March 27, 2014

To:  Local Authorities
     Medicaid-certified Nursing Facilities

Subject: Information Letter No. 14-17
Pre-admission Screening and Resident Review Coordination and Cooperation between Local Authorities and Nursing Facilities

The federal Pre-admission Screening and Resident Review (PASRR) process requirements are intended to identify an individual who may have an intellectual disability, developmental disability, or a mental illness (Level I-PASRR) and determine the appropriateness of the individual’s admission to or remaining in a Medicaid-certified nursing facility and the eligibility for specialized services related to the individual’s needs (Level II-PASRR Evaluation (PE)). The Department of Aging and Disability Services (DADS) is committed to the federally required PASRR process. DADS is also committed to ensuring an individual is served in the most appropriate setting. The purpose of this letter is to describe the activities DADS requires of a Medicaid-certified nursing facility to help ensure that an individual with an intellectual or developmental disability (IDD) is served in the most appropriate setting and receives services that address the individual’s needs.

Effective May 24, 2013, DADS implemented a new process described in Texas Administrative Code, Title 40, Chapter 17, that complies with federal PASRR requirements. DADS contracts with the local mental health authorities (LMHAs) and the local intellectual and developmental disability authorities (LAs) to conduct PEs. For expedited admissions and resident reviews, the LMHA or LA must visit the nursing facility in order to review documentation and records, and to meet face-to-face with the nursing facility resident (see 40 TAC, Section 17.202(a)(2)(A) and Section17.203(c)(1)). As part of the PE, the LMHA or LA staff must also participate in the nursing facility’s interdisciplinary team (IDT) meeting for the individual [see 40 TAC, Section 17.201(d)(2), Section 17.202(a)(4)(B) and Section 17.203(f)(2)(B)].

Completion of the PE and participation in the IDT meeting requires a nursing facility to provide the LMHA and LA staff with access to the resident and the resident’s records as well as to coordinate with LMHA and LA staff to schedule the IDT meeting. DADS rules governing PASRR require a nursing facility to coordinate with the LMHA or LA, as appropriate, to schedule the IDT meeting and discuss the resident’s recommended specialized services [see 40 TAC, Section 17.302(3)].
During implementation of the new process, DADS identified additional processes to ensure that an individual with IDD is served in the most appropriate setting and receives services that address the individual’s needs. These additional processes are being implemented by the LAs under the direction of DADS and require participation and cooperation by nursing facility staff.

DADS requires the LA to provide service coordination to a Medicaid eligible nursing facility resident with IDD, including organizing a service planning team and facilitating service planning related to specialized services, community living options, and transition to community living.

**Note:** The LA service coordinator is responsible for facilitating service planning that is separate and distinct from service planning conducted by nursing facility staff.

The LA is responsible for assigning a service coordinator to each Medicaid eligible nursing facility resident with IDD. The service coordinator is required to visit face-to-face with the resident at least monthly and conduct service planning meetings at least quarterly or more frequently, if necessary.

DADS requires the service planning team to develop an individual service plan (ISP) for a resident that:

- is individualized and developed through a person-centered process;
- identifies the resident’s strengths; preferences; medical, nursing, nutritional management, clinical, and support needs; desired outcomes; and
- identifies the services and supports that are needed to meet the resident’s needs, achieve the desired outcomes, and maximize the resident’s ability to live successfully in the most integrated setting possible.

DADS requires the service planning team to include: the resident; the resident’s legally authorized representative (LAR), if any; the service coordinator; persons providing specialized services for the resident; a nursing facility staff member familiar with the resident’s needs, and, if a specific alternate placement provider has been selected, a representative from that provider. The service planning team may include other concerned persons whose inclusion is requested by the resident or the LAR, and, at the discretion of the LA, other persons who are directly involved in the delivery of services to the resident.

DADS also requires the service planning team to:

- ensure the resident, regardless of whether he/she has an LAR, participates in the service planning team to the fullest extent possible consistent with the individual’s choice, and receive the support necessary to do so, including, communication supports;
- assess the adequacy of the services and supports the resident is receiving;
- monitor the resident’s ISP to make timely additional referrals, service changes, and amendments to the plan as needed;
- identify the specific specialized services to be provided to the resident, including the amount, intensity, and frequency of each specialized service;
- be 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; and
- ensure the resident’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.
For a resident who expresses an interest in transitioning to the community or whose PE reflects the resident’s needs can be met in an appropriate community setting, the service planning team must create a transition plan. The transition plan must:

- describe the activities, timetable, responsibilities, services, and supports involved in assisting the resident to:
  - consider community living options;
  - choose a provider; and
  - transition from the nursing facility to the community, including identifying and securing the elements the resident needs to move into the community, such as a supply of medications, adaptive aids, and specialized equipment; and
- specify the frequency of post-move monitoring visits by the service coordinator and identify at least three monitoring visits during the first 90 days following the resident’s transition to the community, including one within the first seven days after transition.

The service planning team which includes nursing facility staff, must develop, implement, monitor, and revise the transition plan as necessary.

DADS requires and appreciates your cooperation with LMHA and LA staff and in providing access to nursing facility residents and their records in order to meet the federally required PASRR process. DADS also requires and appreciates your participation and cooperation with the additional required processes to ensure that an individual with IDD is served in the most appropriate setting and receives services that address the individual’s needs.

If you have any questions or need additional information about the PE process please contact the PASRR unit message line at (855) 435-7180 or by email at pasrr@dads.state.tx.us.

Please let me know if you have any questions or need additional information, including information about the role and responsibilities of nursing facility staff. Stacy Lindsey, Local Procedures Development and Support Unit Manager, serves as the lead staff on this matter and can be reached at (512) 438-4518 or by email at stacy.lindsey@dads.state.tx.us.

Sincerely,

[signature on file]  [signature on file]

Mary Taylor Henderson  Elisa J. Garza
Assistant Commissioner  Assistant Commissioner
Regulatory Services  Access and Intake