# Financing or Arranging for PASRR Specialized Services for Individuals With Serious Mental Illness: Medicaid and Medicare Options

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## INTRODUCTION

Beginning in the 1970s and 1980s, states made significant strides in moving individuals with mental illness out of state-funded institutions (including psychiatric hospitals) and into the community. However, because adequate options for housing were not always available, many individuals were admitted to nursing homes, which served as a kind of default housing. Amid concerns that individuals with mental illness were being inappropriately "warehoused" in nursing homes, Congress created the Preadmission Screening and Resident Review (PASRR) program in 1987, as part of the Nursing Home Reform Act (incorporated into Title XIX of the Social Security Act as Section 1919(e)(7)). A Final Rule establishing the regulations for PASRR was published in 1992 and incorporated into the Code of Federal Regulations at 42 CFR 483.100-138.

The PASRR process applies to any person being considered for admission to a Medicaid-certified nursing facility (NF), regardless of insurance type. In brief, PASRR has three chief goals:

1. To evaluate all individuals applying for NF admission for evidence of a mental illness (MI), an intellectual disability (ID) or a related condition (RC), or both MI and ID or RC
2. To ensure that individuals receive needed care in the least restrictive setting that can meet their needs, whether in a NF or in the community
3. To identify and recommend any services the individuals need to address their PASRR-identified condition

PASRR has two core components: a Level I screen and a Level II evaluation. A Level I screen should yield a positive result if there is evidence that the individual *might* have one of the targeted conditions. When the Level I screen yields a positive result, a more in-depth and individualized Level II evaluation is conducted to verify the Level I findings. The Level II evaluation determines whether alternatives to NF admission or continued stay are appropriate, and it identifies the services needed to address the individual's MI and/or ID or RC needs, regardless of diversion or NF admission.

A Level II evaluation may be repeated after admission if the individual has a significant change in status, to determine whether this change has affected the individual's PASRR level of disability. This post-admission evaluation is called a Resident Review.[1]

## SPECIALIZED SERVICES

When the recommended services resulting from the PASRR evaluations are beyond those normally provided and included in the NF daily rate, they are considered *Specialized Services*. These services have three key characteristics:

1. They address individualized needs related to a person's MI and/or ID or RC, as identified in the Level II evaluation.
2. They are provided to the individual during their residency in the NF.
3. They exceed the services a NF typically provides under its daily rate.

Recall that PASRR applies to any individual applying for admission to a Medicaid-certified nursing facility, regardless of insurance type. Any applicant to a Medicaid-certified NF may need Specialized Services, regardless of insurance type. It then is up to the state to "provide or arrange" for those services for all NF residents (42 CFR 483.116).[2]

Although Specialized Services for individuals with ID or RC is critically important, this document focuses on Specialized Services for individuals with serious mental illness (SMI). Much of the framework we present in this paper for SMI also applies to other types of MI and to ID or RC.

The issues related to which mental illnesses qualify as SMI are complex (see 42 CFR 483.134). For the purposes of this document, SMI is defined as bipolar disorder, schizophrenia, or other psychosis.

Specialized Services for individuals with SMI could include peer supports, a recovery assistant, transitional case management, or participation in community psychosocial activities. Training or education of NF staff on individualized approaches to helping the person manage their behaviors also could be provided. The precise set of Specialized Services that a state provides is up to the state.

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[1] Significant change in condition guidance is available on the PASRR Technical Assistance Center website, last accessed March 15, 2017. http://www.pasrrassist.org/resources/mds-30/what-considered-significant-change-condition

[2] States' obligation to NF residents with private insurance is a complex topic and one that we will not investigate here.

## The Importance of Specialized Services

The 2016 PASRR National Report shows a clear need for Specialized Services that are accessible to NF residents with SMI. The report indicates that many residents with mental illness reside in NFs, and the number of individuals with mental illness has grown slightly since 2011.[3] Because Specialized Services are services that exceed those provided under a NF's daily rate, the PASRR process serves as the mechanism for ensuring that individuals with mental illness receive services unique to their needs during their NF residency.

Access to Specialized Services can ensure continuity of care for NF residents who been receiving community-based treatment, or it can connect the residents with new service providers who can continue to offer support upon the individual's transition to the community. When states supply Specialized Services to NF residents who need them, they address two key objectives: (1) they help the residents preserve and improve their functioning and lead higher quality lives; and (2) they help advance opportunities for the residents to transition back into their community.

## Paying for Specialized Services

One of the central challenges for states is how to pay or arrange for Specialized Services, given that they are not included in the NF daily rate. The contents of this paper should be useful to state staff who recognize that there are gaps in the way their states provide Specialized Services but are unsure how to pay for those services. Similarly, the content should be useful to states that currently fund Specialized Services through state-only dollars and would like to recoup at least some of the money they spend by making those services reimbursable through Medicaid. Our goal is to illuminate the possibilities for financing or arranging Specialized Services, so that states can more readily supply these critical services to NF residents who need them.

States can address the Specialized Services funding challenge using two potential sources: Medicare and Medicaid.

1. *Medicare*. States can leverage Medicare for individuals who qualify. Medicare provides a range of mental health-related services that can address the disability-specific needs of individuals with SMI in a way that does not place a financial burden on the state. These include individual and group psychotherapy, medication management, and diagnostic psychological and neuropsychological testing.

[3] Centers for Medicare & Medicaid Services. 2016 PASRR National Report: A Review of Preadmission Screening and Resident Review (PASRR) Programs. PASRR Technical Assistance Center; January 2017. http://www.pasrrassist.org/sites/default/files/attachments/PASRR_National_Report_2016.pdf

2. *Medicaid*. States can submit a State Plan Amendment (SPA) to include Specialized Services within the NF benefit, as Washington State recently has done for Specialized Services for individuals with ID or RC. (We will review Washington's approach briefly in a later section). Because PASRR is part of Medicaid law and must be completed for all individuals seeking admission to Medicaid-certified NFs, regardless of insurance type, state staff who administer PASRR programs sometimes believe that only Medicaid can pay for Specialized Services. That is a misconception. Indeed, the CFR states the following at 483.116(b)(2): "The State must provide or arrange for the provision of the Specialized Services needed by the individual while he or she resides in the NF." States can *provide* for Specialized Services by financing those services with Medicaid monies or with state-only dollars; they also can *arrange* for those services by leveraging non-state funding sources, especially Medicare.

## USING MEDICARE TO PROVIDE SPECIALIZED SERVICES WITHOUT SPECIAL FINANCING

Created in 1965 as a companion to Medicaid, Medicare provides coverage for individuals aged 65 years and older, for certain individuals younger than 65 years who have disabilities, and for individuals with end-stage renal disease. Medicare can supply critical services that may not be available through Medicaid, even with an approved SPA in place.[4] Additionally, for individuals who are eligible for both Medicaid and Medicare, suitable Medicare-financed services should be accessed first, if possible, because Medicaid is the payer of last resort.

Medicare can enhance the PASRR program because it provides a means to pay for certain Specialized Services identified in an individual's plan of care. Like most forms of insurance, Medicare will not cover all needs of individuals identified by PASRR. It therefore is essential to understand what is covered and what is not.

Medicare Parts A through D provide services to Medicare-eligible residents of NFs who have SMI. Part A is not a source of payment for Specialized Services. Payment options for these services are limited to Parts B through C. Part D would be a resource for NFs to secure payment for psychotropic medications, which normally would be a service provided within the NF. We briefly review the Parts A through C below.

### Part A: Hospital Insurance

Although Part A is not a source of payment for Specialized Services**,** when a NF resident needs hospital acute care or inpatient psychiatric care, which is covered by Part A, there is a need for

[4] The State Plan Amendment process is discussed in detail in this document's section titled *Using Medicaid to Finance Specialized Services*.

effective care coordination between the NF and the hospital to identify any new need for Specialized Services.

### Part B: Supplementary Medical Insurance

If a Medicare-eligible NF resident needs mental health or related services, the resident may obtain those services under Medicare Part B. Part B can provide Specialized Services not included as part of a NF's daily rate or otherwise incorporated as Specialized Services in the NF benefit via a SPA.

Several services covered under Medicare Part B may be used to diagnose, treat, or manage a beneficiary's medical or mental health conditions. These services can enhance the PASRR program and assist in providing Specialized Services. Beneficiaries pay a monthly premium for Part B services and, for certain services, they must pay coinsurance.

Medicare Part B covers services such as the following:

- Physician services
- Preventive Services
- Durable medical equipment
- Outpatient hospital services
- Outpatient mental health services
- Clinical laboratory services
- Diagnostic testing
- Outpatient physical, occupational, and speech therapy
- Partial hospitalization, if the services for the SNF resident are provided by the facility's staff
- One depression screening per year, if done within a primary care setting
- A one-time "Welcome to Medicare" preventive visit to review risk factors for depression, if conducted within 12 months of enrollment.

Under Part B, partial hospitalization services can be provided by a hospital or community mental health center. However, several states do not license community mental health centers, thereby limiting their availability of Specialized Services.

In addition to the services listed above, Medicare Part B can help pay for the following services that could benefit individuals with SMI:

- Individual and group psychotherapy
- Family counseling, if the main purpose is to help with the individual's treatment
- Psychiatric evaluation

- Medication management
- Certain prescription drugs that are not self-administered (e.g., injections)
- Training and education about the individual's condition
- Electroconvulsive therapy (ECT)
- Diagnostic psychological and neuropsychological testing
- Hypnotherapy
- Narcosynthesis
- Biofeedback therapy
- Screening, Brief Intervention and Referral to Treatment (SBIRT)

Medicare will reimburse providers for supplying the diagnostic and treatment services listed above. However, the practitioner must be licensed to perform the services in the state where they are provided. These practitioners include the following:

- Physicians (Medical Doctor or Doctor of Osteopathic Medicine)
- Clinical Psychologists
- Clinical Social Workers
- Clinical Nurse Specialists
- Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Licensed Alcohol and Drug Counselors
- Independently Practicing Psychologists[5]

Allowing use of this broad list of practitioners is critical, because many psychiatrists still do not accept Medicare payment. Also critical is the amount paid to these providers. If payment rates are low, the practitioner has little incentive to treat Medicare beneficiaries. Having a trained workforce that is adequately reimbursed helps improve access to needed Part B services.

Medicare Part B mental health services can be especially beneficial for individuals with SMI, because these services can be provided while they are NF residents. From a fiscal standpoint, it makes sense for states to encourage the use of Part B services as much as possible, because the cost does not fall to the state unless the individual is also a Medicaid beneficiary. For individuals who are eligible both for Medicare and for Medicaid, Medicaid pays deductibles, copayments, and coinsurance. Even in this circumstance, however, the costs to the state are likely to be substantially smaller than the costs of supplying equivalent services through the NF benefit,

[5] Centers for Medicare & Medicaid Services. Medicare Learning Network, Mental Health Services. Last accessed March 24, 2017. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html

where Federal Medical Assistance Percentage (FMAP) for services is available at the state's standard rate.

### Part C: Medicare Advantage Program

Thirty-one percent of people covered by Medicare (16.8 million beneficiaries) were enrolled in a Medicare Advantage (MA) plan in March 2015—up by more than one million beneficiaries from 2014.[6] Medicare Advantage plans cover all Part A and Part B services. Medicare reimbursement to the MA plan is based on a fixed capitated amount each month. All beneficiary services and provider reimbursements are arranged through the MA plan, so services are likely to vary more widely than the services available under standard Part B. State PASRR and NF staff should become familiar with the services available for individuals with mental health conditions who are enrolled in MA programs.

## USING MEDICAID TO FINANCE SPECIALIZED SERVICES

Medicaid entitles eligible individuals to a defined set of benefits. It guarantees federal funding to participating states on an open-ended, reimbursable basis. The federal government contributes FMAP, which is the matched percentage of federal dollars obtainable for services. This contribution ranges from 50 percent to 90 percent, depending on the state and services provided. States have some flexibility to set eligibility, benefits, delivery systems, and the amount, duration, and scope of the services they provide. Although the administrative federal financial participation (FFP) typically is set at 50 percent, an enhanced match of 75 percent is available for all activities that support the efficient and effective running of a state's PASRR program (42 CFR 433.15(b)(9)).

Every state must obtain approval from CMS for a plan that outlines its Medicaid program. This Medicaid State Plan becomes an agreement between a state and the federal government, describing how that state administers its programs. The State Plan ensures that a state will abide by federal rules, and it allows a state to claim federal funds for its program activities. The State Plan identifies the groups of individuals to be covered, services to be provided, credentials for providers, methodologies for providers to be reimbursed, and the state's current administrative activities.

When a state plans to change its program policies, eligibility groups, operational approaches, services covered, or reimbursement practices, it must send a SPA to CMS for review and approval. When a state is seeking Medicaid payment for Specialized Services, it will require a

[6] Jacobson G, Damico A, Neuman T, Gold M. Medicare Advantage 2015 Spotlight: Enrollment Market Update. Kaiser Family Foundation website; June 30, 2015. http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/

SPA because the state will be changing or adding to the list of services eligible for FFP. Changes to State Plans require public notification, and CMS reviews this process to ensure compliance with federal regulations.

Any state considering a SPA should communicate early and often with the Regional Office staff. The template for a SPA is available on the CMS website.[7] A list of all approved SPAs by topic is available on the Medicaid website.[8]

Changes to a State Plan must meet certain federal requirements, including the following:

- *Statewideness*. Services must be available to the entire state and not limited to a specific region or county unless those restrictions meet the exceptions identified at 42 CFR 431.50.
- *Comparability.* Services must be available to all eligible Medicaid individuals who meet the criteria for that service. The Medicaid comparability requirements can be found at 42 CFR 431.40 and further defined in the Social Security Act at Section 1902(a)(10)(B)(i), which states that services made available for any categorically needy individual shall not be less in amount, duration, or scope than the assistance provided to any other categorically needy individual. This provision clearly reinforces Congress's intent to provide comparable services to similarly situated Medicaid recipients.

  Modifying the NF benefit to include Specialized Services raises issues of comparability, in that access to Specialized Services cannot be limited only to individuals who have been identified by PASRR has having a relevant mental illness. Indeed, any NF resident could, in principle, access Specialized Services for SMI, provided he or she had a documented need for those services. One way to mitigate this problem is make identification by PASRR a prior authorization for receiving Specialized Services. Other residents also could receive Specialized Services, assuming they meet the needs-based criteria. In other words, the bar for receiving the services is somewhat higher in the absence of a PASRR-identified condition.
- *Every willing provider.* A Medicaid-eligible individual must be able to choose from any provider who meets the conditions for enrollment. The Medicaid free choice of providers' requirements can be found at 42 CFR 431.5, which allows any individual

[7] The SPA template can be accessed via the Centers for Medicare & Medicaid Services Paperwork Reduction Act of 1995 website. https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10120.html

[8] Approved SPAs can be accessed via the Medicaid.gov Medicaid State Plan Amendments website. https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html

eligible for Medicaid to obtain such services from any institution, agency, pharmacy, or person qualified to perform the service or services required.

Because these SPAs alter NF reimbursement, states may wish to consult the National Institutional Reimbursement Team (NIRT), a consortium of reimbursement experts whose task is to help states with these often-complex issues.[9]

To date, only the State of Washington has received approval for a Specialized Services SPA.[10] The Washington SPA specifically creates access to Specialized Services for individuals with a PASRR-identified condition of ID or RC. This successful SPA is a valuable reference tool for states considering a SPA for individuals with SMI. In developing their SPA, Washington sought to ensure access to services that would have been available to the individual prior to NF admission as part of their Home and Community-Based Services (HCBS) Waiver. States seeking to create access to NF Specialized Services specific to individuals with SMI may want to align those services with services provided under their Medicaid Community Rehabilitation Services Option.

The Washington approach promoted the goal of continuity of care for individuals who had been receiving HCBS services before their NF admission, and it created the opportunity for new service engagement for those who had not been receiving services. The Washington SPA requires providers of SPA services be HCBS providers, ensuring continuity of care for individuals who can transition out of NFs. Although this type of provider requirement would be optional for a state, it can help foster a *Services Follow the Person* model, which has the potential to help individuals make stable, successful transitions.

For technical reasons having to do with payment, the Specialized Services in the Washington SPA are identified as Specialized *Add-on* Services. Despite the slight differences in nomenclature, the titles *Specialized Services* and *Specialized Add-on Services* refer to the same set of services. The issue is that 42 CFR 124 states that "FFP is not available for Specialized Services furnished to NF residents as NF services." SPAs therefore must use the slightly modified phrase Specialized Add-on Services, which avoids the legal restriction.

[9] The State Medicaid Director letter written by D.G. Smith on May 29, 2002, (SMDL #02-010) announced the creation and mission of NIRT. https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd052902.pdf.

[10] The Washington State Specialized Services SPA (#15-0012) was approved on June 23, 2015. https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-15-0012.pdf

The success of Washington's SPA has established an important precedent. States wishing to submit Specialized Services SPAs of their own can be assured that approval is possible.

## CONCLUSION

As states have become increasingly aware of their obligations to provide or arrange for Specialized Services for individuals with PASRR-identified conditions, interest has grown in ways to pay for those services. This document has described how Medicaid can be used to finance Specialized Services using state dollars to secure a federal match by submitting a SPA that adds Specialized Services to the state's NF benefit. Because the PASRR process identifies many individuals who are simultaneously eligible for Medicaid and Medicare, we have reviewed the options for arranging Specialized Services through Medicare Parts B and C.

By design, we have largely avoided talking about how to change Medicaid reimbursement methods to make Specialized Services work. As we have noted, CMS makes resources available through the NIRT. We encourage states to engage their Regional Office staff in regular conversations throughout the process of adopting a SPA.

In addition, we invite states to contact the PASRR Technical Assistance Center (PTAC) for additional guidance. PTAC's website (www.PASRRassist.org) has several useful articles on these topics. PTAC also hosts bi-monthly office hours on the topic of Specialized Services, during which states can ask questions of PTAC and of other states. Finally, states can receive free technical assistance from PTAC and its team of expert consultants by phone, by email, or in person.