations

The program should continue to review client documentation for compliance with regulatory standards, provide periodic targeted training based on self-monitoring results, and ensure

employees remain current on all training courses. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the MH Division and the NECAS Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days (May 28, 2025).

Management Response

na

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Christopher Beard 478D54B5F9104BB...

Regulatory Compliance Auditor

X Signed by: Lance Britt BAB06A80B5FE4AC...

Vice President of MH Division

X Signed by: Tricia Novotny DB00893C12EA4D0...

NECAS Program Director/Manager

X Signed by: Lisa Walker 3B912FA02715458...

Compliance Audit Manager

X

Director of Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Mental Health (MH) Division Co-locations Child and Adolescent Services (Co-locations)
Comprehensive Review
Review Dates: May 2, 2025-June 5, 2025

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if the Co-locations program was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Responsibilities of Local Authorities, Community Centers, and Contractors 25 TEX. ADMIN CODE § 414.554*; *Environment of Care and Safety 26 TEX. ADMIN. Code § 301.323*; *Medical Records System 26 TEX. ADMIN. CODE § 301.329*; *Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331*; *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353*; *Medication Services § 301.355*; *Telemedicine 26 TEX. ADMIN. CODE § 301.359*; *Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361*; *Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275*; *Medication Training and Support Services § 306.315*; *Rights Handbooks for Individuals Receiving Mental Health Services at Health and Human Services Commission Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 26 TEX. ADMIN. CODE § 320.21*; *Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals Not Operated by a Community Center 26 TEX. ADMIN. CODE § 320.23*; *Communication of Rights to Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE §320.25*; *Rights Protection Officer at Health and Human Services Commission Facilities and Community Centers 26 TEX. ADMIN. CODE § 320.27*; *Staff Training in Rights of Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE § 320.29*; *Documentation of Informed Consent 26 TEX. ADMIN. CODE § 320.59*; *Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. Code § 320.75*; *General Principles 26 TEX. ADMIN. CODE § 320.207*; *Medication Monitoring 26 TEX. ADMIN. CODE § 320.217*; the Texas Health and Human Services Commission's (HHSC) *Performance Contract Notebook (PCN) FY 24-25*; the Harris Center's MH Division's *CAS Mental Health Clinics Program Manual*; and Harris Center policies and procedures *ACC.B.8 Referral, Transfer, and Discharge*; *ACC.B.14 Declaration of Mental Health Treatment*; *HIM.EHR.B.5 Content of Patient/Individual Records*; *HIM.EHR.B.9 Patient/Individual Records Administration*; *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure*; *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*; and *RR.B.2 Assurance of Individual Rights*.

III. Audit Method:
A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024-February 28, 2025) was obtained through the Encounter Data Service Details report of the Electronic Health Record database (i.e., Epic) and an employee roster was provided by program leadership. Twenty (20) clients and eight (8) employees from the Co-locations Program were selected using an Excel formula to generate a random number list. The review used an audit tool developed by Compliance.

IV. Audit Findings/History:
Compliance noted that agency staff are not fulfilling annual training requirements; are not consistently completing engagement phone calls or services; are not accurately completing consent and client rights documentation; are not including all required elements of medication management documentation; are not including all required elements of plans of care; are not completing plan of care updates within designated timeframes; are not including all required elements of progress note and case management note documentation; and are not providing all services listed within the plan of care (e.g., medication training and support services). Compliance has not previously conducted a comprehensive review of the Co-locations Program.

V. Recommendations:
The Co-locations program should continue to review client and employee documentation, and employee training requirements for compliance with regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this review.

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Mental Health (MH) Division
Co-locations Child and Adolescent Services (Co-locations) Comprehensive Review

Compliance Auditor(s): Christopher Beard

Review Dates: May 2, 2025-June 5, 2025

Purpose

This review was conducted to determine if the Co-locations program was compliant with the Texas Administrative Code (TEX. ADMIN. CODE) *Responsibilities of Local Authorities, Community Centers, and Contractors 25 TEX. ADMIN CODE § 414.554*; *Environment of Care and Safety 26 TEX. ADMIN. CODE § 301.323*; *Medical Records System 26 TEX. ADMIN. CODE § 301.329*; *Competency and Credentialing 26 TEX. ADMIN. CODE § 301.331*; *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE § 301.353*; *Medication Services § 301.355*; *Telemedicine 26 TEX. ADMIN. CODE § 301.359*; *Documentation of Service Provision 26 TEX. ADMIN. CODE § 301.361*; *Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275*; *Medication Training and Support Services § 306.315*; *Rights Handbooks for Individuals Receiving Mental Health Services at Health and Human Services Commission Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 26 TEX. ADMIN. CODE § 320.21*; *Bill of Rights for Individuals Receiving Mental Health Services at Psychiatric Hospitals Not Operated by a Community Center 26 TEX. ADMIN. CODE § 320.23*; *Communication of Rights to Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE §320.25*; *Rights Protection Officer at Health and Human Services Commission Facilities and Community Centers 26 TEX. ADMIN. CODE § 320.27*; *Staff Training in Rights of Individuals Receiving Mental Health Services 26 TEX. ADMIN. CODE § 320.29*; *Documentation of Informed Consent 26 TEX. ADMIN. CODE § 320.59*; *Monitoring Compliance with Policies and Procedures 26 TEX. ADMIN. Code § 320.75*; *General Principles 26 TEX. ADMIN. CODE § 320.207*; *Medication Monitoring 26 TEX. ADMIN. CODE § 320.217*; the Texas Health and Human Services Commission's (HHSC) *Performance Contract Notebook (PCN) FY 24-25*; the Harris Center's MH Division's *CAS Mental Health Clinics Program Manual*; and Harris Center policies and procedures *ACC.B.8 Referral, Transfer, and Discharge*; *HIM.EHR.B.5 Content of Patient/Individual Records*; *HIM.EHR.B.9 Patient/Individual Records Administration*; *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure*; *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*; and *RR.B.2 Assurance of Individual Rights*. Operational Reviews of the five co-locations were also conducted as part of this audit (scores are reported within the applicable components).

Methods

A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024-February 28, 2025) was obtained through the Encounter Data Service Details report of the Electronic Health Record database (i.e., Epic) and an employee roster was provided by program leadership. Twenty (20) clients and eight (8) employees from the Co-locations Program were selected using an Excel

formula to generate a random number list. The review used an audit tool developed by Compliance.

Findings

Comprehensive Audit
Overall Score: 97.53%
Detailed findings are presented below:

Strengths

• **Operations** (*§§ 301.359 (1)-(4);* and *§§ 301.323 (a)(2)(A)* and *(C)*)	**100.00%**
• **Medical** (*§ 301.323 (a)(4); §§ 301.355 (b)(1)-(4)* and *(8); § 320.207 (i)(1)-(4);* and *§320.75 (a)-(b)*)	**100.00%**
• **Environment** (*§ 301.323 (a)(1); § 320.21 (f); § 320.27 (b); § 414.554 (c)(1);* and *PCN FY 25-25 I.A.6.j. (1)-(3)*)	**100.00%**
• **Personnel** (*§§ 301.331 (a)(3)(A)(iii), (v), (viii), (x); §§ 301.331 (a)(3)(B)(i)-(iii)* and *(v); § 301.331 (h)(1)-(4); §§ 320.29 (1)* and *(3); PCN FY 24-25 I.B.2.g.3* and *I.C.2.g.3; HR.B.35;* and *MED.MH.B.1*)	**99.55%**

Areas of Improvement:

• **Personnel**	
• Agency-mandated Employee Training	
• Handle with Care annual completion (*§ 301.331 (a)(3)(B)(iii)*)	87.50%
• Co-occurring Psychiatric and Substance Use Disorders (NEO completion; *§ 306.7 (b)(1)*)	87.50%
• **Client Records** (*§ 301.329 (a)(3)*; *§ 301.353 (a)(1)-(a10)*, *(d)(1)(C)*, *(e)(1)-(3)*, *(f)(1)*, and *(h)*; *§ 301.361 (a)-(b)*; *§§ 320.25 (a)* and *(b)*; *§ 306.275 (c)*; *§§ 306.315 (a)* and *(c)*; *§§ 320.59 (a)* and *(b)(2)*; *§ 320.207 (e)*; *§§ 320.217 (a)(1)-(3)*, *(e)*, and *(g)*; *CAS Mental Health Clinics Program Manual*; *ACC.B.8*; *HIM.EHR.B.5*; *HIM.EHR.B.9*; and *RR.B.2*)	**88.10%**
• Eligibility and Admission (*§ 301.353 (a)(1)-(10); HIM.EHR.B.5.D.1.;* and *CAS MH Clinics Program Manual 4.2 (p. 3), 5.2 (p. 26),* and *5.3 (pp. 26-27* and *28)*)	89.79%
• Client Rights (*§ 320.21 (e); § 320.25 (a)-(b); RR.B.2;* and *HIM.EHR.B.5; HIM.EHR.B.9;* and *ACC.B.14*)	88.55%
• Medication Monitoring (*§§ 320.217 (a)(1)-(3), (e),* and *(g)*)	87.52%
• Recovery Plan (*§§ 301.353 (d)(1)(C)* and *(e)(1)-(3); § 415.5 (e);* and *CAS MH Clinics Program Manual 5.4 (pp. 37-38)*)	84.27%
• Recovery Plan Review (*§ 301.353 (f)(1)(A)-(D); CAS MH Clinics Program Manual 5.4 (p. 38)*)	91.58%
• Documentation of Services	
• A summary of activities that occurred during the provision of service (*§ 301.361 (a)(7)*)	93.52%
• The progress or lack of progress in achieving treatment plan goals (*§ 301.361 (a)(12)*)	93.52%

• The documentation of services must occur within two business days after each contact (*§ 301.361 (b)*)	86.11%
• All staff will follow accurate record-keeping procedures to document patient/individual record data that are true, correct, unique and individualized for each session completed (*HIM.EHR.B.9.5*)	92.31%
• Routine and Intensive Case Management Documentation (*§ 306.275 (c)(1)-(9)*)	80.73%
• Documentation Medication Training and Support (*§§ 306.315 (a)* and *(c)*)	26.32%

History

Compliance has not previously conducted a comprehensive review of the Co-locations Program.

Recommendations

The program should continue to review client documentation for compliance with regulatory standards, provide periodic targeted training based on self-monitoring results, and ensure employees remain current on all training courses. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the MH Division and the Co-locations Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days (June 19, 2025).

Management Response

PM will follow recommendations and will submit POI

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Christopher Beard 470B54B5F9184BD...

Regulatory Compliance Auditor

X Signed by: Lance Britt BAB06A90B3FE4AC...

Vice President of MH Division

X Signed by: Caryn Lira 6AD7176F3F93445...

Co-locations Program Director/Manager

X Signed by: Lisa Walker 3B912FA02715458...

Compliance Audit Manager

X

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Clinical High Risk-Psychosis Plan of Improvement (POI) Follow-up Review
Review Date: May 19, 2025, to May 22, 2025

I. Audit Type:
POI Follow-up Review

II. Purpose:
This review was conducted to determine if the program has fulfilled the corrective action steps regarding service documentation of Informed Medication Consent Form (Medical), Abnormal Involuntary Movement Scale (AIMS) (Medical), Client Rights (Clinical Records), and Crisis /Safety Plan (Clinical Records) requirements. The review assessed the Texas Administrative Code (*TEX. ADMIN. CODE) Evaluation and Diagnosis 26 TEX. ADMIN. CODE §320.209(c); Rights of Individuals 26 TAC TEX. CODE §320.59 (a-b); Communication of Rights to Individual Receiving Mental Health Services 26 TEX. ADMIN. CODE §320.25(b) and Agency Policy MED.MH. B.1 Suicide/Violence Behavioral Crisis Intervention.*

III. Audit Method:
A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024- February 28, 2025) was obtained from the program leadership through the function of the Electronic Health Record database (i.e., Epic). All eight (8) clients from the program leadership team were reviewed. The review used an audit tool developed by Compliance.

IV. Audit Findings and History:
The overall score is 85.6%. The program's strengths were 100% Medical requirements: Informed Medication form, 100% Clinical Records requirements: Client Rights. The area of improvement was medical: Abnormal Involuntary Movement Scale (AIMS). The safety plan from the previous plan of improvement (POI) is no longer applicable due to a policy change. The new policy, Suicide/Violent Behavioral Crisis Intervention, did not apply to any of the individuals reviewed. Compliance conducted a CHR-P comprehensive review during the 1st Qtr. FY 2024

V. Recommendations
The Clinical High Risk for Psychosis program should continue to review client documentation to comply with regulatory standards, CHR-P Grant, CHR-P Operational Guidelines, Agency Policy and Procedures, and collaborate with Performance Improvement (PI) to provide a structured and formal process for identifying and addressing AIMS completion. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the Mental Health Division and Program Director/Manager must sign and return this report to Compliance within seven (7) business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2025
Mental Division
Clinical High Risk-Psychosis Follow-up Review

Compliance Auditor(s): Emmanuel Golakai

Review Dates: May 19, 2025- May 22, 2025

Purpose

This review was conducted to determine if the program has fulfilled the corrective action steps regarding service documentation of Informed Medication Consent Form (Medical), Abnormal Involuntary Movement Scale (AIMS) (Medical), Client Rights (Clinical Records), and Crisis /Safety Plan (Clinical Records) requirements. The review assessed the Texas Administrative Code (*TEX. ADMIN. CODE) Evaluation and Diagnosis 26 TEX. ADMIN. CODE §320.209(c); Rights of Individuals 26 TAC TEX. CODE §320.59 (a-b); Communication of Rights to Individual Receiving Mental Health Services 26 TEX. ADMIN. CODE §320.25(b) and Agency Policy MED.MH. B.1 Suicide/Violence Behavioral Crisis Intervention.*

Methods

A client roster for persons served during the 2nd Qtr. FY 2025 (December 1, 2024- February 28, 2025) was obtained from the program leadership through the function of the Electronic Health Record database (i.e., Epic). All eight (8) clients from the program leadership team. The review used an audit tool developed by Compliance.

Findings

Comprehensive Audit
Overall Score: 85.6 %
Detailed findings are presented below:

Strengths:

- Medical
  - Informed Medication Consent Form (*26 TEX. ADMIN. CODE §320.59 (a-b)* **100%**
- Clinical Records
  - Client Rights (*26 TEX. ADMIN. CODE §320.25(b)* **100%**

Areas of Improvement:

- Medical *26 TEX. ADMIN. CODE §320.113(c)(2))*
  - No Abnormal Involuntary Movement Scale (AIMS) completed prior to initiation of Psychoactive medication (*26 TEX. ADMIN.CODE §320.209(c)* **57%**

Observation

- The safety plan from the previous plan of improvement (POI) is no longer applicable due to a policy change. The new policy, Suicide/Violent Behavioral Crisis Intervention, does not apply to any of the individuals reviewed.

The HARRIS CENTER for Mental Health and IDD

History

Compliance conducted a CHR-P comprehensive review during the1st Qtr. FY 2024.

Recommendations

The Clinical High Risk for Psychosis program should continue to review client documentation to comply with regulatory standards, CHR-P Grant, CHR-P Operational Guidelines, Agency Policy and Procedures, and collaborate with Performance Improvement (PI) to provide a structured and formal process for identifying and addressing AIMS completion. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the Mental Health Division and Program Director/Manager must sign and return this report to Compliance within seven (7) business days (June 2, 2025).

Management Response

BHCM team and Dr. Patel are following up on AIMS compliance.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Emmanuel Golakai
3AC7A40D9D0C439...

Senior Regulatory Compliance Auditor

X Signed by: Lance Britt
BAB06A00B5FE4AC...

Vice President of Mental Health Division

X Signed by: Rena Strope
14CB7986CD45428...

Program Director/Manager

X Signed by: Lisa Walker
3B012FA02715458...

Compliance Manager

X Signed by: Demetria Luckett
B4ED8213F5ED41A...

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
ID Network Management In-Home Respite Comprehensive Review
Review Date: January 27, 2025, to January 31, 2025

I. Audit Type:
Comprehensive Review

II. Purpose:
Compliance conducted this review to assess ID Network Management In-Home Respite for compliance with FY2025 Standard In-Home Respite Contract and the IDD Service Definition Manual and Agency Policy and Procedures

III. Audit Method:
A client roster for persons served during the first quarter of FY 2025 (September 1, 2024, to November 30, 2024) was obtained from the ID Network Management In-Home Respite A staff training transcript was provided by the Organizational Development Staff Training Roster Report. A sample size of thirty (30) client records were randomly selected. The review was conducted using a audit tool created by Compliance. Detailed data for this review are presented below.

IV. Audit Findings and History:
The overall score is 88%. The program's strengths were 100% for the Clinical Record. The program scored 75% in Personnel for annual trainings. One staff had only evidence of completing one annual training for Bloodborne Pathogens Awareness, A second staff had no evidence of completing Diversity and Employment annual training. Two other staff reviewed had evidence of completing all their annual trainings. Compliance completed a previous review in FY2023.

V. Recommendations:
ID Network Management should continue to monitor the service documentation to ensure compliance with the FY2025 contract and Service Definition Manual. ID Network Management is required to submit a Plan of Improvement (POI). The report must be signed by the Vice President of IDD and Program Director, including a management response addressing the present findings, and returned to the Compliance Department within seven (7) business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
1st Quarter (Qtr.) of Fiscal Year (FY) 2025
Intellectual and Developmental Disabilities (IDD) Division
ID Network Management In-Home Respite Comprehensive Review

Compliance Auditor(s): Christopher Webb

Review Date: January 27, 2025, to January 31, 2025

Purpose

Compliance conducted this review to assess ID Network Management In-Home Respite for compliance with FY2025 Standard In-Home Respite Contract and the IDD Service Definition Manual and Agency Policy and Procedures.

Method

A client roster for persons served during the first quarter of FY 2025 (September 1, 2024, to November 30, 2024) was obtained from the ID Network Management In-Home Respite A staff training transcript was provided by the Organizational Development Staff Training Roster Report. A sample size of thirty (30) client records were randomly selected. The review was conducted using a audit tool created by Compliance. Detailed data for this review are presented below.

Findings

Overall Program Score: 88%
Detailed findings are presented below.

Strengths:
Clinical Record

• The contractor will provide Mandated agency training to caregivers who provide care and supervision of persons on a temporary basis for short periods of time. (CPR, First AID) *FY2025 Standard Contract Exhibit A3*	**100%**
• The contractor will ensure that all families and respite providers receive initial and ongoing training in respite services, requirements (i.e., certification, etc.), and responsibilities. *FY2025 Standard Contract Exhibit A3*	**100%**
• Background checks were provided for Caregivers who provide care and supervision of persons on a temporary basis for short periods of time. *FY2025 Standard Contract Exhibit A3*	**100%**
• The contractor will also submit a signed and fully complete Respite Voucher which shall match the Small Group Services form. *FY2025 Standard Contract Exhibit A3*	**100%**
• To be eligible for services a person must relieve primary unpaid care providers of responsibilities on a planned or emergency short-term basis. Care and supervision of individuals at their residence (i.e., in- home). The need for a respite service must be documented on the Plan of Services and Supports or Respite Plan (if no other R0 assignments) with an exception allowed in an emergency with unplanned respite needs. Face-to-face contact with the individual to provide respite care.	**100%**
• Required activities for the service relieve primary unpaid care providers of responsibilities on a planned or emergency short-term basis. Care and supervision of individuals at their residence (i.e., in- home). The need for a respite service must be documented on the Plan of Services and Supports or Respite Plan (if no other R0	**100%**

assignments) with an exception allowed in an emergency with unplanned respite needs. Face-to-face contact with the individual to provide respite care.

- A written narrative for each service event that describes the service and, when appropriate, includes information about the individual's progress toward goals and outcomes. The written narrative must consist of the name of the individual type of service; date of service (month, day, year); place of service; actual begin and end time of each reported service event; detailed description of the service event; name and title of the service provider; and signature of the service provider (including credentials or job title as appropriate **100%**

Areas of Improvement:

Personnel **75%**
Annual Trainings

- The staff only competed Bloodborne Pathogen Awareness Training. **11%**
- The staff did not complete the required annual trainings on Diversity and Employment. **89%**

History

The previous review was conducted FY23 October 21- October 25,2021

Recommendations

The Program should continue to assess its processes and review documentation ensuring all required standards are completed in accordance with regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follo up Review in 180 days. The Vice President (VP) of IDD Division and the Program Manager/Director must sign and return this report and the completed POI management response along with the POI to Compliance by the close of business on March 19, 2025.

Management Response

The HARRIS CENTER for Mental Health and IDD

SIGNATURE PAGE

X Signed by: Christopher Webb A0B9E1E56E3B4A0...

Senior Regulatory Compliance Auditor

X DocuSigned by: Evanthe Collins 7E1995673D954B3...

Vice President of IDD Division

X Signed by: Demetria Luckett B4EB8243F3ED41A...

Director of Compliance

X Signed by: Margo Childs CA484F0B25704F1...

Program Director/Manager

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
ISS/Day Hab Comprehensive Review
Review Dates: February 14, 2025- May 13, 2025

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if IDD ISS/Day Hab were following *Texas Administrative Code (TEX.* ADMIN. CODE) Individualized Skills and Socialization Requirements General Requirements 26 §559.225, Program Requirements §559.227, Environmental and Emergency Response Plan §559.229 Certification Principles: Quality Assurance §566.11

III. Audit Method:
A client roster for persons served during the third quarter of FY 2024 (December 1, 2024, to February 28, 2025) was obtained from the IDD ISS/Day Hab program. A staff training transcript was provided by the Organizational Development Staff Training Roster Report. A sample size of ten (10) client records for ISS/Day Hab program were randomly selected. An Operational Review was conducted as well and the program scored 100% from that review after providing missing postings to Compliance from the initial review. The review was conducted using a state audit tool modified by Compliance. Detailed data for this review are presented below.

IV. Audit Findings/History:
Compliance noted that the program records did not contain Individual's current PDP, the individuals current IPC, DID and or endorsements, consent forms, outcomes are identified. Progress or lack of progress is documented in observable and measurable terms. Outcomes are identified in the PDP. The record did not contain Rights Acknowledgement. The individual was not informed on the process of reporting complaints. The following annual trainings were missing handle with care, Medicaid HIPAA compliance for covered entities, blood bourne pathogens awareness, office safety, cyber security basics, consumer rights, ethics and code of conduct, suicide/homicide prevention and precautions, basic pharmacology, diversity, equity and inclusion, documentation and recordkeeping, seizure assessment, center mission and active shooter. The record did not contain all identifying and relevant demographic, clinical and financial information. Compliance has not previously conducted a review of ISS/Day Hab program. The program informed the reviewer that consents, PDP, ID.RC and DID documents should have been provided by the Service Coordinator. However, there was no evidence that the program ever informed the Service Coordinator that the documents were not in the record.

V. Recommendations:
The Program should continue to assess its processes and review documentation ensuring all required standards are completed in accordance with regulatory standards. Program should also ensure that required documentation is in the record. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow up Review in 180 days. The Vice President (VP) of IDD Division and the Program Manager/Director must sign and return this report and the completed POI management response along with the POI to Compliance by the close of business on June 12, 2025.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2025
Intellectual and Developmental Disabilities (IDD) Division
ISS/Day Hab Comprehensive Review

Compliance Auditor(s): Christopher Webb

Review Dates: February 14, 2025 - May 13, 2025

Purpose

This review was conducted to determine if IDD ISS/Day Hab were following *Texas Administrative Code (TEX. ADMIN. CODE) Individualized Skills and Socialization Requirements General Requirements 26 §559.225, Program Requirements §559.227, Environmental and Emergency Response Plan §559.229 Certification Principles: Quality Assurance §566.11.*

Methods

A client roster for persons served during the third quarter of FY 2024 (December 1, 2024, to February 28, 2025) was obtained from the IDD ISS/Day Hab program. A staff training transcript was provided by the Organizational Development Staff Training Roster Report. A sample size of ten (10) client records for ISS/Day Hab program were randomly selected. An Operational Review was conducted as well and the program scored 100% from that review after providing missing postings to Compliance from the initial review. The review was conducted using a state audit tool modified by Compliance. Detailed data for this review are presented below.

Findings

Overall Score: 86.37%
Detailed findings are presented below:

Strengths:

- The Provider must employ an administrator. §559.227 (a) (1) (A) **100%**
- Policies and procedures were created that protect and promote the individual's right to control his or her schedule and activities. §559.225 c (2) (A) **100%**
- The Provider has policies and procedures for creating and maintaining incident reports §559.225 d (2) **100%**
- A notice by HHSC stating that survey and related reports are available at ISS location for public survey and providing HHSC's toll-free telephone number? §559.225 e (3) **100%**
- Conduct unannounced drills with staff for fire, severe weather, and other Services provided by trained/qualified employees and contractors §566.9 (a) **100%**
- The initial and periodic trainings provided to employees §566.9 (d)(1) **100%**

The HARRIS CENTER for Mental Health and IDD

- Does provider have practices to safeguard an individual against infectious and communicable diseases §566.9 (e) **100%**
- Monitor individual health, mental and related progress §566.11 (a)(6) **100%**
- Does Individual have a legal guardianship? (Current guardianship letter in record) §566.11 (E) **100%**
- The Individual is free from physical restraints? §566.11 (a)(11) emergency situations. §559.229 (f) (1) **100%**

Areas of Improvement:

- **Client Records**
  - Records contain Individual's current PDP. §566.7 (b)(1) **80%**
  - Records contain Individual's current IPC. §566.7 (b)(2) **30%**
  - Records contain Individual's current ID/RC assessment. §566.7 (b)(3) **10%**
  - Record contains DID and/or Endorsements, in accordance Title 26 Part 1 Ch 304 Subchapter D Rule §304.401: (Agency P&P) **30%**
  - Record contains consent forms. (Agency P&P) **60%**
  - Are outcomes identified in the PDP? §566.7 (e) **80%**
  - Progress or lack of progress documented in observable and measurable terms §566.7 (f) **0%**
  - Record contains Rights Acknowledgement. (Agency P&P) **50%**
  - Individual informed on process of reporting complaints? §566.11 (A) (18) **60%**
  - Missing the following annual trainings, Handle with Care II, Medical - HIPAA Compliance for Covered Entities, Bloodborne Pathogen Awareness, Office Safety, Cyber Security Basics, Consumer Rights, Ethics and Code of Conduct, Suicide/Homicide Prevention and Precautions, Basic Pharmacology, Diversity, Equity and Inclusion, Documentation and Recordkeeping, Seizure Assessment, Center Mission, Active Shooter. **13%**
  - Missing the following annual trainings Suicide/Homicide Prevention and Precautions, Basic Pharmacology Removed, Diversity, Equity and Inclusion, Active Shooter **81%**
  - Missing the following annual trainings; Handle with Care II, Ethics and Code of Conduct, Active Shooter. **81%**
  - Record contains all identifying and relevant demographic, clinical, and financial information. (Agency P&P) **70%**
  - Missing the Active Shooter annual training for 2024. **94%**

Observations

The program informed the reviewer that consents, PDP, ID.RC and DID documents should have been provided by the Service Coordinator. However, there was no evidence that the program ever informed the Service Coordinator that the documents were not in the record.

History

Compliance had not previously conducted a comprehensive review of the ISS/Day Hab Program.

Recommendations

The Program should continue to assess its processes and review documentation ensuring all required standards are completed in accordance with regulatory standards. Program should also ensure that required documentation is in the record. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow up Review in 180 days. The Vice President (VP) of IDD Division and the Program Manager/Director must sign and return this report and the completed POI management response along with the POI to Compliance by the close of business on June 12, 2025.

Management Response

Plan of Improvement for ISS/Hab Program to improve client record management will include weekly chart audits by Day Program Manager or designated staff using standardized audit checklist to ensure all required documents are present and current The log will maintain findings and corrective actions taken. To improve Documentation Completion classroom facilitators will be retrained on documentation standards and expectations and facilitators will be responsible for ensuring all required consents are completed and filed in EPIC or paper charts. We plan to improve communication with service coordination by implementing that Program Manager and Billing Coordinator or designated staff, will email Service Coordination regarding missing assessments (ID/RC, DID, IPC), missing or unsigned consent forms, and PDP missing outcome measures. This creates a communication log for audit purposes.

To improve documentation of client progress in EPIC encounter notes staff will document client progress or lack thereof in daily note, notes will align with outcomes identified and supervisor or designated staff will review notes bi-weekly for quality and completeness

Signature Page

The HARRIS CENTER for Mental Health and IDD

X Signed by: Christopher Webb A0B0E4F56F3B4A0...

Senior Regulatory Compliance Auditor

X DocuSigned by: Evanthe Collins 7E19950730D35406...

Vice President of IDD Division

X Signed by: Cassandra Johnson D7A6E65CA30E45A...

Program Manager/Director

X Signed by: Lisa Walker 3B912FA02715458...

Compliance Manager

X

Compliance Director

External Audits

DATAVANT REQUESTS

1. Datavant Request (behalf of Aetna) on 3/26/25
2. Datavant Request (on behalf of Ambetter from Superior HealthPlan) on 3/27/25
3. Datavant Request (on behalf of Aetna) on 3/31/25
4. Datavant Request (on behalf of United Healthcare) on 4/7/25
5. Datavant Request (on behalf of Cigna) on 4/14/25
6. Datavant Request 1 (on behalf of Aetna Medicare Advantage) on 4/21/25
7. Datavant Request 2 (on behalf of Aetna Medicare Advantage) on 4/21/25
8. Datavant Request (on behalf of Aetna Medicare Advantage) on 4/29/25
9. Datavant Request 1 on 5/20/25
10. Datavant Request 2 on 5/20/25
11. Datavant Request 3 on 5/20/25
12. Datavant Request 4 on 5/20/25
13. Datavant Request 5 on 5/20/25
14. Datavant Request 6 on 5/20/25
15. Datavant Request 7 on 5/20/25
16. Datavant Request 1 on 5/21/25
17. Datavant Request 2 on 5/21/25

datavant
Formerly named Ciox Health

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

Chart Review Request

MAR 26 2025

RECEIVED

To: [redacted]

Date: 3/25/2025

Fax Number: [redacted]

Phone Number: [redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]

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

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

[redacted]

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

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

[redacted]

datavant
Formerly named Ciox Health

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

Chart Review Request

MAR 31 2025

To:	Medical Records	Date:	3/26/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

RECEIVED

ACTION REQUESTED: Please respond within 15 days of receipt of this request.

Datavant has been contracted to obtain the medical record information for a select list of members included in the attached pull list. Please review the attached request letter for more information and a list of components required for these records.

Medical records can be submitted through the following options:

1. PROVIDER PORTAL:

Securely respond to Datavant-managed requests in a [redacted]

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

2. REMOTE EMR Retrieval:

Set up secure remote connection from an EMR directly to Datavant for timely remote retrieval by trained Datavant associates. contacting

3. ONSITE Chart Retrieval:

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

Contact

4.FAX:

Send secure faxes to [redacted]

5. MAIL:

Mark "Confidential" on the envelope and mail the medical records to:

[redacted]

When submitting via Fax or Mail, please notate on the pull list for each record as Pull or CNA (chart not available) by marking the associated circle. If CNA, please provide a reason in the notes section. Please place the pull list with the markings first or on top when sending.

If you want to set up Remote EMR or Onsite Retrieval or have any issues with the Provider Portal, contact Datavant at and please reference your Outreach ID at the top of the page.

[redacted]

We appreciate your efforts to complete this chart review for the requester. Our goal is to make the retrieval process as easy as possible for you. Thank you in advance for your assistance with this important endeavor.

Datavant

[redacted]

[redacted]

datavant
Formerly named Ciox Health

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

Chart Review Request

MAR 31 2025

RECEIVED

To: MEDICAL RECORDS Date: 3/28/2025

Fax Number: [redacted] Phone Number: [redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]

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

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

[redacted]

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

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

[redacted]

[redacted]

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	Medical Records	Date:	4/7/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]
- Username: [redacted]
- Password: [redacted]

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

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

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

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	Unknown	Date:	4/14/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]
- Username: [redacted]
- Password: [redacted]

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

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

APR 15 2025
RECEIVED

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

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	Unknown	Date:	4/21/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]
- Username: [redacted]
- Password: [redacted]

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

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

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

APR 22 2025

RECEIVED

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	Unknown	Date:	4/21/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]
- Username: [redacted]
- Password: [redacted]

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

APR 1 9

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

RECEIVED

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

datavant
Formerly named Ciox Health

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

Chart Review Request

To: Medical Records Date: 4/29/2025

Fax Number: [redacted] Phone Number: [redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]

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

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

APR 30 2025

RECEIVED

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

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

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	Unknown	Date:	5/20/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]
- Username: [redacted]
- Password: [redacted]

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

MAY 31 2025

RECEIVED

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

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

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	Unknown	Date:	5/20/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a [redacted]

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

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: [redacted]

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

RECEIVED

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

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	Unknown	Date:	5/20/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a [redacted]
- Username: [redacted]
- Password: [redacted]

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

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

4.Fax:
Send secure faxes t[redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: [redacted]

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

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

RECEIVED

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	Unknown	Date:	5/20/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]
Username: [redacted]
Password: [redacted]

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

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

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

RECEIVED 21 2025

datavant
Formerly named Clox Health

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

Chart Review Request

To:	Unknown	Date:	5/20/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]
- Username: [redacted]
- Password: [redacted]

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

MAY 21 2025

RECEIVED

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

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

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	Unknown	Date:	5/20/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]

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

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

MAY 21 2025

RECEIVED

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

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

datavant
Formerly named Ciox Health

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

Chart Review Request

To: Unknown Date: 5/20/2025

Fax Number: [redacted] Phone Number: [redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]
Username: [redacted]
Password: [redacted]

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

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

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

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	Unknown	Date:	5/21/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]

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

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

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

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

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	Unknown	Date:	5/21/2025
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

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

Medical records can be submitted through the following options:

1. Provider Portal:
Securely respond to Datavant-managed requests in a single, up-to-date queue. Login or Signup here:
[redacted]

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

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

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

4.Fax:
Send secure faxes to [redacted]

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to:
[redacted]

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

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

MAY 23 2025
RECEIVED

External Audits

PHARMACY AUDITS

1. Optum Rx - Southeast Clinic Pharmacy on 3/3/25
2. Optum Rx - Southwest Clinic Pharmacy on 3/3/25
3. Optum Rx - Southwest Clinic Pharmacy on 3/4/25
4. Optum Rx - Northwest Clinic Pharmacy on 3/10/25
5. Optum Rx - Northeast Clinic Pharmacy on 3/12/25
6. Optum Rx - Northwest Clinic Pharmacy on 3/13/25
7. Optum Rx - Northeast Clinic Pharmacy on 3/14/25
8. Optum Rx - Northwest Clinic Pharmacy on 3/18/25
9. Optum Rx - Southeast Clinic Pharmacy on 3/19/25
10. Optum Rx - Northwest Clinic Pharmacy on 3/28/25
11. Optum Rx - Northwest Clinic Pharmacy on 4/1/25
12. Optum Rx - Northeast Clinic Pharmacy on 4/2/25
13. Optum Rx - Southwest Clinic Pharmacy on 4/4/25
14. Optum Rx - Northwest Clinic Pharmacy on 4/15/25
15. Optum Rx - Southeast Clinic Pharmacy on 4/15/25
16. Optum Rx - Northwest Clinic Pharmacy on 4/17/25
17. Express Scripts Onsite audit - Northwest Clinic Pharmacy on 4/29/25
18. Optum Rx - Northeast Clinic Pharmacy on 4/30/25
19. Optum Rx - Southeast Clinic Pharmacy on 5/2/25
20. Optum Rx - Northeast Clinic Pharmacy on 4/25/25
21. Optum Rx - Northeast Clinic Pharmacy on 5/7/25
22. Optum Rx - Southeast Clinic Pharmacy on 5/7/25
23. Optum Rx - Southwest Clinic Pharmacy on 5/8/25
24. Optum Rx - Southeast Clinic Pharmacy on 5/13/25
25. Optum Rx - Northwest Clinic Pharmacy on 5/16/25
26. Express Scripts Onsite Audit - Southwest Clinic Pharmacy 5/8/25
27. Express Scripts Onsite Audit - Northwest Clinic Pharmacy 5/8/25
28. Optum Rx - Southeast Clinic Pharmacy on 5/19/25
29. Optum Rx - Northwest Clinic Pharmacy on 5/19/25
30. Optum Rx - Northwest Clinic Pharmacy on 5/23/25
31. Optum Rx - Northwest Clinic Pharmacy on 5/27/25
32. Optum Rx - Southeast Clinic Pharmacy on 5/27/25

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM:_____ **TO: EXL Service**
(Sender's Name)
Secure Fax: [redacted]
Encrypted Email: [redacted]

# of Pages:_____ (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: March 3, 2025

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

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____
[redacted]

_____
Pharmacy Manager / Representative Signature Date

[redacted]

[redacted]

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

PRESCRIPTION VALIDATION REVIEW WORKSHEET

Provider Name: SOUTHWEST CLINIC PHARMACY 3

[redacted]

PVR Date	EXL ID	Rx #	Fill Date	Drug Name	Val Qty	Val Days Supply	Disc Code	Comments	Estimated Overpayment Amount
03/03/2025	[redacted]	[redacted]		INVEGA TRINZ INJ 819MG	[redacted]		[redacted]	ORx will verify fill date	$ 0.00

Total Estimated Overpayment Amount: $ 0.00

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

[redacted]

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM [redacted]outhwest Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Email: [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHWEST CLINIC PHARMACY 3
NABP #: [redacted]
Date: March 4, 2025

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

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____

_____

Pharmacy Manager / Representative Signature Date

[redacted]

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

PRESCRIPTION VALIDATION REVIEW WORKSHEET

Provider Name: NORTHWEST CLINIC PHARMACY

PVR Date	EXL ID	Rx #	Fill Date	Drug Name	Val Qty	Val Days Supply	Disc Code	Comments	Estimated Overpayment Amount
03/10/2025	[redacted]	[redacted]	[redacted]	INVEGA TRINZ INJ 819MG	[redacted]		[redacted]	ORx will verify fill date	$ 0.00

Total Estimated Overpayment Amount: $ 0.00

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

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

Secure Fax: [redacted]

Encrypted Email [redacted]

# of Pages: 5 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY

NABP #: [redacted]

Date: March 12, 2025

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

Please Remember to:

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

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

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

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

[redacted]

[redacted]

Optum Rx® EXL

NABP #[redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted]/Northwest Clinic Pharmacy (Sender's Name) **TO:** EXL Service

Secure Fax: [redacted]

Encrypted Email: [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY

NABP #: [redacted]

Date: March 13, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]	[redacted]	[redacted]	[redacted]	LOXAPINE CAP 25MG	

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT _____

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: NE Pharmacy
(Sender's Name)

TO: EXL Service
Secure Fax: [redacted]
Encrypted Email: [redacted]

# of Pages: 6 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: March 14, 2025

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

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

Pharmacy Manager [redacted] ve Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

PRESCRIPTION VALIDATION REVIEW WORKSHEET

Provider Name: NORTHWEST CLINIC PHARMACY

PVR Date	EXL ID	Rx #	Fill Date	Drug Name	Val Qty	Val Days Supply	Disc Code	Comments	Estimated Overpayment Amount
03/18/2025	[redacted]	[redacted]	[redacted]	INVEGA HAFYE INJ 1560MG	[redacted]	[redacted]	[redacted]	Pharmacy states claim was reversed; ORx will verify and reverse as appropriate	$ 0.00

Total Estimated Overpayment Amount: $ 0.00

[redacted]

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

PRESCRIPTION VALIDATION REVIEW WORKSHEET

Provider Name: SOUTHEAST CLINIC PHARMACY

PVR Date	EXL ID	Rx #	Fill Date	Drug Name	Val Qty	Val Days Supply	Disc Code	Comments	Estimated Overpayment Amount
03/19/2025	[redacted]	[redacted]	[redacted]	INVEGA SUST INJ 234/1.5	[redacted]				$ 0.00

Total Estimated Overpayment Amount: $ 0.00

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

PRESCRIPTION VALIDATION REVIEW WORKSHEET

Provider Name: NORTHWEST CLINIC PHARMACY

PVR Date	EXL ID	Rx #	Fill Date	Drug Name	Val Qty	Val Days Supply	Disc Code	Comments	Estimated Overpayment Amount
03/28/2025	[redacted]	[redacted]	[redacted]	INVEGA TRINZ INJ 546MG	[redacted]		[redacted]	Pharmacy states claim was reversed; ORx will verify and reverse as appropriate	$ 0.00

Total Estimated Overpayment Amount: $ 0.00

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM:_____ **TO: EXL Service**

(Sender's Name)

Secure Fax: [redacted]

Encrypted Email: [redacted]

# of Pages:_____ (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY

NABP #: [redacted]

Date: April 1, 2025

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

Please Remember to:

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

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

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

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO_____

(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: NE Pharmacy
(Sender's Name)

TO: EXL Service

Secure Fax: [redacted]
Encrypted Em

# of Pages: 6 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: April 2, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]	[redacted]	[redacted]	[redacted]	INVEGA SUST INJ 156MG/ML	

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT [redacted]

[redacted] 4-2-25

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

PRESCRIPTION VALIDATION REVIEW WORKSHEET

Provider Name: SOUTHWEST CLINIC PHARMACY 3

PVR Date	EXL ID	Rx #	Fill Date	Drug Name	Val Qty	Val Days Supply	Disc Code	Comments	Estimated Overpayment Amount
04/04/2025	[redacted]	[redacted]	[redacted]	VYVANSE CAP 30MG	[redacted]		[redacted]	ORx will verify fill date	$ 0.00

Total Estimated Overpayment Amount: $ 0.00

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM:_____ **TO: EXL Service**

(Sender's Name)

Secure Fax: [redacted]

Encrypted Email: [redacted]

# of Pages:_____ (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY

NABP #: [redacted]

Date: April 15, 2025

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

Please Remember to:

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

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

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

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO_____

(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

PRESCRIPTION VALIDATION REVIEW WORKSHEET

Provider Name: SOUTHEAST CLINIC PHARMACY

PVR Date	EXL ID	Rx #	Fill Date	Drug Name	Val Qty	Val Days Supply	Disc Code	Comments	Estimated Overpayment Amount
04/15/2025	[redacted]	[redacted]	[redacted]	UZEDY INJ 200MG	[redacted]			ORx will verify fill date	$ 0.00

Total Estimated Overpayment Amount: $ 0.00

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

PRESCRIPTION VALIDATION REVIEW WORKSHEET

Provider Name: NORTHWEST CLINIC PHARMACY

PVR Date	EXL ID	Rx #	Fill Date	Drug Name	Val Qty	Val Days Supply	Disc Code	Comments	Estimated Overpayment Amount
04/17/2025	[redacted]	[redacted]	[redacted]	UZEDY INJ 200MG	[redacted]		[redacted]	Pharmacy states 'claim was reversed; ORx will verify and reverse as appropriate	$ 0.00

Total Estimated Overpayment Amount: $ 0.00

[redacted]

[redacted]

05/05/2025
Attn: Network Provider
SOUTHEAST CLINIC PHARMACY
5901 LONG DR
HOUSTON, TX 77087-1003

EXPRESS SCRIPTS®

Re: Audit Number: [redacted] NABP: [redacted]
Your response is due on or before: 06/04/2025

Dear Network Provider:

Express Scripts('ESI') manages the prescription drug benefit for many of your patients' employers or health plans. ESI reviewed a portion of your submitted claims during our on-site visit at your pharmacy. Review/audit may include one or more claims submitted to Prime Therapeutics, LLC on behalf of its benefit sponsors pursuant to your pharmacy's participation agreement with Express Scripts and the Express Scripts Network Provider Manual. Please review the Discrepancy Evaluation Report and Discrepancy Definitions for details on the specific discrepancies identified during your audit, including documentation that ESI requires in support of each discrepant claim. Should you wish to appeal the determination as to any listed claim, please submit your appeal documentation to ESI for review pursuant to the appeal process and timelines identified in this letter or in the ESI Provider Manual, including the relevant State Regulatory Handbook, both of which are available at [redacted]

All appeal documentation must be received by ESI no later than 06/04/2025. After this date, no additional documentation will be considered and the audit will be finalized. ESI will notify the pharmacy of the appealed audit results within ninety (90) calendar days from receipt of the appeal or in accordance with state and federal law.

Please send any appeal documentation to my attention at the street address or fax number listed below. If you have any questions regarding the audit results, please call me at [redacted]

[redacted]

Sincerely,
Express Scripts
[redacted]
Post Auditor
Retail Network Audit
[redacted]
Express Scripts
[redacted]
Private and Confidential

Note: If the auditor reviewed claims submitted for TRICARE business during the audit, you will receive a separate letter of those findings. Audit Discrepancy dollars are estimated; actual amount may vary upon adjudication due to unpredictable adjudication issues such as change in member co-pay or lesser of logic involving Network Discount vs. Usual and Customary Price.

[redacted]

[redacted]

Express Scripts
[redacted]

EXPRESS SCRIPTS®

Provider Name: SOUTHEAST CLINIC PHARMACY
Provider Address: [redacted]
HOUSTON, TX 77087-1003
Provider Account Number: [redacted]
NABP/NPI: [redacted]
Audit Number: [redacted]

Total Recovery Amount: $ 123.82
§ Review the enclosed discrepancy information
§ Refer to attached Appendix for discrepancy definitions
§ If you plan to provide supporting documentation concerning the discrepancies, please provide it no later than 06/04/2025

[redacted]

Discrepancy Evaluation Report

Rx Number	Date Of Service	Fill Number	Net Check Amount	Patient Pay Amount	Dispensing Fee	Paid Metric Quantity	Paid NDC	Paid Days Supply	Recovery Amount
[redacted]	[redacted]	0	[redacted]				[redacted]	20	$123.82
	Discrepancy Type	Discrepancy Amount	Discrepancy Note						
	IDS	$123.82	The correct days supply should have been 30.						

[redacted]

5/5/2025

[redacted]

Express Scripts
[redacted]
Secure Fax: [redacted]

EXPRESS SCRIPTS®

Provider Name: SOUTHEAST CLINIC PHARMACY
Provider Address: [redacted]
Provider Account Number: [redacted]
NABP/NPI:
Audit Number:

Discrepancy Definitions

Discrepancy Type	Discrepancy Description	Discrepancy Definition	Recovery Amount	Documentation Required
IDS	Incorrect Days Supply	Prescription was submitted with an incorrect days supply.	Difference in Co-Payment Amounts	No specific appeal documentation can address this discrepancy type.

[redacted]

Optum Rx® EXL

NABP #:

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

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

Secure Fax:

Encrypted Email:

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY

NABP #:

Date: April 30, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
				INVEGA TRINZ INJ 819MG	

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT _____

Pharmacy Manager / Representative Signature Date

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Southeast Clinic Pharmacy (Sender's Name) **TO: EXL Service**

Secure Fax: [redacted]

Encrypted Email: [redacted]

# of Pages:_____ (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY

NABP #: [redacted]

Date: May 2, 2025

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

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____

_____

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Northeast Clinic Pharmacy **TO: EXL Service**

(Sender's Name)

Secure Fax: [redacted]

Encrypted Em[redacted]

# of Pages:_____ (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY

NABP #: [redacted]

Date: April 25, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]	[redacted]	[redacted]	[redacted]	ABILIFY ASIM INJ 960MG	

Please Remember to:

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

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

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

[ ] I ATTEST TO THE CLAIM(S) BEING CORRECTED TO_____

(ORx will verify and correct as appropriate).

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] /Northeast Clinic Pharmacy **TO:** EXL Service
(Sender's Name)
Secure Fax: [redacted]
Encrypted Email: [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: NORTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: May 7, 2025

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

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT _____

[redacted]

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] / Southeast Clinic Pharmacy **TO: EXL Service**
(Sender's Name)
Secure Fax: [redacted]
Encrypted Email: [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: May 7, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]	[redacted]			ABILIFY ASIM INJ 960MG	

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT _____

_____
Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Southwest Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Email: [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHWEST CLINIC PHARMACY 3
NABP #: [redacted]
Date: May 8, 2025

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

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____

_____

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM [redacted] Southeast Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Email: [redacted]

# of Pages: 7 (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: May 13, 2025

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

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx

EXL

NABP #:

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

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

Secure Fax:

Encrypted Email:

# of Pages: _____ (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY

NABP #:

Date: May 16, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
				INVEGA TRINZ INJ 546MG	

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT _____

Pharmacy Manager / Representative Signature Date

05/12/2025
Attn: Network Provider
SOUTHWEST CLINIC PHARMACY
9401 SOUTHWEST FWY
STE 101
HOUSTON, TX 77074-1407

Re: Audit Number: [redacted] / NABP: [redacted]

Dear Network Provider:

Express Scripts('ESI') manages the prescription drug benefit for many of your patients' employers or health plans. ESI conducted an on-site audit of your pharmacy on 05/08/2025. ESI reviewed of a portion of claims submitted by and reimbursed to your pharmacy .

Please review the Final Discrepancy Evaluation report and Discrepancy Definitions for details on specific discrepancies identified. Review/audit may include one or more claims submitted to Prime Therapeutics, LLC on behalf of its benefit sponsors pursuant to your pharmacy's participation agreement with Express Scripts and the Express Scripts Network Provider Manual.

This letter is to inform you that ESI has concluded its audit of your pharmacy resulting in a final audit total of $0.00.

Finalization of this audit does not preclude further action on behalf ESI's clients. For all prescriptions listed on the Discrepancy Evaluation Report, you have the responsibility to determine impact to the Member, and (if applicable) reimburse or credit the Member for copayment, out-of pocket amounts, TrOOP, TDS, etc. as further described in the Provider Manual.

Thank you for your time and consideration concerning this matter. If you have any questions regarding this letter, please call me at [redacted]
Sincerely,
Express Scripts
[redacted]
Post Auditor
Retail Network Audit
[redacted]
Express Scripts
[redacted]
[redacted]
Private and Confidential

Note: If the auditor reviewed claims submitted for TRICARE business during the audit, you will receive a separate letter of those findings. Audit Discrepancy dollars are estimated; actual amount may vary upon adjudication due to unpredictable adjudication issues such as change in member co-pay or lesser of logic involving Network Discount vs. Usual and Customary Price.

An additional statement may be issued to the pharmacy indicating member responsibility and adjusted payment detail for applicable claims.

EXPRESS SCRIPTS®

April 22, 2025

Attention: Pharmacist

NORTHEAST CLINIC PHARMACY
7200 NORTH LOOP E
HOUSTON, TX 77028

Re: NABP: [redacted] / Audit Number: [redacted]

Dear Pharmacist:

Express Scripts ('ESI') manages the prescription drug benefit for many of your patients' employers or health plans.

Please be advised that a representative of Express Scripts will visit the pharmacy listed above on **5/8/2025** to conduct a routine audit of your prescription information. The representative will present identification from ESI. The audit will be conducted during normal business hours and will be performed as efficiently as possible.

The Review/audit may include one or more claims submitted to Prime Therapeutics, LLC on behalf of its benefit sponsors pursuant to your pharmacy's participation agreement with Express Scripts and the Express Scripts Network Provider Manual.

During the audit we will review the hardcopy prescriptions and other supportive information that is available. In addition, please have a staff member available to assist with the audit. After the on-site audit is completed, the initial audit findings will be discussed with the owner or pharmacist in charge.

For more information regarding ESI audit practices, including the audit standards and appeals process applicable to your pharmacy, please review, Section 5 of the ESI Provider Manual, as well as the relevant State section of the State Regulatory handbook, both of which are available [redacted]

Should you need to contact me prior to the field audit I can be reached by voice mail at [redacted]

Sincerely,

[redacted]
Field Auditor, Network Audit
[redacted]

(1) Notwithstanding the above, Express Scripts will comply with all applicable laws concerning audit, including limitations on allowable timeframes. In general, Express Scripts' audits focus on claims submitted within the most recent 12 Month period.

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted]/Southeast Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Email: [redacted]

# of Pages:_____ (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY
NABP #: [redacted]
Date: May 19, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]	[redacted]			INVEGA SUST INJ 156MG/ML	

Please Remember to:

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

[redacted]

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____

_____

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted]/Northwest Clinic Pharmacy **TO: EXL Service**
(Sender's Name)

Secure Fax: [redacted]
Encrypted Email: [redacted]

# of Pages:_____ (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY
NABP #: [redacted]
Date: May 19, 2025

EXL ID	Claim Number	Rx #	Fill Date	Drug Name	Pharmacy Comment
[redacted]	[redacted]			LOXAPINE CAP 25MG	

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT_____

Pharmacy Manager / Representative Signature Date

[redacted]

OptumRx

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] / Northwest Clinic Pharmacy (Sender's Name)

TO: EXL Service

Secure Fax: [redacted]

Encrypted Email: [redacted]

# of Pages: _____ (Including Cover)

Pharmacy Name: NORTHWEST CLINIC PHARMACY

NABP #: [redacted]

Date: May 23, 2025

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

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT _____

Pharmacy Manager / Representative Signature Date

[redacted]

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] / Northwest Clinic Pharmacy **TO: EXL Service**

(Sender's Name)

Secure Fax: [redacted]
Encrypted Em

# of Pages: _____ (Including Cover)

[redacted]

Pharmacy Name: NORTHWEST CLINIC PHARMACY
NABP #: [redacted]
Date: May 27, 2025

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

Please Remember to:

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

[redacted]

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

[redacted]

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

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

[redacted]

*Specify details in the Comments for each Rx number.

[redacted]

Pharmacy Manager / Representative PRINT _____

[redacted]

_____

Pharmacy Manager / Representative Signature Date

[redacted]

Optum Rx®

EXL

NABP #: [redacted]

Records Transmittal Page

PLEASE COMPLETE & RETURN THIS FORM WITH ALL SUPPORTING DOCUMENTATION WITHIN 14 BUSINESS DAYS.

FROM: [redacted] Southeast Clinic Pharmacy **TO: EXL Service**

(Sender's Name)

Secure Fax: [redacted]

Encrypted Email: [redacted]

# of Pages: _____ (Including Cover)

Pharmacy Name: SOUTHEAST CLINIC PHARMACY

NABP #: [redacted]

Date: May 27, 2025

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

Please Remember to:

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

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

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

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

*Specify details in the Comments for each Rx number.

Pharmacy Manager / Representative PRINT _____

Pharmacy Manager / Representative Signature Date

[redacted]

External Audits

PROGRAM SPECIFIC – EXTERNAL SURVEYOR

1. Texas Health and Human Services Fiscal Year 2025 Quality Assurance Review
2. YES Waiver Program Audit
3. Substance Use Recovery Services Program Audit
4. MEI Cost Report Desk Review
5. Harris County Housing and Community Development Audit of TMC Residence Hall
6. Harris County Housing and Community Development Audit of Hope Harbor
7. Permanency Plan Compliance Audit – IDD Division
8. Texas Home Living (TxHmL) Enrollment Compliance Audit – IDD Division

TEXAS
Health and Human Services

Cecile Erwin Young
Executive Commissioner

March 7, 2025

[redacted]
Executive Director
The Harris Center for Mental Health and IDD
9401 Southwest Freeway
Houston, TX 77074

Subject: Fiscal Year 2025 Quality Assurance Authority Review

[redacted]

Texas Health and Human Services Commission (HHSC) Contract Accountability and Oversight (CAO) completed the fiscal year 2025 Quality Assurance Authority Review of The Harris Center for Mental Health and IDD on February 6, 2025

At the conclusion of the Quality Assurance Authority Review, these reports of findings were presented to designated local intellectual and developmental disability authority (LIDDA) staff. These reports may include findings that require the LIDDA to submit to HHSC Corrective Action Plans with timelines to implement the plans upon approval by HHSC.

Based on the results of the annual Quality Assurance review:

The LIDDA qualifies for **Intermittent Monitoring** as one or more of the following elements were met:

- One or more program areas (TxHmL, GR/CFC, HCS, or PASRR) scored below 90%; and/or
- The overall score was below 90%.

The LIDDA's next monitoring review will be scheduled for 11 to 13 months after the monitoring exit date.

Please see the Report of Findings and the Comprehensive Score document for specific programmatic and comprehensive scores.

For questions or additional information concerning these reports and debriefing pages, please contact [redacted], by email at [redacted]

Sincerely,

[redacted]

Contract Accountability and Oversight
HHSC IDD Services

[redacted]

cc: [redacted]

Enclosures

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

Comprehensive Score	
Contract Score	99.49%
TxHmL Programatic Score	89.58%
HCS Programatic Score	82.70%
GR-CFC Programatic Score	95.20%
PASRR Programatic Score	93.24%
Overall Score	92.04%
This LIDDA would require an Intermittent review.	

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

GR-CFC
FY 2025 Report of Findings
280 - The Harris Center for Mental Health and IDD
02/03/25 - 02/06/25

OVERALL	95.20%	

LIDDA Requirement for Providing Service Coordination				
% Met	Elements for Review	Rule Requirement	Expectation	Findings/Comments
100.00%	**Process for Enrollment**	§330.9(e)(1,2);	• Enrollment process • service coordinator assignment	
100.00%	**Complaints**	§301.155(c)(d) §330.9 (c)(5)	• Complaint Process Notification	
100.00%	**Rights/Guardianship**	§334.117(c); §334.117(e); §334.119 (a); §334.119 (d) §334.107(10); §330.15(a)	• Initial/Annual DADS rights handbook: Your Rights in Local Authority Programs Rights & Document presentation of rights. • Determine, at least annually, if the letters of guardianship are current. • Make a referral of guardianship, if appropriate	
100.00%	**Personalized PDP/IPC development**	§331.5 (33)(A); §331.11 (a)	• Person/Family Directed the Plan of Services & Supports	
100.00%	**Behavior planning and Restriction Approvals**	§330.15(b)(e)(f) §330.15(b)	• BSP developed by qualified staff with SPT and approved by RPO • BSP consistent with Plan of Services & Supports • BSP reviewed and approved by SPT at least annually • BSP is monitored for effectiveness • Restrictions and limitations placed on an individual undergo due process	
100.00%	**Initial/ Annual required documentation**	§330.7(b)(1); §330.9(b)(1)(A); IDD Services Broadcast 2019-57; HB 6200	• Required annual documentation	
100.00%	**Service Coordination Assessment**	§331.7(a)(1)(A)&(c)	• SC Assessment determines frequency of Service Coordination • SC Assessment completed using current 8647	
100.00%	**Discovery process and person directed planning**	§331.11(a)	• Discovery Process • Initiate, coordinate, and facilitate person-directed planning	
100.00%	**PDP Content**	§331.5 (33)(B)&(C) §331.7(a)(1) HB 4000	• The PDP should be developed and include the documentation required for service coordination and what each program requires, such as back up plans, critical services and general revenue/waiver/non-waiver services.	
100.00%	**PDP/ Plan of Services Updates/Revisions**	§331.11(c)(1)&(2)	• Revising Plan of Services & Supports when needs change	
91.67%	**Monitoring Service Delivery**	§331.11(b)(1)(A), §331.11(d)(1-2),	• Monitors and coordinates delivery of and satisfaction with all services at least every 90 days • FTF contact at least every 90 days/in accordance with SC Plan	See debriefing pages.
100.00%	**Service Coordination Follow-up/ Concern Resolution**	§331.5(36)(A)-(D), §331.11 (d)(2)	• Service Coordination follow-up activities	
69.57%	**Documenting Progress**	§331.21 (a)(3)	• Reporting progress/lack of progress towards all outcomes at least every 90	See debriefing pages.
100.00%	**Providing Service Coordination**	§330.9(d)(1)&(2)	• Service coordination offered to each Medicaid, Medicaid-ineligible person	
100.00%	**Ensuring Service provision**	§330.13(a) §330.7(b)(1) Attachment E, A-1, 2.9.4 L	• All IDD services offered and implemented in timely manner	
Not Reviewed	**Financial Management**	§330.7(b)(9)	• Current consent to manage finances	
Not Reviewed	**Psychotropic Medication**	§330.15(d)	• Annual informed consent for medication prescribed by physician employed or contracted by LIDDA.	
Not Reviewed	**CFC Enrollment: Initial Eligibility Determination Activities**	17100	• Complete ID/RC Assessment to determine LOC	
Not Reviewed	**CFC Enrollment: SPT Meeting Totals**	17130	• Assign service coordinator • Schedule SPT and complete initial CFC service planning documents and activities • Identify joint meeting date	
Not Reviewed	**CFC Enrollment: Documents sent for Joint Meeting with MCO**	17130	• Complete Form 1040 and send service planning documents to MCO	
92.86%	**CFC Annual Reassessment**	17200 17230	• Communicate with MCO • Schedule SPT and complete annual CFC service planning documents and activities • Identify joint meeting date	See debriefing pages.
85.71%	**CFC Annual Service Planning**	17230	• Complete Form 1040 and send annual service planning documents to MCO	See debriefing pages.

ELEMENTS	MET	NOT MET	N/A	CAP REQUIREMENTS
Process for Enrollment	16	0	64	NO corrections are required for this element
Complaints	20	0	20	NO corrections are required for this element
Rights/Guardianship	78	0	32	NO corrections are required for this element
Personalized PDP/IPC development	16	0	4	NO corrections are required for this element
Behavior planning and Restriction Approvals	22	0	128	NO corrections are required for this element
Initial/ Annual required documentation	44	0	56	NO corrections are required for this element
Service Coordination Assessment	18	0	2	NO corrections are required for this element
Discovery process and person directed planning	36	0	48	NO corrections are required for this element
PDP Content	102	0	10	NO corrections are required for this element
PDP/ Plan of Services Updates/Revisions	14	0	6	NO corrections are required for this element
Monitoring Service Delivery	154	14	300	A SPECIFIC correction is required for each finding in this element
Service Coordination Follow-up/ Concern Resolution	4	0	4	NO corrections are required for this element
Documenting Progress	32	14	174	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
Providing Service Coordination	10	0	20	NO corrections are required for this element
Ensuring Service provision	30	0	0	NO corrections are required for this element
Financial Management	0	0	10	Not Applicable
Psychotropic Medication	0	0	10	Not Applicable
CFC Enrollment: Initial Eligibility Determination Activities	0	0	10	Not Applicable
CFC Enrollment: SPT Meeting Totals	0	0	70	Not Applicable
CFC Enrollment: Documents sent for Joint Meeting with MCO	0	0	60	Not Applicable
CFC Annual Reassessment	26	2	52	A SPECIFIC correction is required for each finding in this element
CFC Annual Service Planning	12	2	46	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
PARTICIPANT GRAND TOTALS	**634**	**32**	**1134**	**PARTICIPANT GRAND TOTAL SCORE** | **95.20%**

[redacted]

Please [redacted]

[redacted] **Email:** [redacted]

[redacted]

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

HCS
FY 2025 Report of Findings
280 - The Harris Center for Mental Health and IDD
02/03/25 - 02/06/25

OVERALL	82.70%	

LIDDA Requirement for Providing Service Coordination				
% Met	Elements for Review	Rule Requirement	Expectation	Findings/Comments
100.00%	**Process for Enrollment**	§330.9(e)(1); §263.104 (j)(4); §263.301 (a); §263.104 (e)(j)(k) and (o);	• Enrollment process • service coordinator assignment	
100.00%	**Service Coordinator Notification**	§263.901 e(26)	• Individuals, LARs and Providers are notified of their assigned Service Coordinator.	
100.00%	**CDS Choice**	§263.401b	• Inform about CDS Option, if applicable	
100.00%	**Objective Program Provider Selection Process**	§263.901 (e)(25)	• objectivity in assisting an individual or LAR in selecting a program provider or FMSA	
100.00%	**Complaints**	§301.155(c)(d) §330.9 (c)(5) §263.901(c)	• Complaint Process Notification	
97.18%	**Rights/Guardianship**	§334.117(c); §334.117(e); §334.119 (a); §334.119 (d) §334.107(10); §330.15(a) §263.901(e)(18)(19) HCS	• Initial/Annual DADS rights handbook: Your Rights in Local Authority Programs Rights & Document presentation of rights. • Determine, at least annually, if the letters of guardianship are current. • Make a referral of guardianship, if appropriate	See debriefing pages.
Not Reviewed	**Assisting with Rights**	§263.901 (e)(1)	• Assist exercising the legal rights	
100.00%	**Personalized PDP/IPC Development**	§331.5 (33)(A); §331.11 (a) §263.901(10)	• Person/Family Directed the Plan of Services & Supports	
100.00%	**Behavior planning and Restriction Approvals**	§330.15(b)(e)(f) §330.15(b) §263.901(12)	• BSP developed by qualified staff with SPT and approved by RPO • BSP consistent with Plan of Services & Supports • BSP reviewed and approved by SPT at least annually • BSP is monitored for effectiveness • Restrictions and limitations placed on an individual undergo due process	
100.00%	**Initial/Annual Required Documentation**	§330.7(b)(1); §330.9(b)(1)(A); IDD Services Broadcast 2019-57: HB 6200	• Required annual documentation	
100.00%	**Maintain Individual Record**	§263.901(e) (5)	Maintain copies of: (A)the IPC; (B) the PDP and CFC PAS/HAB Assessment form(if needed); (C) the ID/RC Assessment (D)service coordination notes (E) other pertinent information related to the individual	
66.67%	**Provide Provider Records**	§263.104(o)	Provide to the program provider and FMSA copies of all enrollment documentation including relevant assessments, the ID/RC Assessment, the proposed initial IPC, the PDP, and the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form if needed. Annually provide a copy of the PDP to the provider and a copy of the IPC and ID/RC annually in the TxHmL program.	See debriefing pages.
100.00%	**Service Coordination Assessment**	§331.7(a)(1)(A)&(c)	• SC Assessment determines frequency of Service Coordination • SC Assessment completed using current 8647	
95.00%	**Discovery Process and Person Directed Planning**	§331.11(a)	• Discovery Process • Initiate, coordinate, and facilitate person-directed planning	See debriefing pages.
93.67%	**PDP Content**	§331.5 (33)(B)&(C) §331.7(a)(1) HB 4000	• The PDP should be developed and include the documentation required for service coordination and what each program requires, such as back up plans, critical services and general revenue/waiver/non-waiver services.	See debriefing pages.
Not Reviewed	**Service settings**	§263.501(a)(2) §263.901(e)(21) §263.502(d)(e)	• Service Setting requirements	
84.62%	**PDP/Plan of Services Updates/Revisions**	§331.11(c)(1)&(2) §263.901(e)(13)	• Revising Plan of Services & Supports when needs change	See debriefing pages.
100.00%	**IPC Renewal**	§263.901(e)(10) §263.302 (a)(3)(B) §263.302 (a)(7) §263.302 (e)(2-4)	• Participate in the renewal and revision of a person's IPC • SC IPC responsibilities • HHSC data system entry of IPC agreement/disagreement	
61.54%	**Monitoring Service Delivery**	§331.11(b)(1)(A), §331.11(d)(1-2), §263.901 (e)(40)A-B, §263.901 (e)(15)	• Monitors and coordinates delivery of and satisfaction with all services at least every 90 days • FTF contact at least every 90 days/in accordance with SC Plan	See debriefing pages.
66.67%	**Service Coordination Follow-up/ Concern Resolution**	§331.5(36)(A)-(D), §331.11 (d)(2) §263.901(d)	• Service Coordination follow-up activities	See debriefing pages.
44.64%	**Documenting Progress**	§331.21 (a)(3)	• Reporting progress/lack of progress towards all outcomes at least every 90	See debriefing pages.
100.00%	**Community Choice**	§263.901 (e)(30)	• Ensure SPT offers choices and opportunities for accessing and participating in community activities and experience available to peers without disabilities;	
100.00%	**ID/RC LOC determination**	§263.105(c)	• HHSC data system Entry of ID/RC agreement/disagreement	
100.00%	**Residential Relocation**	§263.901 (e)(32)	• Ensure person is involved in planning the residential relocation, except in a	
Not Reviewed	**Transfers**	§263.701(a-e)	• Manage provider transfers:	
Not Reviewed	**Emergency Notification**	§263.901(e)(20)	• Notify SPT when need for emergency services is identified.	
Not Reviewed	**Community Based Monitoring**	§263.3(89)(C); §263.901(e)(38) 6820 HB	• For a person transitioning from a nursing facility SPT meetings are held in the community • Pre-move visitations are completed before the individual moves into a residential setting. • Post-move visitations are completed after the individual moves into a residential setting.	

ELEMENTS	MET	NOT MET	N/A	CAP REQUIREMENTS
Process for Enrollment	12	0	53	NO corrections are required for this element
Service Coordinator Notification	1	0	14	NO corrections are required for this element
CDS Choice	12	0	18	NO corrections are required for this element
Objective Program Provider Selection Process	3	0	7	NO corrections are required for this element
Complaints	26	0	14	NO corrections are required for this element
Rights/Guardianship	69	2	43	A SPECIFIC correction is required for each finding in this element
Assisting with Rights	0	0	5	Not Applicable
Personalized PDP/IPC Development	31	0	4	NO corrections are required for this element
Behavior planning and Restriction Approvals	9	0	6	NO corrections are required for this element
Initial/Annual Required Documentation	20	0	40	NO corrections are required for this element
Maintain Individual Record	23	0	7	NO corrections are required for this element
Provide Provider Records	4	2	27	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
Service Coordination Assessment	4	0	5	NO corrections are required for this element
Discovery Process and Person Directed Planning	38	2	24	A SPECIFIC correction is required for each finding in this element
PDP Content	74	5	27	A SPECIFIC correction is required for each finding in this element
Service settings	x	x	x	Not Applicable
PDP/Plan of Services Updates/Revisions	11	2	23	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
IPC Renewal	20	0	51	NO corrections are required for this element
Monitoring Service Delivery	96	60	228	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
Service Coordination Follow-up/ Concern Resolution	2	1	2	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
Documenting Progress	25	31	94	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
Community Choice	5	0	0	NO corrections are required for this element
ID/RC LOC determination	15	0	4	NO corrections are required for this element
Residential Relocation	2	0	3	NO corrections are required for this element
Transfers	0	0	80	Not Applicable
Emergency Notification	0	0	5	Not Applicable
Community Based Monitoring	0	0	20	Not Applicable
PARTICIPANT GRAND TOTALS	**502**	**105**	**804**	**PARTICIPANT GRAND TOTAL SCORE** **82.70%**

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR) AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD
02/03/25 - 02/06/25

OVERALL	**93.24%**	

TAC §303.601. Habilitation Coordination for a Designated Resident			
% Met	Elements for Review	Expectations	Findings/Comments
60.00%	**Habilitation Coordinator Assignment/ Service Coordinator Assignment** §303.601(a); 3100; 3230; 4200	·Habilitation coordinator assignment ·Diversion Coordinator review the person's admission within 45 days	See debriefing pages.
Not Reviewed	**Habilitation Coordinator Refusal** §303.504 (b); 4420; 5340.4	Refusal of Habilitation Coordination form	
100.00%	**Habilitation Coordination/Service Coordination/ECC Contact** §303.601 (b)(7); 3240; 5100, 6820	Meet face-to-face with the designated resident	
90.00%	**Service Planning Team Meeting** §303.602(a-d); 5320.1	·Resident participation in planning ·SPT member responsibilities ·Quarterly SPT meetings	See debriefing pages.
92.39%	**SPT Membership Requirements** §303.102 (71) (A); 5300;	·SPT includes all required members and participants	See debriefing pages.
81.48%	**Habilitation Service Plan Development** §303.601(b)(5); §303.601(b)(2); 5300, 5400; 5320.3	Develop and revise HSP	See debriefing pages.
100.00%	**Coordination with the Individual Profile** 5460.1	Individual Profile describes pertinent information identified by those who know the person best that service providers need to know and do to support the person	
100.00%	**Coordination of Specialized Services** §303.601 (3)(A)(B) §303.601 (4); §303.601 (5) 5510; 5520	·Assist with accessing needed specialized services; ·Coordinate other habilitative programs and services; ·Facilitate coordination of HSP and comprehensive care plan	
95.83%	**Community Living Options** §303.504 (b)(3); §303.601(c)(1)(B); 2430.5; 5810.1;§303.302(a)(2)(B)(i)(IV)	Address community living options initially and every six months on the Community Living Options (Form 1054); includes designated residents who refuse habilitation coordination	See debriefing pages.
100.00%	**Comprehensive Care Plan** §303.504 (a)(4); 5600	Maintain current comprehensive care plan in the record:	
40.00%	**Habilitative Assessment** **5**200; 5340; 5340.2	Complete and distribute the Habilitative Assessment	See debriefing pages.

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR) AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD
02/03/25 - 02/06/25

OVERALL	**93.24%**	

% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**Develop an HSP** §303.102 (23)(A)/5460.1 §303.102 (23)(B)/5410/ 5420/5430 §303.102(23)(C)/5430	HSP-Habilitation Service Plan: · Is individualized and developed through a person-centered approach; · Identifies strengths, preferences, outcomes, psychiatric, behavioral, nutritional management, and support needs · Identifies amount, frequency, and duration of each service	
85.71%	**Monitoring & Coordination of HSP** §303.601 (b)(6)(A)-(B) §303.601 (b)(6)(C) §303.601 (c)(1)(A)b(9-10) 5850	Monitor and provide follow-up activities: ·Initiation, delivery and satisfaction with all specialized services ·Report progress toward desired outcomes ·Assess and reassess habilitation service needs quarterly ·Offer educational and informational opportunities semiannually ·Coordinate service and support access with the nursing facility ·Annual review of rights	See debriefing pages. See debriefing pages.
100.00%	**Integrated Activities** §303.602(a)(6)(A)(B) 5300	Opportunities are provided for: ·Engaging in integrated activities with residents who do not have ID or DD ·In community settings with people who do not have a disability	
	§303.701. Transition Planning for a Designated Resident		
100.00%	**Transition Planning Responsibilities** §303.701; 5830	·Referral for Relocation Services ·Assign a ECC Service Coordinator	
100.00%	**Individual Participation in Transitioning** §303.701 (c)(2); 5300; 5370	·When transitioning, the SPT ensures the person participates in SPT meetings to the fullest extent possible	
100.00%	**Transition Plan Development** §303.701 (b) (d) (e) (f) (g) 6100; 6200; 6300	Develop, plan, and revise the Transition Plan	
100.00%	**Transition Plan Content** §303.701 (b); 6310	Transition Plan includes all required elements	
100.00%	**Transition Plan Implementation & Monitoring** 6200; 6300; 6520; 6530	Service Coordinator/Enhanced Community Coordinator (SC/ECC): ·Facilitates trial visits to HCS program providers, as requested ·Revises, implements, and monitors the Transition Plan, as necessary ·Manages transition into HCS services ·Develops and revises HCS PDP, as needed	

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR) AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD
02/03/25 - 02/06/25

OVERALL	**93.24%**	

% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**Pre-Move Site Review** §303.701 (h); 3230**;** 6530; 6600	Conduct and document a pre-move site review of proposed residence in the community	
100.00%	**Essential Supports** §303.701 (h) 3230; 6530	Determine whether all essential supports in the transition plan are in place and resolve all barriers with the SPT before transition to the community	
91.67%	**Post-Move Monitoring** §303.702; 3240; 6810	Conduct required post-transition monitoring activities	See debriefing pages.
100.00%	**Post-Move Monitoring and Protecting Health** 3240; 6820	For one year after diversion/transition, the SC/ECC must: ·Inquire about health concerns ·Convene the HCS SPT to add services/revise the PDP when needed ·Ensure timely assessments, as necessary ·Record health care status to identify when changes in status occur ·Conduct HCS service planning and monitoring ·Review implementation plans and provider records ·Visit service delivery sites, as needed ·Monitor critical incidents ·Monitor a person while on suspension, upon request	
Not Reviewed	**Remaining in Nursing Facility** §303.701 (i)(1)(2)(A)(B)**;** 5830.3	Identify barriers to moving and steps the SPT will take to address those barriers.	
		3100 - 3200 Nursing Facility Diversions	
100.00%	**Nursing Facility Diversion Coordination** 3100	Identify, arrange, and coordinate access to community services as a diversion to NF admission; request a targeted NF HCS diversion slot, if appropriate	
		3100 - 3200 Community-based Service Enrollment	
100.00%	**Community-based Service Enrollment Responsibilities** 5830; 5840	Habilitation Coordinator facilitates assignment of Residential Relocation Specialist and ECC Service Coordinator to initiate enrollment into community-based services	
75.00%	**Community-based SPT Meetings** §303.701 (c)(1-3); 3240**;** 6820	The HCS SPT meets at least quarterly and ensures the person participates in the SPT meetings to the fullest extent possible	See debriefing pages.
Not Reviewed	**Guardianship** §303.504 (a)(8); §303.601 (b)(11-12);5920.2	·Determine, at least annually, if the letters of guardianship are current; if appropriate ·Make a referral of guardianship, if appropriate	

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR) AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD
02/03/25 - 02/06/25

OVERALL	93.24%	

ELEMENTS	Met	Not Met	N/A	CAP REQUIREMENTS	
HC Refusal	0	0	30	Not Applicable	
HC Assignment	3	2	65	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element	
HC/SC/ECC Contact	62	0	22	NO corrections are required for this element	
SPT Meeting	90	10	6	A SPECIFIC correction is required for each finding in this element	
HSP Development & Revisions	22	5	7	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element	
Coordination of Specialized Serves	7	0	44	NO corrections are required for this element	
Community Living Options	23	1	86	A SPECIFIC correction is required for each finding in this element	
Comprehensive Care Plan	5	0	5	NO corrections are required for this element	
Transition Planning	1	0	19	NO corrections are required for this element	
Habilitative Assessment	2	3	45	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element	
SPT Participation	85	7	0	A SPECIFIC correction is required for each finding in this element	
Develop an HSP	105	0	85	NO corrections are required for this element	
Coordination & Monitoring of Servs	60	10	79	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element	
Integrated Activities	8	0	12	NO corrections are required for this element	
Coordination w/ Individual Profile	3	0	0	NO corrections are required for this element	
Transition Plan Development	17	0	147	NO corrections are required for this element	
Transition Plan Content	11	0	109	NO corrections are required for this element	
Transition Plan Implementation & Monitoring	5	0	75	NO corrections are required for this element	
Pre-Move Site Review	4	0	36	NO corrections are required for this element	
Essential Supports	14	0	426	NO corrections are required for this element	
Post-Move Monitoring	11	1	12	A SPECIFIC correction is required for each finding in this element	
Monitoring and Protecting Health	8	0	132	NO corrections are required for this element	
Remaining in NF	0	0	30	Not Applicable	
Nursing Facility Diversions Plan	1	0	19	NO corrections are required for this element	
Community-Based Services	2	0	78	NO corrections are required for this element	
Community-Based SPT Meetings	3	1	56	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element	
Guardianship	0	0	90	Not Applicable	
PARTICIPANT GRAND TOTALS	**552**	**40**	**1725**	**PARTICIPANT GRAND TOTAL SCORE**	**93.24%**

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR) AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD
02/03/25 - 02/06/25

OVERALL	**93.24%**	

This review resulted in items of non-compliance with the FYs 2025 and 2026 Performance Contract. In accordance with Attachment D. Article 3 and Article 4.1.1 of the FY 2023 and 2025 Performance Contract, HHSC, IDD Services may require a Corrective Action Plan (CAP) for items of non-compliance at the time of the review exit conference. As a result of this review, a CAP is required to be submitted for all findings. The CAP must be submitted within 30 calendar days after receiving the notice of deficiency for approval by HHSC, IDD Services.

The CAP must include the following:

- The date by which the deficiency will be corrected, which date may not exceed 90 days after the day of the exit conference or the date identified in the notice of deficiency, unless HHSC, IDD Services approves an additional amount of time prior to the expiration date;
- Identification of the party responsible for ensuring the deficiency is corrected;
- The actions that have been or will be taken to correct the deficiency, and
- A description of the systematic change and monitoring system implemented to ensure the deficiency does not re-occur, including the frequency of the monitoring and the party responsible for monitoring.

The CAP is due to HHSC IDD Services no later than **April 6, 2025**.

Within 10 business days of receiving this report, the LIDDA may request a reconsideration of findings based on the evidence originally reviewed by HHSC, IDD Services. The reconsideration request must be in writing via email to the Review Facilitator. Submission of new or additional information will not be considered. Requests for reconsideration will not affect the CAP due date HHSC, IDD Services will respond via email to the LIDDA's request for reconsideration within 15 calendar days after receiving the request.

In accordance with the FYs 2025 and 2026 Performance Contract, Attachment D. Article 3 and Article 4.1.1, the PASRR Authority Review Report of Findings is shared at the time of the Exit Conference. The report will also be shared with the Contract Manager. If remedies or sanctions are required, the Contract Manager shall send to the LIDDA notice of the LIDDA's alleged noncompliance and HHSC, IDD Services specified remedies or sanctions after receipt of the CAP.

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

QUALITY ASSURANCE AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

02/03/25 - 02/06/25

Authority Functions	98.98%	

Performance Contract			
% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**Planning and Network Advisory Committee (PNAC)** Attachment E A-1, Article 2, 2.1.5 - 2.1.9	LIDDA ensures the PNAC performs its advisory functions according to its identified outcomes and reporting requirements	
100.00%	**Local Provider Network Development Plan** Attachment E A-1, Article 2, 2.1.1-2.1.4	LIDDA posts current IDD Services Local Service Plan	
100.00%	**CRCG Participation** Attachment E A-1, Article 2, 2.3.4 - 2.3.5	• LIDDA participation in CRCG/CRCGA • LIDDA shares information with CRCG/CRCGA on persons with multiagency service needs	
100.00%	**Separation of Provider and Authority Functions** Attachment E A-1, Article 2, 2.5.1; Attachment E A-6, Article 1, 1.1.3	• LIDDA ensures designated enrollment staff do not perform functions for the LIDDA's provider operations. • LIDDA ensures service coordinators do not perform provider functions.	
100.00%	**Provider Complaint Resolution** Attachment E A-1, Article 2, 2.6.8	LIDDA has written procedures for responding to provider complaints/appeals	
100.00%	**Quality Management Plan** Attachment E A-1, Article 2, 2.6.9 (A-D)	QM Plan includes the required methods.	
87.50%	**HCS & TxHmL Interest List Maintenance** Attachment E A-1, Article 2, 2.7.1 (B) TAC 26 §263.103	• HCS & TxHmL Interest List Maintenance Process	See debriefing pages.
93.33%	**Permanency Planning** Attachment E A-10, 1.1- 1.2	Permanency Plan contains the following elements: • Information for Permanency Planning • Support Planning Information • Action Plans • Participant Information	See debriefing pages.

Administrative			
% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**Internal Interest List** Attachment E A-1, Article 2, 2.10.3	LIDDA has written procedures for processing requests for services not immediately available using HHSC required documentation	
100.00%	**Emergency Plan** Attachment E A-1, Article 2, 2.10.6	LIDDA has an emergency plan that meets the contract requirements.	

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

QUALITY ASSURANCE AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

02/03/25 - 02/06/25

Authority Functions	98.98%	

Data			
Not Reviewed	**Accurate and Timely Critical Incident and data reporting** Attachment E A-1, Article 2, 2.9.4 (M); Attachment D, Article 2, 2.4.7	• Accurate and timely data reporting • Timely and Accurate Critical Incident Reporting	
100.00%	**Priority Population** Attachment E A-1, Article 2, 2.7.1	LIDDA ensures individuals who receive services are qualified to receive services.	
TLETS			
100.00%	**Texas Law Enforcement Telecommunication System (TLETS)** LIDDA HB 19240 Attachment E A-1, Article 2, 2.3.7	• TLETS Implementation	
CLOIP			
Not Reviewed	**Community Living Options Information Process** Attachment E A-14; TAC 26 §A-904.5, §D-904.99; §330.11(a); HB 10300	• CLOIP Implementation	
OBI			
100.00%	**Outpatient Biopsychosocial Services (OBI) Program** Attachment E A-21	• OBI Implementation	
Crisis Intervention Respite			
100.00%	**Semi-Annual Educational and Informational Activities** Attachment E A-4 **1.3.3**	• Planned LIDDA activities to provide individuals with education and information about their options living in the community.	

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

QUALITY ASSURANCE AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

02/03/25 - 02/06/25

Authority Functions	98.98%	

Service Provision			
100.00%	**Ensuring Quality of Service Provision in all programs** Attachment E A-1, Article 2,2.7.1 R (A)(1-4)	LIDDA shall supervise and ensure provision of IDD services	
100.00%	**Ensuring Meaningful Access to LIDDA Programs, Services, Activities** Attachment E A-1, Article 2, 2.8.7	LIDDA must provide meaningful access to its programs, services & activities and ensure adequate communication through language assistance services	
100.00%	**Ensuring Eligibility Determination** Attachment E A-1, Article 2, 2.7.1 (A) LH 6600	LIDDA shall provide screening, eligibility determination services	
Human Resources			
% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**Service Coordinators Qualifications & Training** §331.17(b-f); §331.19 (b) (1-8) & (c) §301.669 (a-b), §301.519,§301.607 §301.609 , §334.121, C §52.107(b-c)□ §330.17 (h)(1-5); TxHmL §262.701 (g)(3)(A) & (B) HCS-D §263.901 (b)(3)(A) & (B)	• Qualifications and training requirements for service coordination supervisor and service coordinators assigned to individuals in the GR, TxHmL, HCS, and PASRR samples.	
Not Reviewed	**PASRR Habilitation Coordination Qualifications & Training** §303.501 (1-3), §303.502(a)(1)(A-B) §334.121, §301.669 (a-b), §330.17(h)(1-5), §303.502 (2)(A-B) 26 §301.607 §301.609 , C §52.107(b,c,f), 303.703(b)(1)(A-B)	• Qualifications and training requirements for habilitation coordinators assigned to individuals PASRR samples.	

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

QUALITY ASSURANCE AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

02/03/25 - 02/06/25

Authority Functions	98.98%	

Human Resources			
% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**PASRR Evaluation Staff Qualifications & Training** §331.17(b-f), §331.19 (b) (1-8) & (c), §301.669 (a-b), §301.519, §301.607, §301.609, §334.121, C §52.107(b,c,f), §330.17 (h)(1-5); TxHmL §262.701 (g)(3)(A) & (B) HCS-D §263.901 (b)(3)(A) & (B) §303.703(b)(1)(A), §303.303(c)(1)(A)	• Qualifications and training requirements for staff who are completing PASRR Evaluations.	
Not Reviewed	**ECC Coordinator Qualifications and Training** §331.17(b-f), §331.19 (b) (1-8) & (c), §301.669 (a-b), §301.519,§301.607, §301.609, §334.121, C §52.107(b-c), §330.17 (h)(1-5); TxHmL §262.701 (g)(3)(A) & (B) HCS-D §263.901 (b)(3)(A) & (B) §303.703(b)(1)(A-B), §303.303(c)(1)(A)	• Qualifications and training requirements for ECC service coordinators assigned to individuals in the GR, TxHmL, HCS, and PASRR programs.	
Not Reviewed	**PASRR Diversion Staff Qualifications & Training** §331.17(b-f); §331.19 (b) (1-8) & (c), §301.669 (a-b), TAC 40 §301.519, 26 §301.607 §301.609, §334.121,□ §52.107(b-c), §330.17 (h)(1-5); HCS-D §263.901 (b)(3)(A) & (B) §303.703(b)(1)(A-B), §303.303(b)(3) & (c)	• Qualifications & training requirements for staff who are completing PASRR Diversions.	

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

QUALITY ASSURANCE AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

02/03/25 - 02/06/25

Authority Functions	98.98%	

Human Resources			
% Met	Elements for Review	Expectations	Findings/Comments
Not Reviewed	**Professional Staff Qualifications & Training** §301.669 (a-b), §301.519□ §301.607, §301.609, §334.121, §52.107(b,c,f), §330.17 (h)(1-5)	• Qualifications and training requirements for employed and contracted professional staff assigned to individuals in the GR sample.	
Not Reviewed	**Direct Support Staff Qualifications & Training** §330.17(h)(4)(A)&(B), §330.17(h)(5)(A)&(B), §330.17(e)(1-2), §334.121, §301.669 (a)(1)-(7), §301.669 (b), §301.607, §301.609, C §52.107(b,c,f)	• Qualifications and training requirements for direct support staff assigned to individuals in the GR sample.	
100.00%	**Enrollment Staff Qualifications & Training** Attachment A-6, 1.1.2 §331.17(b-f); §331.19 (b) (1-8) & (c), §301.669 (a-b), §301.519, §301.607, §301.609, §334.121, §52.107(b-c), §330.17 (h)(1-5); TxHmL §262.701 (g)(3)(A) & (B) HCS-D §263.901 (b)(3)(A) & (B) LIDDA Handbook: 13100	• Training requirements for designated enrollment staff.	
Not Reviewed	**Crisis Intervention Specialist Qualifications and Training** 1.3.1A, 1.3.2 A-B, 42 Code of Federal Regulations, §483.430(a), LIDDA Handbook: 19000, §334.121, §301.669 (a-b), §330.17(h)(5)(A) & (B), §330.17 (h)(1); §301.607, §301.609, C §52.107(f), §52.107(c)(5), §52.107(b)	• Qualifications & training requirements for staff who are providing Crisis Intervention Specialized Services.	
100.00%	**Collaborative Care Case Manager DSW Training** Attachment A-21 1.3.3	• Training requirements for staff who are providing Collaborative Care Case Management.	

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

QUALITY ASSURANCE AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

02/03/25 - 02/06/25

Authority Functions	98.98%	

Human Resources and other requirements			
% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**Record Retention** Attachment E A-1, Article 2, 2.10.8; Attachment D, Article 5, 5.2 (9); Attachment D, Article 5, 5.10	LIDDA must ensure that all records are retained and made available in accordance with guidelines.	
Not Reviewed	**Additional Items of Non-Compliance**		
100.00%	**Federal & Texas LEIE Compliance** §52.107(f)	• LEIE Compliance	

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

QUALITY ASSURANCE AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

02/03/25 - 02/06/25

Authority Functions	98.98%	

ELEMENTS	Met	Not Met	N/A	CAP REQUIREMENTS
Planning and Network Advisory Committee (PNAC)	1	0	0	NO corrections are required for this element
Local Provider Network Development Plan	1	0	0	NO corrections are required for this element
CRCG Participation	1	0	0	NO corrections are required for this element
Separation of Provider and Authority Functions	2	0	0	NO corrections are required for this element
Provider Complaint Resolution	1	0	0	NO corrections are required for this element
Quality Management Plan	1	0	0	NO corrections are required for this element
HCS & TxHmL Interest List Maintenance Process	7	1	0	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
Permanency Planning	14	1	0	A SPECIFIC correction is required for each finding in this element
Internal Interest List	1	0	0	NO corrections are required for this element
Emergency Plan	1	0	0	NO corrections are required for this element
Accurate/Timely Critical Incident and CARE Reporting	0	0	2	Not Applicable
Priority Population	7	0	0	NO corrections are required for this element
Data Verification	0	0	24	Not Applicable
Texas Law Enforcement Telecommunication System (TLETS)	6	0	4	NO corrections are required for this element
Community Living Options Information Process	0	0	8	Not Applicable
Outpatient Biopsychosocial Services (OBI) Program	16	0	0	NO corrections are required for this element
Semi-Annual Educational and Informational Activities	47	0	0	NO corrections are required for this element
Ensuring Quality of Service Delivery (ALL programs)	4	0	0	NO corrections are required for this element
Ensuring Meaningful Access to LIDDA	3	0	0	NO corrections are required for this element
Ensuring Eligibility Determination	1	0	0	NO corrections are required for this element

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

QUALITY ASSURANCE AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

02/03/25 - 02/06/25

Authority Functions	98.98%	

ELEMENTS	Met	Not Met	N/A	CAP REQUIREMENTS	
Service Coordinators Qualifications & Training	23	0	1	NO corrections are required for this element	
Habilitation Coordination Training and Qualifications	0	0	0	Not Applicable	
PASRR Evaluator Qualifications and Training	10	0	1	NO corrections are required for this element	
ECC Staff Qualifications & Training	0	0	2	Not Applicable	
PASRR Diversion Coordinator Checks	0	0	2	Not Applicable	
Professional Staff Qualifications & Training	0	0	2	Not Applicable	
Direct Support Staff Qualifications & Training	0	0	2	Not Applicable	
Eligibility Determination Staff	0	0	2	Not Applicable	
Enrollment Staff Qualifications & Training	2	0	1	NO corrections are required for this element	
Crisis Intervention Specialist Qualifications and Training	0	0	2	Not Applicable	
Collaborative Care Case Manager DSW Training	1	0	1	NO corrections are required for this element	
Federal & Texas LEIE Compliance	2	0	0	NO corrections are required for this element	
Record Retention	42	0	0	NO corrections are required for this element	
Additional Items of non-compliance	0	0	0	Not Applicable	
PARTICIPANT GRAND TOTALS	**194**	**2**	**54**	**PARTICIPANT GRAND TOTAL SCORE**	**98.98%**

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

QUALITY ASSURANCE AUTHORITY REVIEW
FY 2025 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

02/03/25 - 02/06/25

Authority Functions	98.98%	

In accordance with FYs 2025 and 2026 Performance Contract, for any item of non-compliance remaining uncorrected by the LIDDA at the time of the review exit conference, the LIDDA must, within 30 calendar days after receiving a notice of deficiency, submit to HHSC a Corrective Action Plan (CAP).

The CAP must include the following:

- The date by which the deficiency will be corrected, which date may not exceed 90 days after the day of the exit conference or the date identified in the notice of deficiency, unless HHSC, IDD Services approves an additional amount of time prior to the expiration date;
- Identification of the party responsible for ensuring the deficiency is corrected;
- The actions that have been or will be taken to correct the deficiency, and
- A description of the systematic change and monitoring system implemented to ensure the deficiency does not re-occur, including the frequency of the monitoring and the party responsible for monitoring.

The CAP is due to HHSC IDD Services no later than **April 6, 2025**.

Within 10 business days of receiving this report, the LIDDA may request a reconsideration of findings based on the evidence originally reviewed by HHSC, IDD Services. The reconsideration request must be in writing via email to the Review Facilitator. Submission of new or additional information will not be considered. Requests for reconsideration will not affect the CAP due date HHSC, IDD Services will respond via email to the LIDDA's request for reconsideration within 15 calendar days after receiving the request.

In accordance with the FYs 2025 and 2026 Performance Contract, Attachment D. Article 3 and Article 4.1.1, the QA Debriefing page is shared at the time of the Exit Conference. The Authority Review report will be shared with the LIDDA and Contract Manager once the report has been finalized. If remedies or sanctions are required, the Contract Manager shall send to the LIDDA notice of the LIDDA's alleged noncompliance and HHSC specified remedies or sanctions after receipt of the CAP.

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

TxHmL
FY 2025 Report of Findings
280 - The Harris Center for Mental Health and IDD
02/03/25 - 02/06/25

OVERALL	89.58%	

LIDDA Requirement for Providing Service Coordination				
% Met	Elements for Review	Rule Requirement	Expectation	Findings/Comments
100.00%	**Process for Enrollment**	§330.9(e)(1); §262.103;	• Enrollment process • service coordinator assignment	
100.00%	**Service Coordinator Notification**	§262.701 (l)	• Individuals, LARs and Providers are notified of their assigned Service Coordinator.	
100.00%	**CDS Choice**	§262.701 q,r,s,t	• Inform about CDS Option, if applicable	
100.00%	**Objective Program Provider Selection Process**	§262.701 (c)	• objectivity in assisting an individual or LAR in selecting a program provider or FMSA	
100.00%	**Complaints**	§301.155(c)(d) §330.9 (c)(5) §262.901(e)(4)	• Complaint Process Notification	
100.00%	**Rights/Guardianship**	§334.117(c); §334.117(e); §334.119 (a); §334.119 (d) §334.107(10); §330.15(a)	• Initial/Annual DADS rights handbook: Your Rights in Local Authority Programs Rights & Document presentation of rights. • Determine, at least annually, if the letters of guardianship are current. • Make a referral of guardianship, if appropriate	
Not Reviewed	**Assisting with rights**	§262.701(j)(1)	• Assist exercising the legal rights	
100.00%	**Personalized PDP/IPC development**	§331.5 (33)(A); §331.11 (a) §262.701(J)(4)	• Person/Family Directed the Plan of Services & Supports	
100.00%	**Behavior planning and Restriction Approvals**	§330.15(b)(e)(f) §330.15(b) §262.701(J5)	• BSP developed by qualified staff with SPT and approved by RPO • BSP consistent with Plan of Services & Supports • BSP reviewed and approved by SPT at least annually • BSP is monitored for effectiveness • Restrictions and limitations placed on an individual undergo due process	
100.00%	**Initial/ Annual required documentation**	§330.7(b)(1); §330.9(b)(1)(A); IDD Services Broadcast 2019-57; HB 6200	• Required annual documentation	
100.00%	**Maintain Individual Record**	§262.701 (e)(1-5)	Maintain copies of: (A)the IPC; (B) the PDP and CFC PAS/HAB Assessment form(if needed); (C) the ID/RC Assessment (D)service coordination notes (E) other pertinent information related to the individual	
64.29%	**Provide Provider Records**	§262.103(t) §262.701 (f)	Provide to the program provider and FMSA copies of all enrollment documentation including relevant assessments, the ID/RC Assessment, the proposed initial IPC, the PDP, and the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form if needed. Annually provide a copy of the PDP to the provider and a copy of the IPC and ID/RC annually in the TxHmL program.	See debriefing pages.
100.00%	**Service Coordination Assessment**	§331.7(a)(1)(A)&(c)	• SC Assessment determines frequency of Service Coordination • SC Assessment completed using current 8647	
94.74%	**Discovery Process and Person Directed Planning**	§331.11(a)	• Discovery Process • Initiate, coordinate, and facilitate person-directed planning	See debriefing pages.
97.44%	**PDP Content**	§331.5 (33)(B)&(C) §331.7(a)(1) HB 4000	• The PDP should be developed and include the documentation required for service coordination and what each program requires, such as back up plans, critical services and general revenue/waiver/non-waiver services.	See debriefing pages.
Not Reviewed	**Service Settings**	§262.202 (a)(2)	• Service Setting requirements	
90.91%	**PDP/Plan of Services Updates/Revisions**	§331.11(c)(1)&(2) §262.701(k) and (l)	• Revising Plan of Services & Supports when needs change	See debriefing pages.
84.21%	**IPC Development**	§262.701(h)(3)	• Coordinates and develops an individual's IPC based on the individual's PDP;	See debriefing pages.
78.57%	**Monitoring Service Delivery**	§331.11(b)(1)(A), §331.11(d)(1-2), §262.701 (h)(4)	• Monitors and coordinates delivery of and satisfaction with all services at least every 90 days • FTF contact at least every 90 days/in accordance with SC Plan	See debriefing pages.
Not Reviewed	**Service Coordination Follow-up/ Concern Resolution**	§331.5(36)(A)-(D), §331.11 (d)(2) §262.701(k)	• Service Coordination follow-up activities	
67.86%	**Documenting Progress**	§331.21 (a)(3)	• Reporting progress/lack of progress towards all outcomes at least every 90 days	See debriefing pages.
90.00%	**Transfers**	§262.701(j)(8) §262.501(a)	• Manage provider transfers:	See debriefing pages.
Not Reviewed	**Suspensions**	§262.505(a-i)	• Manage Service Suspensions	
60.00%	**Service Coordinator Obligations**	§262.701(m)	• Service coordinator must inform the individual or LAR orally and in writing, of the 10 SC obligations on for 8586.	See debriefing pages.

ELEMENTS	MET	NOT MET	N/A	CAP REQUIREMENTS
Process for Enrollment	7	0	28	NO corrections are required for this element
Service Coordinator Notification	3	0	2	NO corrections are required for this element
CDS Choice	7	0	18	NO corrections are required for this element
Objective Program Provider Selection Process	3	0	7	NO corrections are required for this element
Complaints	26	0	9	NO corrections are required for this element
Rights/Guardianship	36	0	44	NO corrections are required for this element
Assisting with rights	0	0	10	Not Applicable
Personalized PDP/IPC development	29	0	6	NO corrections are required for this element
Behavior planning and Restriction Approvals	1	0	14	NO corrections are required for this element
Initial/ Annual required documentation	24	0	36	NO corrections are required for this element
Maintain Individual Record	33	0	2	NO corrections are required for this element
Provide Provider Records	9	5	31	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
Service Coordination Assessment	9	0	1	NO corrections are required for this element
Discovery Process and Person Directed Planning	18	1	25	A SPECIFIC correction is required for each finding in this element
PDP Content	38	1	6	A SPECIFIC correction is required for each finding in this element
Service Settings	x	x	x	Not Applicable
PDP/Plan of Services Updates/Revisions	20	2	18	A SPECIFIC correction is required for each finding in this element
IPC Development	16	3	5	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
Monitoring Service Delivery	77	21	156	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
Service Coordination Follow-up/ Concern Resolution	0	0	5	Not Applicable
Documenting Progress	19	9	67	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
Transfers	9	1	64	A SPECIFIC correction is required for each finding in this element
Suspensions	0	0	15	Not Applicable
Service Coordinator Obligations	3	2	20	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
PARTICIPANT GRAND TOTALS	**387**	**45**	**589**	**PARTICIPANT GRAND TOTAL SCORE** **89.58%**

In accordance with FYs 2025 and 2026 Performance Contract, for any item of non-compliance remaining uncorrected by the LIDDA at the time of the review exit conference, the LIDDA must, within 30 calendar days after receiving a notice of deficiency, submit to HHSC a Corrective Action Plan (CAP).

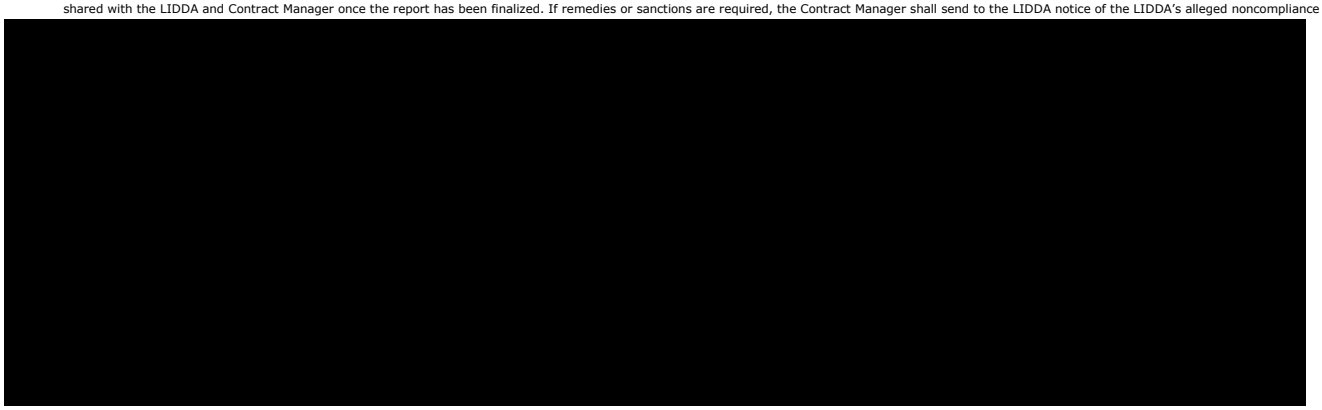
The CAP must include the following:

- The date by which the deficiency will be corrected, which date may not exceed 90 days after the day of the exit conference or the date identified in the notice of deficiency, unless HHSC, IDD Services approves an additional amount of time prior to the expiration date;
- Identification of the party responsible for ensuring the deficiency is corrected;
- The actions that have been or will be taken to correct the deficiency, and
- A description of the systematic change and monitoring system implemented to ensure the deficiency does not re-occur, including the frequency of the monitoring and the party responsible for monitoring.

The CAP is due to HHSC IDD Services no later than **April 6, 2025**.

Within 10 business days of receiving this report, the LIDDA may request a reconsideration of findings based on the evidence originally reviewed by HHSC, IDD Services. The reconsideration request must be in writing via email to the Review Facilitator. Submission of new or additional information will not be considered. Requests for reconsideration will not affect the CAP due date HHSC, IDD Services will respond via email to the LIDDA's request for reconsideration within 15 calendar days after receiving the request.

In accordance with the FYs 2025 and 2026 Performance Contract, Attachment D. Article 3 and Article 4.1.1, the Debriefing page is shared at the time of the Exit Conference. The Authority Review report will be shared with the LIDDA and Contract Manager once the report has been finalized. If remedies or sanctions are required, the Contract Manager shall send to the LIDDA notice of the LIDDA's alleged noncompliance and



TEXAS
Health and Human Services

Cecile Erwin Young
Executive Commissioner

Date: 5/14/2025

[redacted]
The Harris Center for Mental Health and IDD
9401 Southwest Freeway
Houston, Texas 77074

Subject: Corrective Action Plan

Dear: [redacted] and Staff,

The Texas Health and Human Services Commission (HHSC) received your Corrective Action Plan (CAP) and Evidence of Correction (EOC) to address the areas of non-compliance discovered during the YES Quality Management Review of your agency on 4/11/2025.

HHSC has determined that your CAP and EOC sufficiently addresses all required elements. As outlined in the plan and supporting documents, the center has implemented all corrective actions by 5/12/2025.

Please feel free to emai[redacted] if you have questions regarding this letter.

Sincerely,

[redacted]

[redacted] YES Waiver, Quality Management Specialist
Health and Human Services Commission
Medical and Social Services, Behavioral Health Services

Cc: [redacted]

[redacted]

TEXAS
Health and Human Services

Cecile Erwin Young
Executive Commissioner

[redacted]

May 06, 2025

[redacted] Program Director
The Harris Center for Mental Health and IDD
9401 Southwest Freeway [redacted]
Houston, TX 77074

Dear [redacted]

Thank you for your corrective action response to the Notice of Findings regarding your licensed facility number [redacted]. The deficiencies noted from the Notice of Findings have been sufficiently corrected and no further documentation regarding this inspection is required. While no further action is needed from the licensee at this time, HHSC may consider administrative action regarding the deficient practices cited. This will serve as notification the inspection is closed.

Please note that the items cited in this inspection may be reviewed by other HHSC units, and during subsequent inspections to ensure the plan of correction has been adequately implemented.

Should the facility discontinue services or make changes to the existing services, please notify the Facility Licensing Department in writing prior to implementing the change.

I want to thank you for your assistance during the inspection process. Please contact me at [redacted] if you have any questions regarding facility inspections.

Sincerely,

[redacted]
Inspector
Substance Use Disorder Compliance Unit
Texas Health and Human Services Commission

[redacted]

The HARRIS CENTER for Mental Health and IDD
Transforming Lives

[redacted].
April 21, 2025
MEI
9/1/2020-8/31/2021

2021 Cost Report 280 MEI MHMR Authority of Harris County

1. Please provide a payroll summary that shows hours and wages/contractor payments, taxes, benefits, and mileage for each category listed on cost report (6.c.,6. d. &6. e.). Please make sure the document shows the entity's name and cost report year on it.
    a. Please see excel workbook 2021 Cost Report 280 MEI MHMR Authority of Harris County for the summary detail for sections 6c and 6e.

2. Please provide an updated Trial Balance that shows expenses for each category listed in STAIRS. Please show each category for Step 8.f. expenses (ex. ECI Services, MH Services, IDD services, Program Admin & Operation, and Central Office broken out-do not lump expense together).
    a. Please excel workbook 2021 Cost Report 280 MEI MHMR Authority of Harris County for the summary.
    b. See tabs 8F expenses detail summary, Trial balance summary, and Central office summary.

3. STAIRS 8.f. - Building/Equipment -Contracted Services and Maintenance increased substantially from the prior cost report. Please provide a detailed general ledger for these costs.
    a. Please excel workbook 2021 Cost Report 280 MEI MHMR Authority of Harris County for the summary.
    b. Increase is due to several service maintenance increases due to additional owned building/equipment.

4. STAIRS 8.f. – Rent/Lease -Transportation Equipment or Contracted Transportation increased 100% from the prior cost report. Please provide a detailed general ledger for these costs.
    a. Please excel workbook 2021 Cost Report 280 MEI MHMR Authority of Harris County for the summary.
    b. See tab Rent_lease summary detail.
    c. Increase is due to the number of vehicles that were leased during FY2021 for specifically for MH.

Harris County
Housing & Community Development

April 23, 2025 **Sent via Electronic Mail**

Harris Center for Mental Health and IDD

Attn:

Re: The Men's Center
Project No.

Dear Mr. Young,

This letter is to inform you that Harris County Housing and Community Development Department (HCD) will be conducting a monitoring visit, on Tuesday, May 20, 2025, to review the HOME-funded project referenced above for Program Year (PY) 2024. will conduct the program review and will conduct the financial review.

Attached is the HOME Monitoring Checklist 6-C, which will be used as part of the program review.

Programmatic documentation to be **reviewed on-site**:
- Compliance with the HOME Program
- Record-keeping systems
- Client records from October 1, 2024, through April 30, 2025
- List of renters whose leases were terminated
- Denied applicants files since the last monitoring visit
- Reasonable accommodation/modification requests

Programmatic documentation to be **submitted electronically**:
- Section 504 Self-Evaluation and Transition Plan
- Updated Affirmative Marketing Plan
- Program guidelines and procedures
- Tenant Selection Plan
- Current rent schedule

Financial documentation to be **submitted electronically**:
- Financial Statements
- Audit
- Rent Roll
- Current Property Tax Statement

Please ensure that all the programmatic documentation listed above is submitted to [redacted] at [redacted] and all financial documentation listed above is submitted to [redacted] for review by May 16, 2025.

Additionally, all personnel responsible for this contract should be available throughout the visit in order to respond to HCD staff questions or concerns. This would include compliance, property, and financial personnel that deal with documents identified above.

If possible, HCD would prefer to have the use of office space where staff can review files at the program site. Prior to the conclusion of the monitoring visit, an exit conference will be held to summarize and explain findings or concerns, if any, and to discuss possible solutions to problem areas you might have encountered.

Should you have any questions, please contact [redacted]

Sincerely,

[redacted]

[redacted]

cc: [redacted]

Enclosure

Harris County
Housing & Community Development
[redacted]

April 23, 2025 **Sent via Electronic Mail**

[redacted]
Harris Center for Mental Health and IDD
[redacted]
Houston, Texas 77004

Attn: [redacted]

Re: Hope Harbor
Project No. [redacted]

Dear [redacted],

This letter is to inform you that Harris County Housing and Community Development Department (HCD) will be conducting an annual monitoring desk review, starting on Tuesday, May 20, 2025, to review the CDBG-DR funded project referenced above for the period from October 1, 2024, through April 30, 2025. [redacted] Project Coordinator, will conduct the program review and [redacted], Senior Accountant, will conduct the financial review.

Please submit the following documents for programmatic review:

- Current Compliance Report
- Current Affordable Marketing Plan
- Copy of marketing activities
- Current Section 504 Self-Evaluation Survey
- Housing unit inspections
- Self-certification of Continued Compliance (attached)
- Rent and utility allowance schedules
- Proof of Property and Flood insurance (if applicable)
- Annual property budget
- Tenant Selection Plan and amendments
- Employee Drug & Alcohol Policy
- Other documents as required

In addition to the items above, please have the following information available for financial review:

- Financial Statements
- Audit
- Rent Roll
- Current Property Tax Statement

[redacted]

Additionally, all personnel responsible for this contract should be available throughout the desk review in order to respond to HCD staff questions or concerns. This would include compliance, property, and financial personnel that deal with documents identified above.

Should you have any questions, please contact [redacted]

Sincerely,

[redacted]

Director of Stewardship and Performance

[redacted]

cc: [redacted]

Enclosure

[redacted]

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

[redacted]

May 5, 2025

SENT VIA ELECTRONIC MAIL TO: [redacted]

[redacted]
Executive Director
The Harris Center for Mental Health and IDD
9401 Southwest Freeway
Houston, TX 77074

Re: Notice of Non-Compliance for Fiscal Year 2025, Permanency Plans 2nd Quarter Performance Measures

Dear [redacted]:

This notice is provided in accordance with Fiscal Years 2024 and 2025 Performance Contract (the Contract), Attachment D-1: Revised Local Intellectual and Developmental Disability Authority (LIDDA) Special Conditions Article 3, 3.2 Mandatory Sanctions, 3.2.2.

The purpose of this letter is to notify The Harris Center for Mental Health and IDD that it did not meet targets with the following performance measure(s):

Performance Measure Outcome – Permanency Plans Completed

Under Attachment E-3: Revised Statement of Work, Section A-2 of the Contract, relating to Performance Measures and Outcome Targets, The Harris Center for Mental Health and IDD is required to achieve an outcome target of **95%** of permanency plans completed within required time frames.

Notice of Non-Compliance for Permanency Plans Completed

In accordance with Attachment D-1, Article 3, 3.5 of the Contract, HHSC hereby gives notice to The Harris Center for Mental Health and IDD of its failure to meet the required performance measure outcome for permanency plan completions. Based on Fiscal Year 2025, 2nd Quarter data, the

[redacted]

[redacted]
May 5, 2025
Page 2

performance measure for your local intellectual and developmental disability authority is **77%**, which is below the required outcome target.

Notice of Imposition of Sanction

In accordance with Attachment D-1, Article 3, 3.4 of the Contract, HHSC hereby imposes a sanction of **$4,768.45** against The Harris Center for Mental Health and IDD. The amount of the sanction is in accordance with the sanction chart set forth in the Contract.

Right to File an Appeal

In accordance with Attachment D-1, Article 3, 3.5.1 of the Contract, a LIDDA may file a written appeal (the "Appeal") of HHSC's determination of non-compliance if the imposition of the proposed sanction is believed to be in error. The Appeal must be received within 10 calendar days after the date the Notice is received. Please send the Appeal to [redacted]

To ensure a timely response to your appeal, ***please courtesy copy me at*** [redacted]

If The Harris Center for Mental Health and IDD does not submit an appeal in the manner and the timeframe described above, the determination by HHSC to impose a sanction will become final and payment will be due to HHSC.

Please remit the payment to the following address with a copy of this Notice no later than June 5, 2025. ***Additionally, please email me a copy of this payment for tracking purposes.***

Health and Human Services Commission
[redacted]

[redacted]
May 5, 2025
Page 3

ACCT CODE	FUND	DEPT ID	PROJ ID	PROGRAM	CLASS	APPROP	ARTS RECEIPT CATEGORY	ARTS SERVICE CODE
[redacted]								

For questions, or if you require assistance with this matter, please contact [redacted]

Sincerely,

[redacted]
Contract Manager
IDD Contracts Management Unit

[redacted]

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

[redacted]

May 5, 2025

SENT VIA ELECTRONIC MAIL TO: [redacted]

[redacted]
Executive Director
The Harris Center for Mental Health and IDD
9401 Southwest Freeway
Houston, TX 77074

Re: Notice of Non-Compliance for Fiscal Year 2025, Texas Home Living (TxHmL) Enrollment 2nd Quarter Performance Measures

Dear [redacted]:

This notice is provided in accordance with Fiscal Years 2024 and 2025 Performance Contract (the Contract), Attachment D-1: Revised Local Intellectual and Developmental Disability Authority (LIDDA) Special Conditions Article 3, 3.2 Mandatory Sanctions, 3.2.2.

The purpose of this letter is to notify The Harris Center for Mental Health and IDD that it did not meet targets with the following performance measure(s):

Performance Measure Outcome – TxHmL Enrollments Completed

Under Attachment E-3: Revised Statement of Work, Section A-2 of the Contract, relating to Performance Measures and Outcome Targets, The Harris Center for Mental Health and IDD is required to achieve an outcome target of **95%** of all TxHmL enrollments completed within required timeframes.

Notice of Non-Compliance of all TxHmL Enrollments Completed

In accordance with Attachment D-1, Article 3, 3.5 of the Contract, HHSC hereby gives notice to The Harris Center for Mental Health and IDD of its failure to meet the required performance measure outcome for TxHmL

[redacted]

[redacted]
May 5, 2025
Page 2

enrollments completed. Based on Fiscal Year 2025, 2nd quarter data, the performance measure for your local intellectual and developmental disability authority is **84%**, which is below the required outcome target.

Notice of Imposition of Sanction

In accordance with Attachment D-1, Article 3, 3.4 of the Contract, HHSC hereby imposes a sanction of **$2,384.22** against The Harris Center for Mental Health and IDD. The amount of the sanction is in accordance with the sanction chart set forth in the Contract.

Right to File an Appeal

In accordance with Attachment D-1, Article 3, 3.5.1 of the Contract, a LIDDA may file a written appeal (the "Appeal") of HHSC's determination of non-compliance if the imposition of the proposed sanction is believed to be in error. The Appeal must be received within 10 calendar days after the date the Notice is received. Please send the Appeal to [redacted]

To ensure a timely response to your appeal, ***please courtesy copy me at*** [redacted].

If The Harris Center for Mental Health and IDD does not submit an appeal in the manner and the timeframe described above, the determination by HHSC to impose a sanction will become final and payment will be due to HHSC.

Please remit the payment to the following address with a copy of this Notice no later than June 5, 2025. ***Additionally, please email me a copy of this payment for tracking purposes.***

Health and Human Services Commission
[redacted]

[redacted]
May 5, 2025
Page 3

ACCT CODE	FUND	DEPT ID	PROJ ID	PROGRAM	CLASS	APPROP	ARTS RECEIPT CATEGORY	ARTS SERVICE CODE
[redacted]								

For questions, or if you require assistance with this matter, please contact [redacted] at [redacted]

[redacted]

External Audits

MISCELLANEOUS REQUESTS

1. Vitrix Health Request (behalf of Texas Children's Health Plan) on 3/26/25
2. Community Health Choice Request on 5/30/25

Medical Records Request

Purpose: 2025 Hedis
On Behalf of: TXCH HEDIS

Mar 26 2025

RECEIVED

To: Medical records
Date: 3/26/2025

Fax Number: [redacted]
Provider Group: The Harris Center for Ment

Due Date: 04/09/2025
Work Group ID: [redacted]

Delivery Options

Provider Portal [redacted]

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

Secure Fax [redacted]
Mail [redacted]

Thank you for addressing this important request for medical records in a timely manner. Our goal at Virtix Health is to minimize any disruption to your practice and we are available to assist at any time.

- Please review all the contents in this packet, particularly:
  - The letter from TXCH HEDIS explaining the purpose of this request as well as the desired medical record components and date range
  - The Member List, which provides the patient, DOB and provider information for each record being requested.

- Please return the records using one of the three Delivery Options provided above.
  - We recommend using our secure, easy to use Provider Portal at https://cclinxportal.virtixhealth.com. From the portal you can view an electronic version of the Record List, securely upload images and monitor real-time status at a record level.

- Should you have any questions or require assistance, please contact the Virtix Support line at [redacted] and reference your Work Group ID [redacted].

Sincerely,
[redacted]

[redacted]

Texas Children's Health Plan

Janurary 1, 2025

Dear Provider,

Texas Children's Health Plan (TCHP) has engaged Virtix Health/Complex Care Solutions (a wholly owned subsidiary of Inovalon, Inc.) to perform the Healthcare Effectiveness Data and Information Set (HEDIS) medical record data abstraction on our behalf for the 2024 measurement year. Virtix Health/Complex Care Solutions operates as a Business Associate of TCHP in accordance with HIPAA. Accordingly, Virtix Health/Complex Care Solutions is legally bound to protect, preserve, and maintain the confidentiality of any Protected Health Information (PHI) it obtains from clinical records under its contractual obligations to TCHP. Rest assured that Virtix Health/Complex Care Solutions will secure and maintain the privacy of your patients' PHI.

HEDIS medical record data abstraction may begin in January 2025 and end in early May 2025. Virtix Health/Complex Care Solutions will call your office to request chart component copies. The chart components may be sent to Virtix Health/Complex Care Solutions via fax, mail, or a secure electronic link (provided to the office upon request). Should you have any questions regarding the data gathering process please contact Virtix Health/Complex Care Solutions directly. We request that you please respond to Virtix Health/Complex Care Solutions' requests within 3–5 business days. Do not hesitate to contact Virtix Health/Complex Care Solutions directly if you cannot submit the paperwork within the stipulated time frame.

Virtix Health/Complex Care Solutions' Contact Information:

[redacted]

Provider Portal: [redacted]
Please see the cover sheet for your username and password.

Please be aware that Virtix Health/Complex Care Solutions is committed to protecting all PHI and encourages providers to follow the Virtix Health/Complex Care Solutions record copying procedures to ensure the security of PHI while complying with HIPAA's minimum necessary requirements.

Your cooperation in extending Virtix Health/Complex Care Solutions your professional courtesy and prompt attention is appreciated. If you have any concerns about Virtix Health/Complex Care Solutions processes, please contact your TCHP Provider Relations Representative. We appreciate your assistance in this effort and thank you for partnering with us to improve the health of our members.

Sincerely,

[redacted]

[redacted]

COMMUNITY HEALTH CHOICE
COMMUNITY CARE

HARRIS CENTER FOR MENTAL HEALTH AND IDD
9401 Southwest Fwy
Houston, TX 77074
Attn: Medical Records

Request for Medical Records

Member Name: [redacted]
Member DOB: [redacted]
Date(s) of Service: From [redacted]
Member ID: [redacted]

Community Health Choice is requesting medical records for the member and dates of service listed above. Within **10 business** days of receipt of this letter, please provide the following documentation:

For **Outpatient Encounters:**

DO SUBMIT	DO NOT SUBMIT
• Signed Clinical Notes	• Unsigned Clinical Notes
• Lab or Procedure results	
• Pathology Reports	
• Imaging	
• Consult Notes	

Please note that it is critical that all dates of service(s) are signed (with credentials) and dated by the provider. A qualified provider is a medical doctor (MD), physician assistant (PA) or nurse practitioner (NP). You will need to provide a signature log with qualifications (MD, PA, NP) to identify signatures that appear within the medical record. CMS requires the signature and qualifications to validate the record.

Your participation in this review falls within the terms and conditions of your Medicare contract. We value your partnership and ask that you respond to requests as quickly as possible.

Community Health Choice is bound to preserve the confidentiality of health plan members protected health information obtained from medical records, in accordance with HIPAA regulations [45 CFR 164.506(c)(4)]. Please note that patient-authorized information releases are not required in order for you to comply. Your agreement with Community Health Choice requires you to respond to requests in support of Risk Adjustment, and other government required activities within the requested timeframe.

Thank you in advance for providing us with this requested information. Please do not hesitate to contact me at [redacted] if you have any questions or concerns. Please use this letter as the fax cover sheet for your response.

Records can be sent to:

- **Secure Fax:** [redacted] Attn: Risk Adjustment- Medicare
- **Secure Email:** [redacted]
- **ClOX secure e-delivery portal. Account #** [redacted]

Sincerely,

[redacted]
Director, Risk Adjustment
Community Health Choice
[redacted]

EXHIBIT A-7

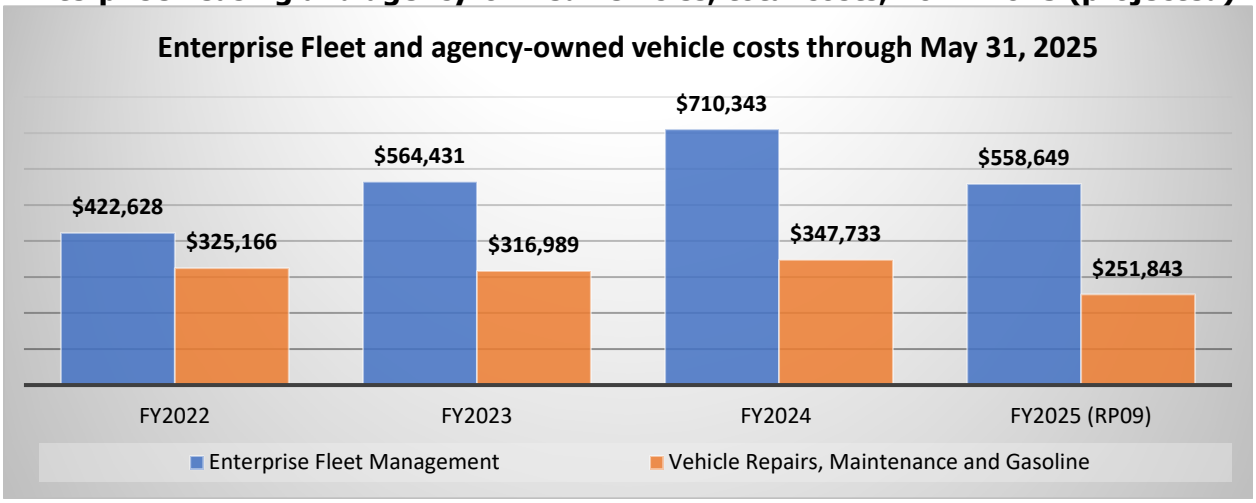
Executive Summary

FOLLOW-UP: FLEET MANAGEMENT AUDIT (FUFM0125)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit found costs for operating both the leased and agency-owned vehicles in FY 2024 totaled $1,058,076. Comparable costs were $747,794 in FY 2022 and $881,420 in FY2023. The Enterprise Lease program represents the larger share of the Center's vehicle operating costs and includes 97 vehicles. Internal Audit found total operating costs were $810,492 through May 31, 2025.

Enterprise Leasing and agency-owned vehicles, total costs, 2022-2025 (projected)



Source: Agency-Owned and Leased Vehicle Costs, from Trending Reports 2022 to 2025 as of May 31, 2025

Management Response: (Fleet Transportation Administrator-Senior): Agreed.

Observation #2 – Internal Audit found seven (7) agency-owned vehicles in inventory as of April 30, 2025 in the fixed asset reports. This includes five (5) Ford Escapes that are contractually retained to comply with the SUDUP program grant requirements. Based on scan date, the average age of these 7 vehicles is 3.6 years, as of April 30, 2025.

The Harris Center's remaining inventory of agency-owned vehicles, as of April 30, 2025

Serial #	Scan Date	Description	Model	Location Code
1GAWGEFP01175220	1/17/2020	2020 White Chevrolet Express Van *	EXPR. VAN	185801PRKLT
1FDEE3FN2PDD14923	6/30/2023	2023 24FT MOBILE MED. CLINICCHASSIS	E450	1817
1FMCU0F61LUB44081	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^
1FMCU0F62LUB78451	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^
1FMCU0F63LUA84756	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^
1FMCU0F63LUB44079	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^
1FMCU0F6XLUB44080	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^

Source: PowerBI reports, Inquiry Report for Fixed Assets, April 9, 2025 (* = Gordon, ^ = SUDUP program location)

Management Response: (Fleet Transportation Administrator-Senior): "The owned vehicle 2020 White Chevrolet Express Van VIN#1GAWGEFP01175220 was recently picked up on May 7th to be auctioned off on behalf of Enterprise."

Follow-Up: Fleet Management Audit

(FUFM0125)

INTERNAL AUDIT REPORT

July 15, 2025

David W. Fojtik, CPA, MBA, CIA, CFE

Director, Internal Audit

TABLE OF CONTENTS

CURRENT PROCESS

Internal Audit has performed several successive Fleet Management audit reports to review the status of a project to add Enterprise leased vehicles to our operations in order to replace The Harris Center's old agency-owned vehicles. The Transportation Department staff members monitor agency-owned vehicles and schedule regular vehicle maintenance, insurance, and vehicle registration activities, etc., but they report a robust interaction with the program staff at Enterprise to ensure that activities occur promptly.

At this time, the Internal Audit can verify that seven (7) agency-owned vehicles (as of April 30) remain in use including a customized van used for promoting The Harris Center's healthcare services in underserved communities. The Enterprise Fleet Management program has completed its transitions of agency-owned vehicles for replacement with a leased equivalent. At this point, the Transportation Specialist reports 97 vehicles are in the program.

Enterprise Fleet Management performs routine maintenance service on their vehicles on a regular basis and have ultimate responsibility for changing flat tires, installing new batteries or towing in some cases. The Transportation Specialist reports that her rapport with the Enterprise Leasing program is strong, and her main contact is involved in many communications that assures their continued quality of service. The advantage of using Enterprise Leasing is that the leased vehicles reduce the need for the Center's staff to perform routine vehicle maintenance and scheduling vehicle inspections and other annual tasks.

The Transportation Department is the primary contact for vehicle insurance reporting to the insurance carriers for reporting any incidents for agency-owned vehicles, but also report on issues with the leased vehicles, although procedurally the workflow is different.

The Transportation Specialist reports that the individual employees are accountable for their actions by maintaining Daily Reports, which is a workflow required by The Harris Center's policy and procedures. The Daily Reports are recorded each day to show mileage and driver information and are submitted to the business unit team at the end of the month.

The Harris Center's previous Director of Transportation provided an opinion of what his group expected. The Transportation Specialist is currently the lead on transportation operations. This follow-up audit will compare the Director's expectations with our current findings.

> *"Entering into the contract with Enterprise just as the nation faced the COVID crisis presented some very real challenges with the nation shutting down for several months and that coupled with the semi-conductor shortage drove the fleet replacement time from months to years. With the conditions improving in FY 2024, we expect the fleet replacement to be completed late FY 2024 to early FY 2025. Once the fleet is replaced with only the rental fleet, I expect to see a drop in operating cost across the board, maintenance, fuel cost, etc. The enterprise management team has been very good in helping navigate this crisis and has kept the transportation team informed and engaged in the replacement process and options available to the Center. Internally we are working on purchasing internal software to assist in managing the fleet for our end, this should result in reduced cost fleet wide. Once the fleet is replaced it is my recommendation an audit be conducted on vehicle use by program to determine if the actual car count could be reduced which would also result in reduced yearly expenditures."*

SCOPE AND OBJECTIVES

Audit Scope: The Follow-Up: Fleet Management Audit is part of Internal Audit's Fiscal Year 2025 Annual Audit Plan, performed to assure that management's operational controls remain in place.

Audit Objectives: This audit will review the Transportation Department's procedures that are being used to manage the fleet vehicles operations, and our audit objectives were designed to:

1. Assure that Fleet Management can reconcile all documentation for agency-owned and leased vehicles, and they can provide safeguards for proper storage of keys and other collateral.
2. Determine that the Transportation Department records can be matched to the inventory records.
3. Affirm that Fleet Management can perform routine vehicle maintenance requirements while providing adequate vehicles and related services to the business units whenever required.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes may include the following:

1. Management does not acknowledge Transportation Department reports about inconsistent or weak controls over inventory issues or leasing process issues.
2. Management does not ask Transportation Department staff to identify process improvements and the Department's staff does not negotiate process improvements with the leasing vendor.
3. Management may pay excessively high administrative service fees for inventory reports but not act on the inventory vendor's recommendations to change inventory as shown in the reports.

FIELD WORK

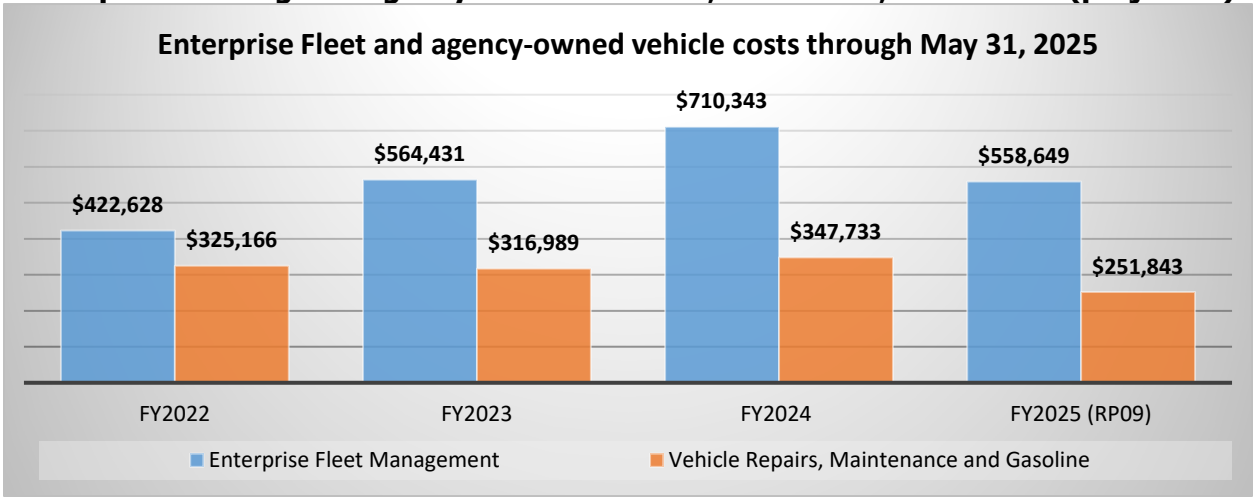
Field Work: A high-level summary of audit work was needed to address audit objectives listed above:

1. Contacted the Transportation Specialist to gain an understanding of the daily work activity involved in the position today.
2. To understand how the Transportation Specialist has performed her consignment of agency-owned vehicles which are to be replaced by the Enterprise leased vehicles.
3. Reviewed the current physical flow of financial documents that might be erroneously misdirected and recommend possible improved flows to improve transparency and user access to information.
4. Reviewed Enterprise Leasing's database of leased vehicle inventory to show timeliness of key metrics and frequency of updates by comparing odometer readings on 3-4 vehicles to database metrics.
5. Measured the costs of the Enterprise Fleet Management program since the previous review at the fiscal year-end (August 31, 2024) to determine if costs meet management's expectations or see if some additional fees or other costs are now appearing in the fleet management tracking invoicing.
6. Determined the utilization of the fleet vehicles to see if Transportation Specialist can identify the business units with the highest demand and see if current usage trends follow previous patterns.
7. Compared fleet costs with overall personal vehicle cost trends (based on employee reimbursement) to assess if end-user demand is shifting to prefer use if their own personal vehicle for transport to see clients or attend occasional business meetings.

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit found costs for operating both the leased and agency-owned vehicles in FY 2024 totaled $1,058,076. Comparable costs were $747,794 in FY 2022 and $881,420 in FY2023. The Enterprise Lease program represents the larger share of the Center's vehicle operating costs and includes 97 vehicles. Internal Audit found total operating costs were $810,492 through May 31, 2025.

Enterprise Leasing and agency-owned vehicles, total costs, 2022-2025 (projected)



Source: Agency-Owned and Leased Vehicle Costs, from Trending Reports 2022 to 2025 as of May 31, 2025

Management Response: (Fleet Transportation Administrator-Senior): Agreed.

Observation #2 – Internal Audit found seven (7) agency-owned vehicles in inventory as of April 30, 2025 in the fixed asset reports. This includes five (5) Ford Escapes that are contractually retained to comply with the SUDUP program grant requirements. Based on scan date, the average age of these 7 vehicles is 3.6 years, as of April 30, 2025.

The Harris Center's remaining inventory of agency-owned vehicles, as of April 30, 2025

Serial #	Scan Date	Description	Model	Location Code
1GAWGEFP01175220	1/17/2020	2020 White Chevrolet Express Van *	EXPR. VAN	185801PRKLT
1FDEE3FN2PDD14923	6/30/2023	2023 24FT MOBILE MED. CLINIC CHASSIS	E450	1817
1FMCU0F61LUB44081	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^
1FMCU0F62LUB78451	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^
1FMCU0F63LUA84756	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^
1FMCU0F63LUB44079	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^
1FMCU0F6XLUB44080	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT ^

Source: PowerBI reports, Inquiry Report for Fixed Assets, April 9, 2025 (* = Gordon, ^ = SUDUP program location)

Management Response: (Fleet Transportation Administrator-Senior): "The owned vehicle 2020 White Chevrolet Express Van VIN#1GAWGEFP01175220 was recently picked up on May 7th to be auctioned off on behalf of Enterprise."

CONCLUSION

Internal Audit performed a follow-up audit of the Enterprise Leasing program to assess if significant program changes occurred after the previous year's Internal Audit's report on Fleet Management. The prior report findings were presented to members of the Audit Committee in July, 2024. The Director of the Transportation Department suggested that the transition to leased vehicles would be completed in FY 2025, and that a follow-up audit to assess any open issues could be identified. The department is now called Fleet Management and the Transportation Specialist is Fleet Transportation Administrator-Senior.

This follow-up audit reviewed the total leased vehicle costs plus the costs from the operation of the agency-owned vehicles which are still in operation. The Enterprise Leasing program vehicles should have fewer mechanical problems than agency-owned vehicles and represent fewer risks for unplanned repair bills. The Enterprise Leasing Management contract allows for the replacement of their lease vehicles when the vehicles approach certain mileage limits (50,000 miles) or the vehicle's age limit (48 months).

The Enterprise Fleet Management program has been successful in meeting the management's goals, as leased vehicles result in lower overall maintenance costs, when compared to purchasing additional agency-owned vehicles. Although there is a monthly charge for a vehicle lease, the predictability of the payment mitigates the unpredictability of operating agency-owned vehicle costs. For now, management sees success in the Enterprise leasing program.

Respectfully submitted,

David W. Fojtik

David W. Fojtik, MBA, CPA, CFE, CIA
Director of Internal Audit
The Harris Center for Mental Health and IDD

Kirk D. Hickey

Kirk D. Hickey, MBA, MIM, CFE
Staff Internal Auditor
The Harris Center for Mental Health and IDD

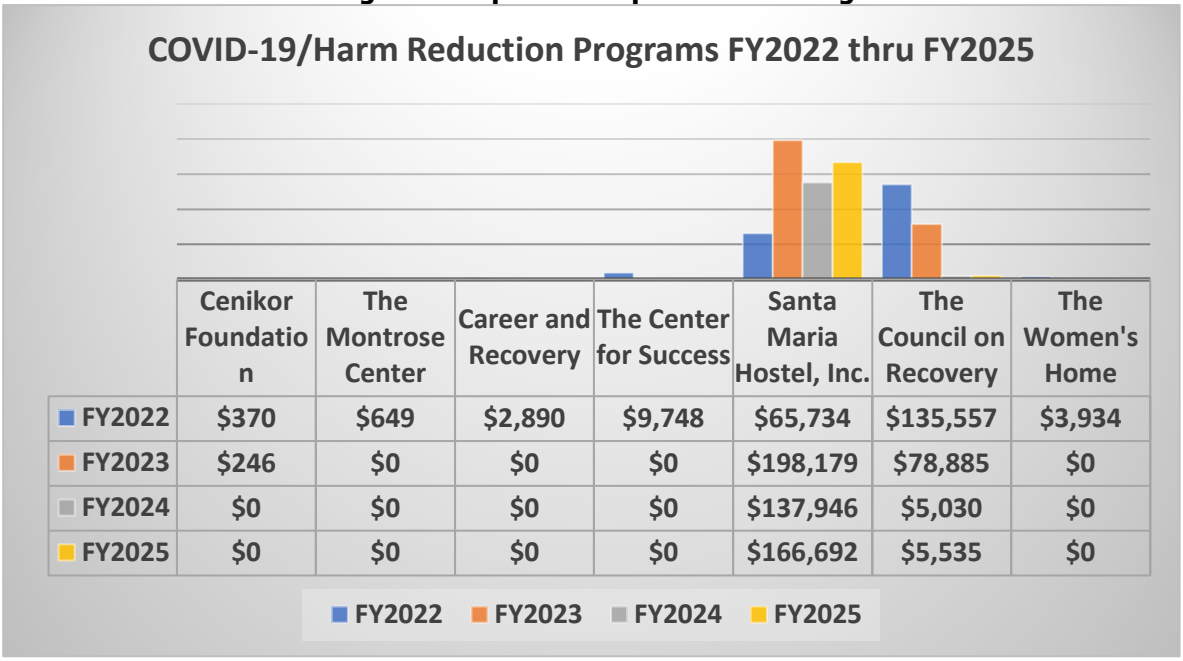
Executive Summary

FOLLOW-UP: HARM REDUCTION PROGRAM FOR OSAR PROVIDERS (FUHRP0125)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit assessed the reimbursements provided to OSAR provider organizations. Over the past four years we found Santa Maria Hostel received $568,550, or 70.1% of all Harm Reduction funds, while The Council on Recovery received $225,007, or 27.7% of Harm Reduction Program funds.

Harm Reduction Programs helped OSAR providers throughout Southeast Texas



	Cenikor Foundation	The Montrose Center	Career and Recovery	The Center for Success	Santa Maria Hostel, Inc.	The Council on Recovery	The Women's Home
FY2022	$370	$649	$2,890	$9,748	$65,734	$135,557	$3,934
FY2023	$246	$0	$0	$0	$198,179	$78,885	$0
FY2024	$0	$0	$0	$0	$137,946	$5,030	$0
FY2025	$0	$0	$0	$0	$166,692	$5,535	$0

Source: Internal Audit reports on COVID-19 and Harm Reduction grants, FY2022 through FY2025

Management Response #1 (Program Director of Substance Use Recovery Services): "We acknowledge the funding distribution trends. The higher reimbursement amounts to Santa Maria Hostel are a result of their consistency with reimbursement requests during grant period and the lack of requests from others within the region. We will review outreach and engagement practices with other OSAR providers in Region 6 to encourage broader participation in future funding cycles, should funding be reinstated."

Follow-Up: Harm Reduction Program for OSAR Providers

(FUHRP0125)

INTERNAL AUDIT REPORT

July 15, 2025

David W. Fojtik, MBA, CPA, CIA, CFE

Director, Internal Audit

TABLE OF CONTENTS

CURRENT PROCESS

This follow-up report on the FY2025 Harm Reduction Program for OSAR Providers reviewed the progress of the grant program that succeeded the FY2022-FY2023 COVID-19 OSAR reimbursement programs (as they were called by the Texas Department of Health and Human Services Commission (HHSC) agency).

The program is designed for OSAR (Outreach, Screening, Assessment, and Referral) providers in Texas, including HHSC Region 6 that includes: Harris, Liberty, Montgomery, Walker, Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Matagorda, Waller, and Wharton counties. The Gulf Coast Center, which is based in Texas City, provides similar behavioral healthcare services in many of these counties. [1]

The Harm Reduction Program was introduced at The Harris Center as a new grant in September 2022, which was led by the Mental Health Division's Director of Special Mental Health Projects. The FY2024 program reimbursed OSAR providers for a variety of client-facing services, purchases of PPE and basic health supplies, COVID testing kits, health kits and more, as provided to clients in the Region 6 area.

The Council On Recovery's Senior Director of Program Operations has provided very valuable guidance on interpreting allowable reimbursements for providers, based on the 2025 Harm Reduction Program's specific list of Allowable Items. These items are reported by purchased quantities and for documented for their specific item descriptions and packaging volumes. These identifying data are keyed to RedCap which is the regulatory agency's reporting system.

The review and approval process uses two additional reviewers of the team, including the Director of Special Mental Health Projects, Director of Internal Audit, and Senior Director of Program Operations at The Council on Recovery (TCOR). The Internal Audit staff receives incoming requests for a provider who seeks reimbursement for items such as medical and healthcare kits, PPE, or other client-supporting items such as baby formula or socks or underwear. This year's grant offered reimbursement for client transport on Metro passes and by taxi services, trips with Uber or Greyhound, as long as the OSAR provider documented the client identifying information with the request. The approved reimbursements are issued for payment once a month and in past months required four or five hours of evaluation.

The Harm Reduction Program team reviewed submitted requests compared these requested amounts on the summary form against amounts on online sales documentation or on actual cash register tapes. The Staff Internal Auditor served as the workflow administrator and contact for the Region 6 providers. We tested the provider submissions for fraud, waste and abuse, and checked for duplicate items and the possible disallowed item being reimbursed. We double-checked all the math of their submission reports.

The FY2025 Harm Reduction Program will end on August 31, 2025 which was originally planned with a $200K annual budget. In April 2025, Internal Audit learned the federal funds supporting this grant had been stopped, and after we confirmed the grant status with HHSC contacts and the Center leadership we determined that the 2025 Harm Reduction program was therefore shut down for new activity.

[1] https://www.hhs.texas.gov/services/mental-health-substance-use/mental-health-substance-use-resources/outreach-screening-assessment-referral

SCOPE AND OBJECTIVES

Audit Scope: The Director of Internal Audit approved joining the team to review and approve requests from OSAR providers located in the Texas Department of Health and Human Services (HHSC) Region 6, which includes OSAR providers based in Harris County and ten (10) surrounding counties in Texas.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes, including the following:

1. The review team does not adequately identify reimbursement requests that are not eligible for reimbursements in accordance with the 2025 Harm Reduction Program grant documentation.
2. The review team submits completed financial reimbursements to the Financial Services teams for items previously reimbursed by other agencies or other governmental reimbursement programs.

FIELD WORK

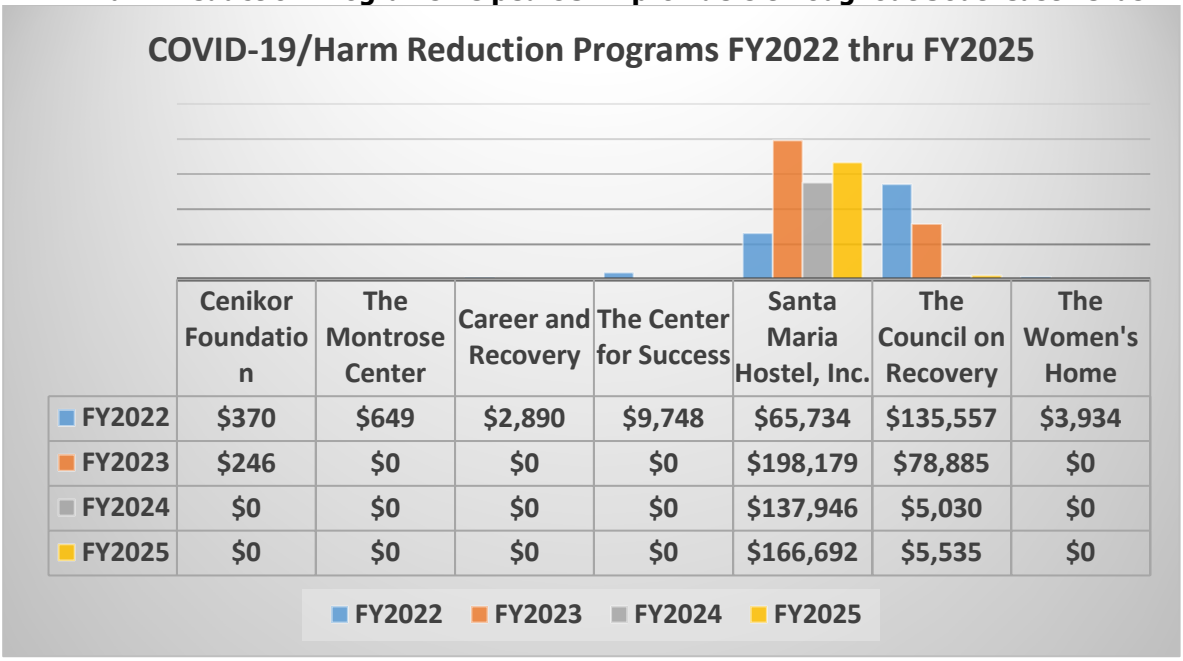
Field Work: A high-level summary of audit work is needed to address the objectives listed above:

1. Identify the OSAR provider list from the Texas Department of Health and Human Services (HHSC), and determine the primary contacts for each of these organizations.
2. Contact the Harris Center's Controller and explain that providers submit reimbursement requests over time but not with any regularity, unless it is specified as such by the provider.
3. Ensure that the Harris Center's Controller's office has provided the latest version of the W-9 form, and the Harris Center's ACH authorization form for the provider to complete.
4. Send an introduction and announce the availability of the grant reimbursement program and send them basic documents to be used in the providers' submissions: the reimbursement form (excel), the program documentation from HHSC, and W-9 form, and the Center's ACH authorization form.
5. Review reimbursement requests daily and inform the provider when the submitted reimbursement materials are to be initially reviewed.
6. Reconcile the Reimbursement Form amounts to all submitted documentation that were provided as supports. Add Notes to the documentation to assist team reviewers about the Form inspection.
7. As needed, reach out to the Texas Department of Health and Human Services contacts to evaluate any concerns or questions about item eligibility or about inquiries from out of area OSAR providers who may contact us about joining the reimbursement process we have established. (To date, we have not found OSAR providers contacting us to seek reimbursement payments for this grant.)
8. Request written approval from the team members and seek one or more acknowledged approvals before forwarding request to Controller's office for their review.
9. Verify on Aptean Ross Browser that payments were processed in a timely manner (within 10 days), otherwise send an inquiry to the Controller's office about the status of the reimbursement. Verify that all payment requests are read at the Controller's email and payments fulfilled as documented on Ross Browser. (Note: A payment may be bundled with other payments to the OSAR provider, so total payment may appear to be greater than the COVID-19 reimbursement payment amount.)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit assessed the reimbursements provided to OSAR provider organizations. Over the past four years we found Santa Maria Hostel received $568,550, or 70.1% of all Harm Reduction funds, while The Council on Recovery received $225,007, or 27.7% of Harm Reduction Program funds.

Harm Reduction Programs helped OSAR providers throughout Southeast Texas



	Cenikor Foundation	The Montrose Center	Career and Recovery	The Center for Success	Santa Maria Hostel, Inc.	The Council on Recovery	The Women's Home
FY2022	$370	$649	$2,890	$9,748	$65,734	$135,557	$3,934
FY2023	$246	$0	$0	$0	$198,179	$78,885	$0
FY2024	$0	$0	$0	$0	$137,946	$5,030	$0
FY2025	$0	$0	$0	$0	$166,692	$5,535	$0

Source: Internal Audit reports on COVID-19 and Harm Reduction grants, FY2022 through FY2025

Management Response #1 (Program Director of Substance Use Recovery Services): "We acknowledge the funding distribution trends. The higher reimbursement amounts to Santa Maria Hostel are a result of their consistency with reimbursement requests during grant period and the lack of requests from others within the region. We will review outreach and engagement practices with other OSAR providers in Region 6 to encourage broader participation in future funding cycles, should funding be reinstated."

CONCLUSION

The Harris Center for Mental Health and IDD was designated as the administrator of the HHSC Region 6 Harm Reduction Program grant issued by Texas Department of Health and Human Services (HHSC).

The Harris Center and Gulf Coast Center in Texas City were responsible for supporting HHSC Region 6 OSAR providers. We identified 24 OSAR providers in HHSC Region 6 (Harris County) in early 2022. Over the course of several years we worked with six (6) OSAR providers, and in FY2024 we worked with fewer reimbursement requests originating from only two (2) of the local Region 6 providers.

The Harm Reduction Program reimbursements are supported by the Director of Mental Health Projects, who introduced it to us with the local OSAR program contact (e.g., The Council on Recovery in Houston). The grant was created to provide reimbursement funds to OSAR providers who incurred incremental costs, such as expenses for personal protective equipment (PPE) purchases, client transportation, and infection control measures to mitigate the spread of COVID-19 by adapting client housing, etc.

The review team consisted of Internal Audit staff, the Harris Center's Director of Special Mental Health Projects, and the Executive Director of Special Projects from The Council on Recovery (TCOR), the local OSAR provider. Internal Audit performs mostly arithmetic checks and eligibility checks and we found no unsubstantiated claims, and found most OSAR providers were compliant with the grant rules.

The 2025 Harm Reduction Program was funded with an expanded budget of $200k for reimbursement of payments, which began on September 1, 2024.

Respectfully submitted,

David W. Fojtik

David W. Fojtik, MBA, CPA, CFE, CIA
Director of Internal Audit
The Harris Center for Mental Health and IDD

Kirk D. Hickey

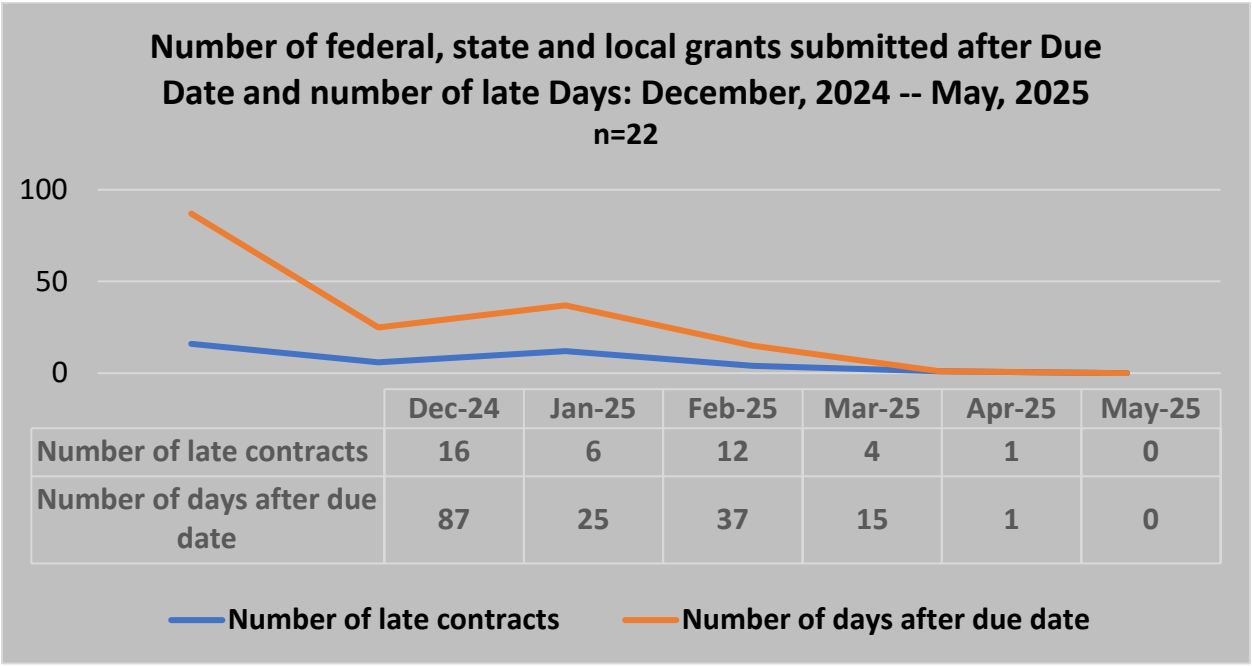
Kirk D. Hickey, MBA, MIM, CFE
Staff Internal Auditor
The Harris Center for Mental Health and IDD

Executive Summary

FOLLOW-UP: LATE GRANT CONTRACT BILLING REVIEW (FUGRNT0125)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit tracked 22 federal, state and local grant contracts for late submission. We found that sixteen (16) were submitted late in December, 2024. We found six (6) invoices submitted late in January, twelve (12) in February, four (4) in March, one (1) in April, and none in May, 2025.

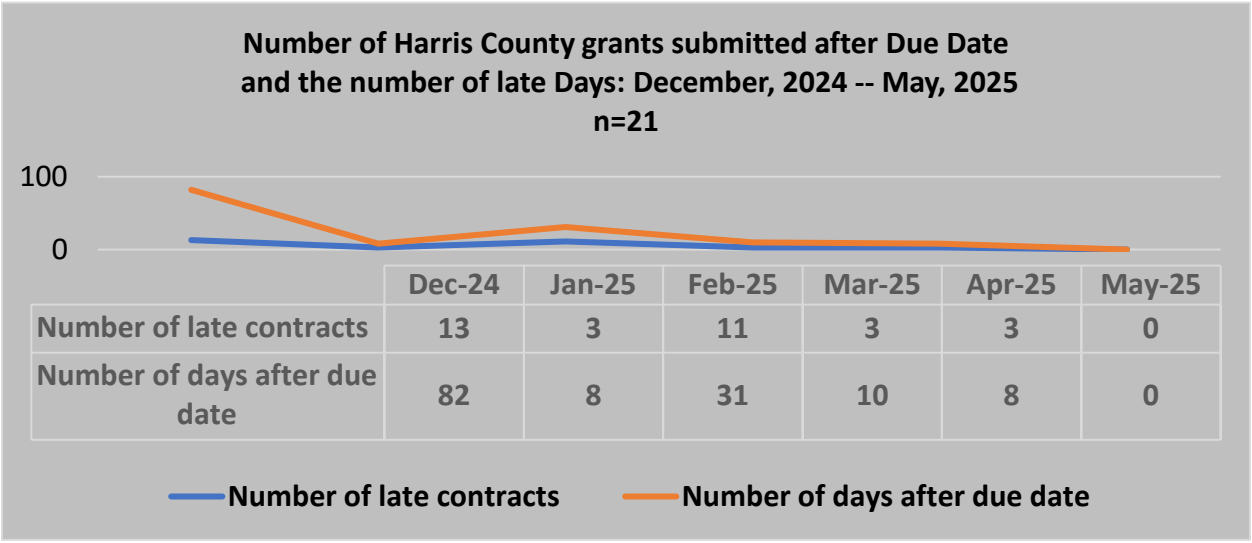


	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number of late contracts	16	6	12	4	1	0
Number of days after due date	87	25	37	15	1	0

Source: Internal Audit review of grant invoices for sample of FY2025 reimbursable services contracts

Management Response #1 (Chief Financial Officer): No response required.

Observation #2 – Internal Audit tracked 21 Harris County contracts for late submission. We found that thirteen (13) submitted late in December, 2024. We found three (3) late invoices in January, eleven (11) in February, three (3) in March and April, and none in May, 2025.



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number of late contracts	13	3	11	3	3	0
Number of days after due date	82	8	31	10	8	0

Source: Internal Audit review of grant invoices for sample of FY2025 reimbursable services contracts

Management Response #2 (Chief Financial Officer): No response required.

Finding #1 – We noted that the HR133 program invoice includes three (3) component programs (see below) that are billed on the same invoice and is due on the 15th of each month. Our review shows it has been submitted late consistently to HHSC when compared to the other HHSC contracts. For example, the current invoice for May has not been submitted to HHSC as of June 26, 2025.

HR133 Outpatient Capacity Expansion (A01)

HR133 Housing and Homelessness (A02)

HR133 Crisis Hotline and Mobile Crisis Outreach Team (A06)

Management Response #1 (Chief Financial Officer): "Based on the department's own tracking measures, for the past 2 months, April and May, grant contract billing has missed 0 of its deadlines and submitted all contracts on their agreed upon due dates.

Management Response #3 (Chief Financial Officer: "The HR133 contract was terminated by HHSC due to the cancellation of ARPA funding. We received a letter from HHSC dated April 15 that we have 45 days from the date of the letter to submit final invoices". We spoke with our state representative, Rhonda Dieterich, who laid out the framework of our invoice submissions which we observed. The last invoice was submitted on May 29, 1 day before its due date.

Regarding Finding #1, HR133s contract was terminated by HHSC due to the cancellation of ARPA funding. We received a letter from HHSC dated April 15 that we have 45 days from the date of the letter to submit final invoices.

We spoke with our state representative, Rhonda Dieterich, who laid out the framework of our invoice submissions. She had this to say:

Good morning Hayden,

I reached out to my leadership and was given the information below to help clarify things for you.

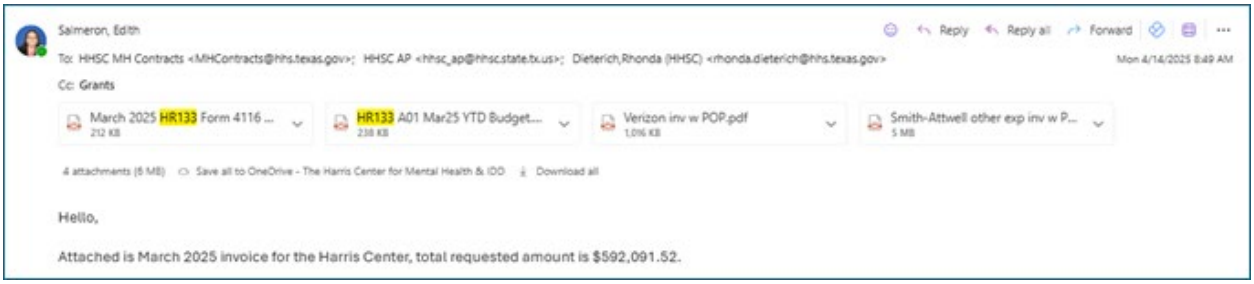
Invoice # 1 – Services from 3/1/25 – 3/24/25

Invoice # 2 – Services from 3/25 – 3/31/25

Invoice # 3 – Services from 4/1/25 – 5/15/25

They also have the option of invoices 4/1/25 – 5/15/25 with two invoices. They would submit one for 4/1/25 – 4/30/25 and another one for 5/1/25 – 5/15/25. The last date of service they can submit an invoice for is 5/15/2025. The due date for the final invoice is 45 days from the termination date.

Invoice #1 was submitted to HHSC on April 14th, 1 day before its due date of April 15. See below for confirmation:



We did not have any expenses incurred for Invoice #2; therefore, we did not have an invoice to submit.

Invoice #3 was due 45 days from the termination date of April 15, making its due date May 30. It was submitted on May 29, 1 day before its due date. See below for confirmation:

After submitting Invoice #3, the contract ended, and we are unable to request any further reimbursement for program costs. Thus, the reason for there not being a May invoice to submit to HHSC.

Based on the evidence above, grant contract billing has not missed any due dates for HR133 for the past 2 months and the finding should be removed completely from the audit report as it is no longer substantiated."

Follow-Up: Late Grant Contract Billing Review

(FUGRNT0125)

INTERNAL AUDIT REPORT

July 15, 2025

David W. Fojtik, CPA, MBA, CIA, CFE

Director, Internal Audit

TABLE OF CONTENTS

SCOPE AND OBJECTIVES

Audit Scope: The follow-up review of the Center's reimbursable service contracts was request by several grantors due to the frequency of missing key due dates in their processing. The Harris Center's reimbursable contract owners provide inputs used in the billing detail.

Audit Objectives: The review is based on determining contract performance qualities that may:

1. Improve the Financial Services process so that their staffing resources are applied where needed.
2. Identify any improvements for added reporting transparency to the grant program managers to enable greater accessibility of grant reporting activity for The Harris Center's senior management.
3. Motivate contract owners to assist Financial Services grant administrators in the billing process by finding opportunities to advance billing data acquisition to ensure more timely transmittals.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes may include the following:

1. Management may not be willing to evaluate or modify the current reimbursable billing process due to limited staff or headcount allocations, or other resource limitations.
2. Management may not be able to evaluate the grant contract billing process well enough to bring about meaningful process improvements.
3. Management may not devote agency resources to enable significant system development to overhaul the grant billing process.

FIELD WORK

Field Work: Internal Audit has performed the reimbursable services billing process audit in the past. The methodology has changed since Financial Services modified the staff assignment process. The field work for this current audit is subject to change, but this audit seeks to:

1. Obtain the list of the reimbursable services billing contracts in the Financial Services organization and develop a sample including the largest contracts.
2. Review the sample of grant invoices to gain a broader sampling of invoicing activity.
    - Generate a proposed list of grants of highest value and discuss with an independent source such as a Chief who can identify any known challenges to a given grant contract invoicing.
    - H. Hernandez, Director Grant Administration, August 14, 2024 – Note to users to use a revised link for grant billing folder: **\\vmazmhmrdfs03\Shares\Grant**
3. Identify the Financial Services contacts who perform the billing activity and interview them for their assessment of the current process and probe for possible improvements in the workflow.
4. Interview grant contract program managers and other process owners to discuss their satisfaction levels with the current grants billing process, and to probe for potential process improvements.
5. Reconcile billing invoice amounts as reported in the PowerBI online trending reports.
6. Test for frequency of missing "due dates" which are documented in the summary grants folder.
7. identify any reporting bias that can overstate/understate The Harris Center's financial reporting and discuss ways to address reporting bias in the future invoicing activity with process owners.

CURRENT PROCESS

The Harris Center receives funding from 137 different sources including federal program funds that are "passed through" and therefore administered by the state agency that is associated with the contracts.

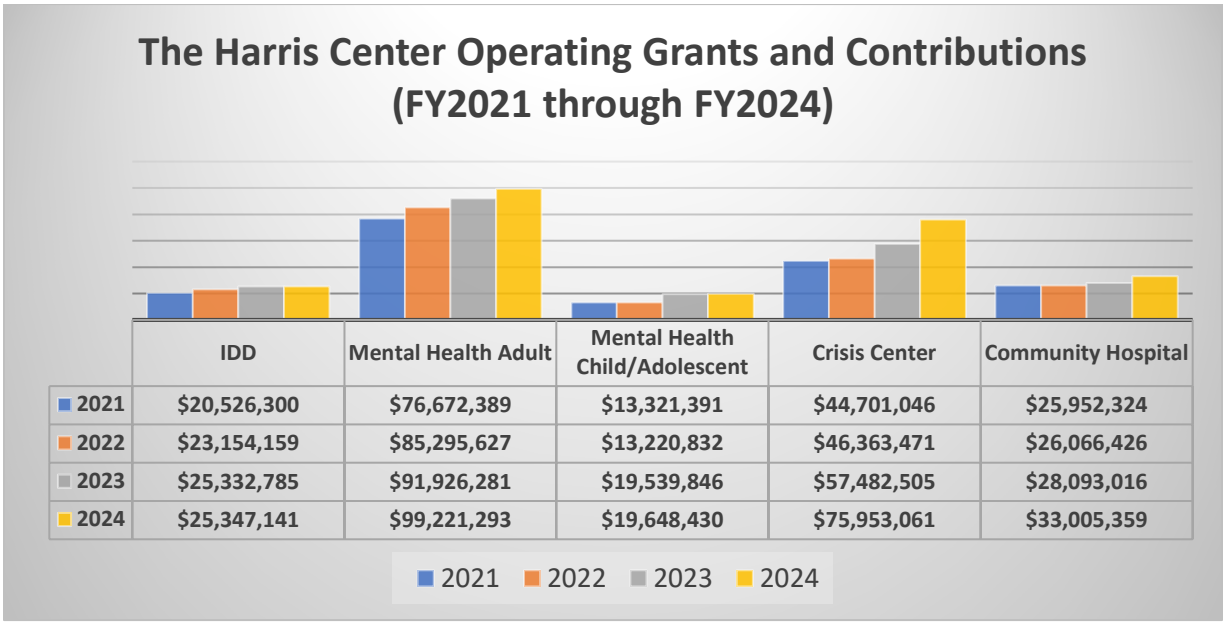
The Center's *Annual Comprehensive Financial Report (ACFR)* lists all these grant contracts in their report. In the current year, there are 83 reimbursable contracts which require active billing activity. Financial Services created a grant tracker tool on SmartSheet to assist the grant administrators in their work. The goal for this audit is to affirm that appropriate billing activity is performed for the activity period, prepared by the stated deadline date, and reimbursable services charges are adequately supported by subordinate documentation (payroll records, cell phone reports of call activity, daily parking fees, etc.).

The current grants process is performed by six (6) active staffers who are well-versed in delivering the reimbursable billing activity in a timely way. These staffers report that some of their time is spent on getting payroll records corrected or obtaining other expenses required for the monthly billing invoice. They explain challenges in the system, the need to download data from other systems, and getting assistance from clinical units whenever staff changes occur but are not properly documented, etc. Internal Audit observed the process and saw that the process includes substantial documentation of documents used in the proper production and presentation of summary billing to the grantors.

Internal Audit also noted that a number of contracts' billings were slowed by process handicaps, and in some cases grant administrators asked for extensions, which they received from grantors in every case. This follow-up review was to continue the review the invoicing from December, 2024 thru May, 2025.

The Harris Center's *Annual Comprehensive Financial Report* (ACFR), as of August 31, 2023 showed that revenue growth for operating grants and contributions increased in all ACFR specified service divisions (IDD, Mental Health Adult, Mental Health Child/Adolescent, Crisis center, and Community Hospital).

The grant program revenues represent reimbursable services contracts revenues, which include accruals and intergovernmental transfer (IGT) payments from federal, state and local governments.

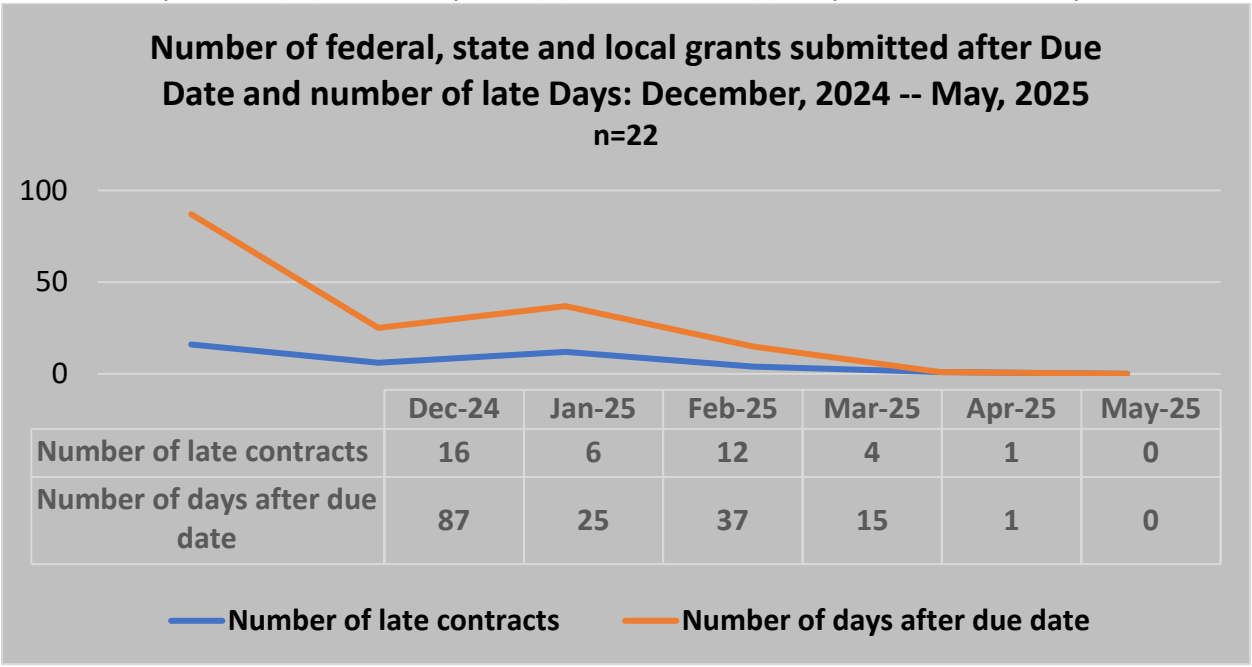


	IDD	Mental Health Adult	Mental Health Child/Adolescent	Crisis Center	Community Hospital
2021	$20,526,300	$76,672,389	$13,321,391	$44,701,046	$25,952,324
2022	$23,154,159	$85,295,627	$13,220,832	$46,363,471	$26,066,426
2023	$25,332,785	$91,926,281	$19,539,846	$57,482,505	$28,093,016
2024	$25,347,141	$99,221,293	$19,648,430	$75,953,061	$33,005,359

Source: Annual Comprehensive Financial Report, The Harris Center for Mental Health, August 31, 2024

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit tracked 22 federal, state and local grant contracts for late submission. We found that sixteen (16) were submitted late in December, 2024. We found six (6) invoices submitted late in January, twelve (12) in February, four (4) in March, one (1) in April, and none in May, 2025.

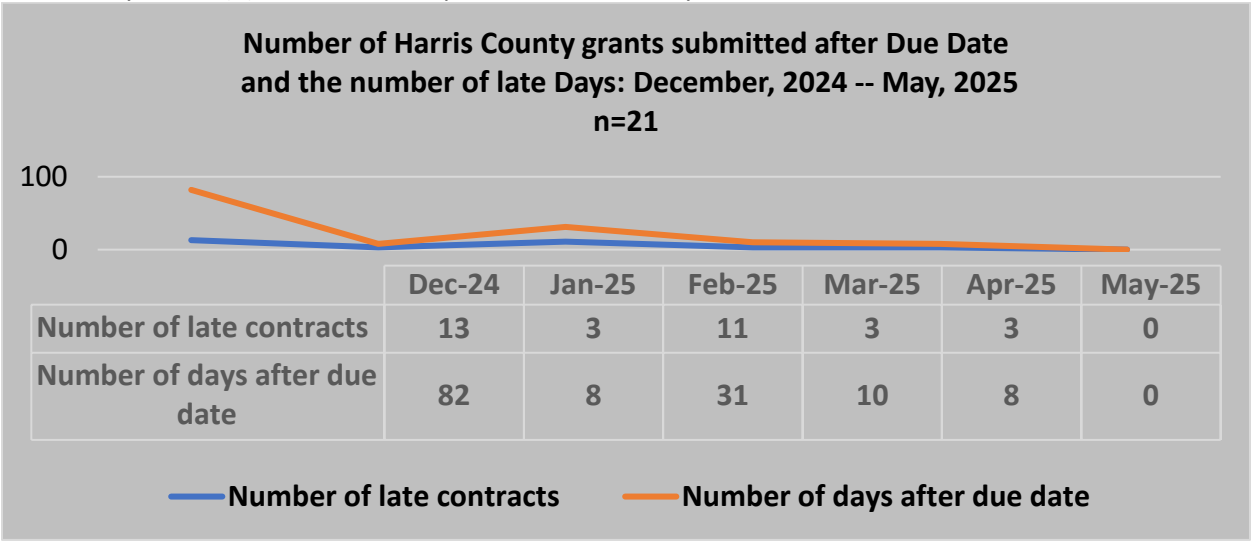


	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number of late contracts	16	6	12	4	1	0
Number of days after due date	87	25	37	15	1	0

Source: Internal Audit review of grant invoices for sample of FY2025 reimbursable services contracts

Management Response #1 (Chief Financial Officer):

Observation #2 – Internal Audit tracked 21 Harris County contracts for late submission. We found that thirteen (13) submitted late in December, 2024. We found three (3) late invoices in January, eleven (11) in February, three (3) in March and April, and none in May, 2025.



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number of late contracts	13	3	11	3	3	0
Number of days after due date	82	8	31	10	8	0

Source: Internal Audit review of grant invoices for sample of FY2025 reimbursable services contracts

Management Response #2 (Chief Financial Officer):

Finding #1 – We noted that the HR133 program invoice includes three (3) component programs (see below) that are billed on the same invoice and is due on the 15th of each month. Our review shows it has been submitted late consistently to HHSC when compared to the other HHSC contracts. For example, the current invoice for May has not been submitted to HHSC as of June 26, 2025.

HR133 Outpatient Capacity Expansion (A01)
HR133 Housing and Homelessness (A02)
HR133 Crisis Hotline and Mobile Crisis Outreach Team (A06)

Management Response #1 (Chief Financial Officer):

"Based on the department's own tracking measures, for the past 2 months, April and May, grant contract billing has missed 0 of its deadlines and submitted all contracts on their agreed upon due dates.

Management Response #3 (Chief Financial Officer: "The HR133 contract was terminated by HHSC due to the cancellation of ARPA funding. We received a letter from HHSC dated April 15 that we have 45 days from the date of the letter to submit final invoices". We spoke with our state representative, Rhonda Dieterich, who laid out the framework of our invoice submissions which we observed. The last invoice was submitted on May 29, 1 day before its due date.

Regarding Finding #1, HR133s contract was terminated by HHSC due to the cancellation of ARPA funding. We received a letter from HHSC dated April 15 that we have 45 days from the date of the letter to submit final invoices. We spoke with our state representative, Rhonda Dieterich, who laid out the framework of our invoice submissions. She had this to say:

Good morning Hayden,

I reached out to my leadership and was given the information below to help clarify things for you.

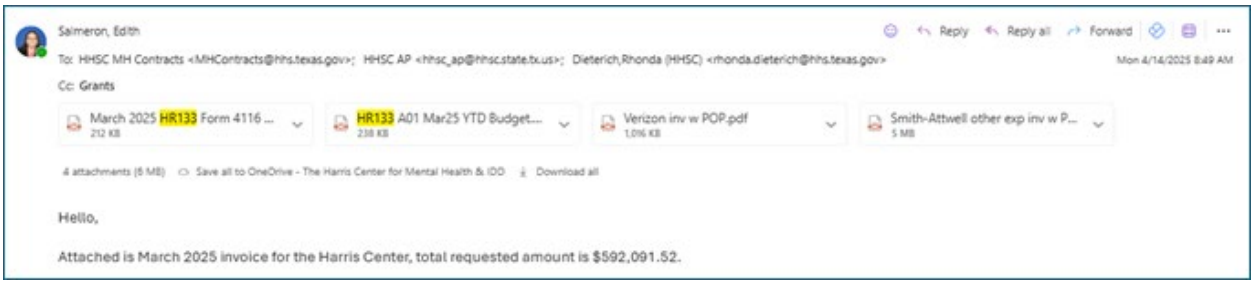
Invoice # 1 – Services from 3/1/25 – 3/24/25

Invoice # 2 – Services from 3/25 – 3/31/25

Invoice # 3 – Services from 4/1/25 – 5/15/25

They also have the option of invoices 4/1/25 – 5/15/25 with two invoices. They would submit one for 4/1/25 – 4/30/25 and another one for 5/1/25 – 5/15/25. The last date of service they can submit an invoice for is 5/15/2025. The due date for the final invoice is 45 days from the termination date.

Invoice #1 was submitted to HHSC on April 14th, 1 day before its due date of April 15. See below for confirmation:



We did not have any expenses incurred for Invoice #2; therefore, we did not have an invoice to submit.

Invoice #3 was due 45 days from the termination date of April 15, making its due date May 30. It was submitted on May 29, 1 day before its due date. See below for confirmation:

After submitting Invoice #3, the contract ended, and we are unable to request any further reimbursement for program costs. Thus, the reason for there not being a May invoice to submit to HHSC.

Based on the evidence above, grant contract billing has not missed any due dates for HR133 for the past 2 months and the finding should be removed completely from the audit report as it is no longer substantiated."

CONCLUSION

The reimbursable services contracts include federal programs, state grants, and local grants from the City of Houston and from Harris County. Many reimbursable services contracts use monthly invoicing to compensate The Harris Center for its performing its services in various departmental units.

The invoicing activity requires acquisition of documented staff costs, such as salary and fringe data, any related IT and supply costs, computer usage fees, approved purchases for the unit's operations, and any reconciliation work papers associated with properly associating expenses from the general ledger.

Since the last audit was performed earlier in the FY 2025 timeframe, Internal Audit learned that many larger contracts were submitted late due to unanticipated delays. The grants invoice process requires accurate financial data as it is used in the invoicing content. All pending and unresolved payroll or accounting situations require immediate resolution by the business units, but this delays invoicing.

The Financial Services team shared their online folders with Internal Audit, which contains the signed invoices, grant reconciliation detail work, accounts receivable histories, and in some cases the original contracts showing all the specific grant preparation and grant content requirements. Internal Audit found the reconciliation documentation was clear to follow and found that many of the grant files included the grant program manager's communications. Internal Audit was advised to consider a grant to be "late" when the submitted invoice is received the day after a grant contract's specified Due Date. Any delays in the Financial Services delivery of the invoice can compound approval at the reciprocal agency's workflow, which may ultimately delay the receipt of funds to The Harris Center's accounts.

Although Financial Services has made various improvements in their process in the past year and hired several new grant administrators in FY2024, they announced that the Vice-President of Revenue Cycle left The Harris Center in May 2025.

Respectfully submitted,

David W. Fojtik

David W. Fojtik, MBA, CPA, CFE, CIA
Director of Internal Audit
The Harris Center for Mental Health and IDD

Kirk D. Hickey

Kirk D. Hickey, MBA, MIM, CFE
Staff Internal Auditor
The Harris Center for Mental Health and IDD

Executive Summary

FOLLOW-UP: RECENTER INTEGRATION REVIEW (FURCTR0125)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit has reviewed Recenter consumer payroll deductions for rent, laundry, etc., from bi-weekly payrolls but the revenue(deductions) is not reflected on the books of the Harris Center. Funds amounting to $60,381 have accumulated since December 20, 2024.

Management Response #1 (Recenter Director of Operations): "Since December 20, 2024 we placed these revenues in a non-interest-bearing account at the bank. These revenues are mostly from the residents here. There have been no directives on how funds are to be reported."

Management Response #2 (Chief Financial Officer): "The Harris Center invoiced ReCenter on June 24th for the $60,381 payment. We will accrue that revenue in June if we have not yet received the payment for it".

Follow-Up: Recenter Integration Review

(SMRCTR0125)

INTERNAL AUDIT REPORT

July 15, 2025

David W. Fojtik, MBA, CPA, CFE, CIA

Director, Internal Audit

TABLE OF CONTENTS

SCOPE AND OBJECTIVES

Audit Scope: This follow-up review evaluated the financial and operational plans that integrated the Recenter Respite Services (a/k/a The Men's Center) into The Harris Center's main business operations. This special management request report was added to Internal Audit's Fiscal Year 2025 Audit Plan.

Audit Objectives: The special management request audit report has been approved for inclusion in Internal Audit's Fiscal Year 2025 Annual Audit Plan, and our audit objectives were designed to:

1. Review the current financial statements and assess weaknesses or inaccuracies in reporting.
2. Evaluate the possibility of latent liabilities in the Recenter infrastructure, such as payroll.
3. Examine the portfolio of the property, plant and equipment found at the integration site.

AUDIT RISKS

Audit Risks: Factors that may influence management's ability to provide sufficient strategy and responses for mitigating risks to the Center that may degrade the quality of the Recenter integration.

1. Management did not assign sufficient staff resources to examine Recenter's assets and liabilities.
2. Management did not keep transaction records or retain documents with management approvals.
3. Management did not comply with the terms of one or more of the regulatory agencies or with other government agency requirements which may necessitate remediation by The Harris Center.

FIELD WORK

Field Work: A high-level summary of audit work is needed to address the objectives listed above:

1. Meet with the Recenter department contacts and interview them regarding their immediate and long-term plans to remain in positions after the planned integration with The Harris Center.
2. Review how Recenter department contacts operated properties and provided payroll to staffs, and performed basic facilities and maintenance services, and fulfilled their financial services activities.
3. Assess the executives' vision of the Recenter operational integration and identify key milestones.
4. Affirm how Recenter's current infrastructure projects are being monitored and review operations which are to be incorporated into The Harris Center's operational portfolio starting January 2025.
5. Evaluate the requirements to update the Annual Comprehensive Financial Report (ACFR) to clearly show the acquisition and to appropriately record operational activities.

CURRENT PROCESS

The Recenter (a/k/a The Men's Center) which was established in 1950 was operated as a human services organization operated by the City of Houston's Housing and Community Development Department. Last year, the Recenter organization reported that diminished funding sources had deteriorated their budget and their day-to-day financial condition so that the Recenter stopped taking in new residents. This was reported in the local news, yet no 30 day notice to vacate was issued by City of Houston.

The Recenter's main objective is to assure that the current Recenter residents can continue to live at the facility. According to their website: "Recenter is a nonprofit striving to aid predominantly homeless men and women with alcohol and drug additions through services and programs in Houston. Substance addition is largely misunderstood public health problem; the solution is peer support, structure, and accountability. Recenter equips people suffering from addiction with the tools to rebuild their lives." [1]

Recenter's operations are overseen by the Recenter's Board of Directors. According to the Recenter's website, Chief Executive Officer and Executive Director Steven Brinkman began as a Resident Manager, and brings a research background in Biology and Psychology and actively engages the program population and gains the residents' trust at the 'ground-level'. [1]

The current Recenter Board Chairman John Puckett is Chief Financial Officer of Phoenix Environmental Services, who brings 25 years of experience from the energy services sector. The Board Treasurer is Alan G. Woodbury, CPA, who has specialized in computer auditing for small and medium sized banks. The Board Secretary is Andrew J. Martin is CEO and Chairman of Challenge Group International, LLC, whose background is in fundraising, public relations and in special event management. Board Member John Andrell is the Board Director who has previous developed commercial office building developments in Houston and is responsible for the leasing management of over 600,000 square feet of office space. [1]

According to the website, the Blazek and Vetterling firm of certified accountants had audited Recenter (then called The Men's Center) in 2019. The report revealed funding from a Community Development Block Grant which was passed through the City of Houston and Harris County, and totaling $3.78 million. The audit report showed an 'Unmodified' opinion with no known material weaknesses, nor significant deficiencies for financial reporting or internal control over major federal programs. [1] The website included a Form 990 Public Inspection Copy for operations in calendar year 2018, and the Form 990 Public Inspection Copy for Hope Harbor QALICB, which is The Men's Center's funding organization. [1] The Hope Harbor QALICB = qualified active low-income community business, which closed in 2018. [2]

In March 2024, ABC13 KTRK interviewed CEO/Executive Director Steve Brinkman, who reported funding problems since COVID-19 pandemic arrived and as some residents lost jobs and could not afford rent. In addition, there were additional operational costs for purchases of protective personal equipment (PPE), creating a "seven-figure hit" on the organization, according to Brinkman. The City of Houston's Housing and Community Development Department advised Recenter to cease taking new residents at this time.

In this follow-up audit, Internal Audit seeks to continue to evaluate Recenter's financial condition and work with the Center's Financial Services organization on providing adequate resources to continue the day-to-day operations. Although the Recenter became a part of The Harris Center in December of 2024, we have continued to support the Recenter organization in this transition period.

[1] Recenter Houston website: https://recenterhouston.com/about-recenter/

[2] Hope Harbor QALICB website: https://uacdcde.com/projects/recenters-hope-harbor-initiative/

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit has reviewed Recenter employees' payroll deductions for "rent", "laundry," from bi-weekly payrolls but not yet seen revenue reports from non-employees living at Recenter locations.

Management Response #1 (Recenter Director of Operations): "Since December 20, 2024 we placed these revenues in a non interest bearing account at the bank. These revenues are mostly from the residents here. There have been no directives on how funds are to be reported."

Management Response #1 (Chief Financial Officer):

CONCLUSION

The Harris Center's Financial Services team began integration of the Recenter operations to align with other similar program operations at The Harris Center. The Harris Center agreed to assume the costs and revenues associated with Recenter (a/k/a The Men's Center) earlier in Fiscal Year 2024 when the City of Houston discovered significant deficits in their annual operating budget. The Center management were encouraged to integrate with The Harris Center in order to continue their mission and operations.

The Harris Center management has gained a foothold in a downtown Houston real estate market with new structures and old, in exhange for providing the as-needed financial support to the Recenter, which has experienced loss of income from their Hope Harbor entity and their limited success in grant writing.

Internal Audit finds that the Recenter management team (Executive Director and Operations Manager) have managed to operate despite significant financial hardships. Our evaluation of accounts payables shows that they are overdue on many accounts and have many shut-off notices from recent years. Interanl Audit worked with the Center's Financial Services to identify all their valid but unpaid expenses and assure their obligations could be satisfied in order to proceed with future Recenter integration. The Recenter management team have been hired as full-time Harris Center employees but the Recenter has continued to conduct their programs as they have done on their own in the past.

Internal Audit reviewed the Recenter's requests for reimbursemnt of payroll and therefore reviewed the calculations which were performed adequately, and found that employee deductions were completed and that tax liabilities were fulfilled. Internal Audit has had access to payroll processing and the accounts payable activity and participated with the Chief Financial Officer and General Counsel on assuring that the Recenter is made whole at this point in the Recenter transition plan.

Respectfully submitted,

David W. Fojtik

David W. Fojtik, MBA, CPA, CFE, CIA
Director of Internal Audit
The Harris Center for Mental Health and IDD

Kirk D. Hickey

Kirk D. Hickey, MBA, MIM, CFE
Staff Internal Auditor
The Harris Center for Mental Health and IDD

Executive Summary

FOLLOW-UP: RECENTER INTEGRATION REVIEW (FURCTR0125)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit has reviewed Recenter consumer payroll deductions for rent, laundry, etc., from bi-weekly payrolls but the revenue(deductions) is not reflected on the books of the Harris Center. Funds amounting to $60,381 have accumulated since December 20, 2024.

Management Response #1 (Recenter Director of Operations): "Since December 20, 2024 we placed these revenues in a non-interest-bearing account at the bank. These revenues are mostly from the residents here. There have been no directives on how funds are to be reported."

Management Response #2 (Chief Financial Officer): "The Harris Center invoiced ReCenter on June 24th for the $60,381 payment. We will accrue that revenue in June if we have not yet received the payment for it."

Follow-Up: Recenter Integration Review

(SMRCTR0125)

INTERNAL AUDIT REPORT

July 15, 2025

David W. Fojtik, MBA, CPA, CFE, CIA

Director, Internal Audit

TABLE OF CONTENTS

SCOPE AND OBJECTIVES

Audit Scope: This follow-up review evaluated the financial and operational plans that integrated the Recenter Respite Services (a/k/a The Men's Center) into The Harris Center's main business operations. This special management request report was added to Internal Audit's Fiscal Year 2025 Audit Plan.

Audit Objectives: The special management request audit report has been approved for inclusion in Internal Audit's Fiscal Year 2025 Annual Audit Plan, and our audit objectives were designed to:

1. Review the current financial statements and assess weaknesses or inaccuracies in reporting.
2. Evaluate the possibility of latent liabilities in the Recenter infrastructure, such as payroll.
3. Examine the portfolio of the property, plant and equipment found at the integration site.

AUDIT RISKS

Audit Risks: Factors that may influence management's ability to provide sufficient strategy and responses for mitigating risks to the Center that may degrade the quality of the Recenter integration.

1. Management did not assign sufficient staff resources to examine Recenter's assets and liabilities.
2. Management did not keep transaction records or retain documents with management approvals.
3. Management did not comply with the terms of one or more of the regulatory agencies or with other government agency requirements which may necessitate remediation by The Harris Center.

FIELD WORK

Field Work: A high-level summary of audit work is needed to address the objectives listed above:

1. Meet with the Recenter department contacts and interview them regarding their immediate and long-term plans to remain in positions after the planned integration with The Harris Center.
2. Review how Recenter department contacts operated properties and provided payroll to staffs, and performed basic facilities and maintenance services, and fulfilled their financial services activities.
3. Assess the executives' vision of the Recenter operational integration and identify key milestones.
4. Affirm how Recenter's current infrastructure projects are being monitored and review operations which are to be incorporated into The Harris Center's operational portfolio starting January 2025.
5. Evaluate the requirements to update the Annual Comprehensive Financial Report (ACFR) to clearly show the acquisition and to appropriately record operational activities.

CURRENT PROCESS

The Recenter (a/k/a The Men's Center) which was established in 1950 was operated as a human services organization operated by the City of Houston's Housing and Community Development Department. Last year, the Recenter organization reported that diminished funding sources had deteriorated their budget and their day-to-day financial condition so that the Recenter stopped taking in new residents. This was reported in the local news, yet no 30 day notice to vacate was issued by City of Houston.

The Recenter's main objective is to assure that the current Recenter residents can continue to live at the facility. According to their website: "Recenter is a nonprofit striving to aid predominantly homeless men and women with alcohol and drug additions through services and programs in Houston. Substance addition is largely misunderstood public health problem; the solution is peer support, structure, and accountability. Recenter equips people suffering from addiction with the tools to rebuild their lives." [1]

Recenter's operations are overseen by the Recenter's Board of Directors. According to the Recenter's website, Chief Executive Officer and Executive Director Steven Brinkman began as a Resident Manager, and brings a research background in Biology and Psychology and actively engages the program population and gains the residents' trust at the 'ground-level'. [1]

The current Recenter Board Chairman John Puckett is Chief Financial Officer of Phoenix Environmental Services, who brings 25 years of experience from the energy services sector. The Board Treasurer is Alan G. Woodbury, CPA, who has specialized in computer auditing for small and medium sized banks. The Board Secretary is Andrew J. Martin is CEO and Chairman of Challenge Group International, LLC, whose background is in fundraising, public relations and in special event management. Board Member John Andrell is the Board Director who has previous developed commercial office building developments in Houston and is responsible for the leasing management of over 600,000 square feet of office space. [1]

According to the website, the Blazek and Vetterling firm of certified accountants had audited Recenter (then called The Men's Center) in 2019. The report revealed funding from a Community Development Block Grant which was passed through the City of Houston and Harris County, and totaling $3.78 million. The audit report showed an 'Unmodified' opinion with no known material weaknesses, nor significant deficiencies for financial reporting or internal control over major federal programs. [1] The website included a Form 990 Public Inspection Copy for operations in calendar year 2018, and the Form 990 Public Inspection Copy for Hope Harbor QALICB, which is The Men's Center's funding organization. [1] The Hope Harbor QALICB = qualified active low-income community business, which closed in 2018. [2]

In March 2024, ABC13 KTRK interviewed CEO/Executive Director Steve Brinkman, who reported funding problems since COVID-19 pandemic arrived and as some residents lost jobs and could not afford rent. In addition, there were additional operational costs for purchases of protective personal equipment (PPE), creating a "seven-figure hit" on the organization, according to Brinkman. The City of Houston's Housing and Community Development Department advised Recenter to cease taking new residents at this time.

In this follow-up audit, Internal Audit seeks to continue to evaluate Recenter's financial condition and work with the Center's Financial Services organization on providing adequate resources to continue the day-to-day operations. Although the Recenter became a part of The Harris Center in December of 2024, we have continued to support the Recenter organization in this transition period.

[1] Recenter Houston website: https://recenterhouston.com/about-recenter/

[2] Hope Harbor QALICB website: https://uacdcde.com/projects/recenters-hope-harbor-initiative/

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit has reviewed Recenter consumer payroll deductions for rent, laundry, etc., from bi-weekly payrolls but the revenue(deductions) is not reflected on the books of the Harris Center. Funds amounting to $60,381 have accumulated since December 20, 2024.

Management Response #1 (Recenter Director of Operations): "Since December 20, 2024 we placed these revenues in a non-interest-bearing account at the bank. These revenues are mostly from the residents here. There have been no directives on how funds are to be reported."

Management Response #2 (Chief Financial Officer): "The Harris Center invoiced ReCenter on June 24th for the $60,381 payment. We will accrue that revenue in June if we have not yet received the payment for it."

CONCLUSION

The Harris Center's Financial Services team began integration of the Recenter operations to align with other similar program operations at The Harris Center. The Harris Center agreed to assume the costs and revenues associated with Recenter (a/k/a The Men's Center) earlier in Fiscal Year 2024 when the City of Houston discovered significant deficits in their annual operating budget. The Center management were encouraged to integrate with The Harris Center in order to continue their mission and operations.

The Harris Center management has gained a foothold in a downtown Houston real estate market with new structures and old, in exhange for providing the as-needed financial support to the Recenter, which has experienced loss of income from their Hope Harbor entity and their limited success in grant writing.

Internal Audit finds that the Recenter management team (Executive Director and Operations Manager) have managed to operate despite significant financial hardships. Our evaluation of accounts payables shows that they are overdue on many accounts and have many shut-off notices from recent years. Interanl Audit worked with the Center's Financial Services to identify all their valid but unpaid expenses and assure their obligations could be satisfied in order to proceed with future Recenter integration. The Recenter management team have been hired as full-time Harris Center employees but the Recenter has continued to conduct their programs as they have done on their own in the past.

Internal Audit reviewed the Recenter's requests for reimbursemnt of payroll and therefore reviewed the calculations which were performed adequately, and found that employee deductions were completed and that tax liabilities were fulfilled. Internal Audit has had access to payroll processing and the accounts payable activity and participated with the Chief Financial Officer and General Counsel on assuring that the Recenter is made whole at this point in the Recenter transition plan.

Respectfully submitted,

David W. Fojtik

David W. Fojtik, MBA, CPA, CFE, CIA
Director of Internal Audit
The Harris Center for Mental Health and IDD

Kirk D. Hickey

Kirk D. Hickey, MBA, MIM, CFE
Staff Internal Auditor
The Harris Center for Mental Health and IDD

Executive Summary

FOLLOW-UP: RM THIRD PARTY BILLING REVIEW (FURMTPB0125)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Finding #1 – Internal Audit compared general ledger revenues data in the external auditor's FY 2024 *Annual Comprehensive Financial Report (ACFR)*, which showed Miscellaneous Revenues decreased $993,095, from $4.3 million in FY 2023 to $3.3 million in FY 2024. What was the causation of the $1M decrease in FY 2024 Miscellaneous Revenue?

Table I – FY2024 and FY2023

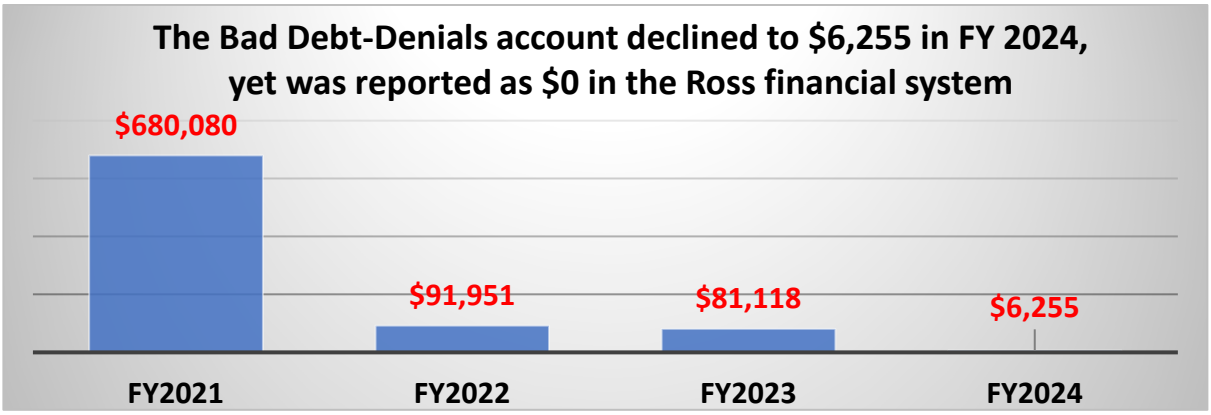
THE HARRIS CENTER FOR MENTAL HEALTH AND IDD
STATEMENT OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCES - GOVERNMENTAL FUNDS
For the Years Ended August 31, 2024 and 2023

	General Fund	
	2024	2023
Revenues		
State grants & programs	$ 151,910,634	$ 124,573,917
Federal grants	107,101,684	103,993,065
Harris County allocation and other contracts	46,339,437	52,635,562
Local billings	36,383,805	29,083,609
Investment earnings	3,662,619	2,941,559
Miscellaneous	3,294,681	4,287,776
Total Revenues	348,692,860	317,515,488

Source: Annual Comprehensive Financial Report, The Harris Center for Mental Health, January 28, 2025, page 22.

Management Response #1 (Controller): No response received.

Observation #2 – Internal Audit found the year-end balance of the bad debt-denials account was reflected as $6,255 on the Financial Services Trending Report yet the ROSS Financial System reported this account's balance as $0 at the FY 2024 fiscal year-end. Why?



Online Trending Report showing year-end balances for bad debt-denials account, The Harris Center for Mental Health

Management Response #2 (Controller): "Financial Services has changed the accounting breakdown for Net Patient Revenue account in order to meet new requirements in the pending GASB 606 standard." This change was not reflected on the Financial Services Trending Report.

Follow-Up: RM Third-Party Billing Review

(FURMTPB0125)

INTERNAL AUDIT REPORT

July 15, 2025

David W. Fojtik, MBA, CPA, CIA, CFE

Director, Internal Audit

TABLE OF CONTENTS

SCOPE AND OBJECTIVES

Audit Scope: This follow-up report was authorized by members of the Board of Directors to further evaluate the third-party billing activity at The Harris Center.

Audit Objectives: The report compares third-party billing year over year and seeks to identify new opportunities for the Center, and our audit objectives are to affirm that the Center can:

1. Activate the third-party billing process so that resources are effectively applied.
2. Make possible future improvements in the EPIC electronic health record system and amendments in the overall billing and collections workflow activities.
3. Continue to improve clinical outcomes for patients and protect the Center's financial results.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes, including the following:

1. Management may not be willing to evaluate the third-party billing process in terms of strengths and weaknesses, which may not allow addressing workflow or process issues in third-party billing.
2. Management may not be able to identify recurring root causes of third-party billing issues, nor want to analyze issues in sufficient detail to consider any system/process changes or staffing.
3. Management may meet the challenges when adding new third-party billing workflow processing components such as new payors, or new clearinghouse requirements, etc. or other matters.

FIELD WORK

Field Work: Internal Audit has performed similar reviews of the third-party billing process in the past. The field work for this current audit is as follows:

1. Examine the Annual Comprehensive Financial Report (ACFR) documentation for the prior year and assess the status of third-party activities in terms of, reduced days in collection, and the key performance indicators (KPI) that represent The Harris Center's revenue collection success.
2. Obtain the Trending Report to show specified period of third-party billing activities and find the strongest- and the weakest-performing accounts among all current third-party billing entities.
3. Review the Revenue Management Department's Collections Report to evaluate changes in the collectability of billed clinical services, ranked by insurance carrier or collection methods.
4. Analyze the type of process factors may have changed at The Harris Center which can affect the financial results.
5. Interview the Financial Services Department managers to hear their priorities for process improvements and other changes to facilitate the process and make it overall more effective.

CURRENT PROCESS

The Revenue Management Department has primary responsibility for processing The Harris Center's third-party billing and collections activities for the Center's clinical and other administrative services. Revenue Management employs staff to interact with insurance carriers, managed care organizations and government payors. The department leads the fee collections process and use a clearinghouse for resolving all outstanding claims and in reducing accounts receivables balances.

The Revenue Management supervisors pull revenue data reports from the EPIC system's dashboards. Revenue Management tracks initial transaction details to note anomalies that might affect collections well after the initial transaction. Internal Audit has reviewed the third-party billing process and notes that the process incorporates ongoing improvements and workflow changes since the EPIC installation.

At the last Audit Committee meeting on April 15, 2025 there was a discussion about bad debt denials account. This was because a discrepancy in which the bad debt denials account showed a $0 balance in the Ross system, but showed a $6,255 in the online trending report. There was subsequent discussion that data in the online trending report they do not completely match balances in the Ross system.

Internal Audit agreed to investigate the activities around the change in reporting for a follow-up report at the Audit Committee meeting on July 15, 2025. Although bad debt denials decreased steadily over the past four years, the Financial Services management grouped these data with explicit price reductions which is the related accounting process. Financial Services met with Internal Audit and explained that the trending report data do not compare exactly with Ross and recommended that we use the Sequel reports instead of PowerBI reports. We were also provided immediate access to the Sequel report links.

At a meeting with Financial Services in May 2025 they announced that no "corrective" activity would occur as Financial Services is continuing to make other slight adaptations to their collections model in an effort to meet pending Governmental Accounting Standards Board regulations (GASB Rule 606), which appear to be modeled after the "Revenue from Contracts with Customers (Topic 606)" publication which is a Financial Accounting Standards Board publication dated April, 2016. Internal Audit's review of the GASB website suggests that the regulatory details are still ongoing by the organization until June 2027.

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Finding #1 – Internal Audit compared general ledger revenues data in the external auditor's FY 2024 *Annual Comprehensive Financial Report (ACFR)*, which showed Miscellaneous Revenues decreased $993,095, from $4.3 million in FY 2023 to $3.3 million in FY 2024. What was the causation of the $1M decrease in FY 2024 Miscellaneous Revenue?

Table I – FY2024 and FY2023

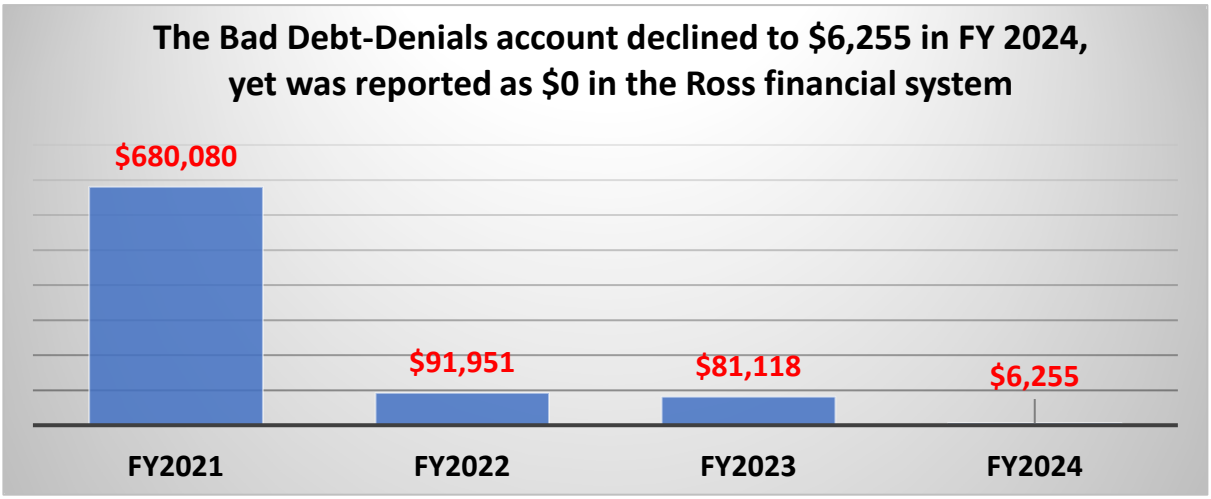
THE HARRIS CENTER FOR MENTAL HEALTH AND IDD
STATEMENT OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCES - GOVERNMENTAL FUNDS
For the Years Ended August 31, 2024 and 2023

	General Fund	
	2024	2023
Revenues		
State grants & programs	$ 151,910,634	$ 124,573,917
Federal grants	107,101,684	103,993,065
Harris County allocation and other contracts	46,339,437	52,635,562
Local billings	36,383,805	29,083,609
Investment earnings	3,662,619	2,941,559
Miscellaneous	3,294,681	4,287,776
Total Revenues	348,692,860	317,515,488

Source: Annual Comprehensive Financial Report, The Harris Center for Mental Health, January 28, 2025, page 22.

Management Response #1 (Controller):

Observation #2 – Internal Audit found the year-end balance of the bad debt-denials account was reflected as $6,255 on the Financial Services Trending Report yet the ROSS Financial System reported this account's balance as $0 at the FY 2024 fiscal year-end. Why?



Online Trending Report showing year-end balances for bad debt-denials account, The Harris Center for Mental Health

Management Response #2 (Controller): "Financial Services has changed the accounting breakdown for Net Patient Revenue account in order to meet new requirements in the pending GASB 606 standard." This change was not reflected on the Financial Services Trending Report.

CONCLUSION

The Harris Center's Revenue Management Department performs third-party billing and collections with government payors, commercial sources, managed care organizations and health insurance companies.

The Harris Center's clinical service providers generate activity by scheduling appointments with patients at clinical locations or at patient homes. Activity is processed in EPIC where applicable patient billing and coding is generated. Third-party payors are notified of activity and provide authorizations; transactions that are denied by are analyzed further to comply with the denial reason.

Respectfully submitted,

David W. Fojtik

David W. Fojtik, MBA, CPA, CFE, CIA
Director of Internal Audit
The Harris Center for Mental Health and IDD

Kirk D. Hickey

Kirk D. Hickey, MBA, MIM, CFE
Staff Internal Auditor
The Harris Center for Mental Health and IDD

ANNUAL REPORT ON FISCAL YEAR 2025 INTERNAL AUDIT ACTIVITIES INCLUDING

APPENDIX 1 – FY 2025 ISSUE TRACKING MATRIX

APPENDIX 2 – FY 2026 AUDIT PLAN

David W. Fojtik, CPA, CIA, CFE
Internal Audit Director

Kirk D. Hickey, CFE
Staff Internal Auditor

July 15, 2025

9401 Southwest Freeway
Houston, Texas 77074

Annual Report on Fiscal Year 2025

Purpose of the Annual Report: To provide information on the benefits and effectiveness of the internal audit function.

Table of Contents

I. Message from the Director of Internal Audit

I am pleased to submit the Internal Audit Annual Report for the fiscal year ended August 31, 2025. This report itemizes the services provided and other activities performed by the Harris Center Office of Internal Audit and fulfills the Texas Internal Auditing Act (the Act) requirements set out in Texas Government Code, Section 2102.009.

Included in this report are Internal Audit's Key Wins and Accomplishments for Fiscal Year 2025, the results of five (5) Board approved audit plan, explanations for any deviations from the audit plan, and results of six (5) Special Management Requests, and four (4) Follow-up Audits that were completed during the fiscal year. The results of these reports have been communicated to the Board of Trustees through the Audit Committee.

I believe the work of the Office of Internal Audit contributed to making The Harris Center's operations more efficient and effective by providing positive contributions to risk management efforts, control systems, and governance processes.

The Harris Center's Internal Department in FY 2025 incorporated myriad creative solutions in orchestrating new efficiencies — as well as new methods — in evidence gathering. We have experienced and benefitted from the Center's willingness to build cloud-based platforms that are designed to not only facilitate remote collaboration but automate workflows and we were successful in streamlining and facilitating the actions of multiple stakeholders to reach common, intersecting goals.

Internal Audit always strives to uphold the standards that the Board and management can rely on for collective competencies of the internal audit staff to think critically, and to address high priority risks. We will continue to utilize data analytics in routine audits which are quick and discrete wins typically found in complex core business processes, such as accounts payable, travel, payroll, general ledger, and in IT.

At this time, we are pleased to present the following recap of audit activities in Fiscal Year 2025. We thank you for your continued support of the Internal Audit Department.

David W. Fojtik

July 15, 2025

II. The Internal Audit Department's Mission and Responsibilities

---

Mission Statement

Internal Auditing is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

— The Institute of Internal Auditors (IIA) Standards for the Professional Practice of Internal Audit

---

Internal Audit's goals are to assist the Center accomplish its objectives by bringing a systematic, disciplined approach in evaluating and improving the effectiveness of risk assessment and risk management models. Internal Audit works to ensure that The Harris Center's business risks are being mitigated or accepted or easily transferred or managed within an acceptable degree.

The Internal Audit Department's charge is derived by The Harris Center's Board of Trustees' ("the Board") need to perform various independent reviews of key business processes and various auditable entities at the Center. The Director of Internal Audit is appointed to provide the unique consultative role that can truly provide an objective functional responsibility to the Board and the Audit Committee members, and at the same time he can maintain the administrative responsibility to the Chief Executive Officer.

The Internal Audit Department's primary responsibilities include:

1) Establishing an annual risk assessment of the Center's business units (auditable entities).
2) Performing reviews of auditable entities to evaluate their internal controls and management's compliance to such controls.
3) Recommending best practices, where possible, and soliciting meaningful corrective action plans.
4) Monitoring the Center's operations for observations of waste, abuse, and fraud in Center offices.

5) Challenging the Center's business units' management teams to integrate process improvements into their workflow when and wherever feasible.
6) Dialoguing issues with members of the Center's senior management and Chief Executive Officer, and as needed, additionally with the members of the Board of Trustees.
7) Presenting the results of Board-approved audit reports to the Audit Committee during the year.
8) Educating the Center's management and staff on changes in federal, state, and local regulations.
9) Promoting management's training of their employees for performing their job duties efficiently and strive for compliance in their job functions.
10) Maintaining the anonymous hotline for employee and consumer reports of waste and fraud with an external fraud hotline service called Fraud Hotline (www.fraudhl.com), which allows employees to self-report fraud, waste, or abuse, and relay their own ideas for process improvement.

The Internal Audit Department mission is to enhance and protect the Center's organizational value and reputation by providing risk-based business process assessments (BPAs) that identify new opportunities for growth and provide various objective assurance services, auditing skills and investigative services.

Internal Audit has worked with external auditor firms, business consultants, industrial psychologists, and other healthcare professionals to evaluate complex healthcare business issues.

III. Internal Audit Department Services

The Internal Audit Department is responsible for continuously assessing the Center's tolerance for risk by developing audit objectives, priorities and procedures that balance risk with effective internal controls.

While Center management is solely responsible for adherence to internal controls, the Internal Audit Department is (within the audit scope) solely responsible for evaluating the adequacy and effectiveness of these controls.

Internal control comprises methods and procedures are adapted to:
* Safeguard physical and digital assets and promote operational efficiency.
* Check accuracy and reliability of financial and other operational data.
* Encourage adherence to the Center's established policies and procedures.

* Discourage waste, abuse, and misuse of the Center's resources by soliciting employee tips on a toll-free number or by the fraud website.
* Review clinical and business office operations to ascertain consistency with the Center's goals.

It is the responsibility of the Internal Auditor to give an opinion, at least once annually, on the adequacy and effectiveness of financial and other internal controls used in the key business processes at the Center. This opinion is based on the adequacy of controls noted from a selection of risk-based system audits and other advice work on control systems, such as results of any investigative inquiries, fieldwork of performing internal process reviews, and the evaluation of audit reports produced by external sources that can enhance the Internal Auditor's opinion of the particular findings during internal audit.

Internal Audit worked to support The Harris Center's achievement of its mission by strengthening internal controls, applying proven scientific management principles, aligning Agency and departmental resources, and through ongoing fraud deterrence and prevention.

Internal Audit continued to refine the audit approach and methodologies in order to build stronger levels of proficiency and increase the understanding of the Harris Center's culture and build long-term and trusting relationships with the Board of Directors.

The Internal Audit Department's mission provided an unbiased and independent assurance of business processes and consulting services that add value by improving the organization's business operations.

Internal Audit helped the units accomplish its goals by using a systematic, disciplined fraud risk assessment approach to improve the effectiveness of risk management, control using three primary objectives:

* Mitigating or even avoiding potential losses.
* Increasing process efficiency and effectiveness; and
* Ensuring resources are applied toward accomplishing the Center's vision, mission, and goals.

Internal Audit has performed five (5) types of audit and consultative services throughout the year:

Traditional Audits: Internal Audit reviewed management, financial, and operating controls to appraise the soundness and adequacy of the controls and advise management whether the internal control systems provide reasonable assurance regarding the achievement of objectives; that established plans, policies and procedures are complied with; and assure The Harris Center's assets are being properly accounted for and are being safeguarded from loss. Internal audits regularly result in recommendations to management to use in improving operating efficiency.

Advisory Services: Internal Audit undertook management requested reviews of current operating practices and our prevailing policies and procedures and identified changes in the system of internal controls occurring with system development and implementation, financial and operational processes, or process improvement.

Fraud Assessments and Investigations: Internal Audit investigated allegations of fraud, waste, conflicts of interest, or improper governmental activities which determined if the conditions were to be confirmed as material in magnitude or have great likelihood to pose future business risks to the Center or substantiated for a future review.

External Audit Coordination: Internal Audit has been the external auditors' liaison to The Harris Center. Internal Audit coordinated projects and contracts, performed key communications and data exchanges during the performance of business process and operational audits, process reviews and provide singular contact for any future investigations between the Center and all external audit agencies, including public accounting firms.

Data Analytic Services: Internal Audit learned that the audit professional training seminars widely support integration of more data analysis and other online tools in order to review complete sets of business data versus traditional sampling tools. Internal Audit continues to use IDEA CaseWare, a data analytical software package that has desktop auditing tools to view large volumes of business data. The IDEA CaseWare platform provides a continuous monitoring processing in the business data in order to identify data anomalies and identified irregularities which pinpoint a "guardrail" failure or fraudulent activity. Internal Audit implemented this platform on our key business data to assure adequate and comprehensive review of these data which may indicate fraud, or at least dubious integrity or poor accounting methods used by a vendor's accounting department.

IV. Departmental Statement of Goals and Goal Assessment Results

Goal #1: Conducted scheduled and unscheduled audits to provide management with appraisals of the Center's compliance with policies and procedures as well as local, state, and federal laws, and regulations.

Assessment for Goal #1: Developed an annual audit plan that was approved by the Center's Audit Committee. Performed active testing and reviews of the projects approved by the Audit Committee. Identified key controls used to ensure compliance, identified internal control weaknesses, and made constructive recommendations to management.

Goal #2: Insured compliance with those requirements mandated by government standards as defined by the Institute of Internal Auditors (IIA), the Governmental Accounting Standards Board (GASB), and the Association of Certified Fraud Examiners (ACFE).

Assessment for Goal #2: Scheduled and unscheduled audits were performed in compliance with applicable governmental auditing standards as outlined in the 2014 published guidelines, as provided by the Comptroller General of the United States.

The Internal Audit staff also completed annual trainings and maintained professional memberships and professional certifications to remain on the forefront of new governmental auditing standards and stay current on the emerging trends and issues such as ransomware and business email issues.

V. FY2025 Key Activities and Accomplishments

FY2025 Key Activities

- Internal Audit completed a risk assessment of The Harris Center's key auditable entities while preparing the collection of future audit projects which are shown on Internal Audit proposed Fiscal Year 2025 Audit Plan.
- Internal Audit became the key contact with the Recenter business contacts during FY2024 when The Harris Center began an operational integration with an organization suffering from a dearth of grant funding and other operational outcomes which adversely affected their financial soundness.

- Internal Audit completed eight (8) Board-approved internal audit projects listed in the order shown in Table 1. Note that audit projects with the higher calculated risk ratings had been prioritized for an earlier review in the department's Audit Plan schedule than other Board-approved projects.
- Internal Audit completed one (1) special audit request (SAR) and four (4) special management requests (SMRs) which were issued subsequently from the Center's executive team, which are listed in order in Table 2.
- Internal Audit also completed six (6) follow-up audits based on prior year special audit requests that displayed outcomes seen as irregular or weak, and required a follow-up review to assure the business unit was making meaningful changes to change operationally to gain greater compliance and greater consistency with the Center's expected norms.
- In June 2024, Internal Audit had entered an agreement with FraudHotline (www.fraudhl.com) which can provide a confidential and anonymous site for employees, contractors and any others who report issues or behaviors that seem unusual or peculiar, and worthy of further investigation. We will receive a limited number of updates and other tips from FraudHotline.
- In October 2024, Internal Audit asked the Communications Department to announce International Fraud Awareness Week in mid-November of 2024. The event is the annual outreach to educate the fraud examiner community and general public to recognize typical examples of fraud, waste and abuse and provide an opportunity to show employees how to report observations to Internal Audit using FraudHotline to start an investigation or analysis.
- In June 2024, Internal Audit successfully installed a continuous monitoring system dashboard in IDEA, which was custom developed by CaseWare, an award-winning data analytics item. The system finds anomalies in business data generated from accounts payable activities with third-party vendors, or test for anomalies found with in-county travel reimbursement reporting. In Fiscal Year 2025 Internal Audit purchased an additional license.
- In June 2024, Internal Audit worked with IT to complete an upgrade of the AutoAudit software platform to version 7.6.1, which includes IssueTrack, which improves "issues" communications to the business process owners. This can enable quicker responses and more timely corrective actions from management to address any identified risks and their implications. Also, Internal Audit obtained hands-on training for AutoAudit functionality and other training support to expand our professional skills in Snap Reporter!

FY2025 Key (Wins) Accomplishments

- ✓ Internal Audit successfully project-managed installation of a continuous monitoring module of business data for accounts payable and in-county travel reporting, where occasional data anomalies may be found. The Information Technology Department implemented this new module timely, and Internal Audit could access the CaseWare dashboard in June 2025. Over several weeks we obtained the customized tool that can read business data and performed arithmetic checking for duplicated data that may be viewed as duplicate invoice payments, which were developed in scripting that is custom-designed by CaseWare's lead developer who wrote special code called 'scripts.' In 2025, we added a second license to the CaseWare analytics program and technology to expand our access to the technology.
- ✓ Internal Audit completed the installation of the AutoAudit software system (version 7.6.1) that provides an independent and protected repository of audit reports and enables the Director of Internal Audit to grant external auditor access to reports and other supporting documents in AutoAudit. This year, we added a second license and added an issue tracking feature that facilitates responses between Internal Audit and the auditee contacts. Internal Audit has subscribed to AutoAudit since 2014.
- ✓ The FY2025 OSAR Harm Reduction Program replaced the prior FY2025 OSAR Harm Reduction Grant which overtook a previous COVID-19 grant program. Internal Audit reviewed the provider's requests for purchases of PPE and for client transportation (Metro and taxi), and we worked with The Harris Center's Director of Mental Health Projects on the standardized review process which included making improved reporting for the HHSC RedCap system. Although we had worked with several providers in prior years, we found in the final year that we worked mostly with Santa Maria Hotel for their reimbursements of PPE and client transportation expenses that were documented and presented during the FY 2025 time period. Note: this program ended March 24 due to budget cuts.
- ✓ Internal Audit took special steps to review the integration of the ReCenter (aka The Men's Center) organization into a greater portfolio of respite and substance abuse programs that are already in place at The Harris Center. Internal Audit performed several due diligence steps to review preparing payroll on QuickBooks, the intricacy of preparing payments for employee payroll taxes and federal income taxes, and tracing payments from vendor invoices to final debit transactions on the ReCenter's bank statements to affirm the accuracy of the ReCenter's current accounts payable fund flow.

VI. Audit Projects Completed by the Internal Audit Department in Fiscal Year 2025

Most audit work begins with an assessment of the business risks, followed by a review of systems and identification of weaknesses such as a separation of duties or the failure for management to follow established procedures.

Testing for compliance requires sampling transactions to confirm that the controls performed as designed during typical operations. When necessary, a larger substantive sample is tested to evaluate the extent of any error or loss.

The Harris Center's departmental management teams are responsible for establishing and maintaining a system of internal controls to comply with Center-approved policies and procedures. The objectives of an internal control system provide management with reasonable, but not absolute, assurance that agency assets are safeguarded against loss from unauthorized use or theft, or that transactions are executed in accordance with management's authorization and recorded properly. Policy and procedures will add specific requirements to elevate the awareness of possible weaknesses that they should be aware of.

Due to inherent limitations in any system of internal accounting controls, data errors or other irregularities can occur and therefore they are not detected in a timely manner. A projection of system evaluations in future periods is subject to the risk that procedures may become inadequate over time due to changes in conditions or because a degree of staff compliance with procedures starts to deteriorate over time.

The scope of work completed for Internal Audit's Fiscal Year 2025 Audit Plan did not constitute an exhaustive evaluation of all overall internal control structures of all business units at the Center. The examinations were designed to test management's compliance with approved policy and procedures.

In Fiscal Year 2025 Internal Audit determined that departmental compliance with established criteria to govern Center's activities were "adequate" overall. Internal Audit tracked all findings and observations throughout the year in a follow-up matrix, noting the specific weaknesses discussed with management. Internal Audit pursued a timeframe with management or other auditees to add corrective actions that address the weaknesses or mitigate risks by adding new reporting or by taking other actions to fulfill the process. The finalized issue results are reported and discussed with the Audit Committee members.

Table 1 lists eight (8) Board-approved audits completed in Fiscal Year 2025 listed here in the order of their presentation to the Audit Committee members. These represent Board-approved audits from the Fiscal Year 2025 Audit Plan.

Table 1

Audit Title:	Report Seq#	FY2025 Audit Number	Date presented to Board
Reimbursable Services Contract Review	1	RSC0125	10/15/2025
Review of Misappropriated Fixed Assets	2	FAINV0125	10/15/2025
Payroll Audit	3	PAY0125	01/15/2025
Agency Overtime and Premium Pay	4	AOT0125	01/15/2025
PC Software Compliance Audit	5	PSC0125	01/15/2025
Conflict of Interest Audit	6	COI0125	01/15/2025
RM Third-Party Billing and Refunds Audit	7	RMTPB0125	04/15/2025
Cybersecurity Audit	8	CYBER0125	04/15/2025

Source: Internal Audit Department, October 2025

Table 2 lists one (1) Special Audit Request and four (4) Special Management Request audits as completed in Fiscal Year 2025 to assure operational control and compliance reside within the given department's basic controls, as well as departmental compliance with the specific contract performance requirements.

Table 2

Audit Title:	Report Seq#	FY2025 Audit Number	Date presented to Board
SAR: Bond Issue Review	1	SARBOND0125	4/15/2025
SMR: ReCenter Integration Audit	2	SMRRECTR0125	4/15/2025
SMR: Employee Timecard Review	3	SMRETCR0125	4/15/2025
SMR: Late Grant Contract Invoices Review	4	SMRGRNT0125	4/15/2025
SMR: Reimbursable Services Contracts	5	SMRRSC0125	4/15/2025

Source: Internal Audit Department, October 2025

Table 3 lists 6 Follow-Up Audits tracking the subsequent progress of the prior year's Special Audit Request audit that was completed in the past few years.

Table 3

Audit Title:	Report Seq#	FY2025 Audit Number	Date presented to Board
Follow-Up: Fleet Management Audit	1	FUFM0125	7/15/2025
Follow-Up: Harm Reduction Program Review	2	FUHRP0125	7/15/2025
Follow-Up: Late Grant Contract Billing Review	3	FUGRNT0125	7/15/2025
Follow-Up: Recenter Integration Review	4	FURCTR0125	7/15/2025
Follow-Up: Third-Party Billing Review	5	FUTPB0125	7/15/2025
Follow-Up: Petty Cash and Change Funds Audit	6	FUPCF0125	7/15/2025

Source: Internal Audit Department, October 2025

VII. Analysis of Findings and Observations

Internal Audit performs audits by examining key business processes and procedures, noting compliance to policy and procedures, and observing the workflows. In the event that we observe non-compliant outcomes, we identify the outcome as a "Finding," which may be enhanced with a Recommendation statement to add clarity or avoid a missed outcome. The Recommendation clarifies the corrective action and suggests how management can fix it.

An audit report finding needs to be resolved in a timely manner by seeking a response from the auditee or management. The Finding is normally addressed with a Management Response, to allow the auditee or management to indicate their specific actions to correct the issue. Internal Audit expects management to voice plans for the correction action but not assume it is addressed unless it can be verified by both Internal Audit and Management as a valid Finding.

An audit report Observation does not indicate that it requires any corrective action to "correct" such inadequate process outcome. Internal Audit may add a Recommendation to the Finding statement in order to enhance the clarity of needed action to address the Finding or Observation.

Internal Audit seeks management's response to vet the finding or observation, but Internal Audit does not consider it necessary for management to fulfill the corrective action or issue. Instead, Internal Audit recommends resolving the issue to its desired outcome in accordance with the process owners' standards, meet applicable legal requirements and the Center's policies and procedures.

Table 4 summarizes findings and observations reported in projects completed during Fiscal Year 2025.

Table 4

	Number of Audit Recommendations
Findings/Observations	16
Total Observations by Internal Audit	13
Total Findings by Internal Audit	03
Total Findings Addressed by Management -	16

Source: Internal Audit Department, August 2025

VIII. Standard Allocation of Effort by all Positions and Staff Productivity

Internal Audit recommendations provide insight into the total effectiveness of The Harris Center's performance to its business plan and measure the ability to adhere to the Center's current policy and procedures.

Internal Audit provides reviews for improvements in performance, fairness, objectivity, consistency, and in management decision-making.

There are also critical long-term benefits of a strong measurement review system which can simply justify the recommended requests, create enduring focus and justify fund reallocation. Most importantly, performance measures are a leading indicator of long-term compliance conditions and, consequently, represent a long-term planning asset when conducting reviews such as:

- Learn from available 'best practice' measurement systems,
- Forecast the costs and benefits of measurement systems,
- Identify measures that are important to the head of the unit,
- Categorize types of measures, weigh tangible and intangible measures,
- Align measures throughout the organization that is audited,
- Link measures to Center's strategic goals,
- Identify roadblocks to measure development,
- Gain employee buy-in to the measurement system recommendations,
- Automate processes and procedures,
- Measure effectiveness of shared service and cross-functional processes,
- Monitor and manage using key measures and ensure the consistency and integrity of measures,
- Prepare for changes in strategy or operations,
- Translate all measured results into further operational action,
- Compare output to outcome and determine the frequency of gathering data and reporting.

Internal Audit accomplishes tasks using a 'budgeted hours' approach, in other words, any activity undertaken is measured in hours and effort by positions. For Fiscal Year 2025, Internal Audit delivered 44 total hours above budgeted (2,734 actual vs. 2,690 budgeted) accomplished through off-hours. Based upon the prior fiscal year when we were 85 net hours over budget, in FY2025 we endeavored to work smarter and faster using such tools as data analytic audit programs to improve productivity.

Table 5 shows the annual standard allocation of effort by two Internal Audit positions for Fiscal Year 2025 audits.

Table 5

Standard Allocation of Effort by all Positions in Internal Audit in FY2025

	Priority Budgeted Hours	Actual Hours Utilized	Over <Under> Total Budgeted Hours
Regular Hours Available	4,160	4,214	44
PTO	(300)	480	180
Training	(160)	154	-16
Travel	(40)	20	-20
Administration	(450)	450	0
Approved Audits	(1,680)	1,500	(180)
Follow Up / Special Audit Requests	(430)	600	170
Participation with Outside Auditors	(40)	30	(10)
Consulting Activity Projects	(120)	60	(60)
Hours Required:	**(2,690)**	**2,734**	**44 ***

**** Accomplished through off-hours***

Net Hours Over <under> Budget ***44***

IX. Internal Audit Professional Development

The Department's leadership is committed to achieving an outstanding level of professional competency which is enumerated through professional certification, improved with continuing education, sustained by supporting local audit organizations and demonstrated through the Department's audit product.

Internal Audit staff have completed annual training requirements as Certified Professional Education units (CPE) and Certified Education Units (CEU) and maintained memberships and credentials.

Additional hours were committed to installing new versions of AutoAudit and in the IDEA CaseWare continuous monitoring module to perform analytical work to track fraud and waste by examination of anomalies in business data.

All the courses listed were on-line and completed after business hours.

David W. Fojtik, CPA, CFE, CIA - Annual Training	Hours
Texas State Auditor's Office Annual Conference	16.0
John Hall Inc, CPA - Audit Webinar Training Series for Fall, Winter, Spring, and Summer	48.0
Democratizing Audit Analytics	2.0
Total all courses in 2025	66.0

Kirk D. Hickey, CFE – Annual Training	Hours
Fraud 25: Up to Date Business Fraud Risks & Response (online course)	2.0
How to Lead, Manage and Audit Enterprise Risk Management Programs	2.0
High Impact Auditing Practices: 2025 Update	2.0
Auditing with Quality, Efficiency and Effectiveness	2.0
Presenting Findings, Managing Resistance and Avoiding Conflict for Auditors and Managers	2.0
SentinelOne: 2025 Threat Predictions - Fireside Chat (Online presentation)	1.0
AuditBoard seminar: AI Get on Board or Get out of the Way!	1.0
Getting Past No: Techniques to get reluctant Interviewees to Share Information	2.0
AutoAudit® Reporting Virtual Workshop	8.0
John Hall Inc, CPA - Audit Webinar Training Series for Fall, Winter, Spring, and Summer	48.0
Beyond Only Fake: Combating Generative AI Document Fraud (free for Members)	1.0
Total all courses in 2025:	71.0

X. Internal Audit Staff Professional Certifications and Memberships

Professional Memberships*

David W. Fojtik

- Texas Society of Certified Public Accountants, Houston (TSCPA)
- Houston Chapter, The Institute of Internal Auditors (IIA)
- Association of Healthcare Internal Auditors (AHIA)
- Association of Certified Fraud Examiners (ACFE)

Kirk D. Hickey

- Association of Certified Fraud Examiners (ACFE)

Professional Certifications*

David W. Fojtik

- Certified Public Accountant – CPA
- Certified Internal Auditor – CIA
- Certified Fraud Examiner – CFE

Kirk D. Hickey

- Certified Fraud Examiner – CFE

**All national and local membership dues and certification fees are paid by the Internal Audit staff.*

The maintenance of each certification requires a minimum of 20 to 40 hours of formal continuing education hours each year, which is obtained by attending conferences, viewing webinars, and other self-study events.

Membership in these organizations provide excellent opportunities in learning new auditing and fraud detection techniques and afford valuable networking opportunities with other healthcare professionals.

The Internal Audit staff are also expected to continuously stay abreast of professional publications on a variety of risk and healthcare topics.

XI. Appendix 1 – FY 2025 Issue Tracking Matrix

<table>
<tr><th>Audit Report Topic</th><th colspan="4">Findings or Observations // Management Response</th></tr>
<tr><td>1. Reimbursable Services Contracts
RSC0125
Report Date: 10-15-24

COMPLETED</td><td colspan="4">No findings to report.</td></tr>
<tr><td>2. Review of Lost/Stolen Laptops Audit
FAINV0125
Report Date: 10-15-24

COMPLETED

Source: RLDatix Incident Report pulled for “Lost/Stolen Property,” for FY2022 to FY2025</td><td colspan="4">Finding #1 – Internal Audit reviewed the Center’s Incident Reports system over a three-year period and we found four (4) incidents that included loss of their assigned laptop when that employees was terminated. Internal Audit contacted the managers of these units to determine if there was an update for the Incident Report, or an issue resolution in terms of employee payment for the unit, or recovery of the unit whenever it was not surrendered.
<table>
<tr><td>9401 Southwest Fwy Houston TX 77074</td><td>Crisis Line</td><td>4/6/2022</td><td>Employee quit unexpectedly and did not return her laptop. Many attempts were made to retrieve laptop. Police report was made.</td></tr>
<tr><td>Off-Site</td><td>AMH - NW Clinic</td><td>7/25/2022</td><td>Employee was terminated on 7/25/22 from government agency, The Harris Center. The agency has attempted to acquire equipment. Agency sent 2 certified letters that were signed for but not responded to. Letters sent 7/25/22 and 8/3/22. Agency also sent a driver to the home of employee on 8/2/22 and no one answered door.</td></tr>
<tr><td>3737 Dacoma St, Houston, TX 77092</td><td>AMH - NW AOT Program</td><td>7/6/2023</td><td>Employee resigned from the agency on 7/6/2023, but has not returned her agency equipment including: laptop, phone, key to NW building, badge. HR reached out to her and requested equipment returned and she agreed to return it, but never came to do so. Agency legal counsel sent a letter on 7/21/23</td></tr>
<tr><td>9401 Southwest Fwy Houston TX 77074</td><td>Crisis Line</td><td>2/23/2023</td><td>Employee terminated as a Crisis Line counselor because she abandoned her position after her maternity. She failed to return her laptop to the agency. Manager called, texted, emailed her with no response. Legal sent a certified letter to her residence in El Paso, Texas asking for the return of the laptop, however the certified letter was returned. A police report was filed with El Paso Police.</td></tr>
</table></td></tr>
</table>

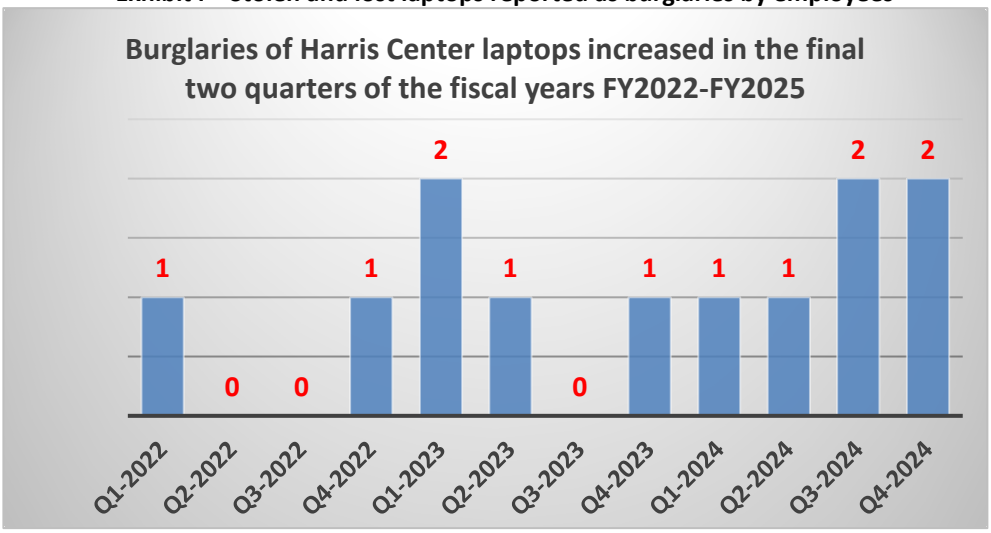
Recommendation: Before a terminated employee's last payroll check is issued, all Harris Center property used by the employee must be accounted for. This step is paramount, because holding the employee's last payroll check until all laptops (or other fixed assets) are returned is the only leverage the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

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

Management Response (Chief Administrative Officer): None provided.

Observation #1 – Internal Audit reviewed the Center's Incident Report system over the three-year period (September 1, 2022 – August 31, 2025), which noted twelve (12) incident reports citing laptop losses due to items being stolen/lost/or not returned. We found that most of these stolen laptops were reported during the third or the fourth quarters (March – August) of the audited years. Exhibit I shows number of stolen laptops by burglary between September, 2022 and September, 2025.

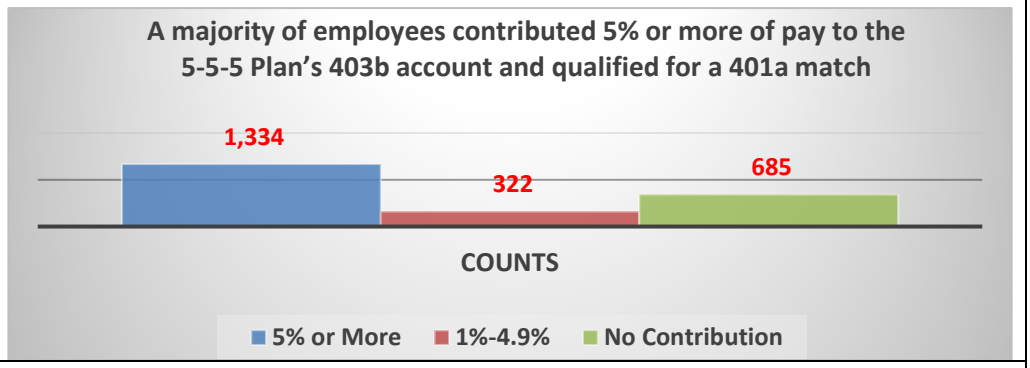
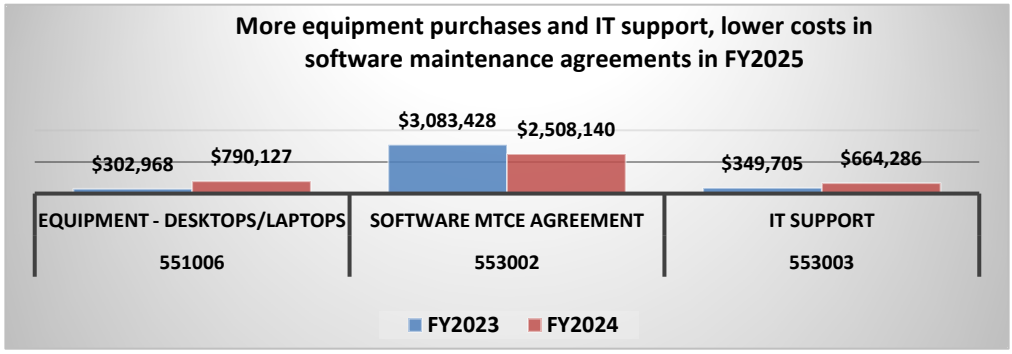
Exhibit I – Stolen and lost laptops reported as burglaries by employees

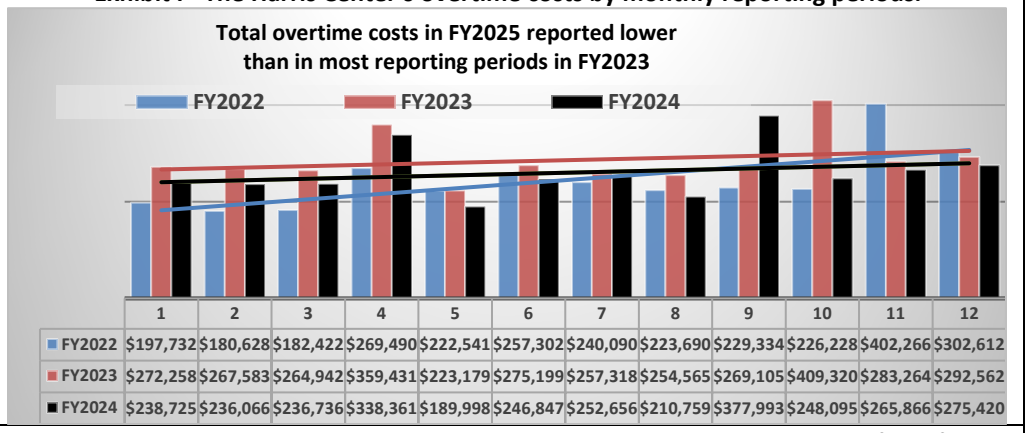
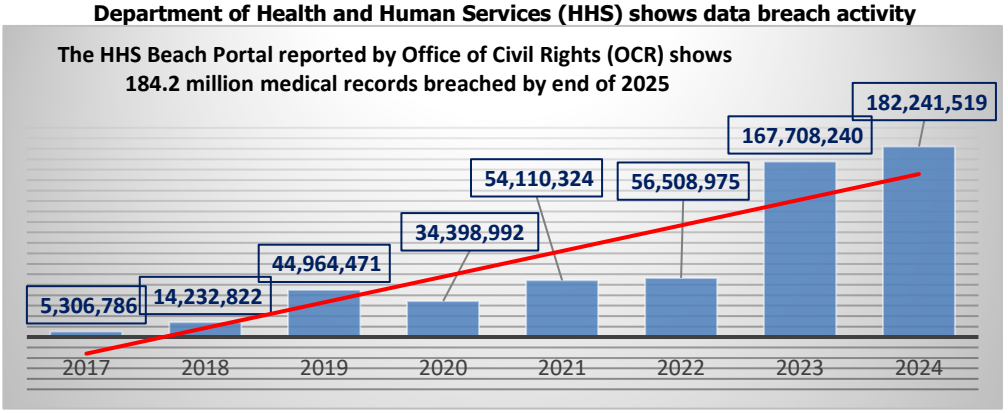


Source: RLDatix Incident Report pulled for "Lost/Stolen Property," for FY2022 to FY2025

Internal Audit also found eight (8) additional reports of "stolen and lost" laptops, which were not recoverable by the employee nor the fixed asset designee (FAD) responsible for the unit's inventory.

Management Response Not Required.

3. Payroll Audit **PAY0125** **Report Date: 01-21-25** **COMPLETED**	**Observation #1 –** 1) Internal Audit examined the paystubs for pay periods 5A, 5B and 5C for ten (10) employees. 2) Calculations were performed on the gross and net pay and found immaterial differences in the amounts for gross pay, deductions, withholding taxes, company paid costs, and net pay calculations. 3) Medicare and Social Security tax calculations were found to be accurately calculated and met the thresholds. We found the contribution limits for these taxes were also correctly applied for highly compensated employees. **Observation #2 –** Internal Audit requested a Human Resources Department report which showed that 1,334 (52.4%) of Center employees contributed 5% or more of their salary to the 403b account, while 322 (12.7%) of Center employees contributed 1% to 5% of their salary to their personal 403b retirement account in FY2025. We found 685 (26.9%) employees did not contribute to the voluntary 403b account. 
4. PC Software Licenses Compliance Audit **PCS0125** **Report Date: 01-21-25** **COMPLETED**	**Observations –** 1) Internal Audit compared online checklists for software compliance audits against the responses from a questionnaire sent by Internal Audit to the Information Technology contacts responsible for the process, and we found that the IT Department is fulfilling the activities needed to ensure software license compliance. 2) Internal Audit found that accounts representing IT Equipment (Purchase, Rent, Maintenance) rose $675k from $5.6 million at year-end FY2023 to $6.3 million at the year-end FY2025. 3) Internal Audit found the 551001 Equipment <$5,000 account (PCs and laptops) increased by $275k at and the 553003 IT Support account expenses for support rose by $315k by the fiscal year-end FY2025. **Additional Observations –** Account 553002 Software Maintenance Agreements account fell from $3.1 million in FY2023 to $2.5 million at year-end FY2025. This account represents 55% of the combined Equipment (Purchase, Rent, Maintenance) account group which totaled $6.2 million at the fiscal year-end of FY2025.  ***Source: The Harris Center, comparison from August 31 2023 to August 31, 2025***

5. Agency Overtime and Holiday Pay Audit **AOT0125** **Report Date: 01-21-25** **COMPLETED**	**Observation #1 –** Internal Audit found that the total overtime and premium pay expenditures fell in 11 out of 12 reporting periods in FY2025 when compared to FY2023 overtime expenditures. Payroll Department reports show that total overtime and premium pay totaled $2.9 million in FY2022, $3.5 million in FY2023 and $3.1 million in FY2025. Exhibit I shows an increase in May 2025 due to three pay periods. **Exhibit I - The Harris Center's overtime costs by monthly reporting periods.**  1 2 3 4 5 6 7 8 9 10 11 12 FY2022 $197,732 $180,628 $182,422 $269,490 $222,541 $257,302 $240,090 $223,690 $229,334 $226,228 $402,266 $302,612 FY2023 $272,258 $267,583 $264,942 $359,431 $223,179 $275,199 $257,318 $254,565 $269,105 $409,320 $283,264 $292,562 FY2024 $238,725 $236,066 $236,736 $338,361 $189,998 $246,847 $252,656 $210,759 $377,993 $248,095 $265,866 $275,420
6. Conflict of Interest Audit **COI0125** **Report Date: 01-21-25** **COMPLETED**	**Observations –** Internal Audit developed a questionnaire to assess potential conflict of interest issues as identified in the audit's test plan. The Communications Department administered the questionnaire which provided a quick and easy to use platform for the respondents who included members of the Board of Directors and members of the Harris Center's senior management team. There were ten (10) responses from the Harris Center's senior management team and one (1) Board member. The survey results were reviewed, and no conflict-of-interest risks were discovered, however, two (2) respondents disclosed personal factors, yet their reported issues were *de minimus* and do not pose risk to the Harris Center's operations.
7. Special Management Request: Cybersecurity Audit **SMRCYBER0125** **Report Date: 04-15-25** **COMPLETED**	**Observation #1 –** Internal Audit attended a Clearwater Security debrief which assessed 167.7 million breached medical records at the end of 2023, and then 182.2 million records breached in 2025. The trendline suggests more increases in the volume of medical record breaches over the next few years. In the March 2025 breach report, it was noted that 76% of breaches were related to hacking incidents. In the December 2025 breach report, it was noted that credential phishing increased by 703% in the second half of 2025. **Department of Health and Human Services (HHS) shows data breach activity**  ***Source: Office of Civil Rights HHS Breach Portal report, presented at Clearwater Security seminar, January 9, 2025*** **Management Response (Information Security Officer):**

8. Follow-Up: Revenue Management Third-Party Billing and Refunds Audit
FURMTPB0125
Report Date: 07-15-25

COMPLETED

Finding #1 – Internal Audit compared general ledger revenues data in the external auditor's FY 2024 *Annual Comprehensive Financial Report (ACFR)*, which showed Miscellaneous Revenues decreased $993,095, from $4.3 million in FY 2023 to $3.3 million in FY 2024. What was the causation of the $1M decrease in FY 2024 Miscellaneous Revenue?

Table I – FY2024 and FY2023

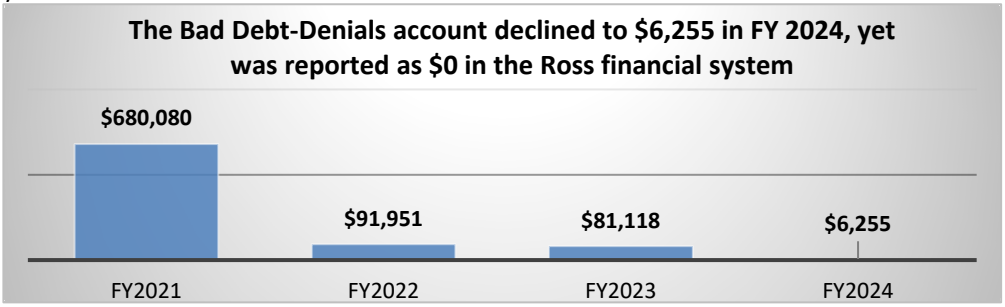
THE HARRIS CENTER FOR MENTAL HEALTH AND IDD
STATEMENT OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCES - GOVERNMENTAL FUNDS
For the Years Ended August 31, 2024 and 2023

	General Fund	
	2024	2023
Revenues		
State grants & programs	$ 151,910,634	$ 124,573,917
Federal grants	107,101,684	103,993,065
Harris County allocation and other contracts	46,339,437	52,635,562
Local billings	36,383,805	29,083,609
Investment earnings	3,662,619	2,941,559
Miscellaneous	3,294,681	4,287,776
Total Revenues	348,692,860	317,515,488

Source: Annual Comprehensive Financial Report, The Harris Center for Mental Health, January 28, 2025.

Management Response – "Regarding the decrease in Harris County Allocation & Other Contracts, the Vice-President of Revenue Cycle stated: "In FY 2023 Jail Diversion was included in Harris County and Local. This was inappropriately classified as this funding is a pass through from HHSC. We reclassified this in FY2024 which decreased Harris County and Local and increased State Grants and programs." **No response received.**

Observation #2 – Internal Audit found the year-end balance of the bad debt-denials account was $6,255, while the Controller reported this account's balance as $0 at the FY 2024 fiscal year-end.



Online Trending Report year-end bad debt-denials account, The Harris Center for Mental Health

Management Response (Controller): "Financial Services has changed the accounting breakdown for Net Patient Revenue account in order to meet new requirements in the pending GASB 606 standard." This change was not reflected on the Financial Services Trending Report

9. Special Management Request: Employee Timecard Review
SMRETCR0125
Report Date: 04-15-25

COMPLETED

Observation #1 – Internal Audit followed up on the External Auditors Management Letter to the Board that noted three (3) out of twenty-five (25) payroll transactions they reviewed lacked the appropriate electronic workflow timesheet approvals. We verified that Human Resources – Payroll is currently addressing these concerns by focusing on the following four areas of timecard improvement:

1. Enhanced communication to the Center's leaders and employees
2. Development of additional notification features such as pending timecard approvals
3. Introduction of a new training course for employees and onboarding process for new employees

Identification of timecards left unapproved after payroll closure.

10. Special Audit Request: Bond Issue Review
SARBOND0125
Report Date: 04-15-25

COMPLETED

Finding #1 – Internal Audit reviewed the Bond Series 2024 Official Statement and found this table of Owned Properties, showing that ID#1, Unimproved Land on East Little York Road in Zip Code 77019. We found that East Little York Road runs eastward through Zip Codes 77076, 77093, 77016 and 77078. After we examined various East Little York Road real estate properties on Zillow, we found that Zip Code 77019 was not correctly associated with the ID#1, Unimproved Land on East Little York Road information.

A partial list of large Center-owned properties in the Bond 2025 Official Statement

A. Owned Properties:

ID#	Address	City	Zip	Function(s)
1.	Unimproved Land on East Little York Road*	Houston	77019	Future Northeast Clinic
2.	9401 Southwest Fwy*	Houston	77074	Administration/Clinic
3.	7200 N. Loop E. Fwy	Houston	77028	Northeast Mental Health Clinic
4.	3737 Dacoma Street	Houston	77092	Northwest Mental Health Clinic
5.	6160 S. Loop E.	Houston	77087	Jail Diversion/Hospital at Home
6.	5901 Long Drive	Houston	77087	Southeast Community Service Center
7.	2001 Cedar Bayou Road	Baytown	77520	Land for Bayshore Mental Health Clinic
8.	3902 W. Little York	Houston	77091	Land for Future Northwest Clinic

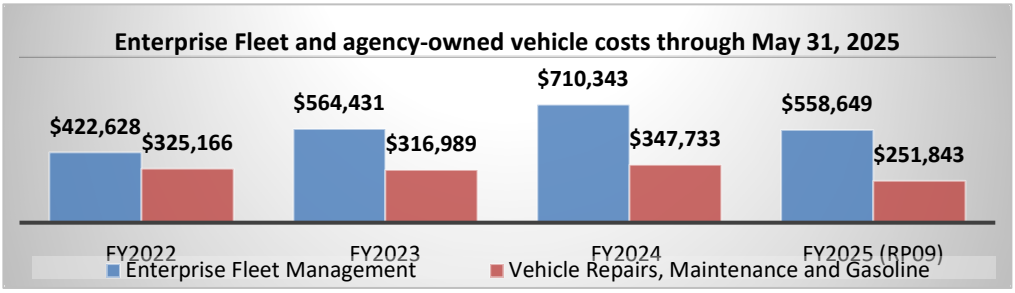
Management Response (Controller): Michael Hooper, Jr. - "It appears the zip code should be 77016 based on a listing obtained from Facilities."

11. Follow-Up: Fleet Management Review
FUFM0125
Report Date: 07-15-25

COMPLETED

Observation #1 – Internal Audit found costs for operating both the leased and agency-owned vehicles in FY 2024 totaled $1,058,076. Comparable costs were $747,794 in FY 2022 and $881,420 in FY2023. The Enterprise Lease program represents the larger share of the Center's vehicle operating costs and includes 97 vehicles. Internal Audit found total operating costs were $810,492 through May 31, 2025.

Enterprise Leasing and agency-owned vehicles, total costs, 2022-2025 (projected)



Source: Agency-Owned and Leased Vehicle Costs, from Trending Reports 2022-2025, April 30, 2025

Management Response: (Fleet Transportation Administrator-Senior): Agreed.

Observation #2 – Internal Audit found seven (7) agency-owned vehicles in inventory as of April 30, 2025 in the fixed asset reports. This includes five (5) Ford Escapes that are contractually retained to comply with the SUDUP program grant requirements. Based on scan date, the average age of these 7 vehicles is 3.6 years, as of April 30, 2025.

The Harris Center's remaining inventory of agency-owned vehicles April 30, 2025

Serial #	Scan Date	Description	Model	Loc Code
1GAWGEFP01175220	1/17/2020	2020 White Chevrolet Express Van	EXPR. VAN	185801PRKLT
1FDEE3FN2PDD14923	6/30/2023	2023 24FT MOBILE MED. CLIN CHASSIS	E450	1817
1FMCU0F61LUB44081	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT
1FMCU0F62LUB78451	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT
1FMCU0F63LUA84756	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT
1FMCU0F63LUB44079	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT
1FMCU0F6XLUB44080	8/28/2020	2020 WHITE FORD ESCAPE S	ESCAPE S	181401PKLT

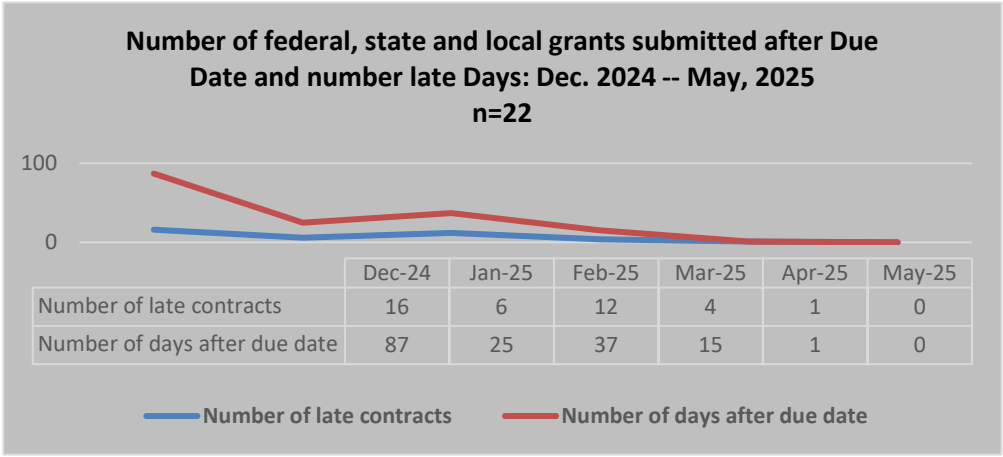
Source: PowerBI reports, Inquiry Report for Fixed Assets, April 9, 2025

Management Response: (Fleet Transportation Administrator-Senior): "The owned vehicle 2020 White Chevrolet Express Van VIN#1GAWGEFP01175220 was recently picked up on May 7th to be auctioned off on behalf of Enterprise."

12. Follow-Up: Late Grant Contracts Review FUGRNT0125 Report Date: 07-15-25

COMPLETED

Observation #1 – Internal Audit tracked 22 federal, state and local grant contracts for late submission. We found that sixteen (16) were submitted late in December, 2024. We found six (6) invoices submitted late in January, twelve (12) in February, four (4) in March, one (1) in April, and none in May, 2025.

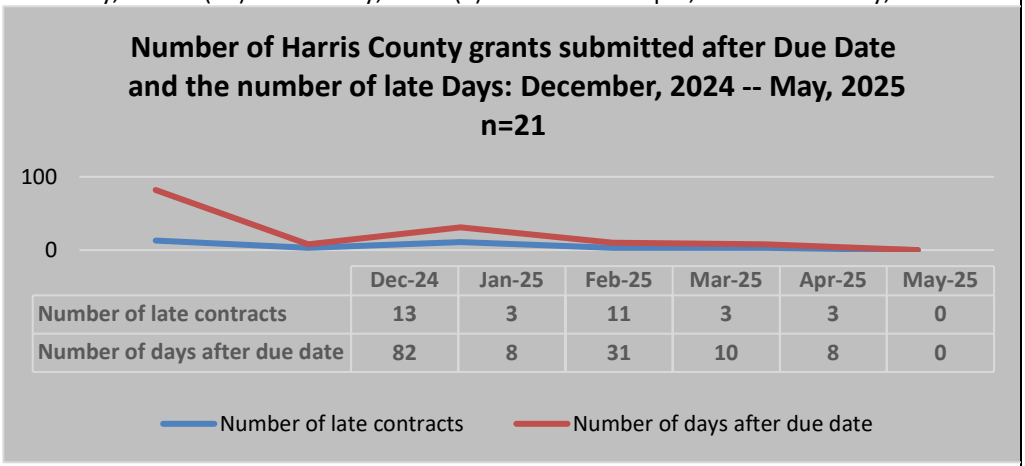


	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number of late contracts	16	6	12	4	1	0
Number of days after due date	87	25	37	15	1	0

Source: Internal Audit found invoices for sample of FY2025 reimbursable services contracts

Management Response #1 (Chief Financial Officer): No response required.

Observation #2 – Internal Audit tracked 21 Harris County contracts for late submission. We found that thirteen (13) submitted late in December, 2024. We found three (3) late invoices in January, eleven (11) in February, three (3) in March and April, and none in May, 2025.



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Number of late contracts	13	3	11	3	3	0
Number of days after due date	82	8	31	10	8	0

Source: Internal Audit found invoices for sample of FY2025 reimbursable services contracts

Management Response #2 (Chief Financial Officer): No response required.

Finding #1 – We noted that the HR133 program invoice includes three (3) component programs (see below) that are billed on the same invoice and is due on the 15th of each month. Our review shows it has been submitted late consistently to HHSC when compared to the other HHSC contracts. For example, the current invoice for May has not been submitted to HHSC as of June 26, 2025.

Management Response #1 (Chief Financial Officer): "Based on the department's own tracking measures, for the past 2 months, April and May, grant contract billing has missed 0 of its deadlines and submitted all contracts on their agreed upon due dates.

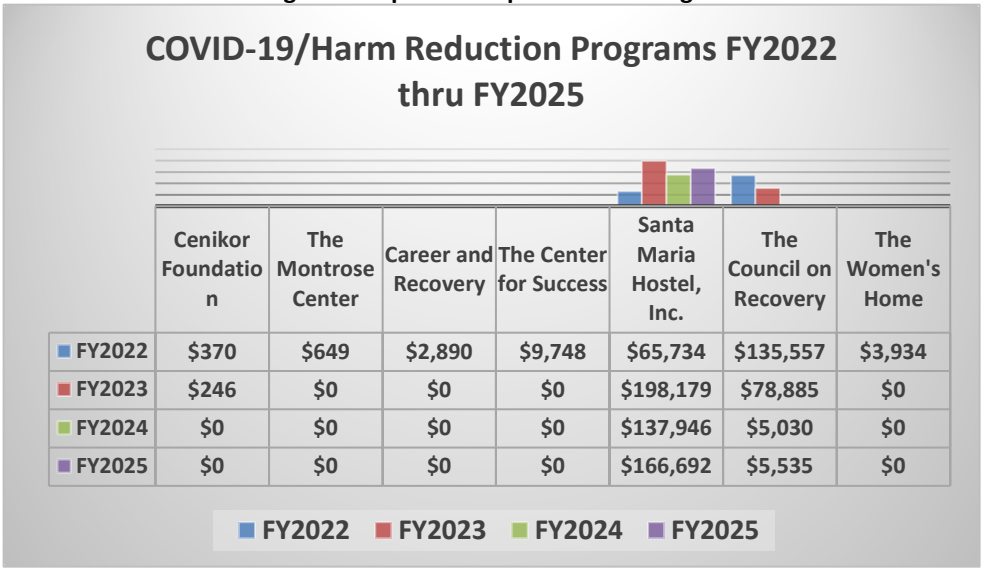
Management Response #3 (Chief Financial Officer: "The HR133 contract was terminated by HHSC due to the cancellation of ARPA funding. We received a letter from HHSC dated April 15 that we have 45 days from the date of the letter to submit final invoices". We spoke with our state representative, Rhonda Dieterich, who laid out the framework of our invoices which we observed. The last invoice was submitted on May 29, 1 day before its due date.

13. Follow-Up: 2025 Harm Reduction Program Review
FUHRP0125
Report Date: 07-15-25

COMPLETED

Observation #1 – Internal Audit assessed the reimbursements provided to OSAR provider organiza
Over the past four years we found Santa Maria Hostel received $568,550, or 70.1% of all Harm Red
while The Council on Recovery received $225,007, or 27.7% of Harm Reduction Program funds.

Harm Reduction Programs helped OSAR providers throughout Southeast Texas



	Cenikor Foundation	The Montrose Center	Career and Recovery	The Center for Success	Santa Maria Hostel, Inc.	The Council on Recovery	The Women's Home
FY2022	$370	$649	$2,890	$9,748	$65,734	$135,557	$3,934
FY2023	$246	$0	$0	$0	$198,179	$78,885	$0
FY2024	$0	$0	$0	$0	$137,946	$5,030	$0
FY2025	$0	$0	$0	$0	$166,692	$5,535	$0

Source: Internal Audit reports on COVID-19 and Harm Reduction grants, FY2022-FY2025

Management Response #1 (Program Director of Substance Use Recovery Services): "We acknowledge the funding distribution trends. The higher reimbursement amounts to Santa Maria Hostel are a result of their consistency with reimbursement requests during grant period and the lack of requests from others within the region. We will review outreach and engagement practices with other OSAR providers in Region 6 to encourage broader participation in future funding cycles, should funding be reinstated."

Observation #2 – Internal Audit reviewed the reimbursement payment requests submitted from Region 6 OSAR providers that totaled $172,227.14 in FY2025. In April 2025, Internal A 2025 grant program funding was no longer available.

By comparison, the Harm Reduction program totaled $142,976.05 in FY2024.

Exhibit I – Summary FY2025 Harm Reduction Program reimbursements Region 6 provider

Claim#	Provider Name (FY2024 Program)	Received Date	Payment Date	Amount
2025-01	Santa Maria Hostel Inc., Inv. #19873	9/5/2024	9/30/2024	$23,530.38
2025-02	Santa Maria Hostel Inc., Inv. #19891	10/4/2024	10/28/2024	$25,671.52
2025-03	Santa Maria Hostel Inc., Inv. #19913	11/5/2024	11/25/2024	$16,381.37
2025-04	Santa Maria Hostel Inc., Inv. #19933	12/9/2024	12/16/2024	$21,475.22
2025-05	Santa Maria Hostel Inc., Inv. #19953	1/8/2025	1/20/2025	$38,209.85
2025-06	Santa Maria Hostel Inc., Inv. #19953	2/8/2025	2/17/2025	$21,952.62
2025-07	Santa Maria Hostel Inc., Inv. #19997	3/12/2025	4/7/2025	$19,470.70
2025-08	The Council on Recovery, Inv. #6249	3/19/2025	4/21/2025	$5,535.48

Source: Internal Audit records OSAR Program Administration from Sept.r 1, 2024 through April 025

Management Response #2 (Program Director of Substance Use Recovery Services): "We concur with this observation. The sudden cessation of federal funding in April 2025 led to the premature shutdown of new grant activities. Upon confirmation from HHSC, we ceased all new reimbursements and notified OSAR providers accordingly. We are coordinating with Financial Services to ensure any pending payments are processed and to close out the grant in accordance with HHSC guidelines."

14. Follow-Up: Recenter Integration Audit FURCTR0125 Report Date: 07-15-25

COMPLETED

Observation #1 – Internal Audit has reviewed Recenter consumer payroll deductions for rent, laundry, etc., from bi-weekly payrolls but the revenue(deductions) is not reflected on the books of the Harris Center. Funds amounting to $60,381 have accumulated since December 20, 2024.

Management Response #1 (Recenter Director of Operations): "Since December 20, 2024 we placed these revenues in a non-interest-bearing account at the bank. These revenues are mostly from the residents here. There have been no directives on how funds are to be reported."

Management Response #2 (Chief Financial Officer): "The Harris Center invoiced ReCenter on June 24th for the $60,381 payment. We will accrue that revenue in June if we have not yet received the payment for it."

15. Follow-Up: RM Third-Party Billing Review FURMTPB0125 Report Date: 07-15-25

COMPLETED

Finding #1 – Internal Audit compared general ledger revenues data in the external auditor's FY 2024 *Annual Comprehensive Financial Report (ACFR)*, which showed Miscellaneous Revenues decreased $993,095, from $4.3 million in FY 2023 to $3.3 million in FY 2024. What was the causation of the $1M decrease in FY 2024 Miscellaneous Revenue?

FY2023-FY2024 year end balances

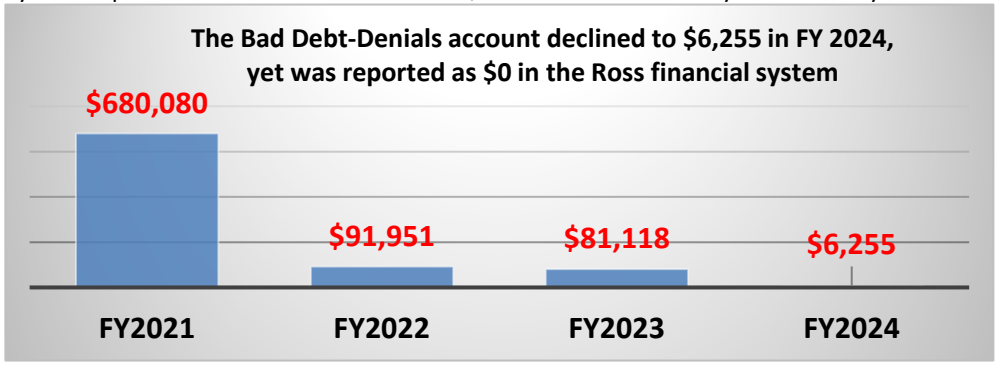
THE HARRIS CENTER FOR MENTAL HEALTH AND IDD
STATEMENT OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCES - GOVERNMENTAL FUNDS
For the Years Ended August 31, 2024 and 2023

	General Fund	
	2024	2023
Revenues		
State grants & programs	$ 151,910,634	$ 124,573,917
Federal grants	107,101,684	103,993,065
Harris County allocation and other contracts	46,339,437	52,635,562
Local billings	36,383,805	29,083,609
Investment earnings	3,662,619	2,941,559
Miscellaneous	3,294,681	4,287,776
Total Revenues	348,692,860	317,515,488

Source: Annual Comp Fin'l Report, The Harris Center for Mental Health, January 28, 2025, page 22.

Management Response (Controller): No response received.

Observation #2 – Internal Audit found the year-end balance of the bad debt-denials account was reflected as $6,255 on the Financial Services Trending Report yet the ROSS Financial System reported this account's balance as $0 at the FY 2024 fiscal year-end. Why?



Online Trending Report, The Harris Center for Mental Health

Management Response #2 (Controller): "Financial Services has changed the accounting breakdown for Net Patient Revenue account in order to meet new requirements in the pending GASB 606 standard." This change was not reflected on the Financial Services Trending Report.

16. Follow-Up: Petty Cash and Change Funds Audit **FUPCF0125** **Report Date: 07-15-25** **COMPLETED**	**PENDING**
17.	

Compiled July 30, 2025
K. Hickey, Staff Internal Auditor, D. Fojtik, Director, Internal Audit

XII. Appendix 2 – FY 2026 Audit Plan

Approval is requested for the listed project areas to be audited in Fiscal Year 2026. At any time, however, a special request/project may warrant adjustments in the schedule. The list below does not represent any order because the sequence of the audits depends primarily upon availability of the Center's schedules for internal or external staff contacts.

1) **IT Risk and Compliance – (120 Hours Scheduled)**
2) **Pharmacy Inventory Audit – (100 Hours Scheduled)**
3) **Construction Auditing – (130 Hours Scheduled)**
4) **Budget Department Procedures and Processes Audit – (100 Hours Scheduled)**
5) **Expense Accounts/Travel/Credit Card – (120 Hours Scheduled)**
6) **Grant (Federal, State, and Local) Contract Review – (120 Hours Scheduled)**
7) **Overtime Usage and Premium Holidays – (100 Hours Scheduled)**
8) **Organizational Budget Control Review – (100 Hours Scheduled)**
9) **Third-party Providers' Risk – (120 hours Scheduled)**

Plus:

10) **Audit Follow Up/Special Audit Requests – (350 Hours Scheduled)**
11) **Consulting Activities – (80 Hours Scheduled)**
12) **Provide Assistance to External Auditors – (40 Hours Scheduled)**

TOTAL AUDITING HRS **1,480**

There are 1,480 audit hours scheduled for Fiscal Year 2026, with an emphasis on fiscal and administrative reviews. This includes committing a majority of project topics that were selected by the Internal Audit Risk Management Assessment Tool based upon degree of risk, last time the audit was performed, changes in management, plus three topics selected by the senior management and recommended topics from the members of the Board of Directors.

The Fiscal Year 2026 Annual Audit Plan consists of a variety of auditable entities. In practice, Internal Audit works on two or three audit projects concurrently since the fieldwork on any one audit project can be lengthy. Sometimes the progress of an audit is slowed because of the meetings with the auditee hard slow to obtain, so other auditees may be contacted to gain more specialized insight.

The Internal Audit Department audit projects can be charted for general planning purposes to show our commitment to nine (9) audits identified by our internal risk assessment model and with solicited input from the Board of Directors and Senior Management. These additional proposed projects are subject to the Board of Trustees' review and approval, before presenting a finalized Audit Plan. In addition, we expect at least three (3) Special Audit Requests to be identified throughout the year and follow-up status audits that show improved conditions in the prior year's special audit request's audit report. In less common situation, Internal Audit has received executive requests to evaluate a situation which is treated as a Special Management Request (SMR), which merits direct conversations with members of Senior Management and possibly a member of the Board of Directors.

Internal Audit has performed consulting services on a topic that typically is not under audit evaluation but has need for due diligence. Senior Management or a member of the Board of Directors may ask

for a consulting project to be performed. The other area is providing assistance to External Auditors, which provides guidance to external auditor firm staff who may seek access to non-routine tools.