Community Living Assistance and Support Services (CLASS) and Deaf Blind with Multiple Disabilities (DBMD) Quarterly Webinar

Participant Q&A

3/20/2024

Service Planning Team (SPT) Signatures

Health and Human Services Commission (HHSC) will allow electronic signatures for in-person meetings per Title 40 Chapter 49 Texas Administrative Code (TAC) Rule §49.305, Records HHSC will accept faxed signatures as well per CLASS TAC Rule §259.65(c)(2), Development of an Enrollment IPC.

Service Planning Team (SPT) meeting signatures are the documentation of agreement with an individual plan of care (IPC) or individual program plan (IPP). Signature dates must be prior to the IPC effective date. SPT meeting notes should include documentation of who attended the SPT and the date of the meeting.

CLASS/DBMD Handbook and Form Updates

HHSC will be updating the CLASS and DBMD Handbooks in the coming months. HHSC will provide a GovDelivery when updates are published.

Form 3625, CLASS/CFC - Documentation of Services Delivered, has been updated and is currently available online.

CLASS Form 3621, CLASS/CFC — Individual Plan of Care, has been updated online and in the IDD Portal.

DBMD Form 6517, Individual Program Plan (IPP) Service Review, was published on 8/31/23. DBMD Form 6501 Individualized Skills and Socialization section can be found on page 14 of the form.

Form H1003, Appointment of an Authorized Representative, is used to appoint an authorized representative to allow another person to act for a person.

H4800 is an internal document for HHSC staff to complete and not for CMA’s.

LTSS Policy is working on updating forms. An alert will be published once the updates are completed.

Individual Participation Mandatory Requirements

Please review CLASS TAC Rule §259.103 and DBMD TAC Rule §260.113.

Mandatory Participation Requirements of an Individual, which outlines requirements for individuals to participate in and attend SPT meetings. This includes admitting case management agency (CMA) and direct service agency (DSA) representatives to the individual's residence for a scheduled meeting.

IPP Service Review Meetings

CLASS IPP Service Reviews are conducted with the individual and legally authorized representative (LAR) in-person to review CLASS Program services. Meetings may occur at a location chosen by the individual/LAR but at least once per IPC year, the meeting must occur in the individual’s home.

DBMD IPP Service Reviews are conducted with the individual and LAR (if applicable) in-person to review DBMD Program services. Meetings occur at a location as requested by the individual/LAR or in the individual’s home.

Please review the IPP Service Review Schedules in accordance with CLASS Program Manual and DBMD Provider Manual.

Our policy team is working to update the CLASS Provider Manual to provide an accommodation for the 4th IPP Service Review to be held separately from the renewal SPT meeting. This will alleviate any conflict if the renewal SPT meeting is conducted by videoconference as allowed in rule. If the SPT meeting is held in-person, then it may be conducted simultaneously with the 4th IPP Service Review.

It is important to remember the purpose of meeting in the setting where services are delivered is to allow the case manager (CM) to verify that services listed on the IPC are delivered as described in the IPP. This function is best accomplished by the CM observing CLASS services in the setting in which they are provided.

The CMA will report any concerns regarding service providers to the DSA or consumer directed service (CDS) employer (as applicable). This may include how services are being provided, lack of services being provided, and/or other observations. The CMA is usually the first point of contact and supports the individual/LAR with concerns and needs of the CLASS Program.

Individualized Skills and Socialization

Individualized skills and socialization is an available service in the DBMD Program. For off-site individualized skills and socialization activities the program provider should work to identify similar interests amongst individuals so that activities could be planned to accommodate transportation availability. The program provider can also develop a plan to find out where the interest is for group activities and provide individuals a choice among a number of activities that would align with their individual goals. Program providers should consider the individual's preference and the individual can provide input in planning and scheduling for the day. Accommodation from the program provider for an individual who chooses not to participate in a scheduled activity or request to engage in an alternative activity should be considered.

Individualized skills and socialization is not an available service in the CLASS Program.

In-Person SPT Meetings

Per the guidance of 26 TAC §259.57, during all service planning activities, the

SPT must follow the person-centered planning (PCP) process. If an individual or LAR requests that an SPT meeting be held in-person, it is the expectation that all SPT members attend the meeting in-person. Both the DSA and the CMA should make accommodations to ensure an in-person meeting is convened with all members of the SPT.

At any time, an individual or LAR may file a complaint with the HHSC Office of the Ombudsman to assist in a resolution if accommodations for in-person meetings are not provided.

Per CLASS TAC Rule §259.79 the CMA may convene a service planning team meeting in-person or by videoconferencing for IPC revisions.

Home and Community Based Services (HCBS) Rule Implementation

HHSC has adopted rules in the CLASS (26 TAC Chapter 259) and DBMD Programs (26 TAC Chapter 260). The rules implement the federal HCBS settings requirements and moved the CLASS and DBMD Program rules from TAC Title 40, Social Services and Assistance to Title 26, Health and Human Services.

Person-Centered Planning Process

The person-centered planning process reflects the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual's preferences for the delivery of such services and supports. This process is driven by the individual within the requirements of the program.

The IPP describes the outcomes to be achieved through the service and the actions and methods to be used to achieve the outcomes. Each program service describes individualized goals for the service. The goals are outcome-based, are measurable, and have a start date and projected completion date.

Case managers for CLASS and DBMD should review and discuss assessments/documents with the individuals. Case managers will complete all sections of CLASS Form 3595 and DBMD Form 6517. These sections include reviewing services received, documenting the progress or lack of progress toward goals and objectives, assessing the individual's satisfaction with the provisions, determining if the service backup plan was implemented and if any changes to the individual's needs have been identified. When meeting with the individual in person, CLASS and DBMD case managers will review program services and CFC services to determine if the services being provided are in accordance with the IPC and IPP. The case manager also reviews the individual's progress towards achieving goals and outcomes described in the individual's IPP for each service listed on the IPC.

Rate Increases and Policy Changes

Program rates are based on legislative direction and overseen by HHSC Provider Finance Department. Questions related to CLASS and DBMD Program rates can be sent to PFD-LTSS@hhs.texas.gov.

During the 88th Legislative Session through Rider 29, the DBMD Program case management service rate increase was approved to be effective September 1, 2023. HHSC will be providing additional information related to the implementation of the new rate as it is available.

For rate information, please contact Provider Finance Department.

HHSC has approved increased attendant payment rates per Information Letter 2023-33 in the CLASS and DBMD Programs effective Sept. 1, 2023. In response to the rate increases, action is required only for authorized individual plans of care (IPCs) that include one or more of the service codes outlined in Information Letter 2023-38.

For more information related to payment rates in the CLASS Program and the DBMD Program, visit the Provider Finance Department site on the HHSC webpage.

HHSC Provider Finance Department (PFD) follows a biennial fee review schedule to systemically review Medicaid and other client services reimbursement rates. Prior to each Legislative Session, PFD publishes Rates Tables, which contain information regarding the cost to fully fund each rate according to the methodology established under the biennial fee review process. PFD plans to review the CLASS case management rate and rate methodology as part of biennial fee review. However, all rates are limited to available appropriations, regardless of methodological rates calculated.

A provider agency may contact the Office of the Ombudsman when a CMA has not completed an IPC revision for a rate change. Please note, the provider agency should first take all necessary actions to resolve the issue with the CMA or other agency.

For IPC revisions due to rate changes, case managers should use the IPC and IPP to show the breakdown of units being requested at the old and new rates.
The more detailed version is addressed on slide 39 of CLASS/DBMD December 7, 2023 Webinar, *Providing Examples of Rate Change Revisions.*

An IPC revision may have the same effective date as an IPC renewal. The submitter must ensure that the renewal IPC is submitted, approved and date entered (check MESAV) before an IPC revision is possible. The IPC revision may show an effective date matching the effective date of the renewal IPC.

The FMSA rate for DBMD was increased and effective 9/1/22. The rate was increased to $229.93. The base wage for attendants was increased from $8.11 to $10.60 per hour. For more information regarding attendant rate increase: Information Letter No. 2023-33.

After submitting IPC rate changes to HHSC and have not received a signed copy of the authorized IPC, CMAs, DSAs, Provider Agencies and FMSAs should use MESAV to verify the rate changes have been completed.

For rate changes, it is important to remember that the service planning team (SPT) should include all agencies and individuals involved in the revisions to CLASS Program services. This includes the DSAs and FMSAs to determine the number of units used or expected to be used for each impacted service code. Communication is key for all SPT members involved so that rate changes may be updated, plans revised, and timely submission for authorization from HHSC.

Employment First

HHSC is currently in the process of implementing the Employment First Uniform Assessment Tool for use in the CLASS and DBMD Programs. Employment First provides employment opportunities for individuals with disabilities who are enrolled in Medicaid waiver programs. Employment First intends to increase individuals access to employment support services and ensure their needs are tailored to their person-centered plan.

HHSC published IL 2023-22, Employment First Uniform Assessment Tool and will be providing further guidance in Fall 2023.

The Employment First Discovery Tool is used to ensure that an individual who indicates a desire to work is afforded the opportunity by completing the assessment tool. The tool will guide the service planning team’s discussion of an individual’s employment goals.

The IPP documents the result of person-centered planning. If the individual expresses a desire for employment during the person-centered service planning process, the Employment First Discovery Tool Form 8401 must be completed. The case manager must complete an IPP for enrollment, renewal, and revision of the IPC.

The Employment First Discovery Tool webinar was January 10, 2024 and recording of this webinar can be found here. If an individual does not express a desire to work, the case manager does not need to complete the Employment First Discovery Tool.

MESAV/ Data Entry Errors

For a MESAV corrections, CLASS TAC guidance states that once HHSC approves an IPC, a CMA and DSA must review MESAV to identify any inconsistencies.

Whoever is authorized to bill for the services may request changes to be made.

Per CLASS TAC RULE §259.69 and §259.79, if the information on the enrollment, renewal or revised IPC is inconsistent with the information in MESAV, notify HHSC of the inconsistency and initiate CLASS Program services and CFC services for the individual in accordance with the individual's enrollment, renewal, or revised IPC no later than seven calendar days after the CMA receives HHSC's notification.

PCS data enters what is provided on an authorized IPC and will not calculate differences made for increases.

When MESAV is not correct, CMA/DSA would need to determine the cause of the error / defect. Depending on the outcome of this process, the SPT may need to contact HHSC UR or PCS through the CLASS/DBMD message line at 512-438-4896. The September 7, 2023, CLASS and DBMD Webinar offered detailed information on this process.

If the IPC is showing the incorrect information the process to get MESAV corrected, case managers may need to contact Provider Claims Support at fax number 512-438-4380. The September 2023, CLASS and DBMD Webinar provided detailed information on this process.

When Provider Claims Support (PCS) receives a fax requesting a correction, there is a 10-day time frame. HHSC requests that program providers wait for the original request for correction to be processed before submitting additional requests for the same issue. If more than one request is sent before the original request is processed, it can impact the process for the correction to be made.

If a case manager needs assistance with codes on MESAV to assist an individual with eligibility, they may contact pesfairhearingnotifications@hhs.texas.gov.

CPR/ First Aid Training

Per CLASS TAC Rule §259.357, training in cardiopulmonary resuscitation (CPR) and choking prevention includes an in-person evaluation by a qualified instructor of the service provider's ability to perform these actions. Therefore, the training must include an in-person evaluation by a qualified instructor verifying the service provider's ability to perform these actions.

The requirement for First Aid was removed with the new HCBS rule update in February 2023. DBMD TAC 26 Part 1, Chapter 260 Subchapter D RULE §260.205 Training states that program providers must ensure that the program director, case manager, intervener and service providers have current certification in choking prevention and CPR.

Electronic Visit Verification (EVV) Information

For Alternative Device, program providers would be responsible for paying for any Alternative Device outside for the 7.5% when the member meets the certain criteria. Criteria and policy explanation can be found here. EVV Alternative Device Policy (texas.gov).

For individuals that stay with their EVV provider, HHSC does not directly reimburse program providers and FMSAs for the use of an EVV proprietary system. However, program providers and FMSAs can report costs related to their EVV proprietary system through established Medicaid cost reporting processes.

HHSC evaluates this data when setting future Medicaid rates. Not all Medicaid programs utilize cost reports. Email the HHSC Provider Finance Department or contact your MCO for more information about Medicaid cost reporting.

EVV requirements effective 01/01/24 for nursing services, OT and PT apply to RN services, EVV would be required for those services. Please see Electronic Visit Verification (EVV) Programs, Services and Services Delivery Options Required to used EVV, for more information and details.

Beginning October 1, EVV users will be expected to go live with HHAeXchange and use HHAX for any EVV transactions. All EVV Visit Transactions should be completed in the HHAeXhange system on October 1st.

EVV expansion applies to Nursing services, Occupational Therapy, and Physical Therapy in the CLASS and DBMD Programs. This change is not applicable to specialized therapies.

Program providers, FMSAs, and CDS employers must monitor EVV compliance reports monthly.

EVV is required if submitting a claim for an EVV-required service in a member's own home/family home (OHFH) setting. A full list of the EVV-required Home Health Care Services may be found on the EVV Home Health Care Services Bill Codes Table. If the bill code for the assessment is listed in the Services Bill Codes Table, and the assessment is performed in an OHFH setting, EVV would be required.

Nursing services provided in the member's own home or family home will be delivered through EVV.

Processing paperwork for a nursing assessment conducted in the home is a non-billable activity per the CLASS Provider Manual Section 7300, Non-Billable Time and Activities.

When the app is giving misinformation through the HHAX EVV system, it is recommended to open a ticket with HHAX Support to research and resolve the issue. Please contact Txsupport@hhaexchange.com. If you are using a PSO EVV system, please reach out to your PSO vendor to open a ticket for research and resolution.

If assistance with EVV maintenance is provided it would be considered a matching claim once visit maintenance is completed.

The Go-Live date is the "System Start Date" for your current EVV system. Program providers and FMSAs can determine their go-live date by reviewing the EVV Provider Report in the TMHP EVV Portal. The go-live date is also the "System Start Date" if you are using a PSO EVV System. If there have been issues of NPI for Go-

Live date, please send your information to EVV@hhs.texas.gov so the issue can be researched and reviewed.

At this time, there is no official timeframe for specialized therapies to be include through EVV.

Consumer Directed Services (CDS)

Please visit the Consumer Budget Workbooks (Excel) that are posted online for the most recent updates.

Subchapter C, Enrollment and Responsibilities of Financial Management Services Agencies (FMSAs) of TAC Title 40, Part 1, Chapter 41, Consumer Directed Services Option. TAC §41.317 requires FMSAs to provide service utilization reports no less than quarterly to the CDS employer and CM.

Medicaid/ Eligibility

If an individual temporarily loses Medicaid coverage, please contact 2-1-1 and inform your CMA.

CMA is required to notify the DSA (and FMSA if applicable) of fair hearings for Medicaid ineligibility. Please reach out to pesfairhearingnotifications@hhs.texas.gov with any questions regarding the Fair Hearing process, appeal process, and forms.

As with all service providers including DSA's, providers may bill for services rendered however their claims will be denied if there is no valid Medicaid eligibility for the dates of service. Once Medicaid eligibility is reestablished, the provider can attempt to rebill.

If a case manager does not receive the paperwork for the fair hearing, the case manager can follow up with Program Eligibility and Support (PES) by e-mailing PesFairHearingNotifications@hhs.texas.gov to confirm that a fair hearing request was received. The case manager can ask for the date and time of the fair hearing or ask for the hearing officer's contact information.

To verify the status of a hearing notice, a case manager can e-mail PesFairHearingNotifications@hhs.texas.gov and request verification that the hearing notice was received. To find the coverage code and program type for the correct

waiver eligibility, please check the Appendix XIV, TIERS Type Program and Type Assistant Chart website.

To request a change to the Medicaid start date. The case manager may contact 2-1-1 to request coverage. When the case manager submits Form H1746A, they can include in the comments: "Please Test for ME-Waivers with effective date of xx/xx/xxxx. LOC has been approved. MN/ISP questions are not applicable for CLASS Waiver." The case manager will then fill in the blank date from when Medicaid ended.

If an individual or LAR requests a fair hearing before the effective date of the termination of CLASS Program services and CFC services, as specified in the written notice, the DSA must provide services to the individual in the amounts authorized in the IPC while the appeal is pending per 26 TAC §259.161(f).

The information for the Medicaid Eligibility codes for CLASS and program types can be found on the following webpage: hhs.texas.gov/handbooks/community-care-services-eligibility-handbook.

For DSAs who provided services during an appeal process, please email pesfairhearingnotifications@hhs.texas.gov for a step-by-step process for information.

If the individual or their LAR have not received a hearing date letter, the individual, LAR, or the case manager may e-mail PesFairHearingNotifications@hhs.texas.gov to confirm the fair hearing request was received and confirm the individual or LAR mailing address.

If an individual loses Medicaid eligibility, the case manager must send a written request to HHSC to terminate CLASS Program services and CFC services for the individual. After HHSC authorizes a proposed termination, the case manager must send written notice of the proposed termination to the individual or their legally authorized representative (LAR) and include the written notice of the individual's right to appeal HHSC's decision and request a fair hearing. The case manager prepares Form 4800-D when an applicant or individual wishes to appeal an HHSC determination. The case manager must ensure that information on Form 4800-D is sent to the hearings officer through TIERS within five calendar days from the date the request for appeal is received by the HHSC.

H1200 should be sent with the Medicaid Application. If the case manager completes this online, they should call 2-1-1 with the family to see if Medicaid for the Elderly and People with Disabilities (MEPD) will allow the H1200 to be sent after the Medicaid application has been submitted. The case manager must offer direct assistance as necessary to help the individual re-establish eligibility. The case manager should also follow up every two weeks and document progress in their case management notes until Medicaid eligibility is re-established, or the individual's waiver services are terminated.

CMAs should be reviewing MESAV at least once a month for Medicaid Eligibility. Please e-mail PesFairHearingNotifications@hhs.texas.gov if eligibility has been lost and a Notice of Proposed Termination of CLASS Services has not been received.

Important Links

Recordings and presentation copies of webinars can be found on the following HHSC Website location:

CLASS: CLASS Provider Webinars | Texas Health and Human Services.

DBMD: DBMD Provider Training, Webinars and Podcasts I Texas Health and Human Services.

Please see the September 7 CLASS and DBMD Quarterly Webinar for contact information.

Program providers and FMSAs that need help setting up a Compass 21 (C21) Submitter ID or Claims Management System (CMS) Submitter ID should contact the EDI Help Desk at 888-863-3638, Option 4 or visit the TexMedConnect webpage for additional information.

Reporting

Please review CLASS Provider Manual Section 7210 Case Management for monthly contact and billable activities.

Under the 2024-25 General Appropriations Act, House Bill 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 30(a)), HHSC issued Information Letter 2023-33 related to increased payment rates authorized. The new rates took effective Sept. 1, 2023. HHSC approved these rates through our regular public hearing process on July 11, 2023. The adopted payment rates can be accessed on the Provider Finance Department (PFD) webpage. The DSA contracts with the direct care service providers. With the newly published rates, overtime is still allowable and determined by the CLASS direct service agency (DSA).