



COMMISSIONER  
Adelaide Horn

June 20, 2007

To: Home and Community Support Services Agencies (HCSSAs) Contracted With the Texas Department of Aging and Disability Services (DADS) to Provide 1915(c) Medicaid Waiver Services Through the Following Programs or Agencies: Community Based Alternatives (CBA), Consolidated Waiver Program (CWP), Deaf-Blind With Multiple Disabilities (DBMD), and Community Living Assistance and Support Services (CLASS) Direct Service Agencies

Subject: Regulatory Services Provider Letter #07-06  
Community Services Information Letter #07-06  
Clarification of Licensing Rules and Contract Requirements Regarding Accepting Individuals with Complex Needs for Service

This clarification is provided in response to questions about HCSSAs' non-acceptance of individuals for services due to concerns about meeting an individual's needs in the community. **This clarification should not be interpreted as requiring a HCSSA to accept any particular individual for services.**

DADS' mission includes a focus on ensuring self-determination as well as the health and welfare of individuals served in the community. In an effort to ensure individual choice, self-determination, and health and welfare, DADS has put forth several initiatives supporting the Promoting Independence Plan, including the "Money Follows the Person" (MFP) policy. MFP policy allows individuals residing in nursing facilities (NFs) to move into the community without first having to be registered on an interest list for a 1915(c) Medicaid waiver program. As described in HCSSA licensure rules at 40 Texas Administrative Code (TAC) §97.282(f)(1-7), individuals have the right to participate in the planning of their care and must be informed in advance and on an ongoing basis about the care to be furnished and any barriers to treatment.

Over 13,000 individuals have transitioned from NFs using MFP policy since September 2001. In addition to NF residents transitioning to the community, there are potential HCSSA consumers already residing in the community. However, for some potential consumers with complex needs, finding a provider is difficult.

The HCSSA licensure rule most often cited by HCSSAs for non-acceptance of an individual is 40 Texas Administrative Code (TAC) §97.401(b), which states in part:

*"The agency must accept a client for home health services based on a reasonable expectation that the client's medical, nursing, and social needs can be met adequately in the client's residence."*

However, 40 TAC §97.401(b) goes on to say:

*“An agency has made a reasonable expectation that it can meet a client's needs if, at the time of the agency's acceptance of the client, the client and the agency have agreed as to what needs the agency would meet; for instance, **the agency and the client could agree that some needs would be met but not necessarily all needs.**”*

All HCSSAs must comply with licensure rules at 40 TAC Chapter 97. HCSSAs that contract with DADS to provide 1915(c) Medicaid waiver services must comply with the requirements of their contract to provide waiver services in addition to the licensure rules. In an effort to promote consistency and clarify the intent of HCSSA licensing rules and DADS contracting requirements, DADS' Regulatory Services, Provider Services, and Access and Intake divisions jointly provide the following questions and answers. Individuals described in the following questions and answers are assumed to have the capacity to make informed decisions. Negotiations regarding acceptance of responsibility for an individual who has a legal guardian or legally authorized representative (LAR) must include the guardian or LAR.

Question #1: May a HCSSA accept an individual even though it cannot meet all of the individual's needs?

Answer: Yes. DADS Regulatory Services confirms that HCSSAs may establish agreements consistent with 40 TAC §97.401(b). An individual may express a desire to take responsibility for certain needs or to leave certain needs unmet, rather than have the HCSSA meet all needs. An individual may assume responsibility for certain needs under an “individual responsibility agreement” (IRA). No specific format for the agreement is mandated under DADS contract requirements or HCSSA licensure rules, but it must clearly document which needs will not be met by the HCSSA. The individual must have a clear understanding of what the HCSSA will not do and must confirm agreement by signing the IRA. HCSSA licensure rules at 40 TAC §97.292(a) also require HCSSAs to provide individuals with a “client agreement and disclosure” that includes “services to be provided.” Therefore, even separate from any IRA, HCSSAs must clearly advise individuals as to what services will, and will not, be provided.

Question #2: No format is required for an IRA, but would DADS provide an example?

Answer: Yes, the attached example IRA and instructions may be used for service planning, but providers may also develop their own form as long as it meets the following minimum requirements.

- Identifies the applicant/consumer, provider, and provider representative who negotiated the agreement, including the applicant/consumer's Medicaid Number, Social Security Number, or both
- Includes dated signatures of the applicant/consumer and provider representative
- Documents the identified need for which the applicant/consumer agrees to take responsibility

- Includes any details provided by the applicant/consumer regarding specific plans to meet the need
- Includes a statement describing potential consequences for the applicant/consumer and noting that these consequences were explained to the applicant/consumer

A copy of any IRA must be maintained in the clinical record and sent to the appropriate case manager as supporting documentation for the Individualized Service Plan/Plan of Care. **The attached example IRA does not guarantee immunity from civil or criminal liability.** DADS does not require the use of this example agreement and parties should consult with their legal representation regarding the use and limitations of this or any responsibility agreement.

Question #3: When an individual is served in a 1915(c) Medicaid waiver program, who is responsible for assuring “health and welfare” when an IRA is used?

Answer: The Centers for Medicare and Medicaid Services (CMS) require the State to assure the health and welfare of an individual served in 1915(c) Medicaid waiver programs, which include Community Based Alternatives (CBA), Consolidated Waiver Program (CWP), Deaf-Blind with Multiple Disabilities (DBMD), and Community Living Assistance and Support Services (CLASS). CMS’ technical guide for waiver reviews includes the following direction:

*“A waiver’s design must provide for continuously and effectively assuring the health and welfare of waiver participants. Processes that are important for assuring participant health and welfare include (but are not necessarily limited to):*

- *Specifying the qualifications of waiver providers and verifying that providers continuously meet these qualifications;*
- *Periodic monitoring of the implementation of the service plan and participant health and welfare;*
- *Identifying and responding to alleged instances of abuse, neglect and exploitation that involve waiver participants; and,*
- *Instituting appropriate safeguards concerning practices that may cause harm to the participant or restrict participant rights.”*

Question #4: In a DADS 1915(c) Medicaid waiver program, must every DADS-referred individual be accepted for service?

Answer: No, however, the agency must document and advise the individual of the **specific reason(s)** why it is unable to serve the individual. For example, when an agency has served or is serving an individual with needs similar to the individual being considered for services, it must clearly explain and demonstrate the differences that prevent it from serving the individual under consideration. Citing general licensing regulations such as “40 TAC §97.401(b)” is not sufficient.

For an individual served in CBA or CWP, a registered nurse (RN) is required to complete an assessment to identify needs, including those needs an individual requests to take responsibility for or to leave unmet. If, in the professional judgment of the RN after consulting with the individual, an unmet need would pose a serious threat to the individual's health and welfare, the need must be met. The individual must demonstrate how the identified need will be met by the individual or other resources. If the individual is unable or unwilling to meet the need sufficiently to ensure that his/her health and welfare will no longer be seriously at risk, and the HCSSA believes it cannot meet the need, then the HCSSA may refuse the referral.

In the CLASS program, case management agencies (CMAs) provide case management, while HCSSAs provide the direct services as the direct service agency (DSA). The DSA RN and CMA case manager jointly assess individuals for CLASS eligibility. In DBMD HCSSAs provide both case management and direct services; the DBMD agency RN and case manager jointly assess individuals.

In both CLASS and DBMD, the assessments identify all needs, including needs that might be met by other resources. This includes assessing needs for which an individual requests to accept responsibility, assisting to locate community and other resources to meet those needs, and documenting these arrangements in an IRA when appropriate.

In CLASS the DSA communicates any concerns regarding unmet needs (including those unmet needs that might pose a serious threat to health and welfare) to the individual and the CMA. The CMA reviews and consults with the DSA to determine if a denial of CLASS services is appropriate. The CMA may consult with DADS state office program consultants to explore options and alternatives, including IRAs, prior to issuing a denial of CLASS services. In DBMD HCSSAs also seek resources to address potentially unmet needs. They may also consult with DADS state office program consultants to explore options and alternatives, including IRAs, prior to recommending a denial of DBMD services.

Question #5: What if an individual who negotiates a responsibility agreement with a HCSSA experiences problems related to a need that the individual agreed the HCSSA was not responsible for meeting?

Answer: While 40 TAC §97.401(b) allows HCSSAs to establish agreements with an individual that not all needs will be met, HCSSAs must maintain compliance with relevant licensure rules and contract requirements. In particular, HCSSAs must ensure compliance with 40 TAC §97.288(a), which reads:

*"An agency must adopt and enforce a written policy that **requires effective coordination of care with all service providers involved in the care of a client, including physicians, contracted health care professionals, and other agencies.**"*

When any HCSSA employee, volunteer, or contractor becomes aware of an individual experiencing any significant change in condition or circumstances, the HCSSA must enforce its written policy that requires effective coordination of care with all service providers involved

in the care of the individual. **HCSSAs cannot ignore significant changes in an individuals' condition or situation under an IRA.** HCSSAs may discontinue their participation in an IRA upon consultation with the individual. HCSSAs may also seek assistance from DADS or other case managers to locate appropriate services and supports for an individual when needed. The DADS regional relocation specialist may also be able to help locate additional resources. The HCSSA must clearly document all significant changes, actions taken to help the individual find needed assistance, and any conversations related to revising or discontinuing an IRA.

Question #6: Do DADS contract requirements describe what a HCSSA must do if an individual experiences problems related to a need addressed in an IRA?

Answer: Yes. In CBA and CWP, HCSSA RNs must ensure that the service plan is appropriate, including any responsibility agreements. If HCSSA RNs determine a need is not being met as agreed, they must reassess the individual's needs and take appropriate action according to their professional judgment. This action may include consulting with the provider and individual to:

- Request authorization to revise the service plan
- Identify additional community services
- Revise or discontinue an IRA
- Convene an Interdisciplinary Team (IDT) meeting
- Request an IDT to discontinue waiver services

HCSSA RNs must review the service plan and any existing IRA in consultation with the individual at each quarterly nursing assessment required in CBA and CWP and more frequently, if necessary.

In CLASS and DBMD, at a minimum, case managers review an individual's services quarterly. If problems or concerns are discovered, case managers consult with the service provider to determine what actions are needed. If, at any time, any provider staff becomes aware of an individual experiencing any significant change in condition or circumstances, they must notify the case manager to determine the appropriate course of action. This action may include consulting with the provider and individual to:

- Request authorization to revise the service plan
- Identify additional community services
- Revise or discontinue an IRA
- Convene an IDT meeting
- Request an IDT to discontinue waiver services

Question #7: May an individual who does not have informal supports be accepted for service?

Answer: Yes. HCSSAs may accept an individual who does not have informal supports. While “lack of informal supports” is another reason some HCSSAs have cited for choosing not to serve some individuals, the term “informal supports” is not found in state (40 TAC Chapter 97) or federal (42 Code of Federal Regulations, Chapters 418 [hospice] and 484 [home health]) regulations. Informal supports are mentioned in CBA program requirements for those with an identified need for 24-hour supervision, but an IRA may still be used as described above when appropriate. IRAs are considered part of the combination of services and supports in the CBA program.

HCSSAs should refer to the guidance in Questions #1 and #4 of this letter when deciding whether to serve an individual who has no informal supports. Advocates have often stressed that it is difficult for individuals moving out of institutions to locate informal supports until they actually begin residing in the community and get the opportunity to develop a network of community supports.

Question #8: May a HCSSA staff member, a case manager, or a nursing facility staff member require an individual to assume responsibility for a need or to agree to leave a need unmet in order to qualify for services?

Answer: No. An individual must make the decision to request to have needs met through other resources or to accept responsibility for an unmet need. An individual served under the CLASS or DBMD program may request assistance from their case manager if they feel coerced. Complaints against a HCSSA employee, volunteer, or contractor; a case manager; a nursing facility staff member; or any DADS staff may also be made to the DADS Complaint Intake Unit at 1-800-458-9858.

Question #9: If an agency accepts an individual for service under an IRA and something goes wrong, will DADS regulatory surveyors cite the agency?

Answer: Licensure rules do not require HCSSAs to meet an individual's needs or ensure their safety 24 hours a day, seven days a week. Any IRA must clearly document which needs the individual will accept responsibility for or meet through other resources. **If a HCSSA employee, volunteer, or contractor sees anything of concern, they must document the situation and actions taken to help the individual address the problem.** If HCSSAs meet these requirements and an individual still suffers a negative outcome related to a need addressed in an IRA, DADS would not take enforcement action.

Question #10: Are HCSSAs often cited under 40 TAC §97.401(b) for failing to ensure that an individual's medical, nursing, and social needs can be met adequately in the individual's residence?

Answer: No. Between 9/1/04 and 3/1/07, seven citations were issued for HCSSAs violating

40 TAC 97.401(b). Only three of those seven citations were issued since 9/1/05.

Question #11: After one HCSSA/provider agency assesses and declines to accept an individual for service, must each subsequent HCSSA/provider agency use the same assessment?

Answer: No. For an individual served in CBA or CWP, DADS staff may approve additional assessments. For an individual served in CLASS or DBMD, DADS state office program consultants may approve additional assessments. Individuals may ask DADS staff to authorize additional assessments. When a new assessment is authorized, the HCSSA/provider agency performing that assessment is not provided with copies of prior assessments.

Question #12: Is there a right to appeal the decision of a particular HCSSA not to accept an individual for service?

Answer: No. There is no process to request an appeal of the non-acceptance decision of a particular HCSSA. An individual, however, does have the right to appeal a final denial of Medicaid waiver services. When a particular HCSSA declines to serve an individual, that individual is still eligible to receive Medicaid waiver services; no denial of Medicaid waiver services has yet occurred. Meanwhile, DADS staff continue efforts to locate a HCSSA willing and able to serve the individual. If no HCSSA can be found to serve the individual, a final denial of Medicaid waiver services is provided. At that time the individual may pursue an appeal through the Texas Health and Human Services Commission Fair Hearings process. An individual who believes contract requirements have been violated due to a HCSSA declining to accept them for services may report this concern to their local case manager or to the DADS Complaint Intake Unit at 1-800-458-9858.

Question #13: What are some examples of situations where an individual might successfully establish an agreement with a HCSSA to leave a need unmet by the HCSSA?

Answer: Although particular situations vary, examples of agreements that could be established include:

- An individual who cannot transfer independently and chooses to be alone overnight with an emergency response service to use in case of emergency.
- An individual who chooses to obtain needed wound care directly from her physician instead of from HCSSA personnel.
- An individual who chooses to perform some of his personal hygiene tasks instead of having HCSSA personnel meet these needs.
- An individual who self-operates a ventilator at times to assist with breathing and does not have friends or family in the home at all times.

If you have questions about the regulatory content of this letter, please contact a HCSSA program specialist in the Policy, Rules, and Curriculum Development Unit at (512) 438-3161. For other questions, CBA and CWP providers should contact their local contract manager. CLASS and DBMD case managers should contact a CLASS/DBMD program consultant at (512) 438-3190. CLASS and DBMD direct service providers should contact a CLASS/DBMD program consultant at (512) 438-2080.

Sincerely,

*[signature on file]*

Barry C. Waller  
Assistant Commissioner  
Provider Services

*[signature on file]*

Gary Jessee  
Assistant Commissioner  
Access and Intake

*[signature on file]*

Veronda L. Durden  
Assistant Commissioner  
Regulatory Services

BCW:ss

Attachments

## **Example Individual Responsibility Agreement Instructions**

### **PURPOSE**

**Individual Responsibility Agreements (IRAs) do not guarantee immunity from civil or criminal liability.** IRAs are intended to document agreements between applicants/consumers and their providers regarding needs for which an individual desires to take responsibility. IRAs are allowed in accordance with the Licensing Standards for Home and Community Support Services Agencies at 40 Texas Administrative Code §97.401(b).

### **PROCEDURE**

If an IRA is used, it must be maintained as supporting documentation for the Individualized Service Plan (ISP)/Plan of Care (POC). The provider must send a copy of any IRA to the appropriate case manager.

Negotiations regarding an IRA for applicants/consumers with a legal guardian or legally authorized representative (LAR) must include the guardian or LAR. The applicant/consumer may choose to seek assistance from family or friends in negotiating the IRA, but the applicant/consumer, guardian, or LAR must sign the agreement.

The provider must not require any applicant/consumer to negotiate or sign an IRA in order to receive services. If any change to, or termination of, this agreement is proposed that would also change the ISP/POC, the provider must request authorization to revise the applicant/consumer's ISP/POC and take other actions as appropriate.

### **INSTRUCTIONS**

Complete the form entirely; fill in each applicable blank.

1. Enter the applicant/consumer's full legal name.
2. Enter the applicant/consumer's Medicaid Number, Social Security Number, or both.
3. Provide details regarding the identified need for which the applicant/consumer agrees to take responsibility. For example: "Wound care for decubitis on right hip."
4. Describe the applicant/consumer's plan to meet this need or statements describing a preference to leave the service need unmet.
5. Describe potential consequences to the applicant/consumer if the identified need is not met.
6. Obtain signatures from both the applicant/consumer and a provider representative.

A copy of any IRA must be sent to the appropriate case manager to be included as supporting documentation for the ISP/POC.

***Please note: DADS does not require the parties to use this agreement. Parties should consult with their legal representation regarding the use and limitations of this, or any, service agreement.***

## Example Individual Responsibility Agreement (IRA)

*This is an example service agreement between an applicant/consumer and his or her provider. It includes the elements the Texas Department of Aging and Disability Services (DADS) expects to be in a responsibility agreement. DADS does not require the parties to use this agreement. Parties should consult with their legal representation regarding the use and limitations of this, or any, responsibility agreement. **This example IRA does not guarantee immunity from civil or criminal liability.***

This Individual Responsibility Agreement (IRA) is entered \_\_\_\_\_ (provider), as into by: \_\_\_\_\_ represented by \_\_\_\_\_ (provider representative) and \_\_\_\_\_

(the "applicant/consumer"). The specific need described below has been identified, and the applicant/consumer has expressed a preference to take responsibility for meeting this need. The applicant/consumer understands that how this need is addressed may have significant consequences on the applicant's/consumer's health, including those listed under "Possible Consequences if the Need is Not Met."

The applicant/consumer further acknowledges that the possible consequences of not addressing this need have been fully explained and, having considered these consequences, chooses to take responsibility for the identified need. The provider and applicant/consumer agree that the applicant/consumer will take responsibility for the need. This IRA is supporting documentation for the Individualized Service Plan (ISP)/Plan of Care (POC). For each item below, attach additional pages if needed.

1. Applicant's/consumer's Name
2. Applicant's/consumer's Medicaid Number, Social Security Number, or both
3. Identified Need
4. Details of the Applicant's/consumer's Plan to Meet the Need
5. Possible Consequences if the Need is Not Met

If either party desires to change or terminate this agreement, the applicant/consumer and a provider representative must meet to discuss the cause for change or termination. If any change to or termination of this agreement is proposed that would also change the ISP/POC, the provider must request authorization to revise the applicant's/consumer's ISP/POC and take other actions as appropriate.

The applicant/consumer and provider representative have each carefully read this agreement, understand the content, and freely sign it.

\_\_\_\_\_  
Signature - Applicant/consumer or Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature - Provider Representative

\_\_\_\_\_  
Date