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

Live View:https://theharriscentertx.new.swagit.com/views/834/

Audit Committee Meeting
October 20, 2026
8:30 am

I. **DECLARATION OF QUORUM**

II. **PUBLIC COMMENTS**

III. **MINUTES**

A. Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, July 21, 2026
(EXHIBIT A-1)

IV. **REVIEW AND COMMENT**

A. FY 2026 Q4 Internal Audit Power Point
(EHIBIT A-2 David Fojtik)

B. FY 2026 Quarter 4 Audit Reports Compliance Department
(EXHIBIT A-3 Bijul Enaohwo)

V. **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.**

VI. **RECONVENE INTO OPEN SESSION**

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

VIII. **INFORMATION ONLY**

A. FY 2026 -Follow up Late Grant Billing Review
(EXHIBIT A-4)

B. Annual Report on FY2026 Internal Audit Activities
(EXHIBIT A-5)

C. Compliance Department 4th Qtr Binder
(EXHIBIT A-6)

IX. **ADJOURN**

Veronica Franco

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, JULY 21, 2026
MINUTES

Dr. R. Gearing, Board Chair, called the meeting to order at 8:31 a.m. in Room 109, 9401 Southwest Freeway, noting a quorum of the Committee was present.

Committee Members in Attendance: Dr. K. Bacon, Dr. R. Gearing , Dr. J. Lankford, G. Womack

Committee Member in Absence: J. Lykes

Other Board Member Present:

I. **DECLARATION OF QUORUM**

Dr. Gearing called the meeting to order at 8:31 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, April 21, 2026.

MOTION: WOMACK SECOND: LANKFORD

THEREFORE, BE IT RESOLVED that the Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, April 21, 2026 as presented under Exhibit A-1, is approved, and recommended to the Full Board for acceptance.

V. REVIEW AND COMMENT

A. **FY26 Third Quarter Compliance Audit Activities-** Demetria Luckett presented the FY26 Third Quarter Compliance Audit Activities to the Audit Committee.
B. **Compliance Department FY 2027 Work Plan-**Compliance Department presented the FY 2027 Work Plan to the Audit Committee.
C. **FY 2027 Tentative Audit Schedule-**Demetria Luckett presented the FY 2027 Tentative Audit Schedule to the Audit Committee.

VI. EXECUTIVE SESSION

No executive session

VII. RECONVENE INTO OPEN SESSION

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

IX. ADJOURN-

MOTION: LANKFORD **SECOND: WOMACK**
With unanimous affirmative vote
BE IT RESOLVED The meeting was adjourned at 9:11 a.m.

_____

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

DRAFT

EXHIBIT A-2

FY2026 Q4 Audits

Internal Audit Department



David W. Fojtik, CPA, MBA, CIA, CFE
October 20, 2026

FY2026 Q4 Audit Reports

Agenda:

1) FY 2026 Project Presentation

- Follow-Up Review: Late Grant Contract Billing

2) FY 2026 Year-End Analysis

- Year-End Internal Audit Report
- Summary Review of FY 2026 Audit Projects

*** The proposed FY 2027 Internal Audit Plan and FY 2027 Internal Audit Charter will be presented for Review and Approval at October's Full Board Meeting.**

-

FY2026 Q4 Audit Reports

Follow-up Review: Late Grant Contract Billing

Observation #1 –

As a follow-up in relation to the timely grant billing process at the Harris Center**,** 22 **Federal and State** grant contracts were reviewed for late submission from August 2025 – May 2026. We found no billings were submitted late during this time period.

Observation #2 –

Internal Audit also tracked 21 **Harris County and Local** grant contracts for late submission for the period August 2025 – May 2026. We found no billings were submitted late during this time period

FY2026 Q4 Audit Reports

Year-end Internal Audit Report

Purpose of the Annual Report

- Provides a concise summary of Internal Audit services, key activities, and completed work for FY 2026.
- Demonstrates compliance with the reporting requirements of the Texas Internal Auditing Act.

FY2026 Q4 Audit Reports

Year-end Internal Audit Report (cont'd)

FY 2026 Audit Highlights

- **Audit Plan Execution:** Completed Board-approved audits and follow-up work.
- **Responsive Support:** Addressed audit plan deviations, special requests, and management requests.
- **Board Reporting:** Reported engagement results to the Board of Trustees through the Audit Committee.

FY2026 Q4 Audit Reports

Year-end Internal Audit Report (cont'd)

Value Delivered

- Strengthened governance, risk management, internal controls, and continuous improvement through targeted Internal Audit activities.
- Improved audit efficiency by using technology-enabled tools, cloud-based platforms, and enhanced evidence-gathering methods.
- Promoted stronger collaboration and coordination across functional areas.

FY2026 Q4 Audit Reports

Year-end Internal Audit Report (cont'd)

Forward Focus

- Continue expanding data analytics to provide timely insights into:
  - Accounts payable
  - Travel
  - Payroll
  - General ledger
  - Information technology

FY2026 Q4 Audit Reports

Year-end Internal Audit Report (cont'd)

Resource Considerations

- **Reduced Audit Capacity:** A 50% staffing reduction in Internal audit staff implemented by management in October 2025 which reduced the internal audit staff to 1person limited FY 2026 audit capacity, necessitating the strategic allocation and required resources to be prioritized and focused on the highest-priority engagements and work.
- **Risk-based prioritization:** Resources were directed toward the highest-risk areas to preserve audit coverage where oversight was most critical.
- **Continued leadership support:** Ongoing Board and Executive Management support for the Internal Audit Department remains essential to sustaining effective governance, risk management, fraud deterrence, and internal control oversight.

FY2026 Q4 Audit Reports

FY 2026 Issue Tracking Matrix – Summary (cont'd)

Purpose of Tracking Matrix

- **Summarize results:** Present FY 2026 audit findings, observations, management responses, and corrective actions.
- **Consolidate status:** Provide a unified view of completed audit projects and the status of related issues.

FY2026 Q4 Audit Reports

FY 2026 Issue Tracking Matrix – Summary (cont'd)

Completed Audit Projects

Key internal audit work completed to support risk management, compliance, and operational oversight

Operational & Financial Oversight	Risk, Compliance & Controls
• Pharmacy Inventory Audit	• IT Risk and Compliance Review
• Credit Card Audit	• Grant Contracts Billing Follow-Up Review
• Construction Audit	• Budget Procedures and Organizational Budget Controls Audit
• Fraudulent Check Activity Audit	

FY2026 Q4 Audit Reports

FY 2026 Issue Tracking Matrix – Summary (cont'd)

Key Themes

- **Audit results:** Most completed audits reported no formal findings.
- **Control enhancements:** Several observations highlighted opportunities to strengthen controls, monitoring, and documentation.
- **Management action:** Management responses generally focused on corrective actions, process improvements, and enhanced oversight.

FY2026 Q4 Audit Reports

FY 2026 Issue Tracking Matrix – Summary (cont'd)

Notable Control Focus Areas

- **Vendor and Payment Controls:** Vendor bank account change verification, with emphasis on fraud prevention and independent validation.
- **Spending Oversight:** P-card spending trends and discretionary cost monitoring to identify unusual activity and support fiscal discipline.
- **Grant and Contract Administration:** Grant contract billing timeliness to help ensure revenue is captured accurately and promptly.
- **Capital Project Monitoring:** Construction project oversight, including monitoring of project progress, costs, approvals, and accountability.
- **Budget and Financial Stewardship:** Budget monitoring practices that support responsible resource management and informed decision-making.

FY2026 Q4 Audit Reports

FY 2026 Issue Tracking Matrix – Summary (cont'd)

Management Actions to Strengthen Vendor Payment Controls

- **Verification:** Enhanced the vendor payment change verification process to reduce the risk of unauthorized or fraudulent changes.
- **Approval:** Established two-level approval requirements for vendor bank account changes before updates are processed.
- **Monitoring:** Added post-change monitoring to confirm that initial payments are received by the intended vendor account.
- **Training and communication:** Notified staff of the revised controls and provided training to support consistent implementation.

Questions

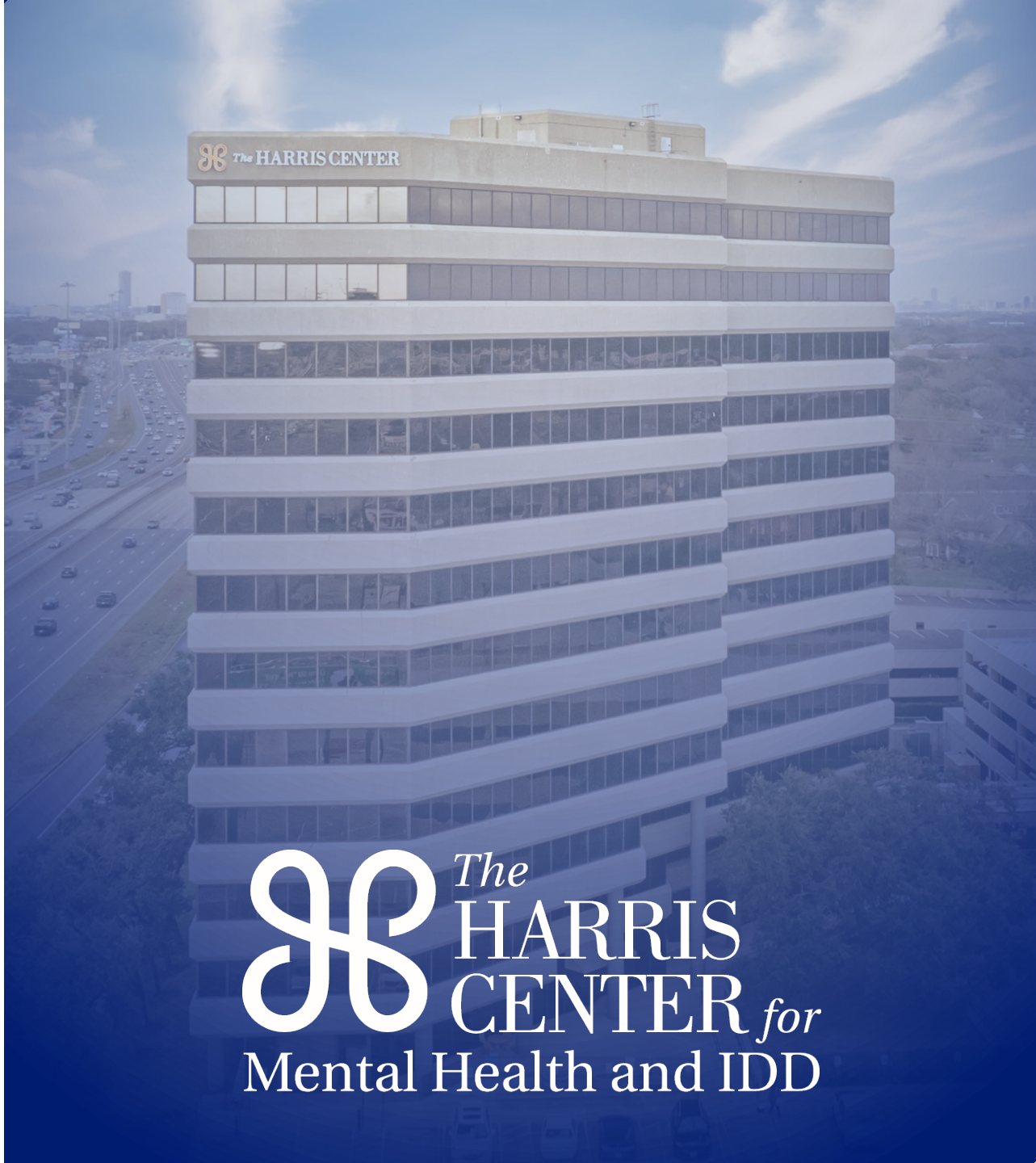
EXHIBIT A-3

FY 2026 Quarter 4 Audit Reports

COMPLIANCE DEPARTMENT

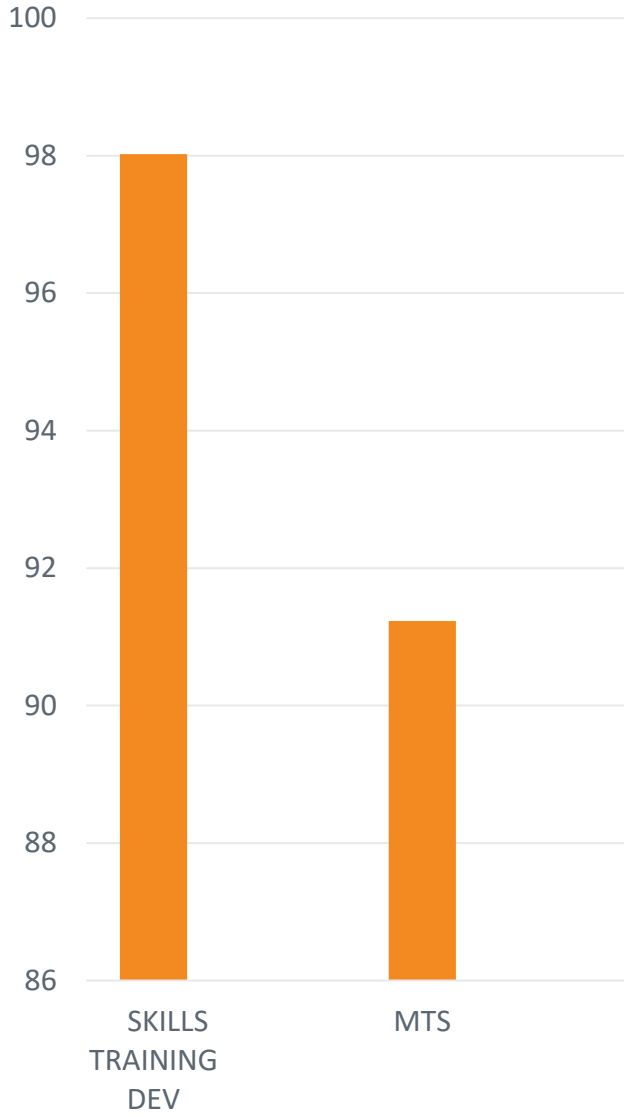
Presented by: Presenter: Bijul Enaohwo, JD,MPH,LPC
Assistant General Counsel

October 20, 2026



BILLING AND CODING FOCUS REVIEW

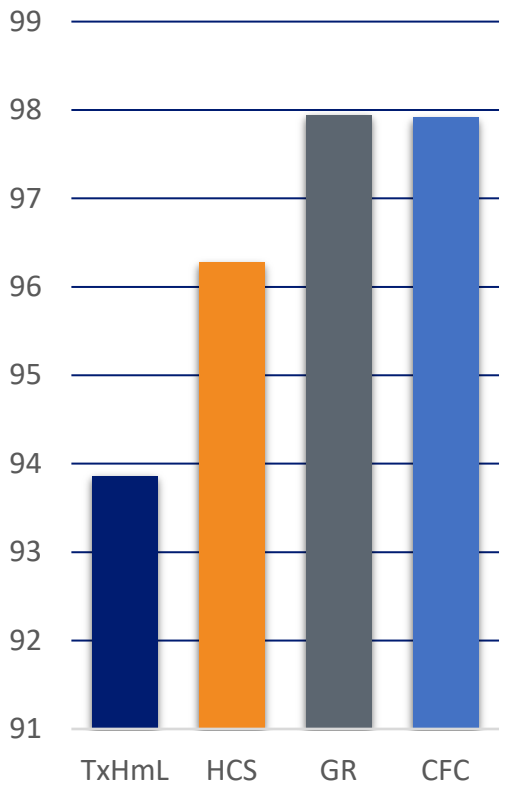
The HARRIS CENTER for Mental Health and IDD



Program	Coding and Clinical Documentation	Operation (Billing)	Overall Score	Audit Activities
Skills Training and Development	98.47%	97.57%	98.02%	**Identified Areas of Improvement:** • The plans of care objectives should be measurable. • Abnormal involuntary movement assessment was administered. **Plan of Improvement Activities:** • Pending
Medication Training and Support (NPC)PES,TCOOMMI, SW CHILD, NEW START	90.71%	91.74%	91.23%	**Identified Areas of Improvement:** • Services provided should align with verified CPT/HCPCS • Accurate, timely progress note **Plan of Improvement Activities:** • The four programs commit to achieving full compliance by October 2026 by utilizing the SMART framework to deliver 1-on-1 template retraining with leadership.

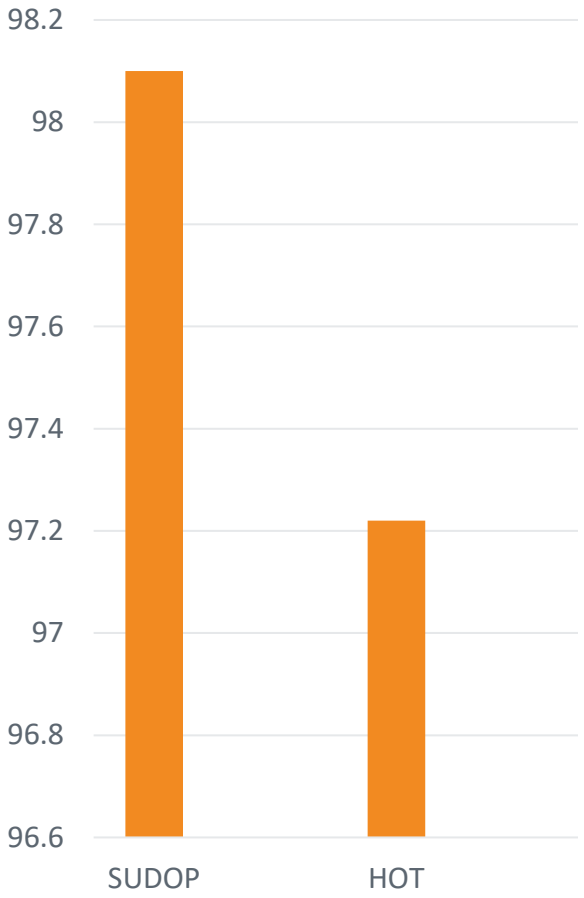
SW Child Follow-up			
Areas below 95% Threshold	Previous Score FY 26 Q2	Follow up Score 26 Q4	Change
Progress Notes Completeness	90.32%	98.85%	+8.53

BILLING AND CODING FOCUS REVIEW



Program	CLENT RECORDS (Coding & documentation)	Operations (Billing and Claims Processes)	Overall score	Audit Activities
TxHmL	90.18%	97.53%	93.86%	**Areas of Improvement Identified:** • Accurate, timely note completion by SC • Documentation of progress towards desired goals. **Improvement Actions:** • Follow-up 90-180 days
HCS	96.91%	95.62%	96.27%	**Areas of Improvement Identified:** • Accurate, timely note completeness by SC **Improvement Actions:** • Follow-up 90-180 days
GR	96.89%	99.0%	97.95%	**Areas of Improvement Identified:** • C & P: Evidence of Copy & Pasting / Cloning within Documentation • Timely, accurate note completion by SC **Improvement Actions:** • All SC's will be trained, or retrained on proper use of copy/paste, and timely documentation. With full implementation by Oct 31,2026
CFC	95.82%	100%	97.91%	**Areas of Improvement Identified:** • Failure to maintain timely progress notes and incomplete service monitoring **Improvement Actions:** • Additional trainings on documentation standards, and timeliness. • SC will receive training on type A and B encounter requirements.

CPEP DIVISION COMPREHENSIVE



Program	Medical	Personnel	Clinical	Overall Score	Audit Activities
Substance Use Disorder Outreach Program Comprehensive	100%	99.17%	95.14%	98.10%	**Identified Areas of Improvement:** • The plans of care objectives should be measurable. • Abnormal involuntary movement assessment was administered. **Plan of Improvement Activities:** • Pending
Homeless Outreach Team Comprehensive	N/A	95.56%	98.89%	97.22%	**Identified Areas of Improvement:** • Staff job duties that involve direct care responsibilities must be current with the training in identifying the causes of aggressive or threatening behavior. **Plan of Improvement Activities:** • Staff will monitor training requirements and ensure they are current with all trainings. They will notify PATH management of any issues or concerns.

CPEP DIVISION
FOLLOW UP AUDITS

The HARRIS CENTER for Mental Health and IDD

Elements below 95% Threshold (CCSI)	Previous Score FY26 Q2	Follow Up Score FY26 Q4	Change	CAP Status
Staff job duties that involve direct care responsibilities must be current with the training in identifying the causes of aggressive or threatening behavior.	57.14%	80.00%	+22.86%	In Progress
The plans of care (Six [6] elements).	62.08%	77.22%	+15.14	In Progress
The rights acknowledgement form must be signed and dated for each person's served annually.	70.00%	90.00%	+20.00%	In Progress
Service Encounter documentation. (Three [3] elements)	57.14%	76.67%	+19.53%	In Progress
Assessments. (Three [3] elements)	90.00%	100%	+10.00%	Fully Implemented

Elements below 95% Threshold (PATH)	Previous Score	Follow Up Score	Change	CAP Status
Staff job duties that involve direct care responsibilities must be current with the training in identifying the causes of aggressive or threatening behavior.	91.67%	100%	+8.33%	Fully Implemented
Direct care staff must be current with all annual required trainings.	90.00%	100%	+10.00%	Fully Implemented
Service encounter documentation must reflect the person served goals and objectives as stated in the plan of care and be consistent with the purpose and intent of the service.	90.00%	100%	+10.00%	Fully Implemented
Service encounter documentation must reflect how the person served demonstrated progress or the lack of progress towards treatment goals.	90.00%	73.33%	-16.67%	In Progress

Step Down State Hospital Transition
Follow-up

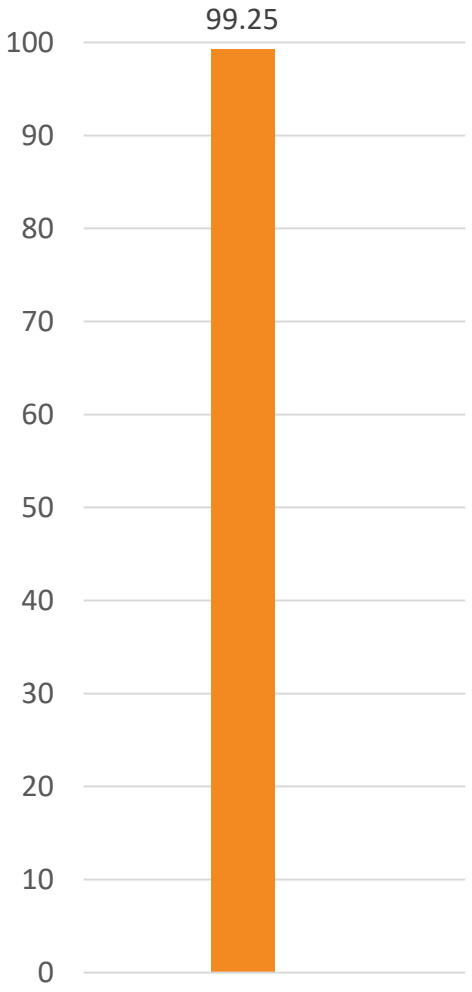
The HARRIS CENTER for Mental Health and IDD

Elements below 95% Threshold	Previous Score FY26 Q2	Follow Up Score FY26 Q4	Change	CAP Status
Staff job duties that involve direct care responsibilities must be current with annual training(s).	75%	100%	+25.00%	Fully Implemented
Pre-service training for Licensed Practitioners of the Healing Arts (LPHA) shall be current with Cognitive Adaptation training.	66.67%	NA	NA	NA
The program must develop a person-centered plan of care for each person served.	88.89%	88.89%	0.00%	In Progress
Service encounter documentation must reflect the person's served goals and objectives as stated in the plan of care and be consistent with the purpose and intent of the service.	85.18%	78.00%	-7.18%	In Progress
Service encounter documentation must show how the person served demonstrated progress or the lack of progress toward achieving their treatment goals.	11.11%	78.00%	+66.89%	In Progress

Program Response

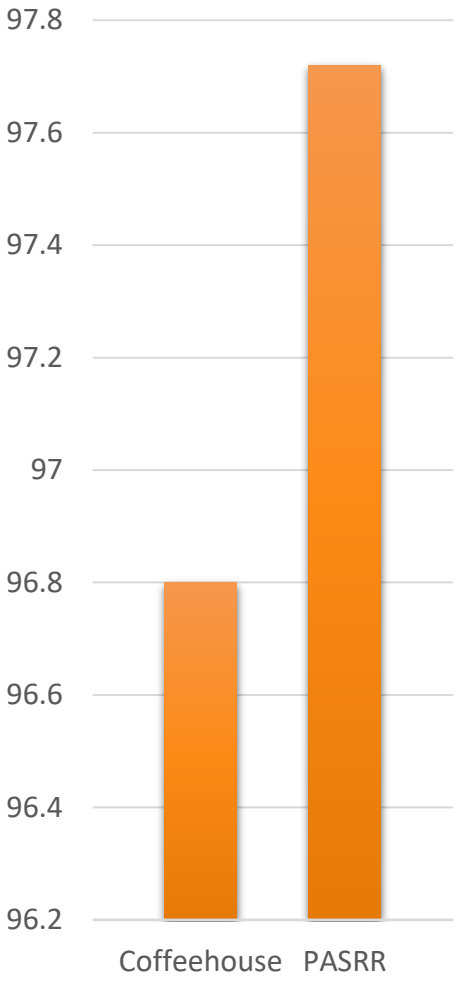
The Step-Down Program Director reported that each client's record will undergo monthly monitoring to verify that a current plan of care is on file. Care Coordinators will continue to review each client's plan of care goals and objectives to ensure that the service encounter documentation accurately reflects both progress and lack of progress towards those goals.

PEER SUPPORT AND REENTRY
COMPREHENSIVE



Program	Operations	Personnel	Environment	Client Record	Overall	Audit Activities
Peer Support and Reentry	100%	100%	100%	97.00%	99.25%	**Areas of Improvement:** • Incomplete or Missing client records. **Plan of Improvement Activities:** • Pending • Follow-up in 90-180 days.

IDD
Comprehensive



PROGRAM	ENVIRONMENT	PERSONNEL	CLINICAL	OPERATIONS	MEDICAL	OVERALL	AUDIT ACTIVIES
Coffeehouse	100%	88%	100%	96%	100%	96.80%	**Identified Areas of Improvement:** • Agency Mandated Training **Plan of Improvement Activities:** • The Coffeehouse program will begin a monthly check of staff training to ensure compliance with agency training for all team members moving forward
PASRR	100%	94%	99.13%	95.45%	100%	97.72%	**Identified Areas of Improvement:** • Staff Training and Personnel Documentation • Fire Drill Log Maintained **Plan of Improvement Activities:** • PASRR Supportive Team Leader will check Habilitation Coordinator trainings quarterly.

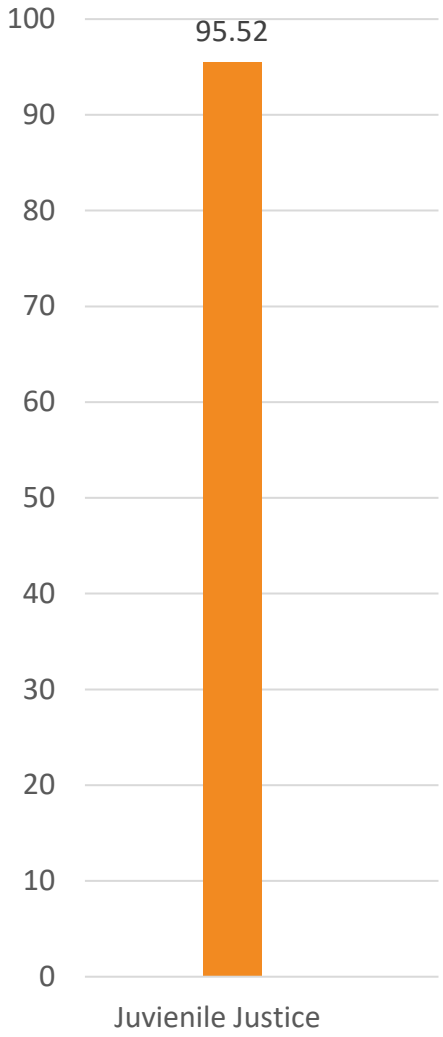
Early Childhood Intervention (ECI)
Follow-up

The HARRIS CENTER for Mental Health and IDD

Elements below 95%	Previous Score FY 26 Q1	Follow Up Score FY 26 Q4	Change	CAP Status
Personnel (6 items)	74.90%	98.85%	+23.95%	Fully Implemented
Procedural Safeguards and Due Process Procedures	99.01%	100.00%	+0.99%	Fully Implemented
Case Management for Infants and Toddlers with Developmental Disabilities	83.33%	100.00%	+16.67%	Fully Implemented
Eligibility, Evaluation, and Assessment (1 items)	80.90%	99.07%	+18.17%	Fully Implemented
Individualized Family Service Plan (2 items)	85.92%	89.31%	+3.39%	In Progress
Service Delivery	84.65%	98.68%	+14.03%	Fully Implemented
Transition (2 items)	67.11%	86.51%	+19.40%	In Progress
Family Cost Share System (1 item)	75.00%	100.00%	+25.00%	Fully Implemented

Program Response
Program leadership stated increased scrutiny of training course deadlines, refresher training on ECI requirements, and increased documentation reviews will be implemented by November 30, 2026.

Juvenile Justice Comprehensive



Program	Personnel	Client Record	Overall	Audit Activities
Juvenile Justice	96.49%	94.55%	95.52%	**Areas of Improvement:** • Client Documentation/record keeping **Plan of Improvement Activities:** • Program leadership stated targeted staff training, enhanced chart-review expectations, revised workflows, and improved EPIC reporting and monitoring would be instituted.

Mental Health Division
Follow up

The HARRIS CENTER for Mental Health and IDD

SUBSTANCE USE RECOVERY SERVICES (SURS) ADULT RECOVERY PROGRAM (ARP)	PREVIOUS SCORE FY 25 Q4	FOLLOW UP SCORE FY 26 Q4	CHANGE	CAP STATUS
Admission (6 items)	51.32%	88.24%	+36.92%	In Progress
Treatment plan (8 items)	17.13%	74.38%	+57.25%	In Progress
Treatment plan review (3 items)	60.42%	61.11%	+0.69%	In Progress
Documentation of services (3 items)	56.11%	98.63%	+42.52%	Fully Implemented
Discharge (8 items)	36.78%	68.20%	+31.42%	In Progress
Employee Training (4 items)	80.28%	97.64%	+17.36%	Fully Implemented

OUTREACH,SCREENING, ASSESSMENT, REFERRAL (OSAR)	PREVIOUS SCORE FY 25 Q4	FOLLOW UP SCORE FY 26 Q4	CHANGE	CAP STATUS
Client Records	82.49%	93.39%	+10.90	In Progress
Personnel	82.61%	100%	+17.39	Fully Implemented

Agency Snapshot
Agency Annual Trainings Audit FY 2026

The HARRIS CENTER for Mental Health and IDD

Purpose/Method: The purpose of this focused audit was to obtain a high-level view of current training compliance across divisions by reviewing assignment and completion status for thirteen required annual trainings in Absorb. This review was designed to assess current visibility, progress monitoring, and consistency across divisions, rather than historical annual due dates.

Key Findings: All required trainings reviewed are being assigned and are accessible in Absorb. The overall score for this review is 96.67%. There were no gaps identified in system assignments for active employees at the time of the review. Supervisors had initial training to Absorb 'Manager View' upon the change in learning module systems. Organizational Development will be sending a refresher to leaders. Two trainings were added to the required courses for all staff. Those trainings are The Harris Center's Dress Code & Professional Appearance and The Harris Center's Time and Attendance Policy Training. The Harris Center's Time and Attendance Policy Training was the latest training requirement for all staff, and its implementation date was August of 2026. This training was excluded from the trainings reviewed due to the implementation date not being until August of 2026. While system assignment failures were not identified, monitoring and prioritization of required new trainings may increase risk of non-compliance if not addressed. Targeted education and oversight will support sustained compliance moving forward.

Recommendation: Based on the current review it appears that staff are completing agency required trainings at a high rate. To maintain compliance across the agency, supervisors should continue to monitor training progress in Absorb. Supervisors should continue to monitor and review assignments, identify overdue trainings, and conduct regular compliance checks which will help create accountability and standard practices across the agency.

Agency Snapshot
Agency Annual Acknowledgments Audit FY 2026

The HARRIS CENTER for Mental Health and IDD

- **Purpose/Method:** The purpose of this focused audit was to evaluate the effectiveness of the organization's policy management system as it relates to employee acknowledgement of the Code of Conduct and Ethics Policy and the Assurance of Individual Rights Policy. Specifically, this audit sought to determine the following: Whether the Code of Conduct and Ethics, and Assurance of Individual Rights policies are consistently assigned to all applicable employees within our policy platform. The extent to which employees are completing acknowledgements on an annual basis and to identify any gaps in our process or system configuration. By assessing these areas, the audit aims to provide leadership with assurance on the adequacy of current workflows and highlight risks where acknowledgements are incomplete or inconsistent. CARF standards reference the need for written documentation when policies, procedures, and staff accountability are involved.
- **Key Findings:** The overall score for this review is 44.18%. The policy acknowledgments were assigned to staff for the policies reviewed in Policy Stat. All staff reviewed have an active Policy Stat account. The staff reviewed were inconsistent in acknowledging the selected policies reviewed for compliance. Four staff reviewed did not show evidence that the policies reviewed had been assigned to them to acknowledge. There is no clear evidence of system failure which causes policy acknowledgement not to be completed annually. The gaps identified in assignment, account activation, and tracking continue to create several risks for our organization: Compliance risk identified in potentially not meeting accreditation recommendations. Staff must be fully aligned with agency code of conduct, ethical standards and the rights of those we serve. Annual policy and procedure acknowledgments are essential; without them, the organization lacks the necessary framework to verify staff awareness of policies and adherence to required operational policies and procedures. Employees who do not claim their accounts cannot be included in acknowledgement tracking, which limits the accuracy of acknowledgement records.
- **Recommendation:** To strengthen the agency's approach to policy acknowledgments, the Compliance Department will continue to take ownership of implementing the following improvements: Compliance will continue to work with Human Resources and Leadership to develop a formal Policy Acknowledgment policy and procedure. It will outline the requirements for employees to acknowledge key policies, including the Code of Conduct and Ethics and the Assurance of Individual Rights at the time of hire and on an annual basis. Currently all new hires are instructed on signing into Policy Stat to claim their accounts once they receive their agency email. Supervisors should encourage staff to log into Policy Stat regularly to check their dashboard for any documents requiring their acknowledgment.

External Audit Activities

Medical Record Request	
5 Datavant Audit requests	These medical records are requested as part of a required Medicare Risk Adjustment (MRA) program. Datavant requests records on behalf of the insurance provider and the insurance company will review.
12 Additional Medical Record requests from other Managed Care Organizations.	Various MCO's requested records for MRA purposes or to review claims.

Pharmacy Audits	
28 Optum Pharmacy Audits	All clinics were audited throughout the quarter to validate claims associated with specific prescription medications. All audits are closed out with no errors, no overpayment identified, and no recoupment due.

City of Houston Housing and Community Development Department (HCDD)-Independent Living

On June 3, 2026, the agency received notice of the completed HCDD limited scope review of the Independent Living Main Street program. The review evaluated compliance with applicable federal, state, local, and program requirements. The review concluded with no findings, confirming compliance with all applicable requirements.

Texas Health and Human Services (HHSC)-Zero Suicide Prevention

The Zero Suicide Visit was conducted July 6-10, 2026, to assess compliance with Zero Suicide standards, including clinical practices, documentation, and quality improvement efforts. The results of the review are pending, and Regulatory Compliance is following up with the program regarding the outcome.

Texas Health and Human Services (HHSC) EOU, ResD, JBCR, PEER Run, Diversion Center, SHSD, PASSR

On June 9, 2026, notification was received from HHSC regarding the Mental Health Quality Management Comprehensive Review, scheduled for September 14-18,2026. The review included a comprehensive desk review and onsite assessment of operations, medical services, quality management, environment, personnel, and applicable program areas, including crisis facilities, the Diversion Center, and State Hospital Step-Down services.

External Audit Activities Cont.

Texas Health and Human Services (HHSC)-Pasadena Cottage B

HHSC conducted an inspection at the Pasadena Cottage B location on July 16, 2026, with an exit date of August 14, 2026. The inspection included a review of allegations related to admission, transfer, and discharge rights. All allegations were determined were determined to be unsubstantiated, and no citations were issued.

Texas Health and Human Services (HHSC)-Life safety Code-Westbury House

HHSC conducted an inspection at the Pasadena Cottage B location on July 16, 2026, with an exit date of August 14, 2026. The inspection included a review of allegations related to admission, transfer, and discharge rights. All allegations were determined were determined to be unsubstantiated, and no citations were issued.



THANK YOU

The HARRIS CENTER for Mental Health and IDD

EXHIBIT A-4

The HARRIS CENTER for Mental Health and IDD

Follow-Up: Late Grant Contract Billing Review

(FUGRANTS0226)

INTERNAL AUDIT REPORT

August 4, 2026

David W. Fojtik, CPA, MBA, CIA, CFE

Director, Internal Audit

Certified Internal Auditor®

TABLE OF CONTENTS

SCOPE AND OBJECTIVES 3

AUDIT RISKS 3

FIELD WORK 3

CURRENT PROCESS 4

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES 5

CONCLUSION 7

EXECUTIVE SUMMARY

Internal Audit performed this 2026 follow-up review for the period September 1, 2025 – May 31, 2026 to evaluate whether improvements to The Harris Center's reimbursable services grant billing process were operating as intended. The review focused on billing timeliness, completeness of supporting documentation, due-date monitoring, communication between Financial Services and program areas, and the sustainability of corrective actions implemented after the prior review.

Overall, the 2026 follow-up results indicate meaningful progress. Internal Audit reviewed sampled federal, state, Harris County, and local grant contracts and found that late invoice submissions had decreased substantially. No late billings were identified for the sampled federal, state, and local contracts.

Financial Services strengthened monitoring of invoice due dates, maintained supporting records in shared grant billing folders, and continued coordinating with program areas to obtain information needed for timely invoice preparation. Reconciliation documentation was generally clear and sufficient to support the invoice preparation and review process.

Based on the work performed, Internal Audit concludes that Financial Services has made meaningful progress in reducing late grant billings. Continued due-date monitoring, timely communication with program areas, accurate supporting documentation, and sustained management attention will be important to maintain these improvements during 2026 and further strengthen the reimbursable billing process.

SCOPE AND OBJECTIVES

Audit Scope: This 2026 follow-up review evaluated The Harris Center's reimbursable service contracts in response to prior grantor concerns regarding missed processing due dates. The review focused on the information provided by reimbursable contract owners and how those inputs support the billing detail used by Financial Services to prepare and submit grant invoices.

Audit Objectives: The 2026 follow-up review was designed to assess current contract billing practices and determine whether prior process concerns have been addressed. Specifically, the review sought to identify opportunities to:

1. Confirm whether Financial Services has improved the reimbursable billing process and appropriately directed staffing resources to the areas of greatest need.
2. Evaluate whether reporting enhancements have increased transparency for grant program managers and provided senior management with better visibility into grant billing and reporting activity.
3. Determine whether contract owners are supporting Financial Services grant administrators by providing billing data earlier and helping ensure invoices are submitted timely.

AUDIT RISKS

Audit Risks: The following risks could affect the continued effectiveness and sustainability of 2026 process improvements:

1. Management may be unable to sustain changes to the reimbursable billing process if staffing constraints, headcount limitations, or competing priorities continue to affect the workflow.
2. Management may not have sufficient information, reporting tools, or available capacity to evaluate billing performance and implement additional improvements where needed.
3. Management may not dedicate sufficient agency resources to support system enhancements or workflow redesign efforts needed to further improve the grant billing process in 2026.

FIELD WORK

Field Work: Internal Audit performed this 2026 follow-up review to evaluate whether reimbursable services billing improvements implemented after the prior audit were operating as intended.

Because Financial Services modified staff assignments and strengthened billing oversight, the 2026 field work focused on current workflow performance, timeliness, documentation, and opportunities for continued improvement. The review included the following procedures:

1. Obtained the current list of reimbursable services billing contracts maintained by Financial Services and selected a sample that included higher-value contracts and contracts with prior timeliness concerns.
2. Reviewed a sample of 2026 for the period September 1, 2025 – May 31, 2026 grant invoices to assess billing timeliness, completeness of support, and consistency with contract requirements.
    - Prioritized grants by value, billing complexity, and known process challenges, and discussed the sample selection with knowledgeable management personnel.
    - Confirmed that grant billing documentation continues to be maintained in the shared grant billing folder used by Financial Services administrators.
3. Identified Financial Services personnel responsible for billing activity and interviewed them regarding current workflow performance, staffing capacity, system limitations, and opportunities for further improvement.
4. Interviewed grant program managers and process owners to obtain feedback on the current billing process, the timeliness of information provided to Financial Services, and potential process enhancements.
5. Reconciled selected invoice amounts to supporting documentation and available Power BI reporting to determine whether billing activity was accurately reflected.
6. Tested selected contracts for evidence of missing, unclear, or inconsistently documented due dates in the grant billing files.
7. Evaluated whether reporting practices could overstate, understate, or otherwise affect the accuracy of grant billing information, and discussed potential mitigation strategies with process owners.

CURRENT PROCESS

The Harris Center continues to receive funding from federal, state, county, city, and other local sources, including federal program funds passed through and administered by associated state agencies.

The Center's *Annual Comprehensive Financial Report (ACFR)* identifies grant contracts and related funding activity. For 2026, the reimbursable contract billing process remains dependent on timely receipt of accurate program and financial information, complete supporting documentation, and clear contract due dates. Financial Services continues to use a grant tracking tool to assist grant administrators in monitoring billing activity and supporting timely invoice preparation.

The current grant billing process is performed by Financial Services staff who prepare reimbursable invoices, obtain supporting records, reconcile expenses, and work with program areas to resolve payroll, accounting, or operational questions that may affect billing accuracy. Internal Audit observed that the process includes substantial documentation supporting the preparation, review, and submission of grant invoices.

During this 2026 follow-up review, Internal Audit noted that prior billing delays had declined significantly. Financial Services continued to monitor due dates, request supporting information from program areas, and document invoice submissions in the shared grant billing files.

The Harris Center's most recent ACFR available during the review continued to show that grant and contribution revenues are an important funding source across agency service divisions, including IDD, Mental Health Adult, Mental Health Child/Adolescent, Crisis, and Community Hospital programs.

Grant program revenues include reimbursable services contract revenues, accruals, and intergovernmental transfer payments from federal, state, and local funding sources.

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – As part of the 2026 follow-up review for the period September 1, 2025 – May 31, 2026 of timely grant billing, Internal Audit reviewed 22 federal and state grant contracts for late invoice submissions during the review period. No late billings were identified for the sampled federal and state contracts.

Source: Internal Audit review of grant invoices for sampled 2026

Management Response #1 (Chief Financial Officer): None required.

Observation #2 – Internal Audit also reviewed 21 Harris County and local grant contracts for late invoice submissions during the 2026 review period of September 1, 2025 – May 31, 2026. No late billings were identified for the sampled federal and state contracts.
Source: Internal Audit review of grant invoices for sampled 2026 reimbursable services contracts

Management Response #2 (Chief Financial Officer): None required.

CONCLUSION

The reimbursable services contracts reviewed in FY 2026 included federal, state, county, city, and local grant programs. Many of these contracts require monthly invoicing so The Harris Center can be reimbursed for services performed by multiple agency departments.

The invoicing process depends on accurate financial information, including salary and fringe data, IT and supply costs, allowable operating expenses, and reconciliation workpapers that tie reimbursable costs to the general ledger.

Since the prior review, Financial Services has strengthened monitoring of invoice due dates and improved coordination with program areas. The 2026 follow-up results indicate that late invoice submissions have decreased substantially, although continued attention is needed to sustain timely billing when payroll, accounting, or program data issues arise.

Financial Services provided Internal Audit access to online grant billing folders containing signed invoices, reconciliation support, accounts receivable history, and, where applicable, contract documentation. Internal Audit found the reconciliation documentation generally clear and sufficient to support the invoice preparation process.

For purposes of this follow-up review, an invoice was considered late when it was submitted after the contract's stated due date. Delayed invoice submission can slow the reciprocal agency's review and approval process and may also delay receipt of grant funds by The Harris Center.

Overall, the 2026 follow-up review indicates that Financial Services has made meaningful progress in reducing late grant billings. Continued monitoring, timely communication with program areas, accurate due-date tracking, and sustained management attention will be important to maintain these improvements and further strengthen the reimbursable billing process.

Respectfully submitted,

David W. Fojtik

David W. Fojtik, MBA, CPA, CFE, CIA
Director of Internal Audit
The Harris Center for Mental Health and IDD

EXHIBIT A-5

The HARRIS CENTER for Mental Health and IDD

ANNUAL REPORT ON FISCAL YEAR 2026 INTERNAL AUDIT ACTIVITIES INCLUDING

APPENDIX 1 – FY 2026 ISSUE TRACKING MATRIX

APPENDIX 2 – FY 2027AUDIT PLAN

David W. Fojtik, CPA, CIA, CFE
Internal Audit Director

ASSOCIATION OF CERTIFIED FRAUD EXAMINERS · CFE ·

Table of Contents

I. Purpose of the Annual Report III

II. Executive Summary III

III. Fiscal Year 2026 Compliance Assessment III

IV. Departmental Statement of Goals and Goal Assessment Results VIII

V. FY2026 Key Activities and Accomplishments (Wins) IX

VI. Audit Projects Completed by the Internal Audit Department in Fiscal Year 2026 XI

VII. Analysis of Findings and Observations XIII

VIII. Standard Allocation of Effort by Positions XIV

IX. Internal Audit Professional Development XV

X. Internal Audit Staff Professional Certifications and Memberships XVII

XI. Appendix 1 – FY 2026 Issue Tracking Matrix XVIII

XII. Appendix 2 – FY 2026 Audit Plan XXVI

I - Purpose of the Annual Report

This report provides the Board of Trustees and executive leadership with a concise overview of Internal Audit's contributions during Fiscal Year 2026, with emphasis on:

- Value delivered to The Harris Center
- Performance against approved priorities
- Overall effectiveness of the Internal Audit function

II - Executive Summary

During Fiscal Year 2026, Internal Audit provided independent, risk-based assurance and advisory services to strengthen governance, risk management, compliance, and internal controls. Despite a 50% reduction in staffing capacity, the internal audit function concentrated resources on the Center's highest-risk areas and:

- Completed six Board-approved audits
- Completed one special audit request
- Completed one follow-up audit
- Expanded technology-enabled monitoring and corrective-action tracking

III - Fiscal Year 2026 Compliance Assessment

Consistent with the Standards of The Institute of Internal Auditors, Internal Audit concluded that the departments maintained an adequate overall level of compliance with the internal control criteria governing The Harris Center's operations.

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, 2026. This report summarizes The Harris Center's internal audit services, activities, and related work and fulfills Texas Internal Auditing Act reporting requirements under Texas Government Code, Section 2102.009.

This report highlights Fiscal Year 2026 key activities, accomplishments, and audit results, including Board-approved audits, audit plan deviations, special requests, management requests, and completed follow-up work. Engagement results were reported to the Board of Trustees through the Audit Committee.

Internal Audit supported The Harris Center's commitment to effective governance, sound risk management, strong internal controls, and continuous improvement.

During Fiscal Year 2026, Internal Audit used technology-enabled tools, cloud platforms, and improved evidence-gathering methods to streamline audit work, support collaboration, and improve coordination across functional areas.

Internal Audit remains committed to professional standards, critical thinking, and a risk-focused perspective. We will continue expanding data analytics to provide timely insights across core processes, including accounts payable, travel, payroll, general ledger, and information technology.

Beginning in October 2025, funding constraints reduced Internal Audit staffing by 50% for 84% of Fiscal Year 2026, materially constraining the function's audit capacity. Accordingly, available resources were prioritized toward the Center's highest-risk areas. As a result, reduced audit coverage, oversight, and discretionary review capacity materially increased the Center's exposure to risks that may not have been identified or remediated timely, underscoring the need to restore additional Internal Audit staffing to provide sustainable, risk-responsive assurance coverage for a growing organization like the Harris Center.

The Board of Trustees and the new Harris Center Executive Management team support for a properly resourced Internal Audit function is critical to sustaining governance, risk management, fraud deterrence, and internal control oversight.

David W. Fojtik

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 supports The Harris Center's objectives through a systematic, disciplined, risk-based review of governance, risk management, and internal controls, helping the Center manage business risks within acceptable tolerance levels.

Governance and Reporting Relationship
The Board of Trustees authorizes Internal Audit to independently review key business processes, internal controls, and auditable entities. The Director provides objective assurance and advisory services to the Board and Audit Committee while reporting administratively to the Chief Executive Officer.

Primary Responsibilities
1) Conduct an annual risk assessment of the Center's business units and auditable entities.
2) Review auditable entities to assess internal controls and management compliance.
3) Recommend best practices and request meaningful corrective action plans.
4) Monitor operations for waste, abuse, fraud, or other control concerns.
5) Encourage practical process improvements when feasible.
6) Discuss audit issues and emerging risks with senior management, the CEO, and, when appropriate, the Board.
7) Present Board-approved audit results to the Audit Committee throughout the year.

8) Inform management and staff of relevant regulatory changes affecting operations or compliance.
9) Promote training that supports efficient performance and compliance.
10) Maintain an anonymous external hotline for reporting suspected fraud, waste, abuse, or improvement concerns.

Mission in Practice - Internal Audit enhances and protects the Center's value and reputation through risk-based assessments, objective assurance, audit expertise, and investigative support. When appropriate, it collaborates with external auditors, consultants, healthcare professionals, and other specialists on complex operational and healthcare issues.

III. Internal Audit Department Services

The Internal Audit Department provides independent, risk-based assurance and advisory services that support The Harris Center's governance, risk management, compliance, and internal control objectives.

Management is responsible for designing, implementing, and maintaining effective internal controls. Internal Audit evaluates those controls within the scope of approved engagements and provides objective assurance, advisory insight, and practical recommendations to strengthen operations and accountability.

Key Internal Control Objectives

- Safeguard physical and digital assets while supporting efficient and effective operations.
- Promote accurate, reliable, and timely financial, operational, and management information.
- Support compliance with applicable policies, procedures, laws, regulations, grants, and contractual requirements.
- Deter and detect waste, abuse, fraud, and misuse of Center resources through monitoring, reporting channels, and follow-up review.
- Assess clinical and business office processes for alignment with the Center's mission, strategic priorities, and operating expectations.

Annual Assurance Assessment: Internal Audit annually provides the Board of Trustees and executive leadership with an independent, risk-based evaluation of the Center's financial and operational controls, supported by audit results, advisory work, investigations, process reviews, and relevant external audit reports.

Internal Audit advances the Center's mission by strengthening internal controls, promoting practical process improvement, aligning audit work with organizational priorities, and supporting ongoing fraud deterrence and prevention efforts.

The department continues to refine its audit methodology, expand its understanding of the Center's operating environment, and maintain productive working relationships with the Board of Trustees, Audit Committee, executive leadership, and management.

Through independent assurance and advisory services, Internal Audit delivers value by helping improve operations, risk management, internal controls, governance, and organizational accountability.

Internal Audit's risk-based work is designed to support three executive priorities:

- Reduce exposure to financial, operational, compliance, and reputational risk.
- Improve process efficiency, effectiveness, and consistency.
- Ensure resources, controls, and business practices remain aligned with the Center's vision, mission, and strategic goals.

Core Assurance and Advisory Services

Traditional Audits: Internal Audit evaluates management, financial, operational, and compliance controls to determine whether processes provide reasonable assurance that objectives are achieved, policies and procedures are followed, and Center assets are properly safeguarded. These engagements result in recommendations to strengthen controls, manage risk, and improve operating performance.

Advisory Services: Internal Audit performs management-requested reviews of operating practices, policies, procedures, systems, financial and operational processes, and process improvement opportunities. These services provide practical insight and risk-informed guidance while preserving Internal Audit's independence and objectivity.

Fraud Assessments and Investigations: Internal Audit evaluates allegations of fraud, waste, abuse, conflicts of interest, or improper governmental activity to determine whether reported matters are substantiated, material, or indicative of broader business risk.

External Audit Coordination: Internal Audit serves as a liaison between The Harris Center and external auditors by coordinating audit activities, facilitating communication and data exchange, and supporting business process reviews, operational audits, and other external assurance activities.

Data Analytic Services: Internal Audit continues to expand its use of data analytics and continuous monitoring to evaluate complete data populations, identify anomalies and irregularities, and provide more comprehensive insight into key

business processes. IDEA CaseWare supports reviews of areas such as accounts payable, travel reimbursement, vendor activity, and other high-risk or high-volume processes.

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. FY2026 Key Activities and Accomplishments

FY2026 Key Activities

- Completed a risk assessment of The Harris Center's key auditable entities to inform the proposed Fiscal Year 2026 Audit Plan and support risk-based prioritization of future audit projects.
- Completed six (6) Board-approved audit projects, prioritized according to calculated risk ratings and presented in the order shown in Table 1.
- Completed one (1) Special Audit Request requested by the executive team, as summarized in Table 2.

- Completed one (1) follow-up audit related to prior-year special audit requests to assess corrective action progress, operational improvements, and alignment with the Center's expected control and compliance standards as summarized in Table 3.
- Maintained FraudHotline as a confidential, anonymous reporting channel for employees, contractors, and other stakeholders to report suspected fraud, waste, abuse, or other unusual activity warranting review.
- Partnered with the Communications Department to promote International Fraud Awareness Week, reinforcing employee awareness of fraud, waste, and abuse indicators and the availability of FraudHotline for reporting concerns.
- Deployed a continuous monitoring dashboard in IDEA, developed by CaseWare, to identify anomalies in accounts payable and in-county travel reimbursement data.
- Partnered with Information Technology to upgrade AutoAudit to version 7.6.1, including IssueTrack functionality to improve communication with business process owners, support more timely management responses, and strengthen corrective action tracking. Internal Audit also completed hands-on training to expand proficiency with AutoAudit and Snap Reporter.

FY2026 Key (Wins) Accomplishments

- ✓ Advanced continuous monitoring capabilities by coordinating implementation of a CaseWare/IDEA dashboard for accounts payable and in-county travel data. The dashboard enables Internal Audit to analyze business data, identify anomalies, and support detection of potential duplicate payments.
- ✓ Strengthened audit management infrastructure by completing the AutoAudit version 7.6.1 implementation. The upgraded platform provides a protected repository for audit reports and supporting documentation, supports controlled external auditor access, and includes IssueTrack functionality to improve auditee communication, management responses, and corrective action tracking.
- ✓ Supported oversight of the FY2026 OSAR Harm Reduction Program by reviewing reimbursement requests for PPE and client transportation costs and working with the Director of Mental Health Projects to strengthen standardized review and reporting practices for HHSC RedCap reporting. The program concluded in March 2026 due to budget reductions.
- ✓ Provided risk-focused due diligence support for The Harris Center's integration of ReCenter, including review procedures related to payroll processing, payroll tax payments, vendor invoice tracing, and accounts payable fund flows through bank statement review.

VI. Audit Projects Completed by the Internal Audit Department in Fiscal Year 2026

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 2026 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.

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 six (6) Board-approved audits completed in Fiscal Year 2026 listed here in the order of their presented to the Audit Committee members. These represent Board-approved audits from the Fiscal Year 2026 Audit Plan.

Table 1

Audit Title:	Report Seq#	FY2026 Audit Number	Date presented to Board
IT Risk and Compliance Review	1	ITRM0126	10/15/2025
Pharmacy Inventory Audit	2	PHAR0126	10/15/2025
Construction Audit	3	CONS0126	01/15/2026
Budget Department Procedures and Processes	4	BDPP0126	01/15/2026
Expense Accounts/Credit Card Audit	5	EXPCC0126	01/15/2026
Organizational Budget Control Review	6	OBCR0126	01/15/2026

Source: Internal Audit Department, October 2026

Table 2 lists one (1) Special Audit Request was completed in Fiscal Year 2026 to assure operational control and compliance controls reside within the given department's basic financial controls.

Table 2

Audit Title:	Report Seq#	FY2026 Audit Number	Date presented to Board
SMR: Fraudulent Check Review	1	SMR FRCH0126	1/15/2026

Source: Internal Audit Department, October 2025

Table 3 lists 1 Follow-Up Audit 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#	FY2026 Audit Number	Date presented to Board
Follow-Up: Late Grant Contract Billing Review	3	FUGRNT0125	10/15/2026

Source: Internal Audit Department, October 2026

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 2026.

Table 4

	Number of Audit Recommendations
Findings/Observations	17
Total Observations by Internal Audit	15
Total Findings by Internal Audit	02
Total Findings Addressed by Management -	02

Source: Internal Audit Department, August 2025

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	7.60
John Hall Inc, CPA - Audit Webinar Training Series for Fall, Winter, Spring,	16.0
Managing Ethical Dilemmas for Texas CPAs	4.00
Total all courses in 2026	27.6

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)

Professional Certifications*

David W. Fojtik

- Certified Public Accountant – CPA
- Certified Internal Auditor – CIA
- 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.

X. Appendix 1 – FY 2026 Issue Tracking Matrix

Audit Report Topic	*Findings or Observations // Management Response*
1. Pharmacy Inventory Audit Report Date: 10-15-25 COMPLETED	No findings to report. Observation - Based on the counted inventory by Button Inventory Service on February 2025, PAP meds represented 79% of the counted inventory valuation.
2. Information Technology Risk and Compliance Report Date: 10-15-25 COMPLETED	No findings to report. **Observation 1 - We found responses to IT risks and Compliance matters are handled appropriately and timely.** This Board-approved audit project was included to review the processes used to identify and assess risks, and reveal how the Harris Center organizes the delivery of risk responses As a result, Internal Audit evaluated multiple sources of information regarding IT risk management and compliance from online sources and followed the recommendations cited as "best practice" for high performing Information Technology organizations. **Management Response : (Chief Information Officer): "IT Risks are handed in a 4-pronged process: identification, assessment, treatment/response planning, and monitoring and review. We are continually looking at our current controls and new ones to see if there is room for improvement, more functionality and/or more robust security identification/response."**
3. Credit Card Audit Report Date: 01-21-26 COMPLETED	No findings to report Observation #1 – **During the period Sept 2019 – July 2025, the Harris Center has doubled the total annual number of p-card transactions and tripled the Center's p-card program expenditures. There are currently 144 p-cards assigned to staff.** **Observation #2 –** Internal Audit reviewed p-card transactions from **September 1, 2024 to July 31, 2025**, and found that 1) **client-related food, supplies, medications**, etc. accounted for **66%** of P-Card expenditures, 2) followed by **14% for facility service costs,** **3) 10% for administration,** **4)** and **10% for information technology**

	OBSERVATION #3 - Internal Audit found annual **p-card discretionary spending** on **non-consumer** items totaled **$62,616.06, which represents 2.31% of overall p-card spending** of **$2,710,142** as of July 31, 2025. **Staff food** - $29,552 **Staff T-shirts/Polos** - $15,307 **(55% OF WAS REIMBURSED)** ACCOUNTED FOR Total $45,000 ***Select discretionary p-card purchases found in p-card statement expense descriptions*** **OBSERVATION #4 - Management Response (Chief Financial Officer):** *"From a Finance Leadership perspective, we're (Financial Services) is starting the process of drilling down to apply the rigor necessary to see where we have some opportunities to reduce costs in FY26,* *Particularly in those cases where we're seeing excessive costs not directly tied to grants, contracts, etc.* *Having said that we (Financial Services) met as a team and developed the initial list where we believe we have the greatest opportunity to reduce costs, and staff food/non-patient travel/misc. other costs are high on the list".*
4. Construction Audit **Report Date: 01-21-26** **COMPLETED**	**No findings to report** **Audit and Audit Scope** - • Focused on the adequacy of the internal controls over administering construction projects. • The audit scope included several process reviews with Facility Services, Purchasing, Contracts and Accounts Payable Departments during the 2025/2026 fiscal year. **OBSERVATIONS** - • The Facility Services Department hired a construction project manager in October 2024 to oversee the building projects. • This oversight had previously been managed by a third-party project manager, mStrategic Partners. **CONCLUSION -** • There were no erroneous transactions detected during the audit period.

5. Follow-up : Grant Contracts Billing Review Report Date: 01-21-25 **COMPLETED**	**No findings to report** **Observation #1 –** As a follow-up in relation to the timely grant billing process at the Harris Center, **22 Federal and State** grant contracts were reviewed for late submission from May 2025 – August 2025. **We found no billings were submitted late during this time period.** **Observation #2 –** Internal Audit also **tracked 21 Harris County and Local grant contracts for late submission** for the period May 2025 – August 2025. **We found only one (MCOT) invoice in July 2025 that was submitted 1 day late during the period.**
6. Budget Department Procedures/Processes and Organizational Budget Control Audit Report Date: 03-21-26 **COMPLETED**	**No findings to report** ***Observation #1*** **-** Internal Audit found the Harris Center Budget Department demonstrates a strong commitment to financial stewardship. ***Observation #2*** **–** The audit identified the Department has solid framework for budgeting, forecasting, and spend oversight. ***Observation #3*** **–** The new Enterprise Resource Planning software is a targeted improvement which will link budget data with financial data and further strengthen financial stewardship across the Center. **Management Response (CFO) –** "As CFO, I have to say that the process that we've implemented and sustained is very effective and we In addition but not limited to from a monitoring standpoint we have departmental operational reviews/visits throughout the year with the departmental leaders along with the VPs to and ensures that all departments are staying compliant and consistently in touch with their respective budgets". "We're constantly challenging ourselves to improve. Having said that In recent years we haven't encountered any challenges or inefficiencies that we haven't been able to overcome". Management Response CONTINUED (CFO) – Per the CFO, "Regarding recommendations for improvements, Having a new financial system will reduce the amount of manual work required regarding the development and reviews of the annual budget process".
7. Fraudulent Check Activity Audit	**Finding #1 – Fraudulent Vendor Bank Account Change**

Report Date: 04-15-25 **COMPLETED**	**Three checks** totaling **$58,851.25**, issued by the Harris Center for services rendered, were not received by the Arc of Harris County during the months of **December 2025 and January 2026**. The loss occurred as a result of a **fraudulent request to change vendor bank account information**, which **redirected** the payments **away** from the Arc of Harris County. **The issues which allowed the fraud to occur** were **process and documentation-related**, not systemic. **Finding #2 – Existing Controls** While staff complied with existing procedures, the **procedures and controls in place were not robust enough to prevent or detect the fraudulent change in bank account information in today's business climate.**
	As a result, the fraud was not identified until after the checks had been issued and diverted.
	Observation #1 – Vendor bank account changes carry inherent risks and in today's business climate require stronger verification processes to defer fraud *Observation #2* – Theft Reports have been filed with the HPD, FBI, and an insurance claim is in progress Internal Audit Recommendation –
	Over the past 2½ years, The Harris Center has experienced **2 incidents of fraudulent vendor-initiated bank account changes totaling $113,000. Arc 58,851 willing workers club 55,200** **In response, Internal Audit has recommended a robust checklist to management** to strengthen internal controls by **implementing multiple layers of documentation** for vendor-requested banking updates. **Given the increased sophistication of identity theft that allow fraudsters to replicate documents** such as W-9s, tax identification numbers, and voided checks—**enhanced procedures are necessary to mitigate the risk of future fraud.**
	Management Response: (Controller) – (cont'd) **"We (Financial Services) acknowledge the findings and conclusions of Internal Audit. Management concurs with Internal Audit's assessment that vendor bank account changes represent an inherently high-risk activity and agrees that enhanced controls are warranted.**
	As a result, Management accepts Internal Audit's recommendations and has already implemented the following corrective actions:

	• **A Verbal Verification of Payment Change Request form was developed and implemented** to create a formal, standardized process for verifying with vendors that the request for change is valid. • **Established a two-level approval process requiring review and approval by both Purchasing and the Controller (or designee)** prior to any bank account changes being entered into the accounting system". **Management Response: (Controller) – (cont'd)** • "**Implemented post-change monitoring procedures to confirm receipt of initial payments** following any bank account update and to promptly investigate and resolve discrepancies. • **Staff were notified and trained accordingly.** **We would like to thank Internal Audit for its work on this project** and **We will continue to work together with Internal Audit, Information Technology, and Risk Management to ensure the revised controls are effectively designed and operating as intended**".

Appendix 2 – FY 2027 Audit Plan

Approval is requested for the Fiscal Year 2027 audit project areas outlined below. The proposed schedule may be adjusted during the year to address special requests, emerging risks, management priorities, or changes in operational availability. The sequence of projects does not indicate priority; timing will depend primarily on the availability of Center staff, external contacts, records, and supporting schedules.

Audits Related to Policy Changes

1) **Travel Expense Reimbursement** — Review the impact of the Board-approved increase in the CEO approval threshold for travel expense reimbursements from $1,000 to $1,500. **(100 hours scheduled)**
2) **Pharmacy Copays** — Review petty cash processes and pharmacy copay payment activity. **(100 hours scheduled)**

Other Planned Internal Audits

3) **Vendor Verification Form Follow-Up Audit** — Review implementation and use of the new vendor verification form. **(100 hours scheduled)**
4) **Overtime Usage and Premium Holidays** — Review overtime usage patterns and premium holiday pay activity. **(120 hours scheduled)**
5) **Capital Projects Review** — Review selected capital project controls, documentation, and oversight practices. **(120 hours scheduled)**
6) **Third-Party Provider Risk Review** — Evaluate selected risks related to third-party providers and related oversight processes. **(120 hours scheduled)**
7) **Stipend and Translation Payment Review** — Evaluate stipend payments and payments made to translation service providers. **(100 hours scheduled)**

Additional Audit Activities

8) **Audit Follow-Up and Special Audit Requests** — Reserve time for follow-up work and special audit requests that arise during the fiscal year. **(150 hours scheduled)**
9) **Consulting Activities** — Provide advisory support on selected matters that require due diligence or risk-informed review but are not formal audit engagements. **(40 hours scheduled)**
10) **External Auditor Assistance** — Assist external auditors by coordinating information requests, supporting access to documentation, and providing guidance on non-routine tools or processes. **(40 hours scheduled)**

TOTAL AUDITING HRS	**1,010**

A total of 1,010 direct audit hours are scheduled for Fiscal Year 2027, with emphasis on fiscal, administrative, operational, and governance-related reviews. Project topics were selected using the Internal Audit Risk Management Assessment Tool, which considers risk level, timing of prior audit coverage, management or leadership changes, senior management input, and recommendations from members of the Board of Trustees.

The Fiscal Year 2027 Annual Audit Plan includes multiple auditable entities. Internal Audit may work on two or three projects concurrently because fieldwork timelines can vary. If meetings, records, or auditee availability delay one project, Internal Audit may advance other planned work or contact additional subject-matter resources to maintain progress.

For planning purposes, the audit plan reflects seven planned audit projects identified through Internal Audit's risk assessment process and informed by input from the Board of Trustees and Senior Management. These proposed projects are subject to Board review and approval before the Audit Plan is finalized. Internal Audit also expects to complete special audit requests and follow-up reviews during the year, including reviews designed to assess whether prior corrective actions have improved control conditions.

Internal Audit may also provide consulting services when Senior Management or a member of the Board requests due diligence, process insight, or risk-informed advisory support on matters not scheduled for formal audit evaluation. In addition, Internal Audit may assist external auditors by coordinating information requests, supporting access to documentation, and providing guidance on non-routine tools or processes.

EXHIBIT A-6

The HARRIS CENTER for Mental Health and IDD

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 four of Fiscal Year (FY) 2026, including internal audit findings, external audit involvement, and ongoing department responsibilities.

Presenter: Bijul Enaohwo, Assistant General Counsel

Explanation of Auditing Format:

Audits are structured across five core components: Personnel, Operations, Environment, Client Records, and Medical. This categorization facilitates the identification of potential risks and opportunities for improvement across all programs and service lines.

This report covers audits completed between June 1, 2026, and August 31, 2026. It includes a breakdown by division and by review type: 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.

There were a total of seven (7) Billing and Coding Focus Reviews completed for the fourth quarter of FY 2026. Each billing and coding focus audit consists of two core areas: billing and coding/clinical documentation.

1. **Home and Community-Based Services (HCS)**
   a. The HCS program demonstrated exemplary performance, achieving an impressive combined Regulatory and Coding/Billing overall compliance score of 98.01%, with Personnel achieving a perfect 100%, Client Records at 99.76%, and Coding/Clinical Documentation at 96.91%. However, a critical subset bottleneck was identified within Reimbursement Validation, which was scored at 78.92% due to unsupported or unauthorized services. We identified a persistent documentation lag in which progress notes missed the mandatory two-business-day completion deadline, thereby failing to ensure that entries were timely and supportive of the service rendered. Additionally, an audit finding identified significant discrepancies in the reimbursement validation component, in which specific claims were processed for unsupported or unauthorized services due to deficiencies in underlying clinical documentation.

2. **Texas Home Living program (TxHmL)**
   a. TxHmL demonstrated a strong baseline score of 94.55%, with Personnel at 99%, Billing at 97.53%, Client Records at Face-to-Face encounters used incorrect Type B codes instead of the required Type A codes. Additionally, an audit finding identified that Type B support encounters were submitted without the required matching monthly Type A face-to-face visit. We identified a persistent documentation lag

The HARRIS CENTER for Mental Health and IDD

across TxHmL, in which progress notes missed the two-business-day deadline. Finally, an audit finding identified that case records lacked documented evidence of the Service Coordinator monitoring client goal progress, tracking service satisfaction, transferring enrollment files, or completing 30-day pre-expiration IPC/PDP updates

3. **Medication Training and Support (MTS) Four Programs**
   a. The Medication Training and Support (MTS) review resulted in an overall compliance score of 91.23%, which fails to meet the established 95.00% threshold due to critical deficiencies in coding, documentation, and billing practices. While the TCOOMMI JR Program achieved exceptional compliance at 99.54% with zero errors, and the Southwest Child Program passed the threshold at 96.37% despite minor consent issues, the other two programs dragged down the overall score. Specifically, the New Start Program failed with a score of 90.09% due to poor HCPCS documentation and cloned notes, while the NPC PES Program performed the worst at 75.73% due to severe gaps in time-based logging and progress notes. Collectively, these documentation vulnerabilities across the failing programs significantly increase the organization's risk of insurance claim denials, financial recoupments, and potential false-claim violations.

4. **Skills Training and Development (Four programs)**
   a.The review yielded an exceptional overall compliance score of 98.02%, successfully exceeding the 95.00% threshold across all four audited programs. The Compliance Department commends the program leadership and staff for exceeding expectations and demonstrating a strong commitment to quality billing practices. However, minor deficiencies were identified in Care Plans, Healthcare Common Procedure Coding System (HCPCS) coding, and Service Consents. If left unaddressed, these limited gaps still carry minor financial risks that could result in service authorization delays or insurance claim denials.

5. **Southwest Mental Health Child Program (Follow-Up Audit)**
   a. The follow-up review yielded an overall compliance score of 96.28%, successfully exceeding the 95.00% established compliance threshold score, and confirming that the corrective actions have been implemented. The follow-up review yielded an overall compliance score of 96.28%, exceeding the 95.00% compliance threshold and confirming that the corrective actions have been implemented. However, a new, isolated deficiency in Current Procedural Terminology documentation was identified due to instances where the billed service code did not consistently align with the documented clinical intervention. Based on the results of your follow-up review. However, a new, isolated deficiency in Current Procedural Terminology documentation was identified due to instances where the billed service code did not consistently align with the documented clinical intervention.

6. **Community First Choice (CFC)**
   a. The Community First Choice (CFC) program demonstrated strong overall performance during this review period, achieving an overall score of 97.91%, exceeding the established 95% threshold score. Despite this strong performance, specific administrative deficiencies lowered the overall score. Coding/Clinical Documentation received (95.82%) while Billing received (100%) Deficiencies were identified in documentation timeliness; Multiple progress notes failed to meet mandatory state timely submission requirements. There were also instances where documentation failed to verify monitoring of service delivery, progress, and satisfaction.

7. **General Revenue (GR)**

a. The General Revenue (GR) program demonstrated strong overall performance during this review period, achieving an overall score of 97.94%, exceeding the established 95% threshold score. Despite this strong performance, specific administrative deficiencies lowered the overall score. Coding/Clinical Documentation received (96.89%), Billing received (99%). Deficiencies identified in documentation, timeliness, and evidence of copy-and-paste. Multiple progress notes failed to meet the mandatory state timely submission requirements. There were also instances where SC documentation failed to verify monitoring of service delivery, progress, and satisfaction.

CPEP Comprehensive Reviews

1. **Substance Use Disorder Outreach Program (SUDOP)**
   a. The SUDOP program demonstrated strong performance, achieving an overall score of 98.10%. The review identified strong compliance with the medical score 100% and the personnel score 99.17% requirements. Although the clinical record score was 95.14%, the program met the performance threshold; several evaluated elements did not meet compliance requirements. Program leadership will need to strengthen documentation controls to ensure alignment with regulatory standards.

2. **Homeless Outreach Team (HOT)**
   a. The HOT program achieved an overall score of 97.22%. The review identified strong compliance with the clinical record requirements, with a score of 98.89% across all elements reviewed except one, documenting the service encounters in the health record within the required timeframe. The personnel score was 95.56%; however, there were instances of non-compliance with agency-mandated training requirements, resulting in the need for a plan of improvement.

Follow-Up Audits

3. **Step Down State Hospital Transition**
   a. The program demonstrated minimal overall compliance, with measurable improvement observed in two of the five elements reviewed, resulting in one element deemed not applicable. Audit scoring showed that one element met and exceeded the 95% performance threshold, indicating strong adherence in that specific area. However, corrective measures remain necessary in the clinical record domain of plan of care development, ensuring service encounter documentation reflects the individual's identified goals and objectives as outlined in the plan of care, and documenting how the person served demonstrated progress or lack of progress towards treatment goals.

4. **Chronic Consumer Stabilization Initiative (CCSI)**
   a. The program demonstrated strong overall compliance and maintained performance improvement across nearly all elements reviewed. Audit results reflected a high level of compliance, with six of the fourteen elements meeting or exceeding the 95% performance threshold, indicating a robust effort in operational practices. However, corrective action remains necessary to ensure adherence to mandated training, plan-of-care development, and appropriate service-encounter documentation.

5. **Projects for Assistance in Transition from Homelessness (PATH)**
   a. The program demonstrated strong overall compliance and maintained performance improvement across nearly all elements reviewed. Audit results reflected a high level of compliance, with three of the four elements meeting and surpassing the 95% performance threshold, indicating strong adherence to operational practices. However, corrective action remains necessary in the domain of service to

encounter documentation, individualizing how the person served demonstrated progress or lack thereof towards treatment goals.

Forensics Comprehensive Reviews

1. **Forensic Peer Support and Reentry**
   a. The program achieved an overall score of 99.25%, up from 97.65% in the 2nd Qtr. FY 2026 review. The program exceeded the minimum compliance threshold of 95.00% in the operations (100.00%), Personnel (100.00%), Client Records (97.00%), and Environment (100.00%) components. During the 2nd Qtr. In the FY 2026 review, the program received a score of 20.00% for Oral Communication of Rights. Documentation reviewed did not consistently demonstrate that the individual and/or parent, conservator, or guardian received an explanation of client rights, as evidenced by the required date and signatures. During the current comprehensive review, the program received a score of 26.00% for Oral Communication of Rights, representing a 6-percentage-point improvement from the previous review. However, the program remains unable to obtain documentation from the Harris County Sheriff's Office front-door process, where client rights are communicated to individuals. Therefore, the program has not yet fully met the requirements of the associated Corrective Action Plan. For a comprehensive review, the Client Records component received an overall score of 97.00%. The AIMS requirement received a score of 75.00%. Trained and competent staff are required to screen applicable individuals quarterly for abnormal involuntary movements using a standardized instrument, such as the Abnormal Involuntary Movement Scale (AIMS). This requirement was not evaluated during the previous follow-up review. Program leadership indicated that they would collaborate with the Harris County Sheriff's Office to identify additional strategies to address the remaining deficiencies.

IDD Comprehensive and Focus Reviews

1. **Coffeehouse Comprehensive review**
   a. The Coffeehouse program demonstrated strong overall performance, achieving an overall compliance score of 96.80%. The review reflected effective operational practices and high adherence to environmental, medical, operations, and clinical standards. While compliance was strong across most domains, deficiencies were identified that necessitate corrective action, primarily within the Personnel Records category. The Personnel Records review identified multiple compliance deficiencies related to required documentation and agency-mandated staff training. Specifically, several staff files lacked evidence of completion of the required training courses. These deficiencies directly contributed to the reduced compliance score in this category and indicate a need for strengthened internal monitoring and documentation processes. The operational walk-through revealed a deficiency in maintaining the fire drill log, which contributed to a lower compliance score and highlighted the need for improved internal monitoring. The progress notes contained a statement indicating that progress was observed, with staff marking "yes." However, the narrative lacks specific details on how progress was achieved. This issue was raised with the program manager during the review, and the manager acknowledged it and expressed her intention to train staff in effective progress note writing. The Coffeehouse program underwent an audit by Compliance in Fiscal Year 2024, covering the period from September 1, 2023, to October 31, 2023. Identified deficiencies included the use of a generic documentation template, an incorrect note format, and the absence of a current plan of care. These issues have since been addressed, resulting in no additional findings in these areas. Furthermore, the program was audited by

the Health and Human Services Commission (HHSC) through Service Coordination from January 26 to January 29, 2026, and no findings were reported.

2. **Preadmission Screening and Resident Review: Comprehensive review**
   a. The PASRR program demonstrated strong performance, achieving an overall compliance score of 97.72%. The review reflected effective operational practices and high adherence to clinical, medical, and environmental standards. While compliance was strong across most domains, deficiencies were identified that necessitate corrective action, primarily within the Personnel Records category. The Personnel Records review identified multiple compliance deficiencies related to required documentation, pre-employment alcohol and drug screening completed prior to service delivery, and agency-mandated staff training. Specifically, several staff files lacked evidence of completion of the training courses required and of meeting other personnel requirements. These deficiencies directly contributed to the reduced compliance score in this category and indicate a need for strengthened internal monitoring and documentation processes. The operations review demonstrated a high level of compliance, with only minor deficiencies in maintaining the Fire Drill Log. While limited in scope, these findings resulted in a slight reduction from a perfect score.

Follow-Up Audits

1. **Early Childhood Intervention Follow-up Review**
   a. The program demonstrated robust improvements in the reviewed elements—with all audit areas exhibiting significant increases in compliance rates and several surpassing the threshold score; however, some areas did not exceed the threshold score. These scores indicate that the program implemented effective corrective actions in most areas. Despite the marked improvement in compliance rates, additional measures are required to ensure acceptable performance in those areas that did not surpass the threshold score.

Behavioral Health Comprehensive and Follow-up Reviews

1. **Outreach, Screening, Assessment, and Referral (OSAR) Performance Improvement (PI) Follow-up Audit**
   a. The program demonstrated significant improvements in the reviewed elements—with the personnel component surpassing the threshold score, three of seven elements in the clinical record component surpassing the threshold score, two clinical record elements nearing the threshold score, and two clinical record elements exhibiting significant improvement. These scores indicate the program implemented effective corrective actions in all areas, despite some areas not surpassing the threshold score. OSAR leadership has developed an additional POI in collaboration with Performance Improvement to address the remaining deficiencies.

2. **Juvenile Justice (JJ) Comprehensive Audit**
   a. The JJ program demonstrated robust performance across many areas of the audit, with an overall compliance score of 95.52%. Evidence obtained from this audit indicates that the program has instituted effective leadership, supervision, and oversight practices to ensure compliance with regulatory standards. Although compliance was strong, deficiencies were identified that necessitate corrective action within the personnel and client records components. Program leadership submitted a POI indicating increased scrutiny of documentation by team leads, updates to the Children and Adolescents Services Program Manual, and additional training will be completed.

The HARRIS CENTER for Mental Health and IDD

3. **Substance Use Recovery Services (SURS)-Adult Recovery Program (ARP) POI Follow-up Audit**
   a. The program provided sufficient evidence to document execution of the corrective actions implemented in response to the 2nd Qtr. FY 2026 comprehensive review. Additionally, the program demonstrated robust improvements in the reviewed elements—with nearly all audit areas exhibiting significant increases in compliance rates; however, most areas did not exceed the threshold score. These scores indicate the program implemented effective corrective actions in many areas; however, despite the marked improvement in compliance rates, additional measures are required to ensure acceptable performance in those areas that did not surpass the threshold score. Program leadership submitted a plan of improvement indicating process changes to increase oversight of documentation; additional training on documentation requirements, and increased monitoring of employee training courses have been instituted.

Agency Focus Audit

1. **Agency-wide Training Compliance Focus Review**
   a. This Focus Review demonstrated that Agency Mandated Annual training is being completed by agency staff. A sample of 105 active employees from across all four (4) Divisions reviewing thirteen (13) required training courses. All required training courses are being completed, and no gaps were identified in system assignments for active employees at the time of this review. While system assignment failures were not identified, monitoring and prioritization of required new training courses may increase the risk of non-compliance if not addressed. Targeted education and oversight will support sustained compliance moving forward.

2. **Policy Acknowledgment Focus Review**
   a. This Focus Review was to evaluate the effectiveness of the organization's policy management system as it relates to employee acknowledgement of the Code of Conduct and Ethics Policy and Assurance of Individual Rights Policy. The review sought to demonstrate if The Code of Conduct and Ethics and the Assurance of Individual Rights is consistently assigned to all applicable employes within the policy platform, the extent to which employees are completing acknowledgments on an annual basis, and to identify any gaps in our process or system configuration. All staff reviewed have an active Policy Stat account. The staff reviewed were inconsistent in acknowledging the selected policies reviewed for compliance. Four staff reviewed did not show evidence that the policies reviewed had been assigned to them to acknowledge. There is no evidence of system failure preventing annual policy acknowledgements.

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

The HARRIS CENTER for Mental Health and IDD

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:

External Datavant Medical Record Requests:

1. Datavant, on behalf of United Healthcare, requested records on 6/18/2026 for the Risk Adjustment medical record request. The request was for the two United Healthcare members, associated with Outreach ID:68660737. Records were submitted by our Release of Information Coordinator.
2. Datavant on behalf of Optum Care requested records on 6/23/2026 for the Risk Adjustment medical record request. The request was for one Optum care member, associated with Outreach ID: 68493941. Records were submitted by our Release of Information Coordinator.
3. Datavant, on behalf of United Healthcare, requested records on 7/09/2026 for the Risk Adjustment medical record request. The request was for one United Healthcare member, associated with Outreach ID: 69380513. Records were submitted by our Release of Information Coordinator.
4. Datavant on behalf of Health Spring requested records on 7/9/2026 for the Risk Adjustment medical record request. The request was for the two Health Spring members, associated with Outreach ID:68163896. Records were submitted by our Release of Information Coordinator.
5. Datavant, on behalf of Health Spring, requested records on 7/30/2026 for the Risk Adjustment medical record request. The request was for the nine Health Spring members, associated with Outreach ID: 69475556. Records were submitted by our Release of Information Coordinator.

Other External Medical Record Requests:

1. On 6/6/2026, the agency was selected by Qlarant Integrity Solutions, LLC for a review of a sample of Medicaid claims with dates of service from October 1, 2022, through September 30, 2024. The objective of the review was to determine whether sampled claims were billed and paid in accordance with applicable federal and state Medicaid laws, regulations, and policies.
2. Optum on behalf of United Healthcare requested records on 6/11/2026 for Medicare Risk Adjustment reporting. The request was forty United Healthcare members. Records were submitted by our Release of Information Coordinator.
3. Optum on behalf of United Healthcare requested records on 6/11/2026 for Medicare Risk Adjustment reporting. The request was for Three Hundred Seventy-Three United Healthcare members. Records were submitted by our Release of Information Coordinator.
4. Advantmed on behalf of United Healthcare requested records on 6/18/2026 for Medicare Risk Adjustment reporting. The request was for two United Healthcare members. Records were submitted by our Release of Information Coordinator.
5. During the third quarter of 2026, Superior Health Plan (Centene) conducted a medical records review of the Access Center. The audit included a request for four member charts with dates of service from April1, 2026, through June 30, 2026. The purpose of the review as to evaluate compliance with Superior HealthPlan documentation requirements and applicable contractual standards. Requested records included diagnostic assessments, documentation of members' current and previous military status, current active recovery plans, current ANSA/CANS assessments, progress notes, and staff credentialing documentation. Records were sent via fax per request.
6. Humana requested records on 7/08/2026 for the Risk Adjustment medical record request. The request was for eight members. Records were submitted by our Release of Information Coordinator.

The HARRIS CENTER for Mental Health and IDD

7. Optum on behalf of Wellpoint requested records on 7/21/2026 for Medicare Risk Adjustment review medical record request. The request was for seventy-five Wellpoint members. Records were submitted by our Release of Information Coordinator.
8. Optum on behalf of United Healthcare requested records on 7/31/2026 for Medicare Risk Adjustment review medical record request. The request was for two United Healthcare members. Records were submitted by our Release of Information Coordinator.
9. Advantmed on behalf of United Healthcare requested records on 8/4/2026 for Medicare Risk Adjustment reporting. The request was for three United Healthcare members. Records were submitted by our Release of Information Coordinator.
10. Optum on behalf of Wellpoint requested records on 8/6/2026 for Medicare Risk Adjustment review medical record request. The request was for four Wellpoint members. Records were submitted by our Release of Information Coordinator.
11. Advantmed on behalf of WellCare requested records on 8/10/2026 for Medicare Risk Adjustment reporting. The request was for fifty-four WellCare members. Records were submitted by our Release of Information Coordinator.
12. BlueCross BlueShield, on behalf of Virtix Health, requested records on 8/18/2026 for Risk Adjustment reporting. The request was for one Virtix health member. Records were submitted by our Release of Information Coordinator.
13. Optum on behalf of United Healthcare requested records on 8/20/2026 for Medicare Risk Adjustment review medical record request. The request was for one United Healthcare member. Records were submitted by our Release of Information Coordinator.
14. Advantmed on behalf of Superior HealthPlan requested records on 8/20/2026 for Medicare Risk Adjustment reporting. The request was for sixty-nine members Superior HealthPlan. Records were submitted by our Release of Information Coordinator.

External Pharmacy Audits:

1. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 6/4/2026 to validate claims associated with Invega Hafye INJ 234/1.5mg. The requested documentation was submitted by the pharmacy representative on 6/5/2026. 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 Southeast Clinic Pharmacy on 6/5/2026 to validate claims associated with Invega Hafye INJ 1560mg. The requested documentation was submitted by the pharmacy representative on 6/5/2026. 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 6/5/2026 to validate claims associated with Invega Sust 819MG. The requested documentation was submitted by the pharmacy representative on 6/5/2026. 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 6/5/26 to validate claims associated with Uzedy 200MG. The requested documentation was submitted by the pharmacy representative on 6/5/26. 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

5. Optum Rx conducted a chart review audit for Southwest Clinic Pharmacy on 6/5/26 to validate claims associated with Invega Trinz INJ 819MG. The requested documentation was submitted by the pharmacy representative on 6/5/26. 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 Northeast Clinic Pharmacy on 6/5/2026 to validate claims associated with Abilify INVEGA NJ 156mg. The requested documentation was submitted by the pharmacy representative on 6/5/2026. 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 Northwest Clinic Pharmacy on 6/8/2026 to validate claims associated with Uzedy Injection 200mg. The requested documentation was submitted by the pharmacy representative on 6/22/2026. 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 Southwest Clinic Pharmacy on 6/9/26 to validate claims associated with Invega Trinz INJ 546MG. The requested documentation was submitted by the pharmacy representative on 6/9/26. 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 Southwest Clinic Pharmacy on 6/10/26 to validate claims associated with Invega Trinz INJ 546MG. The requested documentation was submitted by the pharmacy representative on 6/10/26. 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 Southeast Clinic Pharmacy on 6/10/26 to validate claims associated with Invega Trinz INJ 156MG. The requested documentation was submitted by the pharmacy representative on 6/10/26. 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 Northeast Clinic Pharmacy on 6/10/26 to validate claims associated with Invega Trinz INJ 156MG. The requested documentation was submitted by the pharmacy representative on 6/10/26. Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
12. Optum Rx conducted a chart review audit for Northeast Clinic Pharmacy on 6/12/2026 to validate claims associated with Abilify ASIM INJ 960mg. The requested documentation was submitted by the pharmacy representative on 6/12/2026. 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 Northwest Clinic Pharmacy on 6/16/2026 to validate claims associated with Invega SUST Injection 234/1.5mg. The requested documentation was submitted by the pharmacy representative on 6/16/2026. Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
14. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 7/06/26 to validate claims associated with Invega Trinz INJ 156MG. The requested documentation was submitted by the pharmacy representative on 6/10/26. Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
15. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 7/10/26 to validate claims associated with Invega Trinz INJ 234/15MG. The requested documentation was submitted by the pharmacy representative on 7/10/26. 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 Northeast Clinic Pharmacy on 8/6/26 to validate claims associated with Invega SUST INJ 234/1.5 and INVEGA SUST INJ 156mg/ml. The requested documentation

The HARRIS CENTER for Mental Health and IDD

was submitted by the pharmacy representative on 8/6/26. Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.

17. Optum Rx conducted a chart review audit for Northeast Clinic Pharmacy on 8/7/26 to validate claims associated with Abilify Asim INJ 960Mg. The requested documentation was submitted by the pharmacy representative on 8/10/26. Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
18. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 8/10/26 to validate claims associated with Tresiba Flex INJ 200 Unit. The requested documentation was submitted by the pharmacy representative on 8/10/26. 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 Northeast Clinic Pharmacy on 8/10/26 to validate claims associated with Invega Trinz INJ 156MG. The requested documentation was submitted by the pharmacy representative on 8/10/26. 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 Southwest Clinic Pharmacy on 8/14/26 to validate claims associated with Invega Trinz INJ 819MG. The requested documentation was submitted by the pharmacy representative on 8/14/26. 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 Southwest Clinic Pharmacy on 8/17/26 to validate claims associated with Uzedy 200MG. The requested documentation was submitted by the pharmacy representative on 8/17/26. 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 Northeast Clinic Pharmacy on 8/17/26 to validate claims associated with Invega Trinz INJ 819MG. The requested documentation was submitted by the pharmacy representative on 8/25/26. 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 8/18/26 to validate claims associated with Uzedy INJ 200MG. The requested documentation was submitted by the pharmacy representative on 8/25/26. Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
24. Optum Rx conducted a chart review audit for Northeast Clinic Pharmacy on 8/17/26 to validate claims associated with Abilify Asim INJ 960MG. The requested documentation was submitted by the pharmacy representative on 8/25/26. Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
25. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 8/20/26 to validate claims associated with Abilify Asim INJ 960MG. The requested documentation was submitted by the pharmacy representative on 8/25/26. Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
26. Optum Rx conducted a chart review audit for Northeast Clinic Pharmacy on 8/21/26 to validate claims associated with Invega Sust INJ 156mg/ml. The requested documentation was submitted by the pharmacy representative on 8/25/26. Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
27. Optum Rx conducted a chart review audit for Southeast Clinic Pharmacy on 8/25/26 to validate claims associated with Invega Trinz INJ 156ml. The requested documentation was submitted by the pharmacy representative on 8/31/26. Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.

28. Optum Rx conducted a chart review audit for Southwest Clinic Pharmacy on 8/26/26 to validate claims associated with Abilify Asim INJ 960mg. The requested documentation was submitted by the pharmacy representative on 8/31/26. Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.
29. Optum Rx conducted a chart review audit for Northwest Clinic Pharmacy on 8/28/26 to validate claims associated with Invega Trinz INJ 546mg. The requested documentation was submitted by the pharmacy representative on 8/31/26. Optum Rx validated the claim with no errors identified, confirmed no overpayment, and determined that no recoupment is required from the pharmacy.

External Program Specific Audits:

1. **City Houston Housing and Community Development Department (HCDD) (May 7, 2026):** On June 3, 2026, the agency received notice of the completed HCDD limited scope review of the Independent Living Main Street program. The review evaluated compliance with applicable federal, state, local, and program requirements. The review concluded with no findings, confirming compliance with all applicable requirements.
2. **Texas Health and Human Services (HHSC)-Zero Suicide Annual Site Visit (July 6-10):** The Zero Suicide Visit was conducted July 6-10, 2026, to assess compliance with Zero Suicide standards, including clinical practices, documentation, and quality improvement efforts. The results of the review are pending, and Regulatory Compliance is following up with the program regarding the outcome.
3. **Texas Health & Human Services (HHSC) (June 9,2026):** On June 9, 2026, notification was received from HHSC regarding the Mental Health Quality Management Comprehensive Review, scheduled for September 14-18,2026. The review included a comprehensive desk review and onsite assessment of operations, medical services, quality management, environment, personnel, and applicable program areas, including crisis facilities, the Diversion Center, and State Hospital Step-Down services.
4. **Texas Health and Human Services Commission (HHSC)- Pasadena Cottage B Inspection (July 16, 2026):** HHSC conducted an inspection at the Pasadena Cottage B location on July 16, 2026, with an exit date of August 14, 2026. The inspection included a review of allegations related to admission, transfer, and discharge rights. All allegations were determined were determined to be unsubstantiated, and no citations were issued.
5. **Texas Health & Human Services (HHSC) Life Safety Code-Westbury House (August 26, 2026):** HHSC conducted an onsite Life Safety Code follow-up survey at Westbury House to assess compliance with state licensure and federal ICF/IID Medicare/Medicaid participation requirements. The facility met state licensure requirements and was found to be in substantial compliance with federal participation requirements.

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Home and Community-Based Services (HCS) Q4 Comprehensive Review
Review Dates: July 24, 2026- September 1, 2026

I. Audit Type:
Comprehensive Program Compliance Audit (Plan of Improvement Follow-Up Review / Q3 FY 2026 Data)

II. Purpose:
This comprehensive review assessed the Home and Community-based Services (HCS) program's compliance with federal, state, and internal agency requirements. The audit evaluated compliance with specific Texas Administrative Code (TAC) rules—including 26 Tex. Admin. Code § 262.103, § 262.501, § 301.361, § 262.701, § 331.5, § 331.7, § 331.11, and § 331.21—governing applicant enrollment, program transfers, and LIDDA service coordination and documentation responsibilities. Additionally, the review examined core program operations, personnel requirements, and documentation standards to ensure Type A and Type B encounters were billed and coded correctly.

III. Audit Method:
Program leadership provided client and employee rosters for the 3rd Quarter of FY 2026 (March 1, 2026 – May 31, 2026), from which Compliance utilized Excel randomization functions to select a sample of 10 client records and 10 employee records for the regulatory aspect of the audit, while expanding the sample to 21 clients for the coding, clinical documentation, and billing components. Compliance also developed appropriate review tools to evaluate adherence to applicable program requirements across all these reviewed domains.

IV. Audit Findings/History:
The HCS program demonstrated exemplary performance, achieving an impressive combined Regulatory and Coding/Billing overall compliance score of 98.01%, with Personnel achieving a perfect 100%, Client Records at 99.76%, and Coding/Clinical Documentation at 96.91%. However, a critical subset bottleneck was identified within Reimbursement Validation, which scored at 78.92% due to unsupported or unauthorized services. We identified a persistent documentation lag where progress notes missed the mandatory two-business-day completion deadline, which failed to fully ensure that entries were timely and supportive of the service rendered. Additionally, an audit finding identified significant discrepancies within the reimbursement validation component, where specific claims were processed for unsupported or unauthorized services due to underlying clinical documentation deficiencies.

V. 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 and policy acknowledgements. Program leadership should continue implementing the previous POI protocols, more frequently monitor the documentation of services, and consult with PI to develop additional strategies to resolve deficiencies noted during this review.

VI. Corrective Actions:
Compliance has issued Plan of Improvement (POI) requests to the program managers. Compliance will meet with the program managers and conduct formal follow-up evaluations at the 90-day and 180-day marks to monitor their progress and evaluate their success in achieving their POI goals.

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Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Home and Community-Based Services
Comprehensive Review

Compliance Auditor(s): Lacee Gilbert, Obiageri Pickens, Meredith Greene

Review Dates: July 24, 2026- September 1, 2026

Purpose

The purpose of this review was to assess whether the HCS program successfully implemented the plan of improvement submitted to the compliance department concerning the following Texas Administrative Code (Tex. Admin. Code) rules: Process for Enrollment of Applicants 26 Tex. Admin. Code § 262.103 (t); Process for Individual to Transfer to a Different Program Provider of FMSA 26 Tex. Admin. Code § 262.501 (a); HCS 26 Tex. Admin. Code § 263 LIDDA Requirements for Providing Service Coordination in the elating to Documentation of Service Provision; Code §§ 262.701 (f), (h)(3-4), (j)(8), (k), (l), and (m); Definitions 26 Tex. Admin. Code § 331.5 (33) (B-C); Eligibility 26 Tex. Admin. Code § 331.7 (a)(1); LIDDA's Responsibilities 26 Tex. Admin. Code §§ 331.11 (a), (b)(1)(A), (c)(1-2), and (d)(1-2); and Documentation of Service Coordination § 331.21 (a)(3).

Methods

Program leadership provided client and employee rosters for the 3rd Quarter of FY 2026 (March 1, 2026 – May 31, 2026), from which Compliance utilized Excel randomization functions to select a sample of 10 client records and 10 employee records for the regulatory aspect of the audit, while expanding the sample to 21 clients for the coding, clinical documentation, and billing components. Compliance also developed appropriate review tools to evaluate adherence to applicable program requirements across all these reviewed domains.

Findings

The HCS program showed exemplary performance across many elements included in this comprehensive review, achieving a combined Regulatory and Coding/Billing overall compliance score of 98.01%. This review demonstrates that the HCS program has instituted effective leadership, supervision, and oversight practices to ensure compliance with regulatory standards. Although compliance was strong, deficiencies were identified that necessitate corrective action within the clinical documentation (Note Completeness) and billing (Reimbursement) categories.

Client Records: 99.76%

HCS demonstrated commendable performance in the clinical review, achieving a near-perfect score of 99.76% in Client Records, which deserves great praise and reflects their hard work.

Personnel: 100%

The HCS personnel review achieved a 100% compliance score, demonstrating strong adherence to applicable personnel requirements. The review assessed areas including employee qualifications, required training, personnel documentation, background checks, and performance evaluations. Overall records were well maintained and demonstrated effective program oversight and compliance with established requirements. Completion of agency-mandated training courses, including:

Coding and Clinical Documentation Score: 96.91%

During this review, the Coding and Clinical Documentation domain demonstrated overall compliance; however, deficiencies were identified that contributed to score reduction and present compliance risk.
Specifically, findings were noted in progress note completeness; documentation failed to fully ensure that entries were complete, accurate, timely, and supportive of the service rendered. While other domains maintain high compliance, these specific gaps indicate a need for improved documentation integrity to fully support the billed services under Medicaid requirements.

Key findings include missing or incomplete documentation for the following requirements:

- Note Completeness *(CMS Guidelines, 26 Tex. Admin. Code § 301.361)*

Operations (Billing) Findings – 95.62%

The Billing review demonstrated a strong level of compliance across the HCS programs, with most claims accurately reflecting payer requirements, provider information, coding accuracy, and billing components. Most areas achieved scores above the 95% threshold score, indicating effective billing processes and adherence to regulatory guidelines.
However, specific findings were identified within the reimbursement component that contributed to the overall compliance score reduction. Addressing these reimbursement gaps will be critical to ensuring full financial compliance and optimizing future claim accuracy.

Key findings include missing or incomplete documentation for the following requirements:

- Reimbursement Validation: Discrepancies were identified in reimbursement validation due to unsupported or unauthorized services and documentation deficiencies *(1 Tex. Admin. Code § 355.743 (D)(1–2)) (78.92%)*

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 and policy acknowledgements. Program leadership should continue implementing the previous POI protocols, more frequently monitor the documentation of services, and consult with PI to

develop additional strategies to resolve deficiencies noted during this review. The Vice President of the IDD Division and the HCS Program Directors must sign and return this report to Compliance within seven (7) days.

Management Response

We will continue to review records regularly to maintain all contractual requirements are met and remain in compliance.

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Signature Page

X Signed by: Lacee Gilbert A61C43FEE400449...

Lacee Gilbert, Regulatory Compliance Auditor

X Signed by: Obiageri Pickens 76D92C4BD2D340B...

Obiageri Pickens, Medical Coding Auditor

X Signed by: Annie Cuba 7770DEB618784B8...

Annie Cuba, Director – IDD Authority Services

X Signed by: Randi Garza 8267060A25C6493...

Randi Garza, Program Director V

X Signed by: Crystal Almaguer 4A9162725F88457...

Crystal Almaguer, Program Manager III

X DocuSigned by: Evanthe Collins 7E1995072D35406...

Evanthe Collins, VP – IDD Services

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Texas Home Living Program (TxHmL) Q4 Comprehensive Review
Review Dates: July 24, 2026 – August 28, 2026

I. Audit Type:
Comprehensive Program Compliance Audit (Q4 Review / Q3 FY 2026 Data)

II. Purpose:
This comprehensive review assessed the Texas Home Living (TxHmL) program's compliance with federal, state, and internal agency requirements. The audit evaluated compliance with specific Texas Administrative Code (TAC) rules—including 26 Tex. Admin. Code § 262.103, § 262.501, § 301.361, § 262.701, § 331.5, § 331.7, § 331.11, and § 331.21—governing applicant enrollment, program transfers, and LIDDA service coordination and documentation responsibilities. Additionally, the review examined core program operations, personnel requirements, and documentation standards to ensure Type A and Type B encounters were billed and coded correctly.

III. Audit Method:
Program leadership provided client and employee rosters for the 3rd Quarter of FY 2026 (March 1, 2026 – May 31, 2026), from which Compliance utilized Excel randomization functions to select a sample of 10 client records and 10 employee records for the regulatory aspect of the audit, while expanding the sample to 21 clients for the coding, clinical documentation, and billing components. Compliance also developed appropriate review tools to evaluate adherence to applicable program requirements across all these reviewed elements.

IV. Audit Findings/History:
TxHmL demonstrated a strong baseline score of 94.55%, with Personnel at 99%, Billing at 97.53%, Client Records at 95.24%, and Coding/Clinical Documentation at 90.18%. However, a critical subset bottleneck was identified within Reimbursement Validation, which scored at 78.92% due to unsupported services. We identified that multiple IDD Face-to-Face encounters used incorrect Type B codes instead of required Type A codes. Additionally, an audit finding identified that Type B support encounters were submitted without the required matching monthly Type A face-to-face visit. We identified a persistent documentation lag across TxHmL where progress notes missed the two-business-day deadline. Finally, an audit finding identified that case records lacked documented evidence of the Service Coordinator monitoring client goal progress, tracking service satisfaction, transferring enrollment files, or completing 30-day pre-expiration IPC/PDP updates.

V. 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 and policy acknowledgements. Program leadership should continue implementing the previous POI protocols, more frequently monitor the documentation of services, and consult with PI to develop additional strategies to resolve deficiencies noted during this review.

VI. Corrective Actions:
Compliance has issued Plan of Improvement (POI) requests to the program managers. Compliance will meet with the program managers and conduct formal follow-up evaluations at the 90-day and 180-day marks to monitor their progress and evaluate their success in achieving their POI goals.

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Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Texas Home Living Program (TxHmL)
Comprehensive Review

Compliance Auditor(s): Lacee Gilbert, Obiageri Pickens, Meredith Greene

Review Dates: July 24, 2026- August 28, 2026

Purpose

The purpose of this Comprehensive review was to assess whether the TxHmL program was compliant with applicable federal and state requirements, agency policies and procedures and established program requirements. The review evaluated key areas of program operations, including personnel requirements, client records, service coordination, documentation, and overall program oversight.
Applicable requirements reviewed included: Texas Administrative Code (Tex. Admin. Code) rules: Process for Enrollment of Applicants 26 Tex. Admin. Code § 262.103 (t); Process for Individual to Transfer to a Different Program Provider of FMSA 26 Tex. Admin. Code § 262.501 (a); LIDDA Requirements for Providing Service Coordination in the TxHmL Program 26 Tex. Admin. Tex. Admin. Code § 301.361 relating to Documentation of Service Provision; Code §§ 262.701 (f), (h)(3-4), (j)(8), (k), (l), and (m); Definitions 26 Tex. Admin. Code § 331.5 (33)(B-C); Eligibility 26 Tex. Admin. Code § 331.7 (a)(1); LIDDA's Responsibilities 26 Tex. Admin. Code §§ 331.11 (a), (b)(1)(A), (c)(1-2), and (d)(1-2); and Documentation of Service Coordination § 331.21 (a)(3).

Methods

Program leadership provided client and employee rosters for the 3rd Quarter of FY 2026 (March 1, 2026 – May 31, 2026), from which Compliance utilized Excel randomization functions to select a sample of 10 client records and 10 employee records for the regulatory aspect of the audit, while expanding the sample to 21 clients for the coding, clinical documentation, and billing components. Compliance also developed appropriate review tools to evaluate adherence to applicable program requirements across all these reviewed elements.

Findings

TxHmL demonstrated a highly successful baseline in this comprehensive review, capturing an impressive combined Regulatory and Coding/Billing score of 94.55%. This high mark stands as clear proof that leadership and oversight structures are operating at a premium level. Yet, even with such a strong foundation, the audit spotlighted a critical bottleneck: minor documentation gaps within HCPCS code selection, Type A/Type B tracking, note completeness, progress logs, and Service Delivery and Satisfaction records directly disrupted the program's ultimate financial recovery and reimbursement.

Detailed findings are presented below:

Personnel: 99%

The TxHmL personnel review achieved a 99% compliance score, demonstrating strong adherence to applicable personnel requirements. The review assessed employee qualifications, required training, personnel

documentation, background checks, and performance evaluations. Overall, personnel records were well maintained and demonstrated effective program oversight and substantial compliance with the requirements evaluated.

Client Records: 95.24%

The TxHmL program demonstrated strong overall performance, achieving Client Records compliance score of 95.24%. The review reflected effective program leadership, responsiveness, and program oversight. The majority of records reviewed demonstrated compliance with applicable requirements. Opportunities for improvement were identified within the client-record and billing and coding portions of the review. A Plan of Improvement (POI) is required for the identified client-record deficiency.

Client Record Findings:

- A LIDDA must provide to the selected program provider and FMSA, if applicable: copies of all enrollment documentation and associated supporting documentation, including relevant assessment results and recommendations; TEX ADMIN. CODE §262.103(t) §262.701 (f)
- The individual's needs change: or (B) the individual, LAR or actively involved person, service provider, or other person provides relevant information indicating revision of the plan is appropriate. §331.11(A)(B)
- A LIDDA must ensure that service coordination revises the plan using person-directed planning that is consistent with DADS Person Directed Planning Guidelines. §331.11(2)
- When a service coordination becomes aware that a change to an individual's PDP or IPC may be needed, the service coordination must discuss the need for the change with the individual or LAR, the individual's program provider, and other appropriate persons. §262.701(k)
- At least 30 calendar days before the expiration of an individual's IPC, the service coordination must: update the individual's PDP with the individual's service planning team; and §262.701(l)(1)
- If the individual receives a TxHmL Program service or a CFC service from a program provider, submit to the program provider and the individual or LAR:(A) the updated PDP; and §262.701(l)(2)(A)
- If CFC PAS/HAB is included on the PDP, a copy of the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form. §262.701(l)(2)(B)
- A service coordination must:(1) complete the HHSC TxHmL Service Coordination Notification form with the individual or LAR and provide a copy of the completed form to the individual or LAR: (A) upon receipt of HHSC approval of the enrollment of the individual; §262.701(m)

Coding and Clinical Documentation Score: 90.18%

During this review, the Coding and Clinical Documentation domain demonstrated overall strong compliance, though deficiencies were identified that contributed to score reductions and compliance risks. Specifically, findings in HCPCS code selection, Type A/Type B documentation, note completeness, progress, and service

delivery and satisfaction limited the demonstration of individualized care and impacted program reimbursement under Medicaid requirements.

Key findings include missing or incomplete documentation for the following requirements:

- HCPCS Accuracy: *(CMS / AMA CPT Editorial Panel for CPT Guidelines)*
- Note Completeness: *(CMS Guidelines, 26 Tex. Admin. Code § 301.361)*
- TYPE A/B : Texas Health and Human Services for T1017, *26 TAC §262.701*
- Progress: Documentation reflects progress toward identified goals and outcomes *26 TAC §262.701*, *Texas Health and Human Services for T1017*
- **Svc Del. & Sat.:** Documentation reflects the individual's satisfaction with services received *26 TAC §262.70, Texas Health and Human Services for T1017*

Operations (Billing) Findings – 97.53%

The Billing review demonstrated a strong level of compliance across the TxHmL programs, with most claims accurately reflecting payer requirements, provider information, and general billing components. Most areas achieved near perfect or perfect scores, indicating effective billing processes and adherence to regulatory guidelines.

However, specific areas for improvement were identified within the code selection and reimbursement components that contributed to the overall compliance score reduction. Addressing these coding errors will be critical to resolving the impacted reimbursement and ensuring full financial compliance moving forward.

Key findings include missing or incomplete documentation for the following requirements:

- HCPCS Accuracy *(AMA CPT 2024; CMS Claims Processing Manual)*
- Reimbursement Validation: Discrepancies were identified in reimbursement validation due to unsupported or unauthorized services and documentation deficiencies *(1 Tex. Admin. Code § 355.743 (D)(1–2)) (78.92%)*

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 and policy acknowledgements. Program leadership should continue implementing the previous POI protocols, more frequently monitor the documentation of services, and consult with PI to develop additional strategies to resolve deficiencies noted during this review. The Vice President of the IDD Division and the TxHmL Program Directors must sign and return this report to Compliance within seven (7) days.

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Management Response

Thank you.

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Signature Page

X Signed by: Lacee Gilbert A61C43EEE400449...

Lacee Gilbert, Regulatory Compliance Auditor

X Signed by: Obiageri Pickens 76D92C4BD2D340B...

Obiageri Pickens, Medical Coding Auditor

X Signed by: Annie Cuba 7776DEB613784B8...

Annie Cuba, Director – IDD Authority Services

X Signed by: Winnie Peters 998B67C14335497...

Winne Peters, Program Manager III

X DocuSigned by: Evanthe Collins 7E199307 3D33406...

Evanthe Collins, Div VP – IDD Services

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The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Medication Training and Support (MTS) Four Programs
Review Dates: 7/17/2026 – 8/27/2026

I. Audit Type:
Focus Audit

II. Purpose:
To evaluate program compliance with Texas Medicaid, Texas Medicaid and Healthcare Partnership, and Texas Administrative Code requirements—specifically Title 26 of the Texas Administrative Code Sections 306.315, 301.353, and 301.361—governing clinical documentation accuracy, service authorization, and billing compliance for Medication Training and Support services.

III. Audit Method:
The Compliance Department conducted an audit of Medication Training and Support (MTS) services by pulling a client roster from the Epic Electronic Health Record (EHR) system for the third quarter of Fiscal Year 2026, which ran from March 1, 2026, through May 31, 2026. Utilizing an audit tool developed by the Compliance Department, the team used Epic's reporting functionality to generate a list of completed encounters and applied a random sampling methodology to select specific cases for review. Out of the 123 total encounters randomly selected and audited, the sample was distributed across four programs: 50 from the New Start Program, 30 from the Southwest Mental Health Child Program, 30 from the Neuropsychiatry Center Psychiatric Emergency Services (NPC PES) Program, and 13 from the TCOOMMI JR Program.

IV. Audit Findings/History:
The Medication Training and Support (MTS) review resulted in an overall compliance score of 91.23%, which fails to meet the established 95.00% threshold due to critical deficiencies in coding, documentation, and billing practices. While the TCOOMMI JR Program achieved exceptional compliance at 99.54% with zero errors, and the Southwest Child Program passed the threshold at 96.37% despite minor consent issues, the other two programs dragged down the overall score. Specifically, the New Start Program failed with a 90.09% score due to poor HCPCS documentation and cloned notes, while the NPC PES Program performed the worst at 75.73% because of severe gaps in time-based logging and progress notes. Collectively, these documentation vulnerabilities across the failing programs significantly increase the organization's risk for insurance claim denials, financial recoupments, and potential false claim violations.

V. Recommendations:
It is recommended that the underperforming programs strengthen internal monitoring, mandate targeted staff training on time-based documentation and coding, and submit a mandatory Plan of Improvement to eliminate the risk of claim denials or fund recoupments.

VI. Corrective Actions:
The four programs commit to achieving full compliance by October 31, 2026 by utilizing the Specific, Measurable, Achievable, Relevant, and Time-Bound framework to deliver 1-on-1 template retraining with leadership note reviews for the New Start program, remove the Medication Training and Support service code entirely alongside mandatory documented staff training for the Neuropsychiatry Center Psychiatric Emergency Services program, and validate the permanent template fix previously implemented in the Southwest Mental Health Child program.

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Compliance Department (Compliance) Review Report
Fourth Quarter (Qtr.) of Fiscal Year (FY) 2026
Four Programs
Medication Training and Support (MTS) Coding, Documentation, and Billing Compliance Review

Compliance Auditor(s): Obiageri Pickens

Review Dates: 7/17/2026 – 8/27/2026

Purpose

This review was conducted to evaluate compliance with applicable federal and state regulations, Texas Medicaid requirements, Texas Administrative Code (Tex. Admin. Code) requirements, Texas Medicaid & Healthcare Partnership (TMHP) billing requirements, 26 Tex. Admin. Code § 306.315 relating to Medication Training and Support Services, 26 Tex. Admin. Code § 301.353 relating to Provider Responsibilities for Treatment Planning and Service Authorization, 26 Tex. Admin. Code § 301.361 relating to Documentation of Service Provision, and applicable agency policies and procedures governing Medication Training and Support (MTS) services. The review focused on coding, documentation, and billing compliance in the areas of Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) documentation, medical necessity, progress note requirements, consent for services, copy-and-paste (cloning) practices, total time-based documentation, authorization requirements, billing accuracy, reimbursement requirements, and provider credentialing and approval requirements.

Methods

A client roster for individuals receiving Medication Training and Support (MTS) services during the Third Quarter (Q3) of Fiscal Year (FY) 2026 (March 1, 2026, through May 31, 2026) was obtained from the Epic Electronic Health Record (EHR) system for review. A random sampling methodology was utilized to select encounters for review. Epic EHR reporting functionality was used to generate a list of completed Medication Training and Support encounters during the review period, from which encounters were randomly selected. A total of 123 encounters were reviewed. The sample included 30 encounters from the Neuropsychiatry Center Psychiatric Emergency Services (NPC PES) Program, 13 encounters from the Texas Correctional Office on Offenders with Medical or Mental Impairments Juvenile Rehabilitation Program (TCOOMMI JR), 30 encounters from the Southwest Mental Health Child Program, and 50 encounters from the New Start Program. The review was conducted using an audit tool developed by the Compliance Department.

Findings

The Medication Training and Support (MTS) review resulted in an overall compliance score of **91.23%**, which falls below the established compliance threshold of **95.00%**. The review identified deficiencies in Coding/documentation and billing practices that may affect service authorization, reimbursement, and the supportability of claims submitted for payment. While compliance performance varied among the programs reviewed, the most significant deficiencies were concentrated within the Neuropsychiatry Center (NPC) Psychiatric Emergency Services Program and the New Start Program.

Detailed findings contributing to these scores are summarized below.

NPC PES Program Findings – 75.73%

The Neuropsychiatry Center Psychiatric Emergency Services Program demonstrated deficiencies in Current Healthcare Common Procedure Coding System (HCPCS) documentation, progress note documentation, and total time-based documentation. These deficiencies increase the risk that services billed may not be adequately supported by the clinical record, which may impact service authorization and reimbursement.

Southwest Mental Health Child Program Findings – 96.37%

The Southwest Mental Health Child Program demonstrated deficiencies in Consent for Services documentation and Healthcare Common Procedure Coding System (HCPCS) documentation. Although the program exceeded the established compliance threshold, improvements are needed to ensure service authorization requirements and documentation expectations are consistently met.

New Start Program Findings – 90.09%

The New Start Program demonstrated deficiencies in Healthcare Common Procedure Coding System (HCPCS) documentation, copy-and-paste (cloning) practices, and progress note documentation. These deficiencies increase the risk of inconsistencies between documented services and billed services and may impact reimbursement and compliance.

TCOOMMI JR Program Findings – 99.54%

The Texas Correctional Office on Offenders with Medical or Mental Impairments Juvenile Rehabilitation Program demonstrated exceptional compliance with documentation and billing requirements, with no deficiencies identified during the review.

In contrast to the fully compliant Juvenile Rehabilitation program, **the remaining three audited programs demonstrated several deficiencies** that have the potential to impact service authorization, reimbursement, and claim supportability. Specifically, the vulnerabilities associated with Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) documentation, progress notes, copy-and-paste practices, consent requirements, and total time-based documentation across those specific sites increase the collective risk of claim denials, recoupments, and potential false claim concerns.

Recommendations

It is recommended that the Neuropsychiatry Center Psychiatric Emergency Services Program, Southwest Mental Health Child Program, and New Start Program strengthen internal monitoring processes to ensure compliance with documentation and billing requirements associated with Medication Training and Support (MTS) services. Attention should be given to Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) documentation, consent requirements, copy-and-paste (cloning) practices, progress note documentation, and total time-based documentation. Program leadership should provide additional staff training and ongoing oversight to ensure services are accurately documented, appropriately supported by the clinical record, and compliant with applicable regulatory and billing requirements.

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The deficiencies identified during this review may impact service authorization, reimbursement, and claim supportability. Compliance with documentation and billing standards should be routinely monitored to reduce the risk of claim denials, recoupments, and potential false claim concerns.
A Plan of Improvement (POI) is required for all elements that did not meet the established compliance threshold of 95.00%. Compliance will assess each program's progress toward implementation and completion of corrective actions within 90 – 180 days of issuance of this report. The Vice President, Director, and Program Managers are required to sign and return both this report and the completed Plan of Improvement to the Compliance Department within seven (7) business days of receipt of this report.

Management Response

The findings were reviewed with NPC nursing leadership, and nursing leadership has decided to discontinue use of the MTS service code. Moving forward, nursing staff will no longer utilize this service code. Nursing leadership is actively retraining staff on applicable documentation and billing requirements and will conduct monthly chart audits to monitor ongoing compliance.

Staff were retrained on using MTS service code. Staff were billing MTS when discussing diagnosis and failed to document discussions around medication usage.

Team meeting was held and audit results were reviewed to discuss billing, service, and coding errors. Ongoing training with staff for the next quarter related to MTS notes will be conducted to ensure services are being provided and correct coding is being entered for the service.

I agree with the findings and our team is actively working to implement all corrective actions outlined in the Plan of Improvement (POI)

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Obiageri Pickens 76D02C4BD2D340D...

Compliance Auditor – Obiageri Pickens

X Signed by: Darchel Richards D59D91376A35484...

Director Social Services – Darchel Richards

X Signed by: Kimberly Kornmayer 705073BD206644E...

VP Crisis Services – Kimberly Kornmayer

X Signed by: Samuel Means BB01E0B586904C1...

Director Forensic Juvenile Justice Svcs – Samuel Means

X Signed by: Sean McElroy 94300CAE652E431...

VP Forensic Services – Seam McElroy

X Signed by: Tiffanie Williams-Brooks 8858C6022329497...

Director CAS – Tiffanie Williams-Brooks

X DocuSigned by: Jennifer Boswell 7DB60DBAB68D466...

Director AMH – Jennifer Boswell

X Signed by: Shannon Chenier 7B0AFE91059748A...

Practice Manager V – Shannon Chenier

X Signed by: Lance Britt BAB06A90B5FE4AC...

VP Behavioral Health Services – Lance Britt

X DocuSigned by: Raul Ureste A1E76C42C9154E6...

Practice Manager V – Raul Ureste

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Skills Training and Development Coding, Documentation, and Billing Compliance Review
Four Programs
Review Dates: 7/17/2026 – 8/26/2026

I. Audit Type:
Focus Audit

II. Purpose:
This review evaluated compliance with federal and state regulations, Texas Medicaid and Texas Medicaid & Healthcare Partnership (TMHP) billing requirements, internal agency policies, and specific Texas Administrative Code (TAC) standards—including 26 Tex. Admin. Code § 306.319, § 301.353, and § 301.361—governing Skills Training, treatment planning, and documentation. The audit focused on key billing and coding areas, including Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) coding, medical necessity, progress notes, service consents, copy-and-paste (cloning) practices, time-based tracking, authorizations, billing accuracy, reimbursement, and provider credentialing.

III. Audit Method:
The Compliance Department used an internal audit tool to randomly sample 150 completed Skills Training and Development encounters from the Epic EHR system for Q3 FY2026 (March 1 to May 31, 2026). The audited sample consisted of 41 encounters from the Early Onset Psychosis Program, 40 from the Southwest Behavioral Health Specialty Services Program, 37 from the Northeast Child, Youth and Family Wellness Center Program, and 32 from the Youth Empowerment Services (YES) Waiver Program.

IV. Audit Findings/History:
The review yielded an exceptional overall compliance score of 98.02%, successfully exceeding the 95.00% threshold across all four audited programs. The Compliance Department commends the program leadership and staff for exceeding expectations and demonstrating a strong commitment to quality billing practices. However, minor deficiencies were identified in Care Plans, Healthcare Common Procedure Coding System (HCPCS) coding, and Service Consents. If left unaddressed, these limited gaps still carry minor financial risks that could result in service authorization delays or insurance claim denials.

V. Recommendations:
It is recommended that leadership and staff be commended for their outstanding performance while continuing to strengthen internal monitoring, ongoing oversight, and routine staff education to maintain these high standards and eliminate minor risks related to claim supportability.

VI. Corrective Actions:
The four programs commit to maintaining full compliance by October 31, 2026 by utilizing the Specific, Measurable, Achievable, Relevant, and Time-Bound framework to deliver targeted staff education on Plan of Care elements, refine coding consistency workflows, and ensure all required Consent for Services documentation remains current and complete.

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The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Four Programs
Skills Training and Development Coding, Documentation, and Billing Compliance Review

Compliance Auditor(s): Obiageri Pickens

Review Dates: 7/17/2026 – 8/26/2026

Purpose

This review was conducted to evaluate compliance with applicable federal and state regulations, Texas Medicaid requirements, Texas Administrative Code (Tex. Admin. Code) requirements, Texas Medicaid & Healthcare Partnership (TMHP) billing requirements, 26 Tex. Admin. Code § 306.319 relating to Skills Training and Development Services, 26 Tex. Admin. Code § 301.353 relating to Provider Responsibilities for Treatment Planning and Service Authorization, 26 Tex. Admin. Code § 301.361 relating to Documentation of Service Provision, and applicable agency policies and procedures governing Skills Training and Development services. The review focused on coding, documentation, and billing compliance in the areas of Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) documentation, medical necessity, progress note requirements, consent for services, copy-and-paste (cloning) practices, total time-based documentation, authorization requirements, billing accuracy, reimbursement requirements, and provider credentialing and approval requirements.

Methods

A client roster for individuals receiving Skills Training and Development services during the Third Quarter (Q3) of Fiscal Year (FY) 2026 (March 1, 2026, through May 31, 2026) was obtained from the Epic Electronic Health Record (EHR) system for review. A random sampling methodology was utilized to select encounters for review. Epic EHR reporting functionality was used to generate a list of completed Skills Training and Development encounters during the review period, from which encounters were randomly selected.
A total of 150 encounters were reviewed. The sample included 32 encounters from the YES Waiver Program, 41 encounters from the Early Onset Psychosis Program, 37 encounters from the Northeast Child, Youth and Family Wellness Center Program, and 40 encounters from the Southwest Behavioral Health Specialty Services Program. The review was conducted using an audit tool developed by the Compliance Department.

Findings

The Skills Training and Development Coding, Documentation, and Billing Compliance Review resulted in an overall compliance score of **98.02%**, which exceeds the established compliance threshold of **95.00%**. The review demonstrated strong compliance with applicable coding, documentation, and billing requirements across all programs reviewed. Deficiencies identified during the review were limited and primarily involved Plan of Care documentation, Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) documentation, and Consent for Services requirements.

Detailed findings contributing to these scores are summarized below.

YES Waiver Program Findings – 98.57%

The YES Waiver Program demonstrated strong compliance with documentation and billing requirements. The only deficiency identified during the review involved Wraparound Plan documentation. Although the program exceeded the established compliance threshold, improvements are needed to ensure all required Plan of Care elements are consistently completed and maintained within the medical record.

Early Onset Psychosis Program Findings – 98.02%

The Early Onset Psychosis Program demonstrated strong compliance with documentation and billing requirements. The only deficiency identified during the review involved Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) documentation. While the program exceeded the established compliance threshold, additional monitoring is recommended to ensure services are documented and coded consistently in accordance with regulatory and billing requirements.

Northeast Child, Youth and Family Wellness Center Program Findings – 96.44%

The Northeast Child Youth and Family Wellness Center Program demonstrated strong overall compliance. The only deficiency identified during the review involved Consent for Services documentation. Although the program exceeded the compliance threshold score, improvements are needed to ensure consent requirements are consistently documented and maintained in accordance with agency policy and regulatory requirements.

Southwest Behavioral Health Specialty Services Program Findings – 98.40%

The Southwest Behavioral Health Specialty Services Program demonstrates strong compliance with documentation and billing requirements. The only deficiency identified during the review involved Consent for Services documentation. Although the program exceeded the established compliance threshold score, additional monitoring is recommended to ensure consent documentation remains current and complete.

The Compliance Department commends the leadership and staff of the YES Waiver Program, Early Onset Psychosis Program, Northeast Child, Youth, and Family Wellness Center Program, and Southwest Behavioral Health Specialty Services Program for their outstanding performance during this review period and for exceeding compliance expectations. Their commitment to quality documentation, coding, and billing practices contributed significantly to the overall success of this audit. While overall compliance was strong, deficiencies related to Plan of Care documentation, Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) documentation, and Consent for Services documentation were identified. These deficiencies may affect service authorization, reimbursement, and claim supportability, and increase the risk of claim denials when services are not fully supported by the clinical record.

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Recommendations

It is recommended that the YES Waiver Program, Early Onset Psychosis Program, Northeast Child, Youth and Family Wellness Center Program, and Southwest Behavioral Health Specialty Services Program continue to strengthen internal monitoring processes to ensure compliance with documentation, coding, and billing requirements associated with Skills Training and Development services. Attention should be given to Plan of Care documentation, Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) documentation, and Consent for Services requirements. Program leadership should provide ongoing oversight and staff education to ensure documentation remains complete, accurate, and compliant with applicable regulatory and agency requirements. The deficiencies identified during this review may impact service authorization, reimbursement, and claim supportability. Compliance with documentation, coding, and billing standards should be routinely monitored to reduce the risk of claim denials and reimbursement concerns.
A Plan of Improvement (POI) is required for all elements that did not meet the established compliance threshold of 95.00%. Compliance will assess each program's progress toward implementation and completion of corrective actions within 90-180 days of issuance of this report. The Vice President, Director, and Program Managers are required to sign and return both this report and the completed Plan of Improvement to the Compliance Department within seven (7) business days of receipt of this report.

Management Response

Will proceed.

We will proceed with POI

We will proceed with POI

We will proceed with POI

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Obiageri Pickens 76D92C4BD2D340B...

Compliance Auditor – Obiageri Pickens

X Signed by: Rena Strope 7224670CC91B474...

Practice Manager – Rena Strope

X Signed by: Stella Olise B02A8471D571498...

Program Director – Stella Olise

X Signed by: Juan Cruz 608737C2B3B046C...

Program Manager VI – Juan Cruz

X Signed by: Tricia.Novotny DB00893C12EA4D0...

Practice Manager – Tricia Novotny

X Signed by: Tiffanie Williams-Brooks 8838C8022529497...

Director CAS – Tiffanie Williams-Brooks

X DocuSigned by: Jennifer Boswell 7DB69DBAB68D466...

Director AMH & Specialty Services – Jennifer Boswell

X Signed by: Lance Britt BAB06A90B5EE4AC...

VP Behavioral Health Service – Lance Britt

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Southwest Mental Health Child Program
Coding, Documentation, and Billing Follow-Up Review
Review Dates: 7/17/2026 – 8/28/2026

I. Audit Type:
Focus Audit

II. Purpose:
This review was conducted to evaluate the effectiveness of corrective actions implemented in response to a previous Progress Note Completeness deficiency by assessing compliance with Title 26 of the Texas Administrative Code Section 301.361, Evaluation and Management coding standards, Texas Medicaid and Healthcare Partnership billing guidelines, and applicable agency clinical documentation policies

III. Audit Method:
A client roster for individuals receiving Evaluation and Management (E/M) services during the Third Quarter (Q3) of Fiscal Year (FY) 2026 (March 1, 2026, through May 31, 2026) was obtained from the Epic Electronic Health Record (EHR) system for review. A random sampling methodology was utilized to select encounters for review. Epic EHR reporting functionality was used to generate a list of completed Evaluation and Management service encounters during the review period, from which encounters were randomly selected. A total of 86 encounters were reviewed. The review was conducted using an audit tool developed by the Compliance Department.

IV. Audit Findings/History:
The follow-up review yielded an overall compliance score of 96.28**%**, successfully exceeding the 95.00% established compliance threshold score, and confirming that the corrective actions have been implemented based on the results of your follow-up review. However, a new, isolated deficiency in Current Procedural Terminology documentation was identified due to instances where the billed service code did not consistently align with the documented clinical intervention.

V. Recommendations:
It is recommended that the Southwest Mental Health Child Program continue its efforts to maintain compliance with Progress Note Completeness requirements while strengthening oversight of Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) documentation. Program leadership should ensure that billed service codes accurately correspond with the documented intervention, service type, and progress note content maintained within the medical record. Ongoing staff education and periodic internal monitoring should be implemented to ensure compliance with documentation and billing requirements.

VI. Corrective Actions:
The Southwest Mental Health Child program commits to achieving full, comprehensive compliance by October 31 2026 by utilizing the Specific, Measurable, Achievable, Relevant, and Time-Bound framework to provide immediate 1-on-1 staff education on accurate coding alignment and strictly enforce existing electronic documentation policies.

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The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Southwest Mental Health Child Program
Coding, Documentation, and Billing Follow-Up Review

Compliance Auditor(s): Obiageri Pickens

Review Dates: 7/17/2026 – 8/28/2026

Purpose

This follow-up review was conducted to evaluate corrective actions implemented in response to the Progress Note Completeness deficiency identified during the Southwest Mental Health Child Program audit conducted during the Second Quarter (Q2) of Fiscal Year (FY) 2026. The review was designed to assess compliance with 26 Tex. Admin. Code § 301.361 relating to Documentation of Service Provision and applicable requirements governing progress note documentation, as well as Evaluation and Management (E/M) coding requirements. The review also evaluated compliance with applicable federal and state regulations, Texas Medicaid requirements, Texas Administrative Code (Tex. Admin. Code) requirements, Texas Medicaid & Healthcare Partnership (TMHP) billing requirements, and agency policies and procedures. The review focused on documentation, coding, and billing compliance to determine whether services were appropriately documented, supported by the clinical record, and accurately billed.

Methods

A client roster for individuals receiving Evaluation and Management (E/M) services during the Third Quarter (Q3) of Fiscal Year (FY) 2026 (March 1, 2026, through May 31, 2026) was obtained from the Epic Electronic Health Record (EHR) system for review. A random sampling methodology was utilized to select encounters for review. Epic EHR reporting functionality was used to generate a list of completed Evaluation and Management service encounters during the review period, from which encounters were randomly selected. A total of 86 encounters were reviewed. The review was conducted using an audit tool developed by the Compliance Department.

Findings

The Southwest Mental Health Child Program Follow-Up Review resulted in an overall compliance score of 96.28%, exceeding the established compliance threshold score of 95.00%. This follow-up review was conducted to assess corrective actions implemented in response to the Progress Note Completeness deficiency identified during the Q2 FY 2026 audit. The Compliance Department commends the Southwest Mental Health Child Program for successfully addressing the previously identified deficiency. While the original deficiency was corrected, the review identified a deficiency related to Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) documentation. Instances were identified in which the billed service code did not consistently align with the documented intervention and progress note content. This deficiency may affect service authorization, reimbursement, and claim supportability by increasing the risk that billed services are not adequately supported by the clinical record.

Recommendations

It is recommended that the Southwest Mental Health Child Program continue its efforts to maintain compliance with Progress Note Completeness requirements while strengthening oversight of Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) documentation. Program leadership should ensure that billed service codes accurately correspond with the documented intervention, service type, and progress note content maintained

within the medical record. Ongoing staff education and periodic internal monitoring should be implemented to ensure compliance with documentation and billing requirements.

Management Response

I agree with the findings and our team is actively working to implement all corrective actions outlined in the Plan of Improvement (POI).

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Signature Page

X Signed by: Obiageri Pickens 76D02C4BD2D340B...

Compliance Auditor – Obiageri Pickens

X DocuSigned by: Raul Ureste A1E76C42C9154E6...

Practice Manager – Raul Ureste

X Signed by: Tiffanie Williams-Brooks 8858C6022329497...

Director CAS – Tiffanie Williams-Brooks

X Signed by: Lance Britt BAB06A98B5FE4AC...

VP Behavioral Health Services – Lance Britt

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The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Community First Choice (CFC)
Review Dates: July 24,2026-september 10,2026

I. Audit Type:
Focus Audit

II. Purpose:
This review was conducted to ensure that services are appropriately documented, supported, and delivered in accordance with applicable program guidelines for Community First Choice (CFC). Ensuring compliance with Texas Health and Human Services Commission (HHSC) documentation and billing requirements, as well as compliance with Local Intellectual and Developmental Disability Authority (LIDDA), in accordance with Texas Administrative Code (TAC)

III. Audit Method:
A client roster of individuals receiving service coordination during the third quarter of fiscal year 2026 (March 1, 2026 – May 31, 2026) was extracted from the Epic EHR system. The random sample selected for this audit consisted of 21 active clients, 10 service coordinators, and 50 service encounters. Compliance also developed appropriate review tools to evaluate adherence to applicable program requirements across all reviewed domains.

IV. Audit Findings/History:

The Community First Choice (CFC) program demonstrated strong overall performance during this review period, achieving an overall score of 97.91% exceeding the established 95% threshold score. Despite this strong performance, specific administrative deficiencies lowered the overall score. Coding/Clinical Documentation received (95.82%) while Billing received (100%) Deficiencies were identified in documentation timeliness; Multiple progress notes failed to meet mandatory state timely submission requirements. There were also instances where documentation failed to verify monitoring of service delivery, progress, and satisfaction.

V. Recommendations:
It is recommended that the CFC program strengthens compliance oversight by implementing routine self-monitoring processes to ensure timely documentation, appropriate service monitoring, and alignment between clinical documentation and billed services. Documentation should be individualized, clearly reflect services rendered, and meet requirements for service coordination.

VI. Corrective Actions:
Following collaboration with Performance Improvement (PI), the program submitted a comprehensive Plan of Improvement (POI) to remediate all areas of deficiency. Compliance will assess the efficacy of the POI within 90-180 days

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The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
IDD Division
Community First Choice (CFC)

Compliance Auditor(s): Greene, Meredith and Pickens, Obiageri

Review Dates: July 24,2026- September 10, 2026

Purpose

This review was conducted to ensure that services are appropriately documented, supported, and delivered in accordance with applicable program guidelines for Community First Choice (CFC). Ensuring compliance with Texas Health and Human Services Commission (HHSC) documentation and billing requirements, compliance with Local Intellectual and Developmental Disability Authority (LIDDA), and in accordance with 'Texas Administrative Code' (TAC) *26 Tex. Admin. Code § 262.6 Description of CFC services, 26 Tex Admin code 262 § 701 LIDDA's Requirements, 26 Tex. Admin. Code § 331.21 Documentation of Service Coordination, 26 Tex. Admin. Code 330.9 Access, Intake, and Enrollment Related Responsibilities, & HCPCS coding guidelines (CMS) HCPCS Level II Code Set.*

Methods

A client roster of individuals receiving service coordination during the third quarter of fiscal year 2026 (March 1, 2026 – May 31, 2026) was extracted from the Epic EHR system. The random sample selected for this audit consisted of 21 active clients, 9 service coordinators, and 49 service encounters. Compliance also developed appropriate review tools to evaluate adherence to applicable program requirements across all reviewed domains.

Findings

Summary Overall Score 97.91

The Community First Choice (CFC) program demonstrated strong overall performance during this review period, achieving a **97.91%** compliance score and exceeding the established 95% threshold. Despite this strong performance, specific administrative deficiencies lowered the overall score.

Identified Findings

- Untimely Progress Notes: Multiple progress notes failed to meet mandatory state timely filing requirements.
- Incomplete Service Monitoring: Documentation failed to fully support or verify monitoring of service delivery, progress, and satisfaction.

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Recommendations

It is recommended that the CFC program strengthens compliance oversight by implementing routine self-monitoring processes to ensure timely documentation, appropriate service monitoring of implementation, delivery, satisfaction and alignment between clinical documentation and billed services. Documentation should be individualized, clearly reflect services rendered, and meet requirements for service coordination.

Management Response

Management will ensure all staff in the unit receive training and support, to address areas identified during the audit. Management will complete routine chart reviews to spot any areas of concerns and provide ongoing training as needed.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Meredith Greene

Merdith Greene, Medical Coding Auditor

X Signed by: Daniel German Jr

Daniel German Practice Manager

X Signed by: Alejandra McKinney

Alejandra McKinney Program Director

X DocuSigned by: Evanthe Collins

Evanthe Collins VP of IDD

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
General Revenue (GR)
Review Dates: July 24,2026- September 10,2026

I. Audit Type:
Focus Audit

II. Purpose:
This review was conducted to ensure that services are appropriately documented, supported, and delivered in accordance with applicable program guidelines for General Revenue (GR). Ensuring compliance with Texas Health and Human Services Commission (HHSC) documentation and billing requirements, as well as compliance with Local Intellectual and Developmental Disability Authority (LIDDA), in accordance with Texas Administrative Code (TAC)

III. Audit Method:
A client roster of individuals receiving service coordination during the third quarter of fiscal year 2026 (March 1, 2026 – May 31, 2026) was extracted from the Epic EHR system. The random sample selected for this audit consisted of 21 active clients, 10 service coordinators, and 50 service encounters. Compliance also developed appropriate review tools to evaluate adherence to applicable program requirements across all reviewed domains.

Audit Findings/History:
IV. The General Revenue (GR) program demonstrated strong overall performance during this review period, achieving an overall score of 97.94**%** exceeding the established 95% threshold score. Despite this strong performance, specific administrative deficiencies lowered the overall score. Coding/Clinical Documentation received (96.89%) Billing received (99**%**) Deficiencies identified in documentation timeliness; evidence of copy and pasting Multiple progress notes failed to meet mandatory state timely submission requirements. There were also instances where SC documentation failed to verify monitoring of service delivery, progress, and satisfaction.

V. Recommendations:
It is recommended that the GR program strengthens compliance oversight by implementing routine self-monitoring processes to ensure timely documentation, 1 monthly type A service, and subsequent type B service monitoring of delivery, progress, and satisfaction. Clinical documentation should align with the billed service type; documentation should be individualized, and clearly reflect services rendered.

Corrective Actions:

VI. Following collaboration with Performance Improvement (PI), the program submitted a comprehensive Plan of Improvement (POI) to remediate all areas of deficiency. Compliance will assess the efficacy of the POI within 90-180 days.

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Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
IDD
General Revenue (GR)

Compliance Auditor(s): Meredith Greene, Obiageri Pickens

Review Dates: July 24,2026- September 10,2026

Purpose

This review evaluates compliance with Texas Health Human Services Commission (HHSC) documentation, billing, and program guidelines for individuals receiving General Revenue (GR) services. Specifically, it assesses adherence to Local Intellectual and Developmental Disability Authority (LIDDA) Service Coordination standards, Type A and Type B reimbursement requirements, and the following Texas Administrative Code Tex Admin code 26 § 330.13**:** Provision and Oversight of General Revenue Services**,** 26 Tex. Admin. Code § 331.21**:** Documentation of Service Coordination, *26 Tex Admin code 262 § 701 LIDDA's Requirements.*

Methods

A client roster of individuals receiving service coordination during the third quarter of fiscal year 2026 (March 1, 2026 – May 31, 2026) was extracted from the Epic EHR system. The random sample selected for this audit consisted of 21 active clients, 10 service coordinators, and 50 service encounters. Compliance also developed appropriate review tools to evaluate adherence to applicable program requirements across all reviewed domains.

Findings

Summary Overall Score: 97.94%

The General Revenue (GR) program demonstrated strong overall performance during this review period, achieving a 97.94% compliance score and exceeding the established 95% threshold score. Despite this strong performance, specific administrative deficiencies lowered the overall score.

Identified Deficiencies

- Documentation Cloning: Multiple instances of repetitive progress note across patient records.
- Untimely Progress Notes: Multiple progress notes failed to meet mandatory state and program timely filing requirements.
- Incomplete Service Monitoring: Documentation failed to fully support or verify required service monitoring activities.

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Recommendations

It is recommended that the GR program strengthens compliance oversight by implementing routine self-monitoring processes to ensure timely documentation, 1 monthly type A service, and subsequent type B service monitoring of delivery, progress, and satisfaction. Clinical documentation should align with billed service type, documentation should be individualized, and clearly reflect services rendered.

A Plan of Improvement (POI) is required to address the deficiencies identified in this report. Compliance will also refer the program to Performance Improvement (PI) for assistance with its POI development and implementation. Compliance will assess the program's progress toward completion of the POI within 90 days. The Vice President of the Practice Manager and the Senior Program Director are required to sign and return both this report and the completed POI to the Compliance department within seven (7) business days

Management Response

Management will ensure all staff in the unit receive training and support, to address areas identified during the audit. Management will complete routine chart reviews to spot any areas of concerns and provide ongoing training as needed.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Meredith Greene 81B30442047C40E...

Meredith Greene, Medical Coding Auditor

X Signed by: Daniel German Jr 7F01E0B300BB427...

Daniel German, Practice Manager

X Signed by: Alejandra McKinney 99A8A3BF093B4B3...

Alejandra McKinney, Program Manager

X DocuSigned by: Evanthe Collins 7E1005070D86486...

Evanthe Collins, V.P of IDD

The Harris Center for Mental Health and IDD:
The Compliance Department
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
Substance Use Disorder Outreach Program (SUDOP)
Review Date: August 17, 2026, to September 2, 2026

I. Audit Type:
Comprehensive review.

II. Purpose:
The purpose of this review was to assess the SUDOP program Medical, Personnel, and Clinical Record requirements for compliance with the Texas Administrative Code (Tex. Admin. Code) 26 *Tex. Admin. Code §301.355 Medication Services,* 26 *Tex. Admin. Code §301.361 Documentation of Service Provision, 26 Tex. Admin. Code §301.331 Competency and Credentialing,* 26 *Tex. Admin. Code §320.207 General Principles,* 26 *Tex. Admin. Code §320.29 Staff Training in Rights of Individuals Receiving Mental Health Services,* 26 *Tex. Admin. Code §320.113 Staff Member Training,* 26 *Tex. Admin. Code §301.323 Environment of Care and Safety,* 26 *Tex. Admin. Code §320.25 Communication of Rights to Individuals Receiving Mental Health Services,* 26 *Tex. Admin. Code §320.217 Medication Monitoring,* 26 *Tex. Admin. Code §320.59 Documentation of Informed Consent,* 26 *Tex. Admin. Code §301.353 Provider Responsibilities for Treatment Planning and Service Authorization, SUDOP Statement of Work SOW and SUDOP Operational Guidelines.*

III. Audit Method:
Active records were randomly selected from the Affiliated Harris Center Encounter Data Outpatient Service Detail Auditing report in the Electronic Health Record (EHR) for persons served during the 3rd Qtr. of FY 2026 (March 1, 2026, to May 31, 2026), and the Organizational Development Staff Training Roster Report. Compliance conducted a desk review, sampling fifteen (15) consumer records and eight (8) personnel records were reviewed using an auditing tool developed by the Compliance Department.

IV. Audit Findings and History:
The SUDOP program achieved an overall score of **98.10%.** While compliance was strong across all domains reviewed, there were deficiencies identified that required corrective action measures needed within the Personnel and Clinical Record domains.

V. Recommendations:
Compliance recommends that the SUDOP program review the findings and continue to assess its processes to ensure all required standards are completed in accordance with SUDOP Operational Guidelines and Tex Admin Code: Staff Member Training, Provider Responsibilities for Treatment Planning, Documentation of Service Provision, and Competency and Credentialing. The SUDOP program is required to submit a Plan of Improvement (POI) focusing on the elements in Personnel requirements and Clinical Record requirements. The program will collaborate with Performance Improvement (PI) to help mitigate the reported deficiencies. 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.

VI. Corrective Actions:
Compliance provided the program with an updated Plan of Improvement to complete in collaboration with the Performance Improvement (PI) Department and will conduct a follow-up review within 90-180 days.

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Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Comprehensive Psychiatric Emergency Program (CPEP) Division
Substance Use Disorder Outreach Program (SUDOP) Comprehensive Audit

Compliance Auditor(s): Marvin Williams

Review Dates: August 17, 2026, to September 2, 2026

Purpose

The purpose of this review was to assess the SUDOP program Medical, Personnel, and Clinical Record requirements for compliance with the Texas Administrative Code (Tex. Admin. Code) 26 *Tex. Admin. Code §301.355 Medication Services,* 26 *Tex. Admin. Code §301.361 Documentation of Service Provision, 26 Tex. Admin. Code §301.331 Competency and Credentialing,* 26 *Tex. Admin. Code §320.207 General Principles,* 26 *Tex. Admin. Code §320.29 Staff Training in Rights of Individuals Receiving Mental Health Services,* 26 *Tex. Admin. Code §320.113 Staff Member Training,* 26 *Tex. Admin. Code §301.323 Environment of Care and Safety,* 26 *Tex. Admin. Code §320.25 Communication of Rights to Individuals Receiving Mental Health Services,* 26 *Tex. Admin. Code §320.217 Medication Monitoring,* 26 *Tex. Admin. Code §320.59 Documentation of Informed Consent,* 26 *Tex. Admin. Code §301.353 Provider Responsibilities for Treatment Planning and Service Authorization, SUDOP Statement of Work SOW and SUDOP Operational Guidelines.*

Methods

Active records were randomly selected from the Affiliated Harris Center Encounter Data Outpatient Service Detail Auditing report in the Electronic Health Record (EHR) for persons served during the 3rd Qtr. of FY 2026 (March 1, 2026, to May 31, 2026), and the Organizational Development Staff Training Roster Report. Compliance conducted a desk review, sampling fifteen (15) consumer records and eight (8) personnel records were reviewed using an auditing tool developed by the Compliance Department.

Findings

The SUDOP program achieved an overall score of **98.10%.** While compliance was strong across all domains reviewed, there were deficiencies identified that required corrective action measures needed within the Personnel and Clinical Record domains.

Detailed data for this review is presented below.

Medical Requirements – 100%

The program demonstrated strong overall performance in the medical requirements.

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Personnel Record Findings – 99.17%

The Personnel Records identified two instances of non-compliance with agency-mandated trainings. The review revealed strong compliance in completion of nearly all training courses, which directly contributed to the program almost having a perfect score.

Key findings include missing or incomplete documentation for the following requirements:

- Completion of agency mandated training courses. *(26 Tex. Admin. Code §301.331 (a)(A) (i-x) (B)(i-ii))*
  - Safe Care RL
  - Handle with Care

Clinical Record Findings – 95.14%

The Clinical Records review identified multiple compliance deficiencies. While the program's overall score met the performance threshold, several evaluated elements did not achieve compliance. Program leadership will need to strengthen documentation controls to ensure alignment with regulatory standards, resulting in a requirement for the program to submit a plan of improvement.

Key findings include missing or incomplete documentation for the following requirements:

- For medications known to cause movement disorders staff will screen the patient quarterly for abnormal involuntary movement scale (AIMS) assessment. (26 *Tex. Admin. Code §320.217 (e))*
- Plans of care will be developed after it has been determined the person served is eligible for service. (*§301.353 (d)(1)(c)*)
- The objectives in the plans of care must be measurable. (*§301.353 (e)(2)(D)*)
- The adult crisis risk assessment will be completed for each person served. (*SUDOP Operational Guidelines 5.4)*
- The program will complete the Patient Health Questionnaire (PHQ9) for each person served. (*SUDOP Operational Guidelines 5.4)*
- The Quality-of-Life Enjoyment and Satisfaction Questionnaire (QLESQ) will be completed for every person served. (*SUDOP Operational Guidelines 5.4)*
- A discharge summary will be completed when it has been determined that the person served will no longer receive services. (26 *Tex. Admin. Code §301.353 (h))*
- Each service encounter documentation must be individualized to show how the person served demonstrates progress or the lack of progress toward achieving their treatment goals. (26 *Tex. Admin. Code §301.361 (a) (12))*
- The start and end time must be documented for every service encounter. (26 *Tex. Admin. Code §301.361 (a) (4))*
- There should be no evidence of cloning, copying and pasting in the clinical record.

History

Compliance conducted a review of the SUDOP program during the 2nd quarter of Fiscal Year (FY) 2025.

Recommendations

Compliance recommends that the SUDOP program review the findings and continue to assess its processes to ensure all required standards are completed in accordance with SUDOP Operational Guidelines and Tex Admin Code: Staff Member Training, Provider Responsibilities for Treatment Planning, Documentation of Service Provision, and Competency and Credentialing. The SUDOP program is required to submit a Plan of Improvement (POI) focusing on the elements in Personnel requirements and Clinical Record requirements. The program will collaborate with Performance Improvement (PI) to help mitigate the reported deficiencies. 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 Tuesday, September 29, 2026.

Management Response

The SUDOP PD has received the compliance audit documentation and notes that no further revisions are required beyond the items identified during the exit meeting. I will begin developing the Plan of Improvement (POI) immediately to ensure it is completed and submitted to the compliance department by the close of business on Tuesday, September 29, 2026.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Antonio Wilson FACF9FF4A9674B3...

Program Manager / Director

X Signed by: kim kornmeyer 7050738D206644E...

Vice President of CPEP Division

X Signed by: Marvin Williams 98E4DECC55AE49A...

Regulatory Compliance Auditor

The Harris Center for Mental Health and IDD:
The Compliance Department
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
Homeless Outreach Team (HOT)
Review Date: August 3, 2026, to August 14, 2026

I. Audit Type:
Comprehensive review.

II. Purpose:
The purpose of this review was to assess the Homeless Outreach Team (HOT) program, Personnel and Clinical Record requirements for compliance with the Texas Administrative Code (Tex. Admin. Code) *26 Tex. Admin. Code §301.331 Competency and Credentialing,* 26 *Tex. Admin. Code §320.29 Staff Training in Rights of Individuals Receiving Mental Health Services,* 26 *Tex. Admin. Code §320.113 Staff Member Training*, *26 Tex. Admin. Code §301.331 (h) (1-2) (4) Competency and Credentialing, and HOT Operational Guidelines.*

III. Audit Method:
Active records were randomly selected from the service encounter roster report submitted by HOT program for person's served during the 3rd Qtr. of FY 2026 (March 1, 2026, to May 31, 2026), and the Organizational Development Staff Training Roster Report. Compliance conducted a desk review; sampling of twenty (20) consumer records and three (3) personnel records were reviewed using a tool developed by the Compliance department.

IV. Audit Findings and History:
The HOT program achieved an overall score of 97.22%. The review identified strong compliance with the clinical record requirements; however, there were instances of non-compliance with agency-mandated trainings with the personnel requirements resulting in the need for a plan of improvement.

V. Recommendations:
Compliance recommends that the HOT program review the findings and assess its processes to ensure all required standards are completed in accordance with the HOT Operational Guidelines and TEX Admin Code: Staff Member Training, Competency and Credentialing. The HOT program is required to submit a Plan of Improvement (POI) focusing on the elements in Personnel and the Clinical Record Requirement and Collaborate with Performance Improvement (PI) to help mitigate the reported deficiencies. 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

VI. Corrective Actions:
Compliance provided the program with an updated Plan of Improvement to complete in collaboration with the Performance Improvement (PI) Department and will conduct a follow-up review within 90-180 days.

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Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Comprehensive Psychiatric Emergency Program (CPEP) Division
Homeless Outreach Team (HOT) Comprehensive Audit

Compliance Auditor(s): Marvin Williams

Review Dates: August 3, 2026, to August 14, 2026
Comprehensive Audit

Purpose

The purpose of this review was to assess the Homeless Outreach Team (HOT) program, Personnel and Clinical Record requirements for compliance with the Texas Administrative Code (Tex. Admin. Code) *26 Tex. Admin. Code §301.331 Competency and Credentialing,* 26 *Tex. Admin. Code §320.29 Staff Training in Rights of Individuals Receiving Mental Health Services,* 26 *Tex. Admin. Code §320.113 Staff Member Training*, *26 Tex. Admin. Code §301.331 (h) (1-2) (4) Competency and Credentialing, and HOT Operational Guidelines.*

Methods

Active records were randomly selected from the service encounter roster report submitted by HOT program for person's served during the 3rd Qtr. of FY 2026 (March 1, 2026, to May 31, 2026), and the Organizational Development Staff Training Roster Report. Compliance conducted a desk review; sampling of twenty (20) consumer records and three (3) personnel records were reviewed using a tool developed by the Compliance department.

Findings

The HOT program achieved an overall score of 97.22%. The review identified strong compliance with the clinical record requirements; however, there were instances of non-compliance with agency-mandated trainings with the personnel requirements resulting in the need for a plan of improvement.

Detailed findings are presented below:

Personnel Record – 95.56%

The Personnel Records review identified occurrences of non-compliance with agency mandated trainings. The review disclosed evidence confirming that the required training courses were not completed and documented in the staff personnel file, which directly contributed to the reduced score resulting in the need to enhance internal monitoring.

Identified findings include:

- Receive training in identifying the causes of aggressive or threatening behavior. (*TEX. ADMIN. CODE 26 §320.113(c)(2))*
    - Handle with Care

- Completion of agency mandated training courses, including but not limited to: *(26 TEX. ADMIN. CODE §301.331 (a)(A)(i-x)(B)(i-ii))*
    - Co-Occurring Psychiatric and Substance Use Disorders (COPSD)
    - Trauma Informed Care
    - Safe Care RL

Clinical Record – 98.89%

The clinical record demonstrated progress across all elements reviewed except one, documenting the service encounters in the EHR within the required timeframe after each service which led to not meeting the threshold score.

Key findings include missing or incomplete documentation for the following requirements:

Service encounter documentation was not documented in the Harris Center EHR within 24 hours. *(HOT Operational Guidelines)*

History

Compliance conducted a review of this program during 4th quarter of fiscal year 2024.

Recommendations

Compliance recommends that the HOT program review the findings and assess its processes to ensure all required standards are completed in accordance with the HOT Operational Guidelines and TEX Admin Code: Staff Member Training, Competency and Credentialing. The HOT program is required to submit a Plan of Improvement (POI) focusing on the elements in Personnel and the Clinical Record Requirement and Collaborate with Performance Improvement (PI) to help mitigate the reported deficiencies. 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 Tuesday, September 29, 2026.

Management Response

The staff Daniel German with the missing trainings was a staff who transferred from MCOT to PATH/HOT on 4/26/26 and left the program (transferred) to IDD on 8/15/26. This staff did not complete his trainings prior to transferring to PATH/HOT. PATH/HOT Mgmt was not aware of the missing trainings. This staff is no longer on the unit.

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Signature Page

Signed by:
omar sesay
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Program Manager / Director

Signed by:
kim kommeyer
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Vice President of CPEP Division

Signed by:
Marvin Williams
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Regulatory Compliance Auditor

The Harris Center for Mental Health and IDD:
The Compliance Department
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
Step Down State Hospital Transition
Review Date: July 21, 2026, to July 29, 2026

I. Audit Type:
Plan of Improvement Follow Up review.

II. Purpose:
The purpose of this review was to assess the Step Down State Hospital Transition program for implementation of its POI requirements to ensure compliance with Texas Administrative Code (*Tex. Admin. Code*) *26 Tex. Admin. Code Provider Responsibilities for Treatment Planning and Service Authorization §301.353 (d)(1)(C)*; *26 Tex. Admin. Code Documentation of Service Provision §301.361 (a)(12); Health and Human Service Attachment H Staff Job Duties (Training) §SLGHS H.d.i.2.*

III. Audit Method:
Active records were randomly selected from the *Affiliated Harris Center Encounter Data IP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 4th Qtr. of FY 2026 (June 1, 2026, to June 30, 2026), Compliance conducted a desk review, sampling nine (9) consumer records and three (3) personnel records using a tool that was developed by the Compliance Department. Detailed data for this review is presented below.

IV. Audit Findings and History:
The program demonstrated minimal overall compliance, with measurable improvement observed in two of the five reviewed elements, resulting in one element deemed not applicable. Audit scoring reflected one element which met and surpassed the 95% performance threshold score, indicating strong adherence in that specific area. However, corrective action remains necessary in the clinical record domain of plan of care development and ensuring service encounter documentation reflects the individual's identified goals and objectives as outlined in the plan of care and documenting how the person served demonstrated progress or the lack of progress towards treatment goals.

V. Recommendations:
Program leadership should review the findings and assess its processes to ensure all required standards are completed in accordance with TEX. ADMIN. CODE: Documentation of Service Provision, Provider Responsibilities for Treatment Planning and Service Authorization and Health and Human Service Attachment H Staff Job Duties (Training). The Step-Down program is required to collaborate with Performance Improvement (PI) and submit a Plan of Improvement (POI) focusing on the Clinical Record Requirements. Compliance provided the program with an updated Plan of Improvement to complete in collaboration with the Performance Improvement (PI). The Vice President of the CPEP division and the Program Director must sign the report and return along with POI document to the Compliance Department

VI. Corrective Actions:
Compliance provided the program with an updated Plan of Improvement to complete in collaboration with the Performance Improvement (PI) Department and will conduct a follow-up review within 90-180 days.

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Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Comprehensive Psychiatric Emergency Program (CPEP)
Step Down State Hospital Transition Plan of Improvement (POI) Follow-up Review

Compliance Auditor(s): Marvin Williams

Review Dates: July 21, 2026, to July 29, 2026

Purpose

The purpose of this review was to assess the Step Down State Hospital Transition program for implementation of its POI requirements to ensure compliance with Texas Administrative Code (*Tex. Admin. Code*) *26 Tex. Admin. Code Provider Responsibilities for Treatment Planning and Service Authorization §301.353 (d)(1)(C)*; *26 Tex. Admin. Code Documentation of Service Provision §301.361 (a)(12); Health and Human Service Attachment H Staff Job Duties (Training) §SLGHS H.d.i.2.*

Methods

Active records were randomly selected from the *Affiliated Harris Center Encounter Data IP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 4th Qtr. of FY 2026 (June 1, 2026, to June 30, 2026), Compliance conducted a desk review, sampling nine (9) consumer records and three (3) personnel records using a tool that was developed by the Compliance Department. Detailed data for this review is presented below.

Findings

The program demonstrated minimal overall compliance, with measurable improvement observed in two of the five reviewed elements, resulting in one element deemed not applicable. Audit scoring reflected one element which met and surpassed the 95% performance threshold score, indicating strong adherence in that specific area. However, corrective action remains necessary in the clinical record domain of plan of care development and ensuring service encounter documentation reflects the individual's identified goals and objectives as outlined in the plan of care and documenting how the person served demonstrated progress or the lack of progress towards treatment goals.

Detailed findings are presented below:

Follow-up Audit Element(s)	Previous Score (Qtr. 2 FY 2026)	Current Score (Qtr. 4 FY 2026)
• Staff job duties that involve direct care responsibilities must be current with annual training. (*HHS Attachment H §SLGHS H.d.i.2)*	75.00%	100%
• The program must develop a person-centered plan of care for each person served. (*§301.353 (d)(1)(c)*)	88.89%	88.89%
• Service encounter documentation must reflect the person served goals and objectives as stated in the plan of care and be consistent with the purpose and intent of the service. (*§301.361 (a)(11)*)	85.18%	78.00%
• Service encounter documentation must reflect how the person served demonstrated progress or the lack of progress towards treatment goals. (*§301.361 (a)(12)*)	11.11%	78.00%

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• Pre-service training for Licensed Practitioners of the Healing Arts (LPHA) shall be current with Cognitive Adaptation training. *(HHS Attachment H §SLGHS H.d.ii.1)*	66.67%	NA

History

Compliance previously audited the State Hospital Step Down Transition Program during the 2nd Qtr. FY 2026.

Recommendations

Program leadership should review the findings and assess its processes to ensure all required standards are completed in accordance with TEX. ADMIN. CODE: Documentation of Service Provision, Provider Responsibilities for Treatment Planning and Service Authorization. The Step-Down program is required to collaborate with Performance Improvement (PI) and submit a Plan of Improvement (POI) focusing on the Clinical Record Requirements. Compliance provided the program with an updated Plan of Improvement to complete in collaboration with the Performance Improvement (PI). The Vice President of the CPEP division and the Program Director must sign this report and return along with POI document to the Compliance Department by Tuesday, September 29, 2026.

Management Response

Program Manager provided a Plan of Improvement (POI) focusing on the Clinical Records Requirements as requested by the Compliance Department.

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Signature Page

Signed by:
X Joy Deaver-Lazard
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Program Director / Manager

Signed by:
X kim kornmeyer
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Div. VP – Comprehensive Psychiatric Emergency Program

Signed by:
X Marvin Williams
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Regulatory Compliance Auditor

The Harris Center for Mental Health and IDD:
The Compliance Department
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
Chronic Consumer Stabilization Initiative (CCSI)
Review Date: July 20, 2026, to July 27, 2026

I. Audit Type:
Plan of Improvement Follow Up review.

II. Purpose:
The purpose of this review was to assess the CCSI program for implementation of its POI requirements to ensure compliance with Texas Administrative Code (*Tex. Admin. Code*) *26 Tex. Admin. Code Staff Member Training §320.113 (c)(2)*; *26 Tex. Admin. Competency and Credentialing §301.331 (a)(3)(A)(v)*; *26 Tex. Admin. Code Provider Responsibilities for Treatment Planning and Service Authorization §301.353 (d)(1)(C)(e)(2)(D-E)(f)(1)(a)*; *26 Tex. Admin. Code Communication of Rights to Individuals Receiving Mental Health Services §320.25 (a)(b)*; *26 Tex. Admin. Code Documentation of Service Provision §301.361 (a)(11-12).*

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 persons served during the 3rd Qtr. of FY 2026 (April 1, 2026, to May 31, 2026), Compliance conducted a desk review, sampling ten (10) consumer records and five (5) personnel records using a tool that was developed by the Compliance Department. Detailed data for this review is presented below.

IV. Audit Findings and History:
The program demonstrated strong overall compliance and maintained performance improvement across nearly all elements reviewed. Audit results reflected a high level of compliance with six of the fourteen elements meeting and surpassing the 95% performance threshold score, indicating a robust effort towards fulfilling operational practices. However, corrective action remains necessary in adherence to mandated training, plan of care development, and service encounter documentation appropriateness.

V. Recommendations:
Program leadership should review the finding and assess its processes to ensure all required standards are completed in accordance with TEX. ADMIN. CODE: Documentation of Service Provision. The CCSI program is required to collaborate with Performance Improvement (PI) and submit a Plan of Improvement (POI) focusing on the Clinical Record Requirements. Compliance provided the program with an updated Plan of Improvement to complete in collaboration with the Performance Improvement (PI). The Vice President of the CPEP division and the Program Director must sign the report and return along with POI document to the Compliance Department.

VI. Corrective Actions:
Compliance provided the program with an updated Plan of Improvement to complete in collaboration with the Performance Improvement (PI) Department and will conduct a follow-up review within 90-180 days.

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Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Comprehensive Psychiatric Emergency Program (CPEP)
Chronic Consumer Stabilization Initiative (CCSI) Plan of Improvement (POI) Follow-up Review

Compliance Auditor(s): Marvin Williams

Review Dates: July 20, 2026, to July 27, 2026

Purpose

The purpose of this review was to assess the CCSI program for implementation of its POI requirements to ensure compliance with Texas Administrative Code (*Tex. Admin. Code*) *26 Tex. Admin. Code Staff Member Training §320.113 (c)(2)*; *26 Tex. Admin. Competency and Credentialing §301.331 (a)(3)(A)(v)*; *26 Tex. Admin. Code Provider Responsibilities for Treatment Planning and Service Authorization §301.353 (d)(1)(C)(e)(2)(D-E)(f)(1)(a)*; *26 Tex. Admin. Code Communication of Rights to Individuals Receiving Mental Health Services §320.25 (a)(b)*; *26 Tex. Admin. Code Documentation of Service Provision §301.361 (a)(11-12).*

Methods

Active records were randomly selected from the *Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 3rd Qtr. of FY 2026 (April 1, 2026, to May 31, 2026), Compliance conducted a desk review, sampling ten (10) consumer records and five (5) personnel records using a tool that was developed by the Compliance Department. Detailed data for this review is presented below.

Findings

The program demonstrated strong overall compliance and maintained performance improvement across nearly all elements reviewed. Audit results reflected a high level of compliance with three of the four elements meeting and surpassing the 95% performance threshold score, indicating strong adherence to operational practices. However, a corrective action remains necessary in the domain of service encounter documentation individualizing how the person served demonstrated progress or the lack of progress towards treatment goals.

Detailed findings are presented below:

Follow-up Audit Element(s)	Previous Score (Qtr. 2 FY 2026)	Current Score (Qtr. 4 FY 2026)
• Staff job duties that involve direct care responsibilities must be current with the training in identifying the causes of aggressive or threatening behavior. (*§320.113 (c)(2)*	57.14%	80.00%
• The provider must develop a written treatment plan after it has been determined the person served is eligible for service. (*§301.353 (d)(1)(c)*)	80.00%	80.00%
• The rights acknowledgement form must be signed and dated for each person's served annually. (§320.25 (a)(b))	70.00%	90.00%
• Plans of care for each person served must be developed and finalized within ten (10) business days after eligibility is determined. (§320.25 (a)(b))	50.00%	83.33%
• The credentials of the staff responsible for providing the service must be documented in the plans of care. (§301.353 (d)(1)(C))	75.00%	0.00%

• The plans of care objectives must be measurable using quantifiable criteria. (§301.353 (e)(2)(D)	87.50%	100.00%
• The plans of care must be clearly individualized using person-centered language. (§301.353 (e)(2)(E))	0.00%	100.00%
• Plans of care reviews must be conducted for the continuation of services. (§301.353 (f)(1)(A))	80.00%	100.00%
• Service encounter documentation must include a summary of the skills and techniques utilized to assist the person served in their recovery. (§301.361 (a)(6))	14.29%	76.67%
• Service encounter documentation must reflect the person served goals and objectives as stated in the plan of care and be consistent with the purpose and intent of the service. (*§301.361 (a)(11)*)	85.71%	76.67%
• Service encounter documentation must reflect how the person served demonstrated progress or the lack of progress towards treatment goals. (*§301.361 (a)(12)*)	71.43%	76.67%%
• To determine the person's served appropriateness for the program the provider will complete the Crisis Risk Assessment. *(CCSI Operational Guidelines)*	90.00%	100.00%
• To assist in determining the person served service needs the provider will administer the Patient Health Questionnaire (PHQ9). *(CCSI Operational Guidelines)*	90.00%	100.00%
• The Fagerstrom Tolerance questionnaire will be utilized to assess the persons served nicotine dependency. *(CCSI Operational Guidelines)*	90.00%	100.00%

History

Compliance previously audited the CCSI Program during the 2nd Qtr. FY 2026.

Recommendations

Program leadership should review the findings and assess its processes to ensure all required standards are completed in accordance with TEX. ADMIN. CODE: Documentation of Service Provision, Provider Responsibilities for Treatment Planning and Service Authorization, Communication of Rights to Individuals Receiving Mental Health Services and Staff Member Training. The CCSI program is required to collaborate with Performance Improvement (PI) and submit a Plan of Improvement (POI) focusing on the Clinical Record Requirements. Compliance provided the program with an updated Plan of Improvement to complete in collaboration with the Performance Improvement (PI). The Vice President of the CPEP division and the Program Director must sign this report and return along with POI document to the Compliance Department within seven (7) business days (Tuesday, September 29, 2026).

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Management Response

CCSI demonstrated significant improvement across multiple audit focus areas during Q2 through the development and implementation of a targeted Plan of Action. While the program achieved substantial progress, a perfect score for staff training was not attainable due to one employee being on approved FMLA leave during the review period.

Additionally, CCSI's score for Plan of Care credentialing decreased from 75% to 0% due to a system-wide documentation issue identified within EPIC. Upon review, it was determined that the missing credentialing associated with a specific objective is not unique to the program but reflects a broader electronic health record configuration concern. The CCSI Director has initiated collaboration with the EHR Committee to address and resolve the issue as quickly as possible.

Despite this setback, CCSI leadership remains committed to continuous quality improvement and continues to implement corrective actions and performance improvement strategies through its ongoing Plan of Improvement process. The program will continue monitoring outcomes, addressing identified barriers, and pursuing sustainable solutions to enhance compliance and audit performance.

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Signature Page

X Signed by: amber lonsigner D0BF353B8A5E429...

Program Director / Manager

X Signed by: kim kornmeyer 705073BD206644F...

Div. VP – Comprehensive Psychiatric Emergency Program

X Signed by: Marvin Williams 98E4DFCC55AF49A...

Regulatory Compliance Auditor

The Harris Center for Mental Health and IDD:
The Compliance Department
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program (CPEP) Division
Projects for Assistance in Transition from Homelessness (PATH)
Review Date: July 17, 2026, to July 22, 2026

I. Audit Type:
Plan of Improvement Follow Up review.

II. Purpose:
The purpose of this review was to assess the PATH program for implementation of its POI requirements to ensure compliance with Texas Administrative Code (*Tex. Admin. Code*) *26 Tex. Admin. Code Staff Member Training §320.113 (c)(2)*; *26 Tex. Admin. Competency and Credentialing §301.331 (a)(3)(A)(v)*; *26 Tex. Admin. Code Staff Member Training §320.113 (c)(2))*; *26 Tex. Admin. Code Documentation of Service Provision §301.361 (a)(11-12).*

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 persons served during the 4th Qtr. of FY 2026 (June 1, 2026, to June 30, 2026), Compliance conducted a desk review, sampling ten (10) consumer records and two (2) personnel records using a tool that was developed by the Compliance Department. Detailed data for this review is presented below.

IV. Audit Findings and History:
The program demonstrated strong overall compliance and maintained performance improvement across nearly all elements reviewed. Audit results reflected a high level of compliance with three of the four elements meeting and surpassing the 95% performance threshold score, indicating strong adherence to operational practices. However, a corrective action remains necessary in the domain of service encounter documentation individualizing how the person served demonstrated progress or the lack of progress towards treatment goals.

V. Recommendations:
Program leadership should review the finding and assess its processes to ensure all required standards are completed in accordance with TEX. ADMIN. CODE: Documentation of Service Provision. The PATH program is required to collaborate with Performance Improvement (PI) and submit a Plan of Improvement (POI) focusing on the Clinical Record Requirements. Compliance provided the program with an updated Plan of Improvement to complete in collaboration with the Performance Improvement (PI). The Vice President of the CPEP division and the Program Director must sign the report and return along with POI document to the Compliance Department

VI. Corrective Actions:
Compliance provided the program with an updated Plan of Improvement to complete in collaboration with the Performance Improvement (PI) Department and will conduct a follow-up review within 90-180 days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Comprehensive Psychiatric Emergency Program (CPEP)
Projects for Assistance in Transition from Homelessness (PATH) Plan of Improvement (POI) Follow-up Review

Compliance Auditor(s): Marvin Williams

Review Dates: July 17, 2026, to July 22, 2026

Purpose

The purpose of this review was to assess the PATH program for implementation of its POI requirements to ensure compliance with Texas Administrative Code (*Tex. Admin. Code*) *26 Tex. Admin. Code Staff Member Training §320.113 (c)(2)*; *26 Tex. Admin. Competency and Credentialing §301.331 (a)(3)(A)(v)*; *26 Tex. Admin. Code Staff Member Training §320.113 (c)(2))*; *26 Tex. Admin. Code Documentation of Service Provision §301.361 (a)(11-12).*

Methods

Active records were randomly selected from the *Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 4th Qtr. of FY 2026 (June 1, 2026, to June 30, 2026), Compliance conducted a desk review, sampling ten (10) consumer records and two (2) personnel records using a tool that was developed by the Compliance Department. Detailed data for this review is presented below.

Findings

The program demonstrated strong overall compliance and maintained performance improvement across nearly all elements reviewed. Audit results reflected a high level of compliance with three of the four elements meeting and surpassing the 95% performance threshold score, indicating strong adherence to operational practices. However, a corrective action remains necessary in the domain of service encounter documentation individualizing how the person served demonstrated progress or the lack of progress towards treatment goals.

Detailed findings are presented below:

Follow-up Audit Element(s)	Previous Score (Qtr. 2 FY 2026)	Current Score (Qtr. 4 FY 2026)
• Staff job duties that involve direct care responsibilities must be current with the training in identifying the causes of aggressive or threatening behavior. (*§320.113 (c)(2)*	91.67%	100%
• Direct care staff must be current with all annual required trainings. (*§301.353 (d)(1)(c)*)	90.00%	100%
• Service encounter documentation must reflect the person served goals and objectives as stated in the plan of care and be consistent with the purpose and intent of the service. (*§301.361 (a)(11)*)	90.00%	100%
• Service encounter documentation must reflect how the person served demonstrated progress or the lack of progress towards treatment goals. (*§301.361 (a)(12))*	90.00%	73.33%

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History

Compliance previously audited the PATH Program during the 2nd Qtr. FY 2026.

Recommendations

Program leadership should review the finding and assess its processes to ensure all required standards are completed in accordance with TEX. ADMIN. CODE: Documentation of Service Provision. The PATH program is required to collaborate with Performance Improvement (PI) and submit a Plan of Improvement (POI) focusing on the Clinical Record Requirements. Compliance provided the program with an updated Plan of Improvement to complete in collaboration with the Performance Improvement (PI). The Vice President of the CPEP division and the Program Director must sign this report and return along with POI document to the Compliance Department by Tuesday, September 29, 2026.

Management Response

PATH Program Director and CSTL met with Dean on 8/17/26 discussed the results of the audit. Program Director shadowed Dean during the completion of his group notes after his group concluded on 8/17/26. Program Director and Dean Worked on individualizing notes and specifying the frequency/attendance of the group; i.e. 1-3, 2-3, or 3-3 groups attended weekly. CSTL shadowed LCDC on 8/18/26 during the completion of his LCDC BAM assessment and the amendment of the plan of care. Management will coordinate with the training department to schedule and facilitate a Group Notes refresher, alongside the upcoming August/September Case Management, Rehab, and Housing training series.

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Signature Page

X Signed by: omar sesay D2E29F8798764C5...

Program Director / Manager

X Signed by: kim kornmeyer 705073BD206644F...

Div. VP – Comprehensive Psychiatric Emergency Program

X Signed by: Marvin Williams 98E4DFCC55AF49A...

Regulatory Compliance Auditor

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Peer Support and Reentry Comprehensive & Plan of Improvement (POI Follow-up Review
Review Dates: August 31, 2026-September 9,2026

I. Audit Type:
Comprehensive Review and POI) Follow-up Review

II. Purpose:
The purpose of this review was to determine if the Peer Support and Reentry program was compliant with the Texas Administrative Code (Tex. Admin. Code), 26 Tex. Admin. Code Competency and Credentialing §§ 301.331 (a)(3)(A)(v), (viii), and (x); (a)(3)(B)(iii) and (v); and (a)(3)(C)(ii), (viii), and (xii); 26 Tex. Admin. Code Communication of Rights to Individuals Receiving Mental Health Services §§ 320.25 (a) and (b); 26 Tex. Admin. Code Staff Training in Rights of Individuals Receiving Mental Health Services §§ 320.29 (1) and (3); and 26 Tex. Admin. Code Medication Monitoring §§320.217 (a); 26 Tex. Admin. Code Environment of Care §§ 301.323 (A)(C; 26 Tex. Admin. Code Rights of Individuals §§ 320.21; 1 Tex. Admin. Code Eligibility to Receive Service §§ 354.3011; 26 Tex. Admin. Code Documentation of Service Provision §§ 301.361; Interlocal Agreement (ILS) between The Harris Center for Mental Health and IDD and the Harris County Sheriff's Office; Peer Support Reentry Pilot (MH/PSR) Version 1 Contract; Program Description and the Harris Center procedures HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure and MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention; Harris Center policies and procedures; and if the program had successfully implemented processes to rectify the deficiencies noted in the follow up review conducted during the 2nd Quarters of FY 2026. .

III. Audit Method:
Program leadership provided client rosters of persons served during the 3rd Qtr. FY 2026 (March 1, 2026-May 31, 2026). A random sample of 20 clients (approximately 20% of the caseload of 20% of the Peer Navigators) was generated using Excel functions. Employee rosters were also provided by program leadership. All six (6) employees were selected. The review was conducted using an audit tool developed by Compliance.

IV. Audit Findings/History:

The programs had an overall score of 99.25.00%, an increase from the 2nd Qtr. FY 2026 audit score of 97.65%. The program surpassed the minimum threshold score of 95.00% in the operations (100%), personnel (100.00%), client records (97.00%), and environment (100.00%) components. During the 2nd Qtr. FY2026 review: the program score was 20.00% in Oral communication of Rights, documented on a form bearing the date and signatures of the individual and/or the parent, conservator, or guardian, and the staff member who explained the rights. The form should be filed in the individual's chart. For this comprehensive review, the program score was 26.00%, in the oral communication of rights in the client record, a minor improvement. The program has been unable to obtain records from the Harris County Sheriff's Office, which is the front door where the individual's rights are explained to the patients. The program did not meet the Corrective Action Plan requirement. It was inconclusive in the last review, and it is scored in this comprehensive review. Client records (97.00%) components for the comprehensive review, with a 75% score for Medications known to cause movement disorder. Trained and competent staff were to screen the patient quarterly for abnormal involuntary movements, using a standardized procedure such as AIMS. This was not reviewed in the follow-up review. Program leadership stated they would collaborate with the Harris County Sheriff's Office to identify additional strategies to resolve deficiencies. The contract requires that the program assign a Client Assistant and Registration (CARE) identification number to connect individuals with their prior involvement with the public behavioral health system. This will include those who have been formally diagnosed or otherwise identified. The program utilizes Clinical Management for Behavioral Health Service (CMBHS),

V. Recommendations:
The program should continue to review client documentation for compliance with regulatory standards. Program leadership should continue implementing the previous POI protocols, more frequently monitor service documentation, and consult with Performance Improvement (PI) to develop additional strategies to address deficiencies noted during this review. The Vice President of the Forensic Division and the Forensic Program Directors must sign and return this report to Compliance within seven (7) days.

VI. Corrective Actions:
Compliance provided the program with a new Plan of Improvement (POI) to be completed in collaboration with PI.

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Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Forensic Division Peer Support and Reentry Program
Comprehensive Review and Plan of Improvement (POI) Follow-up Review

Compliance Auditor(s): Emmanuel Golakai

Review Dates: August 31, 2026-September 9, 2026

Purpose

The purpose of this review was to determine if the Peer Support and Reentry program was compliant with the Texas Administrative Code (Tex. Admin. Code), 26 Tex. Admin. Code Competency and Credentialing §§ 301.331 (a)(3)(A)(v), (viii), and (x); (a)(3)(B)(iii) and (v); and (a)(3)(C)(ii), (viii), and (xii); 26 Tex. Admin. Code Communication of Rights to Individuals Receiving Mental Health Services §§ 320.25 (a) and (b); 26 Tex. Admin. Code Staff Training in Rights of Individuals Receiving Mental Health Services §§ 320.29 (1) and (3); and 26 Tex. Admin. Code Medication Monitoring §§320.217 (a); 26 Tex. Admin. Code Environment of Care §§ 301.323 (A)(C; 26 Tex. Admin. Code Rights of Individuals §§ 320.21; 1 Tex. Admin. Code Eligibility to Receive Service §§ 354.3011; 26 Tex. Admin. Code Documentation of Service Provision §§ 301.361; Interlocal Agreement (ILS) between The Harris Center for Mental Health and IDD and the Harris County Sheriff's Office; Peer Support Reentry Pilot (MH/PSR) Version 1 Contract; Program Description and the Harris Center procedures HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure and MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention; Harris Center policies and procedures; and if the program had successfully implemented processes to rectify the deficiencies noted in the follow up review conducted during the 2nd Quarters of FY 2026. .

Methods

Program leadership provided client rosters of persons served during the 3rd Qtr. FY 2026 (March 1, 2026-May 31, 2026). A random sample of 20 clients was generated using Excel functions. Employee rosters were also provided by program leadership. All six (6) employees were selected. The review was conducted using an audit tool developed by Compliance.

Findings

Comprehensive/POI Follow-up Review
Overall Score: 99.25%
Summary:
The program achieved an overall score of 99.25%, up from 97.65% in the 2nd Qtr. FY 2026 review. The program exceeded the minimum compliance threshold of 95.00% in the operations (100.00%), Personnel (100.00%), Client Records (97.00%), and Environment (100.00%) components.

During the 2nd Qtr. FY 2026 review, the program received a score of 20.00% for Oral Communication of Rights. Documentation reviewed did not consistently demonstrate that the individual and/or parent, conservator, or guardian received an explanation of client rights, as evidenced by the required date and signatures.

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During the current comprehensive review, the program received a score of 26.00% for Oral Communication of Rights, representing a 6-percentage-point improvement from the previous review. However, the program remains unable to obtain documentation from the Harris Health front-door process, where client rights are communicated to individuals. Therefore, the program has not yet fully met the requirements of the associated Corrective Action Plan.

For a comprehensive review, the Client Records component received an overall score of 97.00%. The AIMS requirement received a score of 75.00%. Trained and competent staff are required to screen applicable individuals quarterly for abnormal involuntary movements using a standardized instrument, such as the Abnormal Involuntary Movement Scale (AIMS). This requirement was not evaluated during the previous follow-up review.

Program leadership indicated that they will collaborate with the Harris Health to identify additional strategies to address the remaining deficiencies.

Strengths:

- **Operations (***Interlocal Agreement)* **100.00%**
- **Personnel** (26 Tex. Admin. Code *§§ 301.331; Interlocal agreement, Agency Mandated Training, 26 Tex. Admin. Code §§ 354.3211)* **100.00%**
- **Environment** (*26 Tex. Admin. Code §§ 301.323 (a)(2)(A)(C)*; *26 Tex. Admin. Code § 320.21(f)* **100.00%**

Areas for Improvement:

- **Client Records** (1 Tex. Admin. Code 26 *Tex. Admin. Code §§ 354.301; Interlocal agreement;* Peer Support Reentry Pilot (MH/PSR) Version 1 Contract; 26 Tex. Admin. Code *320.163 (a)(b)*; *26 Tex. Admin. Code §§ 320.217 (a)(1)-(a)(10), (a)(3) (e)(g))*; *26 Tex. Admin. Code §§ 320.59(a)(b)(2)* ; *26 Tex. Admin. Code § 320.361 (a)(1)-(a14)*; *26 Tex. Admin. Code § 301.361(b)*; *26 Tex. Admin. Code § 301 329(a)(3)(A-C)* and ; *HIM.EHR.B.9.5.I.*; and *ACC.B.8.*) **97.00%**
  - Abnormal Involuntary Movement Scale (AIMS)*l*; *26 Tex. Admin. Code §§ 320.217 (e)* **75.00%**
  - Client Rights (*26 Tex. Admin. Code §§ 320.163 (b)*; and *HIM.EHR.B.5.5.K.1.* and *3.*) **26.00%**

Observations

- The contract requires that the program assign a Client Assistant and Registration (CARE) identification number to connect individuals with their prior involvement with the public behavioral health system. This will include those who have been formally diagnosed or otherwise identified. The program utilizes Clinical Management for Behavioral Health Service (CMBHS),

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History

Compliance previously conducted a comprehensive/follow-up review of the Forensic Peer Support and Reentry Program during the 2nd Qtr. FY 2026. The previous review identified deficiencies related to Client Records and Oral Communication of Rights. Oral Communication of Rights received a score of 20.00%. During the current review, Oral Communication of Rights increased to 26.00%; however, additional improvement is required to achieve compliance with the established standard.

Recommendations

The program should continue to monitor client documentation for compliance with applicable regulatory, contractual, and agency requirements. Program leadership should continue implementing previously established Plans of Improvement (POIs), with increased monitoring of documentation related to Oral Communication of Rights and AIMS screenings.

Program leadership should collaborate with the Harris Health and Performance Improvement (PI), as appropriate, to develop and implement additional strategies to address the deficiencies identified during this review. Corrective strategies should include clearly defined responsibilities, monitoring processes, and documentation requirements to demonstrate sustained compliance. Compliance will conduct a follow-up review in 90 to 180 days to determine if the program is implementing its POI.

The Vice President of the Forensic Division and the Forensic Program Directors must sign and return this report to Compliance within seven (7) calendar days of receipt by September 24, 2026.

Management Response

The finding stated above regarding documenting oral communication of patient's rights is a responsibility of Harris Health, it is not a responsibility of The Harris Center; therefore, no plan of improvement will be executed. We will relay the findings to Harris Health for them to look into.

Regarding AIMS, there was one patient identified that exceeded the time limit for readmission of AIMS, but the patient had gone ATW at the time of the finding; therefore, an AIMS could not be completed. The program will continue to monitor procedures for the administration of the AIMS to ensure the quarterly guideline is followed.

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Signature Page

Signed by:
X Emmanuel Golakai
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Emmanuel Golakai, Senior Regulatory Compliance Auditor

Signed by:
X Amber Trevino
FD0FC6E0F1314DA...
Amber Trevino, Practice Manager V, Patient Processing and Planning Unit

Signed by:
X Tonya Smith
36A14462BE68432...
Tonya Smith, Program Director VI, Forensics Clinical Services

Signed by:
X Krystin Holmes
E71E92FBDDAD4AD...
Krystin Holmes, Senior Director of Adult Forensic Services

Signed by:
X Sean McElroy
04000CAE652F434...
Sean McElroy, Div VP-Forensic Services

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Coffeehouse Comprehensive Review
Review Dates: July 15, 2026-July 23, 2026

I. Audit Type:
Comprehensive Review

II. Purpose:
This review was conducted to determine if the Coffeehouse program was compliant with the Texas Administrative Code (Tex. Admin. Code Rights Handbooks and Rights Protection Officer 26 Tex. Admin. Code § 320.21) (f); Determination of Ability to Pay 26 Tex. Admin. Code § 301.509 (a)(1)(2); Maintaining documented personnel information HR.B4, HR.A.6; Criminal Background Checks Health and Human Services Commission (HHSC) Grant Agreement; Licensure, Certification and Registration HR.B.14; Agency Mandated Training/HR.B.35; Re-Credentialing Guideline & Procedure.5. Procedure: Competency of All Staff and Volunteers; The Determination of Intellectual Disability Report 26 Tex. Admin. Code § 304.402; Access, Intake, and Enrollment Related Responsibilities 26 Tex. Admin. Code § 330.9 (e) (2); Plan of Care ACC.B.2; Service Definition Manual and Interlocal Agreement Contract.

III. Audit Method:
A client roster for individuals served during the second (3rd) quarter of FY 2026 (March 1, 2026 – May 31, 2026) was provided by program leadership for review. Twenty (20) active records were randomly selected for this review. The program leadership provided a list of seven (7) employees assigned to the program during this review period. All seven (7) employees were reviewed. The review was conducted using an audit tool developed by the Compliance department.
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IV. Audit Findings and History:
The Coffeehouse program demonstrated strong overall performance, achieving an **overall compliance score of 96.80%**. The review reflected effective operational practices and high adherence to environmental, medical, operations, and clinical standards. While compliance was strong across most domains, deficiencies were identified that necessitate corrective action, primarily within the **Personnel Records** category. The Personnel Records review identified multiple compliance deficiencies related to required documentation and agency-mandated staff training. Specifically, several staff files lacked evidence of completion of the required training courses. These deficiencies directly contributed to the reduced compliance score in this category and indicate a need for strengthened internal monitoring and documentation processes. The operational walk-through revealed a deficiency in maintaining the fire drill log, which contributed to a lower compliance score and highlighted the need for improved internal monitoring. The progress notes contained a statement indicating that progress was observed, with staff marking “yes.” However, the narrative lacks specific details on how progress was achieved. This issue was raised with the program manager during the review, and the manager acknowledged it and expressed her intention to train staff in effective progress note writing. The Coffeehouse program underwent an audit by Compliance in Fiscal Year 2024, covering the period from September 1, 2023, to October 31, 2023. Identified deficiencies included the use of a generic documentation template, an incorrect note format, and the absence of a current plan of care. These issues have since been addressed, resulting in no additional findings in these areas. Furthermore, the program was audited by the Health and Human Services Commission (HHSC) through Service Coordination from January 26 to January 29, 2026, and no findings were reported.

V. Recommendations
It is recommended that the Coffeehouse program strengthen compliance oversight by implementing standardized processes to ensure personnel records and operational reviews are complete and current, and to track all agency-mandated trainings. The program should conduct periodic internal reviews of staff training to sustain regulatory compliance and reduce the risk of recurrence.
A Plan of Improvement (POI) is required to address the deficiencies identified in this report. Compliance will also refer the program to Performance Improvement (PI) for assistance with its POI development and implementation. Compliance will assess the program’s progress toward completion of the POI within 90 days. The Vice President of the IDD Division, the Director of IDD Services, and the Program Manager must sign and return both this report and the completed POI to the Compliance department within seven (7) business days.

VI. Corrective Actions:
Compliance provided the program with a Plan of Improvement (POI) to be completed in collaboration with PI.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Intellectual and Developmental Disabilities (IDD) Division
Coffeehouse Comprehensive Review

Compliance Auditor(s): Emmanuel Golakai

Review Dates: July 15, 2026-July 23, 2026

Purpose

This review was conducted to determine if the Coffeehouse program was compliant with the Texas Administrative Code (*Tex. Admin. Code* Rights Handbooks and Rights Protection Officer *26 Tex. Admin. Code § 320.21) (f);* Determination of Ability to Pay *26 Tex. Admin. Code § 301.509 (a)(1)(2); Maintaining documented personnel information HR.B4, HR.A.6; Criminal Background Checks Health and Human Services Commission (HHSC) Grant Agreement*; Licensure, Certification and Registration HR.B.14; Agency Mandated Training/*HR.B.35; Re-Credentialing Guideline & Procedure.5. Procedure: Competency of All Staff and Volunteers; The Determination of Intellectual Disability Report 26 Tex. Admin. Code § 304.402; Access, Intake, and Enrollment Related Responsibilities 26 Tex. Admin. Code § 330.9 (e) (2); Plan of Care ACC.B.2; Service Definition Manual and Interlocal Agreement Contract.*

Methods

A client roster for individuals served during the second (3rd) quarter of FY 2026 (March 1, 2026 – May 31, 2026) was provided by program leadership for review. Twenty (20) active records were randomly selected for this review. The program leadership provided a list of seven (7) employees assigned to the program during this review period. All seven (7) employees were reviewed. The review was conducted using an audit tool developed by the Compliance department.

Findings

The Coffeehouse program demonstrated strong overall performance, achieving an **overall compliance score of 96.80%**. The review reflected effective operational practices and high adherence to environmental, medical, operations, and clinical standards. While compliance was strong across most domains, deficiencies were identified that necessitate corrective action, primarily within the **Personnel Records** category.

Detailed findings contributing to these scores are summarized below

Personnel Record Findings – 88.00%

The Personnel Records review identified multiple compliance deficiencies related to required documentation and agency-mandated staff training. Specifically, several staff files lacked evidence of completion of the required training courses. These deficiencies directly contributed to the reduced compliance score in this category and indicate a need for strengthened internal monitoring and documentation processes.

- Completion of agency-mandated training courses, including but not limited to:

- Basic Pharmacology *HR.B.35)*
- Code of Conduct and Ethics *(HR.B.35)*
- Cybersecurity Awareness Training *(HR.B.35)*
- Handle with Care (II) (MED.MH.B.1.5)
- Office Safety (Agency Mandated)
- OSHA - Emergency and Fire Preparedness (Agency Mandated training);
- Protecting Individual Rights: Understanding and Preventing Abuse (HR.B.35.5)
- AS+K Gatekeeper Training (formerly Safe Talk) (Agency Mandated training)
- Safety in Practice: Suicide & Homicide Prevention (Agency Mandated training)
- Seizure Assessment (HR.B.35)
- Understanding CLAS, Cultural Competency, and Cultural Humility (R.B.35.5)
- Understanding the Harris Center's Mission, Vision, and Beyond (Agency Mandated training)

Observation

- The progress notes contained a statement indicating that progress was observed, with staff marking "yes." However, the narrative lacks specific details on how progress was achieved. This issue was raised with the program manager during the review, and the manager acknowledged it and expressed her intention to train staff in effective progress note writing.

- The operational walk-through revealed a significant gap in maintaining the fire drill log, negatively impacting the compliance score and highlighting the need for improved internal monitoring.

History

The Coffeehouse program underwent an audit by Compliance in Fiscal Year 2024, covering the period from September 1, 2023, to October 31, 2023. Identified deficiencies included the use of a generic documentation template, an incorrect note format, and the absence of a current plan of care. These issues have since been addressed, resulting in no additional findings in these areas. Furthermore, the program was audited by the Health and Human Services Commission (HHSC) through Service Coordination from January 26, 2026, to January 29, 2026, and no findings were reported.

Recommendations

It is recommended that the Coffeehouse program strengthen compliance oversight by implementing standardized processes to ensure personnel records and operational reviews are complete and current, and to track all agency-mandated trainings. The program should conduct periodic internal reviews of staff training to sustain regulatory compliance and reduce the risk of recurrence.
A Plan of Improvement (POI) is required to address the deficiencies identified in this report. Compliance will also refer the program to Performance Improvement (PI) for assistance with its POI development and

implementation. Compliance will assess the program's progress toward completion of the POI within 90 days. The Vice President of the IDD Division, the Director of IDD services, and the Program Manager are required to sign and return both this report and the completed POI to the Compliance department within seven (7) business days of August 14, 2026.

Management Response

Please type Management Response here:

The following is our rebuttal to the findings of this Comprehensive Review:
1. Completion of Agency mandated training courses: Seizure Assessment and Basic Pharmacology trainings are to be located in the agency's online training platform "Absorb". For the personnel identified in this audit, these trainings are not available. As a result, the personnel cannot complete these trainings until HR provides assistance. HR is aware of this issue as multiple requests have been made for them to assist.
2. Fire Drill Log: The Coffeehouse program does not maintain the fire drill log. This is assigned to Risk Management.

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Signature Page

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Emmanuel Golakai, Senior Regulatory Compliance Auditor

X DocuSigned by: Margaret Strobel
EE16382AE2D84E8...
Margaret Strobel, Program Manager-Coffeehouse and Espresso

X Signed by: Amanda Willis
EE4666660A934C7...
Amanda Willis, Director- IDD Clinical Services

X DocuSigned by: Evanthe Collins
7E1995073D35406...
Evanthe Collins, Vice President-IDD Services

X Signed by: Demetria Luckett
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Demetria Luckett, Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Preadmission Screening and Resident Review (PASRR) Comprehensive Review
Review Dates: August 3, 2026-August 22, 2026

I. Audit Type:
Comprehensive Review

II. Purpose:
This review was conducted to determine if the Preadmission Screening and Resident Review (PASRR) program was compliant with the Texas Administrative Code (Tex. Admin. Code), PASRR Screening and Evaluation Process 26 Tex. Admin. Code § 303.204; Habilitation Coordination for a Designated Resident §26 Tex. Admin. Code § 303.601; Service Planning Team Responsibilities Related to specialized Services 26 Tex. Admin. Code §303.602; Habilitation Coordination for a Designated Resident Receiving Individualized Habilitation Specialized Services (IHSS) 26 Tex. Admin. Code § 303.603); Description of Mental Impairment (MI) Specialized Services 26 Tex. Admin. Code §303.901; Process for Service Initiation 26 Tex. Admin. Code §303.905; Persson-Center Recovery Plan 26 Tex. Admin. Code §303.906; Renewal and Revision of Person-Centered Recovery Plan (PCRP) 26 Tex. Admin. Code §303.907; Refusal of the Uniform Assessment or MI Specialized Services 26 Tex. Admin. Code §303.909; Suspension and Termination of MI Specialized Services 26 Tex. Admin. Code §303.910; Mental Impairment (MI) Specialized 26 Tex. Admin. Code §303.912; Agency Mandated Training/HR.B.35; 301.331(a)(3)(C)(viii), HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure. 5. Procedure: Competency of All Staff and Volunteers: Critical competencies, Infection Control Policy and Procedures; Operations Review 42 U.S.C., 26 Tex. Admin. Code 301.323 (a)(3); Medical 29 CFR §1910.151(b); ANSI/IZEA Z308.1-2021; Environment 26 Tex. Admin. Code §301.323 (a), 29 C.F.R. §1903.2 (a)(1) .

III. Audit Method:
A client roster for individuals served during the third (3rd) quarter of FY 2026 (March 1, 2026 – May 31, 2026) was provided by program leadership for review. Fifteen (15) active records were randomly selected for this review. The program leadership provided a list of thirteen (13) employees assigned to the program during this review period. All thirteen (13) employees were reviewed. The review was conducted using an audit tool developed by the Compliance department.

IV. Audit Findings and History:
The PASRR program demonstrated strong performance, achieving an **overall compliance score of 98.70%**. The review reflected effective operational practices and high adherence to clinical, medical, and environmental standards. While compliance was strong across most domains, deficiencies were identified that necessitate corrective action, primarily within the **Personnel Records** category. **The Personnel Records (94.00%)** review identified multiple compliance deficiencies related to required documentation, pre-employment alcohol and drug screening completed prior to service delivery, and agency-mandated staff training. Specifically, several staff files lacked evidence of completion of the training courses required and of meeting other personnel requirements. These deficiencies directly contributed to the reduced compliance score in this category and indicate a need for strengthened internal monitoring and documentation processes. **The operations review (95.45%)** demonstrated a high level of compliance, with only minor deficiencies in maintaining the Fire Drill Log. While limited in scope, these findings resulted in a slight reduction from a perfect score.

V. Recommendations
It is recommended that the PASRR program strengthen compliance oversight by implementing standardized processes to ensure personnel records are complete and current, including verification of required pre-employment documentation and the completion and tracking of all agency-mandated training. Additionally, while clinical, medical, and environmental compliance is strong, the program should reinforce requirements to maintain fire drill logs and ensure that logs are kept for each internal review to sustain regulatory compliance and reduce the risk of recurrence.
A Plan of Improvement (POI) is required to address the deficiencies identified in this report. Compliance will also refer the program to Performance Improvement (PI) for assistance with its POI development and implementation. Compliance will assess the program's progress toward completion of the POI within 90 days. The Vice President of the IDD Division and the Senior Program Director are required to sign and return both this report and the completed POI to the Compliance department within seven (7) business days.

VI. Corrective Actions:
Compliance provided the program with a Plan of Improvement (POI) to be completed in collaboration with PI.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Intellectual and Developmental Disability (IDD) Division
Preadmission Screening and Resident Review (PASRR) Comprehensive Review

Compliance Auditor(s): Emmanuel Golakai

Review Dates: August 3, 2026-August 22, 2026

Purpose

This review was conducted to determine if the Preadmission Screening and Resident Review (PASRR) program was compliant with the Texas Administrative Code (*Tex. Admin. Code*) PASRR Screening and Evaluation Process *26 Tex. Admin. Code § 303.204;* Habilitation Coordination for a Designated Resident *§26 Tex. Admin. Code § 303.601; Service Planning Team Responsibilities Related to specialized Services 26 Tex. Admin. Code §303.602; Habilitation Coordination for a Designated Resident Receiving Individualized Habilitation Specialized Services (IHSS) 26 Tex. Admin. Code § 303.603); Description of Mental Impairment (MI) Specialized Services 26 Tex. Admin. Code §303.901; Process for Service Initiation 26 Tex. Admin. Code §303.905; Persson-Center Recovery Plan 26 Tex. Admin. Code §303.906; Renewal and Revision of Person-Centered Recovery Plan (PCRP) 26 Tex. Admin. Code §303.907; Refusal of the Uniform Assessment or MI Specialized Services 26 Tex. Admin. Code §303.909; Suspension and Termination of MI Specialized Services 26 Tex. Admin. Code §303.910; Mental Impairment (MI) Specialized 26 Tex. Admin. Code §303.912*; Agency Mandated Training/*HR.B.35; 301.331(a)(3)(C)(viii), HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure. 5. Procedure: Competency of All Staff and Volunteers: Critical competencies, Infection Control Policy and Procedures; Operations Review 42 U.S.C., 26 Tex. Admin. Code 301.323 (a)(3); Medical 29 CFR §1910.151(b); ANSI/IZEA Z308.1-2021; Environment 26 Tex. Admin. Code §301.323 (a), 29 C.F.R. §1903.2 (a)(1) .*

Methods

A client roster for individuals served during the third (3rd) quarter of FY 2026 (March 1, 2026 – May 31, 2026) was provided by program leadership for review. Fifteen (15) active records were randomly selected for this review. The program leadership provided a list of thirteen (13) employees assigned to the program during this review period. All thirteen (13) employees were reviewed. The review was conducted using an audit tool developed by the Compliance department.

Findings

The PASRR program demonstrated strong overall performance, achieving an **overall compliance score of 97.72%**. The review reflected effective operational practices and high adherence to clinical standards. While compliance was strong across most domains, deficiencies were identified that necessitate corrective action, primarily within the **Personnel Records** category.

Detailed findings contributing to these scores are summarized below

Personnel Record Findings – 94.00%

The Personnel Records review identified multiple compliance deficiencies related to required documentation and agency-mandated staff training. Specifically, several staff files lacked evidence of completion of the training courses required and of meeting other personnel requirements. These deficiencies directly contributed to the reduced compliance score in this category and indicate a need for strengthened internal monitoring and documentation processes.

Key findings include missing or incomplete documentation for the following requirements:

- Pre-employment alcohol and drug screening completed prior to service delivery *(Agency policy and Procedures HR.B.33)*
- Completion of agency-mandated training courses, including but not limited to:
  - Handle With Care *(MED.MH. B.1.5)*
  - First Aid (*Agency Mandated Training)*
  - CPR or Basic Life Support (Agency Mandated Training; HR.B.35.5*)*
  - OSHA Emergency and Fire Preparedness (Agency Mandated Training)
  - AS+K Gatekeeper Training (formerly Safe Talk)

Operations Findings – 95.45%

The Operations review demonstrated a high level of compliance. However, a Minor deficiency was identified related to the maintenance of the Fire Drill Log. While isolated and limited in scope, this finding contributed to a slight reduction from a perfect score.

Identified issues included:

- The fire drill log was not found on the floor to review. Compliance contacted Risk Management for assistance, but the fire drill log was not available at the conclusion of the review. *(26 Tex. Admin. Code §301.323(a)(3)*

Observations

- Some employees had not completed the annual policy procedure acknowledgments.
- None of the residents reviewed required a transition plan or pre-move and post-move.

History

The PASRR program underwent an audit by the Health and Human Services Commission (HHSC) from January 26, 2026, through January 29, 2026. Findings indicated a lack of face-to-face contact with the designated residents, insufficient resident participation in planning, and an issue with the Service Planning Team (SPT) not including all required members and participants. Additionally, there were concerns regarding the development and revision of the Habilitation Service Plan (HSP). It is essential to conduct and document a

pre-move site review of the proposed community residence. This review should ensure that all necessary supports outlined in the transition plan are in place and that any barriers identified by the SPT are resolved before the residents' transition to the community. Post-transition monitoring activities are required, and at least annually, the status of the letters of guardianship should be verified. If appropriate, a referral for guardianship should be made. An HHSC-required Corrective Action Plan (CAP) has been submitted by the program. HHSC is scheduled to return in January 2027 to follow up on the CAP.

Recommendations

It is recommended that the PASRR program strengthen compliance oversight by implementing standardized processes to ensure personnel records are complete and current, including verification of required pre-employment documentation and the completion and tracking of all agency-mandated training. Additionally, while clinical, medical, and environmental compliance is strong, the program should reinforce requirements to maintain fire drill logs and ensure that logs are kept for each internal review to sustain regulatory compliance and reduce the risk of recurrence.

A Plan of Improvement (POI) is required to address the deficiencies identified in this report. Compliance will also refer the program to Performance Improvement (PI) for assistance with its POI development and implementation. Compliance will assess the program's progress toward completion of the POI within 90 days. The Vice President of the IDD Division and the Senior Program Director are required to sign and return both this report and the completed POI to the Compliance department within seven (7) business days of September 22, 2026.

Management Response

Please Type Management Response here:

I am pleased to have achieved an overall audit score of 97.72%. We will review the audit findings and will ensure that the identified opportunities for improvement are addressed appropriately. The team will continue to focus on strengthening our processes and maintaining consistency to achieve even better results in future comprehensive review.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Signed by: Emmanuel Golakai 3AC7A46D9D6C439...

Emmanuel Golakai, Senior Regulatory Compliance Auditor

X Signed by: Katrina Ware 8C88B9BE5784487...

Katrina Ware, Program Director for PASRR/COS/ECC

X Signed by: annie Cuba 7776DEB613784B3...

Anne Cuba, Director of Authority Services

X DocuSigned by: Evanthe Collins 7E1995073D25406...

Evanthe Collins, Vice President IDD Services

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Early Childhood Intervention (ECI)
Review Dates: July 14, 2026-August 3, 2026

I. Audit Type:
Follow-up Review

II. Purpose:
The purpose of this review was to determine if the ECI Program was compliant with the Texas Administrative Code (Tex. Admin. Code), the Texas Labor Code, the Texas Health and Safety Code, the Texas Government Code (Tex. Gov't Code), the United States Code (U.S.C.), the Code of Federal Regulations (C.F.R.), the Texas Health and Human Services Commission's (HHSC) Performance Contract Notebook (PCN) FY 26-27, HHSC's Making It Work Supervisor Guidelines, and Harris Center policies and procedures; and if the program had successfully implemented processes to rectify the deficiencies noted in the comprehensive review conducted during the 4th Quarter of FY 2025. An annual Operational Review was also conducted as part of the comprehensive review.

III. Audit Method:
Program leadership provided a client roster of persons served between February 1, 2026, and April 30, 2026). A random sample of 40 clients (approximately 10% of the caseload of 20% of the child development specialists) was generated using Excel functions. An employee roster was also provided by program leadership. A random sample of approximately 20% of ECI employees (total of 19 employees) was selected using Excel functions. An appropriate review tool was developed by Compliance.

IV. Audit Findings/History:
The program provided sufficient evidence to document execution of the corrective actions implemented in response to the FY 2025 comprehensive review. Additionally, the program demonstrated robust improvements in the reviewed elements—with all audit areas exhibiting significant increases in compliance rates and several surpassing the threshold score; however, some areas did not exceed the threshold score. These scores indicate the program implemented effective corrective actions in most areas; however, despite the marked improvement in compliance rates, additional measures are required to ensure acceptable performance in those areas that did not surpass the threshold score.

V. Recommendations:
The program should focus on documenting service coordinator changes, and informing parents of the Local Education Agency (LEA) Notification requirements and the LEA Opt Out option in accordance with the Texas Administrative Code. Additionally, the program should continue to monitor employee documentation and training course completion to maintain the high standards established during this review.

VI. Corrective Actions:
Program leadership should consult with Performance Improvement (PI) to develop additional corrective actions to resolve ongoing deficiencies. Compliance will conduct a follow-up review in 90-180 days.

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The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Intellectual and Developmental Disabilities (IDD) Division Early Childhood Intervention (ECI)
Plan of Improvement (POI) Follow-up Review

Compliance Auditor(s): Christopher Beard

Review Dates: July 14, 2026-August 3, 2026

Purpose

The purpose of this review was to determine if the ECI Program was compliant with the Texas Administrative Code (Tex. Admin. Code), the Texas Labor Code, the Texas Health and Safety Code, the Texas Government Code (Tex. Gov't Code), the United States Code (U.S.C.), the Code of Federal Regulations (C.F.R.), the Texas Health and Human Services Commission's (HHSC) Performance Contract Notebook (PCN) FY 26-27, HHSC's Making It Work Supervisor Guidelines, and Harris Center policies and procedures; and if the program had successfully implemented processes to rectify the deficiencies noted in the comprehensive review conducted during the 4th Quarter of FY 2025. An annual Operational Review was also conducted as part of the follow-up review.

Methods

Program leadership provided a client roster of persons served between February 1, 2026, and April 30, 2026. A random sample of 40 clients (approximately 10% of the caseload of 20% of the child development specialists) was generated using Excel functions. An employee roster was also provided by program leadership. A random sample of approximately 20% of ECI employees (total of 19 employees) was selected using Excel functions. An appropriate review tool was developed by Compliance.

Findings

The program provided sufficient evidence to document execution of the corrective actions implemented in response to the FY 2025 comprehensive review. Additionally, the program demonstrated robust improvements in the reviewed elements—with all audit areas exhibiting significant increases in compliance rates and several surpassing the threshold score; however, some areas did not exceed the threshold score. These scores indicate the program implemented effective corrective actions in most areas; however, despite the marked improvement in compliance rates, additional measures are required to ensure acceptable performance in those areas that did not surpass the threshold score.

Detailed findings are presented below:

Follow-up Audit Element(s)	Previous Score (4th Qtr. FY 2025)	Current Score (4th Qtr. FY 2026)
Operations		
Procedural Safeguards and Due Process Procedures (*26 Tex. Admin. Code § 350.207 (c)(1-2)*)	83.33%	100.00%
Public Outreach (*26 Tex. Admin. Code §§ 350.609 (c)-(d)*; *26 Tex. Admin Code §§ 350.611 (a)-(b)*; and *§§ 350.617 (b), (d),* and *(e)*)	8.33%	100.00%
Eligibility, Evaluation, and Assessment (*26 Tex. Admin. Code §§ 350.835 (1-4)*)	66.67%	100.00%
Service Delivery (*26 Tex. Admin. Code §§ 350.1108 (c)* and *(c)(5)*)	0.00%	100.00%
Family Cost Share System (*26 Tex. Admin. Code § 350.1429 (d)*; *26 Tex. Admin. Code § 350.1435 (f)*; and *26 Tex. Admin. Code § 350.1437 (a)*)	0.00%	100.00%

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Personnel		
Staff Qualifications (*PCN FY 26-27*; *Making It Work Supervisor Guidelines*; and *26 Tex. Admin. Code § 350.309 (g)*)	47.00%	100.00%
Agency-mandated Training Courses (*26 Tex. Admin. Code 301.331(a)(3)(A)(v), (viii), (x)*, and *(B)(iii)* and *(v)*; *26 Tex. Admin. Code § 350.235 (c)*; *26 Tex. Admin. Code § 350.309 (c)(2)*; *HR.B.35*; and *MED.MH.B.1*)	78.86%	98.57%
Client Records		
Procedural Safeguard and Due Process Procedures (*26 Tex. Admin. Code §§ 350.203 (a)(3) and (c)(2-3)*; and *26 Tex. Admin. Code §§ 350.708 (a)(2)(B-C)*)	99.01%	100.00%
Case Management for Infants and Toddlers with Developmental Disabilities (*26 Tex. Admin. Code §§ 350.415 (a)(3), (b)(3), (b)(5), (b)(8)*, and *(b)(9)*)	83.33%	100.00%
Eligibility, Evaluation, and Assessment (*26 Tex. Admin. Code § 350.813 (c)(2)*; *26 Tex. Admin. Code § 350.815 (c)(2)*; *26 Tex. Admin. Code §§ 350.817 (a)(2)*; *26 Tex. Admin. Code § 350.825 (a)-(b)(1)*; *26 Tex. Admin. Code § 350.831*; *26 Tex. Admin. Code §§ 350.833 (c)-(d)*; and *26 Tex Admin. Code §§ 350.837 (a)-(c)*)	80.90%	99.07%
Individualized Family Service Plan (IFSP) (*26 Tex. Admin. Code §§ 350.1015 (k)*)	85.92%	89.31%
Service Delivery (*26 Tex. Admin. Code §§ 350.1104 (e)*; and *26 Tex. Admin. Code §§ 350.1111 (6)(B), (6)(C), (8)*, and *(11)*)	84.65%	98.68%
Transition (*26 Tex. Admin. Code § 350.1205 (b)(4)*)	67.11%	86.51%
Family Cost Share System (*26 Tex. Admin. Code § 350.1431 (a)*)	75.00%	100.00%

Observations

Some employees were not current on annual policy acknowledgements and did not complete training courses during the month the courses were due.

History

Compliance previously completed a comprehensive review of the ECI Program during the 4th Qtr. FY 2025.

Recommendations

The program should focus on documenting service coordinator changes, and informing parents of the Local Education Agency (LEA) Notification requirements and the LEA Opt Out option in accordance with the Texas Administrative Code. Additionally, the program should continue to monitor employee documentation and training course completion to maintain the high standards established during this review. Program leadership should complete the provided POI in collaboration with Performance Improvement (PI) to develop additional protocols to address those items that did not meet the threshold score. The Vice President of the IDD Division and the ECI Program Director are required to sign and return this report to Compliance within seven (7) business days (Monday, August 17, 2026).

Management Response

The ECI Program appreciates the Compliance Department's review and feedback. We are pleased that the corrective actions implemented following the FY 2025 comprehensive review resulted in significant improvements across all audited areas. Program leadership acknowledges the remaining opportunities related to documenting Service Coordinator changes, documenting LEA notification requirements and opt-out discussions, and monitoring employee training compliance. We will continue to strengthen oversight, reinforce documentation requirements with staff, and implement additional monitoring strategies through our Plan of Improvement to ensure sustained compliance and continuous quality improvement.

The HARRIS CENTER for Mental Health and IDD

Signature Page

Signed by:
X Christopher Beard
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Christopher Beard, Regulatory Compliance Auditor

Signed by:
X Kenyonika Johnson
EFD2946507C24C4...
Kenyonika Johnson, Director-ECI

DocuSigned by:
X Evanthe Collins
7E1995073D35406...
Evanthe Collins, Div VP-IDD Services

Signed by:
X Demetria Luckett
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Demetria Luckett, Director-Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Outreach, Screening, Referral, and Assessment (OSAR)
Review Dates: June 11, 2026-July 16, 2026

I. Audit Type:
Follow-up Review

II. Purpose:
The purpose of this review was to determine if the subcontracted OSAR provider (i.e., The Council on Recovery) successfully implemented corrective actions in response to the 1st Qtr. FY 2026 comprehensive audit conducted by the Harris Center Compliance Department. This audit also reviewed the program's compliance with the Texas Administrative Code; the Health and Human Services Commission's (HHSC) Grant Agreement No. HHS001644600013 Attachment A Statement of Grant (SOG); the Harris Center policies and procedures, and The Council on Recovery Policy & Procedure Manual Outreach, Screening, Assessment, and Referral (OSAR) (revised February 13, 2026).

III. Audit Method:
Program leadership provided a roster of persons served between May 1, 2026, and May 26, 2026, as well as a current staff roster. All persons served (total of 100) and all staff members (total of two) were included in the review. An appropriate audit tool was developed by Compliance.

IV. Audit Findings/History:
The program demonstrated significant improvements in the reviewed elements—with the personnel component surpassing the threshold score, three of seven elements in the clinical record component surpassing the threshold score, two clinical record elements nearing the threshold score, and two clinical record elements exhibiting significant improvement. These scores indicate the program implemented effective corrective actions in all areas; however, additional measures are required to ensure acceptable performance in those areas that did not surpass the threshold score.

V. Recommendations:
The program should continue to closely monitor the provision of OSAR services by the subcontracted agency to ensure compliance with regulatory standards and provide periodic guidance to the subcontractor based on self-monitoring results.

VI. Corrective Actions:
Program leadership has consulted with Performance Improvement (PI) to develop additional corrective actions, such as electronically tracking program-related information, to resolve ongoing deficiencies. Compliance will conduct a follow-up review in 90-180 days.

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The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Mental Health Division
Outreach, Screening, Referral, and Assessment (OSAR) Performance Improvement (PI) Follow-up Review

Compliance Auditor(s): Christopher Beard

Review Dates: June 11, 2026-July 16, 2026

Purpose

The purpose of this review was to determine if the subcontracted OSAR provider (i.e., The Council on Recovery) successfully implemented corrective actions in response to the 1st Qtr. FY 2026 comprehensive audit conducted by the Harris Center Compliance Department. This audit also reviewed the program's compliance with the Texas Administrative Code (Tex. Admin. Code) *26 Tex. Admin. Code Competency and Credentialing § 301.331*; *26 Tex. Admin. Code Supervision § 301.363*; and *26 Tex. Admin. Code Staff Training in Rights of Individuals Receiving Mental Health Services § 320.29*; the *Health and Human Services Commission's (HHSC) Grant Agreement No. HHS001644600013 Attachment A Statement of Grant (SOG)*; the Harris Center policies and procedures *HR.B.35 Credentialing, Re-Credentialing Guideline & Procedure* and *MED.MH.B.1 Suicide/Violence Behavioral Crisis Intervention*, and *The Council on Recovery Policy & Procedure Manual Outreach, Screening, Assessment, and Referral (OSAR)* (revised February 13, 2026).

Methods

Program leadership provided a roster of persons served between May 1, 2026, and May 26, 2026, as well as a current staff roster. All persons served (total of 100), and all staff members (total of two) were included in the review. An appropriate audit tool was developed by Compliance.

Findings

Follow-up Review

Summary: The program demonstrated significant improvements in the reviewed elements—with the personnel component surpassing the threshold score, three of seven elements in the clinical records component surpassing the threshold score, two elements nearing the threshold score, and two elements exhibiting significant improvement. These scores indicate the program implemented effective corrective actions in all areas; however, additional measures are required to ensure acceptable performance in those areas that did not surpass the threshold score.
Detailed findings are presented below:

Follow-up Audit Element(s)	Previous Score (1st Qtr. FY 2026)	Current Score (4th Qtr. FY 2026)
Clinical supervision must be accomplished by an LPHA or a QMHP-CS as follows: (1) by conducting a documented meeting with the staff member being supervised at least monthly (*§ 301.363 (a)(1)*)	66.67%	100.00%
Agency-mandated training courses	85.27%	100.00%
Specific overdose prevention activities shall be conducted with clients with opioid use disorders and those clients using drugs intravenously (*HHSC SOG (8/2025) IV.B.21.b.i.*)	60.00%	93.33%
If a screening is conducted via telehealth, Grantee shall arrange to obtain required signatures for all related consents and documents through digital or hardcopy within three (3) business days. (*HHSC SOG (8/2025) IV.B.9*)	92.86%	100.00%
An initial follow-up is to be done within two (2) business days after the screening interview. (*The Council on Recovery Policy & Procedure Manual Outreach, Screening, Assessment, and Referral (OSAR) Revised February 13, 2026, Post Screening Client, Services A.4.*)	39.62%	96.84%

During the initial follow-up, the counselor documented if the client used any mind-altering substances since the screening (*The Council on Recovery Policy & Procedure Manual Outreach, Screening, Assessment, and Referral (OSAR) Revised February 13, 2026, Post Screening Client, Services A.4.*)	0.00%	85.37%
At least 3 documented attempts within 15 calendar days, and with each attempt at least one day apart, should be made to contact the client and/or authorized contact unsuccessfully before the file can be closed completely due to no contact. (*The Council on Recovery Policy & Procedure Manual Outreach, Screening, Assessment, and Referral (OSAR) Revised February 13, 2026, Post Screening Client Service A.6.*)	12.50%	100.00%
The counselor will document client's abstinence or level of use at case closure (*The Council on Recovery Policy & Procedure Manual Outreach, Screening, Assessment, and Referral (OSAR) Revised February 13, 2026, Post Screening Client Services, A.8.b.*)	8.11%	83.64%
When completing the case closure note, the counselor will document whether client has engaged in any support or recovery group/meetings (*The Council on Recovery Policy & Procedure Manual Outreach, Screening, Assessment, and Referral (OSAR) Revised February 13, 2026, Post Screening Client Services, A.8.c.*)	11.11%	94.55%

Observations

The Harris Center policy and procedure *MAN.1 Outreach Screening Assessment Referral (OSAR) Policy & Procedure Manual* has not been updated to reflect the changes The Council on Recovery made to their OSAR Manual in February 2026.

History

Compliance previously completed comprehensive reviews of the OSAR Program during the 4th Qtr. FY 2021, the 2nd Qtr. FY 2025, and the 1st Qtr. FY 2026.

Recommendations

The program should continue to closely monitor the provision of OSAR services by the subcontracted agency to ensure compliance with regulatory standards and provide periodic guidance to the subcontractor based on self-monitoring results. Program leadership should update MAN.1 as soon as possible and consult with Performance Improvement (PI) to develop additional plan of improvement protocols. The Vice President of the MH Division and the OSAR Program Directors are required to sign and return this report to Compliance within seven (7) business days (July 30, 2026).

Management Response

Leadership acknowledges the findings as well as the significant improvement from the prior review. We will continue to work towards compliance in all areas.

The HARRIS CENTER for Mental Health and IDD

Signature Page

Signed by:
X Christopher Beard
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Christopher Beard, Regulatory Compliance Auditor

Signed by:
X Byanca Hernandez
E28847 1F70FC454...
Byanca Hernandez, Program Director III

Signed by:
X Rena Strope
7224670CC91B474...
Rena Strope, Practice Manager IV

Signed by:
X Lance Britt
BAB06A90B5FE4AC...
Lance Britt, Div VP-Behavioral Health Services

Signed by:
X Demetria Luckett
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Demetria Luckett, Director-Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Juvenile Justice (JJ)
Review Dates: July 23, 2026-August 4, 2026

I. Audit Type:
Follow-up Review

II. Purpose:
The purpose of this review was to determine if the JJ Program was compliant with the Texas Administrative Code (Tex. Admin. Code), the Texas Health and Human Services Commission's (HHSC) Performance Contract Notebook (PCN) FY 26-27, and Harris Center policies and procedures.

III. Audit Method:
Program leadership provided a client roster of persons served during the 3rd Qtr. FY 2026 (March 1, 2026-May 31, 2026). The client records of all persons served who received services during the reviewed period (total of 17) were reviewed for this audit. An employee roster was also provided by program leadership. A random sample of approximately 20% of JJ employees (total of 8 employees) was selected using Excel functions. An appropriate review tool was developed by Compliance.

IV. Audit Findings/History:
The JJ program demonstrated robust performance across many areas of the audit—with an overall compliance score of 95.11%. Evidence obtained from this audit indicates the program has instituted effective leadership, supervision, and oversight practices to ensure compliance with regulatory standards. Although compliance was strong, deficiencies were identified that necessitate corrective action within the personnel and client records components.

V. 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 and policy acknowledgements.

VI. Corrective Actions:
Program leadership completed a plan of improvement indicating enactment of the following corrective actions: Compliance will conduct a follow-up review in 90-180 days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Mental Health Division Juvenile Justice (JJ) Program
Comprehensive Review

Compliance Auditor(s): Christopher Beard

Review Dates: July 23, 2026-August 4, 2026

Purpose

The purpose of this review was to determine if the JJ Program was compliant with the Texas Administrative Code (Tex. Admin. Code), the Texas Health and Human Services Commission's (HHSC) Performance Contract Notebook (PCN) FY 26-27, and Harris Center policies and procedures.

Methods

Program leadership provided a client roster of persons served during the 3rd Qtr. FY 2026 (March 1, 2026-May 31, 2026). The client records of all persons served who received services during the review period (total of 17) were reviewed for this audit. An employee roster was also provided by program leadership. A random sample of approximately 20% of JJ employees (total of 8 employees) was selected using Excel functions. An appropriate review tool was developed by Compliance.

Findings

The JJ program demonstrated robust performance across many areas of the audit—with an overall compliance score of 95.52%. Evidence obtained from this audit indicates the program has instituted effective leadership, supervision, and oversight practices to ensure compliance with regulatory standards. Although compliance was strong, deficiencies were identified that necessitate corrective action within the personnel and client records components.
Detailed findings are presented below:

Personnel Finding: 96.49%

The employee records reviewed identified multiple compliance deficiencies related to required staff training. Specifically, several staff files lacked evidence of completion of required training courses. These deficiencies directly contributed to the reduced compliance score in this category and indicate a need for strengthened internal monitoring and documentation processes.

Key findings include missing or incomplete documentation for the following requirements:

- Completion of agency-mandated training courses, including:
  - CANS certification *(26 Tex. Admin. Code § 301.331 (a)(3)(C)(ii)*)
  - Co-occurring Psychiatric and Substance Use Disorders (*26 Tex. Admin. Code § 301.331 (a)(3)(C)(viii)*)
  - Handle with Care (*26 Tex. Admin. Code § 301.331 (a)(3)(B)(iii)*)
  - Illness Management and Recovery
  - OSHA—Emergency and Fire Preparedness

- Safe Care RL
- Seeking Safety

Client Records findings: 94.55%

The clinical records demonstrated compliance with many items; however, deficiencies were noted in several categories, which contributed to a score below the acceptable threshold. The deficiencies noted during this review indicate a need for strengthened internal monitoring and documentation processes.

Key findings include missing or incomplete documentation for the following requirements:

- Client Rights (*26 Tex. Admin. Code § 320.21 (e)*; *26 Tex. Admin. Code §§ 320.25 (a)* and *(b)*; and *HIM.EHR.B.5.*)
- Medication Training and Support Services (*26 Tex. Admin. Code § 306.315 (c)*)
- Recovery Plan (*CAS Program Manual*; *26 Tex. Admin. Code § 301.353 (e)*, *(e)(1)(A-C)*, *(e)(3)*, *(e)(2)(D)*, and *(e)(1)(H)(ii)*)
- Documentation of Services (*26 Tex. Admin. Code §§ 301.361 (a)(12)* and *(b)*)
- Routine and Intensive Case Management Documentation (*26 Tex. Admin. Code § 306.275 (c)(4)*)
- Discharge Summary (*26 Tex. Admin. Code § 301.353 (h)(2)*; and *ACC.B.8.*)

Observations

Many clients with medication training and support, case management, and/or psychosocial rehab/skills training as included services on their plans of care did not receive the service. Employee records indicate staff are not completing annual policy and procedure acknowledgement in PolicyStat.

History

Compliance has not previously completed a comprehensive review of the JJ 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 and policy acknowledgements. Program leadership is required to complete and return the provided plan of improvement to address the deficiencies noted in this report. The Vice President of the MH Division and the JJ Program Director must sign and return this report to Compliance within seven (7) business days (Monday, August 17, 2026).

Management Response

The Juvenile Justice corrective action plan is designed to strengthen staff competency, standardize Plan of Care and discharge documentation, improve supervisory oversight, and ensure ongoing compliance with TAC requirements. Corrective actions include targeted staff training, revised POC and discharge workflows, enhanced chart-review expectations for CTLs, removal of outdated or non-required processes, and improved EPIC reporting and monitoring. The overall goal is to create a more consistent, compliant, and sustainable process across Juvenile Justice services.

The HARRIS CENTER for Mental Health and IDD

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X Signed by: Christopher Beard
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Christopher Beard, Regulatory Compliance Auditor

X DocuSigned by: Raul Ureste
A1F70C42C9134F0...
Raul Ureste, Practice Manager V

X Signed by: Tiffanie Williams-Brooks
8858C6022329497...
Tiffanie Williams-Brooks, Director-CAS

X Signed by: Lance Britt
BAB06A90B5FE4AC...
Lance Britt, Div VP-Behavioral Health Services

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Substance Use Recovery Services (SURS) Adult Recovery Program (ARP)
Review Dates: August 12, 2026-August 31, 2026

I. Audit Type:
Comprehensive

II. Purpose:
The purpose of this review was to determine if the SURS-ARP was compliant with the Texas Administrative Code (Tex. Admin. Code), the Texas Health and Human Services Commission's (HHSC) Performance Contract Notebook (PCN) FY 26-27, and Harris Center policies and procedures; and if the program had successfully implemented processes to rectify the deficiencies noted in the comprehensive review conducted during the 2nd Quarter of FY 2025.

III. Audit Method:
Program leadership provided a client roster of persons served between May 1, 2026, and July 27, 2026. A random sample of 36 clients (approximately 50% of the caseload of assigned licensed chemical dependency counselors [LCDC]) was generated using Excel functions. An employee roster was also provided by program leadership. The training records of all employees (total of six) were reviewed. An appropriate audit tool was developed by Compliance.

IV. Audit Findings/History:
The program provided sufficient evidence to document execution of the corrective actions implemented in response to the 2nd Qtr. FY 2026 comprehensive review. Additionally, the program demonstrated robust improvements in the reviewed elements—with nearly all audit areas exhibiting significant increases in compliance rates; however, most areas did not exceed the threshold score. These scores indicate the program implemented effective corrective actions in most areas; however, despite the marked improvement in compliance rates, additional measures are required to ensure acceptable performance in those areas that did not surpass the threshold score.

V. Recommendations:
The program should focus on ensuring staff members obtain all required signatures on client documents (e.g., treatment plans, treatment plan reviews, and discharge plans) accordance with the Texas Administrative Code. Additionally, the program should continue to monitor employee training course completion to maintain the high standards established during this review. Program leadership should complete the provided POI in collaboration with Performance Improvement (PI) to develop additional protocols to address those items that did not meet the threshold score.

VI. Corrective Actions:
Program leadership stated process changes have been initiated to resolve deficiencies identified with treatment plans (e.g., additional training for LCDCs and requiring treatment plans be completed prior to the provision of services), timeliness of documentation entry (e.g., additional oversight by the program's CTL), and employee training (e.g., a comprehensive Excel-based training course monitoring tool).

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The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Mental Health (MH) Division Substance Use Recovery Services (SURS) Adult Recovery Program (ARP)
Plan of Improvement (POI) Follow-up Review

Compliance Auditor(s): Christopher Beard

Review Dates: August 12, 2026-August 31, 2026

Purpose

The purpose of this review was to determine if the SURS-ARP was compliant with the Texas Administrative Code (Tex. Admin. Code), the Texas Health and Human Services Commission's (HHSC) Performance Contract Notebook (PCN) FY 26-27, and Harris Center policies and procedures; and if the program had successfully implemented processes to rectify the deficiencies noted in the comprehensive review conducted during the 2nd Quarter of FY 2025.

Methods

Program leadership provided a client roster of persons served between May 1, 2026, and July 27, 2026. A random sample of 36 clients (approximately 50% of the caseload of assigned licensed chemical dependency counselors [LCDC]) was generated using Excel functions. An employee roster was also provided by program leadership. The training records of all employees (total of six) were reviewed. An appropriate audit tool was developed by Compliance.

Findings

The program provided sufficient evidence to document execution of the corrective actions implemented in response to the 2nd Qtr. FY 2026 comprehensive review. Additionally, the program demonstrated robust improvements in the reviewed elements—with nearly all audit areas exhibiting significant increases in compliance rates; however, most areas did not exceed the threshold score. These scores indicate the program implemented effective corrective actions in most areas; however, despite the marked improvement in compliance rates, additional measures are required to ensure acceptable performance in those areas that did not surpass the threshold score.

Detailed findings are presented below:

Follow-up Audit Element(s)	Previous Score (4th Qtr. FY 2025)	Current Score (4th Qtr. FY 2026)
Personnel		
Agency-mandated Training Courses (*26 Tex. Admin. Code §§ 301.331 (a)(3)(A)(v), (viii), (x), (B)(iii)* and *(v)*, and *(C)(ii)*; *26 Tex. Admin. Code §§ 320.29 (1)* and *(3)*; *26 Tex. Admin. Code §§ 564.303 (c)(1-7), (d)(2)(B), (d)(4), (d)(6)(A)* and *(C)*, and *(d)(6)(B)*; *PCN FY 26-27*; *HR.B.35*; and *MED.MH.B.1*)	79.61%	97.64%
Client Records		
Admission (*26 Tex. Admin. Code §§ 564.802 (b)(1)* and *(d)*; *26 Tex. Admin. Code §§ 564.901 (d)* and *(e)*; and *PCN FY 26-27*)	51.32%	88.24%
Treatment Plan (*26 Tex. Admin. Code §§ 564.804 (b)(1-3), (c), (e-f)*; and *26 Tex. Admin. Code §§ 564.909 (b-c)*)	17.13%	74.38%
Treatment Plan Review (*26 Tex. Admin. Code §§ 564.804 (g), (i)(3)*, and *(j)*)	60.42%	61.11%
Documentation of Services (*26 Tex. Admin. Code §§ 564.804 (l)(1-2)*; and *SURS Operational Program & Practice Guidelines*)	56.11%	98.63%
Discharge (*26 Tex. Admin. Code §§ 564.805 (a-c), (e), (f)(1-2), (g), (h)(1)*, and *(i)(1)*; and *HIM.EHR.B.5*)	36.78%	68.20%

The HARRIS CENTER for Mental Health and IDD

Observations

Some employees were not current on annual policy acknowledgements and did not complete training courses during the month the courses were due.

History

Compliance previously completed a comprehensive review of the SURS-ARP during the 2nd Qtr. FY 2026.

Recommendations

The program should focus on ensuring staff members obtain all required signatures on client documents (e.g., treatment plans, treatment plan reviews, and discharge plans) in accordance with the Texas Administrative Code. Additionally, the program should continue to monitor employee training course completion to maintain the high standards established during this review. Program leadership should complete the provided POI in collaboration with Performance Improvement (PI) to develop additional protocols to address those items that did not meet the threshold score. The Vice President of the MH Division and the SURS-ARP Program Director are required to sign and return this report to Compliance within seven (7) business days, Friday, September 18, 2026.

Management Response

Management acknowledges findings and the improvements made. Management will continue monitoring efforts that have led to improvements and will collaborate with Program Improvement and program staff to address existing findings. Management thanks Compliance Auditor, Christopher Beard, for his assistance throughout this process.

The HARRIS CENTER for Mental Health and IDD

Signature Page

Signed by:
X Christopher Beard
478D54B5F9104BB...
Christopher Beard, Regulatory Compliance Auditor

Signed by:
X Byanca Hernandez
E28847FF70FC454...
Byanca Hernandez, Program Director III

Signed by:
X Rena Strope
722407868C91B474...
Rena Strope, Practice Manager IV

Signed by:
X Lance Britt
BAB06A90B5FE4AC...
Lance Britt, Div VP-Behavioral Health Services

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Agency Wide Training Compliance Focus Review
Review Dates: August 11, 2026 – September 2, 2026

I. Audit Type:
Focus Review

II. Purpose:
The purpose of this focused audit was to obtain a high-level view of current training compliance across divisions by reviewing assignment and completion status for thirteen required annual trainings in Absorb. This review was designed to assess current visibility, progress monitoring, and consistency across divisions, rather than historical annual due dates.

III. Audit Method:
A sample size of 20% of 527 active employees was selected for review across thirteen required training courses applicable across the agency. Training was analyzed for active employees only, and results are broken down by overall scores and individual training. The trainings were audited through December 31st, 2026, due to some employees being current with their trainings through December 2026. Detailed findings and data analysis from this review are presented in the sections below.

IV. Audit Findings/History:
The Focus Review demonstrated that Agency Mandated Annual trainings are being completed by agency staff as evidence by an overall score of 96.92%. All required trainings reviewed are being assigned and are accessible in Absorb. There were no gaps identified in system assignments for active employees at the time of the review. Supervisors have had initial training to Absorb 'Manager View' upon the change in learning module systems. Organizational Development will be sending a refresher to leaders. Two training courses were added to the required courses for all staff. Those trainings are The Harris Center's Dress Code & Professional Appearance and The Harris Center's Time and Attendance Policy Training. The Harris Center's Time and Attendance Policy Training was the latest training requirement for all staff, and its implementation date was August of 2026. This training was excluded from the trainings reviewed due to the implementation date not being until August of 2026. While system assignment failures were not identified, monitoring and prioritization of required new trainings may increase risk of non-compliance if not addressed. Targeted education and oversight will support sustained compliance moving forward.

V. Recommendations:
Based on the current review, it appears that staff are completing the agency's required training at a high rate. To maintain compliance across the agency, supervisors should continue to monitor training progress in Absorb. Supervisors should continue to monitor and review assignments, identify overdue trainings, and conduct regular compliance checks which will help create accountability and standard practices across the agency.

VI. Corrective Actions:
No corrective actions are needed currently.

Docusign Envelope ID: 7D48F666-DF86-83CF-8376-6975DD0A13F5

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Agency Wide Audit
Training Compliance Focus Review

Compliance Auditor(s): Christopher Webb

Purpose
The purpose of this focused audit was to obtain a high-level view of current training compliance across divisions by reviewing assignment and completion status for thirteen required annual trainings in Absorb. This review was designed to assess current visibility, progress monitoring, and consistency across divisions, rather than historical annual due dates.

Methods
A sample size of 20% of 527 active employees was selected for review across thirteen required training courses applicable across the agency. Trainings were analyzed for active employees only, and results are broken down by overall scores and individual training. The trainings were audited through December 31st, 2026, for those staff whose trainings were current up until that time. Detailed findings and data analysis from this review are presented in the sections below.

Findings
Overall Score: 96.92%
Detailed findings are presented below:

Course	Total Staff	Current on Training	Not Current	Percentage
Active Shooter Response	105	105	0	100.00%
Annual Defensive Driving	105	105	0	100.00%
Code of Conduct and Ethics	105	104	1	99.04%
Cybersecurity Awareness Training	105	104	1	99.04%
HIPPA for Covered Entities	105	105	0	100.00%
Office Safety	105	105	0	100.00%
OSHA Bloodborne Pathogens	105	105	0	100.00%
OSHA - Emergency and Fire Preparedness	105	86	19	81.90%
Protecting Individual Rights	105	104	1	99.04%
Understanding The Harris Center's Mission, Vision, and Beyond	105	105	0	100.00%
Safety in Practice	105	105	0	100.00%
Understand Harris Center Mission	105	105	0	100.00%
The Harris Center's Dress Code & Professional Appearance	105	85	20	80.95%
Overall Combined	1365	1323	42	96.92%

Docusign Envelope ID: 7D48F666-DF86-83CF-8376-6975DD0A13F5

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Agency Wide Audit
Training Compliance Focus Review

History

Compliance previously completed a Focus review over agency wide training compliance during the 1st Qtr. of FY2026. The overall score was 81.29%. Individual programs are audited for training records within comprehensive audits.

Key Findings

1. All required trainings reviewed are assigned and accessible in Absorb. No gaps were identified in system assignments for active employees at the time of the review.
2. Supervisors have had initial training to Absorb 'Manager View' upon the change in learning module systems. Organizational Development will be sending a refresher to leaders.
3. Two trainings were added to the required courses for all staff. Those trainings are The Harris Center's Dress Code & Professional Appearance and The Harris Center's Time and Attendance Policy Training. The Harris Center's Time and Attendance Policy Training was the latest training requirement for all staff, and its implementation date was August of 2026. This training was excluded from the trainings reviewed due to the implementation date.

Risk Considerations

While system assignment failures were not identified, monitoring and prioritization of required new trainings may increase risk of non-compliance if not addressed. Targeted education and oversight will support sustained compliance moving forward.

Recommendations/Corrective Action Plan

Based on the current review it appears that staff are completing agency required trainings at a high rate. To maintain compliance across the agency, supervisors should continue to monitor training progress in Absorb. Supervisors should continue to monitor and review assignments, identify overdue trainings, and conduct regular compliance checks which will help create accountability and standard practices across the agency.

Management Response

The overall finding of 96.92% demonstrated a strong level of compliance and awareness across the agency. However, the results also identified opportunities for improvement, particularly in Professional Appearance/Dress Code at 80.95% and Emergency ad Fire Preparedness at 81.90%.

OD will review the identified gaps and areas of opportunity to determine where additional education and reinforcement may be beneficial. In additional OD will continue to leverage the LMS Absorb system to provide targeted alerts, notifications, and reminders related to agency training expectations.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Agency Wide Audit
Training Compliance Focus Review

Signatures

X Signed by: Sharonda McLaurin 76B6F7ACC1B4483...

Sharonda McLaurin, Director Organizational Development Director

X Signed by: Toby Hicks 1BE4E6E4605B428...

Toby Hicks, Senior Director of Human Services

X Signed by: Christopher Webb A0B9E4F56F8B4A0...

Christopher Webb, Senior Regulatory Compliance Auditor

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Agency wide Policy Acknowledgment Focus Review
Review Dates: August 11, 2026 – September 2, 2026

I. Audit Type:
Focus Review

II. Purpose:
The purpose of this focused audit was to evaluate the effectiveness of the organization's policy management system as it relates to employee acknowledgement of the Code of Conduct and Ethics Policy and the Assurance of Individual Rights Policy. Specifically, this audit sought to determine the following: Whether the Code of Conduct and Ethics and Assurance of Individual Rights policies are consistently assigned to all applicable employees within our policy platform. The extent to which employees are completing acknowledgements on an annual basis. To identify any gaps in our process or system configuration. By assessing these areas, the audit aims to provide leadership with assurance on the adequacy of current workflows and highlights risk where acknowledgements are incomplete or inconsistent. CARF standards reference the need for written documentation when policies, procedures, and staff accountability are involved. Formalizing acknowledgement procedures provides the organization with evidence of compliance during survey review.

III. Audit Method:

A sample size of fifty-three (53) active employees across all Divisions was selected for review. Detailed findings and data analysis from this review are presented in the sections below.

IV. Audit Findings/History:

The overall score for this review was 44.18%. The policy acknowledgments were assigned to staff for the policies reviewed in Policy Stat. All staff reviewed have an active Policy Stat account. The staff reviewed were inconsistent in acknowledging the selected policies reviewed for compliance. Four staff reviewed did not show evidence that the policies reviewed had been assigned to them to acknowledge. The staff reviewed were inconsistent in acknowledging the selected policies reviewed for compliance. Four staff reviewed did not show evidence that the policies reviewed had been assigned to them to acknowledge. There is no evidence of system failure preventing annual policy acknowledgements. Compliance has previously conducted a Focus review over our Policy Management System tracking during the 4th Qtr. of FY2025

V. Recommendations:
To strengthen the agency's approach to policy acknowledgements, the Compliance Department will continue to take ownership of implementing the following improvements: Currently all new hires are instructed on signing into Policy Stat to claim their accounts once they receive their agency email. Supervisors should encourage staff to log into Policy Stat regularly to check their dashboard for any documents requiring their acknowledgment

VI. Corrective Actions:
Compliance should continue to work with Human Resources and leadership to develop a formal Policy Acknowledgement Policy and Procedure. It should outline the requirements for employees to acknowledge key policies, including the Code of Conduct and Ethics and Assurance of Individual Rights at the time of hire and on an annual basis.

Docusign Envelope ID: 8E297738-8EF4-8FFD-82D9-CC4BD5CA7697

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2026
Agency Wide Audit
Policy Acknowledgement Focus Review

Compliance Auditor(s): Christopher Webb

Purpose

The purpose of this focused audit was to evaluate the effectiveness of the organization's policy management system as it relates to employee acknowledgement of the Code of Conduct and Ethics Policy and the Assurance of Individual Rights Policy. Specifically, this audit sought to determine the following:

- Whether the Code of Conduct and Ethics and Assurance of Individual Rights policies are consistently assigned to all applicable employees within our policy platform.
- The extent to which employees are completing acknowledgements on an annual basis.
- To identify any gaps in our process or system configuration.

By assessing these areas, the audit aims to provide leadership with assurance on the adequacy of current workflows and highlights risk where acknowledgements are incomplete or inconsistent. CARF standards reference the need for written documentation when policies, procedures, and staff accountability are involved. Formalizing acknowledgement procedures provides the organization with evidence of compliance during survey review.

Methods

A sample size of 10% of 527 active employees across all Divisions was selected for review. Detailed findings and data analysis from this review are presented in the sections below.

Findings

Overall Score: 44.18%

Detailed findings are presented below:

Policy	Total Staff	Acknowledged	Not Acknowledged	NA	Percentage
Code of Conduct and Ethics	53	18	33	2	35.29%
Assurance of Individual Rights	53	26	23	4	53.06
					44.18%

History

Compliance has previously conducted a Focus review over our Policy Management System tracking during the 4th Qtr. of FY2025

Docusign Envelope ID: 8E297738-8EF4-8FFD-82D9-CC4BD5CA7697

HARRIS CENTER for Mental Health and IDD

Key Findings

1. The policy acknowledgments were assigned to staff for the policies reviewed in Policy Stat. All staff reviewed have an active Policy Stat account.
2. The staff reviewed were inconsistent in acknowledging the selected policies reviewed for compliance.
3. Four staff reviewed did not show evidence that the policies reviewed had been assigned to them to acknowledge.
4. There is no clear evidence of system failure which causes policy acknowledgement not to be completed annually.

Risk Considerations

The gaps identified in assignment, account activation, and tracking continue to create several risks for our organization:

- Compliance risk identified in potentially not meeting accreditation recommendations.
- Staff must be fully aligned with agency code of conduct, ethical standards and the rights of those we serve. Annual policy and procedure acknowledgments are essential; without them, the organization lacks the necessary framework to verify staff awareness of policies and adherence to required operational policies and procedures.
- Employees who do not claim their accounts cannot be included in acknowledgement tracking, which limits the accuracy of acknowledgement records.

Recommendations/Corrective Action Plan

To strengthen the agency's approach to policy acknowledgements, the Compliance Department will continue to take ownership of implementing the following improvements:

Compliance should continue to work with Human Resources and leadership to develop a formal Policy Acknowledgement Policy and Procedure. It should outline the requirements for employees to acknowledge key policies, including the Code of Conduct and Ethics and Assurance of Individual Rights at the time of hire and on an annual basis.

Currently all new hires are instructed on signing into Policy Stat to claim their accounts once they receive their agency email. Supervisors should encourage staff to log into Policy Stat regularly to check their dashboard for any documents requiring their acknowledgment.

Docusign Envelope ID: 8E297738-8EF4-8FFD-82D9-CC4BD5CA7697

HARRIS CENTER for Mental Health and IDD

Signatures

X Signed by: Christopher Webb A0B9E4F56F3B4A0...

Christopher Webb, Senior Regulatory Compliance Auditor

X DocuSigned by: Evanthe Collins 7E1995073D35406...

Evanthe Collins V.P. of IDD Services

X Signed by: Lance Britt BAB06A90B5FE4AC...

Lance Britt V.P. of Behavioral Health Services

X Signed by: Sean McElroy 94300CAE652F431...

Sean McElroy V.P. of Forensic Services

X Signed by: kim kornmayer 705073BD206644E...

Kim Kornmayer V.P. Crisis Services

datavant
Formerly named Ciox Health

Outreach ID [redacted]	Site ID: [redacted]

Chart Review Request

To:	Medical Records	Date:	6/17/2026
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:
[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:
[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

JUN 18 2026
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[redacted]

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UnitedHealthcare®
Medicare Solutions

Medical Record Review – Medicare Risk Adjustment

February 2026

Dear Practice or Facility Administrator:

Re: Time sensitive request for medical records for Medicare Risk Adjustment Data

The Medicare Risk Adjustment program ensures Medicare Advantage (MA) plans receive appropriate payments based on the health status of their members. As part of this program, the Centers for Medicare & Medicaid Services (CMS) requires plans and providers to submit complete diagnostic data for members enrolled in certain Medicare-covered health plans. To ensure the information submitted to CMS is complete, MA plans engage in medical record review. Accordingly, UnitedHealthcare requests your cooperation to facilitate a medical record review for services with a discharge date in 2025 for a certain number of your patients enrolled in such plans.

We have engaged Optum and Datavant to conduct the medical chart review. A Datavant representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from **January 1, 2025 to December 31, 2025**.

Notes should include member name, date of visit, and provider signature with credentials.

Please include all of the following medical record documentation available for this chart review:

- Progress Notes
- History and Physical
- Consult/Specialist Notes or Letters
- Operative and Pathology Notes
- Procedure Notes/Reports
- Physical, Speech, and/or Occupational Therapist Reports
- Emergency Department Records
- Discharge Summary

Only if there are no encounter notes for the member, please indicate CNA (Chart Not Available) by the Chart ID along with comments explaining why the chart is not available.

If also available include:

- Health Maintenance Form
- Demographics Sheet (include documentation for name changes, DOB discrepancies)
- Signature Log (complete and return if progress notes contain handwritten signatures or credentials of provider are not contained in patient information being sent)

Note: Pursuant to CMS requirements, providers' signatures and qualifications are required to validate each medical record.

To limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as compiling information for Healthcare Effectiveness Data & Information Set® (HEDIS) measures and assisting in CMS risk adjustment data validation audits.

We are sensitive to the needs of you and your patients. If it would be easier to deliver a limited data set to meet this request, please ensure the following minimum data elements are present:

- Intake and termination notes
- Progress notes
- Modalities and frequency of treatment provided
- Results of clinical tests or screeners
- Overview of diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date

datavant
Formerly named Ciox Health

PULL LIST [redacted]

Charts 2

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES
[redacted]						

The Medical Records provided by this office, as requested on June 2026, are true and accurate copies of the records kept in the usual course of business reflecting the medical care provided to patients on the dates indicated in the Medical Records.

Practice Group Administrator/Custodian of Medical Records
*Person within the company who is responsible for managing and maintaining records.

Date

[redacted]

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	Medical Records	Date:	6/18/2026
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:
[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:
[redacted]

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

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Optum

Dear Provider Group,

This letter is to inform you OptumCare Arizona is now beginning its risk adjustment chart review process, as part of our commitment to quality patient care and provider support. As you know, risk adjustment is the Centers for Medicare and Medicaid Services (CMS) payment methodology to health plans. This methodology is dependent on accurate diagnosis coding. Reviewing medical chart documentation will enable OptumCare Arizona to identify conditions that may exist for plan members but may not have been coded or captured. Ensuring comprehensive care can be received for the member.

We have enlisted the services of Datavant to retrieve the medical records. A Datavant representative will contact you shortly to provide you with retrieval options and a list of the requested members' medical records for services rendered from Jan. 1, 2025 to the present. Please be aware you may see receive multiple requests due to availability of additional member data. Please provide all possible assistance with the medical record retrieval efforts. We ask that you treat Datavant's request for records with high priority. Terms of retrieval are to be established upfront with Datavant. There are many options available to assist with the chart retrieval process:

- **Preferred Methods:**
  - **Secure Remote EMR Retrieval**
  - **Onsite Retrieval** *(A Datavant technician will come onsite to transfer files using an encrypted flash drive)*
- **Other Methods:**
  - **Secure Provider Portal** *(Upload directly to Datavant)*
  - **Fax or Mail** *(Office supplies can be provided on request for paper/toner, with FedEx overnight label)*

For each medical record, the following information is needed for services rendered from **01/01/2025 to present**.

For Physicians	For Hospitals
• Progress notes for face-to-face office visit • History and physical • Consult notes • Demographics sheet • Problem list • Lab and screening results • Signature log - ***CMS requirement***	• Progress notes • Consultation reports • Radiology reports • Prescription for laboratory services • History and physical exam / annual physical exam • Discharge summary • Emergency room records

Any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding confidentiality and HIPAA

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PULL LIST [redacted]

Charts
1

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES
[redacted]						

The Medical Records provided by this office, as requested on June 2026, are true and accurate copies of the records kept in the usual course of business reflecting the medical care provided to patients on the dates indicated in the Medical Records.

Practice Group Administrator/Custodian of Medical Records
*Person within the company who is responsible for managing and maintaining records.

Date

[redacted]

[redacted]

datavant
Formerly named Ciox Health

Outreach ID: [redacted]

Site ID: [redacted]

Chart Review Request

To: [redacted]

Fax Number: [redacted]

Date: [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:
[redacted]

2. Remote EMR
[redacted]
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:
[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 [redacted]

[redacted]

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UnitedHealthcare
Medicare Solutions

Medical Record Review – Medicare Risk Adjustment

February 2026

Dear Practice or Facility Administrator:

Re: Time sensitive request for medical records for Medicare Risk Adjustment Data

The Medicare Risk Adjustment program ensures Medicare Advantage (MA) plans receive appropriate payments based on the health status of their members. As part of this program, the Centers for Medicare & Medicaid Services (CMS) requires plans and providers to submit complete diagnostic data for members enrolled in certain Medicare-covered health plans. To ensure the information submitted to CMS is complete, MA plans engage in medical record review. Accordingly, UnitedHealthcare requests your cooperation to facilitate a medical record review for services with a discharge date in 2025 for a certain number of your patients enrolled in such plans.

We have engaged Optum and Datavant to conduct the medical chart review. A Datavant representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from January 1, 2025 to December 31, 2025.

Dear

Notes should include member name, date of visit, and provider signature with credentials.

Please include all of the following medical record documentation available for this chart review:

- Progress Notes
- History and Physical
- Consult/Specialist Notes or Letters
- Operative and Pathology Notes
- Procedure Notes/Reports
- Physical, Speech, and/or Occupational Therapist Reports
- Emergency Department Records
- Discharge Summary

Only if there are no encounter notes for the member, please indicate CNA (Chart Not Available) by the Chart ID also with comments explaining why the chart is not available.

If also available include:

- Health Maintenance Form
- Demographics Sheet (include documentation for name changes, DOB discrepancies)
- Signature Log (complete and return if progress notes contain handwritten signatures or credentials of providers not contained in patient information being sent)

Note: Pursuant to CMS requirements, providers' signatures and qualifications are required to validate each medical record.

To limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as compiling information for Healthcare Effectiveness Data & Information Set® (HEDIS) measures and assisting in CMS risk adjustment data validation audits.

We are sensitive to the needs of you and your patients. If it would be easier to deliver a limited data set to meet this request, please ensure the following minimum data elements are present:

- Intake and termination notes
- Progress notes
- Modalities and frequency of treatment provided
- Results of clinical tests or screeners
- Overview of diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date

07/08/2026 4:50 PM FAX [redacted] SOUTHWEST MH 0006/0008

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PULL LIST

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

Charts
1

PULL CNA MEMBER/HEALTH PLAN DOB CHART ID

[redacted]

Records.

Practice Group Administrator/Custodian of Medical Records
*Person within the company who is responsible for managing and maintaining records

Date

[redacted]

Printed Date: 7/6/2026

Printed By: System Admin

datavant
Formerly named Ciox Health

Outreach ID: 6[redacted]

Site ID: [redacted]

Chart Review Request

To: [redacted]

Date: 7/6/2026

Fax Number: [redacted]

Phone Number: [redacted]

[redacted]

Medical records can be submitted through the following options:

1. Provider Portal:
[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:
[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

[redacted]

CONFIDENTIALITY OF RECEIPT OF FAX
This communication may contain confidential Protected Health Information. This information is intended only for the use of the individual or entity to which it is addressed. The authorized recipient of the information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is STRICTLY PROHIBITED by Federal law. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

JUL 09 2026

RECEIVED

HealthSpring

February 9, 2026

Information for facilities: Datavant to request medical record documentation for HealthSpring

Dear FACILITY,

We're conducting medical record diagnostic coding reviews as part of our Medicare Advantage risk adjustment process and commitment to quality patient care and provider support. Risk adjustment is the methodology u[redacted] by the Centers for Medicare & Medicaid Services to determine payments to Medicare Advantage health plans.

This methodology is dependent on accurate and complete diagnosis coding. Reviewing medical chart documentation helps us meet these requirements. To make this process as efficient as possible, we've enlisted t[redacted] services of **Datavant** to retrieve medical records.

Next steps: Datavant will contact you to schedule the chart retrieval at a convenient time for your facility. For [redacted] medical record, the following information is needed for dates of service from **Jan. 1, 2025, to current:**

- Admitting documents
- History and physical
- Consult cotes
- Progress notes
- Discharge summary
- Medication list
- Demographic sheet
- Signature log

Please search all electronic and paper records for the specified date range and respond promptly.

Patient authorization for the release of medical records is not required for this audit. HealthSpring is conducting this review to ensure compliance with CMS guidelines for the submission of accurate patient information. This request falls under the terms and conditions of your contract with HealthSpring. Our confidentiality agreement with Datavant and their employees ensures any information shared during this review will be kept strictly confidential in accordance with all applicable state and federal laws regarding confidentiality and Health Insurance Portability and Accountability Act of 1996 requirements. Additional patient authorization is not required.

[redacted]

Thank you for your partnership in providing quality care to our members.

Sincerely,

[redacted]

HealthSpring products and services are provided exclusively by or through operating subsidiaries of Health Care Service Corporation, a Mutual Legal Reserve Company.

[redacted]

Formerly named Ciox Health

PULL LIST [redacted]

1

PULL CNA	MEMBER/REQUESTER	DOB	CHART ID	PROVIDER	NOTE

[redacted]

[redacted]

datavant
Formerly named Ciox Health

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

Chart Review Request

To:	[redacted]	Date:	7/29/2026
Fax Number:	[redacted]	Phone Number:	[redacted]

[redacted]

[redacted]

Medical records can be submitted through the following options:

1. Provider Portal:
[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:
[redacted]

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

JUL 30 2026

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

VERIFICATION OF RECEIPT OF FAX:
This communication may contain confidential Protected Health Information. This information is intended only for the use of the individual or entity to which it is addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is STRICTLY PROHIBITED by Federal law. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

HealthSpring

February 9, 2026

Information for providers: Datavant to request medical record documentation for HealthSpring

Dear PROVIDER:

We're conducting medical record diagnostic coding reviews as part of our Medicare Advantage risk adjustment process and commitment to quality patient care and provider support. Risk adjustment is the methodology used by the Centers for Medicare and Medicaid Services to determine payments to Medicare Advantage health plans.

This methodology is dependent on accurate and complete diagnosis coding. Reviewing medical chart documentation helps us meet these requirements. To make this process as efficient as possible, we've enlisted the services of **Datavant** to retrieve medical records.

Next steps: Datavant will call you to schedule the chart retrieval at a convenient time for your practice. For each medical record, the following information is needed for dates of service from **Jan. 1, 2025, to current**:

- History and physical
- Consultation notes
- Progress notes
- Medication list
- Enhanced encounter/360/HMR documents
- Demographic sheet

Please search all electronic and paper records for the specified date range and respond promptly.

Patient authorization for the release of medical records is not required for this audit. HealthSpring is conducting this review to ensure compliance with CMS guidelines for the submission of accurate patient information. This request falls under the terms and conditions of your contract with HealthSpring. Our confidentiality agreement with Datavant and their employees ensures any information shared during this review will be kept strictly confidential in accordance with all applicable state and federal laws regarding confidentiality and Health Insurance Portability and Accountability Act of 1996 requirements. Additional patient authorization is not required.

[redacted].com.

Thank you for your partnership in providing quality care to our members.

[redacted]

datavant
Formerly named Ciox Health

PULL LIST

Outreach [redacted]

Charts
9

PULL	CNA	MEMBER/REQUESTER	DOB
[redacted]			

Delivery Method: Kiteworks

May 6, 2026

The Harris Center for Mental Health and Idd
9401 Southwest Fwy
Houston, TX 77074

Re: Request for Information
[redacted]

Dear The Harris Center for Mental Health and Idd:

This is to inform you that you have been selected by Qlarant Integrity Solutions, LLC (Qlarant) for a review of sampled claims billed to Medicaid with dates of services from October 1, 2022 through September 30, 2024. The objective of our review is to determine whether the claims for services were billed and paid in accordance with applicable federal and state Medicaid laws, regulations, and policies.

In order to fulfill its contractual obligation with the Centers for Medicare & Medicaid Services (CMS), Qlarant, the Unified Program Integrity Contractor (UPIC) for the South Western Jurisdiction (Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas), performs reviews for program integrity. As a UPIC, Qlarant is authorized by CMS to review any service provided in the South Western Jurisdiction and billed to Medicare or Medicaid.

Section 6034 of the Deficit Reduction Act of 2005 (DRA) established the Medicaid Integrity Program, through which CMS shall conduct reviews of claims submitted by Medicaid providers. As a Medicaid provider and a recipient of funds under the State Medicaid program, you are subject to these reviews. The DRA authorizes CMS to utilize contractors, including Qlarant, to conduct such reviews.

In accordance with the DRA and other applicable state and federal laws, you are required to provide CMS and its contractor, Qlarant, with timely, unrestricted access to all documents and records that relate in any way to Medicaid claims and payments. In this respect, if certain records supporting the services rendered are at another facility, as the billing provider, you are responsible for obtaining those records for our review.

Qlarant understands that the request for documentation, including patient records, may raise questions about the disclosure of protected health information (PHI). The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR § 164.501-512) permits disclosure of PHI without beneficiary authorization to carry out treatment,

payment, or health care operations. When Medicaid beneficiaries enroll in the program, they are informed of Medicaid's use of their protected health information to carry out health care operations. UPICs, including Qlarant, perform health care operations as business associates of CMS with respect to the HIPAA Privacy Rule. Providing the requested documentation does not violate the minimum necessary provision of the HIPAA Privacy Rule and does not require beneficiary authorization.

We have enclosed a list of claim(s) and types of documentation that may be required to support the claim(s). Please submit to Qlarant this requested documentation for each claim listed. The documents must be legible and arranged in an orderly manner. Be aware that this list is not all inclusive and that Qlarant may request additional documentation necessary to conduct and complete its review.

The requested information should be submitted to Qlarant within 30 calendar days of the date this letter was issued, due on June 5, 2026**. The information shall be submitted electronically via Qlarant's Secure File Transfer (Kiteworks), by selecting "Upload" in the toolbar at the top of the screen.** We **cannot** accept this documentation by email. No exceptions. You must not send PHI by email because it would be in violation of federal HIPAA statutes.

Any applicable State sanctions may be imposed against you if you fail to provide the information that is requested. Depending on the laws in your State, sanctions may include, but not be limited to, vendor hold and/or exclusion from participation as a provider in the State Medicaid program until the matter is resolved. Additionally, payments for services for which you fail to produce records to Qlarant will be recovered from you.

Please refrain from any adjusting or voiding of claims under review during the dates of service without prior discussion with Qlarant and the State.

Thank you for your cooperation. If you have any questions regarding our review or the enclosed documentation requested, please respond to [redacted]
You can request a contact phone number if additional information is needed.

Sincerely,

Managed Care Plan Team
[redacted]

[redacted]

Optum

[redacted]

Medical Records Request
Medicare Risk Adjustment
Review Requested patient list, dates of service, and submission options attached.

Attention To: Medical Records
Phone:
Fax:
Request Date:
Optum Reference ID:

[redacted]

If you have received this in error, please contac[redacted]

This facsimile contains confidential personal health information (PHI). The information contained within this transmission is intended for the use of the individual or entity it is addressed to. If you are not the intended recipient, any disclosure, distribution, or reproduction is strictly prohibited. If you have received this facsimile in error, please immediately notify Optum at the email above. Optum will arrange for the proper return of this document and all its contents.

Health information is personal and protected under the law. All PHI transmitted in this facsimile is done so with appropriate authorization or does not require said authorization. The recipient of this facsimile is responsible to protect personal health information in accordance with all state and federal laws. Failure to do so may subject you to all penalties, to include fines and prosecution available under state and federal laws. Protecting PHI is everyone's responsibility. Optum takes these responsibilities seriously. If mailing records, only use services that allow for specific package tracking. Optum is not responsible for the receipt of any information, package or data that is not properly protected in transit of any kind.

JUN 11 2026

RECEIVED

[redacted]

UnitedHealthcare®
Medicare Solutions

Medical Record Review – Medicare Risk Adjustment

June 2026

Dear Practice or Facility Administrator:

Re: Time sensitive request for medical records for Medicare Risk Adjustment Data

The Medicare Risk Adjustment program ensures Medicare Advantage (MA) plans receive appropriate payments based on the health status of their members. As part of this program, the Centers for Medicare & Medicaid Services (CMS) requires plans and providers to submit complete diagnostic data for members enrolled in certain Medicare-covered health plans. To ensure the information submitted to CMS is complete, MA plans engage in medical record review. Accordingly, UnitedHealthcare requests your cooperation to facilitate a medical record review for services rendered from January 1, 2025-Present for a certain number of your patients enrolled in such plans.

We have engaged Optum to conduct the medical chart review. A representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered by date of service as specified on the pull list.

Notes should include member name, date of visit, and provider signature with credentials.

Please include all of the following medical record documentation available for this chart review:

- History and Physical
- Discharge Summary
- Progress Notes
- Consult/Specialist Notes or Letters
- Operative Notes
- Procedure Notes/Reports
- Physical, Speech, and/or Occupational Therapist Reports
- Emergency Department Records
- Physician Orders

Only if there are no encounter notes for the member, please indicate CNA (Chart Not Available) by the Chart ID along with comments explaining why the chart is not available.

If also available include:

- Health Maintenance Form
- Demographics Sheet (include documentation for name changes, DOB discrepancies)
- Signature Log (complete and return if progress notes contain handwritten signatures or credentials of provider are not contained in patient information being sent)

Note: Pursuant to CMS requirements, providers' signatures and qualifications are required to validate each medical record.

To limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as compiling information for Healthcare Effectiveness Data & Information Set® (HEDIS) measures and assisting in CMS risk adjustment data validation audits.

We are sensitive to the needs of you and your patients. If it would be easier to deliver a limited data set to meet this request, please ensure the following minimum data elements are present:

- Intake and termination notes
- Progress notes
- Modalities and frequency of treatment provided
- Results of clinical tests or screeners
- Overview of diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date

From: Fax API User

[redacted]

Optum

[redacted]

Optum on behalf of UnitedHealthcare

UnitedHealthcare
Medical Record Request: Patient List

[redacted]

Please submit member list in all communications with information in the Comments to indicate CNA if chart is not available. Return a separate document for each member named with Optum chart ID via one of the methods below.

Remote Access: Medical records will be retrieved through a designated connection or electronic medical record (EMR) system. If you would like to establish access or have questions, please contact us at [redacted] email [redacted]

[redacted]

United Psychiatry Institute, Llc

Relevant documents:

- History & Physical Reports
- Discharge Summary
- Progress Notes
- Consult/Specialist Notes or Letters
- Operative Notes
- Procedure Notes/Reports
- Emergency Department Records
- Physician Orders
- Physical, Speech, and/or Occupational Therapist Reports

Total Charts Requested: 40

File #	Member Last Name	Member First Name	DOB	Chart ID	Required DOS	Health Plan	Comments
[redacted]							

[redacted]

[redacted]

Optum

[redacted]

Review Requested patient list, dates of service, and submission options attached.

[redacted]

If you have received this in error, please contact **epi_records@optum.com.**

This facsimile contains confidential personal health information (PHI). The information contained within this transmission is intended for the use of the individual or entity it is addressed to. If you are not the intended recipient, any disclosure, distribution, or reproduction is strictly prohibited. If you have received this facsimile in error, please immediately notify Optum at the email above. Optum will arrange for the proper return of this document and all its contents.

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JUN 15 2026

RECEIVED

[redacted]

UnitedHealthcare®
Medicare Solutions

Medical Record Review – Medicare Risk Adjustment

June 2026

Dear Practice or Facility Administrator:

Re: Time sensitive request for medical records for Medicare Risk Adjustment Data

The Medicare Risk Adjustment program ensures Medicare Advantage (MA) plans receive appropriate payments based on the health status of their members. As part of this program, the Centers for Medicare & Medicaid Services (CMS) requires plans and providers to submit complete diagnostic data for members enrolled in certain Medicare-covered health plans. To ensure the information submitted to CMS is complete, MA plans engage in medical record review. Accordingly, UnitedHealthcare requests your cooperation to facilitate a medical record review for services rendered from January 1, 2025-Present for a certain number of your patients enrolled in such plans.

We have engaged Optum to conduct the medical chart review. A representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered by date of service as specified on the pull list.

Notes should include member name, date of visit, and provider signature with credentials.

Please include all of the following medical record documentation available for this chart review:

- History and Physical
- Discharge Summary
- Progress Notes
- Consult/Specialist Notes or Letters
- Operative Notes
- Procedure Notes/Reports
- Physical, Speech, and/or Occupational Therapist Reports
- Emergency Department Records
- Physician Orders

Only if there are no encounter notes for the member, please indicate CNA (Chart Not Available) by the Chart ID along with comments explaining why the chart is not available.

If also available include:

- Health Maintenance Form
- Demographics Sheet (include documentation for name changes, DOB discrepancies)
- Signature Log (complete and return if progress notes contain handwritten signatures or credentials of provider are not contained in patient information being sent)

Note: Pursuant to CMS requirements, providers' signatures and qualifications are required to validate each medical record.

To limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as compiling information for Healthcare Effectiveness Data & Information Set® (HEDIS) measures and assisting in CMS risk adjustment data validation audits.

We are sensitive to the needs of you and your patients. If it would be easier to deliver a limited data set to meet this request, please ensure the following minimum data elements are present:

- Intake and termination notes
- Progress notes
- Modalities and frequency of treatment provided
- Results of clinical tests or screeners
- Overview of diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date

[redacted]

From: Fax API User

Optum

[redacted]

Optum on behalf of UnitedHealthcare

UnitedHealthcare
Medical Record Request: Patient List

[redacted]

Please submit member list in all communications with information in the Comments to indicate CNA if chart is not available. Return a separate document for each member named with Optum chart ID via one of the methods below.

Remote Access: Medical records will be retrieved through a designated connection or electronic medical record (EMR) system. If you would like to establish access or have questions, please contact us at 1-888-292-5313 or email [redacted]

Please contact a Representative regarding questions or to schedule your preferred retrieval method at [redacted]

The Harris Center For Mental Health And Idd

Relevant documents:

- History & Physical Reports
- Discharge Summary
- Progress Notes
- Consult/Specialist Notes or Letters
- Operative Notes
- Procedure Notes/Reports
- Emergency Department Records
- Physician Orders
- Physical, Speech, and/or Occupational Therapist Reports

Total Charts Requested: 373

File #	Member Last Name	Member First Name	DOB	Chart ID	Required DOS	Health Plan	Comments
[redacted]							

[redacted]

United Healthcare Advantmed

URGENT REQUEST FOR MEDICAL RECORDS

Request Send Date: June 16, 2026

[redacted]

ATTENTION TO: Medical Records

TO: THE HARRIS CNTR FOR MENTAL HLTH AND IDD	FROM: ADVANTMED
[redacted]	[redacted]

Dear Physician or Office Administrator:

UnitedHealthcare has partnered with Advantmed to collect and review medical records for HEDIS® Reporting.

REQUESTOR: United Healthcare

DUE DATE: June 23, 2026

Advantmed offers multiple methods to submit records in response to this request. Please consider uploading records through the "SECURE UPLOAD PORTAL" to expedite the process.

[redacted]


[redacted]


[redacted]


[redacted]


[redacted]



[redacted]

[redacted]

RECEIVED

United Healthcare

Re: **Action required: MY2026 HEDIS® medical record collection request from Advantmed**

Dear health care professional:

We measure the quality of care our members receive using standard metrics from national organizations and regu... bodies, including the National Committee for Quality Assurance, CMS and state partners.

What you need to know
Advantmed is a health information organization that requests medical records specific to our members.

Advantmed will work with you to choose the most convenient method for collecting medical records — in person or by f... mail or email. They may request multiple appointments or send multiple requests to complete the medical records collect...

HEDIS® medical record collection is time sensitive. It's important that you respond quickly and return the reque... information on time. You should submit medical records even if a member is deceased, no longer enrolled i... UnitedHealthcare plan, or seen by a physician who is no longer with your practice.

Why this is important
The medical records we receive from your practice contribute valuable data to quality metrics. These metrics help ... interventions and initiatives that may improve health outcomes and reduce health care costs.

Providing these records helps ensure compliance with federal, state and UnitedHealthcare accreditation requirement...

[redacted]

Thank you.

Sincerely,

[redacted]

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc., UHC of Cali... UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of the Mid-Atlantic, Inc., MAMSI Life and Health Insurance C... UnitedHealthcare of New York, Inc., UnitedHealthcare Insurance Company of New York, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Pennsyl... UnitedHealthcare of Texas, Inc., UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Utah, Inc., UnitedHealthcare of Washington, Inc., Optimum Choice, Inc., Oxford Health Insurance, Inc... Health Plans (NJ), Oxford Health Plans (CT), Inc., All Savers Insurance Company, Tufts Health Freedom Insurance Company or other affiliates. Administrative services provided by Optum Pay... Solutions, LLC, OptumRx, Oxford Health Plans LLC, United HealthCare Services, Inc., Tufts Health Freedom Insurance Company or other affiliates. Behavioral health products provided by U.C. B... Health Plan California (UCBHPC), United Behavioral Health (UBH), or its affiliates.

The CIPHI is a registered trademark of the National Committee for Quality Assurance (NCQA).

[redacted]: A-ul 26-00750-MSR-CTR_05142026

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United Healthcare

Advantmed

[redacted]

- Preferred Communication Method: ☐ PHONE: ☐ EMAIL:
- Contact Name: [Medical Record (MR)]
- Method of Record Submission: ☐ FAX ☐ EMAIL ☐ MAIL ☐ UPLOAD ☐ ONSITE ☐ REMOTE DOWNLOAD
- Expected Date to Send Records:
- Single Charts Maintained for Patients Who See More Than One Doctor: ☐ YES ☐ NO

IF YOUR OFFICE PROCESSES MEDICAL RECORD REQUESTS THROUGH A COPY SERVICE, PLEASE CONTACT ADVANTMED PRIOR TO SUBMITTING THIS MEMBER LIST TO YOUR COPY SERVICE.

[redacted]

[redacted]

Good morning The Harris Center,

I am reaching out to confirm Superior's Quarter 3 2026 visit with Access Center New for our audit of charts on Thursday, July 30th 2026 @ 11:00am. Documentation is due by 5PM on July 17th,2026.

The four members Superior is requesting for review for Dates of service: 4/1/2026-6/30/2026. We have selected the four charts for the 4 members for audit due to no other members meeting audit qualifications.

See below for some members for you to pick from or you may choose any two members that you want. If you choose your own members, they must have a minimum of **6** SB58 services notes and they must be an active member with Superior HealthPlan.

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Please fax all required documentation to [redacted] to my attention. You may also send charts by secured email, but please keep in mind due to our office's security settings, all attachments must be smaller than 10MB. If you are experiencing any barriers to sending documentation ahead of time, please feel free to reach out to me by phone or email and we can discuss a solution. Otherwise, please send all necessary documents for all 4 members no later than close of business on July 17th ,2026.

The date span we are requesting documentation for is: 4/1/2026 – 6/30/2026. Please see the attached PDF file for a list of requested documents applicable to that date range.

Best Regards,

[redacted]
Project Coordinator, Behavioral Health Utilization Management
Pronouns: she/her

CENTENE® Corporation

[redacted]

Humana®

7/7/2026

THE HARRIS CENTER FOR MENTAL HEALTH AND IDD
9401 SOUTHWEST FWY

HOUSTON, TX 77074

RE: Please submit requested medical record(s) for your Humana-covered patient(s)

Dear physician or office administrator:

Humana reviews medical records for our members in an effort to report complete and accurate diagnosis coding to the Centers for Medicare & Medicaid Services (CMS) for our Medicare Advantage members and to the U.S. Department of Health and Human Services for our commercial members.

Please return the medical record(s) for the time period(s) requested, with the enclosed patient information form, for the patient(s) listed. Return in one of the following ways:

- Upload records to the secure provider upload portal at www.submitrecords.com/humana (instructions enclosed).
- [redacted]
- Send via mail using the enclosed self-addressed, prepaid trackable postage label(s). A new prepaid label is being used. Please discard old labels.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule states in the Safeguards Principle that individually identifiable health information should be protected with reasonable administrative, technical and physical safeguards to ensure its confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure. **Please submit all electronic and hard-copy medical records via a HIPAA-compliant method.**

Please ensure each record includes the section with the physician's or healthcare provider's signature. Do not submit original medical records. Please include the following:

If a physician record (including telehealth visits):		
Discharge summary	Consult notes	Demographics sheet
	Diagnostic testing reporting (commercial patients only)	Dialysis (commercial patients only)
History and physical	Infusion testing and reporting (commercial patients only)	Operative reports
Physician or healthcare provider signature and credentials (electronic or handwritten)	Problem list	Progress notes
Signature log*	SOAP notes (subjective, objective, assessment, plan)	Telehealth visits progress notes

If a hospital record (including telehealth visits):		
Admit notes (commercial patients only)	Demographics sheet	Coding summary (if not on face sheet)
Consult notes		Diagnostic testing reports
Discharge summary	Emergency department records	Face sheet
History and physical	Infusion testing and reporting (commercial patients only)	Lab results/pathology reports
Operative reports	Physician orders	Physician or healthcare provider signature and credentials (electronic or handwritten)
Problem list	Progress notes	Signature log*
SOAP notes (subjective, objective, assessment, plan)	Telehealth visits progress notes	

***Note:** Signature logs are not accepted in place of the physician's or healthcare provider's electronic or handwritten signature. Signature logs are used to identify a provider's name if the signature is illegible.

[redacted]

JUL 08 2026

RECEIVED

Humana®

Your patient may also have a CMS open Star measure(s). If your patient has an open Star measure, the measure is indicated on the patient list. For your convenience, we have enclosed the 2026 Star measure guidelines and checklist, which details the specific chart components and relevant time periods for each measure.

As this request is time-sensitive, your prompt response is appreciated. If you have questions regarding the medical record review process, or if there are discrepancies in the list provided, please contact the Humana record retrieval call center at [redacted] Monday through Friday, 8:30 a.m. to 6:30 p.m., Eastern time.

Thank you for your continued care of our members.

Sincerely,

[redacted]

Humana.

7/7/2026

THE HARRIS CENTER FOR MENTAL HEALTH AND IDD
9401 SOUTHWEST FWY

[redacted]

Please note that all requested medical records must be signed by the physician or other healthcare provider.

*Please be advised that Section 164.506(c) (4) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule permits you to disclose your Humana-covered patients' medical information to us without authorization from your patients. Additionally, the Office for Civil Rights, which enforces the

[redacted]

Humana.

Frequently asked questions and answers: Risk adjustment record retrieval

1. **Q: Why does Humana retrieve records for risk adjustment?**
   A: The risk adjustment record review process helps improve the accuracy of the information Humana submits to the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS) about the health status of our enrolled members. The risk adjustment models rely on ICD-10-CM diagnosis code specificity. This information could affect future funding or other program decisions made by CMS and HHS.

2. **Q: What are the responsibilities of physicians and other healthcare providers?**
   A: As published by CMS in its training documentation and by Humana in physician training documentation, the responsibilities of physicians and other healthcare providers are as follows:
   - Accurately report ICD-10-CM diagnosis codes, including secondary diagnoses, to the highest level of specificity.
   - Maintain accurate and complete medical record documentation. (ICD-10-CM diagnosis codes submitted must be justified with proper documentation.)
   - Alert Humana to any erroneous data submitted and follow the procedures for correcting it.
   - Report claims and encounter data in a timely manner, generally within 30 days of the date of service (or discharge from a hospital's inpatient facilities).

3. **Q: Is a patient-authorized release required to provide this information to Humana?**
   A: No. Collecting risk adjustment data and requesting medical records to validate payment made to Medicare Advantage organizations (MAOs) does not violate the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Therefore, a patient-authorized release of information is not required to submit risk adjustment data or respond to a medical record request from CMS or an MAO for data validation.

   Refer to the following resources for additional questions concerning HIPAA requirements:
   - General reference:
     - 45 Code of Federal Regulations (CFR) Part 164, Standards for Privacy of Individually Identifiable Health Information, Final Rule
   - On the web:
     - www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/index.html
   - CFR references:
     - 45 CFR Part 164, Subpart E, Section 164.501 – Definitions
     - 45 CFR Part 164, Subpart E, Section 164.502 – Uses and disclosures of protected health information: general rules
     - 45 CFR Part 164, Subpart E, Section 164.506 – Uses and disclosures to carry out treatment, payment or healthcare operations

2026 Star measure guidelines and checklist

For all retrieval requests, please include **all** of the following chart components for the time frame specified. If all chart components are not available, please include the available components. Star measure indicators are on the left and right of each section.

Each section may include submeasures.

Note: For all measures, a demographic sheet or portion of the chart with the patient's date of birth is needed.

BCS: Breast Cancer Screening

BCS

Medical record dates: Oct. 1, 2024 – Dec. 31, 2026

Medical record must include mammogram test, specifically:

- Mammography report
- Progress/encounter notes documenting a mammogram
- History and physical
- Consult notes

BPD: Blood Pressure Control for Patients With Diabetes

BPD

Medical record dates: Jan. 1, 2026 – Dec. 31, 2026

IMPORTANT: Any documentation stating that the patient is not a diabetic is needed.

- Progress notes
- Vital signs sheet
- Problem list
- History and physical
- Consult notes
- Blood pressure – all blood pressure readings collected during the medical records dates including remote blood pressure monitoring report
- Home Health records/CMS-485 (Home Health Certification and Plan of Care)

CBP: Controlling Blood Pressure

CBP

Medical record dates: Jan. 1, 2026 – Dec. 31, 2026

- All documented blood pressure readings collected during the medical record dates including remote blood pressure monitoring report
- Progress/encounter notes
- Vital signs flow sheet
- History and physical
- Consult notes
- Home Health records/CMS-485 (Home Health Certification and Plan of Care)

2026 Star measure guidelines and checklist

For all retrieval requests, please include **all** of the following chart components for the time frame specified. If all chart components are not available, please include the available components. Star measure indicators are on the left and right of each section.

Each section may include submeasures.

Note: For all measures, a demographic sheet or portion of the chart with the patient's date of birth is needed.

COA: Care for Older Adults

COA

Reminder: The healthcare provider's signature is required for this measure.
Medical record dates: Jan. 1, 2026 – Dec. 31, 2026

All submeasures require the same documentation below:

- Health assessment form
- Progress notes
- Outpatient notes, such as physical, occupational and/or speech therapy (PT, OT, ST)
- Consult notes
- History and physical
- Problem list
- Medication List
- Home Health records/CMS-485 (Home Health Certification and Plan of Care)

In addition, submeasures also require the following:

Submeasure	Description	Abbreviation
Medication review	Provider-signed progress note with medication list or notation of "no meds"	COA–MR
Functional Status Assessment	Any functional status assessment, Activities of Daily Living, or Instrumental Activities of Daily Living assessments	COA–FSA

COL: Colorectal Cancer Screening

COL

Colonoscopy record dates: Jan. 1, 2017 – Dec. 31, 2026
Flexible sigmoidoscopy record dates: Jan. 1, 2022 – Dec. 31, 2026
Fecal occult blood test record dates: Jan. 1, 2026 – Dec. 31, 2026
Computed tomography (CT) colonography record dates: Jan. 1, 2022 – Dec. 31, 2026
Cologuard record dates: Jan. 1, 2024 – Dec. 31, 2026

- All labs and pathology
- Medical history (first and most current)
- Preventive screening sheet/log
- X-ray and procedure results (colonoscopy/sigmoidoscopy)
- All consult notes, especially gastrointestinal physicians
- History and physical
- Progress/encounter notes
- Hospital records (discharge summary, admit and consult history and physicals)
- Problem list
- Old medical records from other physicians, if records exist
- Patient refused colonoscopy
- Health maintenance flowsheet

2026 Star measure guidelines and checklist

For all retrieval requests, please include **all** of the following chart components for the time frame specified. If all chart components are not available, please include the available components. Star measure indicators are on the left and right of each section.

Each section may include submeasures.

Note: For all measures, a demographic sheet or portion of the chart with the patient's date of birth is needed.

EED: Eye Exam for Patients with Diabetes — EED

Medical record dates: Jan. 1, 2025 – Dec. 31, 2026

IMPORTANT: Any documentation stating that the patient is not a diabetic is needed.

- Retinal or dilated eye exam during 2025–2026 (optometrist/ophthalmologist consult or eye exam)
- Include retinal or fundus photography with results
- Evidence of a bilateral eye enucleation
- History and physical
- Progress notes
- Preventive screening sheet/log
- Problem list

GSD: Glycemic Status Assessment for Patients With Diabetes — GSD

Medical record dates: Jan. 1, 2026 – Dec. 31, 2026

IMPORTANT: Any documentation stating that the patient is not a diabetic is needed.

- Labs (including most recent hemoglobin A1c, glucose management indicator)
- Progress notes
- Problem list
- History and physical
- Vital signs sheet
- Consult notes
- Home Health records/CMS-485 (Home Health Certification and Plan of Care)

KED: Kidney Health Evaluation for Patients with Diabetes — KED

Medical record dates: Jan. 1, 2026 – Dec. 31, 2026

IMPORTANT: Any documentation stating that the patient is not a diabetic is needed.

- Labs to include: eGFR, BMP, CMP, CBC, renal function panel, and all urine tests
- Progress notes
- Problem list
- History and physical
- Consult notes
- Home Health records/CMS-485 (Home Health Certification and Plan of Care)

2026 Star measure guidelines and checklist

For all retrieval requests, please include **all** of the following chart components for the time frame specified. If all chart components are not available, please include the available components. Star measure indicators are on the left and right of each section.

Each section may include submeasures.

Note: For all measures, a demographic sheet or portion of the chart with the patient's date of birth is needed.

OMW: Osteoporosis Management in Women Who Had a Fracture

OMW

Medical record dates: July 1, 2023 – Dec. 31, 2026

Medical record must include bone mineral density (BMD) testing completed and/or prescription for a medication to treat/prevent osteoporosis. Bone mineral density testing must be completed within 24 months before or 180 days after the fracture. Prescription for a medication to treat/prevent osteoporosis must be completed within 12 months before or 180 days after the fracture. Approved osteoporosis therapies include*:

Bisphosphonates: alendronate, alendronate-cholecalciferol, risedronate, ibandronate, zoledronic acid

Other agents: abaloparatide, denosumab, raloxifene, teriparatide

**Please refer to the NCQA website for a comprehensive list of medications and NDC codes.*

- Progress/encounter notes with BMD test
- Medication list for the medical record dates
- History and physical
- Home Health records/CMS-485 (Home Health Certification and Plan of Care)

TRC: Transitions of Care

TRC

Reminder: The healthcare provider's name and credentials are required for this measure.

Medical record dates: Jan. 1, 2026 – Dec. 31, 2026

All visits within 30 days of each discharge MUST HAVE each of the following with an asterisk (*):

- Progress/encounter notes*
- Provider-signed medication list for the medical record dates*
- All hospital discharge summaries*
- Consult notes*
- Pre-admission/pre-operative exams
- Hospital admission notifications (electronic or telephonic)
- History and physical
- Problem list
- Home Health records/CMS-485 (Home Health Certification and Plan of Care)

All submeasures require the same documentation shown below:

Submeasure	Abbreviation
Notification of inpatient stay	TRC-NIA
Receipt of discharge information	TRC-RD
Patient engagement after inpatient discharge	TRC-PED
Provider-signed medication reconciliation post-discharge	TRC-TRCM

2026 Star measure guidelines and checklist

For all retrieval requests, please include **all** of the following chart components for the time frame specified. If all chart components are not available, please include the available components. Star measure indicators are on the left and right of each section.

Each section may include submeasures.

Note: For all measures, a demographic sheet or portion of the chart with the patient's date of birth is needed.

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Limited proprietary coding is contained in the measure specifications for convenience. NCQA disclaims all liability for use or accuracy of any third-party code values contained in the specifications.

The full text of this notice and disclaimer is available here: http://apps.humana.com/marketing/documents.asp?file=4274309

From: Fax API User

[redacted]

Optum

[redacted]

Optum on behalf of Wellpoint

[redacted]

Medical Records Request
Medicare Risk Adjustment
Review Requested patient list, dates of service, and submission options attached.

Attention To: [redacted]
Phone:
Fax:
Request Date:
Optum Reference ID:

[redacted]

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[redacted]

JUL 21 2026

RECEIVED

Wellpoint

[redacted] Florida · Maryland · Massachusetts · Texas · Washington | Commercial

07/17/2026

9401 Southwest Fwy

Houston TX 77074.0

Subject: Time-sensitive request for medical records for Medicare risk adjustment data

Dear Addressee:

Wellpoint is committed to improving the quality of care provided to our members and is required by the Centers for Medicare & Medicaid Services (CMS) to submit complete and accurate diagnostic data regarding our members enrolled in certain Medicare-covered health plans. Accordingly, Wellpoint requests your cooperation to facilitate a medical record review of 2025-2026 for a certain number of your patients enrolled in such plans.

We have engaged Optum to conduct retrieval of records for 2026 Medicare medical chart review. An Optum representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from January 1, 2025 to Present.

Please include all medical documentation available for this chart review, including but not limited to

- Progress notes.
- History and physical.
- Consult and specialist notes or letters.
- Operative and pathology notes.
- Procedure notes and reports.

In Florida, coverage is provided by Simply Healthcare Plans, Inc., doing business as Wellpoint Florida, Inc. In Maryland, coverage is provided by Wellpoint Maryland, Inc. In Massachusetts, claims are administered by Wellpoint Life and Health Insurance Company. In Texas, coverage is provided by Wellpoint Insurance Company. In Washington, coverage is provided by Wellpoint Washington, Inc., who profoundly acknowledges and respects the inherent sovereignty of the federally recognized Tribes in Washington state. In our efforts to promote high-quality healthcare, we honor the Tribal right of self-governance, holding in deep esteem the government-to-government relationship existing between the state and the Tribes, a bond reiterated by the Centennial Accord and established by RCW 43.376. We heartily commit to enhancing our coordination, collaboration, and recognition of the deeply rooted traditions and values of the Tribal communities.

MULTI-WP-CR-000875-25-GRP231 | December 2025

Optum

[redacted]

Optum on behalf of Wellpoint

Wellpoint

Medical Record Request: Patient List

Secure Online Submission: [redacted]

Username: [redacted]

P [redacted]

Please submit member list in all communications with information in the Comments to indicate CNA if chart is not available. Return a separate document for each member named with Optum chart ID via one of the methods below.

Remote Access: Medical records will be retrieved through a designated connection or electronic medical record (EMR) system. If you would like to establish access or have questions, [redacted]

Fax to: [redacted]

Traceable mail to: [redacted]

Email to: [redacted] To protect ePHI, please use encrypted email.

Onsite retrieval: Contact an Optum Representative to schedule.

Please contact a Representative regarding questions or to schedule your preferred retrieval method at **1-866-243-6057 or** [redacted]

The Harris Center For Mental Health And Idd

Relevant documents:

- History & Physical Reports
- Discharge Summary
- Progress Notes
- Consult/Specialist Notes or Letters
- Operative Notes
- Procedure Notes/Reports
- Emergency Department Records
- Physician Orders
- Physical, Speech, and/or Occupational Therapist Reports

Total Charts Requested: 76

File #	Member Last Name	Member First Name	DOB	Chart ID	Required DOS	Health Plan	Comments
1	[redacted]						

[redacted]

Optum

[redacted]

Optum on behalf of UnitedHealthcare
Address: [redacted]

Medical Records Request
Medicare Risk Adjustment
Review Requested patient list, dates of service, and submission options attached.

Attention To: [redacted]
Phone: [redacted]
Fax: [redacted]
Request Date: [redacted]
Optum Reference ID: [redacted]

[redacted]

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JUL 31 2026

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[redacted]

UnitedHealthcare®
Medicare Solutions

Medical Record Review – Medicare Risk Adjustment

June 2026

Dear Practice or Facility Administrator:

Re: Time sensitive request for medical records for Medicare Risk Adjustment Data

The Medicare Risk Adjustment program ensures Medicare Advantage (MA) plans receive appropriate payments based on the health status of their members. As part of this program, the Centers for Medicare & Medicaid Services (CMS) requires plans and providers to submit complete diagnostic data for members enrolled in certain Medicare-covered health plans. To ensure the information submitted to CMS is complete, MA plans engage in medical record review. Accordingly, UnitedHealthcare requests your cooperation to facilitate a medical record review for services rendered from January 1, 2025-Present for a certain number of your patients enrolled in such plans.

We have engaged Optum to conduct the medical chart review. A representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered by date of service as specified on the pull list.

Notes should include member name, date of visit, and provider signature with credentials.

Please include all of the following medical record documentation available for this chart review:

- History and Physical
- Discharge Summary
- Progress Notes
- Consult/Specialist Notes or Letters
- Operative Notes
- Procedure Notes/Reports
- Physical, Speech, and/or Occupational Therapist Reports
- Emergency Department Records
- Physician Orders

Only if there are no encounter notes for the member, please indicate CNA (Chart Not Available) by the Chart ID along with comments explaining why the chart is not available.

If also available include:

- Health Maintenance Form
- Demographics Sheet (include documentation for name changes, DOB discrepancies)
- Signature Log (complete and return if progress notes contain handwritten signatures or credentials of provider are not contained in patient information being sent)

Note: Pursuant to CMS requirements, providers' signatures and qualifications are required to validate each medical record.

To limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as compiling information for Healthcare Effectiveness Data & Information Set® (HEDIS) measures and assisting in CMS risk adjustment data validation audits.

We are sensitive to the needs of you and your patients. If it would be easier to deliver a limited data set to meet this request, please ensure the following minimum data elements are present:

- Intake and termination notes
- Progress notes
- Modalities and frequency of treatment provided
- Results of clinical tests or screeners
- Overview of diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date

UnitedHealthcare®
Medicare Solutions

Please redact sensitive and personal information not directly related to patients' clinical history, diagnoses, or reason for treatment (e.g. sexual orientation, transgender status, criminal history). Clinical information necessary to understand and support diagnoses should remain unredacted.

Thank you in advance for your assistance.

Sincerely,

[redacted]

Privacy Information

Federal law and related regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the American Recovery and Reinvestment Act of 2009 ("ARRA") govern the privacy of a patient's protected health information (PHI). These laws establish requirements for the use and disclosure of PHI by physicians/health care professionals, health plans, and health plans' business associates and business associate subcontractors.

HIPAA allows a covered entity, such as a health care provider, to disclose PHI to another covered entity, such as a health plan for payment, treatment, or health care operations without a member's authorization. Risk adjustment and quality assessment and improvement activities are such permitted disclosures relating to payment, treatment or health care operations.

In this case, Optum is a business associate of UnitedHealthcare and, consistent with federal law is conducting chart reviews for the purposes of risk adjustment and quality assessment and improvement activities on behalf of UnitedHealthcare. Optum has entered into a business associate subcontract in accordance with the applicable HIPAA and ARRA requirements. These agreements allow Optum to access and to use PHI on behalf of UnitedHealthcare for the purposes of, among other things, risk adjustment and quality assessment and improvement activities.

HIPAA specifically protects psychotherapy notes that are recorded by your clinician that document or analyze the contents of a conversation during your private counseling session. Optum is not requesting those private notes.

Optum

[redacted]

Optum on behalf of UnitedHealthcare

UnitedHealthcare
Medical Record Request: Patient List

Secure Online Submission [redacted]

[redacted]

Please submit member list in all communications with information in the Comments to indicate CNA if chart is not available. Return a separate document for each member named with Optum chart ID via one of the methods below.

Remote Access: Medical records will be retrieved through a designated connection or electronic medical record (EMR) system. If you would like to establish access or have questions, please contact us at 1-888-292-5313 or email OIR_Optum_Records@optum.com

[redacted] To protect ePHI, please use encrypted email.

Onsite retrieval: Contact an Optum Representative to schedule.

Please contact a Representative regarding questions or to schedule your preferred retrieval method [redacted]

The Harris Center

Relevant documents:

- History & Physical Reports
- Discharge Summary
- Progress Notes
- Consult/Specialist Notes or Letters
- Operative Notes
- Procedure Notes/Reports
- Emergency Department Records
- Physician Orders
- Physical, Speech, and/or Occupational Therapist Reports

Total Charts Requested: 2

File #	Member Last Name	Member First Name	DOB	Chart ID	Required DOS	Health Plan	Comments
1	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	

[redacted]

2	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	

[redacted]

United Healthcare

Advantmed

URGENT REQUEST FOR MEDICAL RECORDS

Request Send Date: July 28, 2026

[redacted]

ATTENTION TO: Medical Records

TO:	FROM: ADVANTMED
[redacted]	[redacted]

Dear Physician or Office Administrator:

UnitedHealthcare has partnered with Advantmed to collect and review medical records for HEDIS® Reporting.

REQUESTOR: United Healthcare

DUE DATE: August 04, 2026

Advantmed offers multiple methods to submit records in response to this request. Please consider uploading records through our **"SECURE UPLOAD PORTAL"** to expedite the process.

Please use link for sharing your feedback: [redacted]

Most Convenient and Secure Method:

To u[redacted]

OR [redacted]

[redacted]

[redacted]

[redacted]

To schedule an onsite appointment, please contact us a[redacted]

AUG 0 4 2026

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United Healthcare

Advantmed

[redacted]

- **Preferred Communication Method:** ☐ PHONE: ☐ EMAIL:
- **Contact Name:** [Medical Record (MR)]
- **Method of Record Submission:** ☐ FAX ☐ EMAIL ☐ MAIL ☐ UPLOAD ☐ ONSITE ☐ REMOTE DOWNLOAD
- **Expected Date to Send Records:**
- **Single Charts Maintained for Patients Who See More Than One Doctor:** ☐ YES ☐ NO

IF YOUR OFFICE PROCESSES MEDICAL RECORD REQUESTS THROUGH A COPY SERVICE, PLEASE CONTACT ADVANTMED PRIOR TO SUBMITTING THIS MEMBER LIST TO YOUR COPY SERVICE.

[redacted]

Optum

[redacted]

Optum on behalf of Wellpoint
Address: [redacted]

Medical Records Request
Medicare Risk Adjustment
Review Requested patient list, dates of service, and submission options attached.

Attention To:	**Medical Records**
Phone:	7139707330
Fax:	7139703817
Request Date:	08/05/2026
Optum Reference ID:	[redacted]

[redacted]

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AUG 0 6 2026

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[redacted]

Wellpoint

Florida · Maryland · Massachusetts · Texas · Washington | Commercial

08/05/2026

9401 Southwest Fwy

Houston TX 77074

Subject: Time-sensitive request for medical records for Medicare risk adjustment data

Dear Addressee:

Wellpoint is committed to improving the quality of care provided to our members and is required by the Centers for Medicare & Medicaid Services (CMS) to submit complete and accurate diagnostic data regarding our members enrolled in certain Medicare-covered health plans. Accordingly, Wellpoint requests your cooperation to facilitate a medical record review of 2025-2026 for a certain number of your patients enrolled in such plans.

We have engaged Optum to conduct retrieval of records for 2026 Medicare medical chart review. An Optum representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from January 1, 2025 to Present.

Please include all medical documentation available for this chart review, including but not limited to

- Progress notes.
- History and physical.
- Consult and specialist notes or letters.
- Operative and pathology notes.
- Procedure notes and reports.

In Florida, coverage is provided by Simply Healthcare Plans, Inc., doing business as Wellpoint Florida, Inc. In Maryland, coverage is provided by Wellpoint Maryland, Inc. In Massachusetts, claims are administered by Wellpoint Life and Health Insurance Company. In Texas, coverage is provided by Wellpoint Insurance Company. In Washington, coverage is provided by Wellpoint Washington, Inc., who profoundly acknowledges and respects the inherent sovereignty of the federally recognized Tribes in Washington state. In our efforts to promote high-quality healthcare, we honor the Tribal right of self-governance, holding in deep esteem the government-to-government relationship existing between the state and the Tribes, a bond reiterated by the Centennial Accord and established by RCW 43.376. We heartily commit to enhancing our coordination, collaboration, and recognition of the deeply rooted traditions and values of the Tribal communities.

[redacted]

Optum

[redacted]

Optum on behalf of Wellpoint

Wellpoint
Medical Record Request: Patient List

[redacted]

Please submit member list in all communications with information in the Comments to indicate CNA if chart is not available. Return a separate document for each member named with Optum chart ID via one of the methods below.

Remote Access: Medical records will be retrieved through a designated connection or electronic medical record (EMR) system. If you would like to establish access or have questions, please contact us at [redacted]

[redacted]

The Harris Center For Mental Health And Idd

Relevant documents:

- History & Physical Reports
- Discharge Summary
- Progress Notes
- Consult/Specialist Notes or Letters
- Operative Notes
- Procedure Notes/Reports
- Emergency Department Records
- Physician Orders
- Physical, Speech, and/or Occupational Therapist Reports

Total Charts Requested: 4

File #	Member Last Name	Member First Name	DOB	Chart ID	Required DOS	Health Plan	Comments
1	[redacted]						

[redacted]

2	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
3	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
4	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	

[redacted]

Advantmed

REQUEST FOR MEDICAL RECORDS

Request Send Date: August 07, 2026

[redacted]

TO:	FROM: ADVANTMED
THE HARRIS CENTER FOR MENTAL HEALTH AND IDD	
[redacted]	[redacted]

Dear Physician or Office Administrator:

Wellcare has partnered with Advantmed to collect medical records for Medicare Risk Adjustment.

REQUESTOR: Wellcare

DUE DATE: August 21, 2026

Advantmed offers multiple methods to submit records in response to this request. Please consider uploading records through our **"SECURE UPLOAD PORTAL"** to expedite the process.

[redacted]

AUG 10 2026

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[redacted]

wellcare

RECORDS REQUEST

Dear Provider,

Wellcare is committed to improving the quality of care provided to our members. We are required by the Centers for Medicare & Medicaid Services (CMS) to submit complete diagnostic data regarding our members enrolled in Wellcare. Accordingly, Wellcare requests your cooperation to facilitate a medical record review of January 1, 2025, to present dates of service for a certain number of your patients enrolled in such plans.

We have engaged Advantmed to conduct the medical chart review. A Advantmed representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from January 1, 2025, to present.

What does this mean to you?

In order to limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as compiling information for Healthcare Effectiveness Data and Information Set (HEDIS®) measures and assisting in CMS risk adjustment data validation audits.

Your assistance in helping Advantmed with this retrieval is greatly appreciated.

Please note the items listed below are the components requested, if applicable, for all dates of service from January 1, 2025, to present:

- Patient Demographic Sheet.
- History & physical records, progress notes and consultations.
- Discharge record, consult and pathology summaries, and reports.
- Surgical procedures and operating summaries.
- Subjective and objective assessments, and plan notes.
- Diagnostic testing, including but not limited to cardiovascular diagnostic testing reports (EKG, stress test, Holter monitors, Doppler studies), interventional radiology (MRA, catheter angiography, etc.), neurology (EEG, EMG, nerve conduction studies, sleep studies).
- Emergency and Urgent Care records.
- Consultation reports.
- Specialist Notes.
- Procedure notes/reports.
- Valid signature with credentials.

[redacted] [redacted]

In addition to the pull list above, we ask that you provide all documentation including labs, test results, x-rays, consult summaries, etc. to cover corresponding HEDIS® efforts for the health plan. Additional information on Risk Adjustment and HEDIS® can be found in the FAQ linked at the end of this letter.

We would appreciate your participating in a short anonymous survey letting us know how we are doing. **Please scan the QR code below to complete.**

Scan the QR Code below for Frequently Asked Questions regarding this record request.

Sincerely,

Wellcare

Confidentiality:

Wellcare has entered into a Business Associate Agreement with Advantmed in accordance with the privacy regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This agreement allows Advantmed to perform activities involving the use or disclosure of individually identifiable health information on behalf of WellCare. In addition, it only permits Advantmed to use the information as permitted in accordance with Business Associate Agreement. The regulations promulgated under HIPAA are the federal rules that govern the privacy of an enrollee's protected health information (PHI) and establish requirements for the use and disclosure of PHI by physicians/healthcare professionals and Wellcare in connection with their "healthcare operations" activities. HIPAA allows a covered entity to disclose PHI to another covered entity for the healthcare operations of the entity receiving the information, without an enrollee's authorization or consent, under certain circumstances. Under this provision, you are permitted to disclose PHI to Advantmed, as Advantmed is a Business Associate of WellCare and acting on behalf of WellCare.

In adopting this regulation under HIPAA, the Department of Health and Human Services (HHS) explicitly recognized in the preamble to the HIPAA privacy regulations that WellCare may need to obtain PHI from physicians and other healthcare professionals for the plans' quality related activities, accreditation, and performance measures. HHS confirmed that the provision "was intended to allow information to flow from one covered entity to another for activities important to providing quality and effective healthcare."

[redacted]

Advantmed

[redacted]

- **Preferred Communication Method:** ☐ PHONE: _____ ☐ EMAIL: _____
- **Contact Name:** [Medical Record (MR)] _____
- **Method of Record Submission:** ☐ FAX ☐ EMAIL ☐ MAIL ☐ UPLOAD ☐ ONSITE ☐ REMOTE DOWNLOAD
- **Expected Date to Send Records:** _____
- **Single Charts Maintained for Patients Who See More Than One Doctor:** ☐ YES ☐ NO

IF YOUR OFFICE PROCESSES MEDICAL RECORD REQUESTS THROUGH A COPY SERVICE, PLEASE CONTACT ADVANTMED PRIOR TO SUBMITTING THIS MEMBER LIST TO YOUR COPY SERVICE.

Record Required: All medical records from 1/1/2025 through 2026 YTD including Member Biographical Information Sheet

NO:	ADVANTMED RECORD ID:	PATIENT NAME: (LAST, FIRST)	DOB:	MEMBER ID:	PROVIDER NAME:	CHARTS AVAILABLE:
1	[redacted]					☐ No
2						☐ No
3						☐ No
4						☐ No
5						☐ No
6						☐ No
7						☐ No
8						☐ No
9						☐ No
10						☐ No
11						☐ No

Advantmed

Record Required: All medical records from 1/1/2025 through 2026 YTD including Member Biographical Information Sheet						
NO:	ADVANTMED RECORD ID:	PATIENT NAME: (LAST, FIRST)	DOB:	MEMBER ID:	PROVIDER NAME:	CHARTS AVAILABLE:

[redacted]

Advantmed

Record Required: All medical records from 1/1/2025 through 2026 YTD including Member Biographical Information Sheet						
NO:	ADVANTMED RECORD ID:	PATIENT NAME: (LAST, FIRST)	DOB:	MEMBER ID:	PROVIDER NAME:	CHARTS AVAILABLE:
[redacted]						

Medical Records Request

Purpose: 2026 ACA

On Behalf of: BCBS Association

[redacted]

Due Date: 09/01/2026

[redacted]

Delivery Options

[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 BCBS Association explaining the purpose of this request as well as the desired medical record components and date range.
  - The Member List, which provides the patient name, date of birth (DOB), provider and date of service (DOS) information for each record being requested.
- Please return the records using one of the three preferred delivery options outlined above.
  - We recommend using our secure, easy to use Provider Portal at [redacted] 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.
  - When sending Records via secure fax or mail, please ensure that you include the Medical Records Request cover sheet with the Records.
  - In addition to these preferred delivery options, we offer remote collection and onsite retrieval services that minimize disruption to daily operations, maximize turnaround time and accuracy, and can be tailored to your organization's needs.
- [redacted]

Sincerely,

[redacted]

BlueCross BlueShield of Texas

Dear Provider:

Virtix Health has been contracted on behalf of Health Care Service Corporation to collect medical records[1]. The Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services (HHS) require Medicare Advantage and Commercial plans to submit detailed documentation to support patient conditions. As outlined in your contract, you are required to respond to requests in support of Risk Adjustment, HEDIS and other government required activities within a requested time frame. This includes Virtix requests on behalf of Health Care Service Corporation

[redacted]

We appreciate your patience and assistance during this process.

Thank you,

Health Care Service Corporation

[1]Virtix is contractually bound to preserve the confidentiality of health plan members' protected health information (PHI) in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations. Providers are permitted to disclose PHI to health plans and the contracted partners without authorization from the patient when both the provider and the health plan had a relationship with the patient [45 CFR 164.506 (c) (4)].

Member List

[redacted]

The Harris Center

Total Records Requested: 1

For all available records, please provide all chart detail for the specified date range
*Indicate any unavailable records be checking RNA (Record Not Available)

Record ID	Member	DOB	Provider	DOS Range	RNA
[redacted]					

DOS:

Optum

[redacted]

Optum on behalf of UnitedHealthcare
Address: [redacted]
Phone:
Fax:
[redacted]

Medical Records Request
Medicare Risk Adjustment
Review Requested patient list, dates of service, and submission options attached.

Attention To: **Medical Records**
Phone:
Fax:
Request Date:
Optum Reference ID:
[redacted]

If you have received this in error, please contact [redacted]

This facsimile contains confidential personal health information (PHI). The information contained within this transmission is intended for the use of the individual or entity it is addressed to. If you are not the intended recipient, any disclosure, distribution, or reproduction is strictly prohibited. If you have received this facsimile in error, please immediately notify Optum at the email above. Optum will arrange for the proper return of this document and all its contents.

Health information is personal and protected under the law. All PHI transmitted in this facsimile is done so with appropriate authorization or does not require said authorization. The recipient of this facsimile is responsible to protect personal health information in accordance with all state and federal laws. Failure to do so may subject you to all penalties, to include fines and prosecution available under state and federal laws. Protecting PHI is everyone's responsibility. Optum takes these responsibilities seriously. If mailing records, only use services that allow for specific package tracking. Optum is not responsible for the receipt of any information, package or data that is not properly protected in transit of any kind.

[redacted]

UnitedHealthcare®
Medicare Solutions

Medical Record Review – Medicare Risk Adjustment

February 2026

Dear Practice or Facility Administrator:

Re: Time sensitive request for medical records for Medicare Risk Adjustment Data

UnitedHealthcare is committed to improving the quality of care provided to our members and is required by the Centers for Medicare & Medicaid Services (CMS) to submit complete diagnostic data regarding our members enrolled in certain Medicare-covered health plans. Accordingly, UnitedHealthcare requests your cooperation to facilitate a medical record review of 2025 dates of service for a certain number of your patients enrolled in such plans.

We have engaged Optum to conduct the medical chart review. A representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from **January 1, 2025 to December 31, 2025**.

Notes should include member name, date of visit, and provider signature with credentials.

Please include all of the following medical record documentation available for this chart review:

- Progress Notes
- History and Physical
- Consult/Specialist Notes or Letters
- Operative and Pathology Notes
- Procedure Notes/Reports
- Physical, Speech, and/or Occupational Therapist Reports
- Emergency Department Records
- Discharge Summary

Only if there are no encounter notes for the member, please indicate CNA (Chart Not Available) by the Chart ID along with comments explaining why the chart is not available.

If also available include:

- Health Maintenance Form
- Demographics Sheet (include documentation for name changes, DOB discrepancies)
- Signature Log (complete and return if progress notes contain handwritten signatures or credentials of provider are not contained in patient information being sent)

Note: Pursuant to CMS requirements, providers' signatures and qualifications are required to validate each medical record.

To limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as compiling information for Healthcare Effectiveness Data & Information Set® (HEDIS) measures and assisting in CMS risk adjustment data validation audits.

Thank you in advance for your assistance.

Sincerely,

[redacted]

UnitedHealthcare®
Medicare Solutions

Privacy Information

Federal law and related regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the American Recovery and Reinvestment Act of 2009 ("ARRA") govern the privacy of a patient's protected health information (PHI). These laws establish requirements for the use and disclosure of PHI by physicians/health care professionals, health plans, and health plans' business associates and business associate subcontractors.

HIPAA allows a covered entity, such as a health care provider, to disclose PHI to another covered entity, such as a health plan for payment, treatment, or health care operations without a member's authorization. Risk adjustment and quality assessment and improvement activities are such permitted disclosures relating to payment, treatment or health care operations.

In this case, Optum is a business associate of UnitedHealthcare and, consistent with federal law is conducting chart reviews for the purposes of risk adjustment and quality assessment and improvement activities on behalf of UnitedHealthcare. Optum has entered into a business associate subcontract in accordance with the applicable HIPAA and ARRA requirements. These agreements allow Optum to access and to use PHI on behalf of UnitedHealthcare for the purposes of, among other things, risk adjustment and quality assessment and improvement activities.

Optum Rx®

EXL

[redacted]

June 4, 2026

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

Your pharmacy has **fourteen (14) business** days from the date of this letter to provide all requested prescription hardcopies (front and back) and any additional supporting documentation (e.g., electronically stored prescription clarifications) for validation.

Please make note of the following:

- Documentation provided should support the dispensed prescription claim. ORx will correct the claim, if necessary, based on the documentation provided.
- If the medication has not yet been dispensed and the claim is still valid, the requested documentation for the claim is still required for validation.
- If there is any additional annotation regarding the prescription that is readily retrievable from the electronic patient profile, please include it along with the prescription copy/image.

Pharmacies are required to provide access to records under their Pharmacy Network Agreement with ORx. Failure to do so may result in a claim being determined as a non-supported adjudication and subject to full reversal or recoupment.

All documentation should be submitted to EXL Service via fax or encrypted email as indicated on the Records Transmittal Page of this request. Please include the **Records Transmittal Page** with the submission of your documentation to ensure proper handling and validation of the claim(s).

Pharmacies will be notified of discrepant results from the prescription validation reviews. This includes educational results. Non-discrepant results will not be reported to the pharmacies.

[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

June 5, 2026

[redacted]

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted].

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

Pharmacy Compliance Department

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

June 5, 2026

[redacted]

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

Pharmacy Compliance Department

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

June 8, 2026

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted].

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

[redacted]

June 10, 2026

[redacted]

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

[redacted]

July 10, 2026

[redacted]

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

[redacted]

June 10, 2026

[redacted]

[redacted]

*****PRESCRIPTION VALIDATION REQUEST*****

Dear Pharmacy Provider,

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]



[redacted]

[redacted]

June 12, 2026

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

June 12, 2026

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

[redacted]

June 15, 2026

[redacted]

[redacted]

*****PRESCRIPTION VALIDATION REQUEST*****

Dear Pharmacy Provider,

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

[redacted]

June 16, 2026

[redacted]

[redacted]

*****PRESCRIPTION VALIDATION REQUEST*****

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

[redacted]

July 6, 2026

[redacted]

[redacted]

*****PRESCRIPTION VALIDATION REQUEST*****

Dear Pharmacy Provider,

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[redacted]

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Sincerely,

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

July 10, 2026

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

Your pharmacy has **fourteen (14) business** days from the date of this letter to provide all requested prescription hardcopies (front and back) and any additional supporting documentation (e.g., electronically stored prescription clarifications) for validation.

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Pharmacies will be notified of discrepant results from the prescription validation reviews. This includes educational results. Non-discrepant results will not be reported to the pharmacies.

[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

August 6, 2026

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted].

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

August 7, 2026

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

August 10, 2026

[redacted]

*****PRESCRIPTION VALIDATION REQUEST*****

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

Optum Rx®

EXL

[redacted]

August 14, 2026

[redacted]

[redacted]

*****PRESCRIPTION VALIDATION REQUEST*****

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

August 17, 2026

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

August 18, 2026

[redacted]

[redacted]

*****PRESCRIPTION VALIDATION REQUEST*****

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

[redacted]

August 19, 2026

[redacted]

[redacted]

*****PRESCRIPTION VALIDATION REQUEST*****

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted]

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Sincerely,

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

Optum Rx®

EXL

[redacted]

August 21, 2026

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

[redacted]

August 25, 2026

[redacted]

[redacted]

*****PRESCRIPTION VALIDATION REQUEST*****

Dear Pharmacy Provider,

ExlService.com, LLC is an authorized vendor of Optum Rx, Inc. (ORx) for performance of pharmacy audits and prescription validation reviews. A validation of the claim(s) attached is being requested by EXL Service to ensure proper adjudication and compliance with Benefit Plan contractual agreements.

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[redacted]

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Sincerely,

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

August 26, 2026

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

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[redacted]

Please Note: This is a request for records. No claims are being reversed or recouped at this time.

Sincerely,

[redacted]

[redacted]

Optum Rx®

EXL

[redacted]

August 28, 2026

[redacted]

*******PRESCRIPTION VALIDATION REQUEST*******

Dear Pharmacy Provider,

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[redacted]

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Sincerely,

[redacted]

[redacted]

[redacted]

CITY OF HOUSTON
Housing & Community Development Department

[redacted]

June 2, 2026

[redacted]
Chief Executive Officer
The Harris Center for Mental Health and IDD
9401 Southwest Freeway
Houston, Texas 77074

Re: 2025 End Street Homelessness Fund 2012 Limited-scope Compliance Monitoring Review Letter for The Harris Center for Mental Health and IDD with Interlocal Outline Agreement Number 4600019019

[redacted]

On May 7, 2026, the City of Houston, Housing and Community Development Department (HCDD), Subrecipient Monitoring Section, completed the End Street Homelessness Fund 2012 Limited-scope review of The Harris Center for Mental Health and IDD's (The Harris Center) operation of the Independent Living Main Street with Interlocal Outline Agreement Number [redacted] The compliance review generally covered September 2025 through November 2025.

The objective of this review was to determine whether The Harris Center properly operated its program in accordance with the Agreement provisions, the federal regulations at 2 CFR Part 200, state, local laws, rules, regulations, ordinances, and guidelines, as applicable to the project.

To accomplish our objectives, the monitoring methodology used during the compliance review included an examination of the HCDD and The Harris Center records, reports, and contract; review of regulations and guides; review of the Fraud, Waste, and Abuse Policy requirements; and interviews with the HCDD and The Harris Center personnel. Additionally, a review of the Single Audit Report was completed, and the HCDD compliance personnel are pleased to confirm that there were no findings. The absence of findings reflects the organization's commitment to strong financial management, compliance, and internal controls. HCDD compliance personnel appreciate the efforts of all involved in maintaining these high standards and will continue to support ongoing compliance and accountability.

[redacted]

[redacted]

[redacted]

[redacted]

DocuSigned by:

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Cost Principles:
https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200

[redacted]

Suicide Safer Care Performance Review
Pre-Review Checklist

Document Submission- 1 week prior to Site Visit
Submit the following into the online BOX folder

- ☐ Suicide prevention and postvention policies
- ☐ Staff policies to prevention compassion fatigue
- ☐ Implementation team roster
- ☐ Implementation team meeting minutes (last 6 months)
- ☐ Agency-wide communication related to Zero Suicide mission (within last year)
- ☐ Workforce survey report (if available)
- ☐ Job description for case manager
- ☐ Job description for therapist or counselor
- ☐ Job description for program manager or supervisor
- ☐ HR Training records (25 pulled randomly)
    - Physicians
    - Support or records staff
    - Mobile Crisis Outreach Team member
    - Child/Adolescent Case Manager
    - Adult Case Manager
    - Child Therapist
    - Adult Therapist

Documents for On-Site/Virtual Review
We need virtual access to the EHR to review the following records. In the review we look at the past 12 months of care, when available.

- ☐ Client records (sample of 40):
    - 5 individuals not at risk of suicide
    - 10 child/adolescent individuals with evidence of suicide risk*
    - 10 adult individuals with evidence of suicide risk*
    - 10 individuals served in crisis care with evidence of suicide risk*
    - 5 individuals served in the suicide care pathway program

** Please include 2-5 individuals who have been hospitalized within the last year*

Staff needed for on-site Interviews

- ☐ Suicide prevention coordinator (60 minutes)
- ☐ Human resources/training department director or staff (30 minutes)
- ☐ Child and Adolescent direct care staff (30 minutes)
- ☐ Adult direct care staff (30 minutes)
- ☐ Staff providing treatments to individuals with suicide risk (30 minutes)

For questions regarding requesting materials for the Suicide Safer Care Review please reach out to [redacted]

From: [redacted]
Sent: Tuesday, June 9, 2026 5:23 PM
To: [redacted]

Team,

Please review the notice below and assist with preparing our audit response.

Kindly identify a point of contact for each applicable component area of the review. Additionally, please indicate who should participate in both the entrance and exit meetings. Please also review questions #1 and #4 and provide your responses.

Thank you in advance for your support.

Good morning,

My name is [redacted], and I am reaching out to inform you of your upcoming Mental Health Quality Management Comprehensive Review. We have your review scheduled for September 14th, 2026, to September 18th, 2026. This will be a comprehensive desk review and on-site review. We are tentatively planning on visiting an outpatient clinic to review the environment and interviews with individuals served. It will be with one family and one adult if possible. We will also be visiting the crisis facilities, diversion center, and state hospital step-down to review the environment. We will also be onsite to review personnel, staff interviews, and for the entrance. I will provide specifics once we get closer to the review as well as set up a Teams meeting with the Point of Contact to provide details. The official notification for this review is estimated to be sent out by the end of next week.

We will be having an entrance meeting, status meetings, exit meeting, and a customer service satisfaction process. (exact entrance and meeting times will be discussed and confirmed with the Point of Contact)

Components of the review:

- Operations
- Medical
- Quality Management
- Environment (on site)
- Clinical Records
- Personnel (on site)
- Staff Interviews (on site/virtual)
- Client Interviews (on site)
- Mystery Caller
  - JBCR
  - Crisis Facilities

All contracts are included in the review (PASRR, RTCI, CRISIS, etc.)

I have a few questions to ask regarding this review:

1. Will these dates be acceptable for you?

2. Who will be the point of contact for this review? Please confirm their name, title, and email? [redacted]

3. Do you have anyone else that you would like to designate as a point of contact for this review? Can you provide me with their contact information? (i.e. email and phone number) [redacted]

4. Do you have a location that is a designated crisis walk-in that has a sign out front indicating this, with designated staff, and where you follow Information Item V Crisis walk-in standards? If yes, the address.
   (This isn't the same as someone coming into other locations who is in crisis. We understand that many centers will help anyone who comes into their clinic to address a crisis. This is specifically asking about having a specific location for crisis walk-ins.)
5. Review of personnel records and staff interviews will occur onsite at the admin building. Can you confirm your administration building is located at: *9401 Southwest Fwy, Houston, TX 77074*? Or if not, please provide the correct address? [redacted]

TEXAS Health and Human Services

LTCR 3701
March 2024

Preliminary Findings Based on Survey, Inspection, or Investigation

Facility/Agency/Program Provider Name:	Entrance Date:	Exit Date:
Pasadena Cottage B	7/16/2026	8/14/2026

Physical Street Address:	Purpose of Visit:
[redacted]	☐Survey ☒Investigation ☐Other:

City:	Zip Code:	County:
[redacted]	[redacted]	[redacted]

Facility/Agency/Program Provider Type	Facility ID/Vendor Number
☐ALF ☐DAHS ☐HCSSA ☒ICF ☐NF ☐PPECC ☐DAHS with ISS (traditional DAHS services and ISS) ☐DAHS – ISS only (only provides ISS services)	7807

Administrator/Manager/Program Director Name:

[redacted], Director

This list contains preliminary areas of potential noncompliance with federal and/or state requirements, based on findings from the entrance and exit dates listed above. Note: If the visit was to an assisted living facility, refer to the attached checklists.

State	Federal	Brief Description of Noncompliance
☐	☐	
☐	☐	[redacted]
☐	☐	
☐	☐	[redacted]
☐	☐	
☐	☐	[redacted]
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Signature – Administrator/Program Director or Designee	Date
[redacted]	[redacted]
[redacted]	[redacted]

This list contains preliminary areas of potential complaint/incident outcomes, based on findings from the entrance and exit dates listed above. If the allegation involved abuse, neglect, or exploitation include the name of the alleged perpetrator. **Note:** If the visit was to an assisted living facility, refer to the attached checklists.

TEXAS Health and Human Services

Texas Health and Human Services Commission

08/28/2026

Administrator
Westbury House
[redacted]

[redacted]

Dear Administrator:

On 08/26/2026, Texas Health and Human Services Commission (HHSC) conducted a Life Safety Code non-onsite follow-up, to determine if your facility complies with state licensure requirements and federal participation requirements for ICF/IID facilities in the Medicare or Medicaid (or both) programs. The survey found that your facility **meets** state licensure requirements and **is in substantial compliance** with federal participation requirements.

[redacted]

[redacted]

[redacted]

[redacted]

Enclosure

[redacted]