

MEMORANDUM

Department of Aging and Disability Services (DADS) Regulatory Services Policy – Survey and Certification Clarification

TO: Regulatory Services
Regional Directors and State Office Managers

FROM: Veronda L. Durden
Assistant Commissioner
Regulatory Services

SUBJECT: S&CC 08-04 – Service Delivery and Care Planning Related to Licensing Rules at 40 Texas Administrative Code (TAC) §97.401(b)(2) and §97.404(f)(2)

APPLIES TO: Home and Community Support Services Agencies (HCSSAs)

DATE: **October 27, 2008**

This memorandum clarifies issues that have arisen when a HCSSA client is a Medicaid 1915(c) waiver services consumer. Such a consumer is eligible for Medicaid and entitled to receive care in an institution (i.e., a nursing facility or an intermediate care facility for persons with mental retardation or a related condition) but has elected to receive this care in the community.

Programs in which HCSSAs provide services under Medicaid 1915(c) waivers include:

- Community Based Alternatives (CBA)
- Community Living Assistance and Support Services (CLASS)
- Consolidated Waiver Program (CWP)
- Deaf-Blind With Multiple Disabilities (DBMD)
- Medically Dependent Children Program (MDCP)
- Integrated Care Management (ICM)
- STAR+PLUS

The information in this memorandum is mostly relevant to a HCSSA that provides services to a consumer receiving CBA, ICM or STAR+PLUS services, but it may also be of use for agencies with concerns related to multiple licensure categories.

Key Terms and Definitions

Skilled Services — Services in accordance with a plan of care that requires the skills of a licensed professional as defined in 40 TAC §97.2(91).

Non-skilled care — Services that do not require an order from a practitioner as defined in 40 TAC §97.2(76).

Plan of care — Written orders from a client's practitioner for skilled services as defined in 40 TAC §97.2(75).

Care plan — A document developed by the appropriate health care professional for non-skilled care performed under the agency's license that does not require a practitioner's order.

Unbundle — To separate formerly packaged services so that each service is considered separately. Under the STAR+PLUS program, an individual's specialized services can be separated, or divided up, by a managed care organization (MCO) that then determines the licensure category required for each separated service.

Managed Care Organizations (MCO) — Contracted health plans that manage the services provided under the STAR+PLUS program (AMERIGROUP Community Care, Evercare LLC, Molina Healthcare of Texas or Superior Health Plan).

STAR+PLUS — A Texas Medicaid program administered by the Health and Human Services Commission (HHSC) that provides health care as well as acute and long-term services and support (LTSS) through a managed care system. In STAR+PLUS the HCSSA contracts with the MCO and the MCO contracts with HHSC.

Administrative Services Contractor (ASC) — A contracted entity that performs certain Medicaid managed care administrative services functions under the ICM program (Evercare LLC).

Integrated Care Management (ICM) — A non-capitated primary care case management program of Medicaid managed care administered by HHSC and operated by DADS and the ASC. ICM is available in the 13 counties of the Dallas and Tarrant service areas. ICM is similar to STAR+PLUS in that it integrates acute and long-term care services. Unlike STAR+PLUS, the ASC is not responsible for approving LTSS service plans, paying claims or setting rates. In ICM, the HCSSA contracts with the ASC (in order to receive referrals) and with DADS (for payment of LTSS services). Services cannot be unbundled in the ICM model.

Category of Services

The type of services a client receives determines the licensure category the agency provides services under. It is the responsibility of the HCSSA to determine under which category of service it must list a client. The HCSSA is responsible for providing the surveyor with a client list that identifies the category of service the clients fall under as directed in 40 TAC §97.293.

If the HCSSA has multiple licensure categories and makes the determination that care needs to be provided under the licensed home health (LHH) category, then the HCSSA must develop the appropriate service delivery plan as specified in 40 TAC §97.401(b)(2)(A) or §97.401(b)(2)(B). Under the LHH category, services provided by unlicensed personnel must be provided under the delegation or supervision of a licensed health professional.

If the HCSSA determines that services can be provided under the personal assistance services (PAS) category, the HCSSA must develop an individual service plan as specified in 40 TAC §97.404(f)(2). PAS services provided by unlicensed personnel must be assigned and supervised as specified in the applicable standards in 97.404.

When a client is receiving Medicaid 1915(c) waiver services through a STAR+PLUS MCO, the MCO may unbundle the services. Therefore, a DADS Regulatory Services surveyor may see a STAR+PLUS client receiving services in the appropriate category related to the service authorized (i.e., PAS or LHH) instead of combining services under one category such as LHH, as in the traditional CBA program.

If a client is an ICM member, the ICM contractor may not unbundle the services; therefore, a HCSSA must provide ICM services under the LHH category, pursuant to 40 TAC §53.611.

When a Regulatory Services surveyor identifies a potential contract violation, the surveyor must notify his or her program manager (PM) and discuss the possibility of making a complaint against the HCSSA. If the PM confirms the findings, the surveyor must contact the Consumer Rights and Services hotline to register the complaint. Regulatory Services surveyors do not write citations related to contract requirements. *If the services provided to the client are appropriate services for the licensure category in which the client is placed, the surveyor must survey according to those licensure rules.*

Client Services

The development of the client's service plan is determined by the needs of the client and the services that the agency can provide. The type and array of services needed determine if the client will have a care plan, plan of care or an individualized service plan. The HCSSA is responsible for providing the surveyor with a client list that identifies the category of services for each client as directed in 40 TAC §97.293 (relating to Client List and Services). For a surveyor to determine whether this list is an accurate list and if clients are placed in the appropriate category of services, the surveyor must determine whether the HCSSA is providing skilled or non-skilled LHH services or PAS.

If a HCSSA provides only non-skilled services to a Medicaid 1915(c) waiver services client under the LHH category and a practitioner has signed the care plan, the surveyor should not consider this a plan of care just because it has a practitioner's signature.

- ✓ The signature may be required for payment or eligibility determination, as non-skilled nursing tasks do not require a practitioner's order or development of a plan of care.
- ✓ Examples of nursing tasks that do not require a practitioner's order nor require the HCSSA to provide services under a plan of care include but are not limited to quarterly nursing assessments or filling a pillbox.

If one of the Medicaid 1915(c) waiver programs requires an order for payment purposes or fiscal monitoring the agency may obtain an order solely for the purpose of meeting the contracting standards and a plan of care is not required.

If the surveyor identifies that skilled treatment is provided and the HCSSA developed a care plan for non-skilled care and did not develop a plan of care for the skilled care, then this would be a violation of licensure rules and should be cited appropriately. Again, if the surveyor suspects the agency placed a traditional CBA client under the PAS service category, the surveyor must notify his or her PM and discuss the possibility of making a complaint against the HCSSA for a contract violation.

The HCSSA may provide services that will not change the category of services for the client. One such service includes nursing assessments. This individual is not a HCSSA client just because the HCSSA conducted a nursing assessment when the nursing assessment was conducted in order to determine eligibility.

Nursing Assessments

1) Pre-enrollment

Some HCSSAs use the CBA pre-enrollment assessment for the initial health assessment. However, the pre-enrollment assessment alone does not meet the licensure requirements for a health assessment. The HCSSA may combine the pre-enrollment assessment with the initial health assessment, but the initial health assessment must be done in accordance with 40 TAC §97.401(b)(2) and be performed by a registered nurse (RN). Licensed vocational nurses cannot perform a comprehensive assessment or make staffing assignments to others that address the safety of the client as stated in 22 TAC §217.11(3)(A)(i) and §217.11(1)(s).

In terms of HCSSA licensure requirements, assessments are within the RN's scope of practice and can be performed without a practitioner's order. For fiscal monitoring purposes, the HCSSA does not need a practitioner's order to perform these assessments to be in compliance with 40 TAC §48.6090(b), related to financial errors (reference: Community Care Policy Clarification CCAD 03009 CBA HCSS 03002, dated November 24, 2003). If the HCSSA is performing a nursing assessment as a fulfillment of a contract requirement or to determine eligibility (pre-enrollment), the assessment itself does not affect the category of services as discussed in the client services section of this letter.

2) Nursing Assessments in the PAS Category

Performance of an annual nursing assessment does not automatically make a PAS client a LHH client. The surveyor should investigate how the agency meets the requirements in 40 TAC 97.404(f)(1), regarding documentation of determination of services based on an on-site visit by the PAS supervisor.

Additional information regarding managed care programs
STAR+PLUS

HHSC: <http://www.hhsc.state.tx.us/Starplus/Overview.htm>

DADS: <http://www.dads.state.tx.us/starplus/index.html>

ICM

HHSC: <http://www.hhsc.state.tx.us/medicaid/IntegratedCareManagement.html>

DADS: <http://www.dads.state.tx.us/providers/icm/index.cfm>

Please contact the Policy, Rules and Curriculum Development unit at 512-438-3161 for questions concerning this memorandum.