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CLASS Webinar

February 13, 2017

Agenda

- Person-centered Thinking – Mary Bishop
- HCBS Federal Rules – Desiree Martinez
- Reorganization of DADS PE/UR - Patrick Koch
- CLASS Eligibility and Enrollment – Fabian Aguirre & Angie Hutchison
- Contract Monitoring - Sarah Schmidt
- Contracting for CLASS – Anne Tanner
- CLASS Provider Manual Revisions – Bob Scott
- CLASS Rules Revisions – Bob Scott

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Person-Centered Practices Overview

Mary Bishop, LMSW
Person Centered Practices Coordinator
Policy and Program Development

Why Now?

- November 25, 2013
  - CMS announced the development of “a national partnership to improve the quality of care provided to individuals with dementia living in nursing homes.
  - This partnership is focused on delivering health care that is person-centered, comprehensive, and interdisciplinary.”

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Why Now?

- January 16, 2014
  - CMS Rule issued requiring person-centered plans of care and service plans for Home and Community-Based Settings (HCBS) and requirements for Community First Choice (CFC) and HCBS Waivers.
  - The rule is as of effective March 17, 2014, with full compliance expected by March 17, 2019.

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Why Now?

- Senate Bill (S.B.) 7, 83rd Legislature, Regular Session, 2013, directs HHSC & DADS to promote integrated person-centered planning & person-centered services
- April 2015, CMS updated survey guidance for ICF/IID compliance, which includes person-centered and outcomes for people

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Why Now?

- CFC was implemented on June 1, 2015, with the person-centered planning training requirement due in two years (June 1, 2017) for current staff or two years from date of hire after June 1, 2015
- Added to Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability by CMS Final Rule, April 2016.

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CMS HCBS Requirements

- Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS
- Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
- Optimizes individual initiative, autonomy, and independence in making life choices
- Facilitates individual choice regarding services and supports, and who provides them.

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Person-Centered Planning Overview

- Person-centered thinking
- Person-centered planning process
- Person-centered service plan
- Person centered practices

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Introduction to Person-Centered Planning

- Person-Centered Planning identifies and highlights a person's unique talents, gifts, and capabilities
- Explore and discover where in the "real" world these gifts can be shared and appreciated and where the person's contributions and social roles will be valued

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Core Values of Person-Centered Planning

- Dignity
- Community Inclusion
- Potential and Contribution
- Self-determination

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Person-Centered vs. Traditional Planning

Independence is Being in Control

"Independent living is not about doing things yourself, it is about being in control of how things are done."

Judith Heumann

U.S. State Department

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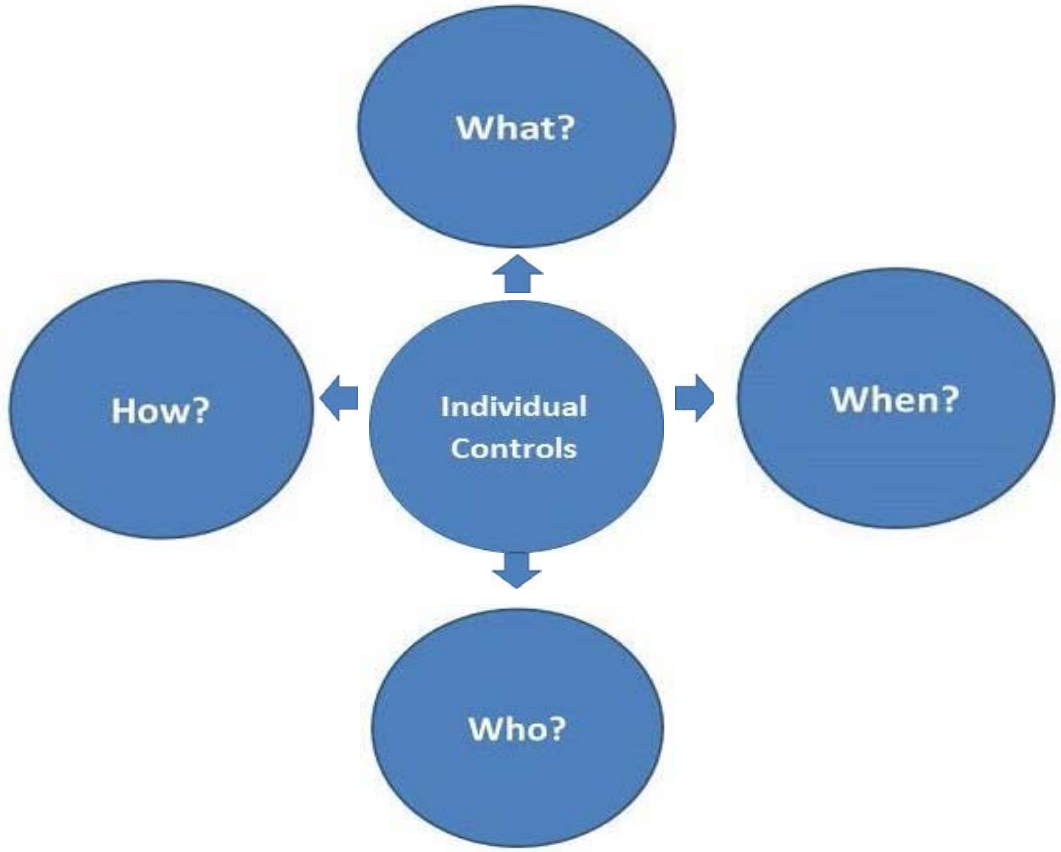
Individual Controls the Process



Domains of Choice

- Individual chooses:
  - Where and with whom they live
  - Where they work
  - Their daily routine
  - Their intimate relationships
  - How much information to share
  - Their services and supports
  - **THEIR OUTCOMES**

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Dimensions of Choice

- To make meaningful choices, individuals need*:
  - Concrete life experiences (experiential context)
  - Access to social support by trusted family members, friends and peers (social context)
  - An array of options (creative context)

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Planning Components

Preferences and Outcomes

- A preference is a choice an individual makes for one option over others.
- An outcome is what a person wants to do, achieve, change, maintain, or experience that is important to them.

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Needs

- Needs are things that individuals must have in order to ensure their safety, health, and successful integration into their community.
- Needs are what is important for the individual as found in functional and clinical assessments.

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Supports

Supports are any form of paid, unpaid, or natural assistance that is available to an individual and any other member of the community.

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Services

Services are any programmatic or professional resource recommended in the functional and/or clinical assessments, which is available to anyone within the community and used to meet his or her personal outcomes.

Short-term Objectives

Action steps and short-term objectives refer to combined activities that enable each personal outcome to be achieved.

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Monitor and Measure

- The individual, in collaboration with his or her planning team, determines:
  - How the steps are to be monitored and measured to reach the outcome
  - When (frequency) the steps/short-term objectives have been accomplished to assist in reaching the outcome
  - Who is responsible for monitoring and measuring the success towards the desired outcome
  - **If the outcome has been accomplished**

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Outcomes Are Key!

- All the components of person-centered service plan are essential, but outcomes are the key!
  - Every person has a life that looks different and unique based on his or her own personal definition of life quality.
  - There is no specific or narrow definition of an outcome that applies to an entire group of people. It is unlikely that any two people will define an outcome in the exact same manner.

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Outcome Defined

An outcome is what an individual wants to **do, achieve, change, maintain, or experience** that is important to them.

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Unpacking the Definition

"Do"

- New actions/activities of any kind

"Achieve"

- A result of action, a milestone or marker that can be seen and measured

"Change"

- A present condition is stopped or replaced with something else

"Maintain"

- Keeping a positive status quo condition or preventing something from happening

"Experience"

- Creating a positive feeling or sensation by seeking or receiving an outcome or by doing something novel

Outcome Barriers and Risk Assessment

- What is the risk of not achieving this personal outcome?
- What is getting in the way of achieving the outcome – the barriers?
- What is the "solution" for achieving the outcome and /or addressing the barriers?
- What are the risks associated with the "solutions" and how can we reduce them?

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The Means is not the Outcome

- Services and supports are a means to achieving an outcome.
- When services and supports do not produce outcomes, they become ends in themselves.
- Thus, the means to an outcome may become confused with the outcome itself.

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Two Central Questions

1. Is the outcome defined by the person present in their life?

2. Are individualized supports and services present in the person's life to assist them to attain this outcome?

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Outcome Monitoring/Measurement

- Again, it is the individual that determines if the outcome has been accomplished.
- “Experience” outcomes can be verified by report and observation.
- Progress of short-term objectives need to be monitored, and objectives should be changed as needed to assure outcomes are met.

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Special Thank You:

Materials in this presentation include person centered concepts, principles and materials from Support Development Associates, The International Learning Community for Person Centered Practices, Institute for Person-Centered Practices, and The Council on Quality and Leadership.

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Resources

- CMS Final Rule, April 2016
  - https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered
- Support Development Associates
  - http://sdaus.com/
- The International Learning Community for Person Centered Practices
  - http://www.learningcommunity.us
- Institute for Person-Centered Practices
  - http://www.person-centered-practices.org/
- The Council on Quality and Leadership
  - http://www.thecouncil.org/

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Questions and Answers

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Thank You!

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HCBS Federal Rules

Desiree' Martinez
Policy Development Support

Purpose

- Provide background on the rules for Home and Community Based Services (HCBS) settings.
- Provide information on the revised statewide transition plan (STP)
- Provide updates on status of implementation and timelines

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HCBS Settings

- These rules apply to:
  - 1915 (c) waivers
    - Community Living Assistance and Support Services (CLASS)
    - Deaf Blind with Multiple Disabilities (DBMD)

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HCBS Settings

- These rules apply to:
  - Home and Community-based Services (HCS)
  - Medically Dependent Children Program (MDCP)
  - Texas Home Living (TxHmL)
  - Youth Empowerment Services (YES)

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HCBS Settings

- These rules apply to:
  - 1915 (i) state plan services
  - Community First Choice (1915 (k) state plan services))
  - HCBS State of Texas Access Reform (STAR+PLUS) Waiver (1115 demonstration waiver)

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HCBS Settings

- These rules are intended to make sure individuals receive services in settings that are integrated in and support full access to the community.
- These rules give people the opportunity to:
  - Seek employment in competitive and integrated settings
  - Take part in the community
  - Be in control of personal resources
  - Get the same access to services as those not receiving HCBS

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HCBS Transition Plan

- States were required to send transition plans to the Centers for Medicare & Medicaid Services (CMS) detailing how they would review their programs and achieve compliance with the rules by March 2019.
- Transition plan requirements include:
  - Internal and external review of existing settings to see if rules and policies support regulations and whether individuals experiences match policy
  - Strategies and a plan for remediation
  - Public and stakeholder input into the assessment and remediation strategies

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Status of Texas' HCBS STP

- Texas submitted a plan to CMS in December 2014 and a revised version in March 2015.
- Texas received initial feedback from CMS in September 2015 and submitted a revised version in February 2016.
- Texas received feedback from CMS in June 2016 and submitted a revised version in November 2016.
- These submissions are to gain initial approval of the STP.
- While pending approval, work continues and the agency is in the assessment period of the plan.

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STP Timeline

- Systemic/Internal Assessment – completed in December 2015
- External Assessment – provider, participant and service coordinator surveys are completed. The analysis of survey results is ongoing.
- Identify any need for additional remedial action and milestones – Spring & Summer 2017
- Remediation Timeline Milestones -anticipated completion date 2018
- Next slide contains more detail on the remediation/timeline milestones

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Remediation Timeline Milestones

- Proposed Completion Dates:
- May 2017
  - Seek legislative funding during 2017 state legislative session to implement regulations
- June 2017
  - Amend waivers to include HCBS regulations and any needed rate adjustments
- December 2017
  - Amend program rules Texas Administrative Code; Augment contract monitoring tools already in place

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Remediation Timeline Milestones

- Proposed Completion Dates:
- March 2018
  - Revise waiver policy manuals to include HCBS regulations
- Ongoing
  - Develop educational webinars for 1915(c) providers about HCBS federal regulations

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Submitting Feedback on Amended STP in Spring 2017

- HHSC will update the STP in the spring of 2017.
- Will include more substantive changes based on results of external assessments.
- The 2017 STP updates will be posted for the full 30 days to allow for public comment and inclusion of comments in the update.
- The posting will be on the HHSC website on the following webpage:
  https://hhs.texas.gov/services/health/medicaid-and-chip/about-medicaid/homecommunity-based-services

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Community Day Habilitation Programs

- Based on the HCBS final rule, day habilitation is a service state staff have identified as non-compliant with the new HCBS settings regulation.
  - CMS guidance indicates settings in which only individuals with disabilities congregate is not considered integrated into the community.
  - HHSC believes additional funding will be needed to restructure how day activity services are delivered to ensure compliance with new settings provisions.

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Legislative Appropriations Request 85th Legislative Session

- Legislative Appropriations Request (LAR)
  - HHSC submitted Legislative Appropriations Request
  - Posted on the Texas HHS Website: **https://hhs.texas.gov/about-hhs/communications-events/news/2016/09/hhs-fiscal-years-2018-19-legislative-appropriations-request**

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Key Aspects of Compliance

- Settings owned and controlled by providers:
  - Legally enforceable lease agreements
  - Privacy/Respect
    - Private access to phone
    - Private medical records
    - Choice of clothing

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Key Aspects of Compliance

- Settings owned and controlled by providers:
  - Privacy/Respect
    - If individual does not need staff assistance--toileting and grooming activities are private
    - Locks on bedroom door if requested
  - Choice of roommates
  - Choice regarding daily activities—independent of group activities if desired

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Key Aspects of Compliance

- Support for access to public transportation to facilitate community integration and autonomy
- Support for competitive employment or volunteer activities if desired
- Residences are completely accessible to individuals with disabilities who live at the residence

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HCBS Resources

- CMS HCBS webpage

  http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services.html

- HHS HCBS webpage

  https://hhs.texas.gov/services/health/medicaid-and-chip/about-medicaid/homecommunity-based-services

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HCBS Resources

- 1915(c) Statewide Transition Plan webpage
  https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/home-and-community-based-services-hcbs/hcbs-rules-statewide-transition-plan

- YES 1915(c) Waiver webpage
  http://www.dshs.texas.gov/mhsa/yes/Centers-for-Medicare-and-Medicaid-Services-HCBS-Rules.aspx

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Ongoing Feedback

Please submit any additional questions or feedback on this topic to:

Medicaid_HCBS_Rule@hhsc.state.tx.us

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Reorganization of DADS Program Enrollment/Utilization Review (PE/UR)

Reorganization of DADS PE/UR

DADS PE/UR was divided into two sections under HHSC's Medicaid & CHIP Department as part of the HHSC transformation that took place on Sept. 1, 2016

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Reorganization of DADS PE/UR

- PE:
  - IDD Program Eligibility & Support (PES) (managed by Cheryl Craddock-Melchor)
  - IDD Eligibility Unit (managed by Fabian Aguirre)

  - Determines LOC (ID/RC PC 2s and 3s) and program eligibility for CLASS
  - Processes CLASS enrollments, transfers, suspensions, and terminations

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Reorganization of DADS PE/UR

- UR:
  - IDD/Community Services/Hospice Utilization Review (managed by Cindy Kenneally)
  - IDD Utilization Review for CLASS and DBMD (managed by Patrick Koch)

  - Utilization Review of IPCs submitted by contracted providers
  - Implementation of UR findings identified by Field UR staff
  - Technical assistance for contracted providers

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CLASS Eligibility and Enrollment

Fabian Aguirre, ***Unit Manager***

Angie Hutchison, ***Program Specialist V***

IDD Program Eligibility & Support

Prior coverage

- The case manager has a monthly responsibility to ensure the individual has Medicaid eligibility, as is stated in 2200 of the CLASS Provider Manual.
  - This is the first step to ensuring that an individual does not have any gaps in Medicaid eligibility.

- Additionally, the case manager should be aware of the date the individual's Medicaid will renew so they can help the individual to be prepare for the renewal.

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Prior coverage

- A case manager is able to call 2-1-1 to get the recertification date, but if the CM is **NOT** listed as an authorized representative on the individual's Medicaid case in TIERS, the individual will have to be present during the call.

- An SSI recipient would not have a recertification date.

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Prior coverage

- When an individual turns 18, this can sometimes result in changes to the individual's Medicaid status as well as any major life changes.
- The case manager should watch the individual's Medicaid status closely during these times and be ready to assist with maintaining eligibility.

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Prior coverage

- Once Medicaid is lost, the case manager must work proactively with the individual and family to re-establish Medicaid.
- One way to do this is by calling the Medicaid worker at 2-1-1 with the individual.
- The Medicaid worker can:
  - Review the previous coverage to verify the assessment for prior coverage was completed
  - That the packet was submitted using the required H1746A cover sheet.

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Prior coverage

- If a gap is discovered after reinstating Medicaid it is important to call 2-1-1 to determine if prior coverage can cover the gap.
- If you still are not able to correct the gap you can call the IDD-PES Hotline for CLASS at:

  512-438-4896

- For additional questions specific to Medicaid for the Elderly and People with disabilities you can email them at: **contact@HHSC.state.tx.us**

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Fair Hearing Activities

- Providers should be on the look-out for an Information letter (IL) to post on Loss of Medicaid Eligibility and CLASS Program Eligibility.
- The Health and Human Services Commission (HHSC) will be combining hearings with Medicaid for the Elderly and People with Disabilities (MEPD) for hearings regarding loss of financial eligibility for CLASS and DBMD waiver programs, and the resultant action of program termination due to loss of eligibility.

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Fair Hearing Activities

- To ensure appeal information for program terminations due to loss of financial eligibility is submitted to the appropriate department, the new process for requesting an appeal of a program termination for loss of financial eligibility due to loss of financial eligibility will be outlined in the IL.
- Submission of appeal requests **WILL NOT** be changing with this procedure change.
  - CMAs will continue to send all program termination appeal requests to HHSC.
  - The change taking place is internally at HHSC, we will combine those hearing activities with MEPD.

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Reduce Remands and Reduce Enrollment Delay – ID/RC Submissions

- ID/RC Assessment (Form 8578)
  - Verify primary diagnosis (Field 19) ***exactly*** matches ICD code (Field 20)
    - For ***exact*** wording, use approved related condition list

https://hhs.texas.gov/sites/hhs/files/documents/doing-business-with-hhs/providers/health/icd10-codes.pdf

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Reduce Remands and Reduce Enrollment Delay – ID/RC Submissions

- Verify all signatures and dates are populated
  - Provider certification section (Fields 56 – 58) must ***always*** be populated.
  - Physician attestation section must be populated ***if***:
    - ID/RC is a Purpose Code 2 (No Current Assessment); or
    - The primary diagnosis has changed.

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Reduce Remands and Reduce Enrollment Delay – ID/RC Submissions

- Verify the RCESI (Form 8662) is fully completed
  - Summary Section (Section 4) must ***accurately*** represent data from Sections 2 and 3.
  - RCESI must be signed by all responsible parties
    - Applicant/individual must sign if he or she is an adult with no guardian.

- Verify the ABL assessment is within 5 years
  - The ABL assessment must be administered ***within 5 years from the requested LOC effective date***.
  - The ABL scoring summary must be included.

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Reduce Remands and Reduce Enrollment Delay – IPC Enrollment

- Verify all standard submission documents are included when submitting IPC enrollment to HHSC
  - List of most common missing standard submission documents:
    - Authorized PC 2 ID/RC (Form 8578)
    - Selection Determination
    - Verification of Freedom of Choice (Form 8601)
    - Addendum E along with the Nursing Assessment (Form 6515)
    - PAS/Habilitation Plan - CLASS/DBMD/CFC (Form 3596)

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Reduce Remands and Reduce Enrollment Delay – ID/RC Submissions

- Verify Individual Program Plan (IPP) (Form 8606) includes the following:
  - Signatures and dates from all required participants
  - Explanation/justification for each service indicated on Individual Plan of Care (IPC) (Form 3621)

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Dual Enrollment

- HHSC will verify termination from disallowed programs prior to authorizing the CLASS enrollment.

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Dual Enrollment

- The CMA remains responsible for all requirements, such as:
  - Coordinating a smooth transition from existing program/service to CLASS
  - Including a **future projected CLASS start date** to allow for the coordination of an end to previous programs when necessary
  - Including a **1st of the month CLASS start date** if previous program is MCO STAR+PLUS (Service Group 19) or MDCP STAR+KIDS (Service Group 18)
  - Submitting IPC enrollment within required timeframes

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Dual Enrollment

- **If CMA fulfilled their requirements**, the CMA may submit the IPC enrollment prior to service group closure.
- In these cases, HHSC will assist with service closures.

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Technical Assistance: CLASS

- CLASS general message line:
  512-438-4896

- CLASS Provider Manual site:
  https://hhs.texas.gov/laws-regulations/handbooks/community-living-assistance-and-support-services-provider-manual

- CLASS Forms:
  https://hhs.texas.gov/laws-regulations/handbooks/community-living-assistance-and-support-services-provider-manual/class-pm-forms

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Frequent Citations

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Case Management Agency - Most Common Citations

Please see CMA Workbook for reference information

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Standard III.5. Renewal SPT

- The CMA must explain to the individual/LAR or person actively involved with the individual, orally and in writing the mandatory participation requirements of an individual as described in §45.302.

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Standard III.5. Renewal SPT

- The SPT meeting must be convened at least annually, between 30 and 90 calendar days before the end of the IPC period.

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Standard III.6. Renewal SPT

- Within 10 business days of DADS notification of approval, the case manager must provide copies of the DADS authorized IPC, IPPs, habilitation plan/habilitation training plan, SPT notes and ID/RC to all members of the SPT and to any additional CLASS service providers (FMSA, Continued Family Services [CFS], and Support Family Services [SFS]), as necessary.

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Additional Documents

- Therapy Justifications (8606As) and Request for Adaptive Aids, Medical Supplies, or Minor Home Modifications (3660) must also be provided with the DADS authorized IPC, IPPs, habilitation plan/habilitation training plan, SPT notes and ID/RC, if applicable.

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Standard III.8. Revision SPT

- The CMA must submit revision documentation to DADS at least 30 calendar days before the proposed effective date.

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Additional Documents

- Within five business days of DADS transmission of the authorized IPC, as evidenced by the fax transmittal date on the documents, the case manager must provide copies of the DADS authorized IPC, IPPs, habilitation plan/habilitation training plan, the Service Planning Team (SPT) notes and intellectual disability/related condition (ID/RC) to all members of the SPT.
- The case manager must provide copies of this documentation to any additional CLASS service providers (FMSA, CFS, and SFS), as necessary.

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Standard III.9. IPP Service Reviews

- The CMA must in accordance with the CLASS Provider Manual
  - Meet with the individual/LAR to complete Form 3595, IPP Service Review
  - Reviewing the individual's progress toward achieving the goals and objectives as described on the IPP.
  - That includes the following documentation for all services on the IPC:

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Standard III.9. IPP Service Reviews (cont.)

- Documentation of progress or lack of progress toward goals/objectives as identified on the IPPs /IPC
- Assess the individual's satisfaction with the provision of CLASS program services
- Identify any changes to the individual's needs, if applicable
- If applicable, FMS option.

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Standard III.9. IPP Service Reviews (cont.)

- *Refer to Appendix X: Quarterly Due Dates Chart*

- The CMA must provide a copy of the IPP Quarterly/90-Day Service Review to the individual/LAR, DSA, and FMSA (if applicable) within 5 business days of the review date.

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Standard III.10. Medicaid Eligibility

- The CMA must verify the individual's Medicaid eligibility monthly.

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Direct Service Agency - Most Common Citations

Please see DSA Workbook for reference information.

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Standard II.2: Staff Qualifications / Training

- Habilitation/CFC Habilitation staff must receive orientation before the first date of service delivery.

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Standard VI.2: Renewal

- Annually, the DSA must explain orally and in writing to the individual and LAR or person actively involved with the individual:
  - Rights and responsibilities including complaint procedures
  - How to report an allegation of abuse, neglect, or exploitation
  - How to make a complaint

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IPP Service Summaries Section 3350

IPP Service Summaries required for the following:

- Auditory enhancement training
- Behavioral support
- Dietary services (nutritional services)
- Habilitation training
- Occupational therapy
- Physical therapy
- Prevocational services

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IPP Service Summaries Section 3350

[cont....]

- specialized therapies
- speech therapy
- supported employment services

Copies of the completed IPP Service Summaries must be provided to the CMA within five business days of completing the IPP Service Summary.

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IPP Service Summary

- The DSA quarterly review/90-Day Service Summary must include the following elements:
  - Current observable/measurable goals and objectives
  - Frequency and duration of sessions attended
  - Rationale for missed sessions

Refer to Appendix X: Quarterly Due Dates Chart

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IPP Service Summary

- The DSA quarterly review/90-Day Service Summary must include the following elements:
  - Progress or lack of progress
  - Actions taken, as applicable (e.g., in-servicing, counseling, etc.)
  - Revisions of goals and objectives, as applicable
  - *Refer to Appendix X: Quarterly Due Dates Chart*

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Transfers

- Copies of the identified records must be delivered to the receiving DSA within five calendar days of notification by the case manager of the individual's decision to transfer to a different DSA.
- The transferring DSA is required to maintain documentation of the specific records that were delivered to the receiving DSA, as well as the date of the delivery.

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Monitoring Review Tools

CLASS Program Monitoring tools (DSA and CMA) can be found on the internet at:

https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/contract-fiscal-compliance-monitoring-tools

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Contract Compliance and Performance Management

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Fax	(512) 438-3639

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Contracting for CLASS

Anne Tanner, *Contract Specialist V*
Contracted Community Services (CCS)

CLASS Contracting Requirements

- Applicants who wish to contract for the CLASS program must reference 40 Texas Administrative Code (TAC) §49.205 (a) (1) (2), which states the following:
  - To be a contractor, an applicant must have a license, certification, accreditation, or other document as follows:

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CLASS Contracting Requirements

- CLASS/Continued Family Services (CFS) and CLASS/Support Family Services (SFS) require a permit to operate a child-placing agency issued by the Department of Family and Protective Services (DFPS) in accordance with Chapter 745; or
- A Home and Community Support Services Agency (HCSSA) license issued by the DADS in accordance with Chapter 97 with:
  - Licensed Home Health Services (LHHS) category; or
  - Licensed and Certified Home Health Services (L&CHHS) category

CLASS Contracting Requirements (cont.)

- CLASS/Direct Services Agency (DSA) requires a HCSSA license issued by HHS in accordance with 40 TAC Chapter 97 with:
  - LHHS category; or
  - L&CHHS category
- CLASS/Case Management Agency (CMA) contracts do not require a license

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CLASS Contracting Requirements (cont.)

- An entity may apply for either a CLASS/CMA contract or a CLASS/DSA contract, **but not both**, in any particular catchment area.
- A CLASS provider must be able and willing to provide the entire array of services to the CLASS individuals they're serving.

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CLASS Contracting Requirements (cont.)

- A CLASS provider must have a business location in the catchment area (service area) for which they wish to provide services.
  - In order to provide direct services in a specific catchment area, a CLASS/DSA provider must have a licensed office location in that catchment area.

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CLASS Contracting Requirements (cont.)

- If you already have an existing contract with Health and Human Services (HHS) (i.e. DBMD contract), you can simply request to add a contract for CLASS.
- The request must be signed by an authorized representative for your agency.
- The request can be faxed to Contracted Community Services (CCS) at (512) 438-5522.

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CLASS Contracting Information

More information about the CLASS program can be found at:

https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/community-living-assistance-support-services-class

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CLASS Contracting Information (cont.)

- More information on how to become a CLASS provider and the address for submitting an application can be found at:

  https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/community-living-assistance-support-services-class/how-become-a-class-provider

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CLASS Contracting Information (cont.)

The Form 5830, Application Packet Checklist, includes all required forms and documents.

This form can be found at:

https://hhs.texas.gov/laws-regulations/forms/5000-5999/form-5830-application-packet-checklist-state-office-enrolled

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CLASS Accepting New Providers

- Current CLASS providers may apply to become a CLASS provider in one of these service areas (catchment areas):
  - Abilene
  - Eagle Pass-Uvalde
  - El Paso
  - Lufkin
  - Midland/Odessa
  - Waco/Temple
  - Wichita Falls

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CLASS Accepting New Providers (cont.)

- A list of the counties in each catchment area can be found on the HHS website under the instructions for Form 3691, Service Area Designation.
- This list can be found at:

  https://hhs.texas.gov/sites/hhs/files//documents/laws-regulations/forms/3691/CountiesbyCatchmentArea.pdf

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Contact Information for CCS

Email:
Community.ServicesContracts@dads.state.tx.us

Phone:

Unit Voice Mail: (512) 438-3550

Fax: (512) 438-5522

Mail:

Health and Human Services
Contracted Community Services
Mail Code W-357
P.O. Box 149030
Austin, Texas 78714-9030

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CLASS Provider Manual Revisions

Bob Scott

CLASS Policy Specialist

Provider Manual Revisions

- Revisions are currently available for stakeholder feedback.
- Alert published January 23, 2017
- Primarily related to inclusion of CFC PAS/HAB
- Revising DADS to HHS
- Comments accepted until COB February 13, 2017
- Comments submitted to **class@dads.state.tx.us**

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Appendix I: Adaptive Aids

- Includes DO as physician
- Revises emergency response system to emergency response service
- Consistent with other waivers definition

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Chapter 1000: Introduction

1. Added waiver bridge explanation
2. Clarified program eligibility criteria
3. Added CFC eligibility criteria

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Chapter 2000: CMA

- Added CFC services
- Defined “direct contact”
- CMA person-centered training requirement
- Medicaid eligibility verification
- Person-centered planning process information
- Requires Form 3629, Individual Program Plan Addendum to document using the person-centered planning process
- Enrollment and renewals occur in individual's home

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Chapter 2000: CMA

- Annual verification of freedom of choice at renewal
- CMA must provide EVV information at enrollment
- Remove habilitation training
- Added new forms requirement
- Revised Immediate Jeopardy sections
- CDS individuals can leave Texas without suspension
- CMA explains CFC State Plan if CLASS is terminated

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Chapter 2000: CMA

- A CLASS CMA is only authorized to provide case management services to individuals served by the CMA.
- 42 CFR §441.301(c)(1)(vi) specifies providers of HCBS for the individual, or those who have an interest in or are employed by a provider of home and community-based services for the individual must not provide case management or develop the person-centered service plan.

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Chapter 3000: DSA

- Added CFC PAS/HAB to replace CLASS habilitation
- Added Transportation – Habilitation
- Person-centered training required if responsible for developing PAS/HAB plan
- Medicaid eligibility verification
- Revised Immediate Jeopardy sections
- Revisions may occur by conference call and fax

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Chapter 3000: DSA

- Replace habilitation-training with CFC PAS/HAB
- DSA may use date stamp on service summaries
- CDS individuals can leave Texas without suspension
- AAs over $500 changes to 3660 instructions
- CFC and CLASS services must be provided in settings determined through person-centered planning process

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Chapter 4000: CDS

- Requires Form 3629, Individual Program Plan Addendum to document using the person-centered planning process
- Additional CDS forms added
- Additional information on CDS support consultation
- CDS services provided when individual is outside Texas
  - Limited to 30 days within IPC year
  - Must notify CMA prior to leaving and upon returning

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Chapter 4000: CDS

- Updated CLASS services which may be self-directed
- Changed “Provider-Managed” to “Agency”
- Requires use of PAS/Habilitation Plan - CLASS/DBMD/CFC
- Updates web address of CDS brochure
- Updates web address of CDS Resource website

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Chapter 5000: UR

- UR Threshold section replaced with Cost Limits
- UR for dental services explained

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Chapter 6000: Contract Monitoring

- Readiness reviews no longer available
- Monitoring process clarified

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Chapter 7000: Billing/Records

- DSA required to continue services if termination appealed
- CMA billable tasks included
- Monthly monitoring required
- Behavior support plan development
- Web site for employment services support added
- Billable tasks for CFC PAS/HAB and support management

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CLASS Forms

- Vehicle evaluation by automotive technician
- IPP Service Review and instructions
- Request for Adaptive Aids, Medical Supplies, Minor Home Modifications or Dental Services/Sedation
- Removed Personal Care Services Selection
- Removed Habilitation Training Plan
- Added requirement to use Individual Program Plan Addendum

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CLASS Rules Revision

40 TAC Chapter 45

CLASS Rules Revision

- Address changes in the authority of the DFPS Adult Protective Services Provider division
- APS Provider division investigates allegations of ANE of an adult or child receiving CLASS or CFC
- Annual verification of choice between waiver and ICF/IID

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Questions?

class@dads.state.tx.us

Wrap Up

- Next Webinar is scheduled for **May 17, 2017**
- Announcement to go out by GovDelivery (Granicus)
- Please keep up-to-date with HHSC email alerts to learn when this webinar is posted to the CLASS webpage.

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Wrap Up

- Your feedback will assist HHSC in refining this communication format to suit the needs of CLASS providers and other interested parties.
- If you have comments regarding this webinar, please send them to the CLASS mailbox at

class@dads.state.tx.us

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Thank you for joining us!