



TEXAS
Health and Human
Services

Supporting Nursing Facility Residents with an Intellectual and Developmental Disability (IDD) Relocating to the Community

Medicaid/Chip Services

Training Objectives



TEXAS
Health and Human
Services

1. Staff will have an understanding of their legal obligation to help residents learn about options for receiving long-term services and supports (LTSS) in the community.

Training is also applicable to other entities that frequent nursing facilities, i.e., Ombudsman, aging and disability resource center (ADRC) staff and managed care organizations (MCOs).

Training Objectives



TEXAS
Health and Human
Services

2. Staff will have an understanding of the roles and responsibilities of the key players in the relocation process for PASRR positive individuals.

Key players to be discussed today include the MCO, the relocation specialist, the nursing facility staff, the habilitation coordinator, the local intellectual and developmental disability authority (LIDDA) service coordinator, the individual and the individual's family.

Training Objectives



TEXAS
Health and Human
Services

3. Staff will understand which questions on the Minimum Data Set (MDS) 3.0 pertain to helping residents relocate.

Provide guidance on how these questions should be presented, such that residents have optimum opportunity to learn about community alternatives to institutional care.

Training Objectives



TEXAS
Health and Human
Services

4. Staff will understand the relocation process, including the referral, transition needs assessment, service planning process, day of move activities, and monitoring and follow-up after the move.

Provide information on Supplemental Transition Supports (STS), provided by the MCO, to help pay for moving expenses and household items above and beyond funds available through Transition Assistance Services (TAS).



TEXAS
Health and Human
Services

Supporting Nursing Facility Residents Relocate to the Community

Legal Obligations

Requirements for helping residents transition

Olmstead Supreme Court decision: Nursing facilities are required by law to provide individuals a choice about where they receive their LTSS.



TEXAS
Health and Human
Services



Olmstead



TEXAS
Health and Human
Services

- People with disabilities have a right to receive services in the community.
- Unnecessary placement of a person in a long-term care facility may violate federal law.
- Continued unnecessary segregation of a person with disabilities may violate federal law.



Olmstead



TEXAS
Health and Human
Services

States are required to provide community-based services for persons with disabilities if:

- Treatment professionals determine community placement is appropriate;
- The person does not oppose such placement; and
- The placement can be reasonably accommodated.

Legal Obligations

Requirements for helping residents transition

- Offer residents information on community-based LTSS;
- Refer residents interested in community-based LTSS to the local contact agency (LCA); and
- Remain actively engaged in the discharge plan.

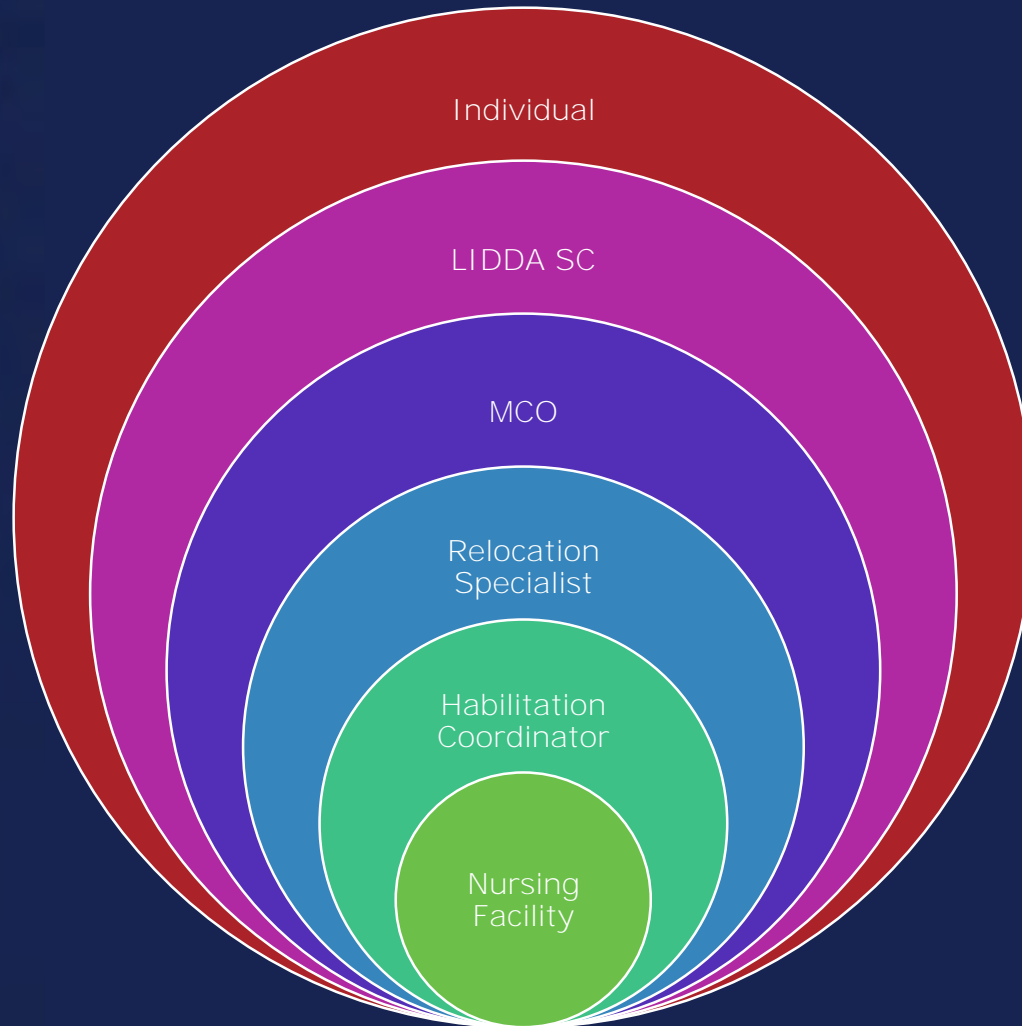


TEXAS
Health and Human
Services



TEXAS
Health and Human
Services

Key Players



Working together improves relocation efforts for the individual with intellectual disability (ID) / developmental disability (DD) by creating a more focused and effective process. Each brings a unique set of knowledge and expertise.

Habilitation Coordinator

Key Players PASRR Process

1. Presents Community Living Options (CLO).
2. If the Home and Community-based Services (HCS) program is selected, the habilitation coordinator (HC):
 - a. **Makes referral to the individual's MCO for relocation services**
 - b. Informs the appropriate LIDDA to assign service coordinator or enhanced community coordination coordinator to begin transition planning.
 - c. Reviews relocation specialists assessment to see if specialized services are needed.
 - d. Participates on the service planning team (SPT).



TEXAS
Health and Human
Services

Relocation Specialists



TEXAS
Health and Human
Services

- Facilitate transition to community
- Assist Medicaid eligible nursing facility residents
- Work for community-based organizations contracted with STAR+PLUS MCOs



Relocation Specialists

Key players PASRR process if the person has decided to transition and picked HCS as the community program

1. Conduct assessment to develop transition plan.
2. Provide plan to habilitation coordinator.
3. Participate on the SPT.
4. Coordinate non-Medicaid services.
5. Help find suitable housing.
6. Help apply for public benefits.
7. Coordinate purchase and delivery of household items.



TEXAS
Health and Human
Services

Relocation Specialists

Key players PASRR process if the person has NOT selected a community program

Provides education on community program options, along with the habilitation coordinator, to support the individual or legally authorized representative (LAR) in selecting the community program that will best meet their needs.



TEXAS
Health and Human
Services

MCO Role

Key Players PASRR Process

1. Contract requirement to participate in the PASRR process.
2. Serve as the LCA for Medicaid recipients.
3. Contract with relocation specialists to outreach to nursing facilities; conduct transition assessments; coordinate move; and, arrange purchase and delivery of necessary household items if not purchased through TAS.
4. Participate on the SPT.
5. Arrange for durable medical equipment and transfer of services to community-based LTSS.



TEXAS
Health and Human
Services

Relocation Process

Identification

Assessment

Service Planning

Monitoring and
Follow up



TEXAS
Health and Human
Services

Local Contact Agency

Provide information on community services

- Nursing facility staff must refer residents to the LCA within a reasonable time after **learning of an individual's interest in learning about living in the community.**
- This includes residents identified through the MDS 3.0 and residents who express interest in conversations with nursing facility staff.
- Based on the PASRR evaluation (PE), the PE may also refer residents to the habilitation coordinator (HC).
- It also includes residents referred by family members, friends and others.



TEXAS
Health and Human
Services

Local Contact Agency

1. For Medicaid residents, nursing facilities:
Contact the individual's MCO
 - a. The nursing facility business office should know the MCO in which the individual is enrolled.
2. For Non-Medicaid residents, nursing facilities:
Contact the local Aging and Disability Resource Center (ADRC)
855-YES-ADRC (855-937-2372)



TEXAS
Health and Human
Services

Local Contact Agency

1. LCA role is not solicitation.
2. Resident is under no obligation to speak to the LCA representative, but must be provided the opportunity to do so.
3. Nursing facility staff must in no way impede the assessment, planning and transitioning process triggered by a referral to an LCA.



TEXAS
Health and Human
Services

Relocation

- Nursing facility residents on Medicaid can receive relocation assistance, including help with transition planning, moving and financial assistance in setting up a new household.
- The nursing facility should cooperate **with the LCA and the individual's** habilitation coordinator, Service Coordinator in the discharge and transition.
- A service coordinator or case manager, depending on the program, will also ensure all necessary community based LTSS are in place at time of move-in.



TEXAS
Health and Human
Services

Referral

Initial Notification:

- The HC refers the individual to the **individual's MCO so a relocation specialist (RS)** can be assigned.

If the RS learns of a referral, the RS:

- provides the appropriate LIDDA with contact information for individuals interested in relocating who have an ID/DD; and
- **notifies the individual's appropriate MCO.**



TEXAS
Health and Human
Services

Relocation Assessment

Within 14 days of the referral, the RS:

- Conducts the relocation assessment to **determine the individual's needs:**
 - Housing;
 - Transportation; and
 - Support with moving expenses (Supplemental Transition Support).
- Sends completed assessment to the HC and MCO.



TEXAS
Health and Human
Services

Service Planning

The LIDDA Service Coordinator (SC):

- reviews the relocation assessment and evaluation;
- contacts the MCO SC and RS to participate in the Transition Plan; and
- schedules the Transition Plan meeting in cooperation with Transition Plan members.



TEXAS
Health and Human
Services

Service Planning

- The SPT uses the relocation assessment and evaluation, as well as other assessments (e.g., medical and behavioral), to guide the development of the Transition Plan.
- The LIDDA SC coordinates with the MCO as needed in accessing community resources the individual may need or be eligible for, including transportation, housing, medical, dental, STS, and other services.



TEXAS
Health and Human
Services

Service Planning

The MCO SC and RS, as members of the SPT, assist an individual with accessing:

- Housing, transportation, medical, dental and prescriptions, depending on the program the individual chooses; and
- STS funding, if the individual qualifies.



TEXAS
Health and Human
Services

Supplemental Transition Support



TEXAS
Health and Human
Services

A one-time Maximum of \$2,500 to pay for expenses related to moving and household start-up costs, if the expenses are:

- Reasonable and necessary;
- Purchased at lowest cost;
- Documented as essential for moving to the community; and
- Reviewed and communicated with the MCO and LIDDA service coordinator.

Transition Assistance



TEXAS
Health and Human
Services

Transition Assistance Services (TAS)

- Provided through the HCS waiver.
- One-time grant, \$2,500 maximum.
- For security and utility deposits, household supplies, moving assistance, essential furnishings, temporary rental assistance, among other items.
- The LIDDA service coordinator conducts the TAS assessment.

Monitoring and Follow-up



TEXAS
Health and Human
Services

For one year following an individual's relocation to the community in the HCS program only, the LIDDA provides:

- Enhanced community coordination and monitoring, and
- assistance with adjustments in service needs.

During the first 90 days following an individual's relocation to a community Medicaid program, the LIDDA completes at least three onsite post-move monitoring visits.

Monitoring and Follow-up



TEXAS
Health and Human
Services

The RS is not required to monitor individuals in the NF ID/DD population after transition.

An MCO SC is responsible for acute care coordination after the day of transition.

Relocation Process



TEXAS
Health and Human
Services

The MCO Perspective

Supporting Nursing Facility Residents Relocate to the Community



TEXAS
Health and Human
Services





TEXAS
Health and Human
Services

Thank you

This document was developed under grant CFDA 93.791 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

