Mental Health Rehabilitation Services and Mental Health Targeted Case Management

Annual Provider Attestation Packet

Providers who wish to provide MHR/TCM to Superior HealthPlan members* must submit an attestation packet with required documentation during Superior's open attestation period to provide services during the upcoming State Fiscal Year September 1-August 31. Attestation packets must be submitted annually for review between May 1 and July 1 of the calendar year and Superior will complete their review by August 15 of each year.

Once all fields of this packet are completed, please return this packet to Superior's Network and Development Team at: MHRTCMAttestations@SuperiorHealthPlan.com.

To be considered for participation providers must be:

- Contracted, or in the process of contracting, with Superior.
- Actively and appropriately enrolled with Texas Medicaid for MHR/TCM services.
- Willing to submit an attestation packet and required documentation, annually during Superior's open attestation period, for continued participation.
- A qualified provider as required under the Texas Health and Human Services Commission (HHSC) Uniform Managed Care Manual (UMCM) Chapter 15.1.
- Trained to provide services for all applicable programs as required under the HHSC UMCM Chapter 15.3.

Reminders for Attested Providers:

- Licensed practitioners must adhere to Superior's contracting, credentialing and claim filing guidelines as outlined in Superior provider manuals. This does not replace credentialing for licensed providers.
- MHR/TCM services may not be provided while a member is inpatient.
- Records may be requested at any time for retrospective review and providers must comply with these requests as a term as outlined in the participating provider agreement with Superior.
- Providers who do not have an NPI:
  - QMHPs or other qualified providers who do not have an NPI must complete **Form 1600 - Permission to Allow Superior HealthPlan to Request Child Abuse/Neglect Central Registry** (for foster care providers). This form is located under the Credentialing section on Superior's Provider Forms webpage.
    - Form 1600 must be submitted every 2 years.
    - If DFPS does not clear the Form 1600, the organization will be informed, and that person may not render services to Superior members.
  - Providers may submit the completed 1600 form with the attestation packet.
    - Providers who join an organization outside of the open attestation period may submit the form 1600 directly to Credentialing@SuperiorHealthPlan.com.
  - The group NPI, once attested, can be used to bill MHR/TCM services performed by qualified providers at a group who do not have an NPI. This form is collected as part of the credentialing process for those providers with an NPI, when required.

**MHR TCM can be provided to Superior STAR, STAR+PLUS, STAR Health, STAR Kids, CHIP or STAR+PLUS Medicare-Medicaid Plan (MMP) if they meet the level of care.*

Annual Provider Attestation and Documentation

WHEREAS, Superior HealthPlan ("Superior"), has executed a Participating Provider Agreement with ____________ ("Entity") pursuant to which Entity has agreed to provide Covered Services to Superior Covered Persons through Entity (the "Agreement"); and

WHEREAS, Superior has requested that the undersigned ("Entity") annually attest to the ability to provide Mental Health Rehabilitative Services and Mental Health Targeted Case Management as required by Senate Bill 58 of the 83rd Legislative Session; and

WHEREAS, as a condition of such participation and Entities designation under this Agreement, entity provider must satisfy HHSC's training and certification requirements and execute this Attestation acknowledging their agreement to comply with, and be bound by, the terms and conditions of the Attestation, and including the required documentation specified in the attestation below.

NOW THEREFORE, Entity hereby agrees as follows, and attests that:

1. Participating Providers are trained and certified to administer, the Adult Needs and Strengths Assessment (ANSA) or the Child and/or Adolescent Needs and Strengths (CANS) assessment tools and agree to use these tools to recommend a level of care by using the current Department of State Health Services (DSHS) Clinical Management for Behavioral Health Services (CMBHS) web-based system. The attached required documentation is included as support and verification of this attestation:
    - Complete list of all providers and supervisors within the organization, using the "Comprehensive List of Providers and Supervisors", including the following: Licensed Practitioner of the Healing Arts (LPHA), Qualified Mental Health Professional – Community Services (QMHP-CS), Community Services Specialist (CSSP), Certified Family Partner (CFP), and peer provider.
    - CANS and/or ANSA certificates for each provider and supervisor.
    - Proof of an active CMBHS account.
2. The Participating Provider has completed all training requirements, as indicated below, and as outlined in the HHSC Uniform Managed Care Manual (UMCM) Chapter 15 before delivering any Mental Health Rehabilitation and Mental Health Target Case Management Services. The attached required documentation is included as support and verification of this attestation:
    - Training certificates and/or the training's date of completion for each staff listed as a provider and/or supervisor in the organization, using the "Provider/Supervisor Certification Training Worksheet".

Adult Mental Health Training - All providers delivering and/or supervising services to adults must complete the following SAMHSA training programs:

- Illness Management and Recovery (IMR)
- Assertive Community Treatment (ACT)
- Individual Placement and Supports (IPS)
- Supported Employment (SE)
- Permanent Supportive Housing (PSH)

Children's Mental Health Training - All providers delivering and/or supervising services to children must complete the following trainings:

- Social Skills and Aggression Replacement Techniques (START)
- Preparing Adolescents for Young Adulthood (PAYA)
    - Youth in Transition (PAYA) Tool Kit
    - Module 1: Money, Home, and Food Management
    - Module 2: Personal, Health, Social and Safety Skills
    - Module 3: Education/Employment/Career Tools, Skills and Strategies
    - Module 4: Housing, Transportation and Community Resources
    - Module 5: Young Parents Guide
    - Module 6: Household Management Activities

- Seeking Safety
- Nurturing Parent Program – Tertiary Treatment Protocols
- Barkley's Defiant Child/Defiant Teen
- Wraparound Planning Process[1]

3. The Participating Entity will complete the Texas Standard Prior Authorization Request Form for all Level of Care (LOC) 4 and LOC deviations and will submit to Superior.
4. The Participating Entity will provide Mental Health Rehabilitative Services and Targeted Case Management using the DSHS Texas Resiliency and Recovery (TRR) Utilization Management Guidelines and the ANSA or the CANS tools for assessing a member's needs for services.
5. The Participating Entity has the ability to provide Covered Persons with the full array of TRR services.

   a. Please identify the specific services/programs available directly through attesting organization:

   Mental Health Rehabilitative Services

   ☐ Medication Training and Support

   ☐ Crisis Intervention

   ☐ Skills Training and Development

   ☐ Psychosocial Rehabilitative Services (adults only)

   ☐ Day Program for Acute Needs (adults only)

   Targeted Case Management

   ☐ Routine Case Management

   ☐ Intensive Case Management

   Behavioral Health Services

   ☐ Psychiatric Diagnostic Interview

   ☐ Counseling

   ☐ Pharmacological Management

   b. Please identify the specific services/programs available through subcontract and list the subcontracted organization using the "Subcontractor Summary Worksheet".

   Mental Health Rehabilitative Services

   ☐ Medication Training and Support

   ☐ Crisis Intervention

   ☐ Skills Training and Development

   ☐ Psychosocial Rehabilitative Services (adults only)

   ☐ Day Program for Acute Needs (adults only)

   Targeted Case Management

   ☐ Routine Case Management

   ☐ Intensive Case Management

   Behavioral Health Services

   ☐ Psychiatric Diagnostic Interview

   ☐ Counseling

   ☐ Pharmacological Management

6. The Participating Entity is familiar with HHSC's cost reporting process and will participate in this process.

Entity Name (print): ______________________________

Facility Signature: ______________________________

Signature Date: ______________________________

Tax ID Number: ______________________________

Group NPI Number: ______________________________

Attestation and required documentation must be emailed within 10 Calendar Days of signature date to the Network and Development Team: MHRTCMAttestations@SuperiorHealthPlan.com. Once approved, the attestation is valid for one year from signature date.

For questions, please contact your Behavioral Health Provider Representative at AM.BH@SuperiorHealthPlan.com. If you are attesting for the first time, **please complete all pages**. If you are submitting an annual re-attestation, all pages are required except for 7-8, as you can communicate regular address changes directly to your Provider Representative.

[1] Providers may begin delivering services before completing wraparound training if they demonstrate evidence of registering for the next available session.

Comprehensive List of Providers and Supervisors

To be completed by Attesting Organization

Name	Credentials	Practitioner NPI or Date of Birth when no NPI	Training worksheet completed (see page 5)

To be completed by Superior HealthPlan

Approved or Denied

Provider/Supervisor Certification and Training Worksheet

One document must be completed for each practitioner

Name: ______________________________

Provider Credentials (LPHA, QMHP-CS, CSSP, CFP, Peer Provider): ______________________________

Level of Education: ______________________________

License type and number, if applicable: ______________________________

Training Log

1. Does provider deliver and/or supervise services to adults? ☐ Yes ☐ No
2. If yes, please indicate the completion dates for the following Adult Mental Health Trainings:
   a. Illness Management and Recovery (IMR): ______________________________
   b. Assertive Community Treatment (ACT): ______________________________
   c. Individual Placement and Supports (IPS) Supported Employment (SE): ______________________________
   d. Permanent Supportive Housing (PSH): ______________________________
3. Does provider deliver and/or supervise services to children? ☐ Yes ☐ No
4. If yes, please indicate the completion dates for the following Children's Mental Health Trainings:
   a. Social Skills and Aggression Replacement Techniques (START): ______________________________
   b. Preparing Adolescents for Young Adulthood (PAYA)
      i. Youth in Transition (PAYA) Tool Kit: ______________________________
      ii. Module 1: Money, Home, and Food Management: ______________________________
      iii. Module 2: Personal, Health, Social and Safety Skills: ______________________________
      iv. Module 3: Education/Employment/Career Tools, Skills and Strategies: ______________________________
      v. Module 4: Housing, Transportation and Community Resources: ______________________________
      vi. Module 5: Young Parents Guide: ______________________________
      vii. Module 6: Household Management Activities: ______________________________
   c. Seeking Safety: ______________________________
   d. Nurturing Parenting Program – Tertiary Treatment Protocols: ______________________________
      i. Please also attach the certificate of completion for this training.
   e. Barkley's Defiant Child/Defiant Teen: ______________________________
   f. Wraparound Planning Process: ______________________________
      i. If not yet completed, please indicate date registered for next available session: ______________________________
5. Has provider completed the ANSA training? ☐ Yes ☐ No
   a. If yes, please attach certificate.
6. Has provider completed the CANS training? ☐ Yes ☐ No
   a. If yes, please attach certificate.

For Internal Use Only:
☐ Approved ☐ Denied Date: ______________________________

Subcontractor Summary Worksheet

Mental Health Rehabilitative Services

	Subcontractor TIN	Entity Name	Phone Number and Contact Name
Medication Training and Support			
Crisis Intervention			
Skills Training and Development			
Psychosocial Rehabilitative Services (adults only)			
Day Program for Acute Needs (adults only)			

Targeted Case Management

	Subcontractor TIN	Name	Phone Number and Contact Name
Routine Case Management			
Intensive Case Management			

Behavioral Health Services

	Subcontractor TIN	Name	Phone Number and Contact Name
Psychiatric Diagnostic Interview			
Counseling			
Pharmacological Management			

Demographic Information

Legal Business Name: ______________________________

Office DBA Name: ______________________________

Physical Address (must be a street address): ______________________________

City: ______________ State: ________ Zip: ________ County: ______________

Office Phone: ______________ Office Fax: ______________

Office Email Address: ______________ Office Website: ______________

Tax ID: ______________ NPI: ______________ Medicare Identification Number: ______________

Specialty: ______________ Sub-Specialty: ______________

Primary Taxonomy: ______________ Additional Taxonomy: ______________

Mailing address same as above? ☐ Yes ☐ No (If **No**, complete information below.)

Mailing Address (must be an address): ______________________________

City: ______________ State: ________ Zip: ________ County: ______________

Facility Phone: ______________ Facility Fax: ______________

PLEASE NOTE: SIGNED AND DATED W-9 MUST BE PROVIDED FOR BILLING ADDRESS

Office Hours and Additional Practice Locations

Primary Location

Your primary location is the physical address listed in the “Demographic Information” section above. Please include office hours for your primary location below:

Office Hours	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Providers can utilize the following page to add any additional locations operating under the same group NPI. If you have multiple group NPIs, please complete pages 7-8 for each NPI.

Physical Location 2

Physical Address (must be a street address): ______________________________

City: ______________________________

State: ______________________________ Zip: ______________________________

County: ______________________________

Office Phone: ______________________________

Office Fax:______________________________

Office Hours	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Physical Location 3

Physical Address (must be a street address): ______________________________

City: ______________________________

State: ______________________________ Zip: ______________________________

County: ______________________________

Office Phone: ______________________________

Office Fax:______________________________

Office Hours	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	