Understanding the PASRR Process

Mississippi PASRR

Presented by Mississippi Division of Medicaid and Maximus

Agenda

Welcome & Introductions

Level I LTSS & SC Referrals – Submission Through Outcome

- Understanding Federal Regulations & Evolving Guidance
- Level I Referrals & Outcomes
- Level II Evaluation Process & Summary of Findings
- Level II ID/RC Evaluations

What Happens After the Assessment:

- Level II Determinations & Approval Process DMH Mental Health Authority
- Reconsiderations & Appeals

Case Examples

Service Monitoring

Best Practices for Communication & Collaboration

MS State Transition Resources – Community Transition Services (EBD Waiver), Transition to Community Referrals, and IDD Waiver Diversion

Questions & Answers

Structure & Purpose of PASRR

Preadmission Screening & Resident Review

- Administered by Centers for Medicare and Medicaid Services (CMS)
- Created in 1987
- Anyone admitting to a Medicaid-certified NF must be screened for:
  - Serious Mental Illness (SMI), Intellectual Disability (ID), or Related Condition (RC)
  - Referred to as a Level I – LTSS Screening
- For anyone with a known or suspected condition→ Brief Level II Activity
  - To ensure NF is most appropriate placement
  - To ensure receipt of needed services

CMS Reform of Requirements for LTC Facilities

- Published October 4, 2016, and effective November 28, 2016
- Revision to the requirements that Long-Term Care facilities must meet to participate in Medicare and Medicaid programs
- First comprehensive update since 1991
- Reflects changes and advancements in LTC
- Targeted at “reducing unnecessary hospital readmissions and infections, improving quality of life, and strengthening safety measures for residents”
- CMS also released a Notice of Proposed Rule Making (NPRM) in 2020→Public Comments submitted in May 2020; still currently under review by CMS. Unclear when changes to PASRR regulations will be released.
- Last major reform to PASRR regulations was in 1997

Risks for Persons with Disabilities

Risks

- Skill loss
- Increased risk of marginalization
  - Lack of symptom or communication understanding
- Shrinking world/sense of loss/loss of control
- High rates of depression, suicide, passive suicide

Mitigation

- Educating providers about service/support needs
- Consider opportunities for community transition
- Admitting NF ensures they can meet the individual's needs and provide individualized and/or disability specific services
- Demystify the disability
- Build relationships

PASRR Supports Identification of Needs and Barriers

Life is a collection of experiences

Discharge planning for persons in PASRR population can present challenges, including:

- Increased need for additional community placement supports vs others not in PASRR population
- Need for disability specific services located and coordinated in the community
- Benefit from case management services in the community

Persons with PASRR conditions often have barriers to the full range of life experiences, including experiencing intimacy and connection with others that may result in increased:

- Loneliness
- Earlier mortality (25+ years)
- Institutional care

Optimize an individual's placement success, treatment success, and

QUALITY OF LIFE

THE MOST APPROPRIATE SERVICES

AT THE MOST APPROPRIATE PLACE

AT THE MOST APPROPRIATE TIME

Reaching that Goal of Optimizing a Person's Treatment Success...

(Source: Dan Timmel, CMS, 8-13-2006, 2013)

Four Questions of **PASRR**

1. Does the individual have a PASRR condition?
2. What is the most appropriate placement for the individual at this time?
3. Might this individual be a candidate for transition to the community? What supports or services would be necessary for the person to return and be successful in his/her community?
4. What unique disability supports and services does this individual need while a resident of a NF to ensure safety, health, and well-being?

1 Does this individual have a PASRR condition?

THE FOUR Ds OF PASRR—MI

1. Diagnosis (or suspicion of)
2. Dementia: If present, is it primary?
3. Duration
4. Disability

PASRR and Persons with ID

States must conduct the PASRR process based on current standards

- MS Department of Mental Health completes the ID/RC PASRR evaluations.
- The federal definition of ID for PASRR was published in 1983
  - By the American Association on Intellectual and Developmental Disabilities (AAIDD), formerly called the American Association on Mental Retardation (AAMR)

Definition requires an IQ score of less than 70

- As measured by a standardized, reliable test of intellectual functioning
- ID encompasses a wide range of conditions and levels of impairment

To qualify as having ID for the purposes of PASRR, an individual must also have concurrent impairments in adaptive functioning

ID must have emerged before the age of 18, and must be likely to persist throughout a person's life

Possible PASRR Related Conditions

Anoxia at birth
Arthrogryposis
Autism
Congenital Blindness
Cerebral Palsy
Congenital Deafness
Down Syndrome
Encephalitis
Fetal Alcohol Syndrome
Fredreich's Ataxia
Hemiparesis
Hemiplegia
Hydrocephaly
Klippel-Feil Syndrome
Meningitis
Multiple Sclerosis
Muscular Dystrophy
Paraparesis
Paraplegia
Polio
PDD
Prader-Willi syndrome
Quadriplegia
Seizure Disorder
Spina Bifida
Spinal Cord Injury
Traumatic Brain Injury
XXY Syndrome

Prior to age 22 – expected to last indefinitely

The person has 3 or more functional limitations in areas of major life functioning:

Self-care | Understanding and Use of Language | Learning
Mobility | Self-direction | Capacity for Independent Living

2 What is the most appropriate placement for this person right now?

- Least restrictive level of care
  - Too acute/not acute enough
- NF (meets LOC and this NF can meet needs)
  - NF MUST incorporate ALL PASRR identified services into care plan
- Specialized Services
  - Disability specific services to the person to meet required needs
- Alternative Placement or Community Placement Services

3

Might this person be a candidate for transition to the community?

What supports or services would be necessary to return to the community?

Community placement

- Independent living
- Group home
- Assisted living

Person directed care

Consumer Directed Attendant Care

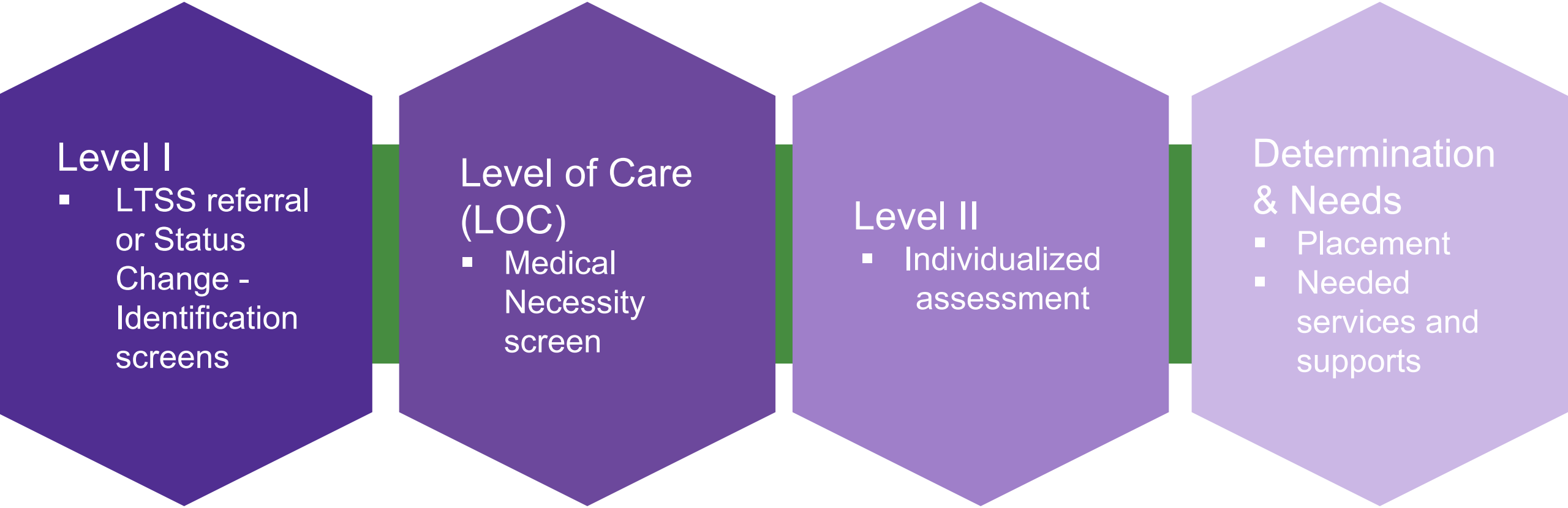
Assertive Community Treatment (ACT)

Guardian/Conservator

4 What unique disability supports and services are needed for an individual in the NF to ensure their safety, health, and well-being?

- Rehabilitative Services
- Specialized Services (disability specific services)
- Highest practicable physical, mental, and psychosocial well-being
  - Any needed service/support
- Not limited to facility's existing resources

PASRR Process Overview



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Current Nursing Facility Process

The NF is contacted regarding an individual who needs to be admitted for long term care placement.

In most cases, NF staff submits an LTSS screening, Informed Choice & uploads supportive documentation.

The LTSS algorithm generates a LOC score & determines the potential need for a PASRR Level II Evaluation.

If an LTSS screening triggers for Level II activity, DOM's PASRR contractor, Maximus, completes a clinical review & determines if a Level II is needed.

The NF enters the 317 in LTSS - the Medicaid Regional Office then determines financial eligibility and issues an approval/denial.

SC process – if the person experiences a significant change in condition affecting their mental health post admission & submission of LTSS screening, a SC is submitted in LTSS.

LEVEL I SCREENS

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Purpose of the Level I

Identification screen

- Is there a known or suspected diagnosis: MI, ID, RC?
- Does the person have Hx of substance use, NCD?
- What are the current mental health symptoms and/or behaviors?
- What medications is the individual prescribed?

First step in process

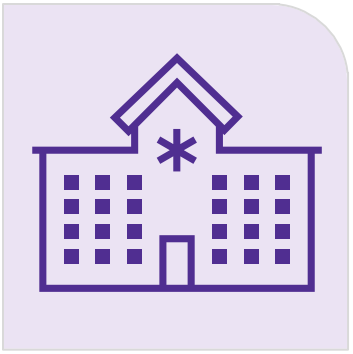
Who Receives a Level I?

For people who are entering/residing in a Medicaid-certified NF

- Regardless of payer source
- Regardless of diagnoses
- Regardless of current location

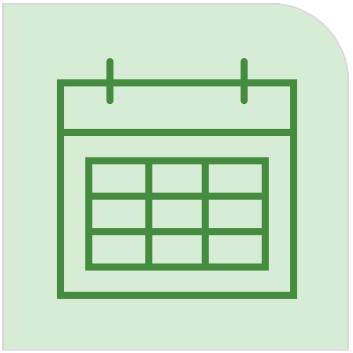
Everyone

When to Submit a Level I



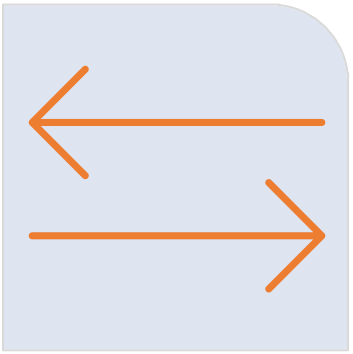
Before NF admission

- LTSS Screening = Initial Level I Preadmission Screening



Expiration of a *time-limited stay*

- Status Change
- Submit 7 days before end date



Significant *change in status affecting mental health*

- Status Change

Required Documents for a Level I Referral

REQUIRED FOR BOTH LTSS SCREENING AND SC:

- H&P dated within the last 12 months
- 3-5 days of nursing notes
- Orders or MAR (both aren't needed)
- Psych evaluation/psych notes (if available)

Level I Outcomes

- Level I Positive – Refer for Level II onsite
- No Status Change
- Cancelled/Withdrawn
- Refer for Level II DBR
- No Level II - Negative
- Exemption and Categoricals

30-day Hospital Exemption — Level I Positive

Provisional Emergency 7 days

Respite Up to 10 days

Categoricals & Hospital Exemption

Severe Illness – Level I Positive

Terminal (Hospice)

Dementia Exemption

LEVEL II ASSESSMENTS

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Importance of the Level II

In-depth Assessment

- Meet the person for bio/psycho/social interview
- Interview support/care providers
- Interview family member (if available & obtain consent)
- Review medical records

Tells who the person is

- Likes/dislikes
- MH History & treatment
- Diagnoses
- Needs

State and Federally required

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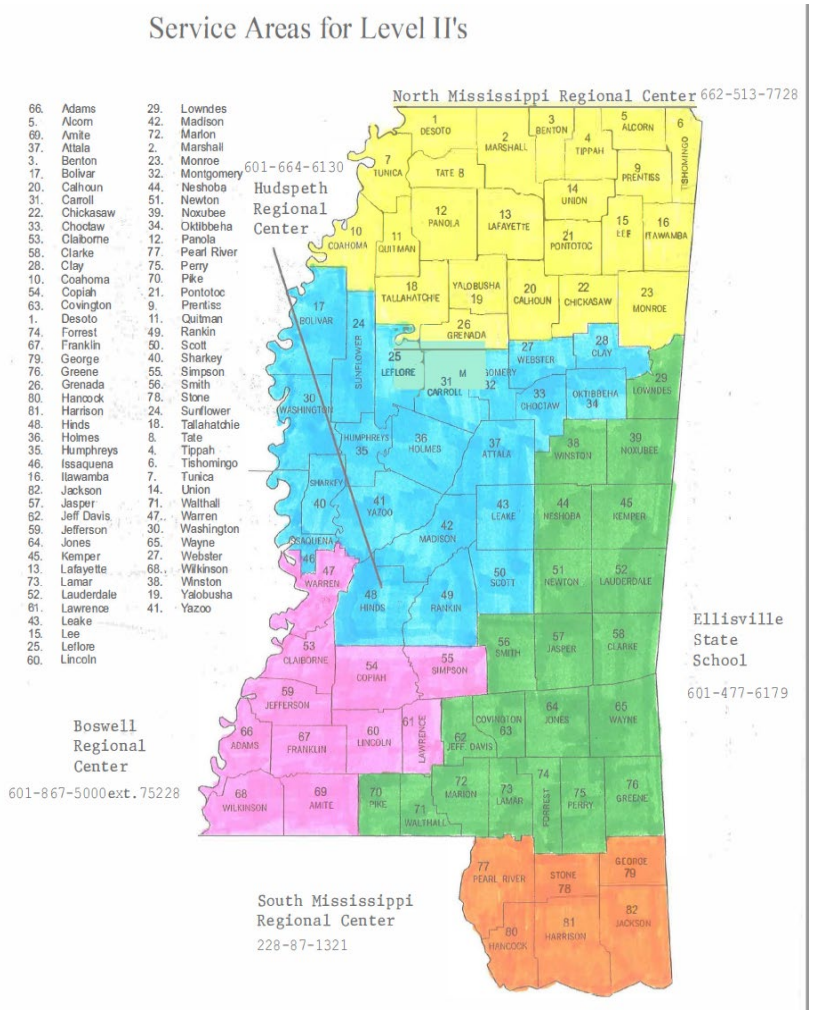
Intellectual and Developmental Disabilities (IDD) and Related Conditions (RC) PASRR Process

Level II IDD Evaluation

When a Level II is required, the LTSS screening form and H&P documentation are submitted to the appropriate IDD Diagnostics and Evaluation (D&E) Team located at 1 of 5 State IDD Regional Program.



Intellectual and Developmental Disabilities (IDD) and Related Conditions (RC) PASRR Process

Steps To Complete A Level II IDD Evaluation:

- D&E Team staff contacts the referring agency/NF to schedule and conducts Level II.
- Level II Summary report must be completed within 5 business days
- Level II Summary report must be submitted to IDD State PASRR Coordinator's Office within 2 business days after evaluation conducted.
- IDD State PASRR Coordinator reviews Level II Summary and completes an IDD Determination within 2 business days.
- Level II Summary and Determination is uploaded in LTSS and sent to the referring Agency using the contact information provided on the LTSS referral.

DMH
Mississippi Department of Mental Health
Supporting a Better Tomorrow...One Person at a Time

Willis Garrison, M.S., CIDDT
Department of Community Supports
State IDD PASRR Coordinator
willis.garrison@dmh.ms.gov

MENTAL HEALTH | INTELLECTUAL AND DEVELOPMENTAL DISABILITY SERVICES | ALCOHOL AND DRUG ADDICTION SERVICES

After the Assessment is Complete...

Level II Determination

Summary of Findings report, includes:

- Consideration of placement options
- PASRR-identified service delivery assurances

The Level II Summary Report has critical information NF providers need to determine if they can provide the needed disability specific services & supports to the person

Outcome & Determination Process

For All MI Level II Assessments:

1. Maximus reviews assessment details and completes the Level II Determination & Summary of Findings (SOF)
2. The PASRR Coordinator reviews each for accuracy of information on:
   - Mental illness diagnosis on a signed H&P from physician
   - Correct name
   - Correct facility
   - Correct pertinent information
   - If the individual needs nursing facility level of care
   - Recommended disability specific services and/or supports
3. Summary is then reviewed and approved by designated psychiatrist
4. After final review and approval, the determination letter and SOF are uploaded in LTSS and available for download. These are also mailed to the attending physician, individual, legal representative, and referring facility.

Options for Level II Determinations

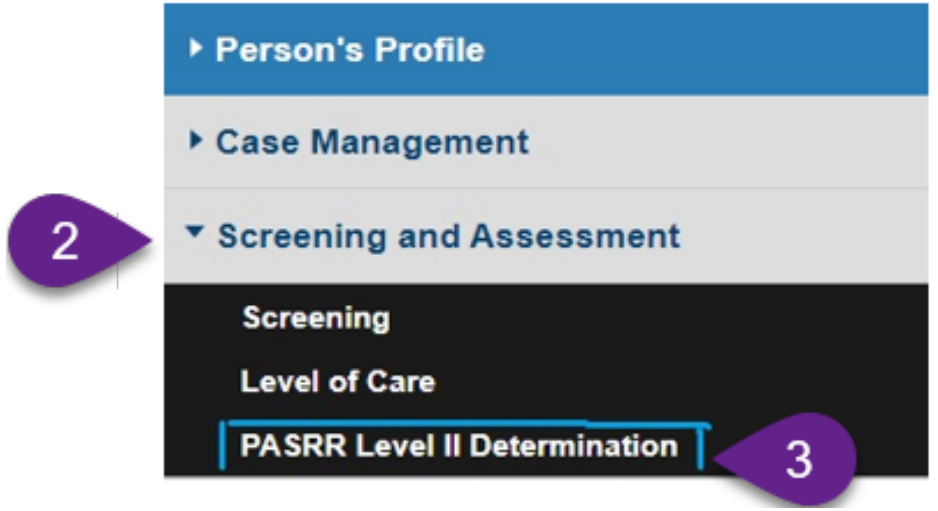
Approved for Short-Term Nursing Facility = 30 calendar days (EHD)

Approved for Long-Term Nursing Facility = no specified time frame

Denied for Nursing Facility admission

Where to Find Outcome/Determination Notices and SOF in LTSS:

1. Navigate to the person's referral
2. Click on ***Screening & Assessment*** (in the left bar)
3. Click on PASRR Level II determination
   - Click on ***View***
   - In the Attachments section, you will be able to find and download these documents



Attachments

Create Date	Created By	Attachment Type	File Name	Actions
7/29/2024	Lori Crawford	Recommendation	[redacted]Level II Determination-SOF.pdf	Download
7/22/2024	Shenna Bridgeforth	Determination Letter	[redacted]_Level I Outcome.pdf	Download

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Reconsiderations

If the individual and/or their representative disagree with the determination, a request for reconsideration may be submitted within 10 days of determination.

Submit request for reconsideration in writing to Maximus along with additional documentation not available prior to submitting the original LTSS screening or SC.

Maximus will request a SC be submitted and submitter must add note in box "submitting for reconsideration." Maximus must make a decision within 5 days of receipt of request.

Appeals

You may appeal through the appeal process with the Department of Mental Health

- Must be done within (30) days of the date of the reconsideration outcome
- All appeals must be clearly marked “Notice of Appeal” and contain a detailed written statement of the facts upon which the appeal is based, and the relief requested
- Appeals will be reviewed by the DMH Executive Director, or designee, and will be final.
- Reviews usually occur within (10) days of receipt.

MORE INFORMATION

1. Code of Federal Regulations, Title 42, Part 483, Subpart C, 483.100- 483.138. There is a notice of proposed rule making under review by CMS to make changes to wording and outdated information.
2. Mississippi’s Division of Medicaid, Title 23: part 206: Mental Health Services, part 207: Institutional long-term care, and part 300: Appeals

Specialized Services: MI Example

A 58-year-old woman is admitted to a NF following a 2-month psychiatric hospitalization due to a suicide attempt. She has a history of Schizoaffective Disorder, Bipolar Type and Alcohol Use Disorder, in partial remission since her early 20s with multiple psychiatric admissions. Her medical dx includes DM Type 2, HTN, and a right below knee amputation. She requires moderate assistance with ADLs and medication management. She has a desire to transition to the community once she is more stable and able to manage better independent. Based on her Level I referral, she is referred for a Level II assessment.

A Level II evaluation leads to the following recommendations for Specialized Services:

- A mechanism for the NF to develop a behavioral care plan with mental health professionals
- Ongoing medication management by a psychiatrist
- Intensive outpatient services (2-3 days/week) if available in the community
- Participation in a local 12-step group to support ongoing sobriety.

In this case, the Level II evaluation also recommends a suite of Specialized Rehabilitative Services, including services necessary to improve her ability to complete her activities of daily living. Unlike Specialized Services, these services are provided under the NF's daily rate.

Specialized Services: MI/ID/NCD Example

A 45-year-old male is being considered for placement in a NF following a long medical hospitalization for complications due to PNA that required ventilation. He also developed a delirium but has returned to his baseline. He has a history of receiving services through his local Regional Center as he was dx'd with Down's Syndrome at birth with a moderate ID with an FSIQ of 65 and development of early onset NCD. He also has major depressive disorder, moderate, recurrent. He takes Pristique to minimize symptoms of anxiety, isolation, and tearfulness. He enjoys art therapy and watching TV. His mom indicated he prefers to be around his peers and notices he's less anxious when involved in activities throughout the day. He has lived with his mother but due to her own health issues, she's no longer able to care for him. Prior to admission, he was receiving home care services, participating in a day program 3 days a week, case management, and community mental health supports.

A Level II evaluation leads to the following recommendations for Specialized Services:

- A mechanism for the NF to develop a behavioral care plan with mental health and IDD professionals
- Medication management by a psychiatrist
- Art Therapy
- Consider potential for transition and submission of HCBS Elderly and Disabled Waiver

In this case, the Level II evaluation also recommends a suite of Specialized Rehabilitative Services, including services necessary to improve his engagement in activities of daily living. Unlike Specialized Services, these services are provided under the NF's daily rate.

MS SERVICE MONITORING

Process Overview

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What is Service Monitoring?

- **PURPOSE:** To identify if the nursing facility incorporated PASRR recommended disability specific specialized and rehabilitative services in Care Plan
  - NF noncompliance is reported monthly to DOM
- **Required documents for SM:**
  - Service Monitoring DBR form (available on the MS PASRR Provider website)
  - POC and MDS showing that SS and RS have been care planned/incorporated into the person's goals
  - MD and Therapy Orders
  - Psych assessment/notes (if available and completed)
- Only required for individuals who were at the nursing facility at least 15 days
- Maximus Project Support Staff faxes a Service Monitoring notification to facility submitter, including notice of non-compliance. A Maximus Quality Coordinator reviews all documentation received and reports on compliance.
- Per PASRR Guidelines, PASRR outcome letters and Summary of Findings MUST be maintained in the individual’s floor record or EHR

MS State Specific Resources Available

Community Transition Services: Elderly and Disabled Waiver service

TCR (Transition to Community Referrals)

ID/DD waiver has PASRR diversion slots (crisis)

Community Transition Services are provided through the Elderly and Disabled Waiver for qualifying NF residents

- The program provides funding for non-recurring set-up expenses and community navigation services provided to a Mississippi Medicaid beneficiary who is transitioning from a nursing facility to a living arrangement in a community residence where the person is directly responsible for his or her own living expenses.
- Referrals can be made by checking CTS on the Transition to the Community Referral form or completing the CTS form found at **https://medicaid.ms.gov/wp-content/upl.oads/2018/01/CTS.1-Initial-Referral.pdf** .

Community Referral Program (TCR)

Who is eligible?

Anyone residing in a NF who decides they would like to live and receive services in the community.

How does the TCR process work?

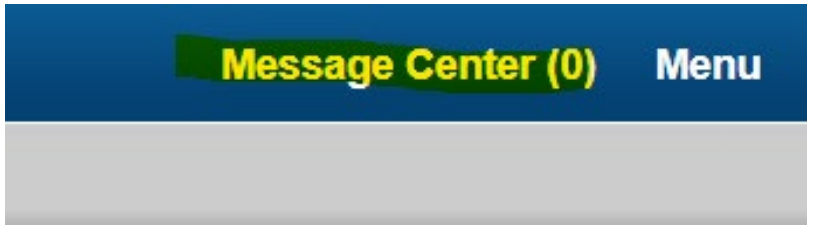
Nursing facility completes TCR form in LTSS within 10 business days of receiving *a "yes"* response from resident for community transition

Fillable form available for download at www.mdhs.ms.gov

LCA (Local County Agency) will review TCR in LTSS and make a determination of program referral and/or community support within 2 business days and send form to the Referral Agency

The Referral Agency will contact the individual or responsible party within 5 business days of receiving referral with information about services and/or resources in the community

Best Practices for Communication Between Maximus & Providers



- **Utilization of the LTSS Message Center**
- **MS Provider Email Notifications**
  - If you or someone at your agency isn't receiving provider emails from Maximus, email the MS PASRR Help Desk with your name, agency, and email address
- **Attend our Quarterly Provider Q&As**
  - Held the 2nd Monday every January, April, July, and October
- **Contact the MS PASRR Help Desk email of phone with any questions**
- **Check our MS PASRR Provider Website**

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Maximus Contact

MS PASRR Provider - User Tools website:
https://maximusclinicalservices.com/svcs/mississippi

MS PASRR Help Desk
MSPASRR@maximus.com

Maximus MS PASRR Helpdesk
833-967-2777

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MS Division of Medicaid (DOM) Contact

LaQuita Reed, MSW

Institutional Long Term Care/Case Mix Director| Office of Long Term Care

601-359-5251

Email: laquita.reed@medicaid.ms.gov

Website: http://www.medicaid.ms.gov

LTSS FEI Help Desk

Report any LTSS system issues to:

LTSSMSHelpDesk@feisystems.com

Support Line: 844-366-5877 (844-DOM-LTSS)

QUESTIONS & ANSWERS

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