

ATTACHMENT A-4

ARTICLE 1 PASRR REQUIREMENTS AND ENHANCED COMMUNITY COORDINATION

1.1 Definitions:

“**Individual**” means an individual 21 years of age or older with an intellectual disability, related condition, or both, who is a Medicaid recipient.

“**Individual in a nursing facility**” means an individual who is admitted to and residing in a nursing facility and has been referred for a stay greater than 30 consecutive days.

1.2 Preadmission Screening and Resident Review (PASRR)

(1) LIDDA must:

(A) Comply with all PASRR requirements set forth in the LIDDA’s Medicaid Provider Agreement for the Provision of Intellectual Disability Service Coordination and PASRR and 40 Tex. Admin. Code Chapter 17. If a PASRR Evaluation (PE) is positive, the LIDDA must complete and provide the PASRR Evaluation Report Form 1014 to the individual and LAR that describes the specialized services being recommended. If, during a PE, the LIDDA suspects an individual of having ID or DD but is unable to confirm the individual has a diagnosis of ID or DD due to lack of records or access to family history, the LIDDA must ensure compliance with the requirements in Section 1.2 (1)(A)(i)-(iii) of this Attachment A-4.

(i) LIDDA staff conducting the PE must:

- (a) complete a “referral” in Section F1000 of the PE:
 - I. in Section F1000A, mark 19 for “Other”;
 - II. in Section F1000B, enter a statement that the individual is being referred for a Determination of Intellectual Disability (DID);
 - III. enter the phone number of the LIDDA staff completing the PE in F1000C;
 - IV. in Section F1000D, enter the “date of referral” for the DID; and mark the PE negative to indicate the individual does not have ID or DD (i.e., in Sections B0100 and B0200, enter “No”); and
- (b) not send the individual or LAR a notice of denial of eligibility for specialized services and an opportunity for a fair hearing.

(ii) LIDDA must:

- (a) within 45 calendar days after the “date of referral” entered in Section F1000D, ensure a DID is conducted on the individual in accordance with [HHSC] rules governing diagnostic assessment (40 Tex. Admin. Code, Chapter 5, Subchapter D); and
- (b) within 30 calendar days after the DID is conducted, submit a copy of the written DID report to the PASRR unit via the Secure File Transfer Protocol (SFTP) file folder named “PASRR Reporting.”

(iii)LIDDA must:

- (a) if the DID report indicates the individual does not have ID or DD:
 - I. enter a note on the previously completed negative PE by clicking on the “add note” button on the yellow Form Action bar of the PE and state that the individual does not have ID or DD per the result of the DID; and
 - II. send the individual or LAR a notice of denial of eligibility for specialized services and an opportunity for a fair hearing.
- (b) if the DID report indicates the individual has ID or DD, then, within seven calendar days after the DID report is completed, complete a new PE for the individual and mark it positive to indicate the individual has ID or DD.

(2) Within five working days after the initial interdisciplinary team (IDT) meeting, document the following information in the Long Term Services (LTS) online portal:

- (A) Confirm if representatives of the LIDDA attended the IDT meeting, either in person or by telephone;
- (B) Contact the NF to conduct the another IDT if the IDT was held without the required LIDDA attendance;
- (C) Contact the NF to address any disagreement with the services recommended on the IDT, Allow seven days for the NF to update the services; and
- (D) Either agree or disagree that the specialized services listed in the LTS online portal for an individual were those that were agreed upon during the individual’s IDT meeting.

1.3 Nursing Facility Diversion

(1) LIDDA must designate a staff member as the Diversion Coordinator who:

- (A) is at least credentialed as a qualified intellectual disabilities professional (QIDP); and
 - (B) has two years' experience in coordinating or providing services to individuals with IDD, including those with complex medical needs, in the community.
- (2) LIDDA must ensure that the Diversion Coordinator performs the following duties:
- (A) Identify available community living options, services, and supports to assist individuals to successfully live in the community;
 - (B) Provide information and assistance to service coordinators and other LIDDA staff who are facilitating diversion for individuals at risk of admission to a nursing facility and for individuals transitioning to the community from a nursing facility;
 - (C) Coordinate educational activities for service coordinators and other LIDDA staff about available community services and about strategies to avoid nursing facility placement;
 - (D) Coordinate educational activities for referring entities about available community resources, services and strategies to avoid nursing facility placement;
 - (E) Within 45-75 calendar days after an individual is admitted into a nursing facility, review the individual's admission to ensure that community living options, services and supports that could provide an alternative to nursing facility placement have been explored and if not, refer the individual to his or her service coordinator for that purpose;
 - (F) On a quarterly basis, as indicated in the PASRR Reporting Manual, report to System Agency the number of individuals admitted to nursing facilities, diverted from nursing facilities, and residing in a nursing facility for more than 90 days; and
 - (G) On a quarterly basis, as indicated in the PASRR Reporting Manual, provide System Agency with information about barriers individuals have experienced in moving from a nursing facility to the community.
- (3) When conducting a PASRR Evaluation (PE), LIDDA must inform the individual referred for admission to a nursing facility, their family, and the legally authorized representative (LAR) of the community options, services, and supports for which the individual may be eligible. LIDDA, under the direction of the Diversion Coordinator, must identify, arrange, and coordinate access to these services in order to avoid admission to a nursing facility, wherever possible and consistent with an individual's informed choice.
- (4) LIDDA's initiation of enrollment in HCS as a diversion from admission to a nursing facility must occur before the individual's admission to a nursing facility when, consistent with the PE, community living options, services, and/or supports provide an appropriate alternate placement to avoid admission to a nursing facility, consistent with the individual's choice.

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

1.4 Service Coordination

- (1) LIDDA must assign a service coordinator to an individual in a nursing facility within 30 calendar days after completion of the individual's PE.
- (A) If the individual refuses service coordination, the service coordinator must use Form 1044 (Refusal of Service Coordination for Individuals Residing in Nursing Facilities) to document the refusal, obtain necessary signatures and maintain documentation copy of the completed form in the individual's record.
 - (B) For an individual who refuses service coordination, the LIDDA must ensure the individual receives information about the range of community living options (CLO) using System Agency materials during the individual's initial meeting with a service coordinator and at least annually thereafter, documenting the discussion on Form 1039 (Community Living Options).
- (2) LIDDA must ensure the assigned service coordinator for an individual in a nursing facility:
- (A) Meets face-to-face with the individual on a monthly basis, or more frequently, if needed;
 - (B) Facilitates the development of the individual's ISP on Form 1041 (Individual Service Plan/Transition Plan – NF) with the individual's service planning team (SPT), including documenting SPT discussions, within 30 calendar days after the completion of the PE;
 - (C) Facilitates revisions to the individual's ISP on Form 1041 (Individual Service Plan/Transition Plan – NF), as needed, including documenting SPT discussions;
 - (D) Facilitates coordination between an individual's ISP and the nursing facility's plan of care;
 - (E) Facilitates the coordination of the individual's specialized services;
 - (F) Documents the coordination and initiation of specialized services by the LIDDA and/or the nursing facility within 30 days of the IDT meeting;
 - (G) Monitors the delivery of all services and supports provided to the individual;
 - (H) Reports refusal or failure to Consumer Rights and Services if a nursing facility and/or LIDDA refuses or fails to comply with requirements to initiate specialized services, within 30 days of the IDT meeting; and

- (I) Submits reports of non-compliance to initiate specialized services to the PASRR unit using the PASRR Reporting of Non-Compliance form (formerly the form entitled “PASRR LIDDA/LMHA Report of NF Non-Compliance to Consumer Rights and Services”) by the 15th of every month for the previous month’s data.

- (3) LIDDA must ensure the assigned service coordinator for an individual in a nursing facility convenes the individual’s SPT at least quarterly, or more frequently if requested by the individual or LAR, or if there is a change in service needs. Quarterly SPT meetings must take place every three months in accordance with the instructions for Form 1041 (Individual Service Plan/Transition Plan – NF).

- (4) The assigned service coordinator must complete the *PASRR Specialized Services Form* for every SPT meeting (initial, quarterly, and any updates). LIDDA must submit the information on the completed form via the Long-Term Care Portal.

- (5) LIDDA must ensure that the assigned service coordinator for an individual in a nursing facility:
 - (A) Provides information and discusses with the individual and LAR about the range of community living options (CLO) using System Agency developed materials during the individuals initial meeting with the service coordinator and at least semi-annually thereafter, documenting the discussion on Form 1039 (Community Living Options);
 - (B) Facilitates visits to community programs, when appropriate, and addresses concerns about community living with the SPT; and
 - (C) Offers the individual and LAR opportunities for educational and informational activities described in Section 1.6 (2) of this Attachment.

- (6) LIDDA must ensure that the assigned service coordinator completes Section 9 (Transition Plan to the Community) Phase I of the Individual Service Plan /Transition Plan (Form 1041) for an individual in a nursing facility:
 - (A) whose MDS 3.0 indicates the individual is interested in speaking with someone about transitioning to the community;
 - (B) whose PASRR evaluation reflects that the individual’s needs can be met in an appropriate community setting; or
 - (C) who expresses an interest in transitioning to the community.

1.5 Service Planning Team

- (1) For an individual in a nursing facility for whom the LIDDA provides service coordination, the LIDDA must ensure the individual's SPT includes the following persons:
 - (A) the individual being served;
 - (B) the individual's LAR, if any;
 - (C) the service coordinator;
 - (D) a nursing facility staff familiar with the individual's needs;
 - (E) person(s) providing specialized services for the individual;
 - (F) System Agency-contracted relocation specialist, if the individual desires to move to the community;
 - (G) a representative from the community Medicaid program provider, if one has been selected; and
 - (H) other participants such as:
 - (i) a concerned person whose inclusion is requested by the individual or the LAR; and
 - (ii) at the discretion of the LIDDA, other persons who are directly involved in the delivery of services to individuals with IDD.
- (3) The SPT must ensure an individual in a nursing facility, regardless of whether he or she has an LAR, participates in the SPT to the fullest extent possible and will receive the support necessary to do so, including, but not limited to, communication supports.
- (4) LIDDA must ensure the SPT:
 - (A) reviews the PE and all applicable functional assessments;
 - (B) develops an ISP using Form 1041 (Individual Service Plan/Transition Plan – NF) that:
 - (i) Is individualized and developed through a person-centered process;
 - (ii) Identifies the individual's:
 - I. strengths;
 - II. preferences;
 - III. psychiatric, behavioral, nutritional management, and support needs; and
 - IV. desired outcomes;
 - (iii) identifies the specific specialized services to be provided to the individual, including the amount, intensity, and frequency of each specialized service; and

- (iv) Identifies the services and supports that are needed to meet the individual's needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated setting possible;
- (C) is responsible for planning, ensuring the implementation of, and monitoring all specialized services identified in the ISP, and transition planning in coordination with the nursing facility's care planning team;
- (D) ensures the individual's ISP, including specialized services, is integrated into the nursing facility's plan of care and that specialized services are planned, provided, and monitored in a consistent manner, and integrated with the services provided by the nursing facility; and
- (E) assesses the adequacy of the services and supports that the individual is receiving; and
- (F) monitors the individual's ISP to make timely additional referrals, service changes, and amendments to the plan as needed.

1.6 Administrative Requirements

- (1) Upon notice from and in a format approved by System Agency, the LIDDA must provide data and other information related to the services and requirements described in this Attachment A-4.
- (2) At least semi-annually, LIDDA must provide or arrange for the provision of educational or informational activities addressing community living options for individuals in nursing facilities in the LIDDA's local service area and their families. These activities may include family-to-family and peer-to-peer programs, providing information about the benefits of community living options, facilitating visits in such settings, and offering opportunities to meet with other individuals who are living, working, and receiving services in integrated settings, with their families, and with community providers.
 - (A) These educational or informational activities must be provided by persons who are knowledgeable about community services and supports.
 - (B) These activities must not be provided by nursing facility staff or others with a contractual relationship with nursing facilities.
 - (C) LIDDA must maintain documentation related to an offer of and attendance at educational or informational activities in the record for each individual in a nursing facility.
 - (D) LIDDA must maintain evidence of the content of and attendance at each semi-annual educational or informational activity.

- (3) LIDDA must maintain a list of all individuals residing in a nursing facility who express an interest in transitioning to the community to any employee, contractor, or provider of specialized services. For each individual on the list, LIDDA must notify the service coordinator to discuss community living options.
- (4) For an individual in a nursing facility, LIDDA must request reimbursement for the delivery of specialized services provided by the LIDDA in accordance with instructions on Form 1048 (Summary Sheet for Services to Individuals with IDD in a Nursing Facility).
- (5) For an individual in a nursing facility receiving service coordination who is not transitioning to the community, LIDDA must fund service coordination using the Nursing Facility PASRR Service Coordination allocation set forth in Attachment B, Table 1 (Allocation Schedule).
- (6) For an individual in a nursing facility receiving service coordination who is transitioning to the community, LIDDA must fund service coordination through Targeted Case Management.

ARTICLE 2 ENHANCED COMMUNITY COORDINATION

2.1 Qualifications and Duties of Enhanced Community Coordinator

- (1) For all individuals diverting or transitioning from a nursing facility (NF) or state supported living center (SSLC) as required in Articles III and IV of this Attachment A-4, LIDDA shall ensure:
 - (A) the individual is assigned an enhanced community coordinator who:
 - (i) meets the qualifications of a service coordinator in accordance with 40 Tex. Admin. Code, §2.559 (Minimum Qualifications); and
 - (ii) has extensive experience in providing service coordination to individuals with IDD, including those who have complex medical needs; and
 - (B) the assigned enhanced community coordinator:
 - (i) complies with the rules governing service coordination for an individual with an intellectual disability (40 Tex. Admin. Code, Chapter 2, Local Authority Responsibilities, Subchapter L, Service Coordination for Individuals with an Intellectual Disability);
 - (ii) provides intensive and flexible support to achieve success in a community setting, including arranging for support needed to prevent and manage a crisis, such as a Transition Support Team or crisis respite;
 - (iii) provides pre- and post-transition services;
 - (iv) monitors the individual as required by Articles III and IV of this Attachment A-4 for one year after transition or diversion; and

- (v) maintains a case load of no more than 30 individuals regardless of whether the community coordinator provides service coordination to other individuals who are not covered under the provisions of this Attachment A-4.

2.2 Use of Designated Funds for Enhanced Community Coordination

- (1) LIDDA shall utilize designated funds, as submitted and approved by System Agency, to enhance an individual's natural supports and promote successful community living, such as:
 - (A) One-time emergency assistance:
 - (i) Rental or utility assistance;
 - (ii) Nutritional supplements;
 - (iii) Clothing; and
 - (iv) Medication;
 - (B) Items to address an individual's special needs, including minor home modifications not funded by other sources;
 - (C) Transportation to and from trial visits with community providers; and
 - (D) Educational tuition assistance, such as vocational programs through community colleges so an individual can develop job skills.

2.3 Reporting

- (1) LIDDA shall submit quarterly reporting to the Performance Contracts mailbox by the 15th of the month that follows the previous fiscal quarter using a format prescribed by System Agency. A quarterly report must contain:
 - (A) narrative of the results of the provision of enhanced community coordination, including positive and negative outcomes and barriers encountered during the provision of enhanced community coordination;
 - (B) A list of the names of individuals receiving enhanced community coordination at any time during the quarter being reported and the date they began receiving enhanced community coordination; and
 - (C) An expenditure report including but not limited to salaries, employee benefits, training, travel and other operating expenses.

2.4 Payments

- (1) Contingent on the Centers for Medicare and Medicaid approving Money Follows the Person funding, System Agency will pay LIDDA an amount not to exceed the allocation provided to the LIDDA to provide enhanced community coordination as stated in this Attachment A-4. Funds will be paid in compliance with the OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (UGG), which may be found online at: <http://www.ecfr.gov/cgi-bin/text-idx?node=2:1.1.2.2.1&rgn=div5>.
- (2) Under these requirements, LIDDA may request payment be provided in advance or may submit requests for reimbursement of costs.
 - (A) Under 2 CFR §200.305, Reimbursement is the preferred method when the requirements in paragraph (b) cannot be met, when the federal awarding agency sets a specific condition per §200.207 (Specific conditions), or when a non-federal entity requests payment by reimbursement. Requests for advance payment are subject to the financial management standards test and requirements established by UGG. An advance payment request must:
 - (i) be limited to cash needed to meet the immediate needs of the grant project;
 - (ii) minimize time between advances and payments for grants activities; and
 - (iii) be deposited in a separate interest bearing account and interest earned on grant funds must be returned to the federal government.
 - (B) If the LIDDA requests reimbursement for costs, LIDDA must submit an invoice, no later than the 15th day of the month that follows the month of service delivery, on a template provided by System Agency and include supporting documentation as described by System Agency.

ARTICLE 3 ENHANCED COMMUNITY COORDINATION FOR INDIVIDUALS DIVERTING OR TRANSITIONING FROM AN NF.

3.1 HCS as a diversion from Nursing Facility admission

- (1) For an individual enrolling in HCS as a diversion from Nursing Facility admission, LIDDA shall ensure the assigned enhanced community coordinator:
 - (A) before the individual enrolls in HCS:
 - (i) develops, and revises as necessary, using Form 1050 (Diversion Plan) with an individual's service planning team (SPT), as defined in rules governing the HCS Program in 40 Tex. Admin. Code §9.153 (Definitions);

- (ii) using all available assessments, along with individual's SPT, develops, and revises as necessary, an HCS person-directed plan Person-Directed Plan (HCS-PDP) Form 8665 (Person-Directed Plan), which identifies the individual's strengths and preferences, and medical, nursing, nutritional management, clinical, and support needs; and
 - (iii) conducts a pre-move site review using Form 1042 (Pre-Move Site Review), to determine whether supports are in place and any areas of concern are being addressed.
- (B) for one year after an individual has diverted to the HCS waiver program:
- (i) conducts SPT meetings at least quarterly, or more frequently if there is a change in an individual's needs or if requested by the individual or LAR;
 - (ii) revises the HCS PDP, as necessary, and coordinates the individual's services and supports;
 - (iii) conducts at least monthly face-to-face visits with an individual, or more frequently if determined by the SPT based on risk factors, and monitors the delivery of all services and supports;
 - (iv) conducts onsite visits of community service delivery sites to determine whether supports continue to be in place and any areas of concern are being addressed using Form 1043 (Post-Move Monitoring);
 - (v) inquiries about any recent hospitalizations, emergency department contacts, increased physician visits, or other crises, including medical crises, and if the individual experiences such, convenes the SPT to identify all necessary revisions to the individual's HCS PDP to address additional need for services;
 - (vi) ensures an individual receives timely assessments of behavioral, medical, nursing, specialized therapies and nutritional management needs, as necessary and as indicated on the HCS PDP;
 - (vii) records health care status sufficient to readily identify when changes in the individual's status occurs;
 - (viii) conducts service planning, ensures implementation of services, and monitors all services identified on the HCS PDP, including:
 - I. reviewing the HCS Program provider's implementation plans and provider records, as well as visiting service delivery sites, as needed to determine the individual's needs are being met; and
 - II. monitoring critical incidents involving the individual and convening the service planning team to provide needed prevention or intervention services for an individual; and

- (ix) monitors an individual while on suspension from the HCS waiver program at least monthly and provide reports to System Agency upon request.

3.2 Transition to HCS from Nursing Facility

- (1) For an individual 21 years of age or older who is transitioning to HCS from a nursing facility, LIDDA shall, before the individual transitions from the nursing facility, ensure the assigned enhanced community coordinator:
 - (A) develops, implements, monitors, and revises as necessary, Section 9 (Transition Plan to the Community) Phases II and III of the individual service plan, Form 1041 (Individual Service Plan/Transition Plan - NF) with an individual's SPT, as defined in rules governing the HCS Program in 40 Tex. Admin. Code §9.153 (Definitions);
 - (B) provides increased coordination and interaction with an NF's care planning team and the assigned relocation specialist;
 - (C) facilitates trial visits to providers in the community for the individual, including overnight visits where feasible, as requested by the individual or LAR;
 - (D) using all available assessments, along with the individual's SPT, develops and revises as necessary an HCS person-directed plan (HCS PDP), Form 8665 (Person-Directed Plan), which identifies the individual's strengths and preferences, and medical, nursing, nutritional management, clinical, and support needs; and
 - (E) conducts a pre-move site review using Form 1042 (Pre-Move Site Review), to determine whether supports are in place and any areas of concern are being addressed and ensure all essential supports identified on the transition plan are in place before the individual transitions.

- (2) For an individual of any age who transitioned to HCS from a nursing facility, LIDDA shall, for at least one year after the individual has transitioned, ensure that the assigned enhanced community coordinator:
 - (A) for an individual under the age of 21 years, communicate with an appropriate staff of the entity that was responsible for transitioning the individual from the nursing facility (for FYs 2018 and 2019, the entity is EveryChild, Inc.) to gather all necessary information and documents to ensure a successful transition for the individual;
 - (B) conducts service planning team meetings at least quarterly, or more frequently if there is a change in an individual's needs or if requested by the individual or LAR;

- (C) revises the service plan, as necessary, on the HCS PDP and coordinates the individual's services and supports;
- (D) conducts at least monthly face-to-face visits with an individual, or more frequently if determined by the SPT based on risk factors, and monitors the delivery of all services and supports;
- (E) conducts onsite visits of community service delivery sites to determine whether supports continue to be in place and any areas of concern are being addressed using Form 1043 (Post-Move Monitoring);
- (F) inquires about any recent hospitalizations, emergency department contacts, increased physician visits, or other crises, including medical crises, and if the individual experiences such, convenes the SPT to identify all necessary revisions to the individual's HCS PDP to address additional need for services;
- (G) ensures an individual receives timely assessments of behavioral, medical, nursing, specialized therapies and nutritional management needs, as necessary and as indicated on the HCS PDP;
- (H) records health care status sufficient to readily identify when changes in the individual's status occurs;
- (I) conducts service planning, ensures implementation of services, and monitors all services identified on the HCS PDP, including:
 - (i) reviewing the HCS Program provider's implementation plans and provider records, as well as visiting service delivery sites, as needed to determine the individual's needs are being met; and
 - (ii) monitoring critical incidents involving the individual and convening the service planning team to provide needed prevention or intervention services for an individual; and
- (J) monitors an individual while on suspension from the HCS waiver program at least monthly and provides reports to System Agency upon request.

3.3 Transition to a Community Medicaid Program from Nursing Facility

- (1) For an individual 21 years of age or older who is transitioning from a Nursing Facility to a community Medicaid program (i.e., a community ICF/IID or a Medicaid waiver program other than HCS), LIDDA shall ensure the assigned enhanced community coordinator:
 - (A) before the individual transitions from the Nursing Facility:
 - (i) develops, implements, monitors, and revises as necessary, Section 9 (Transition Plan to the Community) Phases II and III of the individual

service plan, Form 1041 (Individual Service Plan/Transition Plan - NF) with an individual's SPT;

- (ii) provides increased coordination and interaction with an Nursing Facility's care planning team and, if the individual is transitioning to a Medicaid waiver program other than HCS, the assigned relocation specialist;
- (iii) facilitates trial visits to providers in the community that offer residential services (for example, an ICF/IID, a Star+Plus waiver assisted living facility) for the individual, including overnight visits where feasible, as requested by the individual or LAR;
- (iv) provides all available assessments to the selected community Medicaid Program provider; and
- (v) conducts a pre-move site review using Form 1042 (Pre-Move Site Review), to determine whether supports are in place and any areas of concern are being addressed and ensure all essential supports identified on the transition plan are in place before the individual transitions.

- (B) for at least one year after the individual has transitioned to a community Medicaid program conducts the following activities to determine whether necessary services and supports are being provided and areas of concern are being addressed and to assess the individual's adjustment to community life and the individual's (and LAR's) satisfaction with community life:
 - (i) post-move monitoring using Form 1043 (Post-Move Monitoring); and
 - (ii) face-to-face service coordination contacts monthly during the first six months following the individual's move from the NF, and quarterly during the second six months following the individual's move.

ARTICLE 4 ENHANCED COMMUNITY COORDINATION FOR INDIVIDUALS DIVERTING OR TRANSITIONING FROM A STATE SUPPORTED LIVING CENTER

4.1 HCS as a Diversion from SSLC Admission

- (1) For an individual enrolling in HCS as a diversion from SSLC admission, LIDDA shall ensure that the assigned enhanced community coordinator:
 - (A) before the individual enrolls in HCS:
 - (i) develops, and revises as necessary, using Form 1050 (Diversion Plan) with an individual's service planning team (SPT);
 - (ii) using all available assessments develop the HCS PDP; and

- (iii) conducts a pre-move site review using Form 1042 (Pre-Move Site Review), to determine whether supports are in place and any areas of concern are being addressed.
- (B) for one year after an individual has diverted to the HCS waiver program:
- (i) performs SPT meetings at least quarterly, or more frequently if there is a change in the individual's needs or if requested by the individual or LAR;
 - (ii) conducts at least monthly face-to-face visits with the individual and monitors the delivery of all services and supports by:
 - I. conducting post-move monitoring using Form 1043 (Post-Move Site Review) to determine whether supports are in place and any areas of concern are being addressed;
 - II. ensuring the individual receives timely assessments of behavioral, medical, nursing, specialized therapies and nutritional management needs, as necessary and as indicated on the HCS PDP;
 - III. reviewing the HCS Program provider's implementation plans and provider records, as well as visiting service delivery sites, as needed to determine the individual's needs are being met;
 - IV. monitoring critical incidents involving the individual and convening the service planning team to provide needed prevention or intervention services for an individual; and
 - V. monitoring an individual while on suspension from the HCS waiver program at least monthly and provide reports to System Agency upon request.

4.2 Transition to HCS from SSLC

- (1) For an individual transitioning to HCS from an SSLC, LIDDA shall ensure the assigned enhanced community coordinator:
- (A) before the individual transitions from the SSLC:
 - (i) participates in developing the CLDP with SSLC staff as required by 40 Tex. Admin. Code, §2.278 (Community Living/Discharge Plan by Alternate Living Arrangements);
 - (ii) uses all available assessments to develop the HCS PDP;
 - (iii) participates in the pre-move site review conducted by SSLC staff to determine whether supports are in place and any areas of concern are being addressed; and
 - (iv) complies with the requirements contained in 40 Tex. Admin. Code, §2.277(b)-(d) (relating to Arrangements for the Move to an Alternate

Living Arrangement of an Individual Residing in a State MR Facility)
using Form 8630 (Continuity of Care);

- (B) for one year after the individual has transitioned to HCS:
 - (i) conducts at least monthly face-to-face visits with an individual for one-year;
 - (ii) complies with the monitoring activities and agreement portions set forth in the CLDP;
 - (iii) conducts periodic monitoring (i.e., every 90 days) and, using an System Agency -prescribed format, develops written reports of monitoring that addresses specific findings for any significant monitoring activity, including:
 - I. psychiatric or medical hospitalization;
 - II. any visits to an emergency room within the period being reported;
 - III. death;
 - IV. arrest or incarceration;
 - V. any contacts with law enforcement within the period being reported;
 - VI. unable to locate or left program;
 - VII. HCS Program provider issue – change of homes;
 - VIII. HCS Program provider issue – closure;
 - IX. HCS Program provider issue – confirmed abuse, neglect or exploitation;
 - X. HCS Program provider issue – change of program provider;
 - XI. return to the SSLC; and
 - (iv) submits the written reports required in Section 4.2.(1)(B)(iii) to the SSLC admission placement coordinator (APC), System Agency, and the HCS Program provider.

4.3 Transition from SSLC to a setting other than HCS

- (1) For an individual transitioning from an SSLC to setting other than HCS (such as a community ICF/IID or family's home), LIDDA shall ensure the assigned enhanced community coordinator:
 - (A) before the individual transitions from the SSLC:
 - (i) participates in developing the CLDP with SSLC staff as required by 40 Tex. Admin. Code, §2.278 (Community Living/Discharge Plan by Alternate Living Arrangements);

- (ii) participates in the pre-move site review conducted by SSLC staff to determine whether supports are in place and any areas of concern are being addressed; and
 - (iii) complies with the requirements contained in 40 Tex. Admin. Code, §2.277(b)-(d) (relating to Arrangements for the Move to an Alternate Living Arrangement of an Individual Residing in a State MR Facility) using Form 8630 (Continuity of Care); and
- (B) for one year after the individual has transitioned from an SSLC:
- (i) complies with the monitoring activities and agreement portions set forth in the CLDP; and
 - (ii) conducts periodic monitoring (i.e., every 90 calendar days) and, using an System Agency prescribed format, develops written reports of monitoring that addresses specific findings for any significant monitoring activity, including:
 - I. psychiatric or medical hospitalization;
 - II. any visits to an emergency room within the period being reported;
 - III. death;
 - IV. arrest or incarceration;
 - V. any contacts with law enforcement within the period being reported;
 - VI. unable to locate, left community program, moved out-of-state;
 - VII. move to another residence;
 - VIII. community program provider issue – closure;
 - IX. community program provider issue – confirmed abuse, neglect or exploitation;
 - X. community program provider issue – change of program provider; and
 - XI. return to the SSLC; and
 - XII. submits written reports required in Section 4.3.(1)(B)(ii) of this Attachment A-4 to the SSLC admission placement coordinator (APC) and System Agency.