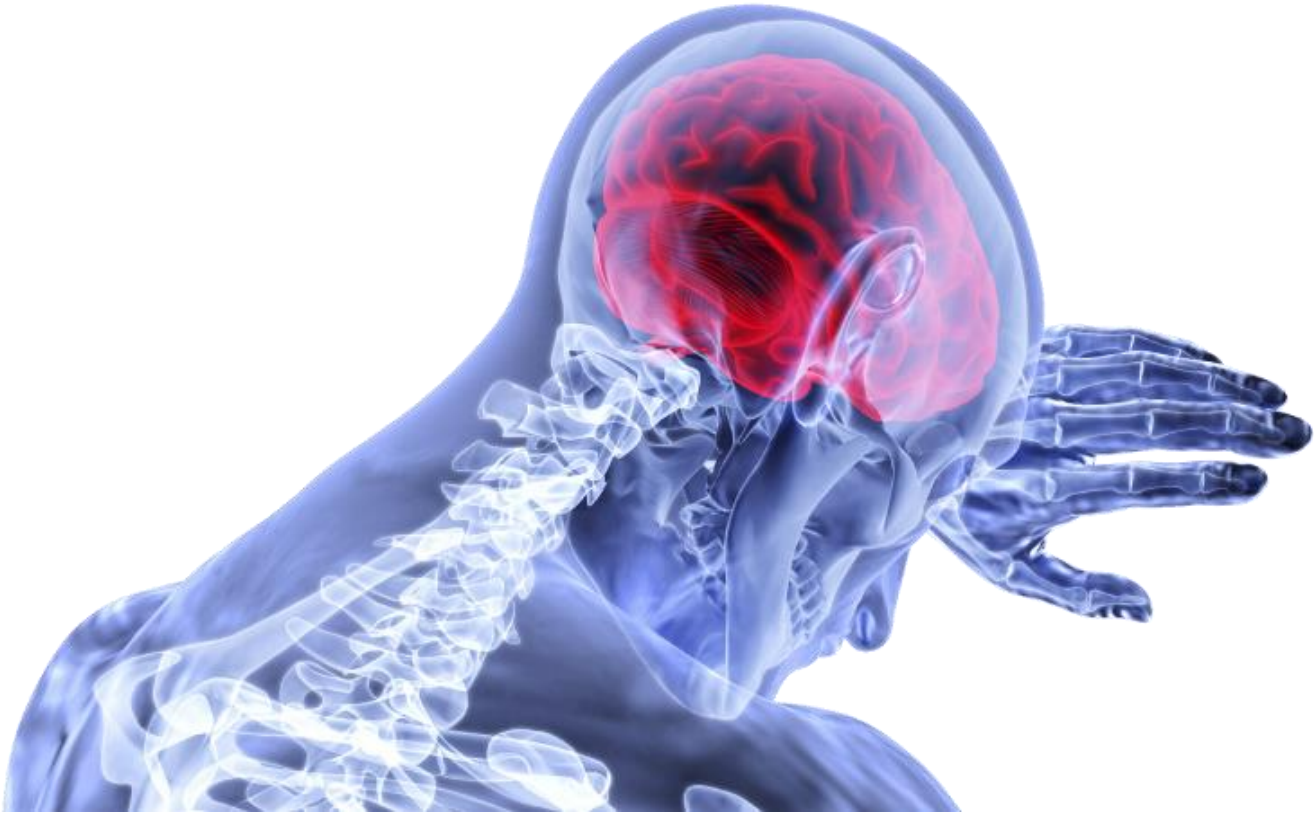

Intellectual and Developmental Disability System Redesign Advisory Committee
November 2, 2021

Intellectual and Developmental Disability System Redesign Advisory Committee advises on the implementation of the acute care services and long-term services and supports system redesign for individuals with intellectual and developmental disabilities. Members include:

Carole Smith, Chair
LTSS provider, managed care
Austin, TX

Mickey Atkins
Representative of private Intermediate Care Facility for Individuals with Intellectual Disability (ICF-IID) providers
Austin, TX

Kelly Barr
Specialty Health Care Provider, non-managed care
Killeen, TX

Jodie Braden
Representative of private ICF-IID providers
San Angelo, TX

Lynne Brooks
Long Term Services and Supports (LTSS) provider, non-managed care
San Antonio, TX

Susan Burek
Advocate for individuals with IDD receiving services
Austin, TX

Jennifer Caruso
Representative of home and community-based service (HCBS) providers
Cibolo, TX

Susan Garnett, Co-chair
Representative, Community Mental Health and Intellectual Disability Centers
Fort Worth, TX

Gilda Gil-Lopez
Advocate for individuals with IDD receiving services
El Paso, TX

Brooke Hohfeld
Advocate for individuals with IDD receiving services
Austin, TX

Linda Levine
Advocate for individuals with IDD receiving services
Bee Cave, TX

Amy Litzinger
Recipient of IDD-related services
Austin, TX

Susan Murphree
Advocate for individuals with IDD receiving services
Austin, TX

Leah Rummel
MCO Representative
Austin, TX

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Emily Clark
Advocate for individuals with IDD receiving services
Desoto, TX

Sheri Talbot
Representative of Medicaid LTSS provider
Katy, TX

Caren Zysk
MCO Representative
Austin, TX

1. Welcome and introductions. The meeting was convened by the Chair, Carole Smith. A quorum was present.

2. Consideration of July 29, 2021, meeting minutes The minutes were approved as written.

3. Texas Home Living renewal update.

What is TxHmL?

TxHmL is a Medicaid waiver program that supplies essential services and supports to Texans with an intellectual disability (ID) or a related condition so that they can continue to live in the community. TxHmL services are intended to supplement rather than replace services received from other programs, such as Texas Health Steps, or from natural supports, including families, neighbors or community organizations.

Who can get TxHmL? TxHmL may be available to any Texas resident living in his or her own home or family's home who:

- Has an IQ of 69 or below or has an approved related condition with an IQ of 75 or below.
- Has mild to severe deficits in adaptive behavior.
- Is eligible for Medicaid benefits.

● Is not enrolled in any other Medicaid waiver program.

What services can TxHmL provide?

• Day habilitation

• Respite services

• Employment services

• Nursing services

• Dental services

• Behavioral support

• Community support (transportation)

• Occupational therapy

• Physical therapy

• Speech therapy

• Audiology services

• Dietary services

• Minor home modifications

• Adaptive aid

The TxHmL provider can also provide personal assistance services, habilitation or emergency response services through the Community First Choice (CFC) program. Individuals can also receive unlimited prescriptions though the Medicaid Vendor Drug Program. 16D0212

The Consumer Directed Services (CDS) option is available for this program. Through CDS, individuals who live in their own home or family home can self-direct certain services and will assume and retain responsibility to:

● Recruit their service providers.

● Conduct criminal history checks.

● Determine the competency of service providers.

● Hire, train, manage and fire their service providers.

All TxHmL services and CFC PAS/HAB are available through the CDS option. Financial management services and support consultation are also available to individuals who choose the CDS Option.

Individuals who use the CDS option must select a financial management services agency (FMSA) that will provide training, pay the service providers, pay federal and state employer taxes, and conduct criminal history checks.

Who provides TxHmL services? The Texas Health and Human Services Commission (HHSC) contracts with public and private entities to provide TxHmL services. HHSC regularly monitors these providers to ensure quality of services. When enrolling in the TxHmL program, applicants choose their provider from a list of available providers in their area. Individuals are able to change providers at any time, even if they move to another area of Texas. Individuals can also choose to hire and train their own service providers under the consumer directed services option.

Interested in receiving services? Those interested in receiving TxHmL services are placed on an interest list by contacting the local intellectual and developmental disability authority (LIDDA) that serves the county in which they live. Find the LIDDA that serves your area at https://apps.hhs.texas.gov/contact/la.cfm . An offer of the TxHmL program depends on individual need, one's date of placement on the interest list and the availability of funding for the program. Once HHSC approves an offer for TxHmL, the LIDDA serving a local service area will assist with the application process, as well as coordinate the enrollment and ongoing services

There has been open discussion between this group and HHSC. The public notice of intent was submitted and the official submittal of the renewal will be at the end of November to be effective March 1st. The renewal updates technical items and align with current policies. The renewal must occur every five years. Measures have been added related to required assurances:

- Administrative authority
- Level of Care process
- Qualified providers
- Service planning
- Health and Welfare

- Financial integrity

Projections for the next 5 years were updated related to participation including the CDS option.

In April there were some recommendations from this group. The committee plan is in the final stages of release and the recommendations were not addressed because it is on a separate track. Recommendations are still under consideration and will be worked through an amendment if not included.

Questions/Answers/Comments

An alternative name of ISS had been agreed to. Members might want to get this to HHSC (In School Suspension). What is the deadline for renaming this service? HHSC stated the rules are still being worked on.

It is not uncommon to have LAR names not match operational names

I am assuming that you all also use rider 42 study recommendations. HHSC stated yes that all the recommendations addressing this issue have been considered.

Have the recommendations increasing the limit to $2,000 been considered? HHSC stated that that is still under consideration and will be handled possibly as an amendment.

"Meaningful Day and Individualized Supports" was the name of the service previously discussed.

CFC is a state plan benefit, but the service is implemented based on how the services are defined in the different waivers, as such this is not within the scope of the TxHML renewal.

4. Review of bylaws. A small subgroup had gotten together to review the bylaws and recommend changes. The proposed revisions were reviewed and discussed. The discussion is not included in this report. The decision was to move the recommendations and revisions to an action memo for consideration by the Executive Commissioner, including elimination of the member two term limit.

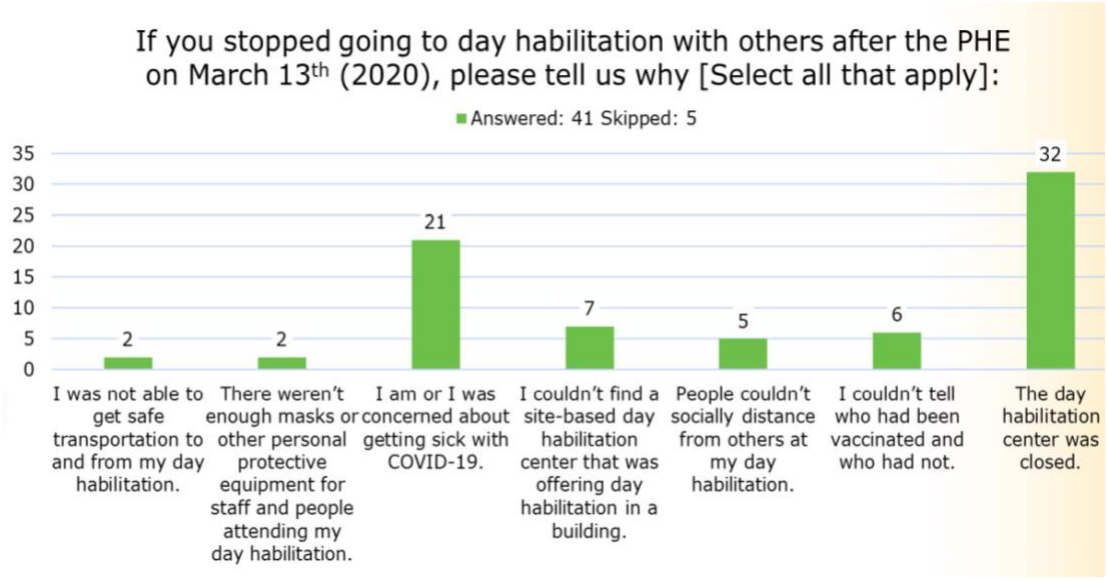
5. Day Habilitation survey results In August 2021, HHSC surveyed day habilitation providers and participants with the purpose of learning more about how the COVID-19 public health emergency (PHE) has impacted providers of site based day habilitation services and individuals who receive site-based day habilitation services.

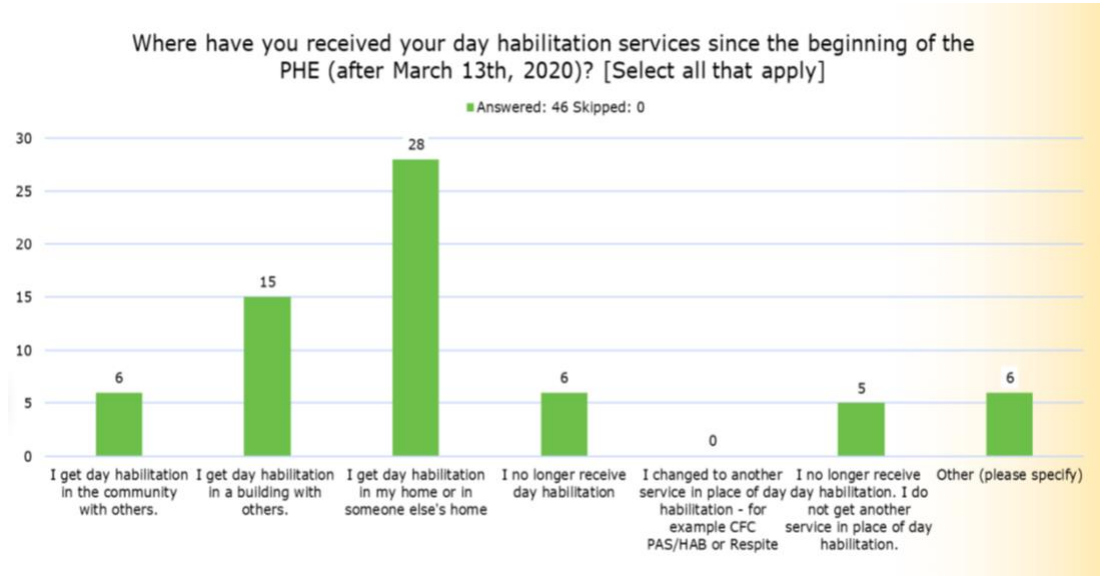
Pre-COVID-19 Day Habilitation

- 33 of the 45 respondents (73%) reported that they received day habilitation in a building.
- 12 of the 45 respondents (27%) reported that they received day habilitation services in the community.
- 6 of the 45 respondents (13%) reported that they received day habilitation services in their home.
- 35 respondents (81%) either continue to attend the same day habilitation they attended before the COVID-19 PHE, or plan to return when their same day habilitation allows them to return.

Day Habilitation Preferences. The top three preferences selected were:

- 31 of the 45 respondents (69%) stated that they liked to receive day habilitation in a building with others.
- 25 of the 45 respondents (57%) stated that they liked to receive day habilitation in the community with others.
- 14 of the 45 respondents (31%) stated that they liked to receive day habilitation in their home or in someone else's home.



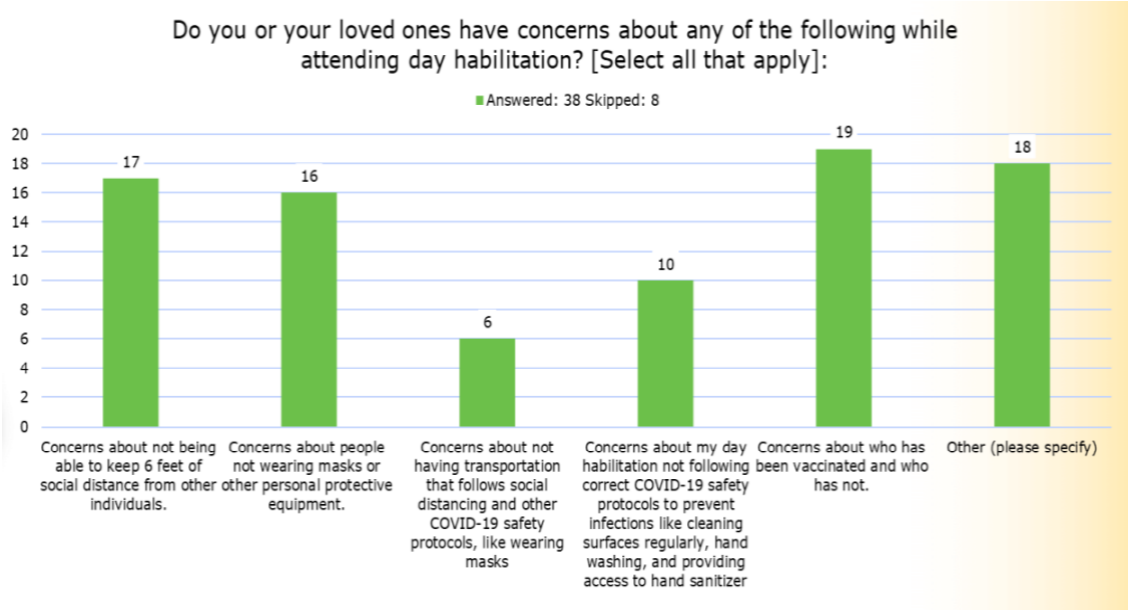


Current Participant Concerns Surrounding Day Habilitation The top three concerns selected were:

- 19 of the 38 respondents (50%) chose the option "concerns about who has been vaccinated and who has not."
- 17 of the 38 respondents (45%) chose the option "concerns about not being able to keep 6 feet of social distance from other individuals."
- 16 of the 38 Respondents (42%) chose the option "concerns about people not wearing masks or other personal protective equipment."

Additional Concerns Voiced Included:

- 3 respondents stated that they had concerns about going into the community safely.
- 1 respondent stated that they had concerns that the day habilitation would close again.
- 1 respondent said, “waiting for unknown reopening is causing anxiety, loneliness.”
- 1 respondent stated that it was too high risk.
- 1 respondent stated that they have regularly received notices that people are getting sick at the day habilitation site with COVID-19.
- 1 respondent stated that they would like more community-based outings.



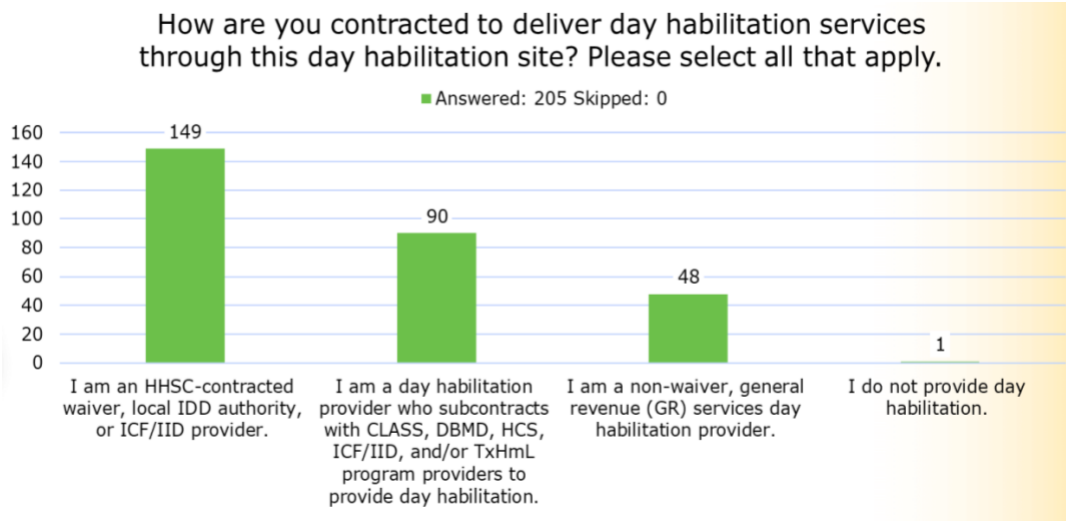
Questions/Answers/Comments

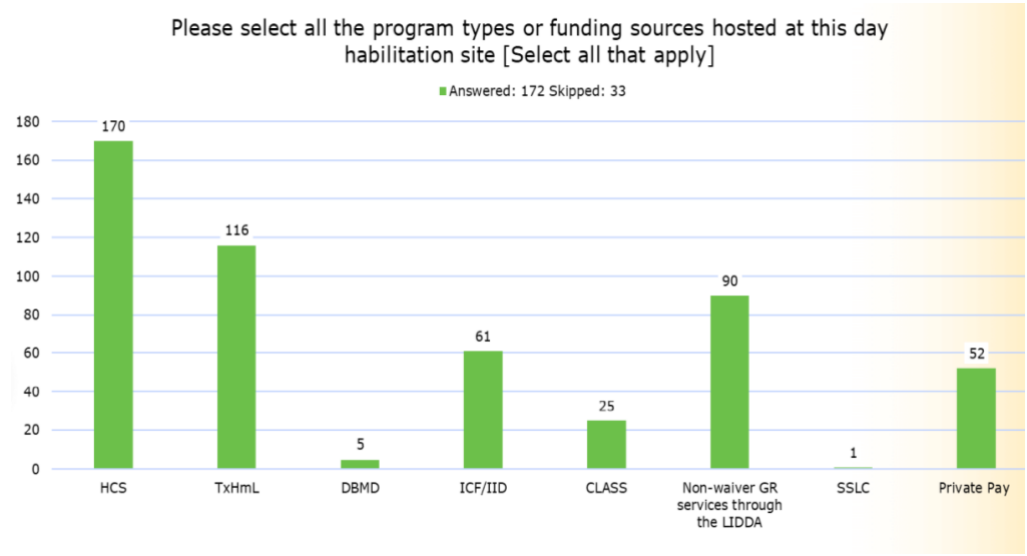
Why was the response rate so low? HHSC stated they relied on word of mouth to encourage people to take the survey. The survey was sent out by many sources and several times.

It is reflective of how difficult COVID had made it to be in touch with each other.

The time of year for the survey might have had an impact as well.

Responses from Providers of Site-Based Day Habilitation



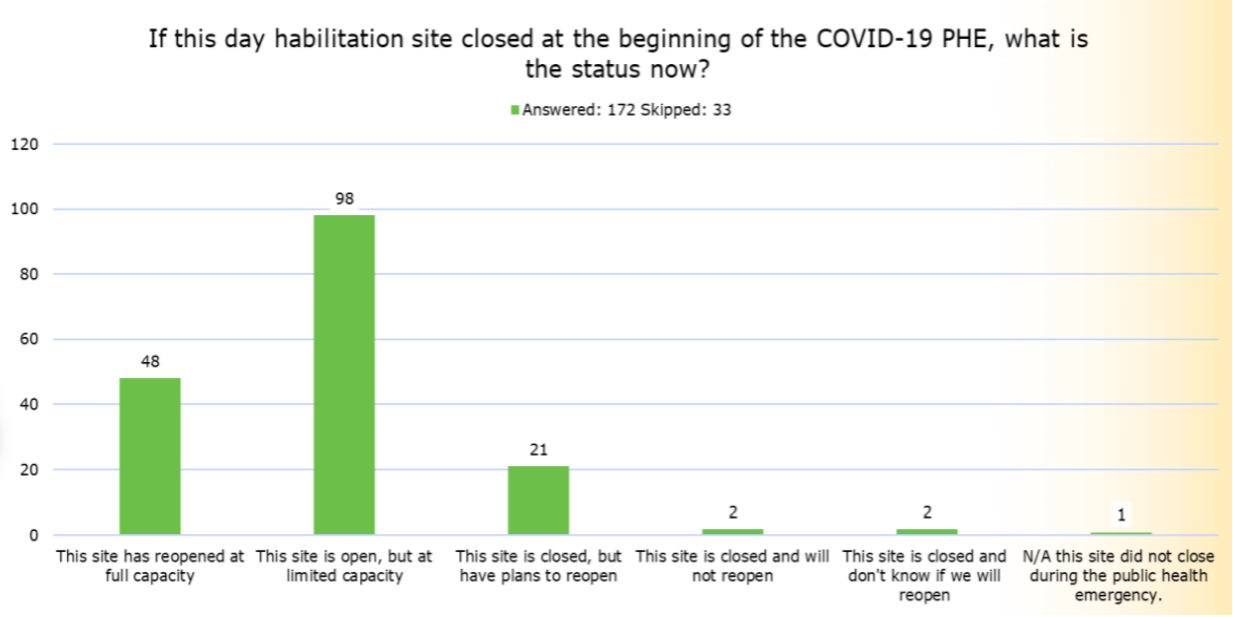


Wages, Staffing, and Revenue

The average increase in wage reported by 77 respondents was $1.55 per hour. 102 respondents answered this question initially, but some respondents reported percentage increases that were unable to be translated to a dollar amount. The average pay rate for direct care staff prior to the

COVID-19 PHE reported by 165 respondents was $10.43/hour, while current average pay reported by 163 respondents was $11.25/hour. In addition:

- 66 out of 163 respondents (40%) reported average staff vacancy rates during the COVID-19 PHE of 50% or more due to inability to hire or retain qualified staff.
- 99 out of 163 respondents (61%) reported that positions are vacant for an average of more than three months until filled.
- 109 respondents (63% of the 172 respondents who answered this question) reported a greater than 50% loss in revenue for their day habilitation center since March 13, 2020.



76 providers (45%) report that more than 50% of the individuals have returned since the beginning of the COVID-19 PHE.

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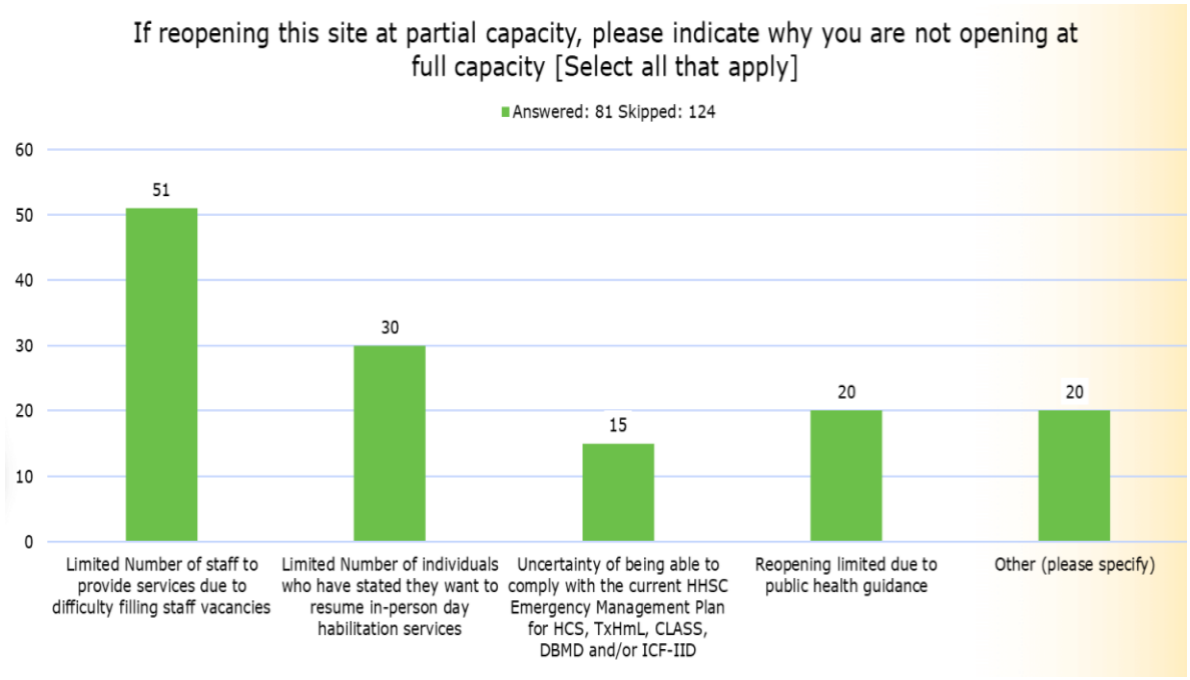


The top two struggles that providers of day habilitation cited as barriers to reopening at full capacity were:

- Staffing shortages, staff concerns about exposure to COVID-19, and inability to hire qualified staff due to inability to pay a competitive compensation rate.
- Limited indoor space available to maintain social distancing requirements from DSHS as well as difficulties providing transportation while maintaining appropriate social distancing requirements.

Questions/Answers/Comments

What are the plans for this data? HHSC stated they are digesting the data and presenting it to stakeholders. This can be discussed at the next subcommittee meeting.

There may be some strategies about communicating with people and stakeholders, but what this shows is a huge staffing crisis (50% vacancies in three months).

Do we know how many have closed and not reopened? People who did not respond however are not represented in the survey results.

6. House Bill 3720, 87th Legislature, Regular Session (2021) House Bill (H.B.) 3720, Section 2(b)(c), Established under Section 534.053, 87th Legislature, Regular Session 2021.

HHSC will consult with Intellectual and Developmental Disability System Redesign Advisory Committee and the state Medicaid managed care advisory committee to develop the questionnaire with the minimum information:

- Contact information for the individual or the individual's parent or other legally authorized representative
- The individual's general demographic information
- The individual's living arrangement
- The types of assistance the individual requires

House Bill (H.B.) 3720, Section 2(b)(c), Established under Section 534.053, 87th Legislature, Regular Session 2021

HHSC will consult with Intellectual and Developmental Disability System Redesign Advisory Committee and the state Medicaid managed care advisory committee to develop the questionnaire with the minimum information:

- The individual's current caregiver supports and circumstances that may cause the individual to lose those supports
- When the delivery of services under a waiver program should begin to ensure the individual 's health and welfare and that the individual receives services and supports in the least restrictive setting possible

The medicaid-waiver-programs-interest-list-study-sept-2020 (1).pdf

- Explores strategies based on how other states reformed their systems for interest list management
- Texas' combined waiver interest lists increased from 78,626 unduplicated individuals in 2010 to 150,364 in 2019 (91.2 percent)

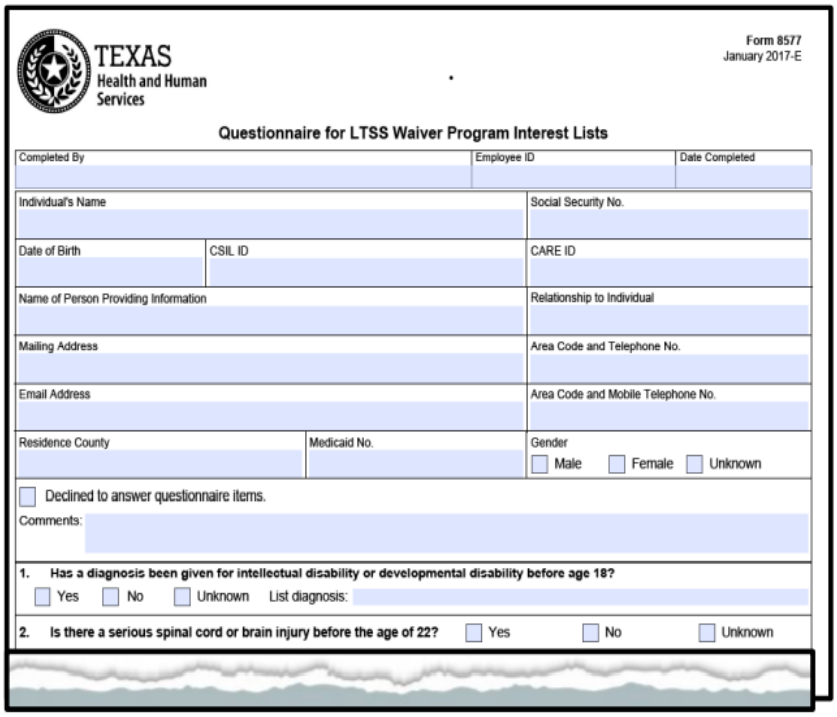
With respect to the questionnaire content, this project seeks to implement HB 3720, Section 2 (87th Legislature, 2021) by:

- Updating Community Services Interest List (CSIL) application and form 8577 with revised questionnaire elements.
- Gathering input from the Intellectual and Developmental Disability System Redesign Advisory Committee (IDD SRAC) external stakeholders for questionnaire element inputs.

With respect to the questionnaire content, this project seeks to implement HB 3720, Section 2 (87th Legislature, 2021) by:

- Developing a plan for the administration of the revised questionnaire to existing individuals on interest list(s).
- Creating an annual IDD-SRAC report with active/inactive statistics.

CSIL questionnaire is based on Form 8577 For programs outside of CSIL, verbal answers are recorded on Form 8577



TEXAS Health and Human Services

Form 8577
January 2017-E

Questionnaire for LTSS Waiver Program Interest Lists

Completed By	Employee ID	Date Completed

Individual's Name	Social Security No.

Date of Birth	CSIL ID	CARE ID

Name of Person Providing Information	Relationship to Individual

Mailing Address	Area Code and Telephone No.

Email Address	Area Code and Mobile Telephone No.

Residence County	Medicaid No.	Gender
		☐ Male ☐ Female ☐ Unknown

☐ Declined to answer questionnaire items.

Comments:

1. **Has a diagnosis been given for intellectual disability or developmental disability before age 18?**
   ☐ Yes ☐ No ☐ Unknown List diagnosis:
2. **Is there a serious spinal cord or brain injury before the age of 22?** ☐ Yes ☐ No ☐ Unknown

Implementation Timeframe

- Start Date: 09/01/2021
- Updated Questionnaire Target: June 2022

HB 3720, Section 5, As soon as practicable after the effective date of this Act, the Health and Human Services Commission shall develop the questionnaire required by Section 531.06011(b), Government Code, as added by this Act.

- Timeline is dependent upon receiving estimate from HHSC IT for CSIL updates and existing pipeline of work.

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- HHSC will meet internally to review proposed changes to the questionnaire and plans to collaborate with IDD-SRAC in December 2022.

Source Business Documents

- HB 3720 Texas Legislature Online - 87(R) History for HB 3720
- Form 8577 (See HHSC website)
- Medicaid Waiver Programs Interest List Study (September 2020) Medicaid Waiver Programs Interest List Study (texas.gov)

Questions/Answers/Comments

There was a bill that passed that had to do with updating Medicaid. It had a mechanism to ask people how they would want to be contacted, including email. Text and phone. That would be helpful for this process. (HB1911)

Be sure you are getting feedback from the LIDDAs.

The questionnaire is used for people following up. HHSC stated we have to change the 8577 and the questionnaire in CECL(?). We do not know how that will be operationalized.

7. American Rescue Plan Act, Texas Federal Medical Assistance Percentage (FMAP) proposal to Centers for Medicare and Medicaid Services (CMS). CMS released a state Medicaid letter related to enhanced FMAP for a select set of services. States must spend the 10% as a reinvestment of enhancing home and community based services .

Overview

The American Rescue Plan Act (ARPA) of 2021 was signed into law on March 11, 2021. Section 9817 of ARPA provides states with a temporary ten (10) percentage point increase to the federal medical assistance percentage (FMAP) for Medicaid HCBS, if certain federal requirements are met. States must use funds equal to the amount of federal funds attributable to the increased FMAP to implement activities that enhance or strengthen Medicaid HCBS. HHSC submitted an initial spending plan to the Centers for Medicare and Medicaid Services (CMS) on July 12, 2021.

On August 19, 2021 CMS responded to HHSC's initial submission with partial approval and requests for clarification about specific activities in the plan. Read CMS's letter to HHSC (PDF).

HHSC met with CMS in September to get answers to HHSC's outstanding questions. On September 21, 2021 HHSC responded to CMS's questions and documented a summary of the information provided by CMS. HHSC also updated the spending plan and narrative to reflect the clarification CMS asked for. A copy of HHSC's response can be found here (PDF).

Quarterly Updates

States are required to provide updates to CMS about their spending plans and highlight any changes from their original plan. HHSC submitted its first quarterly update on October 26, 2021. Read the update here (PDF).

Stakeholder Communication

- Sign up to receive updates about the HCBS spending planning.
- On July 15, 2021, HHSC held a webinar to update stakeholders about HHSC's submission:
- Stakeholder Webinar Presentation (PDF).
- Stakeholder Webinar Recording(link is external)
- When another webinar is scheduled, we will post the information here.
- Email Medicaid HCSB Rule with questions.

Timeline

HHSC is waiting for full federal and state approval before spending any of the money described in the plan.

Areas proposed in the plan include supporting providers, supporting clients, and supporting the infrastructure.

- Provider retention bonus including CDS
- Additional slots approved for all waiver programs
- Replacement of DayHab
- Monitoring increases
- Portal enhancements
- Strengthening CDS
-

Questions/Answers/Comments

Is there anything that could stop the roll out of the appropriated waiver slots. HHSC stated that releases were started in September and October, but it can take up to a month. ARPA dollars are proposed to be used but if denied then GR can be used.

We hoped we could use ARPA and GR. Is that off the table? HHSC stated that the Legislature did not weigh in on that and we cannot obligate he Legislature for additional MOE. This applies to all the waivers. Attrition slots are still be used.

The Chair stated that retention funding is important. The dollars will only be available for a 6 month period. Is there a way to distribute the dollars earlier because providers will not be able to hang on until March. HHSC stated that there are reasons for the March date. There are provisions to move dollars into the provider pool under a re-allocation scenario. SB8 also has retention dollars provided and those will be allocated as fast as possible. We risk a duplication of payments and as such timing is crucial.

8. IDD-SRAC recommendations for the annual legislative report on the implementation of acute care and long-term service and supports for individuals with intellectual and developmental disabilities

The annual report on the Implementation of Acute Care Services and Long-Term Services and Supports (LTSS) System Redesign for Individuals with an Intellectual or Developmental Disability (IDD) is submitted in compliance with Texas Government Code Section 534.054.

Chapter 534 directs the Health and Human Services Commission (HHSC) to design and implement an acute care and LTSS system for individuals with IDD to improve outcomes; improve access to quality, person-centered, efficient, and cost-effective services; and implement a capitated, managed care delivery system and the federal Community First Choice Option (CFC). Chapter 534 also created the IDD System Redesign Advisory Committee (IDD SRAC) to advise HHSC in the development and implementation of the system redesign.

Over the past eight years, HHSC has made substantial progress on the IDD system redesign. Milestones achieved to date are outlined below and more information is provided in Appendix B: Historical IDD System Redesign Implementation Activities.

- Between 2014-2016, HHSC completed the transition of all eligible recipients1 of Medicaid IDD waiver programs and community-based intermediate care facilities for individuals with intellectual disabilities (ICF/IID) from Medicaid fee-for-service (FFS) to capitated managed care programs (STAR+PLUS and STAR Kids) for all acute care services.

- Since 2014 and ongoing, HHSC has increased and enhanced community support services to promote independence and prevent institutionalization of individuals with IDD through the Money Follows the Person Demonstration.
- In 2015, HHSC implemented the CFC option, a Medicaid State Plan benefit, to increase access to services for individuals with IDD, particularly those currently on interest lists for IDD waiver programs.
- In early 2019, HHSC completed and published evaluations to inform managed care transitions and provide information to legislators and stakeholders.
- In 2019, HHSC deployed a new no-wrong-door complaints process to funnel most member complaints to the Office of the Ombudsman; implemented complaint standardization across HHSC and Managed Care Organizations(MCOs); and revised MCO reporting requirements from quarterly to monthly to aid in early issue detection.

In 2019, the legislature outlined a new key priority of the IDD system redesign. House Bill (H.B.) 4533, 86th Legislature, Regular Session, 2019, amends Government Code Chapter 534 and requires HHSC to establish a pilot program in STAR+PLUS prior to the transition of LTSS to managed care for individuals with IDD. H.B. 4533 also establishes the STAR+PLUS Pilot Program Workgroup (SPPPW) to advise HHSC in collaboration with the IDD SRAC in developing, operating and evaluating the pilot program. STAR+PLUS Pilot Program milestones to date include:

- Development of a workplan and workgroups comprised of cross-agency state staff to inform pilot program development.
- Collaboration with IDD SRAC and SPPPW to develop key elements of the pilot program design including, but not limited to, eligibility criteria, services, a needs-based assessment tool, and providers.
- Completion of a dental study required by H.B. 4533 to inform dental benefits for pilot program participants.
- Collaboration with Centers for Medicare and Medicaid Services (CMS) regarding federal authority and operation of the pilot program.
- Authority through 2020-2021 General Appropriations Act, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 25) to fund pilot program technology changes, evaluation, and HHSC staffing required for the pilot program implementation on September 1, 2023.

In the coming year, HHSC will continue pilot program development in collaboration with the IDD SRAC and SPPPW; and will continue to monitor the acute care transition to managed care and utilization of CFC services in collaboration with the IDD SRAC

9. Electronic visit verification

- EVV Policy handbook consolidating all policies was published November 1.
- Compliance information is in the handbook
- Quarterly updates to the handbook will occur
- Working on a CDS section
- We are working with employers about rounding (but there is no update)
- Information letter is being written addressing noncompliance for the FSAs

Compliance issues

- The system is mandatory for clocking in and out and is monitored through the payment process
- Landline use is verified
- Free Text reviews are included
- Compliance measures are in a grace period for all of 2021
- Manually created visits should be the exception and not the rule, looking at percentage of CDS visits creation
- More information will be available through the handbook
- MCOs will be doing compliance reviews

EVV Usage

The Health and Human Services Commission (HHSC) Electronic Visit Verification (EVV) Usage Policy requires HHSC and Managed Care Organizations (MCOs), the payers, to monitor the number of manually entered EVV visit transactions and the number of rejected EVV visit transactions to meet the minimum state fiscal year quarter EVV Usage Score.

See the EVV Compliance Reviews policy for more information.

Manually entered EVV visit transactions are EVV visits that were manually entered into the EVV system when the service provider or CDS employee did not use the EVV system to clock in and clock out when service delivery started and ended.

See the Clock In and Clock Out Methods policy for more information.

Rejected EVV visit transactions are EVV visit transactions that were not accepted by the EVV Aggregator and may require visit maintenance.

The FMSAs will be evaluated for the number of rejections. There is an extension for CDS employers. They are being given more time to be sure they can come into compliance until January 1, 2022.

The EVV Usage Score measures:

- Manually entered EVV visit transactions
    1. Excludes a manual EVV visit transaction with zero bill hours
    2. Includes a manual EVV visit transaction accepted into the EVV Aggregator
    3. Negatively impact the EVV Usage Score one time
        1. A manually entered EVV visit transaction will negatively impact and count against the EVV Usage Score one time. Example: If the service provider or CDS employee does not use the EVV system to clock in and clock out, a manually entered EVV visit transaction must be entered into the EVV system. The manually entered EVV visit transaction will count against the EVV Usage Score once.
- Rejected EVV visit transactions
    1. Negatively impact the EVV Usage Score each time the EVV Aggregator rejects an EVV visit transaction
        1. A rejected EVV visit transaction will negatively impact and count against the EVV Usage Score as many times as the EVV visit transaction is rejected. Example: If the EVV visit transaction was rejected and the program provider, FMSA or CDS employer corrected the rejected visit transaction then resubmitted the EVV visit transaction and the EVV visit transaction was rejected again, the EVV visit transaction would count against the EVV Usage Score twice.

Program Providers

Program providers must achieve and maintain a minimum EVV Usage Score of 80% rounded to the nearest whole percentage, each state fiscal year quarter, unless noted by HHSC.

Program providers below the EVV Usage Score will be reviewed. Payers may choose to review all program providers or a sample of program providers that did not meet the minimum EVV Usage Score.

Score Calculations

The EVV Usage Score for a program provider equals the manual EVV visit transaction score plus the rejected EVV visit transaction score.

The manual EVV visit transaction score equals the number of total electronic (non-manual) visit transactions divided by the total number of accepted visit transactions by the EVV Aggregator and then multiplied by 60 percent.

The rejected EVV visit transaction score equals the number of non-rejected visit transactions divided by the total number of exported visit transactions sent to the EVV Aggregator and then multiplied by 40 percent.

FMSAs

FMSAs must achieve and maintain a minimum EVV Usage score of 80% rounded to the nearest whole percentage, each state fiscal year quarter, unless noted by HHSC.

FMSAs below the EVV Usage Score will be reviewed. Payers may choose to review all FMSAs or a sample of FMSAs that did not meet the minimum EVV Usage Score.

Score Calculations

The EVV Usage Score, for an FMSA, equals the rejected EVV visit transaction score.

The rejected EVV visit transaction score equals the number of non-rejected visit transactions divided by the total number of exported visit transactions sent to the EVV Aggregator.

CDS Employers

CDS Employers must achieve and maintain a minimum EVV Usage Score of 80% rounded to the nearest whole percentage, each state fiscal year quarter, unless noted by HHSC. See table below for CDS employer EVV Usage Score requirements based on service delivery dates.

CDS employers below the EVV Usage Score will be reviewed. Payers may choose to review all CDS employers or a sample of CDS employers that did not meet the minimum EVV Usage Score.

Misuse of Reason Codes—The compliance reviews on these will not be performed and they are being discontinued.

Additional information

- Appendix I: EVV Reason Codes Table
- Appendix II: EVV CDS Employer Policy Handbook
- Appendix III: EVV Contact Information Guide
- Appendix IV: Historical Alerts and Archived Policies

Information letter 2149

Home & Community-based Services (HCS) | Texas Health and Human Services information letters can be found by following this link, however the information letter discussed has not been published

to the website at this writing. Follow this link at a later date to access the letter. Communications to HHS LTC Providers Information and Provider Letters (texas.gov)

The letter recently went out the FMSAs must share with Employers. HHSC is also working on a letter related to compliance. It is still under development.

Questions/Answers/Comments

A comment was made about correcting errors in reports from employers. HHSC stated that there are different edits that can be done without creating a new entry. There are restrictions in the system that disallows the clock in and clock out time. HHSC stated they will follow up.

A question was asked if there would be a report that matches up pay with what was entered into the system in CDS. Dealing with EVV can be a fulltime job. What was billed compared to what was approved and what was paid out. We don't know what is paid now. HHSC stated they are not sure the system can do that unless the FMSA is doing payroll within the EVV system. HHSC stated they will investigate this issue.

Training

- 2 trainings took place in August
- Webinars are available on the HHS Learning Portal
- Meeting with the training and outreach subcommittee regularly for input
- FMSAs processing visit maintenance should be reviewed
- Numerous training opportunities exist for employers
- A revised system training is being made available
- A FAQs document is being developed

EVV Proprietary Systems have been paused. Different readiness reviews will occur in 2022. We are looking at efficiencies in the systems.

Cures Act requires implementation of Home Health in EVV and this is being planned.

~~10. IDD-SRAC subcommittee updates~~ No updates provided

11. Public comment

Michael Vaughn, Representing Himself addressed item 7, and the release of the Medicaid funds. He said we should push the issues because it is important for the survival of people with disabilities.

We must get these issues solved. The government is not doing their job when it comes to helping people with disabilities. He asked for the committee to do what they can (for staffing issues)

Linda Litzinger, stated that there were decisions made a while ago impacting attendants. She gave examples of how coming and going on EVV. This can require manual adjusting the record or pulling out transportation hours and supported employment. This has created a hardship because of two IT departments and charts.

12. Review of action items and agenda items for next meeting: January 27th, 2022

Update on ARPA

Update EVV

Update on interest list initiative

Update on the new HCBS rules and compliance and heightened scrutiny

Update on family members in the same household and providing in-home dayhab and attendant care

13. Adjourn. There being no further business, the meeting was adjourned.

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