# TITLE 26 HEALTH AND HUMAN SERVICES

# PART 1 HEALTH AND HUMAN SERVICES COMMISSION

# CHAPTER 303 PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

# SUBCHAPTER 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 nursing facility (NF) or a resident of a NFreceives 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 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 care and needs specialized services;

(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 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) Acute care hospital--A health care facility in which an individual 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) 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 . Alternate placement assistance includes transition planning, pre-move site review, and post-move monitoring.

(4) ANSA--Adult Needs and Strengths Assessment. The ANSA is the Texas uniform assessment tool approved for adult mental health services.

(5) APRN--Advance practice registered nurse. An individual licensed to practice professional nursing as an advance practice registered nurse in accordance with Texas Occupations Code Chapter 301.

(6) 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.

(7) CMWC--Customized manual wheelchair. In accordance with 40 TAC §19.2703 (relating to Definitions), 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.

(8) Collateral contact--A source of information that is knowledgeable about the individual seeking admission to a NF or the resident, such as family members, previous providers or caregivers, and who may support or corroborate information provided by the individual or resident.

(9) Coma--A state of unconsciousness characterized by the inability to respond to sensory stimuli as documented by a physician.

(10) 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.

(11) 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 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.

(12) DD--Developmental disability. A disability that meets the criteria described in the definition of "persons with related conditions" in 42 CFR §435.1010.

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

(14) 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 within the previous 365 days.

(15) DME--Durable medical equipment. The items described in 40 TAC §19.2703(10).

(16) 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.

(17) 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.

(18) 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.

(19) Exempted hospital discharge--A category of NF 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 services for the condition for which the individual was hospitalized.

(20) Expedited admission--A category of NF 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.

(21) Habilitation coordination--Assistance for a designated resident residing in a NF 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.

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

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

(24) HSP--Habilitation service plan. A plan developed by the SPT while a designated resident is residing in a NF 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.

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

(26) IDD--Intellectual and developmental disability.

(27) 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 from the NF 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 specified by the resident, LAR, NF, 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.

(28) 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.

(29) 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.

(30) 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.

(31) LAR--Legally authorized representative. An individual authorized by law to act on behalf of an individual seeking admission to a NF 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.

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

(33) LCSW--Licensed clinical social worker. An individual who is licensed as a licensed clinical social worker in accordance with Texas Occupations Code Chapter 505.

(34) Licensed psychologist-- An individual who is licensed as a psychologist in accordance with Texas Occupations Code Chapter 501.

(35) 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.

(36) LMFT--Licensed marriage and family therapist. An individual who is licensed as a marriage and family therapist in accordance with Texas Occupations Code Chapter 502.

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

(38) LPC--Licensed professional counselor. An individual who is licensed as a professional counselor in accordance with Texas Occupations Code Chapter 503.

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

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

(41) 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 in Texas is required to submit for a resident admitted into the facility.

(42) MI--Mental illness. Serious mental illness, as defined in 42 CFR §483.102(b)(1).

(43) 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.

(44) MI specialized services--Specialized services for 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

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(45) NF--Nursing facility. A Medicaid-certified facility that is licensed in accordance with the Texas Health and Safety Code Chapter 242.

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

(47) NF PASRR support activities-- Actions a NF takes in coordination with a LIDDA, LMHA, or LBHA to facilitate the successful provision of an IHSS or MI specialized service, including:

(A) arranging transportation for a NF resident to participate in an IHSS or a MI specialized service outside the facility;

(B) sending a resident to a scheduled IHSS 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 services at times that conflict with IHSS or MI specialized services.

(48) NF specialized services--The following specialized services available to a resident with ID or DD:

(A) therapy services;

(B) CMWC; and

(C) DME.

(49) PA--Physician assistant. An individual who is licensed as a physician assistant in accordance with Texas Occupations Code Chapter 204.

(50) 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.

(51) 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.

(52) PE--PASRR level II evaluation. A face-to-face evaluation:

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

(B) performed by a LIDDA, LMHA, 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;

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

(iii) identify alternate placement options.

(53) Physician-- An individual who is licensed to practice medicine in accordance with Texas Occupations Code Chapter 155.

(54) PL1--PASRR level I screening. The process of screening an individual seeking admission to a NF to identify whether the individual is suspected of having MI, ID, or DD.

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

(A) the IHSS required by the NF baseline 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.

(56) Preadmission process--A category of NF 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; and

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

(57) QIDP--Qualified intellectual disability professional. An individual who meets the qualifications described in 42 CFR §483.430(a).

(58) QMHP-CS--Qualified mental health professional-community services. An individual who meets the qualifications of a QMHP-CS as defined in §301.303 of this title (related to Definitions).

(59) Referring entity--The entity that refers an individual to a NF, 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.

(60) Resident--An individual who resides in a NF and receives services provided by professional nursing personnel of the NF.

(61) 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 MI, ID, or DD who experienced a significant change in condition, to:

(i) assess the resident's need for continued care in a NF;

(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;

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

(iii) identify alternate placement options.

(62) 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.

(63) Respite--Services provided on a short-term basis to an individual because of the absence of or the need for relief by the individual’s unpaid caregiver for a period not to exceed 14 days.

(64) RN--Registered nurse. An individual licensed to practice professional nursing as a registered nurse in accordance with Texas Occupations Code Chapter 301.

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

(66) Service coordinator--An employee of a LIDDA who provides service coordination.

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

(68) 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.

(69) Significant change in condition--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.

(70) Specialized services--The following support services, other than NF 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 specialized services;

(B) IHSS ; and

(C) MI specialized services.

(71) 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:

(I) a NF staff person familiar with the designated resident's needs; and

(II) an individual providing a specialized service 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 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 who is directly involved in the delivery of services to people with ID or DD.

(72) 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.

(73) Surrogate decision maker--An actively involved person 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.

(74) 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.

(75) Therapy services--In accordance with 40 TAC §19.2703(46) , 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.

(76) 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 to living in the community.

§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.

# TITLE 26 HEALTH AND HUMAN SERVICES

# PART 1 HEALTH AND HUMAN SERVICES COMMISSION

# 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 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.

(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 admission, if the individual seeking admission to a NF, 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 through the expedited admission process , 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 admitted through an exempted hospital discharge process if:

(1) the resident's stay in the NF 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); 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; or

(B) is determined by a NF 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;

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

(3) provide the completed PL1 as follows:

(A) to the NF 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, 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 through the preadmission process;

(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 to schedule the PE or resident review; and

(ii) meet face-to-face with the individual or resident at the referring entity or NF 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 or a resident has a PE or resident review that is positive for ID, DD, or MI and a NF 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 that will certify it can meet the needs of the individual or resident.

(c) If an individual seeking admission to a NF or a resident has a PE or resident review that is positive for ID, DD, or MI and a NF 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 to schedule an IDT meeting to discuss specialized services; :

(2) participate in the resident's IDT meeting as scheduled by the NF 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 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 entered information from the IDT meeting, confirm the LIDDA’s, LMHA’s, or LBHA’s participation in the meeting and the specialized services recommended in the LTC online portal ; and

(4) if Medicaid or other funding is available:

(A) initiate MI specialized services within 20 business days after the date of the IDT meeting; and

(B) provide the 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; and

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

(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 a LMHA or LBHA;

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

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

(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 who:

(1) is a QIDP; or

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

(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 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) RN;

(B) LCSW;

(C) LPC;

(D) LMFT;

(E) Licensed Psychologist;

(F) APRN;

(G) Physician; or

(H) 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, or a resident with MI, ID, or DD, or the individual's or resident's LAR in choosing another NF 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.

§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, 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) presenting community living options using HHSC-developed materials and forms, and offering educational opportunities and informational activities about community living options;

(I) arranging visits to community providers;

(J) accessing specialized services for a designated resident;

(K) the rights of an individual with an ID, 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; and

(L) advocacy for individuals with ID or DD;

(2) person-centered thinking training ; 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 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;

(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 services, supports, and alternatives;

(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 completed *Refusal of Habilitation Coordination* forms;

(2) documentation of the specialized services discussed in the initial IDT and any SPT or IDT 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 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. 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 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 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;

(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;

(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, assess 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) 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;

(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;

(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) 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.

(b) 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 or LAR in exercising the legal rights of the designated resident as a citizen and as a person with a disability;

(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 or NF comprehensive care plan, whichever is most current.

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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 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, 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.

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

(1) training that addresses:

(A) this chapter;

(B) HHSC's IDD PASRR Handbook;

(C) the role of a relocation specialist and MCO service coordinator for a NF resident who wants to transition to the community;

(D) services available through Texas Medicaid State Plan and all home and 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) developing and implementing a transition plan for a designated resident;

(F) an overview of community living options, educational opportunities, and informational activities about community living options; and

(G) the rights of an individual with ID, 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; and

(2) person-centered thinking training ; 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.

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# SUBCHAPTER H COMPLIANCE REVIEW

§303.801. 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 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.

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# SUBCHAPTER I MI SPECIALIZED SERVICES

§303.901. Description of MI Specialized Services.

(a) The LMHA or LBHA staff must conduct an ANSA 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 an ANSA.

The LMHA or LBHA staff person administering the ANSA must be certified in administering the ANSA by the Praed Foundation. This certification must be updated annually.

§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 ANSA;

(3) ensure the resident with MI, or LAR on the resident with MI’s behalf, understands the purpose of the ANSA; and

(4) have the resident with MI, or LAR on the resident with MI’s behalf, agree or decline to receive an ANSA 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 ANSA;

(2) develop the PCRP; and

(3) for a resident with MI only, convene a meeting to discuss the results of the ANSA 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 ANSA 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 ANSA and PCRP to the NF for inclusion in the resident with MI’s NF comprehensive care plan.

§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 ANSA accurately reflects the resident with MI’s need for MI specialized services in the identified frequency, amount, and duration, or if an updated ANSA 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 ANSA is required, a QMHP-CS must, within seven calendar days after the meeting is held, update the ANSA 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 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 an ANSA or MI Specialized Services.

When a resident with MI refuses an ANSA or MI specialized services, the LMHA or LBHA must:

(1) ensure the resident with MI or the LAR signs the Refusal of PASRR MI Specialized Services form;

(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 still refuses an ANSA or MI specialized services after 90 days, inform the resident with MI that an annual IDT meeting will still occur, and services may be offered again.

§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 services delivered by the LMHA or LBHA.