>> Good morning. And thank you for joining the CLASS quarterly Webinar for Tuesday, May 22, 2018. My name is Letha Smith and I will be your Webinar administrator today. Before we get started I have a few housekeeping items for you. The Webinar interface is two parts. Viewer window on the left of the viewer screen which allows you to see everything the presenters share on their screen. On the right of your screen is the Webinar control panel. By clicking the arrow in the orange box on the grab tab you can open and close your control panel. By default you join the Webinar by microphone and speakers. If you prefer you can join using the phone by selecting the telephone radio button in the control panel. The dialing information, including an audio pin, will be displayed. As a reminder, all attending are on mute. During the presentation you can send questions through the questions pane by typing a question and clicking send. Due to limited time questions will be saved for the Q&A session at the end of the Webinar. We sent the PowerPoint handout to those who registered by 4:00 p.m. yesterday. If you did not receive that email, you can get it copied from the bottom of the control panel. Look for the option called handout. In addition to the PowerPoint handouts there is a link for those hold like to utilize the closed captioning option. You will copy and paste the link into your browser and this will bring up the closed captioning screen. It will begin streaming the closed caption transcript. If you have difficulty accessing the screen, close and reopen your browser and start with a new screen. I will now pass the Webinar over to Bob Scott. >> Bob Scott: Good morning everyone and welcome to the CLASS Webinar May 22, 2018. We've got some topics as to present to you today. -- to present to you today we hope are interesting to you. I will begin with showing you the -- the topics. The first topic you'll note is called an Employment First training across the state. This was a topic we were able to include at the last moment. Therefore you were not notified of it in the original notification of the Webinar, but it's something that I would really -- I was really excited to include in the Webinar. I know in the past we presented other Webinars on Employment First opportunities and these are all aimed at helping people in our CLASS program and other programs to find competitive integrative employment. Nehtra Davis will give us that information. If you'd like to start please. >> Sure. Good morning, everyone. Before I get started I'd like to reference that if you guys have any questions, I know that the instructions were to ask at the end, but for me I do have to leave after I'm done, so if you guys have any employment questions, go ahead and send them and I can answer them as I'm presenting. Okay? So we actually received and we're waiting, this project is pending, but we received an accepted proposal to do Employment First training across the state of Texas. Again, the project is pending. We're just waiting for the green light for the funding so we can go ahead and get started, but we will be doing in-person training, one-day training. It's free, to folks across the state. And my portion today I'll go over some resources with you guys at the end and some trainings that are available for providers to provide employment services. So here are some details about the training. Of course we say Employment First is the policy that Texas has adopted, and it works. I mean, HHSC is following this policy when it comes to employment for people with disabilities, and we will go over that in the training. The Texas Employment First policy. We'll also go over in the training how employment services work within the Medicaid waivers, including the billable services and billing information, how Medicaid waiver employment services and the Texas workforces solutions, vocational rehabilitation services works together. That is formerly known as DARS. So when you hear of Vocational

Rehabilitation Services, that was formerly known as DARS. I know that's confusing to some folks because for years and years and years we've known them to be DARS. We'll also do an overview of Social Security benefits and how that effects work. We'll go over some of the HCBS settings rule changes that will impact rehabilitation as we know it. We'll also go over a position known as the employment recruitment coordinator, that's the ERC. She goes around the state and builds connections with folks throughout the state to kind of build relationships with employers, to help us with the initiative of hiring people with disabilities. So who should attend the training? Again, I want to reiterate that the training is free. It's open to providers, professional -- LIDDAs, professional direct care staff, also individuals we serve and their families and guardians are welcome to attend. The training overall is just for anyone who wants a better understanding of how employment services work through the waivers. The locations again will be statewide. They'll be posted on the HHS Employment First Web page along with the registration links for the various locations, and we will have the locations near different areas, so I think we're having -- we plan to have 33 sites total, but again, more details will be posted as we get the green light. So the month that we plan to start, and this is again -- we're like crossing our fingers for that green light. We plan to start in July and run through October, possibly November, but the times that the trainings will be from 9:00 a.m. to 4:00 p.m. There will also be a special session for like executive leadership, managers and administrators, from 4:00 to 5:00 p.m. More information again on the exact dates and locations will be posted on the Web site once we get that green light, so just keep an eye out on the Web page and for any other communication that is come from HHS. So a little bit about the trainers. I myself will be one of the trainers. All of us are what we call SMURFS, and that is subject matter utilization resource facilitators, and that just basically means that we have all been trained on Social Security benefits and work on how that's all -- and how that's all combined, because we often hear the myth that if I work I'm going to lose my benefits, and that's not the case. So we'll definitely be going into detail about that in the training. One of the trainers is a part-time staff at the Texas Workforce Commission. All of the trainers are familiar with the Employment First initiative across the state. Here are some resources that I wanted to provide for you guys. That first one is the employment services Web-based training. I would definitely suggest that you guys take that. It's, I believe, 11 or 12 modules that kind of go through employment services, kind of a surface basis but gives you a good understanding to understand how employment services work. The next one is the Guide to Employment for People with Disabilities, and that just is kind of like an overview, again, of employment. This -- the next one, the Employment First Web site, this is the Web site you want to pay attention to as far as communication goes for the Employment First administration training. You'll find it at this point. The next one is Texas Transition and Employment Guide and that's self-explanatory, explains transition and employment effort. The next one is a pretty important one, working and benefits. That's the Social Security Web site link for that. The next one is a link for formally known as DARS, we call it TWS-VRS or Twizzlers. That's the Texas workforces Vocational Rehabilitation Services Web page. Here's the provider training I was talking about for providers to be able to provide employment services. Here's some more from ODEP. You've got the Department of Labor, Virginia commonwealth, it's a resource there. College of employment services and the DADS Guide to Employment for People with Disabilities. Here is my contact info where you can email me. Feel free to email me any questions that you may have. Are there any questions that come up about employment? >> We'll see. Somebody just wrote one. Will the CMA assist the individual with the service? Case Management Agency. >> With employment services? >>

Yeah, with employment services. >> Yes, for sure. I'm guessing that's like another word for provider? >> Yes, the case manager coordinates the service. >> Well, so we have the DSA and we have the case management. So the Case Management Agency would add the services and help justify them, et cetera, and then the DSA would be the one that would actually contract with the provider, or if they meet the qualifications I think they can provide it themselves as well. >> And we all definitely like to say with employment, it takes a -- a group of people for it to come together. And not just for a group of individuals but even just for one. It does take teamwork, especially when we're talking about the biggest piece that we see in employment being an issue is transportation. So that's just something -- we'll discuss it in the training but that's just something we always like to throw out there. It does take teamwork. Transportation is probably going to be the biggest challenge, but it's doable. Any other questions? >> Not yet. >> Okay. Well, again, do you have my contact information, so if you do have a question that pops up, feel free to email me. >> Bob Scott: Thanks very much, Nehtra. >> I'm going to hand it back over to Bob and you all have a great day. >> Bob Scott: Thank you very much, Nehtra. I would like to tell everyone that the PowerPoint -- the PDF of the PowerPoint, if you open that it will -- the links in that PDF document will be active. You can get those links or minimally copy and paste them into the browser. I'm really excited about this. The application first initiative -- Employment First initiative, we started to hear two years ago, three years ago, and I'm really excited for CLASS individuals to participate in it. If you have any questions please don't hesitate to send them to me at the CLASS mailbox or you can certainly send them directly to Nehtra, and you can print out that PDF version of this PowerPoint so you can get those links. Now I'd like to turn it over to Lauren Chenoweth, she'll give us updates on CLASS policy changes. Policy Lead for CLASS and DBMD so Lauren, take it away, please. >> Thank you. Hi, everyone, good morning. Thanks for joining us. Yes, I'm just going to give some CLASS policy updates, some different things that are going on. If you guys have been listening to the DBMD webinars, some of this won't be new to because we're doing similar things in CLASS and DBMD. So back in 2014 CMS issued some guidance to us and we didn't have to come into full compliance until the waiver renewal, DBMD just renewed March 1, 2018 and CLASS is set to renew September 1, 2019. So we started doing some of this stuff with DBMD and now we're working on it for CLASS. So there's a link there to the guidance. It's kind of -- it was kind of issued as a letter I guess to the different states and it kind of clarifies what their expectations are for the different assurances, so one of those has to do with incident management systems, and then there's also Waiver Technical Guidance, which I gave you guys the link to. You can find these on the Medicaid Web page, but I provide the link in case you wanted to see it. So beginning September 1, 2018, CLASS and DBMD providers are required to submit critical incident reports to HHSC by the last calendar day of the month following the incident. And we are working on this information letter right now. We're hoping to get it out really soon. We have an on-line form, which I'll show you guys some screenshots of as we get into that. And the time frame on this, the last day of the month following the incident, we went with the same time frame that HCS currently has for incident reporting. The difference is CLASS and DBMD will be able to report at the individual level where is HCS does reporting in an aggregate type of way, which if you go and look at the guidance, it says you have to be able to get down to the individual and we have to be able to say for a critical incident or a specific situation that happened, if it needs follow-up we need to be able to say how we followed up at the individual level or what was done to protect that individual. So the categories, elopement/missing individual, which we'll define all of these. This information is going to live in the

provider manual, so that will be coming out around the same time as the information letter. Choking. Emergency room visit. Medication errors. Theft or property damage under $25. Emergency situations, which is like natural disasters, things like that. Criminal conduct. Physical altercation. Authorized restraint. That's only for DBMD. Currently we have no guidance for CLASS around restraints and the waiver application does say that they are prohibited because we have no guidance, and so at this time there is no authorized restraint CLASS, so that's why that doesn't apply to CLASS. Death reporting. DBMD has a separate process so death reporting will only be done on this report -- CLASS. Other incidents or events, we couldn't possibly name them all, but that are of a similar level as these other ones, we would want you to report that as well. The other piece is for our direct service agencies that are HCSSAs, you're already reporting abuse and neglect, form 3613, so if you -- 3613, if you report it using 3613 you don't need to report it using our form. We don't want that duplication and we don't want duplicate work for you guys, so that's where you draw the line. If you've reported it already using the 3613, because some aspect of that incident was abuse, neglect or exploitation or expected to be, because you may not know the final word on whether or not it was determined to be ANE won't come till much later, but if you've reported it by that means we'll get that information from our internal partners and don't report it on here. Now, if there's part of the incident that -- you know, something that happened at the same time but you didn't include it on the abuse report, for example, if there's a part that's missing on that, then you could still do this form and report it that way. Okay? So again, I already talked about this part. That's the link to the form. So the actual form where you'll report is a Salesforce platform. I know I got a question from somebody about it being a dot-com. That is correct. It's not a.gov. That's how they do the sales force stuff, but I'll let you know that everything is secured before -- we followed all those protocols. So you would just go to this Web site, and again, I'll show you screenshots in a little bit. Type in the information and then you'll submit it. But the thing is since there's not like a special log-in or anything like that, once you submit it it's gone. It goes to us, so if you find that it needs to be updated or corrected, you would want to contact us and let us know, hey, you know, I got more facts about this or I found out it actually occurred on a different date or something like that, you would send that to our policy mailboxes and then we can go in on the back end and fix it. The thing about this form that's good is you can report multiple incidents on one form, so -- but you can only report for one individual on one form. So you could go in and report for the whole month if somebody had more than one incident occur, you could put those all within one report, so you don't have to re-enter the provider information again or the individual's information, just the incident and the follow-up for each incident. Timelines, so you have to report it by the last calendar day of the following month, and I do want to be clear that it's based on the date of awareness, so with individuals being in their homes, we know that you may not be aware, right, when something happens. This is just for -- once you become aware. That's when they timelines begin. So you'll want to document as soon as you become aware of one of these things, and then be sure to submit the report to us by the last calendar day of the following month. So, for example, if something happens on, you know, June 3, but you don't become aware until July 1, you wouldn't need to report it until August 31. I think those are all the right days, but you see what I'm saying. So please report as soon as possible, but we are giving you guys some time. Now, I will say also that HCS, we borrowed this from HCS and HCS is currently going through an audit on their critical incidents. There's a lot of focus on critical incident reporting and critical incident management by the office of inspector general and by centers for Medicaid and Medicare, and if they

get -- if they get into trouble with those timelines or if it's found that that's not ideal and HCS ends up changing any of their timelines, then we might have to change ours as well. But at this point this is what it's going to be. The other part that's different for CLASS is because we have a CMA and a DSA, whoever reports it first we don't want you guys to both report it, so whoever reports it first needs to let the other one know that they have reported it and send them -- the way we've decided to do this is that they will -- you can print out the form at the end, so you would print it out, you'd keep one in your records and then you'd also send one over with the 2067 to the CMA or the DSA depending on who's doing the reporting. But so -- so everybody is in the loop what's going on. And if the CMA has reported it the DSA doesn't need to and vice versa. Here's what it looks like. You can -- at the top you can indicate what kind of reporter you are, a case managing agency, a DSA. Are you a HCSSA or an ALF, that only applies to DSAs and DBMD providers, provide as much information as you can. The more information the better. The less likely we have to call and follow up and ask for additional information. Also the easier it is for us to match it up with other reports or with any ANE reports that have been done. And the ones with the little asterisk, those are the ones that are required, so it won't let you submit without those. You'll also see at the top is a link to the CLASS provider manual and to the DBMD provider manual as well. We'll try to get that to be more specific to where it will take you specifically to the page where the instructions are for the form. We don't have that page live yet, so we don't have that piece done yet. And then there's also links to the 3613 and 3613A, just for your convenience so that you can go look at the form or if you determine, oh, you know what? This really is abuse. I need to submit that other kind of form instead. So this is the individual information. Their name, their last name, their date of birth, are they in CLASS or DBMD. What's their Medicaid number. Communication abilities. That's just helpful to us to figuring out, you know, what kind of level of risk and really figuring out what the situation was, and then any additional information, feel free to use that to provide any other information that's important that maybe there's not already a place for that to live. Here is the actual incident information, and just to point out, so date of incident, date of discovery. So if you -- if you witnessed the incident, then the date of the incident and the date of the discovery would be the same. And you can say if you witnessed it or if you discovered it. Now, if you don't discover until later, this is where you'd want to explain that, oh, the person didn't tell me till our quarterly meeting or our service review meeting, so that's when I discovered it and that's when our timeline as far as -- for compliance would look. And then when you submit it -- now, we will see on our internal side the date of submission as well, not that anybody would do this, but -- so don't try to say you submitted it earlier than you did because we'll still be able to see on our side, the location of the incident, and then the way these little boxes work you can choose multiple incidents there. You can -- I think if you press control, you can select multiple incidents and then do you the little arrow button and it moves it over, and then you can also add additional incidents at that button up there at the top, which I know is kind of hard to see, but that's where you would say if you wanted to put a separate incident that occurred on a different date. And then here's what you did to follow-up. Include as much -- as much as you did. The point of this is to show that you took sufficient action, depending on whatever the incident was, so maybe you added services to help protect the individual or if they had a behavior incident, maybe you looked at getting them behavior support or created a behavior support plan, notified the family. There's a bunch of different options, and you'll want to select as many as apply. And then other involved entities. If there's any -- you know if law enforcement was involved you could include that. Yeah. Okay. The next piece is abuse, neglect and

exploitation training. So there's some new training requirements. Some of this was already required in chapter 49, which is the contracting for community services, I believe is the title of that chapter. But a little bit of it is new. I think it's the -- is it the signs and symptoms? >> Bob Scott: (inaudible). >> So for CLASS -- all of this was already included, whether it was in chapter 49 or in the provider manual, but now it's in the actual program rules, and other pieces that you have to be trained on it and you have to demonstrate knowledge. So we've done, we're in the process -- the final stages, hopefully, of developing a training and a competency exam, and this is how people in the CLASS program will be required to demonstrate that knowledge of the topics on the slide before. Originally we're going to provide just a study guide and then a test that you guys could print out on your own, but we decided that it would be better to do a computer-based training and the exam is included within the training, so you would just send your staff to take the training, then they take the test at the end, print out proof that they took it and that can go in their file. We're anticipating that this will be effective 9/1/18. We're still working on getting the rules and getting the training completely ready, but we're hopeful that this will be effective by 9/1/18. So new staff that are hired 9/1/18 or later would have to meet this training requirement immediately. Current staff , if they came in and got their training on August 15, for example, we're not going to make you bring them back in and redo the training on 9/1/18. They'll have until their next annual training to take any additional -- to do the new test, and that's just to reduce burden, keep you guys from having to bring all your staff all in. Some other additional changes, this is coming up in the rule project and we'll also be doing an information letter, but DSAs and CMAs will have to have tracking systems in place, and this is to help us on our performance measures, so there's -- there's two parts, and we'll get into the other side of it in a minute, but timely renewal of plans is something that we don't perform as well on as we would like to. Now, some of that is because plans are submitted incorrectly. Some of that is because they're submitted late, and then other things are, you know, the review or the remand process, so there are several different things that are going on. So we're trying to address that. So one of the ways we're addressing it is we're going to try and make sure that timely submissions happen, that things get submitted when they're supposed to according to the rules, and that's where these tracking systems come into play. It doesn't need to be complicated or advanced or, you know, electronic even. You just need to have some kind of system in place where it's clear that you know who's got a renewal coming up, whose level of care is due, and you know, you know when you need to have your meetings in order to get everything submitted on time. Here's the other part. This is to that same thing, but the Coordination of Care Form. So this is a new form that we've developed, and what you'll see is on the left we have the nursing assessment addendum E form, and on the right is our new Coordination of Care Form. This also helps with our waiver, subassurances and assurances that we'll ensure individuals in the program's health and safety and health and welfare, and the way we're doing that is when the nurse goes out and does their assessment, if they identify any concerns or anything -- anything like that, any recommendations, they would document it on addendum E, and then what the SPT does is they document how they address it on the Coordination of Care Form and sign off. I always use the same example so forgive me. Let's say the nurse goes out and notices that the individual is at risk for pressure sores. One way that the SPT might address that is they might say, let's add an eval for a pressure sore mattress, and they're addressing that concern and helping prevent anything happening to that individual's health and welfare, so that's kind of how it's designed to work. Freedom of choice form. This is another one again we're anticipating September 1, 2018. Any SPTs that occur on that date or later

must provide choice between institutional care and community-based waiver program at enrollment and annually thereafter. And I may have made an error on this slide. It's either the SPT is occurring on that date or we'll give you guys plenty of time so that SPTs that occur with an effective date of September 1, 2018, we're kind of -- we'll spell that out very clearly when we get the information letters out. But CMS has told us they want to make sure that individuals know that they have a choice and we need to offer that choice to them not just at enrollment, which was the current requirement, but also every year, just to make sure that people are aware of their options, and there's a link for the form. And that's it. I will say, to wrap up the other part of what we're doing, so we're doing policies and procedures to help ensure timely submission. Another piece that's coming soon that we originally weren't sure what kind of time limit we were going to do but we've been working on computer-based training for CLASS similar to what DBMD has. And the point is really just the basics of what a person needs to know to successfully submit a packet for various things, you know, a revision, a renewal, an enrollment, a transfer. So it's kind of like a refresher course and the basics on how to do that. I think we're also including suspensions in there. And we're looking at making that required possibly annually for individuals, for case managers and program directors most likely, just to help so that we get -- we reduce remands in that way as well so we make sure people -- any way we can easily prevent a remand process is if you just need to turn in one more form or need to understand how -- how to fill something out better, that's kind of what the goal is of that training. So that will also be coming soon, but all of this, there's more information to come. We'll ensure whenever the information letter gets out that we give plenty of time for service planning. Yes, that's what's going on with our policy stuff. I'll turn it back over to Bob. >> Bob Scott: Thank you, Lauren. Do we have any questions that we want to address right now? >> I can answer them now if you'd like. I did get a couple questions. For ANE training competency exam, is this for office staff and have service provides? Yes, so the ANE training is -- and I don't have the rule right in front of me but I believe it's for everyone. We want everybody that interacts with individuals to -- to know what ANE is and how to recognize it and how to prevent it and how to report it and all that stuff, it is part of the way that we help protect individuals from abuse, neglect and exploitation. >> Bob Scott: If I can add, Lauren, the CLASS provider manual had those -- has had those requirements for quite a few years. The rule will try to write it to mirror what was already in place. >> Okay. Okay. The next question is if there is no incident, do we still have to do an incident report? I guess I'm a little confused by the question, but I think what you're saying is if it's -- maybe if it's ANE but there's no other incident do you have to do an incident report? No. Or do you have to report on every individual every month, whether they have an incident or not? No. So only if there's something that happened to that individual that meets the criteria in the definitions of those different incidents would you actually have to do a report. I think I gave an example – the question is give an example using the time frame. I think I did that but I'll do it again. And this may have come in before I got to that part. But -- so assuming that somebody -- an incident occurred on June 3, but the provider didn't become aware until July 1. They would have to submit that incident to HHSC using the form by August 31, the last day of the following calendar month from when they became aware. Okay. I hope that helps. Does HHSC offer any training? Like I said, we do -- we are offering this computer-based training that's going to have learning checks and it's going to be somewhat interactive, so we will have that. I think that we do offer some other ANE trainings, but I think they're more geared towards nursing facilities. If you feel there's a need for in-person type training, send that in as a comment and we'll see if that's something we could

accommodate. This other question, not sure. So it says, when a client refused nursing service such as LVN service, is there a TAC rule on the agency's RN responsibilities? I don't think that we have that in TAC. Now, you would need to refer to the board of nursing and any supervision requirements there. We are looking at possibly releasing some guidance around CDS nursing when you have an LVN providing that, and if you can add units for the RN to do the supervision, which you can. You don't -- there was some misunderstanding that it needs to come out of the LVN's rate, but it would be very difficult, I think, to find an RN that would accept a portion of the LVN rate and then how would you pay the RN. You can't add RN units to supervise the LVN and we would just direct you to the board of nursing on the requirements for LVN supervision. >> We had a few more come in on this topic. Do you want to hold on for -- >> It doesn't matter for me. Do you want me to go ahead or -- >> Bob Scott: Well, if they're on the supervision -- RN supervision, those are specific to the board of nursing rules. >> I meant on the ANE. >> Bob Scott: Oh. We've got some time. This -- >> Okay. I'll read it. >> Yeah, just read. >> Get it down in time. -- done in time. When does the nursing assessment addendum E take place? Is it available now? >> The addendum E is already available. That is not a new form. The coordination of care is the new form and I believe it's already on the Web site although you aren't required to do it yet. Once we get the information letter out, that's when we'll clearly state when the requirement needs to start and when you need to start completing that. Addendum E is part of the nursing assessment so it would be completed with the nursing assessment. >> The next one is what is the incident report for. What is it determine began the individual and what is the end result of the report? >> Okay. So the incident report is because CMS has told us that -- to come into compliance for the renewals, so DBMD just renewed the waiver application and CLASS is renewing 9/1/19 but we're trying to get it in place ahead of time so that we start collecting some data and start working out the kinks. But it is for -- so that we can first of all have a system in place where we have data on what critical incidents are occurring and that we're ensuring that there's proper follow-up to those incidents, that appropriate action is occurring, and if appropriate action has not occurred, that we're aware of that and that we can intervene. So basically CMS -- they call it remediation, so we'd actually be able to remediate and we'd be able to take action to prevent possible future occurrences of different incidents as well. So that's what we'd be using the information for, you know, Suzy fell down because her porch step was broken. The provider had a minor home modification done to correct the -- to put a ramp instead so that she can use a ramp, because we wouldn't do -- we wouldn't do a minor home mod for regular wear and tear of a home, but maybe she needs a ramp. Maybe she's not able to use -- to get her Walker down the stairs and that's why she fell. So if the provider did a minor home modification we'd say -- we'll review that and say, okay, that seems appropriate to prevent a future incident like that from occurring. So that's kind of how we'd be looking at it. We'd also be using the data just to see how many different types of incidents are occurring and how many providers are responding appropriately, and then we have to report that back to centers for Medicare and Medicaid and say, you know, out of this many incidents that occurred in the last year, 95% of them were responded to appropriately by providers. >> Okay. Who is responsible for completing the coordination of care? The CMA or the DSA? >> The service planning team, but it is -- it is a form, and I believe we say that the case manager completes it, but the service planning team would sign off and the whole team is responsible for reviewing and discussing and determining how to respond to any recommendations or concerns that the nurse documented on her form. So it's meant to be a discussion that everybody signs off on. >> So every time a person is hospitalized or goes to the emergency room an

incident report is required. So we are now required to keep track of every emergency room visit? >> If you become aware of it, yes, you are to report that. We consider that to be a critical incident, and we would like you to report it. If you're not aware of it, then you're not aware of it and we obviously can't expect you to report it. You know, we know individuals are in their own homes and you may not become aware, but yes, if somebody goes to the emergency room because of a serious injury or illness, we would -- we would consider that to be a critical incident and we'd want to know about that and know, you know, how do we prevent that injury in the future, are there any -- have their needs changed as a result of this serious illness? And you can report it in the aggregate and you can also -- there's the option to say, you know, no action needed, so you could report, they went to the emergency room because they had a headache and nothing was found to be wrong, and so no action was needed. Maybe we did a follow-up visit with their primary care doctor. It doesn't have to be -- it just has to be reasonable. >> Is ANE reporting still being changed from 24 hours to one hour? If so, when will this go into effect? >> No. No. We heard your feedback, we took it, and it is the same as what the HCSSA rules already require, so it's the 24 hours. Yes, we changed that. You'll see that when the rules post for final feedback through the Texas register. >> How would a CLASS provider be able to tell that the other, in quotations, assigned provider also 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. >> So the way that that's going to be handled, as part of the rules and part of the requirement, once you've reported to HHSC using the form, you print it out, you put -- you fax a copy over to the -- if you're the CMA you fax a copy to the DSA with the 2067 or vice versa, if you're the DSA you fax it to the CMA and then you save that copy and put it in the file. And that way the other person will get the -- the CMA or DSA will also get the details of the incident and they're able to act appropriately if they need to as well>> Also, just to verify, all changes will be effective 9/1/2018 or 9/1/2019. >> The waiver renewal is 9/1/2019. Many of these changes will go into effect 9/1/2018, but we have not yet issued the information letter. There are still, you know -- here at the state we have to have a lot of reviewers and a lot of people have to look at things. We want to make sure we get all the policy right. So it is possible that it might be later than 9/1/2018, but when we do issue it, if it's something you need for service planning we'll ensure that there's about 90 days, because I know you guys meet prior to the service -- prior to the renewal being effective. And we'll try to -- we'll give you plenty of time to make sure that you can come into compliance. We're not going to issue something the day before, but again, more information to come. This is kind of more of a heads-up and letting you know what's coming in an informal conversation about what's coming up. You can ask questions, but there will be an information letter and that will be the initial implementation-- and it will be in the rule eventually as well. All right. I think that's all the questions we have for now. If you have more I'll still be here for the rest of the time but I am going to pass it back over to Bob. Thanks so much. >> Bob Scott: Thanks, Lauren. That's some really good information. I would like to reassure providers that we are on your side. We understand that meetings are held in advance, that levels of care are prepared in advance. We encourage you to follow those timelines, and we hope that that's a benefit that you can receive from the IPC and LOC tracking systems that the rules would require to you implement. Now I'd like to go on, and Lauren mentioned the fact that we are developing a computer-based training. I'd like to go into that a little bit if I can. The training is designed to provide CLASS service providers, that's CMAs and DSAs, with the information on developing and completing a successful service planning packet. Within the training you'll find

information regarding submission and enrollment, renewal, revised individual plan of care packets. We're going to include some specific information for completing IPC forms, transfers, the level of care documentation, the IDRC and the individual program plans-- the IPPs that accompany each service. We're also going to include a section with the out -- outlining the most common mistakes. This is the proposed Web site. It is not live right now so don't worry about it. Just -- we're testing it at this site but it's not publicly available, so don't worry about trying to get it. Try to divide it into the responsibilities of each of the providers, the CMA, the DSA. The information specific to renewing levels of care is -- applies only to the DSA, and CMA responsibilities on IPC include a large amount of cooperation between the two agencies in obtaining the information and providing -- receiving the information and documenting it hopefully so that the remand process is minimized. These are the topics, as we've got them right now. If you've got any suggestions, you can certainly feel free to send them to the CLASS policy mailbox. I'll give that at the end of our presentation. And these are some of the other topics that we're going to include. If you want to, if you print out the PDF version of the presentation, I tried to fit them all under one slide. They're on two. If you want to look at them, and again, we're happy to take any suggestions. We want to include all the forms the DSA must complete and submit to HHS for approved level of care, and that includes the enrollment level of care and the renewal. We want to include all the forms that DSA -- the DSA must complete and provide to the CMA for enrollment or renewal, and revision. And all the forms a DSA must complete only if a specific service is requested as part of enrollment, renewal, or even revision, where you have a section -- we have a section all the forms a CMA must submit for enrollment, renewal or revision, and that is going to be consistent with what we currently call the submission standards in the provider manual. We're going to have a section on transferring the forms required to the DSA/CMA, depending upon what agencies are being transferred. If only CMAs are being transferred, there's not too much needed from the DSA. The forms -- the forms required for change from agency directed services to consumer directed services. That is not a transfer, that is simply a revision. That's addressed in the computer-based training. We've got a list of suggestions of the actions a CMA must take to ensure a successful enroll him. We've got a couple slides on common errors in IPCs, as noted by the utilization review staff. Common errors on ID/RC document. Again, that's -- as noted by the utilization review staff. The common errors on eligibility screening assessment form. We also include a list of all the ABL assessments for CLASS. These are all different slides we want to provide to you guys as a -- possibly a condensed version that you can take with you on visits. I know it's frustrating to receive a remand for not including a form. We're hoping that this computer-based training can alleviate some of that. We're going to have a helpful tips section, including a timeline for enrollments, submission timelines for IPCs and ID/RCs. Quality assurance check suggestions. Timelines for the enrollments, while we've got the timeline outlined in TAC, we certainly understand that individuals do not always cooperate with our timeline. If problems occur that are based upon an individual's problems in decision, failure to apply for Medicaid, we do encourage the case manager and the direct services, whoever is most impacted by those delays, to document so that the contract monitoring staff can get a clear picture of what happened, why it happened, so that the appropriate agency is not cited. Excuse me. We've got some frequently asked questions about service limits, specialized therapy requisition fees, third-party resources, and a clarification for bids on adaptive aids and minor home modifications. That's just a brief summary of them to -- do we have any questions that look like they need to be addressed? >> I haven't gotten any just yet. >> Bob Scott: Okay. Well, I'd like to go ahead and continue, and we'll

have Ms. Alicia Alaniz give us standard -- we want to talk to you about the most common citations. Alicia? >> Hello, good morning, everyone. As Bob mentioned, my name is Alicia Alaniz, I'm currently the interim manager for the CLASS and DBMD contract monitoring unit and we'll go ahead and get started with the presentation. So some of the points to remember, please ensure that the employee, subcontractors, or volunteers can effectively communicate with an individual or LAR about service planning. You may also need to provide an interpreter. I've seen this happen not as often, thankfully, but this can occur when you have a family who, for instance, is Spanish-speaking but yet your case manager doesn't speak the language. So obviously this can kind of confuse the families, confuse individuals. The documentation may not support their statements, when we're receiving complaint investigations, that may also come into play. So please be aware of that and try to accommodate as best as you can. A second portion, do not allow any individual to perform services under the contract or perform other work that benefits the contractor. Thankfully we have not seen that, so that's not that much of an issue, and the third bullet on that is comply with the terms of the contract, which requires compliance with federal, state laws, rules, regulations and TAC chapter 49. Okay. Subscribe to receive the HHSC email updates. A lot of the times the -- we have found that the contractors are either not subscribed or perhaps someone else in your agency is, such as an executive director, and these messages aren't always communicated to the contractor. These are especially important because this is our primary way of communicating with you all as contractors, and this comes into play with contract monitoring. We find a lot of the times we're coming out, we are now looking at A, B and C, and as contractor the program director, you are not made aware of that expectation, because the information letter went out, the alert went out, we do hold you accountable for that. So please be sure that whoever is receiving these -- subscribe to receive these emails, that they're actually communicating that with you. If you do not understand whether this applies to you or not, please reach out to our policy folks, okay, because most of the time what happens is these changes come into effect. They announce that they're coming into effect, and then they change up our tool within contract monitoring so that we now have to monitor compliance for that rule. There's a link for you as well, if you haven't subscribed yet, I would highly, highly encourage you to do so. The last two points are also an issue with us. As contractors you are obligated to notify HHSC of a change of ownership or any change to contact information like mailing, address, physical address, email address, phone, fax numbers, et cetera, and at least 30 days before the change, okay? So some of you who have already experienced contract monitoring know that we will fax notification letters and/or mail notification letters to whatever address we currently have on record. So if there is a change that needs to be made, please make sure that you make that. Otherwise, the notification is going somewhere else or our phone calls will not be successful. Our fax -- our faxes, because we also fax over notifications, will not also be successful. So the changes, though, do have to be submitted to contract enrollment, which is a totally different unit from us, and I will be leaving their contact information at the end of my presentation, and I believe that we have a member, Paul Straka, who's also coming in, and will go into further detail. But please note that only the individual with signature authority can actually make any amendments, and it should be on the company letterhead. So just things to keep in mind. Next slide, please. We'll be going over frequent citations for the Case Management Agency. You will also see a link for the monitoring workbook. This is the tool that we use to monitor the contracts, okay? I would caution you all to be reserved about how you utilize that tool. As contractors you're not also privy to the discussions or interpretation or instructions on how we

should be looking at things, the work -- the tool also tends to change and that's not something that is always related or communicated to you all. So it's just supposed to be a helpful guide, but as you all are not trained on the tool, because this is not something that you're utilizing, this is something that you may misinterpret, okay? So it's just used to be as a guide for you all. Next slide, please. Okay. So for the CMA, the very first topic, the mandatory participation requirement, so this is something we're still kind of missing out with the CMAs. We can discuss it orally, but with contract monitoring, our reviews are over your records. So unless there is something in writing that says that you actually went over the participation requirements with the individual, then you will receive a citation for that. We would love to be able to take your word for it, but unfortunately that's not how we can function. So please be aware of that. Some really clever and time-efficient ways that I have found contractors to do this is they usually have a checklist of all of the items that they're needing to present during renewals, and they check off all of that list and they have the parent or LAR or individual sign on the bottom of that form, and we can definitely accept that, and that's only one sheet, and I definitely recommend that for you, but of course this is completely up to you as a contractor. The only requirement is you need to show documentation that you did review that material with them. The second one is the SPT must be convened at least annually between 30 and 90 calendar days before the end of the IPC period. This is very tough. This is something that we're still missing out on as far as case management agencies, and again, because of the length of time that you have, you're going to be hard-pressed to be able to justify why you could not meet with the individual sooner. Some acceptable justification and documentation would be if the individual was out of town, for example, or if they were hospitalized, okay? But of course with that we would expect to see documentation, we would expect to see suspension notices as well, and given who your families are, as case managers, you should recognize by now unless you're a brand-new case manager, which of your families is maybe a little more difficult to get ahold of because of their work schedule, et cetera, and really try to aim for that 90 calendar days and start trying to schedule them as soon as possible to try to avoid that, you know, kind of a panic and time is running out of kind of situation. The third one, within ten business days of you receiving that approved IPC, so you get that fax, and please keep those fax letterheads attached with it because we will be asking you, when did you receive this notification? Because this is something we monitor. So within ten business days you have to present copies of the authorized IPCs, IPPs, hab plan, the SPT notes and ID/RC to all members of the SPT. We are actually improving on this greatly. The only way that I see this kind of falling out is with the FMSAs, so sometimes as case managers we forget about the FMSA, and our tools specifically request to see and ask -- what they actually provided to the FMSA. So just please be aware of that. A recommendation for you is using the same form to send it to all three entities. So if you have a 2067 or if you just have just a regular communication sheet and you list the DSA, the FMSA and the individual name on one sheet, and so that will also spare you from having to look for this one random documentation showing us that you sent it to the FMSA. It will also remind you that I need to send it to all three entities. But again, this is only a recommendation, but the expectation is that documentation clearly shows that you did send copies of the approved IPC to everybody. So again, copies to everyone before it gets approved and copies after it gets approved. Next slide. The therapy justification as well as -- or the 8606As as well as the 3660, this actually is required as well. Copies of these must be sent to all entities -- all three entities that I mentioned before, and this is missed quite regularly. And again, with your 8606As, if you have several, make sure that your documentation clearly indicates which ones. If

you just mention 8606As, that's pretty broad in general, and we're going to ask you if you could provide documentation proving that the aquatic therapy for 8606A, the horseback therapy, massage therapy, what you actually spent. So again -- sent. So again, I would suggest outlining that in a list, a check-off list for you, and that way your staff can heck it off as they go, and there isn't any question about that in your contract monitoring -- and your contract monitoring review will go a lot smoother and you'll get less requests for documents, because the monitor can easily see when that was sent. Next slide. The CMA must submit revision documentation to HHSC at least 30 days before the proposed effective date, so this is a big citation within the case management agencies. Okay? And some of the talk we've heard is sometimes the families are pushing for that, sometimes the DSAs are pushing for that. Whatever it might be, the point is that you're the one as the contractor who is held responsible for that, okay? So if you find that this is occurring, you need to speak to the SPT team, let them know that depending on when you received the documents back, then you have to submit this 30 days before the proposed effective date. Okay? Anything less than that for revision will result in a citation, exceptions being things for immediate jeopardy. The second point there is within five business days of receiving the authorized IPC, the case manager must provide copies to everyone. Again, I had heard a statistic that 50% of the CLASS individuals were enrolled in FMSA, so, you know, that should trigger something for you all as staff members, as -- because that's usually the entity that's left out. The CMAs will remember to send it out to the individual and to the DSA, but sometimes will neglect to send it to the FMSA, and this is actually a very specific question in our tool, so we will ask you for that documentation. Next slide. Okay. Standard No. 3, which is the service reviews. For those of us who have been here for quite a while, these were once called quarterly reviews. Okay? So the CMA must meet with your individuals and reviewed the individual's progress towards achieving the goals described in the IPP. So we've listed something in there referred to appendix X or 10, quarterly due dates chart, okay? So the quarterlies are actually dependent on the IPC effective date. This is sometimes confused with contractors because if they get a new transfer in, then they're going to do within three months of when the individual transferred in, or they're doing actually every four months, so they're meeting on the fourth month rather than within the three months. I would highly, highly recommend that you look this up, this appendix, as monitors this is what we utilize to monitor this particular standard. So that is nicely broken up into the IPC effective date, and it actually includes the due dates for both DSA and the CMA. So this is what we use to ensure that you as contractors did meet with them on a timely basis. So I would highly recommend that you refer to that. You have your case managers trained on that as well. Next slide. Okay. The continuation of the quarterly reviews or the service reviews as they are now called. So documentation of progress or lack of progress. This is actually a pretty big citation as well within the CLASS program. So what we generally find is sometimes we'll find quarterlies that read almost the exact same verbatim with the same typos and the same spacing, and the only thing that changes is the date, okay? And a lot of the individuals also have goals within their therapy, okay? As case managers the reason that we ask the DSAs to send over their summaries is so that you can incorporate it in your quarterly review and discuss that with the family to see if this is still an appropriate goal for them, is this still an appropriate service, okay? So the -- the quarterly or service review notes should not read exactly the same. There should be some sort of discussion regarding the services and progress or lack of progress. The other information, I don't see as much of a problem regarding assessing satisfaction or identifying changes to the individual's needs or providing a copy. Case managers have been doing that or have been improving upon that. The only way

that they do fall off though is within the five business days of the review date, okay? So that is something that is regularly missed. It's past the five business days and that does result in a citation for you. Next slide. Medicaid eligibility. So the CMA must verify the individual's Medicaid eligibility monthly. And I add an additional note to ensure that documentation clearly indicates the dates that Medicaid eligibility was verified within the month. So I've seen this being problematic with the Medicaid batches, okay? So the Medicaid batches are printed out in bulk, and I had to see some of you all's binders and my sympathies go out to you for that one. But the problem with the Medicaid batches at least is that it doesn't indicate what date the Medicaid eligibility was actually checked. So, for instance, today I can run a Medicaid batch for an individual for July of 2017 to make sure that that individual had Medicaid in 2017, but that's not really checking to see if they have Medicaid within that month. So we've struggled as monitors and contractors, I know, to try to find where we could have that information, and as far as I know in my experience, that information isn't available on the sheets, and normally like it would say printed on but it doesn't have that either because they're batches, so that becomes challenging for you as contractors. My recommendation, which I find to be both time efficient and cost efficient for you as contractors, you may also create a spreadsheet, rather than printing out the Medicaid batches. So within the spreadsheet you can include all of your individuals, with their Medicaid numbers, and then a third column having dates that the Medicaid eligibility was checked, and at the bottom of that sheet whichever staff actually checked that can sign that, verifying that they are the ones who did verify the Medicaid eligibility. So in doing these spreadsheets, that could actually reduce the paperwork, and it could only be 12 pages as opposed to 400. So this is something we accept as monitors, and again, just a recommendation for you, if you choose to go another route, please make sure that the date where you checked that Medicaid eligibility is clearly indicated on whatever documentation you're choosing to present to us. Next slide. As far as billing is concerned, we do have a few issues with this as well. The 3625, we don't have an issue with how they're filled out but the fact that we are not given written documentation to support that billing unit, okay? And this can be done in a variety of ways. I've seen people create a communication log and just kind of staple it to the 3625. I've seen contractors who will write on the back of the 3625 to indicate what it was that they were actually doing to merit that billing. It's not -- I don't see that it would be very difficult to try to amend that, but we are finding that that's still an issue. And finally the timekeeper. So there should be a timekeeper that should sign your 3625. Next slide. Moving on to the DSA now, and again, you're getting the link to the DSA monitoring workbook, and this is formidable, okay? And I'm giving you the exact same reservations as far as, you know, this is meant to be a guide, and this isn't something that contractors are exactly trained to do or are privy to how we should interpret this monitoring workbook or how we should approach it. So again, the tool here is only meant to be as a guide for you. Next slide. So for the DSAs, our frequent citations center around staff qualifications and training. So the habilitation orientation must be completed before the first date of service delivery. I find this to be problematic mostly whenever the attendance are family members, like mom or dad. And usually it's because as DSA contractors we already assume that they know how to best care for their loved one or their child. However, once they are an employee of yours, the expectation is that the orientation is completed before the first date of service delivery. And that documentation should indicate that. The second one is all DSA staff must receive the annual training every 12 months. So this is actually -- I view this as a marked improvement. This was something that was regularly missed with the DSAs, but we have been improving upon that. The DSAs have been showing

improvement in creating their own tracking systems and ensuring that everyone pretty much receives the training around the same time, and of course during their -- or for any initial employees who are just beginning. Next slide. Renewal. So for the DSAs, you know, I think we forget as a DSA that we're also responsible for our portion of the paperwork, seeing how the bulk of it does lie with the CMA. So some of the most frequently seen citations is that we -- that the DSA must explain orally and in writing to the individual, LAR or person actively involved about rights and responsibilities, how to report allegations of abuse, neglect or exploitation, and how to make a complaint. So again, with the DSA contractors I highly recommend a similar recommendation as CMAs. You can create a check-off list for yourself and have the parent just sign one form and all of those forms -- or all of these required forms should be included on that check-off list. Next slide. The quarterly reviews or 90-day service summaries. So this is actually our number one most citeable offense for the DSAs. And I sympathize with the DSAs contractors -- sorry -- yes, with the contractors, because this element actually is a bit frustrating for you, as most of the time these citations are a result of the subcontractor, okay? So this usually is for therapy, specialized therapy. There should be a current observable measurable goal. There should be discussion about the progress or lack of progress of goals. Frequency and duration and the rationale for submit sessions. What I'm finding with the therapy summaries is first of all you're not receiving it on time, and if that's the case, please make sure to stamp that somehow to indicate this is when I received it. If we don't have something like that in place, we're actually going to be going with the date that's listed on the actual therapy summary, because another expectation is that you forward copies of that to the CMA. So if you're not date stamping the therapy summaries that you're receiving, I would highly recommend that you start doing that. The second portion of that is because of contractors, DSA contractors, you're not reading the summaries back-to-back. You're reading summaries as they come in. You find that they're acceptable, that they meet all the required elements, and then you send copies to everyone you need to and -- and you stow it away. However, as monitors we're actually checking the summaries back-to-back, so similar to the quarterlies -- or service summaries we see with the CMAs, we will find a lot of repetition with the therapy summaries, and they will have the same verbatim language. They will have the same typos and space issues. So the only thing that's changing is the date. So at this point there is there really is no discussion about progress or lack of progress, and my -- the question I would pose to you as a contractor, if there really was no change, then how would you justify the need for the service? And furthermore, if there is no change, then as an SPT I would expect you all to meet and change that goal. So again, something to be aware of as the DSA, you may want to just glance at the other summaries to ensure that there's actual real discussion on that for you all. Next slide. So here are the standards that require a service summary. I will tell you right now that for the most part everyone is aware of everything except for the pre-vocational services. I find that people are unaware that summaries are required for pre-vocational services, so that's just one thing that I do want to point out. So the summaries are required for any individuals that are receiving pre-vocational services. Next slide. So a copy of the IPP service summaries, which again are the therapy summaries or any of those services that we just listed, must be provided to the CMA within five business days of completing the IPP service summary. So again, I want to reiterate, if you're not getting that until ten days past the date the therapist actually indicated there, you may want to date stamp that. That way we understand as monitors that that's the date that you received it and so therefore you did five business days from then. However, as contractors I would expect that you have a discussion with your subcontractors to let them

know your expectations as far as receiving that documentation on time. Next one. Transfers. So we do have some difficulty with the transfers, and I want to inform you all that we only look at transfers if you're transferring an individual out of your agency. We do not look at transfers if they're coming in. So that being said, once you receive notification from the CMA or from the individual that you -- that they wish to transfer, you actually have five calendar days, not business days, five calendar days, to ensure that the receiving agency has copies of all the identified records, and as a transferring DSA you are required to maintain documentation as well as the date of delivery. So this is actually a very specific question, so please ensure you have documentation clearly indicated when you were informed and when you provided copies of that to the receiving agency. Corrective action plans, or otherwise known as the CAP. We require a CAP for any standards that are -- or that scored below a 90%. There's no official form for the CAP. You can decide which format works best. I received CAPs in Word or in Excel. If you want to get really creative you can do it by PowerPoint or pop-up book. But it does not matter which format you use so long as you have the required elements that are listed within your exit conference sheet. And all CMAs and DSAs must continue to adhere to any CAP approved by HHSC. Next slide. Who to contact? So contract enrollment and administration, this is their fax number, this is their email, and then the Unit Voicemail Box. So this is actually Paul Straka and his group. So if you're requiring any changes or any amendments, such as a change of ownership or address change, phone number, fax, et cetera, this is who you need to send it to, okay? If you send it to us we'll just kick it out to them, so we'll assist you on that, but this is who you should be sending it to, and again, only the person who has signature authority can make those changes or request those changes, and it must be on the company letterhead. Next slide. Who to contact. So we're going through a bit of a vacancy issue with the unit right now, so as I said, I'm the interim manager. We have two monitors, currently in place, Tinnea Collins and Angie Campos. As you can imagine, the monitors travel quite extensively, so I would highly recommend that you email them or you can email they as well. We've also acquired a new unit email that you see at the bottom. It's not quite discernible here, but anytime there's a space, that's an underscore. So if you have any questions and you aren't getting a response back from the monitor or you call the monitor and the monitor has not responded, you can always email that unit email and we will get back to you as soon as possible. And again, I would highly suggest that because the monitors are currently traveling at 100%. So they won't be getting to you any voice messages anytime soon, and their emails, they will get to them usually after 5:00 p.m. because they are performing or conducting audits and they are on-site. So they're not going to be able to get back to you right away, but if you email me or you email that unit email, we will definitely get to you much quicker. Next one. That was it. Thank you very much, everyone.
>> Bob Scott: Thank you very much, Alicia. While Alicia was giving her presentation we discovered that Mr. Straka is not going to be able to join us, so we will -- his recitation is on contract requirements, and we also identified particular catchment areas that might meet different providers. Since I have listened to this presentation in the past I'm going to attempt to provide the same information to you. Thankfully Paul was kind enough to put most of it onto the slides. So I will -- forgive me if I read, but we have here the appropriate Texas Administrative Code citation, this defines the qualifications for a contractor or an applicant. In CLASS, the DSAs are subject to having a licensure. Support Family Services when it's provided by a child placing agency. That's a certification to what used to be called the Department of Family and Protective Services, and I do not recall their name right now, but the rules have not changed. They didn't move to a different location, specific to child placing agencies. The HCSSA license is a

requirement of the direct services agencies, and those two categories there at the bottom are the only two acceptable categories of the HCSSA license, that is that they are a Licensed and Certified Home Health Services category or a licensed home health services. I know the PAS services, providers have submitted questions asking if it was permissible for them to have the personal assistant services certification or licensure. No. That is not acceptable. And here's a summary of the same information. It's also contained in chapter 97 of the title 40 of the Texas Administrative Code. CLASS/case management agencies, they do not require licensure. One of the primary requirements for both case management agencies and direct services agencies, is that they must have an office in the particular catchment area. However, the same company cannot be with a Case Management Agency and a direct services agency within the same catchment. We do have companies who in some catchments are licensed for a direct services agency and some -- and other catchments, they are a Case Management Agency. Companies can have both -- contracts of both types but not within the same catchment area. And this is a particularly important point, No. 2, a CLASS provider must be able and willing to provide the entire array of services to the CLASS individuals that they are serving. We have run into some issues with that, particular companies that refuse to delegate. We do want you to be able to provide all services. If you're not able to -- if the RN is not comfortable delegating, that is the RN's decision. We do leave that decision completely up to the RN. This is the -- requires you to have a business location in the catchment area, for which they wish to provide services. That means a physical address, a place where you can receive mail, where you can receive contract monitors when they come out on their visit within the catchment area. And in the case of direct services agencies, they must -- their office must be a licensed location within that catchment area. If you have an existing contract with HHS, possibly a DBMD contract or others similar, you can simply make a request at this number listed here, or to request to add a contract. That request must be signed by authorized signatory representative for your agency as Alicia noted earlier. And more information about the CLASS program can be found at this resource page, and it has links to numerous other documents that are useful to CLASS providers. You can find additional information on how to become a CLASS provider and the address for submitting an application at this location. Again, all of these links are live in the -- or are accessible in the PDF document. And then this is a second page that has additional information about the CLASS program. It's kind of an additional resource page. I'm sorry, we just repeated a slide. Sorry, we are still repeating a slide. I think we're on the right slide now, folks. Excuse my confusion. The form 5830 application packet checklist includes all required forms and that can be found at this location. Again, these slides are live should you decide to print out -- or download the PDF version. This is something that Alicia was referencing in her presentation. Providers must notify HHSC of changes affecting their contracts, such as an ownership update, stock transfer. Those must be made at least 60 days in advance. A change in the name of the individuals authorized to negotiate contracts on behalf of the provider within 30 days of the date of that change. This is particularly related to Alicia's comment. Change in the provider's telephone number, fax number, physical address, mailing address or email address must be made within 30 days of the date of the change, or within three days after the change if the reason is due to a natural or unforeseen disaster. And all requests must come from an individual having signature authority. A change of legal entity will be processed when there's a change in the EIN -- employee identification number, which general indicates a change in the legal entity responsible for the contract. A change in the ownership will be processed when, as a result of a stock transfer, one or more persons who collectively had less than

5% ownership before the stock transfer will now have at least 50% ownership after the stock transfer. I'm sorry, I cannot provide you any details about that. That is not my forte. You must provide HHSC with at least 60 days' advance notice prior to the anticipated effective date of the contract assignment. This is regarding a change of ownership or change of legal entity. And any questions, please refer to this citation in the Texas Administrative Code, this is title 40, chapter -- section 49.210. And here, ladies and gentlemen, is the -- one of the important reasons we include this in the Webinar presentation. These areas have been identified as needing additional providers. I'm sorry, I cannot tell you whether they need additional case management agencies or additional direct services agencies. If it becomes important I will help you. Feel free to contact the CLASS mailbox. I will help you locate those. I believe you can go to the choice list and see those areas which have less than two choices of either CMA or DSA. And the list of all the counties that are within each catchment area can be found on our Web site, and those list the counties all within the instructions for this form 3691. This link does take you to that list of counties. It's useful. I am attempting to get this included on the CLASS private resources page. This is -- >> Anything relating to 2, right? Just -- >> (inaudible). >> Sorry, we had a little interference there. >> Bob Scott: The contract Paul -- >> Sorry. >> Is everybody on mute? >> Bob Scott: To contract the community services contracting group, you may email this address. You may call this phone number. You may fax to this phone number. And then here is the snail mail address. Again, all this information is available in the PDF version of our PowerPoint presentation. It's included on the control panel for the Webinar. Thanks so much, everyone, for your attention. Now looks like we've got time for some questions. >> This is Lauren. I'll go first since I've had time to look at them. I know Bob was presenting. Try to be quick because we have -- we have about 30 minutes left but we have a lot of questions that came through. I had a couple about the HHSC, the portal. Yes, we are still working on that. We were busy working through some issues that it was having, technical difficulties, but we continue to work on it and we will let you all know as soon as we're able to get it out. The next one, any -- will any names be released from the CLASS interest list? Unfortunately we did not get any funding to release names from the interest list for the CLASS program this year, so it's unlikely that we will be releasing anyone anytime soon. That's not official, but without any funding it's unlikely. Let's see. This one is who's responsible to contact or contract with an interpreter, the CMA or the DSA? Can we include the cost as an adaptive aide? Once somebody is enrolled, yes, it included as an adaptive aid. I would say for enrollment, because that's when you would have to foot the bill as the cost of business, that the DSA would need to pay for the nursing assessment and the CMA would need to pay for the SPT meeting. I think that's a fair way to divide it. >> Bob Scott: I'm sorry, Lauren, for the enrollment -- SPT meeting, that would have to be billed to -- can be billed through an adaptive aid, even for an enroll him. It would not be (inaudible) prior approved, but that is one issue that the utilization review has told me, and I will confirm that -- I tell you what, can we take that question and give a more complete response, written? Because I want -- it is something I have discussed with the utilization review group. >> Okay. All right. >> Bob Scott: Yeah. >> So we'll get more information, but definitely for renewals, and we'll let you know about enrollment. Okay? What if the nurse's assessment 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? This also came up with DBMD because of the timing of those two meetings. Yes, I think we would accept if you completed it by fax. The important thing is that the SPT all looks at the form and agrees to whatever action needs to be taken based on the nurse's recommendations, and we don't want you to have to have another meeting.

That's not the goal of the form. So yes, I think you could do it by fax. Do we have to report a critical incident if the nurse's annual visit she's informed by the family of an ER visit from six months ago? Yes, you would still report it. You would just indicate that it did occur six months previously. So obviously whatever action you might take at that point would probably be kind of a moot point, but still please report it for data purposes. Okay. >> I'll go ahead and pick up. Again, this s Alicia Alaniz contract monitoring. I have a few questions I will be answering. If the case manager doesn't send the IPP review forms to the DSA, will the DSA be cited? No, the service summaries for case management are exclusively a case manager responsibility and duty. Second question, what happens if the transferring agency fails to submit the documentation within five days to the receiving agency? Well, for the transferring agency that does result in a citation for you. For the receiving agency as well as the case manager, I would expect there would be some sort of facilitation between you two as far as why there is delay or the lack of cooperation. Again, I would also promote an extending professional courtesy because there could also be an issue where perhaps the DSA is down to -- or understaffed, so again, I would promote professional courtesy. However, the CMA or the receiving agency can always file a complaint against the transferring agency for lack of cooperation for the transfer or lack of -- or the delay of it. If the case manager is weeks late initiating the SPT meeting but DSA has documentation they asked for SPT meeting with the -- would the DSA be cited for having a late SPT meeting? No, they would not be. However, this does bring another point that has been coming up for the case managers. Because we are not ready with all of our 8606As, mostly, and sometimes 3660s, the CMA is unable to forward the IPC renewal to DADS within the required time frame. Okay? So this has resulted in complaint investigations for the case managers as well as whenever we're on-site we're looking for documentation to explain the reason for the delay. So in this case I do highly recommend for both the CMA and the DSA if you are unable to provide all of the documents that you're needing for that IPC renewal, then you should amend that renewal to renew those services and later on add them on as a revision. Otherwise you'll be subjecting the case manager to scrutiny as far as the audit is concerned or a complaint investigation. The DSA, we should be getting started on renewing those 8606As or 3660s, whatever may be appropriate, at least by the third quarter, if not somewhat sooner than that. Again, I understand that you're dealing a lot of times with subcontractors, but if those forms are not ready, you're delaying the CMA and you're also delaying the authorization of renewal of services, which can lead to a risk of interruption of services for that individual. But to answer the original question, no, the DSA would not be cited for a late SPT meeting. Just ensure you have all of your documentation in tow as well. If the DSA notices that therapy summaries are repetitive, could the DSA ask the therapist to redo the summary or do we just document so we don't get cited? Absolutely, you're the employer. The therapies -- therapists are your subcontractors. I would also suggest that you include that within the contract when you're first drafting it up and set out the expectations for them. So you absolutely can do that and request that they redo the summaries. I have heard of contractors, DSAs, that have requested that, and that is an expectation and that is something you can do. What is the time frame for contractors to submit their quarterly reviews to the DSA? So there is no stipulated time frame for the subcontractors to submit quarterly reviews. This is something that as a DSA you should be able to stipulate beforehand. So, for example, if you know an individual quarterly or summary review is due -- or the first one is due no later than January 31, you should be able to stipulate to that subcontractor that you want to have that submitted to you by, you know, five business days before the end of the month, or whatever that may be. But

CLASS as far as rules and provider manuals, does not stipulate that. They just stipulate when you should be having them as far as what months and also five business days that you should be sending out copies to the CMA. Last question. Can an attendant orientation be done the same day as the day of service delivery? Yes, it can. Those are all of my questions. >> Bob Scott: Thank you, Alicia. I've got some questions I'd like to address. What forms are required to be sent to the DSA, FMSA and the individual before approval and which forms after approval? Well, I don't have all -- an index of all the forms available that might be applicable in each situation. I can tell you there is a section in the case management chapter 2000 of the CLASS provider manual, case manager section that includes submission standards for enrollments, renewals and revisions. Those forms we -- we think it's appropriate and fair that the case manager provide copies of what they have sent to the state and copies of what the state has approved. Case managers have portrayed that as a burden. However, in the interest of service provision, continuity of services, we have also learned that since not all forms are completed at the service planning team meeting, the DSAs nor the individuals are -- have even draft versions of the forms that the case managers developed. We even have anecdotal -- or segments that they're -- statements they're being asked to sign blank forms. We do encourage the case managers to prepare for the meetings. The forms that are required at the renewal are probably going to be required at the next renewal. If the individual has changed services, we anticipate that you would be -- case manager would be able to prepare for that, have all those forms available, even if they are completed prior to the meeting. They can be changed by hand, one line to the incorrect entry, your initial. Initials of everyone involved, and a handwritten correction. Next question. Are special cases and inspections required for minor home modification repair that was originally done by CLASS? If so, is it okay to request inspection and specification of these for MHM repair or is it not necessary? That is somewhat dependent on the situation in which the repairs are being made. If they're being made after all the $10,000 lifetime limit has been spent, there is a specific section in TAC that addresses that. If -- then it also depends upon the amount of the repair. There are different requirements for repair under 10,000 -- under $1,000 and over a thousand dollars. Excuse me. 10,000 is the maximum allowable amount for minor modification, for an individual in the CLASS program. If the DSA wants to change office work hours do we inform HHSC? I believe this question is actually addressed within chapter 97, your HHSC rules, if I remember correctly. I confess I don't know it off the top of my head. Should you inform HHSC? I believe you would want to check chapter 49, chapter 97, to determine that. I will also verify -- do this research and provide that in our list of questions. What do we advise our clients when they state the DSA they are transferring out of keep calling them to ask them why they transferred out? At least three calls. Be honest. If they're unhappy with the services, explain that to the DSA. It's a -- the DSA by HHSC rules is required to conduct a satisfaction survey. Also CLASS requires the same of the case management agencies. I would believe that a DSA who's asking why an individual is transferring out is probably trying to obtain information for the satisfaction surveys. Next question, will the state come up with a form for the quarterly reports for all therapies or does the agency have to create a form for service summaries? We've tried to leave that in the hands of the therapist, and I received -- Alicia addressed a few questions about the therapist and their punctuality of their service summaries. I believe this question is related to that. Her suggestion about date stamping information you receive from your therapist I believe is a very useful suggestion. I myself have always thought of the service reviews that occur throughout the year as a means of evaluating the success of the plan as you developed it at the enrollment or the renewal.

Individuals may progress at different rates, depending upon the goals and objectives. If this therapist is sending you his business requirements require him to send it to you more than five days after he wrote it, or the therapist wrote it, Alicia's suggestion of date stamping it when the DSA receives t she's indicated that contract monitors agree with it, I would certainly agree with it also. If the therapist needs to send you the notes for the first quarterly review, first service summary review with a note that -- notes from two weeks prior to the end of that review period, and then the -- would include those notes that were -- should have been with the first review period on the second review period, in a cumulative effect, is what I'm trying to describe. In other words, by the end of the year, the IPC year, the case manager should have received service summaries that summarize the goals and objectives of that therapy for the entire year and give the service planning team sufficient information to determine if the service is still needed, is it still appropriate, and are goals andobjectives that that he came up with still relevant? I submitted a 3585 last week. I mailed it snail mail. How long before I hear back? I would advise you to check the utilization review and program enrollment support. They each have phone numbers. I don't have them with me. You can send a question to the CLASS mailbox. I will provide you with those phone numbers. They are very useful when following up on submissions, and I'll be happy to share those with you. The policy states it's $300 per IPC year for repairs. If the client -- if the individual already exhausted a 10,000 annual cost limit for that IPC year, do we need to wait till the following IPC year if the repair is over $300 and we have to initiate the process for that ? I'm not sure what this question is asking. The exact policy is, $10,000 lifetime limit for minor home modifications. After that $10,000 is expended, $300 annually is available to the individual for repairs of any minor home modifications that were originally purchased by the CLASS program. >> Could they be talking about adaptive aids where the 10,000 refreshes? >> Bob Scott: That is a $10,000 each IPC year. >> I mean, I'm thinking, you can use up to 300 for a repair if it's -- if it's going to cost more than 300, then I think it would have to wait till the next year, right? >> Bob Scott: Well, if the $300 -- once the $10,000 limit is spent, a flat $300 be is cumulative. It doesn't accumulate over the years. >> And that's a hard cap, right? So even if the repair costs more than that -- >> Bob Scott: Yeah, it's -- >> Can we get clarification? This question was asking about an adaptive aid. >> Okay. >> Bob Scott: I would actually encourage -- I tried to make the provider manual as complete as possible, and -- well, all these questions are addressed in the provider manual. I would really encourage -- we made it available electronically. I will tell you a little trick that I learned since we transformed over to the HHSC Web site. The provider manual is displayed in a different way. If you go to the page -- the beginning page of the provider manual, there is a printer friendly link at the top. If you hit that printer friendly link it will convert it into a format that is printer friendly. Using the command control/F will bring up a search box so you can search through the entire manual for specific terms. I see that we're getting close to our end date -- end time, excuse me. We've got about seven minutes left. There are any questions that we need to address, Lauren? >> Yeah, I've got a few. >> Bob Scott: Okay, we've got about seven minutes left. >> Really quick. How do we get a copy of the closed captioning? It will be available when you watch the play-back, but we won't be providing a copy of it separately. To report ER visits, is it for incidents related -- incident-related visits are only for medical issues related to -- medical issues if someone is ill enough they need to go to the emergency room. That's a critical incident. I also want to let you guys know, I didn't just make up these categories. We based it on what HCS had and then also what CMS recommends we report on and OIG came up with a report on what they wanted to see us reporting on, kind of like a best practices, and we

used some of that as well. Again, the closed captioning will be available when you review the recording. It will be part of the recording. How is removal of the services due to unavailable documentation a person centered planning effort? I mean, I see what you're saying by removing it, but then also it can hold up all the other services, which wouldn't be person-centered either. We of course recommend that you do your best to start working on getting all those documents as early as possible so you don't get in a situation where you have to remove services because you don't have the documentation. And then also we of course would want you to add those services back using a revision as soon as possible. Let's see. We have the SPT annual or renewal meeting, we normally put five units for the plan year. How do we utilize these units or how do we bill for them after doing quarterlies. They're for the annual meeting or any meeting needed during the year. If you don't need any meetings then they just wouldn't be billed for. If you do need a meeting, like if they had an SPT meeting because the individual just came out of the hospital and their needs have changed, that's why we allow some extra units there. But again, if you don't need to have those meetings, then you wouldn't use those units. And this one, which I'll take back to you all, is there a timeline or date where the 8606 A is completed too soon, can it be completed for four to five months before the plan year renews? I do think that you have some time frames that they prefer -- >> Bob Scott: You may have heard of -- I may have heard 120 days when the DSA goes out to do the renewal -- I'm association the renewal of the level of care. But, Lauren, I think we would do better to take this back-- >> We'll confirm, yeah. But I think four to five months would likely be too long for them to accept it. But we'll confirm and provide that answer in writing when we get the questions out. I think we have maybe two more questions for Alicia and then we'll probably have to wrap up. >> Yeah, I'll go through mine quickly as well. When does the five-day initiate for a transfer from approval of HHSC or transfer or from CM notifying of transfer. It's from the case manager notifying you of a transfer or the individual, because sometimes the individual will call you and let you know that they're going to need to transfer not knowing that the CMA is responsible for facilitating that. So basically it's when the DSA becomes aware or the CMA becomes aware of it as well. So we will look at 2067s of you communicating back and forth about when that desire for the transfer came in as well as communication logs. So basically date of awareness, date of documentation. Second question, if the CMA provides copies of the HHSC submission packet at the time of submission to the DSA, FMSA, LAR, are they required to resend with authorized IPC or can they simply send the authorized IPC within ten days of receipt? So the expectation is just the authorized IPC. However, if there were remands, if there were any changes made as a result of those remands, then the expectation is that you do send -- resend everything with those changes. That was it for me. >> And then we've got two more that are pretty similar about CMA billing, one is about if a CMA can bill for the service reviews and how many units can a CMA bill for yearly. CMAs have a monthly unit, so you would bill -- if you make your monthly contact which now is required for you to have at least one billable contact every month, then you would bill for that month. You'd get a monthly flat rate but you would not bill again for additional visits or anything like that. It's just one monthly rate. All right. We're out of time. Thank you so much. >> Bob Scott: Thank you so much for your attention. We do want to tell you the next Webinar is scheduled for August in 2018. The announcement will go out by govdelivery, the same way we've always announced it and we encourage you to keep up with HHSC email alerts to learn when this Webinar is posted to the Web page. Alicia provided a link in her presentation. You can also find it on the CLASS provider resource page up in the top right-hand corner. There's a big blue box labeled "subscribe to email updates." We'd like to encourage you to take

the survey at the end of this Webinar. We put a lot of attention on that, and if you have any comments about this Webinar, please send them to CLASS mailbox at the address here. Again, thanks to everyone for joining us, and have a great day.