pennsylvania
DEPARTMENT OF HUMAN SERVICES

Tracking the Provision of Specialized Services Identified during the Preadmission Screening and Resident Review (PASRR)

ODP Announcement 24-045

AUDIENCE:

- Office of Developmental Programs (ODP)
- County ID Office/Administrative Entities (AEs)
- Supports Coordination Organizations (SCOs)
- Community HealthChoices/Managed Care Organizations (MCO)
- Office of Long-Term Living (OLTL) Field Office Nurses

PURPOSE:

This announcement is to explain the Centers for Medicare and Medicaid's (CMS) requirement for tracking Specialized Services(SS) **Social Security Act §1919 (ssa.gov) C (iv)** for individuals who have gone through the Preadmission Screening and Resident Review (PASRR) evaluation and who have been identified with Intellectual Disability (ID), who have been found Nursing Facility Care Eligible (NFCE), who have a Letter of Determination (LOD) from the Office of Developmental Programs (ODP) indicating that the AE has recommended SS and who reside in a skilled nursing facilities (NF) or who have been discharged from a NF to a community setting. The Office of Long-Term Living (OLTL) has developed new processes to track the provision of SS for these individuals

who reside in NFs or to track the provision of similar services for those who are being discharged from the NF back to a community setting.

Background:

PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in a NF for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI), intellectual disability (ID) and/or other related condition (ORC); 2) be offered the most appropriate setting for their needs (in the community, a NF, or acute care settings); and 3) receive the services they need in those settings. Federal regulations issued on November 30, 1992 (42 CFR Parts 405, 431, 433, and 483) **eCFR :: 42 CFR Part 483 Subpart C -- Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals** set forth State requirements for PASRR. The regulations include criteria for determination of need for nursing facility services and specialized services together with procedures for ensuring individual freedom of choice and appeal rights.

Federal regulations place ultimate control and responsibility with the Pennsylvania Department of Human Services (Department) to evaluate and determine the need for services for individuals with ID. The Department has identified OLTL as the lead program office for the PASRR process. The responsibility to evaluate and determine the need for services for individuals with ID was delegated to the ODP Regional Program Managers (RPM).

The AE is responsible for recommending SS for individuals who are NFCE, and are identified with ID per ODP **OBRA Bulletin 00-93-30, Part III, B. 1** and **Part V, B. 1.** The AE is responsible for "providing or arranging for specialized services for individuals residing in nursing facilities," however, with the roll out of the Community HealthChoices/Managed Care Organizations (CHC/MCO) for individuals residing in NF's

the responsibility of the provision of the specialized services transitions from the AE to the MCO. When an ODP waiver participant (Adult Autism, Consolidated, Community Living or Person/Family Directed Support) is identified for and is admitted into a NF, they will transition from the ODP waiver to a MCO for their Long-Term Services and Support (LTSS) per **ODP Announcement 22-039**.

The disenrollment from the waiver is required to open the person's record for CHC/MCO enrollment. This does not mean the AE is not responsible for using base money for specialized services. If SS are required prior to enrollment in the MCO, the AE will need to manage base authorization/payment outside of HCSIS to ensure the assessed needs of the individual are being met during the transition.

When this transitions to the MCO occurs, it is the responsibility of the MCO and the AE to coordinate the transition of Long-Term Care (LTC) services to prevent service interruptions for the individual.

The MCO should be coordinating with the AE that made the initial recommendation for the specialized services as identified in the PASRR Letter of Determination. The MCO should reference the county contact list provided at this link **https://www.dhs.pa.gov/Services/Disabilities-Aging/Pages/ODP-County-MH-ID-Office-Contacts.aspx** for the appropriate county contact information.

Collaboration between the AE, the MCO, the individual, the guardian, their family, the SCO, Nursing Facility, and other members of the individual's support team should be involved in determining which SS is appropriate for the individual's assessed needs. Information related to SS can be found in the PASRR Level II form version 11-2018, the ODP Bulletin 00-93-30, Part III, and the Code of Federal Registry Title 42 Section 483 Subpart C.

Specialized Services are services which result in:

- The acquisition of behaviors necessary for an individual to function with as much self-determination and independence as possible and
- The prevention or deceleration of regression or loss of current optimal functional status.

For individuals with ID SS may include but are not necessarily limited to the following: Assistive technology, behavioral support, communication specialist, companion services, housing transition and tenancy sustaining services, in-home and community support, supports coordination, support (medical environment) and transportation.

The CMS regulations include the tracking and reporting back to the CMS the determinations of the PASRR evaluation process and the provision of recommended SS while an individual is residing in a NF and after the individual is discharge from a NF to a community setting. **Social Security Act §1919 (ssa.gov)**. The OLTL has developed several new processes to ensure the CMS tracking and reporting requirements are being met.

DISCUSSION:

1. **Processes to Track the Provision of SS for Individuals Residing in a NF**

   - **The OLTL Field Office nurses** will review the records of individuals who,
     - currently reside in a NF,
     - have a PASRR Level II that identifies the individual with ID and
     - have been recommended for SS by the AE.
   - If the recommended SS are not being provided,
     - the Field Office Nurses will look for documentation that the individual or their guardian has refused the recommended SS.

        - If no refusal documentation is found,

            - ✓ the Field Office Nurses will look for documentation that the SS are no longer appropriate for the individual.

    - If none of the above documentation is found, the Field Office Nurses will send a letter (called a Referral Letter) notifying the entity (MCO or AE) who is responsible for providing the SS that there is no documented evidence the services are being provided.

    - The Referral Letters will go to:

        - The individuals selected MCO or

        - The AE if MCO selection and transition has not occurred.

    - A copy of the letters will also go to the ODP Regional Office that issued the Letter of Determination, the AE that recommended the SS, the NF, the OLTL PASRR Coordinator, the ODP PASRR Lead, the Director of Fee-for-Service Operations, the Director of Division of Monitoring and Compliance.

- **The MCO and the AE** will follow up on each Referral Letter by collaborating to ensure the identified individual is receiving the appropriate SS to supports the individual assessed needs. Collaboration should also include the individual, their guardian, their family, the SCO, the NF, and other member of the individual's support team.

  Documentation of the results of the collaboration to ensure SS should be provided by the MCO or the AE if the transition to the MCO services have not been completed.

  The documentation should include.

- What SS have been recommended.
- The name of the agency providing the SS.
- If it was determined that the individual or their guardian has refused the recommended SS or
- If the individual has had a change in condition where the SS are no longer appropriate.

This documentation should be sent to the OPD Regional Office that issued the letter of determination, the AE that recommended the SS, the NF, the OLTL PASRR Coordinator, the ODP PASRR Lead, the Director of Fee-for-Service Operations, the Director of Division of Monitoring and Compliance.

- **The ODP Regional Office** will upload the Referral Letters and the follow up documentation into the PASSR Docushare "Specialize Services" folder in the appropriate ODP county folder at this link **AAA Submissions (state.pa.us)**.
- The Regional ODP staff will enter **only** the information from the Referral letters on to the SS Data Spreadsheet for SS **that should have been provided for by the AE.**
- These data spreadsheets will be sent to the ODP PASRR Lead at **c-rgengler@pa.gov** on a quarterly basis. **The ODP PASRR Lead** will analyze the data and prepare an annual report for the OLTL PASRR Coordinator.

2. **Process for tracking that similar services have been arranged to meet the individual's assessed needs after discharge from a NF to a home/community setting.**

- **The NF** will complete a 408 form when an individual is discharged from the NF. A copy of the 408 is sent to the OLTL Field Office Nurses.

- **The OLTL Field Office nurses** will review the 408 form and complete a Program Office (PO) Transmittal form. They will email the PO Transmittal form to the PW, ODP PASRR Transmittal RA account at **RA-PWODPPASRRTRANSMI@pa.gov**. The PO Transmittal form will include information related to the SS. This information will include.
    - Date of Admission
    - Date of Discharge
    - Location of discharge
    - Were SS recommended?
    - Was the individual receiving SS in the NF?
        - If yes, Indicate which services.
        - If no, indicate why.
    - Have similar services been arranged for after discharge?
        - If no, indicate why.
        - If yes, by whom and/or explain how will the services be provided?
- **The ODP Central Office Staff** will enter **only** the information from the PO Transmittal forms for individuals who have been discharged from the NF back to a home/community setting on to the SS Tracking Spreadsheet. The ODP Central office staff will then upload the PO Transmittal form into the PASRR Docushare Specialized Services folder in the appropriate ODP county folder.
    - The spreadsheet will be sent to the ODP PASRR Lead on a quarterly basis.

- **The ODP PASRR Lead** will analyze the data and prepare an annual report for the OLTL PASRR Coordinator.

- **The MCO** should collaborate with the AE to ensure home and community-based services are being provide for the assessed needs of the individual after discharge back to the community.

PLEASE DIRECT QUESTIONS TO THE ODP REGIONAL OFFICE OR THE ODP PASSRR LEAD at c-rgengler@pa.gov