Use of PASRR to Divert or Transition Individuals into Home and Community-Based Services (HCBS)

FACILITATOR

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POWER AND POSSIBILITY OF PASRR WEBINAR SERIES

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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Learning Objectives

- Context of long-term services and supports (LTSS) in the public health emergency
- History of LTSS and PASRR
- PASRR for diversion and transition

Context of the COVID-19 Pandemic

Context of the Public Health Crisis

- Nationally, there are over 1.3 million people residing in nursing facilities[1]
- CMS reports, as of November 1, 2020, 451,367 confirmed and suspected COVID-19 cases and 65,446 deaths[2]
- Current knowledge about COVID-19 shows that[3]
  - Older people are at higher risk of contracting the virus
  - People with chronic medical conditions such as heart disease, diabetes, kidney disease and respiratory illness are also at increased risk
  - Both groups are heavily represented among the nation's nursing home residents, including those with disability who often have co-morbidities

1. Long-term Care Providers and Services Users in the United States 2015-2016; Centers for Disease Control and Prevention (CDC), February 2019.
2. CMS COVID-19 Nursing Home Data retrieved from data.CMS.gov; October 25, 2020.
3. AARP Answers: Nursing Homes and the Coronavirus; Andy Markowitz, AARP, October 20, 2020.

Current Risks of Congregate Living

- Certain conditions at nursing homes can exacerbate the spread of the disease[1]:
  - shortages of coronavirus tests
  - shortages of or lack of access to personal protective equipment (PPE) such as masks and gowns
  - frequent physical contact between residents and staff
  - understaffing
  - employees who work in multiple facilities, increasing chances for exposure
  - residents sharing rooms
  - transfers of residents from hospitals and other settings

1. AARP Answers: Nursing Homes and the Coronavirus; Andy Markowitz, AARP, October 20, 2020.

Challenges of Congregate Living

- During the pandemic, other challenges of nursing facility living have been highlighted
  - Impacts on social wellbeing because of isolation, disrupted routines, and social distancing for infection control[1]
  - Increased depression, anxiety, worsening dementia, and failure to thrive[2]
  - Use of technology for medical or social supports doesn't work for everyone[3]

1. Social Isolation – the Other COVID-19 Threat in Nursing Homes; Abbasi, July 16, 2020.
2. The Mental Health Consequences of COVID-19 and Physical Distancing; Gelea, Merchant and Lurie, April 10, 2020.
3. Telehealth and Disability: Challenges and Opportunities for Care; Young and Edwards, May 6, 2020.

History of LTSS and PASRR

LTSS Timeline[1]

Nursing Home Era:

1935 – 1974

- Institutional bias in the mid-1930's
- Social Security Act
- Emphasis on laws and rules for nursing facilities
- Older Americans Act (OAA)

Community-Based Services Era:

1974 – 2006

- Comprehensive OAA amendments to prioritize community alternatives
- Mental Health Systems Act emphasizes deinstitutionalization
- HCBS waiver program enacted
- OBRA-87 and the Nursing Home Reform Act initiates PASRR
- Supreme Court's Olmstead decision

Health Reform Era:

2010 – Present

- Affordable Care Act
- Commission on Long Term Care
- HCBS Final Rule
- Nursing Facility Quality Rating System

1. Long-Term Care in the United States: A Timeline; Kaiser Family Foundation, August 31, 2015.

LTSS History

- The efficacy of congregate living has been in question long before the COVID-19 public health emergency
- In the not too distant past, people with disabilities were unfairly and unnecessarily placed in congregate settings
- Much of the system transformation that occurred in the 1980's and 1990's centered on community-based options and de-institutionalization
- Significant efforts by federal and state governments have successfully rebalanced the LTSS system
- Today, the majority of Medicaid LTSS expenditures are for home and community-based services[1]

1. Medicaid Expenditures for Long-Term Services and Supports in FY2016; Eiken, Sredl, Burwell, and Amos, May 2018; and Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018; Murray, Tourtellotte, Lipson, and Wysocki, January 2021.

PASRR – A Visionary Diversion and Transition Program

Pre-Admission Screening and Resident Review (PASRR) was created in 1987 as part of nursing home reform, through language in the Omnibus Budget Reconciliation Act (OBRA '87).

- It has three goals:
  - to identify individuals with mental illness (MI) and/or intellectual disability (ID) or a related condition (RC) - this includes children and adults;
  - to ensure individuals are placed appropriately, whether in the community or in a nursing facility (NF); and
  - to ensure that individuals receive the services they require for their MI or ID.

PASRR and Healthcare Interface

- PASRR can foster continuity of care for individuals with MI, ID, or RC that were being supported with community-based services prior to seeking NF admission, or that will need those services when transitioning back to a community setting.
- PASRR can promote engagement of MI, ID, or RC individuals with needed services, if those services were not active at the time of their seeking NF admission.

Updates to PASRR

- PASRR regulations were promulgated in 1992.
- CMS released a Notice of Proposed Rulemaking (NPRM) to modernize the regulations on February 20, 2020; public comment closed May 20, 2020.
- The Final Rule is forthcoming.

Note that all regulations quoted in this presentation are from the current regulations, not the NPRM.

LTSS Rebalancing: PASRR is a Powerful Tool

Key PASRR Features

- No individual can be admitted to a NF until PASRR has been completed.
- *Additional considerations* granted to individuals with MI, ID, or a RC to receive LTSS in the most integrated setting.
- Identification of service needs related to their condition that are over and above those in the NF benefit (specialized services).
- NF resident reviews required to:
  - identify changes in LTSS needs;
  - recommend community alternatives to continued stays in NFs; and
  - coordinate transition planning back to the community.

PASRR – A Unique Partnership

PASRR is unique within Medicaid in that the statute obligates the state ID and MI agencies as well as the state Medicaid agency to perform certain functions. This represents an important recognition of the role and partnership these agencies have in the delivery of services through the Medicaid program.

These agencies share a similar partnership in developing and delivering LTSS.

PASRR has a key role in state realignment efforts.

Power of PASRR to Support Realignment

- PASRR can **support state "community first" and "self- determination" initiatives.**
- PASRR can make individuals with MI, ID, or RC aware of **alternatives to the NF**.
- PASRR can foster **continuity of care** for individuals with MI, ID, or RC that were being supported with community-based services prior to seeking NF admission, or that will need those services when transitioning back to a community setting.
- PASRR can **promote engagement** of MI, ID, or RC individuals with needed services, if those services were not active at the time of their seeking NF admission.
- CMS includes PASRR as an institutional tool to support rebalancing strategies in the recently released Long-Term Services and Support Rebalancing Toolkit found on Medicaid.gov.

The Role of PASRR

Diversion

- 100% avoidance of NF placement when alternatives exist

Transition

- Shortened length of stay resulting from awareness of HCBS alternatives
- Timely transition through engagement in services and supports that mirror existing HCBS services in a community setting

PASRR – A Focus on Diversion

§483.112 Preadmission screening of applicants for admission to NFs.

- (a) *Determination of need for NF services.* For each NF applicant with MI or ID, the state mental health or intellectual disability authority (as appropriate) must determine, in accordance with §483.130, whether, because of the resident's physical and mental condition, the individual requires the level of services provided by a NF.

PASRR Level I Screening

Purpose: The Code of Federal Regulations (CFR) at §483.128(a) provides guidance on the purpose of the Level I screening:

- a) *Level I: Identification of individuals with MI or ID.* The state's PASRR program must identify all individuals who are suspected of having MI or ID as defined in §483.102. This identification function is termed Level I.

Level II – A Focus on Diversion

§483.126 Appropriate placement.

- Placement of an individual with MI or ID in a NF may be considered appropriate only when the individual's needs are such that he or she meets the minimum standards for admission, and;
- The individual's needs for treatment do not exceed the level of services which can be delivered in the NF to which the individual is admitted either through NF services alone or, where necessary, through NF services supplemented by specialized services provided by or arranged for by the state.

Importance of evaluator having full familiarity with LTSS resources

Diversion – A Quality Measure for State PASRR Programs

Number of preadmission Level IIs recommending community placement instead of NF or other institutional placement.

- Of the 35 states that provided information for this report, 71 percent reported collecting data for this quality measure for people with a Serious Mental Illness (SMI) and 63 percent for people with ID/RC.[1]

1. 2019 PASRR National Report, prepared for CMS, December 2019.

The Transition Role of PASRR

- To be good candidates for transition, individuals who enter NFs should receive services that preserve and improve function.
- For individuals with MI, ID, or RC, those services include s*pecialized services*.

Key PASRR Transition Considerations

- No defined time limit to accomplish transition to the community
- Process starts upon admission (no waiting period)
- PASRR determination and Level II report promote individualized plan of care (POC)
  - Identifies unique needs related to the individual
- Use of community providers for specialized services
  - promotes continuity of care
  - maintains existing linkages/relationships
  - continuation of services upon transition to the community

Resident Reviews – A Focus on Transition (1 of 2)

§483.118 ***Short term residents.*** **….**any resident **who requires only specialized services**, as defined in §483.120, and who **has not continuously resided in a NF for at least 30 months before the date of the determination**, the state must, in consultation with the resident's family or legal representative and caregivers—

- (i) Arrange for the safe and orderly discharge of the resident from the facility in accordance with §483.15(b);
- (ii) Prepare and orient the resident for discharge; and
- (iii) **Provide for, or arrange for the provision of, specialized services for the mental illness or intellectual disability.**

Olmstead v. L.C. 527 US 581 (1999)

Resident Reviews – A Focus on Transition (2 of 2)

§483.118 Residents and applicants **determined not to require NF level of services**. ***Long term residents***... any resident who has continuously **resided in a NF for at least 30 months before the date of the determination, and who requires only specialized services** ....the state must...

- (i) Offer the resident the choice of remaining in the facility or of receiving services in an alternative appropriate setting;
- (ii) Inform the resident of the institutional and non-institutional alternatives covered under the state Medicaid plan for the resident;
- (iv) Regardless of the resident's choice, provide for, or arrange for the provision of specialized services for the mental illness or intellectual disability.

Defining Specialized Services

"Specialized services" means any service or support recommended by an individualized Level II determination that a particular nursing facility resident requires due to mental illness, intellectual disability or related condition, that supplements the scope of services that the facility must provide under reimbursement as nursing facility services.

In other words, specialized services are over and above what the NF would be expected to provide under their daily per diem.

FFP and Specialized Services

In order to be eligible for federal financial participation (FFP), specialized services must be included in the state plan. They are considered "specialized add-on services" that can be provided under the nursing facility benefit authorized the Section 1905(a) of the Social Security Act.

When individuals are identified as having a PASRR disability, this identification can serve as a type of "prior authorization" for access to specialized add-on services.

What Should States Consider When Including Specialized Services in State Plans? – PASRR Technical Assistance Center FAQ

Additional resources on specialized services are available on the PTAC website.

Specialized Services: The Importance of Continuity of Care and Initiating Treatment

- Specialized services may *resemble* services provided in the community in order to promote continuity of care.
- Specialized services may be opportunities to introduce individuals to the types of services they can receive in the community.
- When states use HCBS providers as specialized services providers, it is another way for NF residents to make connections with HCBS and their options for community supports.
- The importance of connecting individuals to needed services is evident in a recent evaluation of the Money Follows the Person (MFP) demonstration.
  - "Use of community-based LTSS before an institutional stay appears to increase the likelihood a beneficiary will transition to the community; upon the transition, previous users of community-based LTSS are more likely to once again use community-based LTSS."[1]

1. Report to the President and Congress: The Money Follows the Person (MFP) Rebalancing Demonstration; retrieved from Medicaid.gov, June 2018.

Specialized Services Examples

Examples of specialized services include:

- Assistive technology
- Employment and/or day support
- Community transition case management
- Community integration
- Behavioral health supports, including peer supports

Specialized Services – Determining the Need

§483.112 **Preadmission screening of applicants for admission to NFs.**

- (b) *Determination of need for specialized services.* If the individual with mental illness or intellectual disability is determined to require a NF level of care, **the state mental health** or intellectual disability **authority (as appropriate) must also determine, in accordance with** §483.130, **whether the individual requires specialized services for the mental illness or** intellectual disability**, as defined in** §483.120.

Specialized Services – A Requirement

§483.120(b) **Specialized services**

The state must provide or arrange for the provision of specialized services, in accordance with this subpart, to all NF residents with MI or ID whose needs are such that continuous supervision, treatment and training by qualified mental health or intellectual disability personnel is necessary, as identified by the screening provided in §483.130 or§483.134 and§483.136.

Specialized Services – Applicants and Residents

§483.130 PASARR determination criteria.

- (1) *Can be admitted to a NF.* Any applicant for admission to a NF who has MI or ID and who **requires the level of services provided by a NF**, regardless of whether specialized services are also needed, may be admitted to a NF, if the placement is appropriate. **If specialized services are also needed, the state is responsible for providing or arranging for the provision of the specialized services.**
- (n) ***Specialized services needed in a NF***. If a **determination** is made **to admit or allow to remain in a NF any individual who requires specialized services**, the determination must be **supported by assurances that the specialized services** can and **will be provided or arranged for by the state while the individual resides in the NF**.

Transition – A Quality Measure for State PASRR Programs

Number of resident reviews recommending transition to the community.

- Of the 35 states that provided information for this report, 63 percent reported collecting data for this quality measure for people with an SMI and 60 percent for people with ID/RC.[1]

1. 2019 PASRR National Report, prepared for CMS, December 2019.

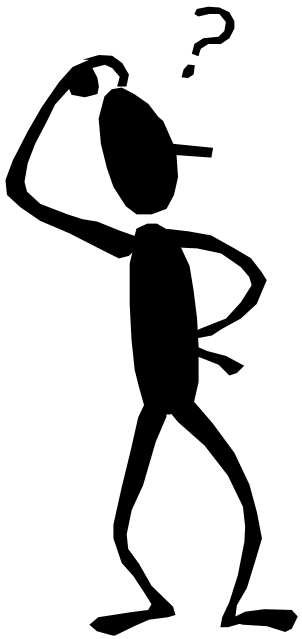
Measuring Your State PASRR Program Rebalancing Role

The state PASRR Program:

- **Supports state "community first" and "self- determination" initiatives.**
  - PASRR can make individuals with MI, ID, or RC aware of alternatives to the NF.
- **Fosters continuity of care**
  - Identify specialized services that mirror LTSS the person was receiving in the community
- **Promotes engagement in services**
  - Linking individuals with specialized services that will continue as LTSS upon discharge

Is your state PASRR program "at the LTSS table"?

QUESTIONS



THANK YOU

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