Questions from CLASS Webinar of 5/22/18

When Medicaid gaps occur, should the case manager assist the individual to re-establish Medicaid? If application not completed by CMA, is the DSA held accountable?

Yes, assisting the individual to establish and maintain Medicaid eligibility is part of the case management service. If problems occur based upon an individual's failure to apply for Medicaid or the individual's problem with making a decision to complete the application, contract monitors encourage the case manager and the direct services agency to document the problems. This can provide contract-monitoring staff a clear picture of what happened and why it happened. This can ensure an agency is not cited.

What is the timeframe for contractors to submit their quarterly reviews to the DSA?

The DSA should require Service Summaries from each of the contracted or employed therapists and should ensure they are submitted to the DSA by a required due date which allows the DSA to provide the service summaries to the case manager by the dates identified in the chart located in Appendix X of the CLASS provider manual. A DSA may also date stamp the IPP Service Summary from each therapist before forwarding to the case manager. This method provides contract monitors the ability to verify the DSA sent the service summary to the case manager within 5 days of receipt from the therapist.

What do we advise an individual when they state the transferring DSA keeps calling them to ask why they transferred out? (at least 3 calls)

- Please contact HHSC to discuss specific situations and determine the best course of action.
- As a new DSA, it seems a bit much for the transferring DSA to call the transferring individuals multiple times (even months after they transferred) with questions as to why they transferred. We have run into problems with the transferring DSA calling and offering more hours to individuals requesting a transfer or individuals who have already transferred.
- As described in 40 TAC §49.206, HHSC may determine a contractor is ineligible to contract with HHSC if the contractor has a conviction of an offense described in Texas Occupations Code, §102.001. Solicitation Of Patients, which makes it an offense to solicit a patient for a person licensed,

certified, or registered by a state health care regulatory agency. An agency should contact their attorney for more information.

When does 5 days initiate for a transfer, from approval of HHSC of transfer or from CMA notifying of transfer?

- CLASS rules in 40 TAC §45.401 and Section 2340 of the CLASS Provider Manual describe the process more specifically.
- When the individual/legally authorized representative (LAR) notifies the case manager they wish to be transferred to a different agency(s), the case manager must:
  - document the date the transfer request was received;
  - provide the individual/LAR with the most current choice list;
  - within three business days, make transfer arrangements with the individual/LAR, the receiving CMA DSA or FMSA, as appropriate. Contract monitors will review all documentation including forms 2067 to determine the date the CMA was made aware of the transfer request.

What happens if the transferring agency fails to submit the documentation within the 5 days to receiving agency

- The transferring agency is cited. The receiving agency can file a complaint against the transferring agency for lack of coordination of care.
- Still do not understand why transfer (5 days) stipulation could start when DSA receives the information before CMA. I believe CMA should be first since usually DSA does not know receiving DSA.
- CLASS rules in 40 TAC §45.401 and Section 2340 of the CLASS Provider Manual describe the process more specifically.

If CM is weeks late in initiating SPT meeting and the DSA has documentation of asking for SPT meeting, would the DSA be cited for having a late SPT meeting?

No, it is not the DSA responsibility to convene meetings of the service planning team (SPT). As described in 40 TAC §45.214, an individual's case manager must convene a service planning team meeting in which the service planning team develops a proposed enrollment IPC. The case manager, as described in 40 TAC §45.223, must also convene a service planning team meeting to develop a proposed renewal IPC.

Is DSA required to have unapproved IPC Form 3621 in individual's file/chart?

This is not a requirement; however this would be best practice to demonstrate progress toward a change or need in an individual’s IPC.

If DSA notices that therapy summaries are repetitive could the DSA ask therapist to re-do the summary or do we just document so we are not cited?

Yes, the DSA is the employer. The therapists are your employees or subcontractors. HHSC also suggests that the required elements are included within the contract to set out the expectations for them. If the summaries are not sufficient, the DSA should request that the therapists redo the summaries.

If CMA does not send IPP review forms to DSA, will DSA be cited?

- No, the IPP Service Reviews are exclusively a case manager responsibility.
- If CMA provides copy of HHSC submission packets at time of submission to DSA, FMSA, and LAR are they required to resend with authorized IPC or can they simply send the authorized IPC within 10 days of receipt.
- The case manager must send copies of all documents used by Utilization Review to authorize services on the IPC. This includes any IPPs or other forms revised during an IPC remand process.
- If DSA wants to change office work hours, do we inform HHSC . Also how many days do we inform them before we make those changes
- As a licensed HCSSA, a DSA must comply with 40 TAC §97.210. There are no specific requirements regarding office hours in 40 TAC Chapter 49, Contracting for Community Services.

Can the same L&CHHS agency contract as a CMA and a DSA and service the same individuals?

No, as stated in 40 TAC §49.207, HHSC denies a contract if a DSA in the CLASS Program is applying to be a CMA in the same catchment area in which the applicant is a DSA; a CMA in the CLASS Program is applying to be a DSA in the same catchment area in which the applicant is a CMA; the applicant is applying to be a DSA and CMA in the CLASS Program in the same catchment area.

If there is no incident do we still have to do an incident report?

No, only if an event happened that meets the definition of any critical incident that involves an individual.

Do we have to report a Critical Incident, if, during the nurse's annual visit; she is informed by the family of an ER visit from 6 months ago?

Yes, you would still report it. You would just indicate that it did occur six months previously.

What if a complaint is found out 6 months later and should have been an ANE? Do we still just do the complaint form?

ANE must be reported as ANE in accordance with current licensure and contracting rules regardless of when the provider became aware. The new form for Critical

Incidents is not for ANE unless the reporter is a CMA. DSAs already report ANE to HHSC through form 3613 and do not need to complete the CI reporting form for ANE. CMAs are not licensed and thus are not required to complete form 3613 so ANE should be reported by calling the DFPS toll-free number at 1-800-252-5400 or using the internet at http://www.txabusehotline.org and by using the CI reporting form 'other' category.

Can you give an example using the timeframes?
If an incident occurred on June 3 and an agency did not become aware until July 1, The incident would have to be submitted to HHSC by August 31, using the HHSC CLASS/DBMD Notification of Critical Incidents form. That is last day of the following calendar month from when the agency became aware.

Regarding report emergency room visit is it for incident related visits only or is it for medical issues too?
For Critical Incident reporting, emergency room visits must be reported when an individual is ill or injured to the extent that there is need to go to the emergency room. That is a critical incident.

Is an incident report required for each occurrence?
Multiple incidents for one individual may be combined into one form assuming all incidents occurred at the same time or as individual parts of one incident.

How would a CLASS provider be able to tell that the "other" assigned provider already made a referral? It seems that based on the established standard each provider may assume that the other party may have fulfilled the reporting requirement.
The proposed rules requirement to report critical incidents will specify that once an agency has reported the critical incident to HHSC using the form, the reporting agency will fax a copy over to the other agency. If the CMA reports the incident first the CMA will fax a copy to the DSA with a 2067 or if the DSA reports the incident first the DSA will fax a copy of the report to the CMA. A copy of the report and the 2067 informing the other agency should be saved and kept in the individual's file. If it is unclear if the other agency has reported the incident it is better to both report the incident rather than neither report the incident.

What is the purpose for an incident report? What is it determining about individual? What is the result of it?

An incident reporting system for waiver programs is a CMS requirement and the CLASS program is coming into compliance with Federal waiver assurances. The goal is to have an incident management system that tracks critical incidents, ensures proper response to critical incidents and helps to prevent future occurrences of critical incidents.

Can the CMA bill for quarterly reviews?
Since CMAs are paid a monthly rate based on one billable telephone contact or face-to-face visit, the CMA will bill for IPP Service Reviews in the same manner.

How many units can the CMA bill for yearly?
Since CMAs are paid a monthly rate based on one billable telephone contact or face-to-face visit, the maximum number of CMA units possible on an IPC is twelve. Since TAC §45.705. CMA Service Delivery requires monthly case management contacts, unless the individual is not active for the entire IPC year (suspension, or enrolled mid-year for example) 12 units of case management should be the standard on all IPCs.

What forms are required to send to DSA, FMSA & individual BEFORE approval and which are due AFTER approval?
All forms sent to HHSC for approval of the IPC must be provided to all members of the SPT. After approval, any forms modified during the approval process must be provided to all members of the SPT. The specific Submission Standards for Enrollments, Renewals, and Revisions are located in Sections 2310, 2320, and 230 of the CLASS Provider Manual.

Will the close caption transcript be available after the call?
It will be available for viewing as part of the webinar recording when posted, but we will not be providing a separate copy.

Does HHSC offer ANE trainings?
HHSC does not offer training on ANE at this time. HHSC Computer Based ANE Training will soon be available on the HHSC website. DFPS currently provides helpful information on this topic which can be found at http://www.dfps.state.tx.us/Contact_Us/report_abuse.asp.

Is the ANE training competency exam for office staff and Hab service providers?
The proposed language in the rules revision will require CMAs and DSAs to ensure that any service provider, staff person, and volunteer of the agency are trained on and knowledgeable of acts that constitute ANE of an individual; the signs and symptoms of ANE; and methods to prevent ANE; and reporting requirements.

Is ANE reporting still being changed from 24 hours to 1 hour? If so, when will this go into effect?
No, the ANE reporting timeframe in the TAC will be 24 hours, consistent with HCSSA rules.

When does the nursing assessment addendum E. take place? Is it available now?

The Nursing Assessment Addendum E is not a new form and the RN should be completing it now as part of the annual nursing assessment requirement. The Coordination of Care is form 6509 and is available now on the HHSC website. CLASS will issue an Information Letter announcing an effective date for the form's requirement.

Will any names be released anytime soon from the CLASS interest list?

Currently, HHSC Interest List Management has not received approval to release individuals due to funding for this biennium.

How does denial of services due to unavailable documentation comply with person centered service planning requirements?

The person-centered planning process is driven by the person getting services and reflective of his or her perspective. The SPT is made up of people the person chooses. The SPT meeting is conducted at a time and place convenient to the person getting services. Additionally, the plan must be reviewed and revised annually with a functional needs assessment. The functional needs assessment must support services the individual is requesting.

What if the Nursing Assessment is completed after the SPT was held? Would the SPT meet again to complete the Coordination of Care form? Or can it be completed via Fax?

CLASS rules in 40 TAC §45.221 requires a nursing assessment to renew the level-of-care. The level-of-care is due to HHSC at least 60 days prior to IPC expiration. This allows the nursing assessment to be available for the SPT to review during the annual reassessment. It is important for the SPT to review the annual nursing assessment to complete the Coordination of Care so the SPT can ensure the individual's healthcare needs are included in the IPC.

Will the state come up with a form for the DSA service summaries for all therapies or does the agency have to create a form for Service Summaries?

HHSC allows each DSA and their therapists to determine the format for their service summaries.

If a DSA has to come up with a form what questions does the form consist of?

The elements required of each service summary are contained in Section 3350 of the CLASS Provider Manual. Those elements are:

- current observable/measurable goals and objectives;
- frequency and duration of sessions attended;
- rationale for missed sessions;

- progress or lack of progress;
- actions taken, as applicable (e.g., counseling; and
- revisions of goals and objectives, as applicable.

Who is responsible to contract an interpreter? CMA or DSA? Can we include the cost as an Adaptive Aid?

As described in 40 TAC §49.302, a contractor must ensure that an employee, subcontractor, or volunteer can effectively communicate with an individual or LAR concerning service planning and the provision of services, which may require the contractor to provide an interpreter for the individual. Once enrolled interpreter funds may be added as adaptive aids but for enrollment ensuring effective communication is the responsibility of the agency. Which agency is responsible for this cost would depend on which agency is requesting the meeting.

Who is responsible for completing the Coordination of Care the CMA or DSA?

The case manager completes the form based on the discussions of the SPT about Addendum E of the Nursing Assessment.

Can an Attendant Orientation be done the same day as the first day of service delivery?

- Assuming all other training requirements before delivering services as described in Section 3000 of the CLASS Provider Manual have been met, the orientation may be provided on the same day as the day of service delivery.
- All changes described during this webinar will they be effective 9/1/2018 or 9/1/2019.
- The changes described in this webinar are tentatively planned for September 1, 2018. Please ensure you are receiving GovDelivery alerts as that is how we will communicate the official announcement of any new requirements.

Can we do face-to-face conferences about CLASS?

Since CLASS is statewide it can be difficult to conduct face-to-face trainings with providers. HHSC does offer biannual provider trainings which are face-to-face. Additionally, HHSC hosts these webinars and offers technical assistance to providers regularly over the phone. If a provider has a particularly complex situation they would like to discuss with us face-to-face please email CLASSPolicy@hhsc.state.tx.us

Will this up-coming training on the forms, will it also be a project where we can go back to and review as needed with updated information?

The CLASS Computer-Based Training is designed to provide CLASS CMAs and DSAs, with the information on developing and completing a successful IPC or IDRC submission. Within the training, you will find information regarding submission of

enrollment, renewal, and revision IPC packets. It will include information for completing IPC forms for CMAs. For DSAs, it will provide information on submitting the level of care documentation, the IDRC, and the the IPPs that justifying each service. There will also be a section outlining the most common mistakes encountered by UR when submitting IPC and LOC packets. This training will be updated periodically and providers can access a part or all of the training at any time to review.

Is the CLASS waiver program planned to go under managed care in 2021 per SB7 (83R)? If so how will this affect medical services and specialized therapies? Would individuals still be able to keep their specialized therapy services?

Yes CLASS is included in the SB7 legislation which includes provisions around the transition of CLASS to managed care in 2021. Currently, workgroups are meeting to plan how to transition Texas Home Living (TxHmL) to managed care, as it is scheduled for 2020. Those discussions and the subsequent transition as well as future discussions specific to the CLASS program will guide how specific services are transitioned. Please note that legislation is subject to change during legislative session.

The Adaptive Aid Policy states that it is 300 dollars per IPC year for repairs. If the Individual already exhausted the $10,000 for that IPC year, do we need to wait until the following IPC year if repair is over $300?

Appendix I of the CLASS Provider Manual states: "The maximum amount HHSC will authorize as payment to a direct services agency (DSA) for all adaptive aids and dental treatment combined for an individual is $10,000 per IPC period, which includes the cost of repair and maintenance of an adaptive aid. A maximum of $300 per IPC period may be authorized for repair and maintenance of an adaptive aid(s) so the SPT is not required to complete Form 3660 for repair and maintenance funds requests that do not exceed $300."

Will the CMA assist the Individual with employment services?

The case manager as facilitator of the person-centered planning process coordinates the SPT discussion for employment services and documents the individual's interest in receiving employment assistance services and supported employment services. The DSA contracts with the service provider for both services. More information is available on the Employment First website.

Can an individual be a provider of employment services? Can class participants work as supervising providers?

Provider qualifications for employment assistance and supported employment can be found in 40 TAC §45.803. Additional information regarding employment assistance and supported employment can be located in 40 TAC §45.808. An

individual enrolled in the CLASS program could be a provider of employment services if they meet the staff qualifications and are able to deliver the required components of the service.

When we have the SPT annual or renewal meeting, we normally put 5 units of DSA for the plan year. How do we utilize these units or when can we bill for them, after doing quarterlies?

The SPT is responsible for determining how services are utilized based on the service's definition. Typically, the SPT will include hours necessary for a DSA to attend SPT meetings throughout that IPC year including the annual renewal meeting for the next IPC year. Often the DSA will also include nursing units to conduct any assessments required to renew an individual's level of care and any nursing assessments required after an individual has been discharged from a hospital. The DSA must provide information supporting the addition of these hours to the SPT. If the units added are not needed during that IPC year then the DSA should not bill for them. Generally, services become billable through TMHP after a service has been rendered and remains billable for a 12 months period thereafter.

Is HHSC still working on a Portal?

The IDD Operations portal is an active and viable project. The agency remains committed to providing users an accessible, quality product that will be a useful resource to replace faxing and mailing documents to HHSC. HHSC will share a revised implementation timeline with all targeted users as soon as possible.

Is there an update on the proposed online portal that would facilitate submission of documents?

The IDD Operations portal is an active and viable project. The agency remains committed to providing users an accessible, quality product that will be a useful resource to replace faxing and mailing documents to HHSC. HHSC will share a revised implementation timeline with all targeted users as soon as possible.

Are specifications and Inspection required for a Minor Home Mod repair that was originally done by CLASS?

This response depends on when CLASS purchased the MHM. CLASS rules in 40 TAC §45.618 place responsibility for repair of a MHM needed within one year after the date the minor home modification is complete are the responsibility of the DSA. For repairs required more than one year after the date the minor home modification is complete, the process described in 40 TAC §45.612 applies.

Is there a timeline/date where the 8606A is completed too soon? Can it be completed 4-5 months before the Plan year renews?

The case manager prepares Attachment A to form 8606 when skilled or specialized therapy is proposed by the service planning team. The SPT may meet as soon as 90

days prior to expiration of the individual's IPC. As a result documentation should not exceed 90 days.

How should a CM proceed with preparing for a SPT meeting without having therapy 8606-As to complete the IPPs needed for the SPT meeting?

The case manager prepares Attachment A to form 8606 when skilled or specialized therapy is proposed by the service planning team. Attachment A must be completed by the appropriate professional. The SPT may meet as soon as 90 days prior to expiration of the individual's IPC.

The renewal packet must be submitted no later than 30 days prior to the IPC start date and the case manager has until that time to make any adjustments as needed, with the approval of the service planning team.

When a individual receives nursing services such as LVN services, is there a TAC rule on the agencies RN's responsibilities?

All rules regarding RN supervision of a LVN are located in Texas Occupational Code §301.452(b)(13) and 22 Texas Administrative Code §217.11.