Important Nursing Facility Updates

Information posted May 23, 2014

Several important updates are scheduled to implement June 27, 2014, to the Long Term Care (LTC) Online Portal and Preadmission Screening and Resident Review (PASRR). Some of the changes include new availability of the Update Form button, and Service Coordination Assignment and Transition Planning.

Update Form Button
The Update Form button, which allows updates to the PASRR Level 1 (PL1) Screening Form for users with the appropriate security permission, will now appear on converted PL1s with the same functionality as is currently used. Not all fields on the PL1 are updateable and there are certain form statuses that prevent form updates. For additional information on the Update Form button usage and available fields, refer to the Corrections and Updates section of the LTC Nursing Facility/Hospice User Guide.

Minimum Data Set (MDS) Rejections
If a PASRR Level 1 (PL1) Screening Form has not been submitted prior to the MDS Long Term Care Medicaid Information (LTCMI) submission, the LTCMI will not be accepted on the LTC Online Portal. NFs will be able to save the LTCMI as a draft and resubmit the LTCMI after the PL1 has been submitted. If a NF admits a Preadmission individual without the PL1 being submitted on the LTC Online Portal, the NF will need to contact the LA to submit the PL1 due to NFs not being allowed to submit positive Preadmission PL1s. NFs are able to submit PL1s for Expedited Admissions, Exempted Hospital Discharge Admissions and negative PL1 Screening Forms.

For Preadmission individuals, the first MDS assessment will inherit medical necessity (MN) determination from the positive PASRR Evaluation (PE) that is associated with it. The MDS LTCMI will be rejected waiting for the MN determination on the PE.

Service Coordination Assignment and Transition Planning
The Department of Aging and Disability Services (DADS) requires the Local Authority (LA) to provide service coordination to Medicaid-eligible Nursing Facility residents with Intellectual and Development Disabilities (IDD), including organizing a service planning team and facilitating service planning related to specialized services, community living options, and transition to community living.

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

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

DADS requires the service planning team to develop an individual service plan (ISP) for a resident that:
- Is individualized and developed through a person-centered process.
- Identifies the resident’s strengths, preferences, medical, nursing, nutritional management, clinical, and support needs, and desired outcomes.
- Identifies the services and supports that are needed to meet the resident’s needs, achieve the desired outcomes, and maximize the resident’s ability to live successfully in the most integrated setting possible.

DADS requires the service planning team to include:
- The resident.
- The resident’s legally authorized representative (LAR), if any.
- The service coordinator.
- Persons providing specialized services for the resident.
- A Nursing Facility staff member familiar with the resident’s needs.
- If a specific alternate placement provider has been selected, a representative from that provider.

The service planning team may include other concerned persons whose inclusion is requested by the resident or the LAR, and, at the discretion of the LA, other persons who are directly involved in the delivery of services to the resident.

DADS also requires the service planning team to:
- Ensure the resident, regardless of whether they have an LAR, participates in the service planning team to the fullest extent possible consistent with the individual’s choice, and receive the support necessary to do so, including communication supports.
- Assess the adequacy of the services and supports the resident is receiving.
- Monitor the resident’s ISP to make timely additional referrals, service changes, and amendments to the plan as needed.
- Identify the specific, specialized services to be provided to the resident, including the amount, intensity, and frequency of each specialized service.
- Be responsible for planning, ensuring the implementation of, and monitoring all specialized services identified in the ISP, and transition planning in coordination with the Nursing Facility’s care planning team.
- Ensure the resident’s ISP, including specialized services, is integrated into the Nursing Facility’s plan of care and that specialized services are planned, provided, and monitored in a consistent manner, and integrated with the services provided by the Nursing Facility.

For a resident who expresses an interest in transitioning to the community or whose PASRR Evaluation (PE) reflects that the resident’s needs can be met in an appropriate community setting, the service planning team must create a transition plan. The
transition plan must describe the activities, timetable, responsibilities, services, and supports involved in assisting the resident to:

- Consider community living options.
- Choose a provider.
- Transition from the Nursing Facility to the community, including identifying and securing the elements the resident needs to move into the community, such as a supply of medications, adaptive aids, and specialized equipment.
- Specify the frequency of post-move monitoring visits by the service coordinator and identify at least three monitoring visits during the first 90 days following the resident’s transition to the community, including one within the first seven days after transition.

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

Contact TMHP at 1-800-626-4117, Option 1, for questions about the upcoming changes to the LTC Online Portal.