

ATTACHMENT G

Requirements for Individuals with IDD Related to Nursing Facilities

I. General Requirements:

A. As used in this Attachment:

1. “Individual” means an individual 21 years of age or older with an intellectual disability, related condition, or both who is a Medicaid recipient.
2. “Individual in a nursing facility” means an individual who is residing in a nursing facility and has been referred for a stay greater than 90 days or who has been and determined eligible to need a stay greater than 90 days.
3. “Individual in the community” means an individual who has transitioned or been diverted from a nursing facility through enrollment in community-based Medicaid services, until one year after the date of enrollment.

B. The LA must designate and report the following to DADS on Form S:

1. A designated contact for Pre Admission Screening and Resident Review (PASRR) requirements.
2. A Diversion Coordinator to identify and arrange community services to divert individuals from nursing facilities. The designated Diversion Coordinator must be at least credentialed as a qualified intellectual disabilities professional (QIDP) who has experience in coordinating and/or providing services to individuals with IDD, including those with complex medical needs, in the community; and
3. At least one medical specialist, who is a qualified registered nurse, advanced practice nurse, or medical doctor, to provide training, technical assistance, and support, as needed, to residential and other providers who serve individuals with IDD with complex medical needs who have been diverted or transitioned from nursing facilities to services in the community.

C. Upon notice from and in a format approved by DADS, the LA must provide data and other information related to the services and requirements described in this Attachment.

D. Upon notification by DADS, at least quarterly the LA must provide or arrange for the provision of educational or informational activities

addressing community living options for individuals in nursing facilities and their families. These activities may include family-to-family and peer-to-peer programs, providing information about the benefits of community living options, facilitating visits in such settings, and offering opportunities to meet with other individuals who are living, working, and receiving services in integrated settings, with their families, and with community providers.

1. These educational or informational activities must be provided by persons who are knowledgeable about community services and supports.
2. These activities must not be provided by nursing facility staff or others with a contractual relationship with nursing facilities, with the exception of providers of PASRR related specialized services.

II. Pre Admission Screening and Resident Review (PASRR)

The LA must:

- A. Comply with all PASRR requirements in the LA's Medicaid Provider Agreement for the Provision of Intellectual Disability Service Coordination and PASRR and 40 TAC, Chapter 17.
- B. Upon notification by DADS, negotiate and comply with screening and/or evaluation requirements and timetables identified in any negotiated Plan of Completion or Implementation Plan, approved by DADS, for individuals identified by DADS.

III. Nursing Facility Diversion

- A. When conducting the PASRR evaluation, the LA must inform individuals referred for admission to a nursing facility, their families, and LAR of community options, services, and supports for which the individual may be eligible. The LA, under the direction of the Diversion Coordinator, must identify, arrange, and coordinate access to these services in order to avoid admission to a nursing facility, wherever possible and consistent with an individual's informed choice.
- B. Initiation of enrollment in community-based Medicaid services as a diversion from admission to a nursing facility occurs before the individual's admission to a nursing facility or within 90 days after admission to a nursing facility when, consistent with the PASRR evaluation, community living options, services, and/or supports provide an appropriate alternate placement to avoid admission to, or a stay beyond 90 days in, a nursing facility, consistent with the individual's choice.

- C. The LA must ensure that no individual in a nursing facility will be served in another nursing facility or in a residential setting that serves more than four individuals, and that no individual in the community will be served in a residential setting that serves more than four individuals, unless the Diversion Coordinator:
 - 1. In consultation with the individual's service planning team (SPT), attempted and was unable to address barriers to placement in a more integrated setting; and
 - 2. Verified that the individual, family, and/or LAR made an informed decision regarding alternate living options.

IV. Service Coordination

- A. Unless an individual refuses service coordination, the LA must assign a service coordinator to an individual as follows:
 - 1. For an individual in a nursing facility identified through a PASRR evaluation on or after September 1, 2013, the LA must offer and assign a service coordinator within 30 days after completion of the individual's evaluation.
 - 2. The LA must negotiate, develop, and implement a plan, approved by DADS, to contact, offer and assign a service coordinator for:
 - a. An individual in a nursing facility who was not receiving service coordination as of May 24, 2013; and
 - b. An individual in a nursing facility identified through a PASRR evaluation conducted between May 24, 2013, and September 1, 2013, but who is not receiving service coordination.
- B. The assigned service coordinator for an individual in a nursing facility or an individual in the community is responsible for:
 - 1. Convening and facilitating the individual's service planning team (SPT);
 - 2. Facilitating the development of the individual's service plan;
 - 3. Facilitating revisions to the service plan, as needed; and
 - 4. Facilitating the coordination of services and supports.

- C. The assigned service coordinator must meet face-to-face with an individual in a facility and an individual in the community on a monthly basis, or more frequently if needed.
- D. For an individual in a nursing facility, the LA must ensure the service coordinator:
 - 1. Upon the individual's admission to a nursing facility and at least every six months thereafter, provides information and discusses with the individual and LAR about the range of community living service and support options and alternatives in order to better enable the individual and LAR to make an informed decision about transitioning;
 - 2. Facilitates visits to community programs when appropriate and addresses concerns about community living;
 - 3. Ensures that the individual receives the educational and informational activities described in I.D. of this attachment;
 - 4. Facilitates coordination between an individual's service plan and the nursing facility's plan of care; and
 - 5. Coordinating and ensuring consistent implementation of the nursing facility community options information process developed by DADS.
- E. For an individual in a nursing facility who is transitioning to the community, the LA must ensure the service coordinator facilitates the SPT's transition planning responsibilities, including the development of a Community Living Discharge Plan (CLDP) as described in Section VI of this attachment.
- F. For an individual in the community for whom the LA provides service coordination, the LA must ensure the service coordinator:
 - 1. Is responsible for the requirements described in IV.B. of this attachment;
 - 2. Inquires about any recent hospitalizations, emergency department contacts, increased physician visits, or other crises, including medical crises. If the individual experiences any hospitalization, emergency room contacts, and/or crises, the service coordinator must convene the SPT to identify all necessary modifications to the individual's service plan and must work with the SPT to arrange for any additional needed services or supports;

3. Records health care status sufficient to readily identify when changes in the individual's status occurs; and
 4. Ensures that the individual receives timely initial and ongoing assessments of medical, nursing, and nutritional management needs.
- G. The LA must ensure that caseload ratios for service coordinators are sufficient to effectively serve individuals in a nursing facility and individuals in the community, and are based on individual needs and the person-centered planning process, recognizing that transitioning an individual from a nursing facility to a community placement and that serving individuals with complex needs in the community can require intensive service coordination.
- H. For an individual in the community for whom the LA provides service coordination, after the individual has been enrolled in the community program for 180 days, the LA must continue to identify and track that individual with the service coordination frequency required by the rules for the community program in which the individual is being served.

V. Service Planning Team (“SPT”)

- A. The LA must ensure that the SPT for an individual in a nursing facility and an individual in the community is convened at least quarterly, or more frequently if requested by the individual or LAR, or if there is a change in service needs.
- B. The SPT must ensure that an individual in a nursing facility or an individual in the community, regardless of whether he or she has an LAR, participates in the SPT to the fullest extent possible and will receive the support necessary to do so, including, but not limited to, communication supports.
- C. For an individual in a nursing facility or an individual in the community for whom the LA provides service coordination, the LA must ensure that the SPT will:
1. Develop a service plan that:
 - a. Is individualized and developed through a person-centered process;
 - b. Identifies the individual’s strengths; preferences; medical, nursing, nutritional management, clinical, and support needs; and desired outcomes; and

- c. Identifies the services and supports that are needed to meet the individual's needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting possible.
 - 2. Assess the adequacy of the services and supports that the individual is receiving; and
 - 3. Monitor the individual's service plan to make timely additional referrals, service changes, and amendments to the plan as needed.
- D. For an individual in a nursing facility for whom the LA provides service coordination, the LA must ensure that the SPT will:
 - 1. Include the following persons: the individual being served; his or her LAR; the service coordinator; nursing facility staff familiar with the individual's needs; persons providing specialized services for the individual; and, if a specific alternate placement provider has been selected, a representative from that provider. The SPT may include: other concerned persons whose inclusion is requested by the individual or the LAR and, at the discretion of the LA, other persons who are directly involved in the delivery of services to individuals with IDD;
 - 2. Identify the specific specialized services to be provided to the individual, including the amount, intensity, and frequency of each specialized service;
 - 3. Be responsible for planning, ensuring the implementation of, and monitoring all specialized services identified in the service plan, and transition planning in coordination with the nursing facility's care planning team; and
 - 4. Ensure that the individual's service plan, including specialized services, is integrated into the nursing facility's plan of care and that specialized services are planned, provided, and monitored in a consistent manner, and integrated with the services provided by the nursing facility.
- E. For an individual in the community for whom the LA provides service coordination, the SPT will:
 - 1. Include the persons specified in the rules for the program in which the individual is enrolled;

2. Be responsible for planning, ensuring the implementation of, and monitoring all services identified in the service plan; and
3. Determine the sufficient frequency of face-to-face service coordination contacts based on risk factors including, but not limited to, recent transition from a nursing facility, the assessed need for more intensive monitoring; recent or repeat hospitalizations; recent or repeat emergency room contacts; or factors placing the individual at risk of readmission to a nursing facility due to identified medical, psychiatric, or behavioral conditions.

VI. Transitioning from Nursing Facilities

- A. Upon notification by DADS that an individual in a nursing facility whose response in Section Q of the MDS 3.0 indicated that the individual is interested in speaking with someone about returning to the community, the LA, within 30 days after receipt of this information, must contact the individual to determine whether the individual is interested in transitioning to the community.
- B. For an individual in a nursing facility whose PASRR evaluation reflects that the individual's needs can be met in an appropriate community setting or who expresses an interest in transitioning to the community the SPT must create a CLDP.
 1. A CLDP:
 - a. describes the activities, timetable, responsibilities, services, and supports involved in assisting the individual to consider community living options, choose a provider, and transition from the nursing facility to the community; and
 - b. specifies the frequency of monitoring visits by the service coordinator and identify at least three monitoring visits during the first 90 days following the individual's move, including one within the first seven days.
 2. The SPT must develop, implement, monitor, and revise the CLDP as necessary.
- C. For an individual in a nursing facility who is transitioning to the community, the LA must ensure that:
 1. Trail visits to providers in the community are facilitated for the individual, including overnight visits where feasible.

2. Enrollment in the HCS or TxHmL program for the individual must occur within the time frames described in Attachment K, specifically II.A.1, unless DADS grants an extension to the LA.
 3. All essential supports identified in the individual's CLDP are in place prior to the individual's transition to the community, and that the determination of such is documented.
 4. The service coordinator conducts monitoring:
 - a. in accordance with the CLDP, including at least three monitoring visits during the first 90 days following the individual's move, including one within the first 7 days; and
 - b. using the monitoring tool developed by DADS.
 5. In the event the SPT makes a recommendation that the individual maintain placement at a nursing facility, the SPT must:
 - a. document the reasons for the decisions,
 - b. identify the barriers to placement in a more integrated setting, and
 - c. describe in the service plan the steps the team will take to address those barriers.
- D. The LA must track all individuals in a nursing facility who express an interest in transitioning to the community to any employee, contractor, or provider of specialized services.

VII. Specialized Services Provided by the Local Authorities

For an individual in a nursing facility, the LA must:

1. provide specialized services to the individual as required by rules governing PASRR (40 TAC, Chapter 17);
2. monitor the delivery of all specialized services provided to the individual; and
3. request reimbursement for the delivery of specialized services provided by the LA in accordance with DADS instructions.