

New Chapter Governing

Preadmission Screening and Resident Review (PASRR)

Chapter 17, Subchapters A-E

EFFECTIVE DATE: July 7, 2015

Attached are new rules governing Preadmission Screening and Resident Review (PASRR). Please remove Chapter 17, governing the same, with an effective date of May 24, 2013, from your collection of DADS rules and replace it with this document.

What's Different?

The three key differences between the repealed rules and these new rules are as follows:

- The rules no longer include nursing facility responsibilities. Nursing facility responsibilities related to PASRR are contained in Chapter 19, Subchapter BB.
- A new Subchapter E is added that addresses service planning and service coordination requirements for a designated resident (i.e., a Medicaid recipient with ID or DD who is 21 years of age or older, and who is a resident or has transitioned to the community from a nursing facility).
- Specialized services have changed. Vocational training is no longer a specialized service and the following are new specialized services:
 - Behavioral support
 - Day habilitation
 - Employment assistance
 - Independent living skills training
 - Supported employment

Process

The new chapter was proposed for public comment in the April 3, 2015, issue of the *Texas Register*. The adoption is published in the July 3, 2015, issue of the *Texas Register*.

Questions

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**DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)
40 TAC, CHAPTER 17, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER A, GENERAL PROVISIONS**

TABLE OF CONTENTS

<u>Section</u>	<u>Title</u>	<u>Page</u>
Subchapter A, General Provisions		
§17.101.	Purpose.	1
§17.102.	Definitions.	1
§17.103.	Fair Hearing Process.	6
Subchapter B, PASRR Screening and Evaluation Process		
§17.201.	Preadmission Process.	7
§17.202.	Expedited Admission Process.	7
§17.203.	Admission Process for Exempted Hospital Discharge.	7
§17.204.	Resident Review Process.	7
Subchapter C, Responsibilities		
§17.301.	Referring Entity Responsibilities Related to the PASRR Process.	8
§17.302.	LIDDA and LMHA Responsibilities Related to the PASRR Process.	8
Subchapter D, Vendor Payment		
§17.401.	Reimbursement for a PE or Resident Review.	10
Subchapter E, Service Planning for a Designated Resident		
§17.501.	Service Coordination for a Designated Resident.	11
§17.502.	Service Planning Team (SPT) Responsibilities for a Designated Resident.	11
§17.503.	Transition Planning for a Designated Resident.	12

Subchapter A, General Provisions

§17.101. Purpose.

Effective: July 7, 2015

(a) The purpose of this chapter is to:

(1) describe the responsibilities of a local intellectual and developmental disabilities authority (LIDDA) and a local mental health authority (LMHA) related to preadmission screening and resident review (PASRR), to ensure that:

(A) an individual seeking admission to a Medicaid-certified nursing facility or a resident of a nursing facility receives a PASRR Level 1 Screening (PL1) to identify whether the individual or resident is suspected of having mental illness (MI), an intellectual disability (ID), or a developmental disability (DD); and

(B) an individual or resident suspected of having MI, ID, or DD receives a PASRR

evaluation (PE) to confirm MI, ID, or DD and, if confirmed, to evaluate whether the individual or resident needs nursing facility care and needs specialized services; and

(2) describe the responsibilities of a LIDDA related to designated residents who receive service planning and transition planning as described in Subchapter E of this chapter.

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

§17.102. Definitions.

Effective: July 7, 2015

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

(1) **Alternate placement assistance** -- Assistance provided to a resident to locate and secure services chosen by the resident or LAR that meet the resident's basic needs in a setting other than a nursing facility. Assistance includes the identification of specific services and supports available through alternate resources for which the resident may be eligible and an explanation of the possible benefits and consequences of selecting a setting other than a nursing facility.

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

(A) Behavioral support includes:

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

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

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

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

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)
40 TAC, CHAPTER 17, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER A, GENERAL PROVISIONS

modifying the plan as necessary.

(B) A qualified service provider of behavioral support:

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

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

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

(iv) is certified by DADS as described in §5.161 of this title;

(v) is licensed as a licensed clinical social worker in accordance with Texas Occupations Code, Chapter 505;

(vi) is licensed as a licensed professional counselor in accordance with Texas Occupations Code, Chapter 503; or

(vii) is certified as a behavior analyst by the Behavior Analyst Certification Board.

(3) **Collateral contact** -- A person who is knowledgeable about an individual's situation and who may support or corroborate information provided by the individual.

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

(5) **Comprehensive care plan** -- A plan, defined in §19.2703 of this title (relating to Definitions).

(6) **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.

(7) **DADS** -- The Texas Department of Aging and Disability Services. For purposes of the PASRR process, DADS is the state authority for intellectual and developmental disabilities.

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

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

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

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

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

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

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

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

(11) **Designated resident** -- A Medicaid recipient with ID or DD who is 21 years of age or older, and who is a resident or has transitioned to the community from a nursing facility.

(12) **DSHS** -- Department of State Health Services. For purposes of the PASRR process, DSHS is the state mental health authority.

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

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

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

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)
40 TAC, CHAPTER 17, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER A, GENERAL PROVISIONS

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

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

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

(E) participating in service planning team meetings.

(15) **Exempted hospital discharge** -- A category of nursing facility admission that occurs when a physician has certified that an individual who is being discharged from a hospital is likely to require less than 30 days of nursing facility services for the condition for which the individual was hospitalized.

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

(17) **ID** -- Intellectual disability. Mental retardation, as defined in the Code of Federal Regulations (CFR) Title 42 §483.102(b)(3)(i).

(18) **IDT** -- Interdisciplinary team. A team consisting of:

- (A) a resident with MI, ID, or DD;
- (B) the resident's LAR, if any;
- (C) a registered nurse from the nursing facility with responsibility for the resident;

(D) a representative of:
(i) the LIDDA, if the resident has ID or DD;

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

(iii) the LIDDA and the LMHA, 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) a person specified by the resident or LAR, nursing facility, or LIDDA or LMHA, as applicable, who is professionally

qualified or 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.

(19) **Independent living skills training** -- Individualized activities that are consistent with the individual service plan and provided in a person's residence and at community locations (e.g., libraries and stores). Supports include:

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

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

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

(20) **Individual** -- A person seeking admission to a nursing facility.

(21) **ISP** -- Individual service plan. A service plan developed by the service planning team for a designated resident in accordance with §17.502(2) of this chapter (relating to Service Planning Team (SPT) Responsibilities for a Designated Resident).

(22) **LAR** -- Legally authorized representative. A person authorized by law to act on behalf of an individual 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.

(23) **LIDDA** -- Local intellectual and developmental disability authority. An entity designated by the executive commissioner of the Texas Health and Human Services Commission, in accordance with Texas Health and Safety Code §533.035.

(24) **LMHA** -- Local mental health authority. An entity designated by the executive

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)
40 TAC, CHAPTER 17, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER A, GENERAL PROVISIONS

commissioner of the Texas Health and Human Services Commission, in accordance with Texas Health and Safety Code §533.035. For the purposes of this chapter, LMHA includes an entity designated by the Department of State Health Services to perform PASRR functions.

(25) **LTC Online Portal** -- Long Term Care Online Portal. A web-based application used by Medicaid providers to submit forms, screenings, evaluations, and the long term services and supports Medicaid identification section of the MDS assessment.

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

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

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

(29) **Nursing facility PASRR support activities** -- Actions a nursing facility takes in coordination with a LIDDA or a LMHA to facilitate the successful provision of LIDDA or LMHA specialized services, including:

(A) arranging transportation for a nursing facility resident to participate in a LIDDA or LMHA specialized service outside the facility;

(B) sending a resident to a scheduled LIDDA or LMHA specialized service with food and medications required by the resident; and

(C) including in the comprehensive care plan an agreement to avoid, when possible, scheduling nursing facility services at times that conflict with LIDDA or LMHA specialized services.

(30) **PASRR** -- Preadmission screening and resident review.

(31) **PE (PASRR Level II evaluation)** -- A face-to-face evaluation of an individual suspected of having MI, ID, or DD performed by a LIDDA or a LMHA to determine if the individual has MI, ID, or DD and, if so, to:

(A) assess the individual's need for care in a nursing facility;

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

(C) identify alternate placement options.

(32) **PL1 (PASRR Level I screening)** -- The process of screening an individual to identify whether the individual is suspected of having MI, ID, or DD.

(33) **Pre-admission** -- A category of nursing facility admission from a community setting that is not an expedited admission or an exempted hospital discharge.

(34) **Referring entity** -- The entity that refers an individual to a nursing facility, such as a hospital, attending physician, LAR or other personal representative selected by the individual, a family member of the individual, or a representative from an emergency placement source (e.g., law enforcement).

(35) **Resident** -- An individual who resides in a Medicaid-certified nursing facility and receives services provided by professional nursing personnel of the facility.

(36) **Resident review** -- A face-to-face evaluation of a resident performed by a LIDDA or LMHA:

(A) for a resident with MI, ID, or DD who experienced a significant change in status, to:

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

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

(iii) identify alternate placement options; and

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

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

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

(iii) identify alternate placement options.

(37) **Respite** -- Services provided on a short-term basis to a person because of the absence

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)
40 TAC, CHAPTER 17, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER A, GENERAL PROVISIONS

of or the need for relief by the person's unpaid caregiver for a period not to exceed 14 days.

(38) **Service coordination** -- As defined in §2.553 of this title (relating to Definitions), assistance in accessing medical, social, educational, and other appropriate services and supports that will help a person achieve a quality of life and community participation acceptable to the person and LAR on the person's behalf.

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

(40) **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.

(41) **Specialized services** -- Support services, other than nursing facility services, that are identified through the PE or resident review and may be provided to a resident who has MI, ID, or DD.

(A) Nursing facility specialized services for a resident with ID or DD are:

(i) physical therapy, occupational therapy, and speech therapy;

(ii) a customized manual wheelchair; and

(iii) durable medical equipment, which consists of:

(I) a gait trainer;

(II) a standing board;

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

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

(V) a positioning wedge;

(VI) a prosthetic device;

and

(VII) an orthotic device.

(B) LIDDA specialized services for a resident with ID or DD are:

(i) service coordination, which

includes alternate placement assistance;

(ii) employment assistance;

(iii) supported employment;

(iv) day habilitation;

(v) independent living skills training; and

(vi) behavioral support.

(C) LMHA specialized services for a resident with MI, including alternate placement assistance, are defined in 25 TAC Chapter 412, Subchapter I (relating to MH Case Management) and 25 TAC Chapter 416, Subchapter A (relating to Mental Health Rehabilitative Services).

(42) **SPT** -- Service planning team. A team that develops, reviews, and revises the ISP for a designated resident.

(A) The team always includes:

(i) the designated resident;

(ii) the designated resident's LAR,

if any;

(iii) the service coordinator;

(iv) while the designated resident is in a nursing facility:

(I) nursing facility staff familiar with the designated resident's needs; and

(II) persons providing specialized services for the designated resident;

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

(vi) a representative from the LMHA, if the designated resident has MI.

(B) Other participants on the SPT may include:

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

(ii) at the discretion of the LIDDA, a person who is directly involved in the delivery of services to people with ID or DD.

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

**DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)
40 TAC, CHAPTER 17, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER A, GENERAL PROVISIONS**

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

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

(C) participating in service planning team meetings.

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

(45) **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 nursing facility.

§17.103. Fair Hearing Process.

Effective: July 7, 2015

An individual, resident, or an individual's or resident's LAR who is not in agreement with a denial of specialized services may request a fair hearing to appeal the denial in accordance with 1 TAC Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules).

(1) If the hearing officer reverses a denial of specialized services, the LIDDA, the LMHA, or the nursing facility, as applicable, must provide the services.

(2) If the hearing officer sustains the denial of specialized services, the LIDDA, the LMHA, or the nursing facility must not provide the services.

**DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)
40 TAC, CHAPTER 17, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER B, PASRR SCREENING AND EVALUATION PROCESS**

**Subchapter B, PASRR Screening and
Evaluation Process**

§17.201. Preadmission Process.

Effective: July 7, 2015

(a) Except as provided in §17.301(b) of this chapter (relating to Referring Entity Responsibilities), a referring entity must complete a PL1 when an individual is seeking admission into a nursing facility, and:

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

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

(B) must provide a copy of the PL1 to the LIDDA or LMHA, 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 nursing facility for admission.

(b) If a LIDDA or LMHA is notified in accordance with subsection (a)(1)(A) of this section, the LIDDA or LMHA must:

(1) complete a PE in accordance with §17.302(a)(2) of this chapter (relating to LIDDA and LMHA Responsibilities Related to the PASRR Process); and

(2) comply with §17.302(b) and (c) of this chapter.

§17.202. Expedited Admission Process.

Effective: July 7, 2015

If the LTC Online Portal generates a notice to the LIDDA or LMHA that an individual being admitted to a nursing facility through the expedited admission process is suspected of having MI, ID, or DD, the LIDDA or LMHA, as applicable, must:

(1) complete a PE in accordance with §17.302(a)(2) of this chapter (relating to LIDDA and LMHA Responsibilities Related to the PASRR Process); and

(2) comply with §17.302(b) and (c) of this chapter.

**§17.203. Admission Process for Exempted
Hospital Discharge.**

Effective: July 7, 2015

A LIDDA or LMHA must conduct a resident review in accordance with §17.204 of this subchapter (relating to Resident Review Process) for a resident of a nursing facility admitted through an exempted hospital discharge process if:

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

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

§17.204. Resident Review Process.

Effective: July 7, 2015

(a) The LTC Online Portal generates an automated notification to a LIDDA or LMHA that a resident review must be completed if:

(1) a resident with MI, ID, or DD experiences a significant change in status as determined by the MDS Significant Change in Status Assessment Form; or

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

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

(B) is determined by a nursing facility, DADS, or DSHS to need a resident review for any other reason.

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

(1) complete a resident review in accordance with §17.302(a)(2) of this chapter (relating to LIDDA and LMHA Responsibilities Related to the PASRR Process); and

(2) comply with §17.302(b) and (c) of this chapter.

**DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)
40 TAC, CHAPTER 17, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER C, RESPONSIBILITIES**

Subchapter C, Responsibilities

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

Effective: July 7, 2015

(a) Except as provided in subsection (b) of this section, a referring entity must:

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

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

(3) provide the completed PL1 as follows:

(A) to the nursing facility selected by the individual or LAR:

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

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

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

(b) A referring entity is not required to comply with subsection (a) if the individual has not had an interruption in nursing facility residence, other than for acute care lasting fewer than 30 days, and the individual is returning to the same nursing facility.

(c) 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 nursing facility in completing the PL 1.

§17.302. LIDDA and LMHA Responsibilities Related to the PASRR Process.

Effective: July 7, 2015

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

(1) enter in the LTC Online Portal the data from a PL1 completed by a referring entity for an individual who is suspected of having MI, ID, or DD and who is seeking admission to a nursing facility under the preadmission process;

and

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

(A) within 72 hours after receiving a copy of the PL1 from the referring entity or notification from the LTC Online Portal:

(i) call the referring entity or nursing facility to schedule the PE or resident review; and

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

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

(i) gather information needed to complete the PE or resident review, including:

(I) reviewing the individual's or resident's medical records;

(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 by telephone, mail, or face-to-face with collateral contacts as necessary; and

(IV) obtaining additional information as needed; and

(ii) enter the data from the PE or resident review in the LTC Online Portal.

(b) After completing a PE or resident review, if a nursing facility certifies in the LTC Online Portal that it cannot meet the needs of an individual or resident with MI, ID, or DD, then the LIDDA or LMHA, as applicable, must assist the individual, resident, or LAR in choosing another nursing facility that will certify it can meet the needs of the individual or resident.

(c) After completing a PE or resident review, if a nursing facility certifies in the LTC Online Portal that it can meet the needs of a resident with MI, ID, or DD, or certifies in the LTC Online Portal that it can the needs of an individual with MI, ID, or DD seeking admission and admits the individual, the LIDDA or LMHA, as applicable, must:

DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)
40 TAC, CHAPTER 17, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER C, RESPONSIBILITIES

(1) coordinate with the nursing facility to schedule an IDT meeting to discuss specialized services;

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

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

(B) identify the nursing facility PASRR support activities for the resident; and

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

(3) within five business days after the IDT meeting, confirm in the LTC Online Portal, in accordance with DADS instructions, the specialized services agreed upon in the IDT meeting; and

(4) if Medicaid or other funding is available:

(A) initiate specialized services within 30 days after the date that the specialized services are agreed upon in the IDT meeting; and

(B) provide the specialized services agreed upon in the IDT meeting to the resident.

**DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)
40 TAC, CHAPTER 17, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER D, VENDOR PAYMENT**

Subchapter D, Vendor Payment

§17.401. Reimbursement for a PE or Resident Review.

Effective: July 7, 2015

(a) A LIDDA and LMHA must accept the reimbursement rate, established by the Texas Health and Human Services Commission, as payment in full for the following activities:

(1) completing a PE or resident review in accordance with §17.302(a)(2) of this chapter (relating to LIDDA and LMHA Responsibilities Related to the PASRR Process);

(2) assisting an individual or resident with MI, ID, or DD or the individual's or resident's LAR in choosing a nursing facility that will certify it can meet the needs of the individual or resident as described in §17.302(b) of this chapter;

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

(4) submitting to DADS, in accordance with DADS instructions, information related to participation in the IDT meeting and specialized services agreed upon during the IDT meeting.

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

**DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)
40 TAC, CHAPTER 17, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER E, SERVICE PLANNING FOR A DESIGNATED RESIDENT**

Subchapter E, Service Planning for a Designated Resident

§17.501. Service Coordination for a Designated Resident.

Effective: July 7, 2015

(a) A LIDDA must assign a service coordinator to each designated resident. A designated resident may decline service coordination.

(b) A service coordinator must:

(1) while a designated resident is residing in a nursing facility and, if the resident moves into the community, during the first 180 days after the designated resident has moved into the community:

(A) meet face-to-face with the designated resident on a monthly basis, or more frequently if needed;

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

(C) facilitate the development of the designated resident's ISP using a DADS-approved form; and

(D) facilitate revisions to the ISP, as needed;

(2) while a designated resident is residing in a nursing facility:

(A) at a service coordinator's first visit with the designated resident, and at least every six months thereafter, provide information about and discuss with the designated resident and LAR, if any, the range of community living service and support options and alternatives, using DADS-approved materials, form, and instructions;

(B) facilitate the coordination of the designated resident's specialized services;

(C) ensure the designated resident and LAR are informed of the educational and informational activities arranged and scheduled by the LIDDA; and

(D) facilitate coordination between the designated resident's ISP and the nursing facility's comprehensive care plan for the designated resident; and

(3) for a designated resident who wants to move to the community, facilitate the SPT's transition planning responsibilities, including:

(A) developing a transition plan in accordance with §17.503 of this title (relating to Transition Planning for a Designated Resident) using a DADS-approved form; and

(B) facilitating visits to community programs, when appropriate, and addressing concerns about community living.

§17.502. Service Planning Team (SPT) Responsibilities for a Designated Resident.

Effective: July 7, 2015

The SPT of a designated resident must:

(1) 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, but not limited to, communication supports;

(2) develop an ISP for the designated resident that:

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

(B) identifies the designated resident's:

(i) strengths;

(ii) preferences;

(iii) psychiatric, behavioral, nutritional management, and support needs;

(iv) desired outcomes; and

(v) for a designated resident who has transitioned to the community, medical and nursing needs; and

(C) identifies the specialized services to be provided to the designated resident, including frequency, intensity, and duration for each service;

(3) monitor and coordinate services, including specialized services, identified on the ISP and provided to the designated resident to ensure the designated resident's needs are being met;

(4) considering the designated resident's preferences, ensure the designated resident is provided opportunities for engaging in integrated activities:

**DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)
40 TAC, CHAPTER 17, PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
SUBCHAPTER E, SERVICE PLANNING FOR A DESIGNATED RESIDENT**

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

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

(5) make timely referrals, service changes, and amendments to the ISP as needed;

(6) be responsible for transition planning in accordance with §17.503 of this title (relating to Transition Planning for a Designated Resident); and

(7) ensure that the designated resident's ISP, including specialized services, is coordinated with the nursing facility's comprehensive care plan.

§17.503. Transition Planning for a Designated Resident.

Effective: July 7, 2015

(a) A designated resident's SPT must develop a transition plan, using a DADS-approved form and instructions, as described in subsection (b) of this section for the designated resident if:

(1) the designated resident's response in Section Q of the MDS 3.0 indicates the designated resident is interested in speaking with someone about transitioning to the community;

(2) the designated resident's PE or resident review reflects that the designated resident's needs can be met in an appropriate community setting; or

(3) the designated resident expresses an interest in moving to the community.

(b) A transition plan for a designated resident must:

(1) describe the activities, timetable, responsibilities, services, and supports involved in assisting the designated resident to consider the available community living options and programs, choose a provider, and move from the nursing facility to the community; and

(2) specify the frequency of monitoring visits by a service coordinator, which will be at least three monitoring visits during the first 90 days after the designated resident's move, with one visit conducted within the first seven days after the move.

(c) The SPT must revise, implement, and

monitor the transition plan as necessary.

(d) For a designated resident who is moving to the community, a service coordinator must conduct, and document on a DADS-approved form, a pre-move site review of the designated resident's proposed residence in the community to determine whether all essential supports identified in the designated resident's transition plan are in place before the designated resident's move to the community.

(e) For a designated resident who is moving to the community, the SPT must ensure and document that all essential supports identified in the designated resident's transition plan are in place before the designated resident moves to the community.

(f) For a designated resident who has moved to the community, a service coordinator must conduct, and document on a DADS-approved form, at least three post-move monitoring visits, scheduled in accordance with subsection (b)(2) of this section, to:

(1) assess whether essential supports identified in the transition plan are in place;

(2) identify any gaps in care; and

(3) address such gaps, if any, to reduce the risk of crisis, re-admission to a nursing facility, or other negative outcome.

(g) If the SPT makes a recommendation that the designated resident continue to reside in a nursing facility, the SPT must:

(1) document the reasons for the recommendation;

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

(3) describe in the ISP the steps the SPT will take to address those barriers.