TEXAS
Department of Aging
and Disability Services

COMMISSIONER
Jon Weizenbaum

July 14, 2015

To: Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions Program Providers

Subject: Information Letter No. 2015-39
Requirements Related to Individuals Moving from a Nursing Facility to an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions Program

The purpose of this Information Letter (IL) is to inform Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) program providers of new requirements related to individuals moving from a nursing facility (NF) to an ICF/IID effective immediately. An ICF/IID program provider must participate in service planning and work collaboratively with the local intellectual and developmental disability authority (LIDDA) to ensure the successful transition of individuals who have been evaluated though a preadmission screening and resident review (PASRR) and who move from a Medicaid-certified NF to an ICF/IID. An ICF/IID program provider must comply with this IL in accordance with the Medicaid Provider Agreement for ICF/IID Services.

A LIDDA service coordinator provides service planning and enhanced monitoring to an adult individual who moves from an NF to a community setting of the individual's choice (including an ICF/IID). The service coordinator:

- schedules and facilitates a service planning team (SPT) meeting to develop a transition plan. The SPT begins meeting while the individual is still residing in the NF.
- conducts a pre-move site review of an individual's proposed residence in the community to determine if the essential supports identified on the individual's transition plan are ready to be provided before the individual moves to the residence.
- conducts post-move monitoring, consisting of at least three visits to the individual's residence, day program, or work site.
    - The purpose of a monitoring visit is to:
        - determine if essential supports and non-essential supports identified on the individual's transition plan are being provided;
        - interview program provider staff about the individual's adjustment to community life; and
        - assess the individual's and legally authorized representative's satisfaction with community life.
    - The visits are completed at the following intervals: within 7 days after the individual moves into the community; between 8 and 45 days after the individual moves into the community; and between 46 and 90 days after the individual moves into the community.

- Conducts face-to-face service coordination contacts monthly during the first six months following the individual's move from the NF, and quarterly during the second six months following the individual's move. The service coordinator conducts additional contacts based on the individual's needs.

A LIDDA service coordinator will contact an ICF/IID program provider to schedule SPT meetings, a pre-move site review, and post-move monitoring visits.

The ICF/IID program provider must:

- identify a representative to serve on the SPT and ensure the representative participates in transition planning while the individual is residing in the NF; and
- cooperate with the LIDDA service coordinator by providing timely access to:
  - the individual;
  - the individual's residence, day program, and records;
  - staff of the program provider and day program; and
  - information needed by the service coordinator to complete the required documentation for the review and monitoring visits.

If you have questions about this letter, please email ICFquestions@dads.state.tx.us.

Sincerely,

[signature on file]

Elisa J. Garza
Assistant Commissioner
Access and Intake

[signature on file]

Donna Jessee
Director
Center for Policy and Innovation