INFORMATIONAL LETTER NO.1760-MC-FFS

DATE: January 31, 2017

TO: Iowa Medicaid Nursing Facilities (NFs), Skilled Nursing Facilities (SNF) and Nursing Facilities for Individuals with Mental Illness (NF/MIs)

APPLIES TO: Fee-for-Service and Managed Care

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Care Planning For Preadmission Screening and Resident Review (PASRR) Level II Identified Services

EFFECTIVE: Immediately

This informational letter clarifies concerns raised by NF providers related to care planning for individuals identified by PASRR Level II as being in need of PASRR identified services.

The goal of PASRR is to ensure that individuals with mental health, intellectual/developmental disabilities and related conditions live in the most appropriate setting and receive the services they need in that setting. To achieve this goal, the PASRR process must identify the services and supports that an individual may need in the NF or community and identify whether an individual meets the level of care criteria for a NF. This includes all rehabilitative services, specialized services and any services that may relate to short-term approval and/or preparation for discharge to a lower level of care.

If the NF setting is found to be the most appropriate setting for an individual, PASRR identified services and supports must be delivered in the NF through a combination of state, NF and other resources.

The Code of Federal Regulations (42 CFR § 483) and the PASRR Final Rule clarify the expectation for PASRR identified services and supports to be incorporated into the individual's care plan at the NF.

The IME, the Department of Inspections and Appeals (DIA), DHS Mental Health and Disabilities Services Division (MHDS), and Ascend, the PASRR contractor, have worked together to determine the basic requirements needed for a compliant individual care plan. The results of this collaboration concluded:

- A care plan must be developed for a resident of a NF upon admission and reviewed quarterly or when there is a significant change in need.
- NFs must obtain and retain, in the individual's file, a copy of the PASRR which identifies the services and supports that the NF is required to provide for the resident.
- The PASRR identified services must be incorporated into the individual's care plan and address the following four criteria:
    1. Start Date – the date the services started or will start
    2. Expected Duration – how long will the services be provided
    3. Anticipated Frequency – how often will the services be provided
    4. Provider – credentials of the individual or profession that will be providing the service

- If the service is a specialized service, the credentials of the provider need to be identified. If available, the name of the specific provider should be provided.
- If the resident refuses a specialized service, PASRR requires that the NF address, in the care plan, how they intend to meet the need that the PASRR identified service was intended to address and how they will monitor the resident's continued willingness to accept or decline the services.
- If a PASRR identified specialized service is declined or cannot be arranged for other reasons, the individual's care plan must include how the NF plans to address the identified need in the absence of those services.

The IME and the MHDS would also like to provide clarification on the following concerns:

Specialized Services:

For the purposes of PASRR, the term "specialized services" means any service or support identified by an individualized Level II determination that a particular NF resident requires due to mental illness, intellectual disability or related condition, which exceeds the scope of services that the facility must provide under reimbursement as NF services.

The PASRR identified specialized services need to be addressed in the individual's care plan along with all other PASRR identified services.

Community Placement Supports:

Community placement supports are those supports and services that an individual needs when they are living in the community. It is a federal requirement for every PASRR Level II to have community placement supports identified in the PASRR Summary of Findings. The NF must address these in the individualized care plan if the resident:

1. receives a short term approval from PASRR,
2. has a goal to return to a lower level of care, or
3. has identified in the Minimum Data Set (MDS) Section Q, that they wish to pursue the possibility of return to a lower level of care.

The NF may not know specifically who the provider of community placement supports will be so they should address who will be contacted to deliver those services at the time they are needed.

PASRR Care Planning Tool:

A PASRR Care Planning Tool has been created to assist NFs in writing a care plan. The use of this tool is **NOT** required. As long as the care plan thoroughly addresses the four criteria above, it will meet the requirements of a compliant care plan.

ServiceMatters Care Plan Reviews:

Federal regulations require that NF residents receive all services identified by PASRR Level II. Ascend is contracted to conduct ServiceMatters Reviews (ServiceMatters) of the provider's delivery of PASRR identified specialized services for residents with specialized service needs.

ServiceMatters is an intensive review, technical assistance, and coaching process to assist NFs with development of PASRR compliant care plans. When reviewing an individual's care plan for ServiceMatters, the reviewer is looking to make sure the care plan identifies the PASRR identified services and the documentation provided by the NF supports the delivery of the specialized services.

Documentation that supports the delivery of specialized services can vary based on how the NF tracks the information. Some examples of documentation include:

- Detailed electronic health record documents that shows treatment occurred with dates and providers indicated.
- A form utilized by the NF and completed by the specialized service provider outlining when the individual was seen, medications, what kind of review occurred at the appointment, and next appointment, if applicable.
- Copies of the individual's actual treatment records

The ServiceMatters review process will identify compliance or noncompliance of care plans and whether PASRR identified services are being delivered. NFs determined to be noncompliant for individual care planning and service delivery through ServiceMatters will be referred to the IME Program Integrity (PI) Unit for additional review. The IME PI Unit will evaluate each referral and follow their standard operating procedures based on the specifics of the noncompliant referral. Continuous non-compliance of individual care planning and service delivery by a NF may result in sanctions including probation, recoupment, payment suspension and suspension from participation.

Health Insurance Portability and Accountability Act (HIPAA) Concerns:
Please be assured that the Ascend system is secure and fully HIPAA compliant. Sensitive information that is requested by Ascend may be directly uploaded into their secure PASRR database when logging into the PASRR web page. If and when you are asked to send documents to DHS/MHDS, please be assured that the email system is also secure. If sensitive information is being sent to DHS/MHDS, please mail or fax to the address specified in the correspondence you receive.

Managed Care Organization (MCO) Community Based Case Management:
With the transition to managed care on April 1, 2016, the MCOs are required to assign community-based case managers (CBCMs) to residents of NFs. CBCMs should be included in the care planning process and utilized for assistance in locating or arranging services when needed. CBCMs may assist with the identification and coordination of services needed for those members who need PASRR identified services.

PASRR Resources:
Provider tools, frequently asked questions and training opportunities are available on the PASRR web page[1]

[1] http://www.pasrr.com/IowaDefault.aspx