THE ROLE OF MEDICAID MANAGED CARE PLANS IN THE PREADMISSION AND RESIDENT REVIEW PROCESS

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Purpose

This paper was produced to provide technical assistance to CMS and Preadmission Screening and Resident Review (PASRR) state authorities (Single State Medicaid Agencies, state Intellectual Disability/Developmental Disability authorities (SIDA) and state mental health authorities (SMHA)) in considering the role that PASRR programs can play within managed care plans delivery systems.

1. Medicaid Managed Care and PASRR – Opportunities for Collaboration

As states increasingly contract through a Medicaid managed care plan (MCP) to support individuals who receive long-term services and supports (LTSS), it is important to consider the role that Preadmission Screening and Resident Review (PASRR) programs can play within these delivery systems. PASRR programs can help states and MCPs achieve improved coordination and continuity of care for Medicaid-participating individuals with mental illness, intellectual disability, or related conditions (MI/ID/RC) who require nursing facility (NF) level of care, as well as helping those individuals understand their options for community placement.

It may be possible for PASRR programs and a MCP to work together without explicit contract language, as MCPs are already responsible for routine care coordination, care planning, and other healthcare assessments, but including PASRR in the MCP contract offers opportunities to advance state initiatives related to person-centered planning, community integration, and recovery. This paper discusses both informal and contractual approaches to increasing engagement of MCPs in the PASRR process by delegating specific functions to them or promoting their interface with others who performs those functions.

Managed Care and Long-Term Services and Supports

Medicaid and the Children's Health Insurance Program (CHIP) offer public health care coverage to more than 80 million people in the United States.[1] Approximately two-thirds of these individuals receive coverage through managed care.[2] Today, forty states and the District of Columbia use Medicaid managed care to deliver at least some services to Medicaid beneficiaries. In most of these states, managed care is the dominant model; 24 states enroll 75 percent or more of their Medicaid beneficiaries in managed care plans and an additional 12

states enroll between 50 and 75 percent.[6] State Medicaid agencies establish contract arrangements with MCPs to provide health coverage, improve appropriate health care utilization, and improve health outcomes for Medicaid beneficiaries.[3]

Medicaid agencies pay MCPs a per-member per-month capitated rate for contracted services,[4] which may include behavioral health services, pharmacy benefits, and LTSS, in addition to coverage for primary and acute care.[5] State approaches to managed care have evolved over time. Managed care states have traditionally begun the transition to a managed care system by first enrolling children and low-income adults. More recently, states have begun enrolling seniors and people with disabilities, two groups that often have complex health needs.[7] Today, 21 states enroll 75 percent or more of seniors and people with disabilities in their MCPs.[8] The growth of MCP coverage for these higher-need populations is expected to increase Medicaid payments to MCPs, which already account for almost half of Medicaid spending.[9]

Enrollment trends for seniors and groups needing LTSS mirror the rise in state "carve-ins" of LTSS to MCPs. While LTSS and other services, commonly behavioral health, have historically been "carved out" of MCP contracts and covered directly by Medicaid fee-for-service (FFS), an increasing number of states (23 as of 2019) now include LTSS in MCP contracts.[10]

These services are known as managed LTSS, or MLTSS. This trend has occurred in part due to rising cost pressures associated with LTSS. The absolute amount spent on MLTSS programs has increased more than three-fold in the past 20 years, climbing from $6.7 billion in FY 2008 to $30.1 billion in FY 2018.[11] States have increasingly pursued MLTSS to control spending while providing high-quality care to Medicaid beneficiaries, 1.8 million of whom were enrolled in MLTSS nationwide in 2018.[12]

PASRR as a State Responsibility

PASRR is a federal requirement and state responsibility that ensures all applicants to Medicaid-certified nursing facilities receive a preliminary assessment to determine whether they might have serious mental illness (SMI) and/or intellectual disabilities or related conditions (ID/RC), to prevent individuals from inappropriate placement in NFs for long-term care. All Medicaid-certified NFs must evaluate applicants for SMI and ID/RC and ensure that each individual is offered placement in the least restrictive setting possible that can meet their needs – in the community with home and community-based services (HCBS) or in a NF with specialized services.[13] This requirement, which was clarified in the 1999 *Olmstead v. L.C.* Supreme Court opinion,[14] reflects federal law and regulations aimed at ensuring person-centered long-term care in the most appropriate setting for all individuals who are eligible for long-term care benefits. PASRR also ensures that individuals receive all necessary services, regardless of where they are placed. Medicaid must cover LTSS provided in NFs and offers several options for HCBS provision. Today, however, most Medicaid LTSS spending (55 percent) is spent on HCBS.[15]

The state Medicaid agency retains ultimate responsibility for implementing the state's PASRR program, but certain PASRR activities and processes are overseen by states' Intellectual Disability/Developmental Disability authorities (SIDA) and states' mental health authorities (SMHA).[16] Each state's PASRR process must follow the Medicaid requirements of that state, including requirements related to processes, training, personnel qualifications, rights of appeal, and standards for LTSS care.[17]

Informal Approaches to Promoting MCPs PASRR Awareness and Engagement

While federal regulations assign specific responsibilities to the three authorities responsible for operating the state's PASRR program, it is well understood that the effectiveness of the program is dependent on a wide range of stakeholders. Hospital discharge planning staff, contractual PASRR Level 1 screeners and Level II evaluators, nursing facility staff, and providers of specialized services are likely to understand federal regulations relevant to their role and, hopefully, the specific objectives or goals of the state PASRR program. This is generally accomplished through continued access to PASRR training or information and open lines of communication rather than formal contracts.

As noted in the previous section, MCPs have a clear role in supporting individuals with SMI or ID/RC, making them a valuable stakeholder in a state PASRR program. It is important that states determine if MCPs are currently included in their group of key stakeholders. The PASRR contract components discussed in section 2 can serve as prompting questions for states that choose a more informal approach to engaging MCPs in their PASRR program.

State Role in Specifying PASRR Obligations in MCPs Contracts

State Medicaid programs retain responsibility for administering MLTSS, including setting capitation rates, setting performance targets, promoting Medicaid program goals, and handling enrollment for special populations, including individuals with ID/DD.[18] They must also seek approval from the Centers for Medicare & Medicaid Services (CMS) to deliver LTSS through managed care. States can use several Medicaid authorities to implement MLTSS, for example: either Section 1115 waivers or combining Section 1915(c), Section 1915(i), Section 1915(j), or Section 1915(k) home and community-based services (HCBS) waiver authorities with Section 1915(a), Section 1915(b), or Section 1932 managed care authorities. MLTSS plans must adhere to the same regulations as other Medicaid managed care plans and are subject to additional MLTSS-specific regulations and guidance. [19]

State MLTSS programs are subject to the same requirements as other types of Medicaid managed care programs and should incorporate certain elements, such as stakeholder engagement and person-centered care principles, codified respectively at 42 C.F.R. § 438.70 and 42 C.F.R. § 438.208(c)(3)(ii), to comply with CMS guidance for effective MLTSS programs. States therefore have an obligation to ensure that MCPs are prepared to fulfill any PASRR

obligations included in their Medicaid managed care contracts and to ensure that services meet CMS quality and oversight standards.

States play an important role in setting contract language and managing successful transitions from LTSS in an FFS setting to LTSS in a managed care setting. State MCP contracts typically define the range of contracted services, the payment structure, and incentives or penalties related to performance. Some states have used these incentives to promote HCBS, as opposed to institutional placements for individuals with ID/DD.[20] The state retains responsibility for holding MCPs accountable to their contract requirements and can generally withhold payments or otherwise penalize a MCP for failing to comply with their obligations.[21] Section 2 discusses specific topics and contractual strategies that states should consider to ensure effective PASRR-related policies in their managed care programs.

2. Creating PASRR Inclusive Contracts with MCPs

MCP Contract Considerations

It can be easy for states to overlook the importance of including PASRR in MCP contracts, as PASRR programs are often small components of much larger state Medicaid, SMHA, and SIDA systems of care. As such, it is important that state Medicaid agencies, which hold the contract with MCPs, involve PASRR operations staff in contract development discussions and seek their input on PASRR-related contract language when conducting the MCP readiness review. PASRR staff will be most familiar with the aspects of PASRR program design and operation that would support broader MCP contract goals and can help align MCP efforts with existing or planned initiatives for individuals with SMI or ID/RC.

PASRR Contract Components

States should consider incorporating a wide range of PASRR-related requirements in their contracts. At a minimum, MCPs should be aware of all PASRR related expectations when an individual enrollee is being considered for, or needs, nursing facility level of care. Those expectations may include PASRR roles the facility staff may have, PASRR education and training resources for the staff, coordination with MH/ID authorities, developing plans of care, delivery of specialized services, tracking and reporting, case management, and community transition.

In addition, the COVID-19 pandemic highlights the importance of states considering contract language with NFs and HCBS facilities, related to how the MCP would carry out (and expect facilities to carry out) PASRR responsibilities during any similar emergency event.

Some considerations for inclusion in the MCP contract include:

- **MCP Staff PASRR Roles**: The contract may stipulate that the MCP must interact and coordinate with individuals or agencies the state uses to perform PASRR Level I and

Level II functions, including resident reviews, or it may require that the MCP staff perform these functions through subcontract or direct employment. In the latter case, the contract should ensure that the MCP maintains appropriate levels of staffing to ensure adequate coverage for direct contact with members.

- **Education and Training for MCP Staff**: The contract should be clear that PASRR is a federal requirement intended to help ensure that individuals are not inappropriately placed in NFs for LTSS. Education and training of care coordinators, case managers, and other key staff identified by the MCP would ensure such staff members' understanding that PASRR requires all applicants to a Medicaid-certified NF be evaluated for SMI and/or ID/RC, that they be offered the most appropriate setting for their needs, and that they receive the services they need in those settings.
- **Coordination with MH/ID Authorities and Nursing Facilities**: The contract could address any expectations around coordination with the MH/ID authorities. The level of coordination will likely vary depending on the MCPs role in the Level I and Level II phases of PASRR, and it will be especially important in securing access to specialized services that may not be included as a covered service by the managed care plan but that are funded by the state. Additionally, the contract should define terms for MCP coordination with NFs to ensure that members receive specialized services specified by the state as part of the Level II PASRR, to the extent that those services are covered by the managed care plan.
- **Developing Plans of Care:** Staff affiliated with the MCP will likely be key members of the NF interdisciplinary team responsible for developing the member's person-centered plan of care. As such, the contract should include a requirement for participation agreements with NFs that detail PASRR completion requirements, including a Level I screening before admission, a Level II evaluation before admission when indicated by the Level I screening, and a review based upon a significant physical or mental change in the resident's condition that might impact the member's need for or benefit from specialized services.
- **Delivery of Specialized Services**: As noted earlier, the contract may include defined roles for MCP staff in the Level I and Level II phases of PASRR, but any expectations around the MCP role in delivering specialized services during the period of NF residency should also be addressed. Those services are likely to mirror any LTSS the member was receiving prior to nursing facility admission, and the role of the MCP in ensuring continuity of care should be clear.
- **Tracking/Reporting**: Expectations regarding PASRR tracking and reporting will largely reflect the state's overall PASRR monitoring process, but the MCP contract could specify any required reporting templates, tracking of members residing in NFs that went

through the PASRR process who were identified as having a qualifying PASRR condition, and tracking members who receive specialized services.

- **Case Management & Community Transition**: The MCP contract could address any case management expectations as well as reporting on members with SMI or ID/RC who transition to the community.
- **Continuity of PASRR during an Emergency Event**: The MCP contract could include an expectation that the MCP will have strategies in place to maintain essential PASRR responsibilities during an emergency that disrupts routine access to hospitals or NFs. For example, the COVID-19 emergency raised awareness of the value of having access to telehealth resources.

PASRR MCPs Contract Promising Practices

As noted, incorporating PASRR into a MCP contract will involve having the MCP perform specific PASRR functions or interface with others in the state who perform those functions. In preparing this paper, we found MCP contract examples of the delegated model and similar examples of the interface with other PASRR entities. In both models, it is clear that there is a high degree of coordination and collaboration focused on meeting the needs of MCP members with SMI or ID/RC who need NF care.

The following examples from MCP contracts reflect an awareness of the role PASRR plays in their states' broader LTSS programs. We have removed state references, contract section designations, and numbers while retaining relevant text from those sections. The states have utilized contract language to convey expectations about how the MCP interacts with their state authorities and NFs on PASRR activities. Such clarity offers opportunity for MCPs, state authorities, and NFs to act in partnership to support individuals with SMI or ID/RC

Excerpts from State Managed Care Plans	
Area of Responsibility	**Contract Language**
Staff Roles	"The MCP shall be responsible for conducting or subcontracting to conduct PASRR Level II evaluations of members upon referral from OBH [Office of Behavioral Health]. Referrals will be based upon the need for an independent evaluation to determine the need for nursing facility services and/ or the need for specialized services to address mental health issues while the member is in a nursing facility. PASRR Level II evaluations must be performed by an LMHP [Licensed Mental Health Practitioner] independent of OBH and not delegated to a nursing facility or an entity that has a direct or indirect affiliation or relationship with a nursing facility as per 42 CFR 483.106."
Staff Roles	"If a member will be admitted to a nursing facility, the case manager must ensure and document that a PASRR have been completed by the State prior to admission."
Education and Training	"Contractor shall ensure that case managers are provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor pursuant to this Contract (includes as follows): "The PASRR process that is completed by the State and the requirement for the Contractor to provide Specialized Services as specified by the State as part of the PASRR Level II process that are included in the LTSS benefit package."
Coordination with State Authorities	"In order to comply with federally mandated timelines, the MCP shall submit the completed Level II evaluation report to OBH (Office of Behavioral Health) within four (4) working days of receipt of the referral from OBH." • "If at any time the MCP should become aware that a member residing in a nursing home who has an SMI has not received a Level II determination, the MCP shall notify OBH." • "The MCP shall notify OBH as outlined in the reporting template of any problems or issues with the PASRR process."

Area of Responsibility	Contract Language
Coordination with State Authorities	"The Contractor shall collaborate with the Division of Substance Abuse and Mental Health (DSAMH) and or the Division of Developmental Disabilities Services (DDDS) and the nursing facility to develop a plan of care that includes all of the Specialized Services specified by the State."
Delivery of Specialized Services	"The MCP shall ensure that members who are identified by OBH as needing specialized services for behavioral health while in a nursing facility have access to such services as required under 42 CFR §483.120 and determined by OBH. For individuals denied nursing facility placement, the MCP shall ensure members have access to medically necessary covered services needed to maintain them in the community."
Delivery of Specialized Services	"The Contractor shall include all Specialized Services specified by the State as part of the Level II PASRR process in the member's plan of care, including Specialized Service that are not Covered Services, and shall coordinate with the DSAMH and/or DDDS (as applicable) and nursing facilities to ensure that members receive Specialized Services specified by the State as part of the Level II PASRR that are not included in the LTSS benefit package. The Contractor shall coordinate with DSAMH and/or DDDS (as applicable), the nursing facility and the provider(s) providing Specialized Services to ensure that Specialized Services covered by the Contractor are provided to each member as specified by the State as part of the PASRR Level II process." "The State will provide Specialized Services as determined necessary by the State as part of the PASRR Level II process that are not included in LTSS benefit package."

Area of Responsibility	Contract Language
Tracking and Reporting	"The MCP shall utilize the LDH-issued template reporting utilization of the PASRR process. The MCP is responsible for tracking for members residing in a nursing facility who went through the PASRR process, those identified with SMI and those receiving specialized services as per 42 CFR §483.130. The MCP shall track and report quarterly to OBH the delivery of all PASRR specialized behavioral health services as defined and required under 42 CFR §483.120. The MCP shall advise OBH and Medicaid on any barriers to completing the PASRR evaluations or tracking process. Records shall be retained for 10 years in order to support OBH determinations, and to protect the individual's appeal rights as per 42 CFR §483.130." • PASRR Reporting: **"**The MCP shall report to LDH indicators relative to individual evaluations on a monthly basis with information available by region, type of placements, results of recommendations, location of individuals and referral sources as outlined in the LDH issued reporting template." • "Upon request, the MCP shall provide the PASRR Level II authority (OBH) with documentation supporting appropriate limits on a service on the basis of medical necessity for individuals determined by the PASRR Level II authority to need specialized behavioral health services."
Case Management & Community Transitions	"If a member is already working with the DSAAPD (Division of Services for Aging and Adults with Physical Disabilities) Aging & Disability Resource Center's (ADRC's) Diversion program, the Contractor shall partner with the Diversion program to support a successful diversion. For those members whose transition assessment indicates that they are candidates for transition to the community, the case manager shall facilitate the development of and complete a transition plan within 14 calendar days of the member's transition assessment. The case manager shall include other individuals such as the member representative, member's family and/or Caregiver in the transition planning process if the member requests and/or approves those individuals, and such persons are willing and able to participate."

3. PASRR Role in MCP Compliance Activities

States must ensure proper administration and compliance with all applicable laws and regulations pertaining to their Medicaid programs, including for Medicaid managed care.[22] These requirements include, among others, implementing managed care quality assessment and evaluation strategies and conducting annual external reviews of care quality and services for each managed care contract.[23] States with managed care programs and states with carve-outs for certain types of services must remain aware of the potential for fragmentation of services and coordination challenges, which could impact both quality of care and consistent compliance with Medicaid regulations across MCPs.[24] States must also ensure that their PASRR and managed care programs comply with higher-level goals and expectations for MLTSS, including person-centered planning and compliance with HCBS regulations, as set out in the Medicaid Managed Care Final Rule CMS issued on May 6, 2016.[25]

Certain regulatory and compliance requirements may assume increasing LTSS-related importance, particularly readiness reviews and state monitoring system requirements. Readiness review processes, mentioned in Section 2 above, ensure that MCPs can meet all service, regulatory, and performance standards before enrolling new members. In 2016, CMS issued regulations at 42 C.F.R. § 438.66(d) requiring that states conduct readiness reviews when requiring their MCPs to provide or arrange for the provision of covered benefits to new eligibility groups.[26] This requirement applies to an increasing proportion of states that have been including LTSS benefits in their managed care contracts.[27] States must also have formal monitoring systems for their managed care programs pursuant to 42 C.F.R. § 438.66(a), including mechanisms to oversee and ensure compliance with all regulations and guidance pertaining to LTSS delivery.[28]

As states increasingly pursue MLTSS for PASRR-covered populations, the importance of involving stakeholders and PASRR staff in managed care readiness review and ongoing monitoring becomes increasingly apparent. In many cases, staff involved in implementing the state's PASRR program may be able to provide unique insight into implementation processes, challenges, and systems that can positively influence the design of state compliance and monitoring structures. CMS also requires at 42 C.F.R. § 438.70 that states must create stakeholder advisory groups and solicit and address input from the group on MLTSS, which provides an additional opportunity for states to solicit feedback and involvement from PASRR staff. Involving appropriate stakeholders and creating thoughtfully designed compliance structures may help ensure that there are no gaps in PASRR services provided through an MCP. Broad participation can also help ensure all entities involved in the PASRR process are aware of their responsibilities, which can reduce the risk of states losing federal financial participation payments due to poor compliance with PASRR regulations.

Since 1982 states have provided significant documentation that on an aggregate level, the average cost of all Medicaid services for an individual receiving HCBS was less than the average cost of individuals served in institutional settings. Collaborative efforts of MCPs and PASRR staff can ensure the cost effectiveness of the state budget. This collaboration can create opportunities for individuals with SMI or ID/RC to choose less costly community settings to address their needs, and provide individuals choosing or currently receiving NF care, with specialized services that help advance their return to cost effective services in the community.

4. Summary

Today, managed care is the dominant model to deliver services to Medicaid beneficiaries. State approaches to managed care have evolved over time and MCPs coverage for higher-need populations, including those with SMI or ID/RC has grown. As states increasingly contract with MCPs to support individuals who receive LTSS, it is important to consider that state PASRR programs can play a key role in helping states and MCPs achieve improved coordination and continuity of care for individuals with SMI or ID/RC.

It is important that state Medicaid agencies involve PASRR operations staff in discussions to ensure that MCPs are at the PASRR table, either through consistent informal engagement efforts or contractual language.

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