TO: Medical Care Advisory Committee

DATE: February 11, 2021

FROM: Sonja Gaines, Deputy Executive Commissioner of IDD and Behavioral Health Services

SUBJECT: Preadmission Screening and Resident Review (PASRR) Rule Revision

Agenda Item No.: 7

Amendments, new sections, and a repeal in: 26 TAC Chapter 303, relating to Preadmission Screening and Resident Review (PASRR)

BACKGROUND: ☒ Federal Requirement ☐ Legislative Requirement ☒ Other: Program Initiative

The Texas Health and Human Services Commission (HHSC) proposes amendments to Sections 303.101, 303.102, 303.201 - 303.204, 303.301 - 303.303, 303.401, 303.501, 303.502, 303.504, 303.601, 303.602, 303.701, 303.703, and 303.801; new Section 303.103, Section 303.603, new Subchapter I, comprised of Sections 303.901 - 303.913; and the repeal of Section 303.103, in Texas Administrative Code (TAC), Title 26, Part 1, Chapter 303, concerning Preadmission Screening and Resident Review (PASRR).

The purpose of the amendments, new sections, and repeal is to describe the responsibilities of local intellectual and developmental disability authorities (LIDDAs) regarding intellectual and developmental disabilities (IDD) habilitative specialized services. The amendments, new sections, and repeal make the requirements in Chapter 303 consistent with new rules currently being developed in 26 TAC Chapter 368, regarding Intellectual and Developmental Disabilities (IDD) Habilitative Specialized Services.

HHSC is also clarifying definitions, updating TAC references, adopting person-first respectful language, incorporating the abbreviation for IDD habilitative specialized services (IHSS) and nursing facility (NF), revising certain responsibilities of the LIDDA, local mental health authority (LMHA), and local behavioral health authority (LBHA) related to PASRR, clarifying and updating training requirements, and revising requirements of a LIDDA regarding transition planning.

Finally, a new subchapter and related provisions are added to this chapter. The new subchapter and related provisions describe the requirements of a LIDDA, LMHA, and LBHA regarding specialized services for individuals with mental illness (MI) in accordance with 42 CFR §483.120 and the Performance Contracts with the LIDDAs, LMHAs, and LBHAs.

ISSUES AND ALTERNATIVES:

HHSC received questions and concerns regarding 26 TAC Chapter 303 from stakeholder groups representing community-based providers since the Chapter was adopted in 2019. The stakeholders requested clarification of rule terminology, guidance regarding responsibilities of the LIDDAs, LMHAs, and LBHAs, and guidance

regarding transition planning. These proposed amendments , new rules, and repeal address the questions and concerns identified.

HHSC anticipates stakeholders may be concerned with rules that rely on a NF's compliance, such as the requirement for the habilitation coordinator to send the service provider agency the NF baseline care plan or comprehensive care plan. HHSC is actively working on revisions to 40 TAC Chapter 19 to address these concerns.

The LIDDAs may also have concerns about the additional requirements of LIDDAs and habilitation coordinators. Although LIDDAs will no longer be the providers of IHSS, they will have responsibilities related to provider selection, the process for service initiation, and coordinating transfers between service provider agencies. HHSC will work with LIDDAs to mitigate any concerns about these requirements, which are necessary to ensure designated residents have provider choice and receive the services they need.

It is the intent of HHSC that the amended rules, new rules, and repeal comply with federal regulations and describe the requirements for LIDDAs, LMHAs, and LBHAs related to PASRR.

STAKEHOLDER INVOLVEMENT:

Draft rules were posted on the HHSC Rulemaking website from June 12, 2020, to June 25, 2020, and sent to key external stakeholders for review and informal comment. Comments received from stakeholders were reviewed by HHSC staff and taken into consideration. Stakeholders that commented were Disability Rights Texas, Office of the State Long-term Care Ombudsman, Integral Care, Texana Center, Texas Medical Association, Bluebonnet Trails Community Services, and the Texas Council of Community Centers. Stakeholders commented on several rules and requested additional information be provided in guidelines or handbook. Stakeholders commented on the issues described above as anticipated.

Stakeholders requested minimal revisions to definitions to ensure clarity of terminology referenced in the rules. HHSC incorporated most recommendations. However, some recommendations were outside of the scope of this rule project and were not incorporated. For example, one stakeholder requested that HHSC define "active treatment" in Chapter 303. HHSC declined to make this change because the term is not used in the Chapter and adding it to the Chapter is outside of the scope of this rule project.

A stakeholder had concerns about removing provider qualifications from the definitions of the IHSS. The stakeholder stressed the importance of ensuring that the various services, assessments, examinations, and other acts authorized or required under these rules are conducted by qualified individuals, within their authorized scope of practice, as defined by the applicable Texas licensing laws. HHSC is aware of the importance of specifying the requirements of the service provider providing IHSS. These requirements are being addressed in a separate chapter specifically on IHSS (26 TAC Chapter 368). Consequently, the provider qualifications will be removed from Chapter 303 as they are no longer a necessary part of this Chapter.

A stakeholder expressed concern that the proposed draft rules would create a substantial burden on habilitation coordinators, in addition to their current duties, and asked HHSC to consider transferring some of these responsibilities to the NF. HHSC cannot accommodate this request as it is outside the scope of the rule project.

Another stakeholder expressed concern about the quality assurance rule requiring an LMHA or LBHA to allow advocacy agencies access to the resident with MI or the resident with MI's record. The concern noted was advocacy organizations do not have authority to access an individual's record unless it is with consent of the individual or legally authorized representative (LAR). HHSC believes this language by itself does not give anyone access to records without appropriate consent. Therefore, this suggestion was not incorporated into the rules.

The proposed rules will be presented to the Executive Council meeting on February 18, 2021.

FISCAL IMPACT:

☒ None ☐ Yes

RULE DEVELOPMENT SCHEDULE:

February 11, 2021	Present to the Medical Care Advisory Committee
February 18, 2021	Present to HHSC Executive Council
March 2021	Publish proposed rules in *Texas Register*
July 2021	Publish adopted rules in *Texas Register*
July 2021	Effective date

REQUESTED ACTION: (Check appropriate box)

☒ The MCAC recommends approval of the proposed rules for publication.

☐ Information Only

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 303 PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes in Texas Administrative Code (TAC), Title 26, Part 1, Chapter 303, concerning Preadmission Screening and Resident Review (PASRR), amendments to §§303.101, 303.102, 303.201 - 303.204, 303.301 - 303.303, 303.401, 303.501, 303.502, 303.504, 303.601, 303.602, 303.701, 303.703, and 303.801. HHSC also proposes new §303.103, §303.603, and new Subchapter I, concerning MI Specialized Services, comprised of §§303.901 - 303.913, and the repeal of §303.103.

BACKGROUND AND PURPOSE

The purpose of the amendments, new sections, and repeal is to describe the new responsibilities of local intellectual and developmental disability authorities (LIDDAs) regarding intellectual and developmental disabilities (IDD) habilitative specialized services. The amendments, new sections, and repeal make the requirements in Chapter 303 consistent with new rules currently being developed for IDD habilitative specialized services in Chapter 368 (Intellectual and Developmental Disabilities (IDD) Habilitative Specialized Services).

HHSC is also clarifying definitions, updating TAC references, adopting person-first respectful language, incorporating the abbreviation for IDD habilitative specialized services (IHSS) and nursing facility (NF), revising certain responsibilities of the LIDDA, local mental health authority (LMHA), and local behavioral health authority (LBHA) related to PASRR, clarifying and updating training requirements, and revising requirements of a LIDDA regarding transition planning.

Finally, a new subchapter and related provisions are added to this chapter. The new subchapter and related provisions describe the requirements of a LIDDA, LMHA, and LBHA regarding specialized services for individuals with mental illness (MI) in accordance with 42 CFR §483.120 and the Performance Contracts with the LIDDAs, LMHAs, and LBHAs.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §303.101, Purpose, adds paragraph (3) which provides a third purpose of the chapter which is to describe the responsibilities of an LMHA and LBHA related to a resident with MI who is eligible for MI specialized services. The term “nursing facility” is replaced with its abbreviation "NF."

The proposed amendment to §303.102, Definitions, provides definitions of certain words and terms used in the chapter. HHSC replaced the term “person” with the term “individual” throughout the rules. The term “nursing facility” has been updated

to the abbreviation “NF,” and the term “IDD habilitative specialized services” has been replaced with the abbreviation “IHSS,” throughout the rules. Formatting edits were also made throughout the rules for consistency. HHSC replaced the term “comprehensive care plan” with the term “NF comprehensive care plan.” HHSC also added definitions for or revised the definitions of the following terms: actively involved person, acute care hospital, behavioral support, customized manual wheelchair (CMWC), day habilitation, developmental disability (DD), durable medical equipment (DME), employment assistance, intellectual and developmental disability (IDD), interdisciplinary team (IDT), IDD habilitative specialized services (IHSS), independent living skills training (ILST), implementation plan, licensed marriage and family therapist (LMFT), licensed professional counselor (LPC), MCO service coordinator, MI quarterly meeting, MI specialized services, NF comprehensive care plan, NF PASRR support activities, physician assistant, preadmission screening and resident review (PASRR), person-centered recovery plan (PCRP), PASRR level II evaluation (PE), physician, plan of care, qualified mental health professional-community services (QMHP-CS), resident, resident review, resident with MI, service provider agency, significant change in condition, service planning team (SPT), supported employment, therapy services, transition plan, and uniform assessment. This section has been renumbered to account for the additions and updates made to existing definitions.

Section 303.103, Fair Hearing Process, is deleted and replaced with a new §303.103, concerning fair hearing process for PASRR determination and specialized services. The new section permits an individual seeking admission to a NF, a resident, or an individual's or resident's LAR to request a fair hearing to appeal a PASRR level II evaluation (PE) that is negative for intellectual disability (ID), developmental disability (DD), or MI; a denial of a specialized service; or the reduction, suspension, or termination of an IHSS or MI specialized service. The new §303.103 also clarifies that the LIDDA, LMHA, LBHA, service provider agency, or NF, as applicable, must ensure the provision of the specialized service if the hearing officer reverses a denial, reduction, or termination of that specialized service.

The proposed amendments to §§303.201, Preadmission Process, 303.203, Admission Process for Exempted Hospital Discharge, 303.301, Referring Entity Responsibilities Related to the PASRR Process, 303.401, Reimbursement for a PE or Resident Review, and 303.701, Transition Planning for a Designated Resident, replace references to a nursing facility with the abbreviation “NF.”

The proposed amendment to §303.202, Expedited Admission Process, clarifies the expedited admission process.

The proposed amendment §303.204, Resident Review Process, clarifies when a LIDDA, LMHA, or LBHA must conduct a resident review as a result of a change in condition of a resident with MI, ID, or DD.

The proposed amendment to §303.302, LIDDA, LMHA, and LBHA Responsibilities Related to the PASRR Process, adds and revises responsibilities for the LIDDA, LMHA, or LBHA related to the PASRR process. If a PE or resident review is positive

for MI, ID, or DD, new subsection (a)(3)(A) requires the LIDDA, LMHA, or LBHA to provide the individual seeking admission, resident, or LAR with a summary of the results of the PE or resident review. If a PE or resident review is negative for MI, ID, or DD, new subsection (a)(3)(B) requires the LIDDA, LMHA, or LBHA to provide the individual seeking admission, resident, or LAR notice of the right to a fair hearing. Amended subsection (c)(1) revises the responsibilities of the LIDDA, LMHA, or LBHA to require the LIDDA, LMHA, or LBHA to coordinate with the NF to schedule the interdisciplinary team (IDT) meeting, to confirm in the long-term care online portal participation in the IDT meeting and the specialized services recommended, and initiate and provide MI specialized services rather than both MI specialized services and IHSS. New subsection (d) requires the LIDDA, LMHA, or LBHA to develop a written policy to address challenges related to a designated resident's, resident with MI's, or LAR's participation in receiving IHSS or MI specialized services. New subsections (e) and (f) require the LIDDA, LMHA, or LBHA to inform a designated resident, resident with MI, or LAR orally and in writing of the processes for filing complaints. New subsection (g) states that the LIDDA is responsible for coordinating with the NF to schedule the IDT meeting for an individual seeking admission to a NF or a resident whose PE or resident review is positive for MI and ID or MI and DD.

The proposed amendment to §303.303, Qualifications and Requirements for Staff Person Conducting a PE or Resident Review, requires an LMHA or LBHA to ensure that the individual conducting a PE or resident review is either a qualified mental health professional--community services or is another type of health professional who has experience working directly with individuals with MI.

The proposed amendment to §303.401, Reimbursement for a PE or Resident Review, clarifies that a LIDDA’s, LMHA’s, or LBHA’s payment for a PE or resident review includes assisting with the selection of another NF that will certify it can meet the needs of an individual seeking admission to a NF or resident with ID, DD, or MI when the original NF refuses to do so.

The proposed amendment to §303.501, Qualifications of a Habilitation Coordinator, changes a reference to intellectual and other developmental disabilities to the appropriate abbreviations for consistency with the other rules.

The proposed amendment to §303.502, Required Training for a Habilitation Coordinator, updates the required training for a habilitation coordinator to include training on other HHSC rules affecting the LIDDA and on community support services and removes the requirement for person-centered thinking training to be approved by HHSC.

The proposed amendment to §303.504, Documentation Maintained by a LIDDA in a Designated Resident's Record, updates the required documentation that must be maintained by a LIDDA in a designated resident’s record to include the current plan of care and an implementation plan for each IHSS that appears on the plan of care. It also clarifies that the documentation of the designated resident's progress or lack of progress must reflect the designated resident's and LAR's perspectives.

The proposed amendment to §303.601, Habilitation Coordination for a Designated Resident, updates the requirements for habilitation coordination. The requirements for habilitation coordination include the following: determining the designated resident's preferences as well as needs; monitoring to determine if a specialized service agreed upon in an IDT or SPT meeting is requested within required timeframes in accordance with the IDD PASRR Handbook; sharing the habilitation service plan (HSP) with the members of the SPT within 10 days after the HSP is updated or renewed; determining the designated resident's progress or lack of progress toward achieving goals and outcomes identified in the HSP from the designated resident's and LAR's perspectives; coordinating with the NF in accessing medical, social, educational, and other appropriate services and supports that will help the designated resident achieve a quality of life acceptable to the designated resident and LAR on the resident's behalf; providing the designated resident and LAR an oral and written explanation of the designated resident's rights in accordance with the IDD PASRR Handbook; and informing the designated resident and LAR both orally and in writing of all the services available and requirements pertaining to the designated resident's participation.

For a designated resident who has a guardian, habilitation coordination also includes determining at least annually if the letters of guardianship are current. For a designated resident who does not have a guardian, if appropriate, habilitation coordination includes ensuring the SPT discusses whether the designated resident would benefit from a less restrictive alternative to guardianship or from guardianship and making appropriate referrals.

The proposed amendment to §303.601 also clarifies the habilitation coordinator's responsibilities regardless of whether the designated resident receives or refuses habilitation coordination. In both instances, the habilitation coordinator must address community living options with the designated resident and LAR and annually assess the designated resident's habilitative service needs by gathering information from the designated resident and other appropriate sources, such as the LAR, family members, social workers, and service providers, to determine the designated resident's habilitative needs and preferences.

Finally, the proposed amendment to §303.601 allows HHSC to waive the requirement that the habilitation coordinator meet face-to-face with the designated resident to provide habilitation coordination.

The proposed amendment to §303.602, Service Planning Team Responsibilities Related to Specialized Services, adds that the SPT must develop the plan of care regarding IHSS.

Proposed new §303.603, Habilitation Coordination for a Designated Resident Receiving IHSS, describes habilitation coordination for a designated resident receiving IHSS. The section requires the habilitation coordinator to facilitate the coordination of the designated resident's plan of care; assist a designated resident, LAR, or actively involved person in exercising the legal rights of the designated

resident as a citizen and as a person with a disability; provide a designated resident, LAR, or family member with a written and oral explanation of the rights of a designated resident receiving IHSS; document the explanation of rights and ensure that the documentation is signed by the designated resident or LAR and the habilitation coordinator; immediately notify the NF and service provider agency if the habilitation coordinator becomes aware of an emergency that impacts the designated resident's health or safety; be objective in assisting a designated resident or LAR in selecting a service provider agency; ensure that a designated resident, LAR, and service provider agency are informed of the name of the designated resident's habilitation coordinator and how to contact the habilitation coordinator; and give the service provider agency a copy of the NF baseline care plan or NF comprehensive care plan. If the habilitation coordinator identifies a concern with the implementation of the plan of care, the habilitation coordinator must also ensure the concern is communicated to the service provider agency and attempts are made to resolve the concern.

The proposed amendment to §303.703, Requirements for Service Coordinators Conducting Transition Planning, revises the training requirements that a service coordinator must complete prior to providing service coordination for a designated resident. This training no longer needs to include the process for making a referral for relocation services and housing options. In addition, the training must include an overview of community living options rather than how to present community living options.

The proposed amendment to §303.801, LIDDA Compliance Review, revises the name of the section to "Compliance Review." The amendment clarifies that HHSC conducts compliance reviews of the LMHAs and LBHAs, in addition to the LIDDAs, to ensure compliance with the PASRR process.

Proposed new §303.901, Description of MI Specialized Services, describes MI specialized services, which are specialized services available to a resident with MI. The LMHA or LBHA staff must conduct a uniform assessment to determine which level of care the resident with MI will receive. MI specialized services include: crisis intervention services; day programs for acute needs; medication training and support services; psychiatric diagnostic interview examination; psychosocial rehabilitation services; routine case management; and skills training and development.

Proposed new §303.902, Eligibility Criteria, specifies that a resident with MI is eligible for MI specialized services funded by Medicaid if the resident with MI requires the provision of at least one MI specialized service.

Proposed new §303.903, MI Specialized Services Team, identifies the required members of the MI specialized services team. It also states that the MI specialized services team may include a concerned individual whose inclusion is requested by the resident with MI or the LAR.

Proposed new §303.904, Qualifications for Conducting the Uniform Assessment, requires the LMHA or LBHA staff person administering the uniform assessment to be certified in administering the uniform assessment.

Proposed new §303.905, Process for Service Initiation, describes the process for service initiation. Subsection (a) requires the LMHA or LBHA to comply with §303.302 of this chapter (relating to LIDDA, LMHA, and LBHA Responsibilities Related to the PASRR Process). Subsection (b) requires the LMHA or LBHA staff participating in the initial IDT meeting, in conjunction with the IDT, to review the MI specialized services recommended on the PE; explain the uniform assessment; ensure the resident with MI, or LAR on the resident with MI's behalf, understands the purpose of the uniform assessment; and have the resident with MI, or LAR on the resident with MI's behalf, agree or decline to receive a uniform assessment and MI specialized services. Subsection (c) requires the LMHA or LBHA, within 20 business days after the IDT meeting, to complete the uniform assessment; develop the PCRP; and for a resident with MI only, convene a meeting to discuss the results of the uniform assessment and PCRP and to determine the MI specialized services the resident with MI will receive. Subsection (d) requires the meeting convened in accordance with subsection (c)(3) to be attended by the QMHP-CS who completed the uniform assessment and PCRP; the resident with MI; the resident with MI's LAR, if any; and a NF staff person familiar with the resident with MI's needs. Subsection (e) requires the QMHP-CS to ensure the resident with MI participates in the meeting convened in accordance with subsection (c)(3) to the fullest extent possible and receives the support necessary to do so. Subsection (f) requires the LMHA or LBHA to provide a copy of the completed uniform assessment and PCRP to the NF for inclusion in the resident with MI's NF comprehensive care plan within 10 calendar days after the meeting convened in accordance with subsection (c)(3).

Proposed new §303.906, Person-Centered Recovery Plan, requires the QMHP-CS, in conjunction with the MI specialized services team, to develop, periodically review, and revise as needed the PCRP for each resident with MI.

Proposed new §303.907, Renewal and Revision of Person-Centered Recovery Plan, covers the renewal and revision of the PCRP. Subsection (a) requires the QMHP-CS to convene an MI quarterly meeting to review the PCRP to determine whether the MI specialized services previously identified remain relevant and determine whether the current uniform assessment accurately reflects the resident with MI's need for MI specialized services or if an updated uniform assessment is required. Subsection (b) requires the MI specialized services team to revise the PCRP in response to changes in the needs of the resident with MI. Any MI specialized services team member may ask the QMHP-CS to convene a meeting at any time to discuss whether a resident with MI's PCRP needs to be revised. Subsection (b) also requires the QMHP-CS to convene a meeting within seven calendar days after learning of the need to revise the resident with MI's PCRP. Subsection (c) requires the QMHP-CS to update the uniform assessment and provide it to the MI specialized services team within seven calendar days after the meeting, if the MI specialized services team agrees to add a new MI specialized service or determines an updated uniform assessment is required. Subsection (d) requires the QMHP-CS to document

revisions on the PCRP within five calendar days after a team meeting and retain the revised PCRP documentation in the resident with MI's LMHA or LBHA record.

Proposed new §303.908, Service Delivery, describes the requirements for service delivery. Subsection (a) requires the LMHA or LBHA to begin delivering all MI specialized services in accordance with the PCRP within five calendar days after the MI specialized services team meeting. Subsection (b) requires the LMHA or LBHA to confirm that the resident with MI is a Medicaid recipient and receive authorization to deliver the MI specialized services. Subsection (c) requires the LMHA or LBHA to accurately and consistently document in observable, measurable terms a resident with MI's progress or lack of progress toward achieving an identified outcome from the resident with MI's or LAR's perspective. Subsection (d) requires the LMHA or LBHA to monitor a resident with MI's and LAR's satisfaction with MI specialized services. Subsection (e) requires the LMHA or LBHA to inform the NF of any significant changes to the resident with MI's behavioral or medical condition during the provision of MI specialized services.

Proposed new §303.909, Refusal of the Uniform Assessment or MI Specialized Services, outlines what steps an LMHA or LBHA must take when a resident with MI refuses a uniform assessment or MI specialized services. First, the LMHA or LBHA must ask the resident with MI or the LAR to sign the Refusal of PASRR MI Specialized Services form and inform the resident with MI of the need to conduct follow up visits every 30 days for 90 days after the initial IDT meeting. If the resident with MI or the LAR still refuses a uniform assessment or MI specialized services after 90 days, the LMHA or LBHA must inform the resident with MI that an annual IDT meeting is required and will be conducted, at which time a uniform assessment and MI specialized services will be offered again. A resident with MI or LAR may agree to receive a uniform assessment or MI specialized services at any time.

Proposed new §303.910, Suspension and Termination of MI Specialized Services, describes when an LMHA or LBHA suspends or terminates MI specialized services. Subsection (a) requires the LMHA or LBHA to suspend a resident with MI's MI specialized services when the resident with MI is admitted to an acute care hospital for fewer than 30 days and is returning to the same NF; the resident with MI loses Medicaid eligibility; or the resident with MI or LAR requests that MI specialized services be suspended when transferring from one NF to another NF without an intervening hospital stay. Subsection (b) permits an LMHA or LBHA to terminate one or more of a resident with MI's MI specialized services if the resident with MI loses Medicaid eligibility for more than 90 days or the resident with MI or LAR requests the MI specialized services be terminated.

Proposed new §303.911, Transition Planning for Residents with MI Only, specifies the process for transition planning for residents with MI only. Subsection (a) requires the QMHP-CS to facilitate the development of, revisions to, implementation of, and monitoring of a transition plan if a resident with MI only, or the LAR on the resident with MI's behalf, expresses an interest in moving to the community. Subsection (b) requires a transition plan to identify the services and supports a

resident with MI needs to live in the community, including those essential supports that are critical to the resident with MI's health and safety.

Proposed new §303.912, Documentation, identifies the documentation that an LMHA or LBHA must maintain in the resident with MI's record. This documentation is: all assessments used for service planning; documentation related to the initiation and delivery of MI specialized services; documentation related to monitoring MI specialized services; documentation of all meetings; guardianship paperwork and consents, if applicable; and documentation of a resident with MI's refusal of MI specialized services, if applicable.

Proposed new §303.913, Quality Assurance, addresses quality assurance. Subsection (a) requires the LMHA or LBHA to allow access to the resident with MI or the resident with MI's record by advocacy agencies and HHSC staff. Subsection (b) requires the LMHA or LBHA to develop, update as necessary, and implement a written quality assurance process to evaluate and improve the quality of MI services delivered by the LMHA or LBHA.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rules will be in effect, enforcing or administering the rules do not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:

(1) the proposed rules will not create or eliminate a government program;
(2) implementation of the proposed rules will not create new HHSC employee positions;
(3) implementation of the proposed rules will result in no assumed change in future legislative appropriations;
(4) the proposed rules will not affect fees paid to HHSC;
(5) the proposed rules will create new rules;
(6) the proposed rules will expand existing rules;
(7) the proposed rules will not change the number of individuals subject to the rules; and
(8) the proposed rules will not affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The amendments, new sections, and repeal do not require small businesses, micro-businesses, or rural communities to change current business practices.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to protect the health, safety, and welfare of the residents of Texas, do not impose a cost on regulated persons, and are necessary to receive a source of federal funds or comply with federal law.

PUBLIC BENEFIT AND COSTS

Sonja Gaines, Deputy Executive Commissioner for IDD and Behavioral Health Services, has determined that for each year of the first five years the rules are in effect, the public benefit will be that service delivery provided by LIDDAs, LMHAs, and LBHAs will be improved by the clarification of existing rules regarding roles and responsibilities and training requirements. The additional public benefit of adding new §§303.901-303.913 will be that LMHAs and LBHAs will have specific requirements in rule for delivering services to individuals with MI residing in NFs.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules. The proposal does not impose new costs or fees on those required to comply.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC IDD Services, Lisa Habbit, Mail Code 354, P.O. Box 149030, Austin, Texas 78714-9030, or by email to idd-bh_pasrrspa@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the Texas Register. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 20R049" in the subject line.

STATUTORY AUTHORITY

The amendments, new sections, and repeal are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code Chapter 531, Subchapter A-1, which provides for the consolidation of the health and human services system; Texas Government Code §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Human Resources Code §32.021, which provides that HHSC will adopt necessary rules for the proper and efficient administration of the Medicaid program.

The amendments, new sections, and repeal implement Texas Government Code §531.0055 and §531.021 and Texas Human Resources Code §32.021.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 438-5018.

Legend:
Single Underline = Proposed new language
[~~Strikethrough and brackets~~] = Current language proposed for deletion
Regular print = Current language
(No change.) = No changes are being considered for the designated subdivision

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 303 PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER A GENERAL PROVISIONS

§303.101. Purpose.

(a) The purpose of this chapter is to:

(1) describe the responsibilities of a LIDDA, LMHA, and LBHA related to PASRR, to ensure that:

(A) an individual seeking admission to a NF [~~nursing facility~~] or a resident of a NF [~~nursing facility~~] receives a PL1 to identify whether the individual or resident is suspected of having MI, ID, or DD; and

(B) an individual seeking admission to a NF [~~nursing facility~~] or resident suspected of having MI, ID, or DD receives a PE or resident review to confirm MI, ID, or DD and, if confirmed, to evaluate whether the individual or resident needs NF [~~nursing facility~~] care and needs specialized services; [~~and~~]

(2) describe the responsibilities of a LIDDA related to a designated resident who receives habilitative service planning and transition planning as described in Subchapters E, F, and G of this chapter (relating to Habilitation Coordination, Habilitative Service Planning for a Designated Resident, and Transition Planning); and

(3) describe the responsibilities of an LMHA and LBHA related to a resident with MI who is eligible for MI specialized services as described in Subchapter I of this chapter (relating to MI Specialized Services).

(b) The rules regarding the responsibilities of a NF [~~nursing facility~~] related to PASRR are in 40 TAC Chapter 19, Subchapter BB (relating to Nursing Facility Responsibilities Related to Preadmission Screening and Resident Review (PASRR)).

§303.102. Definitions.

The following words and terms, when used in this chapter, have the following meanings unless the context clearly indicates otherwise.

(1) Actively involved person--An individual who has significant, ongoing, and supportive involvement with a designated resident, as determined by the SPT based on the individual's:

(A) observed interactions with the designated resident;

(B) availability to the designated resident for assistance or support when needed; and

(C) knowledge of, sensitivity to, and advocacy for the designated resident's needs, preferences, values, and beliefs.

(2) [~~(1)~~] Acute care hospital--A health care facility in which an individual [~~a person~~] receives short-term treatment for a severe physical injury or episode of physical illness, an urgent medical condition, or recovery from surgery and:

(A) may include a long-term acute care hospital, an emergency room within an acute care hospital, or an inpatient rehabilitation hospital; and

(B) does not include a stand-alone psychiatric hospital or a psychiatric hospital within an acute care hospital.

(3) [~~(2)~~] Alternate placement assistance--Assistance provided to a resident to locate and secure services chosen by the resident or LAR that meets the resident's needs in a setting other than a NF [~~nursing facility~~]. Alternate placement assistance includes transition planning, pre-move site review, and post-move monitoring.

(4) [~~(3)~~] APRN--Advance practice registered nurse. An individual [~~A person~~] licensed to practice professional nursing as an advance practice registered nurse in accordance with Texas Occupations Code[~~,~~] Chapter 301.

(5) Behavioral support--An IHSS that:

(A) is assistance provided for a designated resident to increase adaptive behaviors and to replace or modify maladaptive behaviors that prevent or interfere with the designated resident's interpersonal relationships across all service and social settings;

(B) is delivered in the NF or in a community setting; and

(C) consists of:

(i) assessing the behaviors to be targeted in an appropriate behavior support plan and analyzing those assessment findings;

(ii) developing an individualized behavior support plan that reduces or eliminates the target behaviors, assisting the designated resident in achieving the outcomes identified in the HSP;

(iii) training and consulting with the LAR, family members, NF staff, other support providers, and the designated resident about the purpose, objectives, and methods of the behavior support plan;

(iv) implementing the behavior support plan or revisions to the behavior support plan and documenting service delivery in accordance with the IDD Habilitative Specialized Services Billing Guidelines;

(v) monitoring and evaluating the success of the behavior support plan

implementation;

(vi) revising the behavior support plan as necessary; and

(vii) participating in SPT and IDT meetings.

[~~(4) Behavioral support--Specialized interventions by a qualified service provider to assist a person to increase adaptive behaviors and to replace or modify maladaptive behaviors that prevent or interfere with the person's inclusion in home and family life or community life.~~

~~(A) Behavioral support includes:~~

~~(i) assessing and analyzing assessment findings so that an appropriate behavior support plan may be designed;~~

~~(ii) developing an individualized behavior support plan consistent with the outcomes identified in the HSP;~~

~~(iii) training and consulting with family members or other providers and, as appropriate, the person; and~~

~~(iv) monitoring and evaluating the success of the behavior support plan and modifying the plan as necessary.~~

~~(B) A qualified service provider of behavioral support:~~

~~(i) is licensed as a psychologist in accordance with Texas Occupations Code, Chapter 501;~~

~~(ii) is licensed as a psychological associate in accordance with Texas Occupations Code, Chapter 501;~~

~~(iii) has been issued a provisional license to practice psychology in accordance with Texas Occupations Code, Chapter 501;~~

~~(iv) is a certified authorized provider as described in 40 TAC §5.161 (relating to Certified Authorized Provider);~~

~~(v) is an LCSW;~~

~~(vi) is an LPC; or~~

~~(vii) is licensed as a behavior analyst in accordance with Texas Occupations Code, Chapter 506.~~]

(6) [~~(5)~~] CMWC--Customized manual wheelchair. In accordance with 40 TAC §19.2703 (relating to Definitions) and consistent with the requirements of Texas Human Resources Code §32.0425, a wheelchair that consists of a manual mobility base and customized seating system and is adapted and fabricated to meet the individualized needs of a designated resident.

(7) [~~(6)~~] Collateral contact--A person who is knowledgeable about the individual

seeking admission to a NF [~~a nursing facility~~] or the resident, such as family members, previous providers or caregivers, and who may support or corroborate information provided by the individual or resident.

(8) [~~(7)~~] Coma--A state of unconsciousness characterized by the inability to respond to sensory stimuli as documented by a physician.

[~~(8) Comprehensive care plan--A plan, defined in 40 TAC §19.2703.~~]

(9) Convalescent care--A type of care provided after an individual's release from an acute care hospital that is part of a medically prescribed period of recovery.

(10) Day habilitation--An IHSS that:

(A) is assistance provided for a designated resident to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to successfully and actively participate in all service and social settings;

(B) is delivered in a setting other than the designated resident's NF;

(C) does not include services provided under the Day Activity and Health Services program;

(D) includes expanded interactions, skills training activities, and programs of greater intensity or frequency beyond those a NF is required to provide by 42 Code of Federal Regulations (CFR) §483.24; and

(E) consists of:

(i) individualized activities consistent with achieving the outcomes identified in a designated resident's HSP to attain, learn, maintain, or improve skills;

(ii) activities necessary to reinforce therapeutic outcomes targeted by other support providers and other specialized services;

(iii) services in a group setting at a location other than a designated resident's NF for up to five days per week, six hours per day, on a regularly scheduled basis;

(iv) personal assistance for a designated resident who cannot manage personal care needs during the day habilitation activity;

(v) transportation between the NF and the day habilitation site, as well as during the day habilitation activity necessary for a designated resident's participation in day habilitation activities; and

(vi) participating in SPT and IDT meetings.

[~~(10) Day habilitation--Assistance to a person to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to live successfully in the community and participate in home and community life. Day habilitation provides:~~

[(A) individualized activities consistent with achieving the outcomes identified in the person's service plan;

(B) activities necessary to reinforce therapeutic outcomes targeted by other support providers and other specialized services;

(C) services in a group setting, other than the person's residence, for typically up to five days a week, six hours per day on a regularly scheduled basis;

(D) personal assistance for a person who cannot manage personal care needs during the day habilitation activities; and

(E) transportation during the day habilitation activity necessary for a person's participation in the day habilitation activities.]

(11) DD--Developmental disability. A disability that meets the criteria described in the definition of "persons with related conditions" in 42 CFR [Code of Federal Regulations (CFR)] §435.1010.

(12) Delirium--A serious disturbance in an individual's mental abilities that results in a decreased awareness of the individual's environment and confused thinking.

(13) Designated resident--An individual:

(A) whose PE or resident review is positive for ID or DD;

(B) who is 21 years of age or older;

(C) who is a Medicaid recipient; and

(D) who is a resident or has transitioned to the community from a NF [nursing facility] within the previous 365 days.

(14) DME--Durable medical equipment [Medical Equipment]. The items described in 40 TAC §19.2703(10). [In accordance with 40 TAC §19.2703, the following items, including any accessories and adaptations needed to operate or access the item:]

[(A) a gait trainer;

(B) a standing board;

(C) a special needs car seat or travel restraint;

(D) a specialized or treated pressure-reducing support surface mattress;

(E) a positioning wedge;

(F) a prosthetic device; and

(G) an orthotic device.]

(15) Emergency protective services--Services furnished by the Department of Family and Protective Services to an elderly or disabled individual who has been determined to be in a state of abuse, neglect, or exploitation.

(16) Employment assistance--An IHSS that:

(A) is assistance provided for a designated resident who requires intensive help locating competitive employment in the community; and

(B) consists of:

(i) identifying a designated resident's employment preferences, job skills, and requirements for a work setting and work conditions;

(ii) locating prospective employers offering employment compatible with a designated resident's identified preferences, skills, and requirements;

(iii) contacting prospective employers on a designated resident's behalf and negotiating the designated resident's employment;

(iv) transporting a designated resident between the NF and the site where employment assistance services are provided and as necessary to help the designated resident locate competitive employment in the community; and

(v) participating in SPT and IDT meetings.

[~~(16) Employment assistance--Assistance provided to a person to help the person locate competitive employment in the community, consisting of a service provider performing the following activities:~~

~~(A) identifying a person's employment preferences, job skills, and requirements for a work setting and work conditions;~~

~~B) locating prospective employers offering employment compatible with a person's identified preferences, skills, and requirements;~~

~~(C) contacting a prospective employer on behalf of a person and negotiating the person's employment;~~

~~(D) transporting the person to help the person locate competitive employment in the community; and~~

~~(E) participating in SPT meetings.~~]

(17) Essential supports--Those supports identified in a transition plan that are critical to a designated resident's health and safety and that are directly related to a designated resident's successful transition to living in the community from residing in a NF [~~nursing facility~~].

(18) Exempted hospital discharge--A category of NF [~~nursing facility~~] admission that occurs when a physician has certified that an individual who is being discharged from an acute care hospital is likely to require less than 30 days of NF

[~~nursing facility~~] services for the condition for which the individual was hospitalized.

(19) Expedited admission--A category of NF [~~nursing facility~~] admission that occurs when an individual meets the criteria for one of the following categories: convalescent care, terminal illness, severe physical illness, delirium, emergency protective services, respite, or coma.

(20) Habilitation coordination--Assistance for a designated resident residing in a NF [~~nursing facility~~] to access appropriate specialized services necessary to achieve a quality of life and level of community participation acceptable to the designated resident and LAR on the designated resident's behalf.

(21) Habilitation coordinator--An employee of a LIDDA who provides habilitation coordination.

(22) HHSC--The Texas Health and Human Services Commission.

(23) HSP--Habilitation service plan. A plan developed by the SPT while a designated resident is residing in a NF [~~nursing facility~~] that:

(A) is individualized and developed through a person-centered approach;

(B) identifies the designated resident's:

(i) strengths;

(ii) preferences;

(iii) desired outcomes; and

(iv) psychiatric, behavioral, nutritional management, and support needs as described in the NF comprehensive care plan or MDS assessment; and

(C) identifies the specialized services that will accomplish the desired outcomes of the designated resident, or the LAR's on behalf of the designated resident, including amount, frequency, and duration of each service.

(24) ID--Intellectual disability, as defined in 42 CFR §483.102(b)(3)(i).

(25) IDD--Intellectual and developmental disability.

[~~(25) IDD habilitative specialized services--The following specialized services available to a resident with ID or DD:~~

~~(A) habilitation coordination;~~

~~(B) day habilitation;~~

~~(C) independent living skills training;~~

~~(D) behavioral support;~~

~~(E) employment assistance; and~~

~~(F) supported employment.~~]

(26) IDT--Interdisciplinary team. A team consisting of:

(A) a resident with MI, ID, or DD;

(B) the resident's LAR, if any;

(C) an RN [~~a registered nurse~~] from the NF [~~nursing facility~~] with responsibility for the resident;

(D) a representative of:

(i) the LIDDA, if the resident has ID or DD;

(ii) the LMHA or LBHA, if the resident has MI; or

(iii) the LIDDA and the LMHA or LBHA, if the resident has MI and DD, or MI and ID; and

(E) others as follows:

(i) a concerned person whose inclusion is requested by the resident or LAR;

(ii) an individual [~~a person~~] specified by the resident, LAR, NF [~~nursing facility~~], LIDDA, LMHA, or LBHA, as applicable, who is professionally qualified, certified, or licensed with special training and experience in the diagnosis, management, needs, and treatment of people with MI, ID, or DD; and

(iii) a representative of the appropriate school district if the resident is school age and inclusion of the district representative is requested by the resident or LAR.

(27) IHSS--IDD habilitative specialized services. IHSS are:

(A) behavioral support;

(B) day habilitation;

(C) employment assistance;

(D) independent living skills training; and

(E) supported employment.

[~~(27) Independent living skills training - Individualized activities that are consistent with the HSP and provided in a person's residence and at community locations, such as libraries and stores. These activities include:~~

~~(A) habilitation and support activities that foster or facilitate improvement or maintenance of the person's ability to perform functional living skills and other daily living activities;~~

~~(B) activities for the person's family that help preserve the family unit and prevent or limit out-of-home placement of the person; and~~

~~(C) transportation to facilitate the person's employment opportunities and participation in community activities, and between the person's residence and day habilitation site.~~]

(28) ILST--Independent living skills training. An IHSS that:

(A) is assistance provided for a designated resident that is consistent with the designated resident's HSP;

(B) is provided in the designated resident's NF or in a community setting;

(C) includes expanded interactions, skills training activities, and programs of greater intensity or frequency beyond those a NF is required to provide by 42 CFR §483.24; and

(D) consists of:

(i) habilitation and support activities that foster improvement of or facilitate a designated resident's ability to attain, learn, maintain, or improve functional living skills and other daily living activities;

(ii) activities that help preserve the designated resident's bond with family members;

(iii) activities that foster inclusion in community activities generally attended by people without disabilities;

(iv) transportation to facilitate a designated resident's employment opportunities and participation in community activities, and between the designated resident's NF and a community setting; and

(v) participating in SPT and IDT meetings.

(29) Implementation plan--A plan for each IHSS on the designated resident's plan of care that includes:

(A) a list of the designated resident's outcomes identified in the HSP that will be addressed using IHSS;

(B) specific objectives to address the outcomes required by subparagraph (A) of this paragraph that are:

(i) observable, measurable, and outcome-oriented; and

(ii) derived from assessments;

(C) a target date for completion of each objective;

(D) the frequency, amount, and duration of IHSS needed to complete each objective; and

(E) the signature and date of the designated resident, LAR, and service provider agency.

(30) [~~(28)~~] LAR--Legally authorized representative. An individual [~~A person~~] authorized by law to act on behalf of an individual seeking admission to a NF [~~nursing facility~~] or resident with regard to a matter described by this chapter, and who may be the parent of a minor child, the legal guardian, or the surrogate decision maker.

(31) [~~(29)~~] LBHA--Local behavioral health authority. An entity designated by the executive commissioner of HHSC, in accordance with Texas Health and Safety Code[~~,~~] §533.0356.

(32) [~~(30)~~] LCSW--Licensed clinical social worker. An individual [~~A person~~] who is licensed as a licensed clinical social worker in accordance with Texas Occupations Code[~~,~~] Chapter 505.

(33) [~~(31)~~] Licensed psychologist--An individual [~~A person~~] who is licensed as a psychologist in accordance with Texas Occupations Code[~~,~~] Chapter 501.

(34) [~~(32)~~] LIDDA--Local intellectual and developmental disability authority. An entity designated by the executive commissioner of HHSC, in accordance with Texas Health and Safety Code[~~,~~] §533A.035.

(35) [~~(33)~~] LMFT--Licensed marriage and family therapist. An individual [~~A person~~] who is licensed as a [~~licensed~~] marriage and family therapist in accordance with Texas Occupations Code[~~,~~] Chapter 502.

(36) [~~(34)~~] LMHA--Local mental health authority. An entity designated by the executive commissioner of HHSC, in accordance with Texas Health and Safety Code[~~,~~] §533.035.

(37) [~~(35)~~] LPC--Licensed professional counselor. An individual [~~A person~~] who is licensed as a [~~licensed~~] professional counselor in accordance with Texas Occupations Code[~~,~~] Chapter 503.

(38) [~~(36)~~] LTC online portal--Long term care online portal. A web-based application used by Medicaid providers to submit forms, screenings, evaluations, and other information.

(39) [~~(37)~~] MCO service coordinator--Managed [~~Medicaid managed~~] care organization service coordinator. The staff person assigned by a resident's Medicaid managed care organization to ensure access to and coordination of needed services.

(40) [~~(38)~~] MDS assessment--Minimum data set assessment. A standardized collection of demographic and clinical information that describes a resident's overall condition, which a licensed NF [~~nursing facility~~] in Texas is required to submit for a resident admitted into the facility.

(41) [~~(39)~~] MI--Mental illness. Serious mental illness, as defined in 42 CFR

§483.102(b)(1).

(42) MI quarterly meeting--A quarterly meeting that is convened by the LMHA or LBHA for a resident with MI to develop, review, or revise the PCRP and the transition plan, if the resident is transitioning to the community.

(43) [~~(40)~~] MI specialized services--Specialized services for [~~available to~~] a resident with MI, if eligible, as described in the Texas Resilience and Recovery Utilization Management Guidelines, including:

(A) crisis intervention services;

(B) day programs for acute needs;

(C) medication training and support services;

(D) psychiatric diagnostic interview examination;

(E) psychosocial rehabilitation services;

(F) routine case management; and

(G) skills training and development

[~~(A) skills training;~~

~~(B) medication training;~~

~~(C) psychosocial rehabilitation;~~

~~(D) case management;~~

~~(E) psychiatric diagnostic interview exam; and~~

~~(F) supported housing, which includes alternate placement assistance and transitioning to the community~~].

(44) [~~(41)~~] NF--Nursing facility. [~~—~~]A Medicaid-certified facility that is licensed in accordance with the Texas Health and Safety Code[~~,~~] Chapter 242.

(45) NF comprehensive care plan--A comprehensive care plan, defined in 40 TAC §19.2703(3).

(46) [~~(42)~~] NF [~~Nursing facility~~] PASRR support activities--Actions a NF [~~Consistent with 40 TAC §19.2703, actions a nursing facility~~] takes in coordination with a LIDDA, LMHA, or LBHA to facilitate the successful provision of an IHSS [~~IDD habilitative specialized service~~] or MI specialized service, including:

(A) arranging transportation for a NF [~~nursing facility~~] resident to participate in an IHSS [~~IDD habilitative specialized service~~] or a MI specialized service outside the facility;

(B) sending a resident to a scheduled IHSS [~~IDD habilitative specialized~~

~~service~~] or MI specialized service with food and medications required by the resident; and

(C) stating in the NF comprehensive care plan an agreement to avoid, when possible, scheduling NF [~~nursing facility~~] services at times that conflict with IHSS [~~IDD habilitative specialized services~~] or MI specialized services.

(47) [~~(43)~~] NF [~~Nursing facility~~] specialized services--The following specialized services available to a resident with ID or DD:

(A) therapy services;

(B) CMWC; and

(C) DME.

(48) [~~(44)~~] PA--Physician assistant [~~Assistant~~]. An individual [~~A person~~] who is licensed as a physician assistant in accordance with Texas Occupations Code[~~,~~] Chapter 204.

(49) [~~(45)~~] PASRR--Preadmission screening and resident review. A federal requirement in 42 CFR Part 483, Subpart C that requires states to prescreen all individuals seeking admission to a Medicaid-certified NF for ID, DD, and MI.

(50) PCRP--Person-centered recovery plan. For a resident with MI, the PCRP identifies the services and supports that are needed to:

(A) meet the resident with MI's needs;

(B) achieve the desired outcomes; and

(C) maximize the resident with MI's ability to live successfully in the most integrated setting possible.

(51) [~~(46)~~] PE--PASRR level II evaluation. A face-to-face evaluation:

(A) of an individual seeking admission to a NF [~~nursing facility~~] who is suspected of having MI, ID, or DD; and

(B) performed by a LIDDA, LMHA [~~LHMA~~], or LBHA to determine if the individual has MI, ID, or DD and, if so, to:

(i) assess the individual's need for care in a NF [~~nursing facility~~];

(ii) assess the individual's need for specialized services; and

(iii) identify alternate placement options.

(52) [~~(47)~~] Physician--An individual [~~A person~~] who is licensed to practice medicine [~~as a physician~~] in accordance with Texas Occupations Code[~~,~~] Chapter 155.

(53) [~~(48)~~] PL1--PASRR level I screening. The process of screening an individual

seeking admission to a NF [~~nursing facility~~] to identify whether the individual is suspected of having MI, ID, or DD.

(54) Plan of care--A written plan that includes:

(A) the IHSS required by the NF baseline care plan or NF comprehensive care plan;

(B) the frequency, amount, and duration of each IHSS to be provided for the designated resident during a plan year; and

(C) the services and supports to be provided for the designated resident through resources other than PASRR.

(55) [~~(49)~~] Preadmission process--A category of NF [~~nursing facility~~] admission:

(A) from a community setting, such as a private home, an assisted living facility, a group home, a psychiatric hospital, or jail, but not an acute care hospital or another NF [~~nursing facility~~]; and

(B) that is not an expedited admission or an exempted hospital discharge.

(56) [~~(50)~~] QIDP--Qualified intellectual disability professional. An individual [~~A person~~] who meets the qualifications described in 42 CFR §483.430(a).

(57) [~~(51)~~] QMHP-CS--Qualified mental health professional-community services. An individual [~~A person~~] who meets the qualifications of a QMHP-CS as defined in §301.303 of this title [~~25 TAC §412.303~~] (relating [~~related~~] to Definitions).

(58) [~~(52)~~] Referring entity--The entity that refers an individual to a NF [~~nursing facility~~], such as a hospital, attending physician, LAR or other personal representative selected by the individual, a family member of the individual, or a representative from an emergency placement source, such as law enforcement.

(59) [~~(53)~~] Resident--An individual who resides in a NF [~~nursing facility and receives services provided by professional nursing personnel of the facility~~].

(60) [~~(54)~~] Resident review--A face-to-face evaluation of a resident performed by a LIDDA, LMHA, or LBHA:

(A) for a resident whose PE is positive for [~~with~~] MI, ID, or DD who experienced a significant change in condition [~~status~~], to:

(i) assess the resident's need for continued care in a NF [~~nursing facility~~];

(ii) assess the resident's need for specialized services; and

(iii) identify alternate placement options; and

(B) for a resident suspected of having MI, ID, or DD, to determine whether the resident has MI, ID, or DD and, if so:

(i) assess the resident's need for continued care in a NF [~~nursing facility~~];

(ii) assess the resident's need for specialized services; and

(iii) identify alternate placement options.

(61) Resident with MI--An individual:

(A) who is a resident of a NF;

(B) whose PE or resident review is positive for MI;

(C) who is at least 18 years of age; and

(D) who is a Medicaid recipient.

(62) [~~(55)~~] Respite--Services provided on a short-term basis to an individual [~~a person~~] because of the absence of or the need for relief by the individual's [~~person's~~] unpaid caregiver for a period not to exceed 14 days.

(63) [~~(56)~~] RN--Registered nurse. An individual [~~A person~~] licensed to practice professional nursing as a registered nurse in accordance with Texas Occupations Code[~~,~~] Chapter 301.

(64) [~~(57)~~] Service coordination--Assistance in accessing medical, social, educational, and other appropriate services and supports, including alternate placement assistance, that will help an individual to [~~a person~~] achieve a quality of life and community participation acceptable to the individual [~~person~~] and LAR on the individual's [~~person's~~] behalf.

(65) [~~(58)~~] Service coordinator--An employee of a LIDDA who provides service coordination.

(66) Service provider agency--An entity that has a contract with HHSC to provide IHSS for a designated resident.

(67) [~~(59)~~] Severe physical illness--An illness resulting in ventilator dependence or a diagnosis, such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, or congestive heart failure, that results in a level of impairment so severe that the individual could not be expected to benefit from specialized services.

(68) Significant change in condition--Consistent with 40 TAC §19.801(2)(C)(ii), when a resident experiences a major decline or improvement in the resident's status that:

(A) will not normally resolve itself without further intervention by NF staff or by implementing standard disease-related clinical interventions;

(B) has an impact on more than one area of the resident's health status; and

(C) requires review or revision of the NF comprehensive care plan, or both.

(69) [~~(60)~~] Specialized services--The following support services, other than NF

[~~nursing facility~~] services, that are identified through the PE or resident review and may be provided to a resident who has a PE or resident review that is positive for MI, ID, or DD:

(A) NF [~~nursing facility~~] specialized services;

(B) IHSS [~~IDD habilitative specialized services~~]; and

(C) MI specialized services.

(70) [~~(61)~~] SPT--Service planning team. A team convened by a LIDDA staff person that develops, reviews, and revises the HSP and the transition plan for a designated resident.

(A) The team must include:

(i) the designated resident;

(ii) the designated resident's LAR, if any;

(iii) the habilitation coordinator for discussions and service planning related to specialized services or the service coordinator for discussions related to transition planning if the designated resident is transitioning to the community;

(iv) the MCO service coordinator, if the designated resident does not object;

(v) while the designated resident is in a NF [~~nursing facility~~]:

(I) a NF [~~nursing facility~~] staff person familiar with the designated resident's needs; and

(II) an individual [~~a person~~] providing a specialized service for [~~to~~] the designated resident or a representative of a provider agency that is providing specialized services for the designated resident;

(vi) if the designated resident is transitioning to the community:

(I) a representative from the community program provider, if one has been selected; and

(II) a relocation specialist; and

(vii) a representative from the LMHA or LBHA, if the designated resident's PE is positive for [~~resident has~~] MI.

(B) Other participants on the SPT may include:

(i) a concerned person whose inclusion is requested by the designated resident or the LAR; and

(ii) at the discretion of the LIDDA, an individual [~~a person~~] who is directly involved in the delivery of services for people with ID or DD.

(71) Supported employment--An IHSS that:

(A) is assistance provided for a designated resident:

(i) who requires intensive, ongoing support to be self-employed, work from the designated resident's residence, or work in an integrated community setting at which people without disabilities are employed; and

(ii) to sustain competitive employment in an integrated community setting; and

(B) consists of:

(i) making employment adaptations, supervising, and providing training related to the designated resident's assessed needs;

(ii) transporting the designated resident between the NF and the site where the supported employment services are provided and as necessary to support the designated resident to be self-employed, work from the designated resident's residence, or work in an integrated community setting; and

(iii) participating in SPT and IDT meetings.

[~~(62) Supported employment--Assistance to sustain competitive employment for a person who, because of a disability, requires intensive, ongoing support to be self-employed, work from the person's residence, or perform in a work setting at which persons without disabilities are employed. Assistance consists of the following activities:~~

~~(A) making employment adaptations, supervising, and providing training related to the person's assessed needs;~~

~~(B) transporting the person to support the person to be self-employed, work from the person's residence, or perform in a work setting; and~~

~~(C) participating in SPT meetings.~~]

(72) [~~(63)~~] Surrogate decision maker--An actively involved family member of a resident who has been identified by an IDT in accordance with Texas Health and Safety Code[~~,~~] §313.004 and who is available and willing to consent to medical treatment on behalf of the resident.

(73) [~~(64)~~] Terminal illness--A medical prognosis that an individual's life expectancy is six months or less if the illness runs its normal course and that is documented by a physician's certification in the individual's medical record maintained by a NF [~~nursing facility~~].

(74) [~~(65)~~] Therapy services--In accordance with 40 TAC §19.2703(46) [~~§19.2703~~], assessment and treatment to help a designated resident learn, keep, or improve skills and functioning of daily living affected by a disabling condition. Therapy services are referred to as habilitative therapy services. Therapy services

are limited to:

(A) physical therapy;

(B) occupational therapy; and

(C) speech therapy.

(75) [~~(66)~~] Transition plan--A plan developed by the SPT or MI quarterly meeting attendees that describes the activities, timetable, responsibilities, services, and essential supports involved in assisting a designated resident or resident with MI to transition from residing in a NF [~~nursing facility~~] to living in the community.

(76) Uniform assessment--The HHSC-approved uniform assessment tool for adult mental health services.

§303.103. Fair Hearing Process for PASRR Determination and Specialized Services.

(a) An individual seeking admission to a NF, a resident, or an individual's or resident's LAR may request a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules) to appeal:

(1) a PE that is negative for ID, DD, or MI;

(2) a denial of a specialized service; or

(3) the reduction, suspension, or termination of an IHSS or MI specialized service.

(b) If the hearing officer reverses a denial, reduction, or termination of a specialized service, the LIDDA, the LMHA, the LBHA, the service provider agency, or the NF, as applicable, must ensure the provision of the specialized service.

[~~§303.103. Fair Hearing Process.~~]

[~~An individual seeking admission to a nursing facility, a resident, or an individual's or resident's LAR who is not in agreement with a denial of specialized services because the individual or resident does not have a diagnosis of ID or DD, in accordance with 42 CFR §483.102(b)(3)(i) and (ii), or a diagnosis of MI in accordance with 42 CFR §483.102(b)(1), may request a fair hearing to appeal the denial in accordance with 1 TAC Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules). If the hearing officer reverses a denial of specialized services, the LIDDA, the LMHA, the LBHA, or the nursing facility, as applicable, must ensure the provision of the specialized services.~~]

TITLE 26 HEALTH AND HUMAN SERVICES
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CHAPTER 303 PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER B PASRR SCREENING AND EVALUATION PROCESS

§303.201. Preadmission Process.

(a) A referring entity must complete a PL1 when an individual is seeking admission into a NF [~~nursing facility~~] through the preadmission process, and:

(1) if the PL1 indicates the individual is suspected of having MI, ID, or DD:

(A) must notify the LIDDA, LMHA, or LBHA, as applicable; and

(B) must provide a copy of the PL1 to the LIDDA, LMHA, or LBHA, as applicable; and

(2) if the PL1 indicates the individual is not suspected of having MI, ID, or DD, must provide a copy of the completed PL1 to the NF [~~nursing facility~~].

(b) If a LIDDA, LMHA, or LBHA is provided a copy of a PL1 in accordance with subsection (a)(1)(B) of this section, the LIDDA, LMHA, or LBHA must:

(1) complete a PE in accordance with §303.302(a)(2) of this chapter (relating to LIDDA, LMHA, and LBHA Responsibilities Related to the PASRR Process);

(2) comply with §303.302(b) and (c) of this chapter; and

(3) make reasonable efforts to arrange for available community services and supports in the least restrictive setting to avoid NF [~~nursing facility~~] admission, if the individual seeking admission to a NF [~~nursing facility~~], or the individual's LAR on the individual's behalf, wants to remain in the community.

§303.202. Expedited Admission Process.

If the LTC online portal generates a notice to the LIDDA, LMHA, or LBHA that an individual suspected of having MI, ID, or DD is being admitted to a NF [~~nursing facility~~] through the expedited admission process [~~is suspected of having MI, ID, or DD~~], the LIDDA, LMHA, or LBHA, as applicable, must:

(1) complete a PE or resident review in accordance with §303.302(a)(2) of this chapter (relating to LIDDA, LMHA, and LBHA Responsibilities Related to the PASRR Process); and

(2) comply with §303.302(b) and (c) of this chapter.

§303.203. Admission Process for Exempted Hospital Discharge.

A LIDDA, LMHA, or LBHA must conduct a resident review in accordance with §303.204 of this subchapter (relating to Resident Review Process) for a resident of a NF [~~nursing facility~~] admitted through an exempted hospital discharge process if:

(1) the resident's stay in the NF [~~nursing facility~~] has exceeded 30 days; and

(2) the resident's PL1 indicates the resident is suspected of having MI, ID, or DD.

§303.204. Resident Review Process.

(a) The LTC online portal generates an automated notification to a LIDDA, LMHA, or LBHA that a resident review must be completed if:

(1) a resident with MI, ID, or DD experiences a significant change in condition as defined in §303.102 of this chapter (relating to Definitions) [~~status as determined by the MDS Significant Change in Status Assessment Form~~]; or

(2) a resident suspected of having MI, ID, or DD:

(A) was admitted as an exempted hospital discharge and has exceeded the allowed 30-day stay in the NF [~~nursing facility~~]; or

(B) is determined by a NF [~~nursing facility~~] or HHSC to need a resident review for any other reason.

(b) A LIDDA, LMHA, or LBHA that receives an automated notification in accordance with subsection (a) of this section must:

(1) complete a resident review in accordance with §303.302(a)(2) of this chapter (relating to LIDDA, LMHA, and LBHA Responsibilities Related to the PASRR Process); and

(2) comply with §303.302(b) and (c) of this chapter.

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 303 PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER C RESPONSIBILITIES

§303.301. Referring Entity Responsibilities Related to the PASRR Process.

(a) A referring entity must:

(1) complete the PL1 for an individual seeking admission into a NF [~~nursing facility~~];

(2) contact a NF [~~nursing facility~~] selected by the individual or LAR to notify the NF [~~nursing facility~~] of the individual's interest in admission; and

(3) provide the completed PL1 as follows:

(A) to the NF [~~nursing facility~~] selected by the individual or LAR:

(i) for an individual who is being admitted through an expedited admission or an exempted hospital discharge; or

(ii) for an individual who is being admitted through a preadmission process and is not suspected of having MI, ID, or DD; and

(B) to the LIDDA, LMHA, or LBHA, as applicable, for an individual who is suspected of having MI, ID, or DD, and is being admitted through a preadmission process.

(b) If a referring entity is a family member, LAR, other personal representative selected by the individual, or a representative from an emergency placement source, the referring entity may request assistance from the NF [~~nursing facility~~], LIDDA, LMHA, or LBHA in completing the PL1.

§303.302. LIDDA, LMHA, and LBHA Responsibilities Related to the PASRR Process.

(a) A LIDDA, LMHA, or LBHA, as applicable, must:

(1) enter in the LTC online portal the data from a PL1 completed by a referring entity in accordance with §303.201(a)(1) of this chapter (relating to Preadmission Process) for an individual who is suspected of having MI, ID, or DD and who is seeking admission to a NF [~~nursing facility~~] through the preadmission process; [~~and~~]

(2) complete a PE or resident review as follows:

(A) within 72 hours after receiving a copy of the PL1 from the referring entity in accordance with §303.201(a)(1)(B) of this chapter or notification from the LTC online portal in accordance with §303.202 or §303.204(a) of this chapter (relating to Expedited Admission Process and Resident Review Process, respectively):

(i) call the referring entity or NF [~~nursing facility~~] to schedule the PE or

resident review; and

(ii) meet face-to-face with the individual or resident at the referring entity or NF [~~nursing facility~~] to gather information to complete the PE or resident review; and

(B) within seven days after receiving a copy of the PL1 from the referring entity or notification from the LTC online portal:

(i) complete the PE or resident review by:

(I) reviewing the individual's or resident's:

(-a-) medical records;

(-b-) relevant service records, including those available in online databases, such as the Client Assignment and Registration (CARE) system, Clinical Management for Behavioral Health Services (CMBHS), and LTC online portal; and

(-c-) previous PEs, service plans, and assessments from other LIDDAs, LMHAs, or LBHAs;

(II) meeting face-to-face with the individual's or resident's LAR or communicating with the LAR by telephone if the LAR is not able to meet face-to-face;

(III) communicating with a collateral contact as necessary;

(IV) providing information to the individual seeking admission or resident and the individual's or resident's LAR, if any, about community services, supports, and programs for which the individual or resident may be eligible; and

(V) obtaining additional information as needed; and

(ii) enter the data from the PE or resident review in the LTC online portal; and[~~.~~]

(3) within three business days after entering the data from the PE or resident review in the LTC online portal:

(A) if the PE or resident review is positive for MI, ID, or DD, provide the individual seeking admission or resident or the individual's or resident's LAR with a summary of the results of the PE or resident review, using HHSC forms; or

(B) if the PE or resident review is negative for MI, ID, or DD, provide the individual seeking admission or resident or the individual's or resident's LAR notice of the right to a fair hearing, using HHSC forms.

(b) If an individual seeking admission to a NF [~~nursing facility~~] or a resident has a PE or resident review that is positive for ID, DD, or MI and a NF [~~nursing facility~~] certifies in the LTC online portal that it cannot meet the needs of the individual or resident, then the LIDDA, LMHA, or LBHA, as applicable, must assist the individual,

resident, or LAR in choosing another NF [~~nursing facility~~] that will certify it can meet the needs of the individual or resident.

(c) If an individual seeking admission to a NF [~~nursing facility~~] or a resident has a PE or resident review that is positive for ID, DD, or MI and a NF [~~nursing facility~~] certifies in the LTC online portal that it can meet the needs of the resident or certifies in the LTC online portal that it can meet the needs of the individual and admits the individual, the LIDDA, LMHA or LBHA, as applicable, must:

(1) coordinate with the NF [~~nursing facility~~] to schedule an IDT meeting to discuss specialized services; [:]

[~~(A) for a PE, within 14 days after admission; or~~

~~(B) for a resident review, within 14 days after the LTC online portal generated an automated notification to the LIDDA, LMHA, or LBHA;~~]

(2) participate in the resident's IDT meeting as scheduled by the NF [~~nursing facility~~] to, in collaboration with the other members of the IDT:

(A) identify which of the specialized services recommended for the resident that the resident, or LAR on the resident's behalf, wants to receive;

(B) identify the NF [~~nursing facility~~] PASRR support activities for the resident; and

(C) determine whether the resident is best served in a facility or community setting;

(3) within five business days after receiving notification from the LTC online portal that the NF [~~nursing facility~~] entered information from the IDT meeting, confirm the LIDDA's, LMHA's, or LBHA's participation in the meeting and the specialized services recommended [~~that the following information is~~] in the LTC online portal [~~, in accordance with HHSC instructions:~~]

[~~(A) the LIDDA, LMHA, or LBHA representative who participated in the IDT meeting; and~~

~~(B) all specialized services that were agreed to in the IDT meeting~~]; and

(4) if Medicaid or other funding is available:

(A) initiate [~~IDD habilitative specialized services or~~] MI specialized services within 20 business days after the date of the IDT meeting; and

(B) provide the [~~IDD habilitative specialized services or~~] MI specialized services agreed upon in the IDT meeting to the resident.

(d) The LIDDA, LMHA, or LBHA must develop a written policy that describes the process the LIDDA, LMHA, or LBHA will follow to address challenges related to the designated resident's, resident with MI's, or LAR's participation in receiving IHSS or MI specialized services.

(e) The LIDDA must ensure that a designated resident or LAR is informed orally and in writing of the processes for filing complaints as follows:

(1) the telephone number of the LIDDA to file a complaint;

(2) the telephone number of the IDD Ombudsman to file a complaint about the LIDDA;

(3) the telephone number of Complaint and Incident Intake to file a complaint about IHSS or the NF;

(4) the telephone number of DFPS Statewide Intake to report an allegation of abuse, neglect, or exploitation; and

(5) the telephone number of the Long-Term Care Ombudsman to file a complaint that relates to action, inaction, or a decision by any individual or entity who provides care or makes decisions related to a designated resident, that may adversely affect the health, safety, welfare, or rights of the designated resident.

(f) The LMHA or LBHA must ensure that a resident with MI or LAR is informed orally and in writing of the processes for filing complaints as follows:

(1) the telephone number of the LMHA or LBHA to file a complaint;

(2) the telephone number of the Ombudsman for Behavioral Health to file a complaint about MI specialized services or about an LMHA or LBHA;

(3) the telephone number of Complaint and Incident Intake to file a complaint about the NF;

(4) the telephone number of DFPS Statewide Intake to report an allegation of abuse, neglect, or exploitation; and

(5) the telephone number of the Long-Term Care Ombudsman to file a complaint that relates to action, inaction, or a decision by any individual or entity who provides care or makes decisions related to a resident with MI, that may adversely affect the health, safety, welfare, or rights of the resident with MI.

(g) If an individual seeking admission to a NF or a resident has a PE or resident review that is positive for MI and ID or MI and DD, the LIDDA is responsible for coordinating with the NF to schedule the IDT meeting to discuss specialized services.

§303.303. Qualifications and Requirements for Staff Person Conducting a PE or Resident Review.

(a) A LIDDA must ensure a PE or resident review is conducted by an individual [~~a person~~] who:

(1) is a QIDP; or

(2) has one of the following qualifications and at least one year of experience

working directly with individuals [~~persons~~] with ID [~~intellectual disability~~] or DD [~~other developmental disabilities~~]:

(A) RN;

(B) LCSW;

(C) LPC;

(D) LMFT;

(E) Licensed Psychologist;

(F) APRN; or

(G) Physician.

(b) An LMHA or LBHA must ensure a PE or resident review is conducted by an individual [~~a person~~] who is a:

(1) QMHP-CS; or

(2) has one of the following qualifications and at least one year of experience working directly with individuals with MI:

(A) [~~(2)~~] RN;

(B) [~~(3)~~] LCSW;

(C) [~~(4)~~] LPC;

(D) [~~(5)~~] LMFT;

(E) [~~(6)~~] Licensed Psychologist;

(F) [~~(7)~~] APRN;

(G) [~~(8)~~] Physician; or

(H) [~~(9)~~] PA.

(c) A LIDDA, LMHA, and LBHA must:

(1) before a staff person conducts a PE or resident review, ensure the staff person:

(A) receives HHSC-developed training about how to conduct a PE and resident review; and

(B) demonstrates competency in completing a PE and resident review; and

(2) maintain documentation of the training received by a staff person who conducts a PE or resident review.

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SUBCHAPTER D VENDOR PAYMENT

§303.401. Reimbursement for a PE or Resident Review.

(a) A LIDDA, LMHA, or LBHA must accept the reimbursement rate established by HHSC as payment in full for the following activities:

(1) completing a PE or resident review in accordance with §303.302(a)(2) of this chapter (relating to LIDDA, LMHA, and LBHA Responsibilities Related to the PASRR Process);

(2) assisting an individual who is seeking admission to a NF [~~nursing facility~~], or a resident with MI, ID, or DD, or the individual's or resident's LAR in choosing another NF [~~a nursing facility~~] that will certify it can meet the needs of the individual or resident as described in §303.302(b) of this chapter;

(3) participating in the resident's IDT meeting; and

(4) confirming in the LTC online portal the information required by §303.302(c)(3) of this chapter.

(b) The reimbursement rate for the activities described in subsection (a) of this section includes travel costs associated with the activities. HHSC does not pay any additional amounts for travel. A LIDDA, LMHA, or LBHA must not request reimbursement for travel time or travel costs associated with the activities described in subsection (a) of this section.

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SUBCHAPTER E HABILITATION COORDINATION

§303.501. Qualifications of a Habilitation Coordinator.

A habilitation coordinator must:

(1) be an employee of a LIDDA;

(2) have a bachelor's or advanced degree from an accredited college or university with a major in a social, behavioral, or human service field, such as psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education, or criminal justice; and

(3) have at least one year of experience working directly with individuals with ID or DD [~~intellectual or other developmental disabilities~~].

§303.502. Required Training for a Habilitation Coordinator.

(a) A LIDDA must ensure a habilitation coordinator completes the following training before providing habilitation coordination:

(1) training that addresses:

(A) appropriate LIDDA policies, procedures, and standards;

(B) this chapter, [~~and~~] other HHSC rules relating to the provision of specialized services, and other HHSC rules affecting the LIDDA;

(C) HHSC's IDD PASRR Handbook;

(D) developing and implementing an HSP;

(E) conducting assessments, service planning, coordination, and monitoring;

(F) providing crisis prevention and management;

(G) community support services;

(H) [~~(G)~~] presenting community living options using HHSC-developed materials and forms, and offering educational opportunities and informational activities about community living options;

(I) [~~(H)~~] arranging visits to community providers;

(J) [~~(I)~~] accessing specialized services for a designated resident;

(K) [~~(J)~~] the rights of an individual [~~a person~~] with an ID [~~intellectual disability~~], including the right to live in the least restrictive setting appropriate to the person's individual needs and abilities and in a variety of living situations, as

described in the Persons with an Intellectual Disability Act, Texas Health and Safety Code[~~,~~] Chapter 592 and in an HHSC-developed rights handbook [~~the *Your Rights in Local Authority Services* booklet~~]; and

(L) [~~(K)~~] advocacy for individuals with ID or DD;

(2) person-centered thinking training [~~approved by HHSC~~]; and

(3) all HHSC-developed training related to PASRR.

(b) A LIDDA must:

(1) ensure a habilitation coordinator demonstrates competency in providing habilitation coordination; and

(2) maintain documentation of the training received by habilitation coordinators.

§303.504. Documentation Maintained by a LIDDA in a Designated Resident's Record.

(a) A LIDDA must ensure a habilitation coordinator maintains the following documentation in a designated resident's record:

(1) all assessments used for service planning;

(2) all documentation of habilitation coordination contacts as described in §303.503(a) of this chapter (relating to Documenting Habilitation Coordination Contacts);

(3) documentation related to monitoring specialized services, including:

(A) the initiation and delivery of all specialized services provided for [~~to~~] the designated resident, including reasons for delays and all follow-up activities;

(B) the designated resident's and LAR's satisfaction with all specialized services; and

(C) the designated resident's progress or lack of progress toward achieving goals and outcomes identified in the HSP, including whether the designated resident is maintaining progress toward achieving goals and outcomes from the designated resident's and LAR's perspectives;

(4) the current NF comprehensive care plan;

(5) the current HSP;

(6) all documents and forms used to:

(A) identify the designated resident's need for specialized services; and

(B) conduct SPT meetings, including written reports from SPT members who are providers of specialized services and completed forms related to assessing for habilitative needs;

(7) the completed HHSC forms that document discussions with the designated resident and LAR about the range of community living options and alternative services and supports available [~~services, supports, and alternatives~~]; [~~and~~]

(8) all pertinent information related to the designated resident, such as guardianship paperwork and consents;[~~.~~]

(9) the current plan of care; and

(10) an implementation plan for each IHSS that appears on the plan of care.

(b) For a designated resident who has refused habilitation coordination, a LIDDA must maintain the following documentation in a designated resident's record:

(1) all [~~the~~] completed *Refusal of Habilitation Coordination* forms [~~form~~];

(2) documentation of the specialized services discussed in the initial IDT and any SPT or IDT [~~annual~~] specialized services review meeting; and

(3) the completed HHSC forms that document discussions with the designated resident and LAR about the range of community living options and alternative services and supports available [~~services, supports, and alternatives~~].

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SUBCHAPTER F HABILITATIVE SERVICE PLANNING FOR A DESIGNATED RESIDENT

§303.601. Habilitation Coordination for a Designated Resident.

(a) A LIDDA must assign a habilitation coordinator to each designated resident to attend the initial IDT and provide habilitation coordination while the designated resident is residing in the NF [~~nursing facility~~]. A designated resident may refuse habilitation coordination.

(b) Unless a designated resident has refused habilitation coordination, the assigned habilitation coordinator must:

(1) assess and reassess quarterly, and as needed, the designated resident's habilitative service needs by gathering information from the designated resident and other appropriate sources, such as the LAR, family members, social workers, and service providers, to determine the designated resident's habilitative needs and preferences and the specialized services that will address those needs and preferences;

(2) develop and revise, as needed, an individualized HSP in accordance with HHSC's rules and IDD PASRR Handbook, and using HHSC forms;

(3) assist the designated resident to access needed specialized services agreed upon in an IDT or SPT meeting, including:

(A) monitoring to determine if a specialized service agreed upon in an IDT or SPT meeting is requested within required timeframes in accordance with the IDD PASRR Handbook [~~20 business days after the IDT or SPT meeting~~] or documenting delays and the habilitation coordinator's follow-up activities; and

(B) ensuring the delivery of all specialized services agreed upon in an IDT or SPT meeting or documenting delays and the habilitation coordinator's follow-up activities;

(4) coordinate other habilitative programs and services that can address needs and achieve outcomes identified in the HSP;

(5) facilitate the coordination of the designated resident's HSP and NF [~~the~~] comprehensive care plan, including ensuring the HSP is shared with members of the SPT within 10 calendar days after the HSP is updated or renewed [~~and the nursing facility~~];

(6) monitor and provide follow-up activities that consist of:

(A) monitoring the initiation and delivery of all specialized services agreed upon in an IDT or SPT meeting and following up when delays occur;

(B) monitoring the designated resident's and LAR's satisfaction with all

specialized services; [~~and~~]

(C) determining the designated resident's progress or lack of progress toward achieving goals and outcomes identified in the HSP; and

(D) determining the designated resident's progress or lack of progress toward achieving goals and outcomes identified in the HSP from the designated resident's and LAR's perspectives;

(7) unless waived by HHSC, meet face-to-face with the designated resident to provide habilitation coordination:

(A) at least monthly or more frequently if needed; or

(B) at least quarterly if the only specialized service the designated resident is receiving is habilitation coordination;

(8) convene and facilitate an SPT meeting at least quarterly, or more frequently if there is a change in service needs or [~~,~~] medical condition, or if requested by the designated resident or LAR;

(9) coordinate with the NF in accessing medical, social, educational, and other appropriate services and supports that will help the designated resident achieve a quality of life acceptable to the designated resident and LAR on the resident's behalf;

(10) initially and annually thereafter:

(A) provide the designated resident and LAR an oral and written explanation of the designated resident's rights in accordance with the IDD PASRR Handbook; and

(B) inform the designated resident and LAR both orally and in writing of all the services available and requirements pertaining to the designated resident's participation;

(11) for a designated resident who has a guardian, determine at least annually if the letters of guardianship are current; and

(12) if appropriate, for a designated resident who does not have a guardian, ensure the SPT discusses whether the designated resident would benefit from a less restrictive alternative to guardianship or from guardianship and make appropriate referrals.

(c) Regardless of whether the designated resident is receiving or has refused habilitation coordination, the habilitation coordinator must:

(1) [~~(9)~~] address community living options with the designated resident and LAR by:

(A) offering the educational opportunities and informational activities about community living options that are periodically scheduled by the LIDDA;

(B) providing information about the range of community living services, supports, and alternatives, identifying the services and supports the designated resident will need to live in the community, and identifying and addressing barriers to community living in accordance with HHSC's IDD PASRR Handbook and using HHSC materials at the following times:

(i) six months after the initial presentation of community living options during the PE described in §303.302(a)(2)(B)(i) of this Chapter (relating to LIDDA, LMHA, and LBHA Responsibilities Related to the PASRR Process) and at least every six months thereafter, but no more than 30 days before a scheduled quarterly SPT meeting;

(ii) when requested by the designated resident or LAR;

(iii) when the habilitation coordinator is notified or becomes aware that the designated resident, or the LAR on the designated resident's behalf, is interested in speaking with someone about transitioning to the community; and

(iv) when notified by HHSC that the designated resident's response in Section Q of the MDS Assessment indicates the resident is interested in speaking with someone about transitioning to the community; and

(C) arranging visits to community providers and addressing concerns about community living;

[~~(10) coordinate with the nursing facility in accessing medical, social, educational, and other appropriate services and supports that will help the designated resident achieve a quality of life acceptable to the designated resident and LAR on the resident's behalf; and~~]

[~~(11) initially and annually thereafter, provide the designated resident and LAR an oral and written explanation of the designated resident's rights contained in the *Your Rights in Local Authority Services* booklet.~~]

(2) annually assess the designated resident's habilitative service needs by gathering information from the designated resident and other appropriate sources, such as the LAR, family members, social workers, and service providers, to determine the designated resident's habilitative needs and preferences.

§303.602. Service Planning Team Responsibilities Related to Specialized Services.

(a) The SPT for a designated resident must:

(1) meet at least quarterly, as convened by the habilitation coordinator;

(2) ensure that the designated resident, regardless of whether he or she has an LAR, participates in the SPT to the fullest extent possible and receives the support necessary to do so, including communication supports;

(3) develop an HSP for the designated resident;

(4) review and monitor identified risk factors, such as choking, falling, and skin breakdown, and report to the proper authority if they are not addressed;

(5) make timely referrals, service changes, and revisions to the HSP as needed; [~~and~~]

(6) considering the designated resident's preferences, monitor to determine if the designated resident is provided opportunities for engaging in integrated activities:

(A) with residents who do not have ID or DD; and

(B) in community settings with people who do not have a disability; and

(7) develop the plan of care for IHSS.

(b) Each member of the SPT for a designated resident must:

(1) consistent with the SPT member's role, assist the habilitation coordinator in ensuring the designated resident's needs are being met; and

(2) participate in an SPT meeting in person or by phone, except as described in subsections (c)(3) or (e) of this section;

(c) An SPT member who is a provider of a specialized service must:

(1) submit to the habilitation coordinator a copy of all assessments of the designated resident that were completed by the provider or provider agency;

(2) submit a written report describing the designated resident's progress or lack of progress to the habilitation coordinator at least five days before a quarterly SPT meeting; and

(3) actively participate in an SPT meeting, in person or by phone, unless the habilitation coordinator determines active participation by the provider is not necessary.

(d) If a habilitation coordinator determines active participation by a provider is not necessary as described in subsection (c)(3) of this section, the habilitation coordinator must:

(1) base the determination:

(A) on the information in the written report submitted in accordance with subsection (c)(2) of this section; and

(B) on the needs of the SPT; and

(2) document the reasons for exempting participation.

(e) A habilitation coordinator must facilitate a quarterly SPT meeting in person.

§303.603. Habilitation Coordination for a Designated Resident Receiving IHSS.

(a) The habilitation coordinator must:

(1) facilitate the coordination of the designated resident's plan of care, including ensuring the plan of care is shared with members of the SPT within 10 calendar days after the plan of care is developed, updated, or renewed;

(2) assist a designated resident, LAR, or actively involved person in exercising the legal rights of the designated resident as a citizen and as a person with a disability, including protection of rights and options to avoid unnecessary rights restrictions;

(3) provide a designated resident, LAR, or family member with a written and oral explanation of the rights of a designated resident receiving IHSS;

(4) document the explanation of rights required by paragraph (3) of this subsection and ensure that the documentation is signed by:

(A) the designated resident or LAR; and

(B) the habilitation coordinator;

(5) immediately notify the NF and service provider agency if the habilitation coordinator becomes aware of an emergency that impacts the designated resident’s health or safety;

(6) be objective in assisting a designated resident or LAR in selecting a service provider agency;

(7) ensure that a designated resident, LAR, and service provider agency are informed of the name of the designated resident’s habilitation coordinator and how to contact the habilitation coordinator; and

(8) give the service provider agency a copy of the NF baseline care plan or NF comprehensive care plan, whichever is most current.

(b) If the habilitation coordinator identifies a concern with the implementation of the plan of care, the habilitation coordinator must ensure the concern is communicated to the service provider agency and attempts are made to resolve the concern.

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SUBCHAPTER G TRANSITION PLANNING

§303.701. Transition Planning for a Designated Resident.

(a) A LIDDA must assign a service coordinator for [~~to~~] a designated resident if the designated resident, or the LAR on the designated resident's behalf, expresses an interest in moving to the community and has selected a community program.

(b) A service coordinator must facilitate the development, revisions, implementation, and monitoring of a transition plan in accordance with HHSC's IDD PASRR Handbook and using HHSC forms. A transition plan must identify the services and supports a designated resident needs to live in the community, including those essential supports that are critical to the designated resident's health and safety.

(c) The SPT for a designated resident must:

(1) meet as convened by the service coordinator;

(2) ensure that the designated resident, regardless of whether he or she has an LAR, participates in the SPT to the fullest extent possible and receives the support necessary to do so, including communication supports; and

(3) conduct transition planning activities and develop a transition plan for the designated resident.

(d) Consistent with an SPT member's role, each SPT member must:

(1) assist the service coordinator in developing, revising, implementing, and monitoring a designated resident's transition plan to ensure a successful transition to the community for the designated resident; and

(2) participate in an SPT meeting in person or by phone, except as described in subsections (e) or (g) of this section.

(e) An SPT member who is a provider of a specialized service must actively participate in an SPT meeting, in person or by phone, unless the service coordinator determines active participation by the provider is not necessary.

(f) If a service coordinator determines active participation by a provider is not necessary as described in subsection (e) of this section, the service coordinator must:

(1) base the determination on the needs of the SPT; and

(2) document the reasons for exempting participation.

(g) At an SPT meeting convened by a service coordinator, the service coordinator must facilitate the SPT meeting in person.

(h) For a designated resident who is transitioning to the community, a service coordinator must, in accordance with HHSC's IDD PASRR Handbook and using HHSC forms, conduct and document a pre-move site review of the designated resident's proposed residence in the community to determine whether all essential supports in the designated resident's transition plan are in place before the designated resident's transition to the community.

(i) If the SPT makes a recommendation that a designated resident continue to reside in a NF [~~nursing facility~~], the SPT must:

(1) document the reasons for the recommendation; and

(2) include in the designated resident's transition plan:

(A) the barriers to moving to a more integrated setting; and

(B) the steps the SPT will take to address those barriers.

§303.703. Requirements for Service Coordinators Conducting Transition Planning.

(a) A LIDDA must ensure that a service coordinator complies with 40 TAC Chapter 2, Subchapter L (relating to Service Coordination for Individuals with an Intellectual Disability), including documenting in the transition plan the frequency and duration of service coordination while the designated resident is in the NF [~~nursing facility~~].

(b) A LIDDA must ensure that a service coordinator who conducts transition planning completes the following training before providing service coordination for [~~to~~] a designated resident:

(1) training that addresses:

(A) this chapter;

(B) HHSC's IDD PASRR Handbook;

[~~(C) the process for making a referral for relocation services, the role of a relocation specialist, and housing options;~~]

(C) [~~(D)~~] the role of a relocation specialist and [~~the~~] MCO service coordinator for a NF [~~nursing facility~~] resident who wants to transition to the community;

(D) [~~(E)~~] services available through Texas Medicaid State Plan and all home and community-based [~~community based~~] services programs for individuals with ID or DD, including but not limited to, access to nursing, durable medical equipment and supplies, and transition assistance supports;

(E) [~~(F)~~] developing and implementing a transition plan for a designated resident;

(F) [~~(G)~~] an overview of [~~presenting~~] community living options, [~~using HHSC-developed materials and forms, and offering~~] educational opportunities, and informational activities about community living options; and

(G) [~~(H)~~] the rights of an individual [~~a person~~] with ID [~~an intellectual disability~~], including the right to live in the least restrictive setting appropriate to the person's individual needs and abilities and in a variety of living situations, as described in the Persons with an Intellectual Disability Act, Texas Health and Safety Code[~~,~~] Chapter 592 and an HHSC-developed rights handbook [~~the *Your Rights in Local Authority Services* booklet~~]; [~~and~~]

(2) person-centered thinking training [~~approved by HHSC~~]; and

(3) all HHSC-developed training related to PASRR.

(c) A LIDDA must:

(1) ensure a service coordinator who conducts transition planning demonstrates competency in conducting transition planning; and

(2) maintain documentation of the training received by service coordinators who conduct transition planning.

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 303 PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER H COMPLIANCE REVIEW

§303.801. [~~LIDDA~~] Compliance Review.

(a) HHSC conducts a compliance review of each LIDDA, LMHA, and LBHA at least annually[~~,~~] to determine if the LIDDA, LMHA, and LBHA are [~~is~~] in compliance with the requirements for a LIDDA, LMHA, and LBHA described in this chapter.

(b) A LIDDA, LMHA, and LBHA must submit to HHSC a plan of correction in accordance with the performance contract for any item of non-compliance. HHSC may take action as specified in the performance contract if a LIDDA, LMHA, or LBHA fails to submit a plan of correction or implement an approved plan of correction.

TITLE 26 HEALTH AND HUMAN SERVICES
PART 1 HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 303 PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER I MI SPECIALIZED SERVICES

§303.901. Description of MI Specialized Services.

(a) The LMHA or LBHA staff must conduct the uniform assessment to determine which level of care the resident with MI will receive.

(b) The following MI specialized services are available to a resident with MI.

(1) Crisis intervention services. Interventions provided in response to a crisis in order to reduce or manage symptoms of MI and to prevent admission of a resident with MI to a more restrictive environment.

(2) Day programs for acute needs. Short term, intensive treatment to a resident with MI who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting.

(3) Medication training and support services. Education and guidance provided to a resident with MI and family members about the resident with MI's medications and their possible side effects as described in §306.315 of this title (relating to Medication Training and Support Services).

(4) Psychiatric diagnostic interview examination. An assessment of a resident with MI that includes relevant past and current medical and psychiatric information and a documented diagnosis by a licensed professional practicing within the scope of his or her license.

(5) Psychosocial rehabilitation services. Social, educational, vocational, behavioral, and cognitive interventions provided by members of a resident with MI's therapeutic team that address deficits in the resident with MI's ability to develop and maintain social relationships, occupational or educational achievement, independent living skills, or housing. Psychosocial rehabilitative services include the following component services:

(A) coordination services;

(B) crisis related services;

(C) employment related services;

(D) housing related services;

(E) independent living services; and

(F) medication related services.

(6) Routine case management. A primarily site-based service to assist a resident with MI or LAR in gaining and coordinating access to necessary care and services appropriate to the resident with MI's needs.

(7) Skills training and development. Training provided to a resident with MI that:

(A) addresses the severe and persistent MI and symptom-related problems that interfere with the resident with MI's functioning;

(B) provides opportunities for the resident with MI to acquire and improve skills needed to function as appropriately and independently as possible in the community; and

(C) facilitates the resident with MI's community integration and increases the resident with MI's community tenure.

§303.902. Eligibility Criteria.

A resident with MI is eligible for MI specialized services funded by Medicaid if the resident with MI requires the provision of at least one MI specialized service.

§303.903. MI Specialized Services Team.

(a) The MI specialized services team must include:

(1) the resident with MI;

(2) the resident with MI's LAR, if any;

(3) the QMHP-CS assigned to the resident with MI;

(4) a representative of the LMHA or LBHA providing the MI specialized services;

(5) the MCO service coordinator, if the resident with MI does not object;

(6) a NF staff person familiar with the resident with MI's needs; and

(7) if the resident with MI is transitioning to the community:

(A) a representative from the community program provider, if one has been selected; and

(B) a relocation specialist.

(b) The MI specialized services team may also include a concerned individual whose inclusion is requested by the resident with MI or the LAR.

§303.904. Qualifications for Conducting the Uniform Assessment.

The LMHA or LBHA staff person administering the uniform assessment must be certified in administering the uniform assessment.

§303.905. Process for Service Initiation.

(a) The LMHA or LBHA must comply with §303.302 of this chapter (relating to LIDDA, LMHA, and LBHA Responsibilities Related to the PASRR Process).

(b) At the initial IDT meeting, the LMHA or LBHA staff participating in the meeting, in conjunction with the IDT, must:

(1) review the MI specialized services recommended on the PE;

(2) explain the uniform assessment;

(3) ensure the resident with MI, or LAR on the resident with MI's behalf, understands the purpose of the uniform assessment; and

(4) have the resident with MI, or LAR on the resident with MI's behalf, agree or decline to receive the uniform assessment and MI specialized services.

(c) Within 20 business days after the IDT meeting, if the resident with MI or LAR agrees, the LMHA or LBHA must:

(1) complete the uniform assessment;

(2) develop the PCRP; and

(3) for a resident with MI only, convene a meeting to discuss the results of the uniform assessment and PCRP, and to determine the MI specialized services the resident with MI will receive.

(d) Attendees at the meeting convened in accordance with subsection (c)(3) of this section must include:

(1) the QMHP-CS who completed the uniform assessment and PCRP;

(2) the resident with MI;

(3) the resident with MI's LAR, if any; and

(4) a NF staff person familiar with the resident with MI's needs.

(e) At the meeting convened in accordance with subsection (c)(3) of this section, the QMHP-CS must ensure the resident with MI, regardless of whether he or she has an LAR, participates in the meeting to the fullest extent possible and receives the support necessary to do so, including communication supports.

(f) The LMHA or LBHA must provide a copy of the completed uniform assessment and PCRP to the NF for inclusion in the resident with MI's NF comprehensive care plan within 10 calendar days after the meeting convened in accordance with subsection (c)(3) of this section.

§303.906. Person-Centered Recovery Plan.

The QMHP-CS, in conjunction with the MI specialized services team, develops, periodically reviews, and revises as needed the PCRP for each resident with MI in accordance with §301.353(e)-(g) of this title (relating to Provider Responsibilities for Treatment Planning and Service Authorization).

§303.907. Renewal and Revision of Person-Centered Recovery Plan.

(a) At least quarterly, the QMHP-CS must convene an MI quarterly meeting to:

(1) review the PCRP to determine whether the MI specialized services previously identified remain relevant; and

(2) determine whether the current uniform assessment accurately reflects the resident with MI's need for MI specialized services in the identified frequency, amount, and duration, or if an updated uniform assessment is required.

(b) The MI specialized services team initiates revisions to the PCRP in response to changes to the needs of the resident with MI.

(1) Any MI specialized services team member may ask the QMHP-CS to convene a meeting at any time to discuss whether a resident with MI's PCRP needs to be revised to add a new MI specialized service or change the frequency, amount, or duration of an existing MI specialized service.

(2) The QMHP-CS must convene a meeting within seven calendar days after learning of the need to revise the resident with MI's PCRP.

(c) If the MI specialized services team agrees to add a new MI specialized service to the PCRP or determines an updated uniform assessment is required, a QMHP-CS must, within seven calendar days after the meeting is held, update the uniform assessment and provide it to the MI specialized services team.

(d) The QMHP-CS must:

(1) document revisions on the PCRP within five calendar days after a team meeting; and

(2) retain the revised PCRP documentation in the resident with MI's LMHA or LBHA record.

(e) Within ten calendar days after the PCRP is updated or renewed, the QMHP-CS must send each member of the MI specialized services team a copy of the revised PCRP.

(f) If the MI specialized services team determines a new MI specialized service is needed or determines a change in the frequency, amount, or duration of an existing service is needed, the PCRP must be revised before the LMHA or LBHA delivers a new or updated service.

§303.908. Service Delivery.

(a) The LMHA or LBHA must begin delivering all MI specialized services in accordance with the PCRP within five calendar days after the MI specialized services team meeting.

(b) Before delivering an MI specialized service, the LMHA or LBHA must:

(1) confirm that the resident with MI is a Medicaid recipient; and

(2) receive authorization to deliver the MI specialized services in accordance with §306.311 of this title (relating to Service Authorization and Recovery Plan).

(c) The LMHA or LBHA must ensure that a resident with MI's progress or lack of progress toward achieving an identified outcome from the resident with MI's or LAR's perspective is accurately and consistently documented in observable, measurable terms.

(d) The LMHA or LBHA must monitor a resident with MI's and LAR's satisfaction with MI specialized services.

(e) The LMHA or LBHA must inform the NF of any significant changes to the resident with MI's behavioral or medical condition during the provision of MI specialized services.

§303.909. Refusal of the Uniform Assessment or MI Specialized Services.

(a) When a resident with MI refuses the uniform assessment or MI specialized services, the LMHA or LBHA must:

(1) ask the resident with MI or the LAR to sign the Refusal of PASRR MI Specialized Services form and document on the form if the resident with MI or LAR refuses to sign;

(2) inform the resident with MI of the need to conduct follow-up visits every 30 days for 90 days after the initial IDT meeting; and

(3) if the resident with MI or the LAR continues to refuse the uniform assessment or MI specialized services after 90 days, inform the resident with MI and the LAR that an annual IDT meeting is required and will be conducted, at which time the uniform assessment and MI specialized services will be offered again.

(b) A resident with MI or LAR may agree to receive the uniform assessment or MI specialized services at any time.

§303.910. Suspension and Termination of MI Specialized Services.

(a) The LMHA or LBHA must suspend a resident with MI's MI specialized services when:

(1) the resident with MI is admitted to an acute care hospital for fewer than 30 days and is returning to the same NF;

(2) the resident with MI loses Medicaid eligibility; or

(3) the resident with MI or LAR requests that MI specialized services be suspended when transferring from one NF to another NF without an intervening hospital stay.

(b) The LMHA or LBHA may terminate one or more of a resident with MI's MI specialized services if:

(1) the resident with MI loses Medicaid eligibility for more than 90 days; or

(2) the resident with MI or LAR requests the MI specialized services be terminated.

§303.911. Transition Planning for Residents with MI Only.

(a) If a resident with MI only, or the LAR on the resident with MI's behalf, expresses an interest in moving to the community, the QMHP-CS must facilitate the development of, revisions to, implementation of, and monitoring of a transition plan.

(b) A transition plan must identify the services and supports a resident with MI needs to live in the community, including those essential supports that are critical to the resident with MI's health and safety.

§303.912. Documentation.

An LMHA or LBHA must maintain the following documentation in the resident with MI's record:

(1) all assessments used for service planning;

(2) documentation related to the initiation and delivery of MI specialized services, including reasons for delays and all follow-up activities;

(3) documentation related to monitoring MI specialized services, including:

(A) the resident with MI's or the LAR's satisfaction with MI specialized services; and

(B) progress or lack of progress toward achieving goals and outcomes identified in the PCRP;

(4) documentation of all meetings, including the required 30, 60, and 90 day follow-up meetings held after a resident with MI refuses MI specialized services;

(5) guardianship paperwork and consents, if applicable; and

(6) documentation of a resident with MI's refusal of MI specialized services, if applicable.

§303.913. Quality Assurance.

(a) The LMHA or LBHA must allow access to the resident with MI or the resident with MI's record by:

(1) advocacy agencies; and

(2) HHSC staff.

(b) The LMHA or LBHA must develop, update as necessary, and implement a written quality assurance process to evaluate and improve the quality of MI

specialized services delivered by the LMHA or LBHA.