PASRR Technical Assistance Center (PTAC) Learning Module 1
CFR Compliance PASRR: Part 1
Transcript

Opening Slide

Welcome. The PASRR Technical Assistance Center, more commonly known as PTAC, Truven Health Analytics, an IBM company, and Mission Analytics, with support from the Centers for Medicare and Medicaid Services (CMS) are pleased to offer this learning module. This is the first of three modules that provide an overview of the Code of Federal Regulations (CFR) requirements, specific to State responsibilities for Preadmission Screening and Annual Resident Review (PASRR) of individuals with a mental illness, intellectual disability, or a related condition. My name is Richard Sanderson, a consultant with PTAC and I will be your guide for this module.

Slide #2

In this module we will be reviewing basic requirements that States must meet in order to be compliant with the CFR. Modules 1, 2, and 3 should be reviewed in order to have a full understanding of those requirements.

While these modules address the "*basic requirements*", PTAC is well aware of the work being done to move beyond just a "*compliance only*" approach to PASRR. **We encourage you to access the additional modules that can help you:**

- **Better integrate person-centered practices into your PASRR system**
- **Learn more about Specialized Services and how they can help you support individuals, and**
- **Learn about state or national health initiatives that can align with your PASRR efforts.**

Slide #3

So what is PTAC? Hopefully, you are already familiar with PTAC, either through prior visits to our website, participation in our monthly webinars, or as a result of having reviewed other Learning Modules. You can learn quite a lot about PTAC by further reviewing our website, at www.pasrrassist.org after you finish this module. Our contract with CMS, which began in 2009, places an emphasis on:

- Helping CMS better understand how state PASRR programs operate and where greater regulatory clarity is needed

- Conducting research or studies on key focus areas, such as our National Reports on Level I and Level II tools, and
- Helping states improve their PASRR Programs through individualized technical assistance, monthly webinars, and regional calls

The intent of this learning module, and the others you can access, is to help states improve their PASRR process, including the PASRR experience for those who do the work or who move through PASRR.

Slide #4

While this learning module, and modules 2 and 3 emphasize regulatory compliance, overall PTAC's training emphasis is on promoting development of a **Holistic PASRR** program. **That holistic model is based on:**

- **CFR policies and regulations**
- **CMS guidance**
- **Lessons learned to date from the research and studies conducted**
- **Growing understanding of person-centered practices**
- **Increased awareness of how health care is changing, and**
- **Better understanding of what is needed to promote continuous quality improvement**

Slide #5

Before we begin looking at the CFR criteria for PASRR, let's take a few minutes to look at why PASRR is so important.

According to the National Center for Health Statistics, there were 1.3 million nursing facility residents in 2014, the most recent year for which data are available.

An estimated 250,00 individual with mental illness, intellectual disability, or related condition are living in nursing facilities at any given time. That is 19% of the population. **Recent PTAC studies of MDS PASRR data suggest this number may be higher. The PTAC report on the analysis of MDS PASRR data is discussed in Learning Module #6.**

Nursing facilities do not operate as primary providers of mental health or intellectual disability services, **thus relatively few have staff to provide disability specific services**.

The recent CMS Proposed Rule for Long Term Care Facilities has increased awareness of the importance of PASRR. **Information about the proposed rule is discussed further in Learning Module #3.**

Slide #6

Our growing understanding of the prevalence of certain behavioral health conditions, which may be co-occurring with nursing facility applicant's medical problem, also point to the importance of PASRR. For example:

- 50% of the disabling disorders worldwide are psychiatric
- Greater than 25% of primary care patients screen positive for a probable mental health or substance abuse problem.
- An increasing number of individuals are developing schizophrenia during middle years and after age 65.
- Depression is among the top chronic diseases and other chronic diseases are often present at the same time.
- Many adults will experience their first depression late in life, greatly adding to the risk of suicide. In fact, older adults are 6 times more at risk of suicide than their younger counterparts.

Unfortunately, we also see evidence that depression in older adults can be dismissed. Recent studies have shown that greater than 30% of primary care physicians believe that depression is a natural part of aging.

A key role of PASRR is to truly look at each person and understand how any behavioral health conditions are impacting them.

Slide #7

Too often these conditions, and the person's needs are overlooked. A number of factors can contribute to this:

- **Chronic medical conditions can obscure recognition of a psychiatric disorder.** We also know that individuals may be reluctant to disclose their mental illness, due to stigma or other factors.
- While we are getting better at understanding the connection of behavioral health and overall health, **there is still too often a lack of understanding around the importance of that holistic part of health.**
- Very often sufficient time is not given to evaluating the totality of and individual's needs, and unfortunately, **our health care system does not always use a person-centered approach**.

Learning Module #4 provides an extensive review of what is meant by "person-centered" and how that approach can enhance your PASRR process.

PASRR addresses all these factors **by placing a primary focus on indentifying a person's unique needs related to their mental illness, intellectual disability, or related condition.**

Slide #8

We have reviewed some of the factors that make PASRR important, beyond the fact that States are required to meet the CFR regulations. This module, and modules #2 and #3 address those requirements, but **PTAC believes it is important for States to continually look for opportunities to move their PASRR system forward, reflecting the changes that have taken place over the years in how we support persons with mental illness or intellectual disabilities, as well as the broader changes that are taking place in our health care system.**

The steps for moving forward are reflected in this graphic, moving from a compliance only approach, to an approach that is grounded in person-centered practices, and to a PASRR system that is integrated with the broader healthcare system. **As the PASRR system moves forward, the range of the person's needs, support options, and stakeholder engagement expand.**

As you move through this module, and subsequent modules, it is important to think about where your PASRR system is today and where you want to be in the future.

Slide #9

PASRR is continually impacted by the changes that occur around it in individual states and nationally. Let's take a moment and look at some of the changes that have taken place over the years

Slide #10

This graphic may be a bit hard to read, but it provides a clear picture of the history of change for PASRR. On the far left you will see a listing of acronyms used at points along the timeline. Let's highlight just a few key points along that timeline:

PASRR was established in 1987 under the Omnibus Budget Reconciliation Act:

> *This created the responsibility for states to create a PASRR system.*

States were required to have their PASRR programs operational by January 1, 1989. The "PASRR Final Rule" within the Code of Federal Regulations, was issued in 1992, providing the first clear guidance to states on what had to be addressed within their PASRR system.

> *As a result of the three-year period between states being given the responsibility for creating PASRR systems and having formal regulatory guidance, there is great variation in state PASRR systems.*

The Supreme Court Olmstead Ruling in 1999 emphasized the obligation of states to create opportunities for individuals with disabilities to live in the most integrated setting possible.

> *The "diversion" role of PASRR is an essential component in that effort.*

CMS Inspector General Reports in 2001 and 2007 identified the need for CMS to develop strategies to help standardize and improve the PASRR process. As a result of those reports, PTAC was established in 2009.

You can see that over time, there are more frequent points of change that have impacted PASRR. **This points to the growing importance of States adapting their PASRR systems to reflect those changes.**

Slide #11

It can be hard to know "where to start" when answering the question, "Where is Your PASRR Process Now?", but there are six key questions that together can serve as a valuable starting point:

Does the current PASRR process:

1. **Support and advance state initiatives that have been developed since you first created your PASRR system**? – We just reviewed some of the many factors that have impacted PASRR since it became a state obligation in 1987.
2. **Promote continuity of care?** – Continuity of care is recognized as a key factor in good outcomes for individuals receiving mental health or intellectual disability services and supports.
3. **Support recovery?** – Learning Module #2 discusses the role PASRR can play in supporting an individual in recovery.
4. **Reflect person-centered thinking and planning?** – Learning Module #4 provides an overview of what is at the core of person-centered practices.
5. **Emphasize community integration?** – Learning Module #5 highlights how Specialized Services can be an essential resource for promoting return to the community.
6. **Promote empowerment of the individual?** – Learning Module #3 identifies how the Level II evaluation offers "voice to the individual", an essential step in empowerment.

Keep these questions in mind as we now begin to look at the strengths or challenges of having a PASRR process that is solely linked to CFR compliance.

Slide #12:

There are clear strengths associated with the CFR Compliance approach to PASSR, **beyond the fact that it reflects the requirement to meet the mandates of the CFR**. A compliance approach will **include clear responsibilities for each state agency**; may be considered **"less complicated"** as it just follows the structure in the final rule; **may include aspects of person-centeredness referenced within the final rule**; is **likely to have a Level II process that includes the elements listed in the final rule;** and **may be seen as requiring less training or education**, given that it relies on everyone simply complying with the rules.

There are challenges or risks for a *CFR Compliance only* approach. There can be **high variation in the Level I process**, largely due to the fact that there is little Level I guidance. The **compliance approach can lead to a "check box" approach for forms**, which can **minimize the opportunity for engaging the individua**l, especially in the Level I stage of PASRR. There is also a **risk of the compliance-only approach**

leading to "one size fits all" recommendations based solely on an individual's diagnosis. Finally, the **CFR provides no guidance on the importance of stakeholder engagement or training.**

This comparison of the strengths and challenges of a *CFR Compliance only* approach to PASRR makes it clear that compliance may not reflect what is now considered "best practice".

So, there are risks, but each state is obligated to have a PASRR process that meets the CFR, so let's now look at those requirements.

Slide #13:

PASRR is a requirement under Medicaid, pursuant to the Omnibus Budget Reconciliation Act and it is meant to **bar admission of any individual with mental illness, intellectual/developmental disability, or related condition to any Medicaid certified nursing facility, if the facility cannot meet the person's total needs for nursing facility services and specialized services**.

The emphasis here is on meeting the total needs of the person. This holistic emphasis points to how visionary PASRR was when created in 1987. You can review Learning Module #5 for a broad discussion on specialized services.

Slide #14

It is important to know that **PASRR applies to all individuals applying for admission to a Medicaid certified nursing facility.** The **source of payment does not alter this requirement**. **The key point is that the facility is Medicaid certified.**

Nursing facilities are responsible for adhering to PASRR, so compliance with **PASRR is an issue of their licensure and this should be monitored by the state compliance entity.**

Slide #15

As we highlighted when looking at the timeline for PASRR, the long period when states were developing PASRR without clear guidance necessitated some flexibility and opportunity for variation in state practices.

Each state's PASRR process inherits all the Medicaid requirements of that state, and those requirements can vary. State's all follow the CFR, so there are common elements across the states, but the CFR also allows for state variation.

For example, states are free to develop their own forms, processes, trainings and guidance material. They also establish the personnel qualifications for who can complete a Level I screening or Level II evaluation. States also establish the timing of Level of Care determinations relative to PASRR.

The variation in practice has been highlighted in the PTAC National Reports that can be accessed via the PTAC website referenced on the first slide in this Learning Module.

As we have stressed, State must meet the CFR minimum requirements, **but they can exceed those federal requirements. Learning Modules 4 through 6 can help States interested in moving beyond the minimum requirements.**

Slide #16

PASRR is unique in Medicaid law in that it assigns responsibilities to agencies other than the Medicaid agency. Indeed, it requires explicit cooperation amongst Federal regulations as it is the **only regulation that defines a clear expectation of a partnership amongst the three Agencies responsible for PASRR.**

The State Medicaid, Mental Health, and Intellectual Disability/Developmental Disability Agencies have specific responsibilities, which we will cover on the next slide. While there is a line of authority amongst the Agencies, there is also autonomy. **For example, the determinations made by the Mental Health or Intellectual Disability/Developmental Disability Agencies must be consistent with the criteria adopted by the Medicaid agency, but the state Medicaid agency cannot countermand those determinations.**

Slide #17

This graphic shows the PASRR regulatory roles and responsibilities of the three state Agencies. You can see that the Medicaid agency has **"oversight**" responsibility, as CMS is the federal agency with responsibility for PASRR. The mental health and intellectual disability/development disability agencies are responsible for **"operating"** PASRR. It is important to note that there is an **"independent evaluator"** listed as well, as the person completing the Level II evaluation for anyone suspected of a mental illness must be independent of the mental health agency.

Let's look at the functions for each of the operating agencies, including the independent evaluator.

The ID/DD agency is responsible for the evaluation and determination functions, but they may delegate those functions to another entity.

The MH agency is responsible for the determination function, and they can delegate that function to another entity. **An evaluator that is independent of the MH agency must complete the MH evaluation.**

One approach for maintaining that independence is for the state Medicaid agency to have the contract with the independent evaluator, although the MH agency would likely need to be involved in the selection process.

This is a functional model for PASRR, linked to the CFR, but we know there are additional stakeholders in the PASRR system, and Learning Module #6 explores a broader view of PASRR. **It is important that this functional model not lead to a "process driven only" approach to PASRR.**

Slide #18

The CFR stresses that one of the objectives of PASRR is to ensure that PASRR identified individuals are "placed" appropriately in the least restrictive setting possible. This objective links directly with the obligations states have under the Olmstead ruling.

While "placed" is the terminology used in the CFR, we anticipate that language will change when the rule is updated, since it does not reflect more current person-first language.

A key point of PASRR leverage for states is the fact that Federal Financial Participation (FFP) is available to nursing facilities only for services furnished "**after PASRR is completed.** Stated more clearly, this means the PASRR process **must be completed before the individual is admitted to the nursing facility.**

Slide #19

Much of the CFR PASRR process emphasizes the importance of an individual receiving the services they need, wherever they are living. This points to the importance of continuity of services for anyone being admitted to a nursing facility who has already been receiving needed MH or ID/DD services in the community.

PASRR also stresses that admission to a nursing facility is only appropriate when level of care standards are met, and when the need for treatment does not exceed the capacity of the nursing facility. That capacity includes their standard services alone, plus additional specialized services.

As we have noted before, Learning Module #5 provides more background on specialized services.

Slide #20

This table is a convenient way of considering the hierarchy of supports and services that move from least restrictive to most restrictive.

PASRR seeks to divert individuals to appropriate community-based alternatives wherever possible. The person may need to be admitted and can be supported only with standard nursing facility services and specialized rehabilitative services. Or, they may need all those services and the additional specialized services that are unique to their MI, ID/DD, or RC.

Individuals that have treatment needs that can only be met in an acute, inpatient setting such as an acute hospital, a psychiatric facility, or an intermediate care facility for intellectual disability, should not be admitted to a nursing facility.

PASRR must prioritize physical and disability specific needs of the individual, taking into account the severity of each condition, and determine whether NF admission is appropriate.

Slide #21

This graphic reflects the PASRR process and the various outcomes. The movement from the Level I screening, to the Level II in depth evaluation, and determination by the

designated state agency, or the entity that has been delegated that function, can lead to a range of outcomes.

The “community” outcome may include a variety of options that will vary from state to state, depending on the initiatives that are in place and the array of community-based resources.

The “NF” outcome may include a recommendation for specialized services.

The “inpatient” outcome may lead to a second PASRR evaluation if NF admission is considered after the individual’s condition is stabilized.

If there is a NF admission, there may still be PASRR involvement at a later date. This can happen as a result of a new MH/ID/RC being identified for someone who did not have those concerns identified on their first screening, which would lead to the NF completing a Level I or notifying the appropriate state authority.

There can also be a significant change in status for someone admitted with a MI/ID-DD/RC and that will lead to the NF notifying the appropriate authority, which will decide if a Level II is required.

Slide #22

Let’s look at the outcomes more closely.

The diversion to a community-based option meets the PASRR obligation for seeking the least restrictive setting. **This is typically made possible by linking the person with existing waiver, state plan options services, or other programs that may be supported with state funds.**

It is essential that PASRR staff who conduct evaluations are aware of the array of services and supports available in their community.

We will look later in Learning Module #5 at the option of some “community-based” services that can be provided to individuals while they are in the nursing facility.

Slide #23

It is important that the PASRR process identify all the services the individual would need to live in the community, even if the NF is the most appropriate option. This ensures that states are aware of the gaps in their system that would prevent successful transition from the NF and this information can be useful in future budget preparations.

Slide #24

As we discussed when looking at the graphic of PASRR outcomes, some individuals may not be appropriate for a NF due to the severity of their treatment needs. While an inpatient psychiatric setting, another acute hospital, or an intermediate care facility for individuals with intellectual disabilities may be needed, this does not rule out the need for additional PASRR services at a later date.

An important reminder here is that an inpatient setting is not considered a “specialized service”. PTAC is aware that some state have defined these

institutional settings as specialized service, but CMS has been clear since 2013 that inpatient settings do *not* qualify as Specialized Services.

Slide #25

A nursing facility admission may be appropriate for an individual with MI/ID-DD/RC, provided they meet the Level of Care requirements of the state, and they may only need the services that are included in the basic package of NF services.

It is important though that admitting an individual with MI/ID-DD/RC whose needs do not warrant that level of care would be a violation of the Supreme Court's Olmstead decision.

Slide #26

The NF basic package of services may vary from facility to facility, but may include 24-hour skilled nursing, rehabilitative services, and specialized rehabilitative services. For someone with a mental illness, those specialized rehabilitative services would include access to a psychiatrist and continuation of their medications.

Slide #27

When the individual needs the basic package of nursing facility services, but also needs services that are unique to their MI/ID-DD/RC, it might be referred to as the **NF Basic Plus model. Those "plus services" are commonly referred to as *specialized services or specialized add-on services***.

Given the variation amongst states, each state must determine where basic NF services end and specialized services begin. Of course, it is important to recognize that specialized services are individualized, so while states might have a listing of what constitutes specialized services, there can be other services identified that are unique to the individual.

Slide #28

I suspect many of you are familiar with the Olmstead ruling and we have referenced it a couple of times so far in this module, but let's be sure we go over this Supreme Court ruling as it has a direct relation with PASRR.

Slide #29

The Olmstead ruling is based on the Americans with Disability Act, or ADA. **The ADA emphasizes that a person with a disability must receive services in the most integrated setting appropriate to the individuals needs.**

With their Olmstead ruling, the Supreme Court stressed that since the ADA prohibited unnecessary institutionalization of persons with disabilities, **states had to make reasonable efforts to ensure that they were creating community services for individuals that were at risk of institutionalization.**

Slide #30

PASRR plays an important role in state efforts to comply with the Olmstead ruling, as it give special protection to individuals with MI/ID-DD/RC by promoting diversion from institutionalization through linkage with community-based services, and PASRR identifies services and supports that are necessary to help the individual transition to the community, if they need to be admitted to the nursing facility.

The individualized evaluations, recommendations, and coordination components make PASRR an effective tool for states to demonstrate their commitment to ADA/Olmstead compliance.

Slide #31

Let's look at some examples of how PASRR can interface with diversion and transition programs. This table includes six initiatives that may be operating in your state and each one offers an opportunity for PASRR to open the door to community integration or successful transition to the community from a nursing facility setting.

You can see that some of the initiatives function in support of both diversion and transition, while some are just focused on diversion.

There may be even other programs or initiatives in your state and it is important that your PASRR evaluators are knowledgeable of those resources.

We will look at each one in brief now, but cover them in greater detail in Learning Module #6.

Slide #32

The Community-Based Care Transition Program is a Medicare program that focuses on improving care transitions from hospitals to other settings and reducing readmissions for high-risk beneficiaries. PASRR can play an important role in promoting better care transition by indentifying the unique services and supports that individuals with MI/ID-DD/RC have and ensuring that they receive services and support to address those needs.

Slide #33

The Program of All-Inclusive Care for the Elderly is a Medicare program that can be effective in helping individuals avoid nursing facility admission. PACE provides comprehensive medical/social services to certain frail, community-dwelling older adults, most of whom are dually eligible for Medicare/Medicaid benefits. The PASRR process aligns with the goals of PACE and can be a valuable resource for Level II evaluators to consider.

Slide #34

The Workforce Innovation and Opportunity Act is primarily an employment law, but it adds a new core service to Center's for Independent Living (CILs) – **transition services**, which include helping individuals leave nursing facilities, but also helping in

efforts to avoid admission. In other words, CILs now play an officially sanctioned role in both NF transition and diversion.

The agency in your state that administers CIL funding can assist you with more information about how your PASRR program can link with their work.

Slide #35

The Money Follows the Person program is a Medicaid program that focuses on transitioning individuals out of institutional settings, including nursing facilities. The PASRR connection is through the Resident Review process, if that review determines that the person can be served in a less restrictive setting.

Slide #36

This concludes Learning Module #1 – CFR Compliance. Please be sure to review Learning Modules #2 & #3 for a full summary of CFR regulations for PASRR.