Behavioral Health Community Partners Expansion to Skilled Nursing Facilities

Executive Office of Health and Human Services

May 9, 2023

Guidance for Participants for Virtual Meetings

- Please mute yourself when not speaking, and please be aware that your background is visible when the camera is on.
- If you have questions throughout the presentation, we encourage you to put them in the chat or share them during the Q&A portion. We will address questions during the Q&A portion as time allows.
- When we reach the Q&A portion, please use the "Raise Hand" feature to indicate that you would like to ask a question. We will start with the questions in the chat and then as time allows take live questions.
- Be sure to share your name, organization, and the slide number you are referencing, if applicable, when you speak.

Agenda

Overview of BH CP Program Expansion

What is PASRR?

Pre-Admission Screening and Resident Review (PASRR) is a federal requirement for all Medicaid-certified nursing facilities.

PASRR requires that all individuals admitted to or residing in Medicaid-certified nursing facilities are: 1) evaluated for Serious Mental Illness (SMI) and/or Intellectual Disability/Developmental Disability (ID/DD), 2) evaluated to determine most appropriate setting for their needs to receive care (i.e. SNF, community, other setting), and 3) for all SNF residents determined to have SMI or ID/DD, receiving the services they need in the most appropriate, least restrictive setting.

Level I PASRR

Hospital discharge planners, nursing facility social workers, or Aging Services Access Points (ASAP) social workers/nurses complete PASRR Level I Screening, a preliminary assessment, to identify individuals who are suspected of having SMI and/or ID/DD. Individuals who screen positive at Level I are referred to a Level II evaluation.

Level II PASRR

The University of Massachusetts (UMass) Medical Center PASRR Unit (DMH's designee) completes the PASRR Level II evaluation for individuals who are suspected of having SMI based on the Level I Screening. Level II evaluation determines whether a person has SMI, whether nursing facility or community placement is most appropriate, and whether the person needs specialized services or other behavioral health services. Such services for SMI may include, but are not limited to:

- Psychiatric evaluation and psychotherapy services
- Neuro-psychiatric evaluation
- Substance use disorder treatment services for the provision of methadone, buprenorphine, buprenorphine/naloxone, or naltrexone
- DMH clubhouse services (a PASRR specialized service)

Skilled Nursing Facility Coordination and Transition Supports – Implementation Planning

The Skilled Nursing Facility Coordination and Transition Supports is a collaboration with the Executive Office of Health and Human Services (EOHHS), MassHealth, and the Executive Office of Elder Affairs (EOEA) to enhance and expand programs to increase access to behavioral health services for nursing facility residents and support their transition to the community. The program enhancements include:

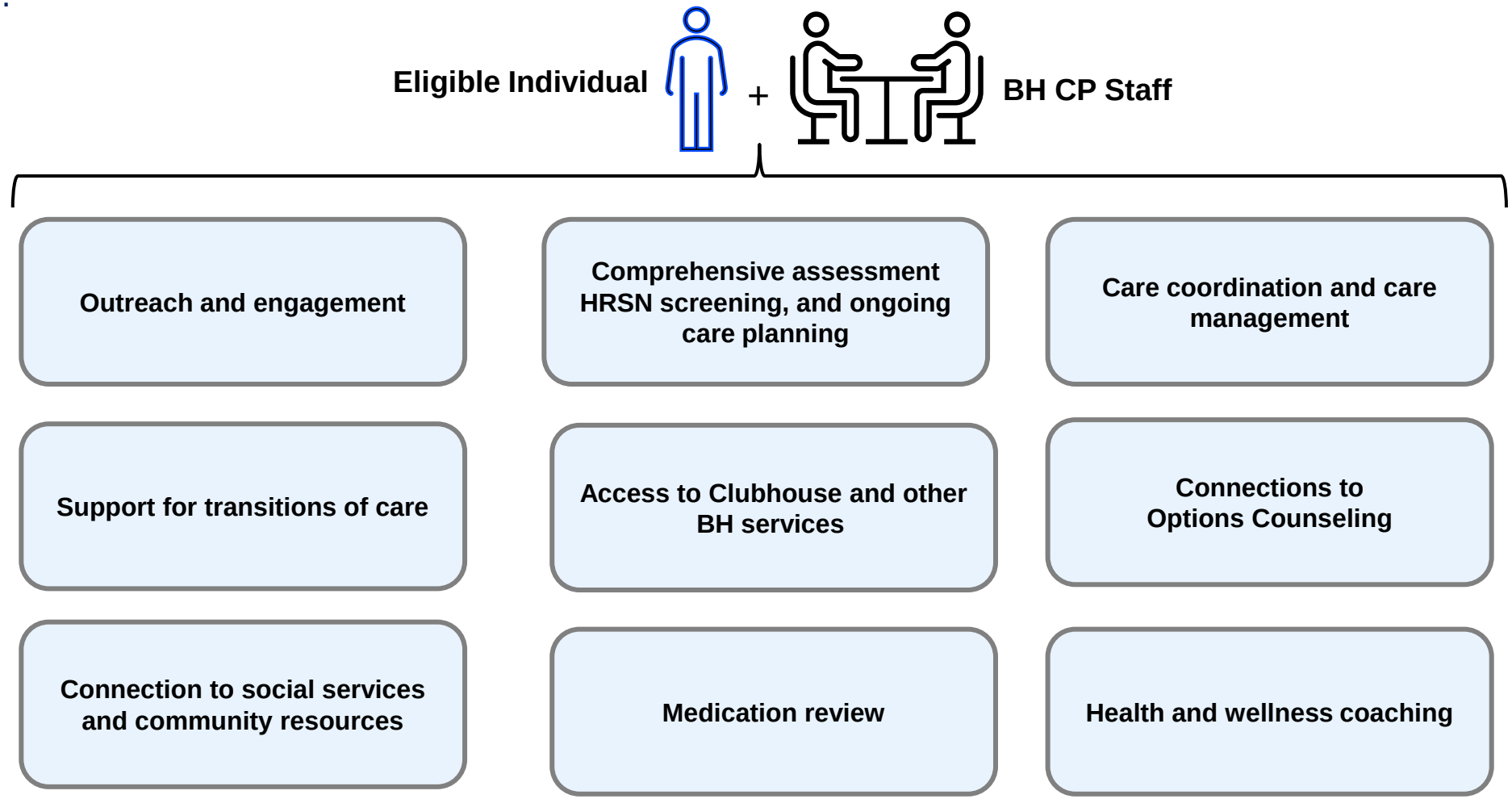
- Expanding Department of Mental Health (DMH) eligibility to all individuals with a positive PASRR Level II determination of SMI.
- Creating a DMH Nursing Facility Transition unit to include NF Transition Manager, NF Nurse Specialist, NF Transition Case Manager Supervisor and Transition Case Managers.
- Leveraging BH CP for the coordination of behavioral health and specialized services for individuals residing in NFs determined to have SMI through a PASRR Level II evaluations.
- Adding DMH Clubhouse services as a specialized service for individuals residing in NFs determined to have SMI and determined to need such service through a PASRR Level II evaluation.
- Assigning a DMH Transition Case Manager to individuals with a 90 day determination (i.e. determined, through the PASRR Level II evaluation, appropriate to reside and receive care in a NF for up to 90 days) to facilitate transition/discharge activities from NF to community.
- Developing a new Enhanced Medical Group Living Environment to provide nursing and hands-on care in the community.

Objectives of the BH CP Program Expansion to SNFs

- **Provide enhanced care coordination** to MassHealth Members and non-MassHealth individuals who have been determined to have SMI and determined appropriate for SNF care for 12 months through a PASRR Level II evaluation.
- Support individuals with SMI and help them **navigate and access BH services** in Massachusetts.
- **Improve Member experience and continuity and quality of care** by holistically engaging individuals residing in a SNF with SMI.
- Create opportunity for ACOs and MCOs **to leverage the expertise and capabilities of existing community-based organizations** serving populations in SNFs with BH needs.
- **Improve collaboration** across BH CPs, providers, and community organizations addressing the social determinants of health; and BH, and physical health care delivery systems in order to break down existing silos and deliver integrated care.

Program Overview

BH CPs are community-based organizations that provide enhanced care coordination to individuals residing in SNFs who have been determined to have SMI and determined appropriate for SNF care for 12 months through a PASRR Level II evaluation.



Care Model Overview

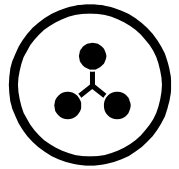
The Care Model is effective in coordinating high quality care and cost-efficient services. In serving individuals who have been determined to have SMI and determined appropriate for SNF care for 12 months through a PASRR Level II evaluation , BH CPs will complete the following:

Meet Face-to-face with the individual

- Contact with individual attempted within 30 days
- Offer monthly meetings

Conduct the BH CP Comprehensive Assessment

- Complete assessment within 90 days of enrollment
- Build and complete Care Plan within 5 calendar months



Connect SNF residents

- Ensure SNF residents can access behavioral health and social services, including but not limited to those identified through the individual's PASRR Level II evaluation, as applicable

BH CPs will work closely with SNFs on care planning and coordination for the individual's needs

Eligibility

Eligibility

The following outlines eligibility for individuals who are in Skilled Nursing Facilities and have been determined to have SMI and determined appropriate for NF care for 12 months through a PASRR Level II evaluation. Payer source is not a factor for program eligibility.

Who is eligible?

Any individual who is in one of the following programs:

- MassHealth Fee-For-Services (FFS)
- MassHealth Primary Care Clinician (PCC) Plan
- MassHealth Accountable Care Organizations (ACO) / Managed Care Organization (MCO)
- Non-MassHealth

Who is not eligible?

Individuals enrolled in MassHealth Integrated Care programs, including:

- One Care (ICO)
- Senior Care Options (SCO)
- Program of All-Inclusive Care for the Elderly (PACE)

Individuals enrolled in these programs receive care coordination through their integrated care enrollment

Enrollment/Disenrollment Process

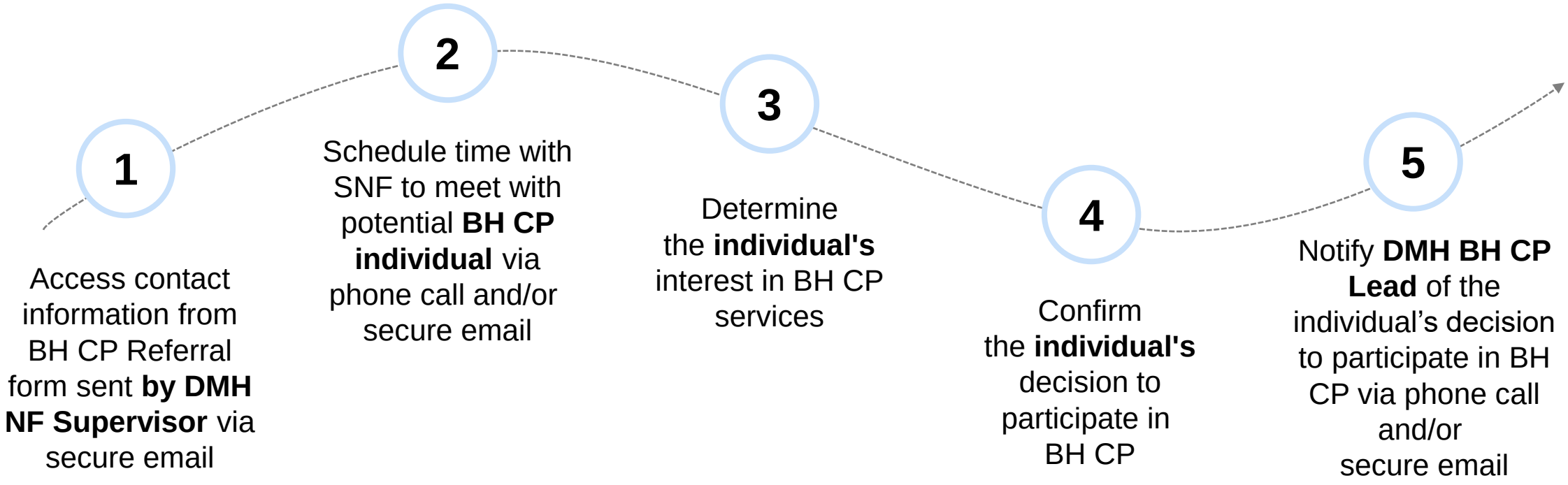
Enrollment Process

Enrollment Process

1	**Member has Level II PASRR Evaluation**	▪ UMass completes PASRR Level II evaluation for individuals who screen positive for suspected SMI through a Level I Screening ▪ Individual residing in SNF is determined to have SMI and determined appropriate for SNF care for 12 months, making them initially eligible for CP Supports ▪ UMass notifies DMH of the individual
2	**DMH Tracks and Enrolls Member in BH CP**	▪ DMH enrolls individual in Meditech system and confirms eligibility (ensures individual is not receiving Integrated Care Services) ▪ DMH maps individual to selected BH CP via referral form
3	**BH CP Tracks and Reviews Roster File**	▪ BH CP tracks and reviews roster file from DMH (ongoing) ▪ BH CP sends discrepancies to DMH
4	**BH CP Receives Referral and Outreaches to Individual**	▪ BH CP receives referral form from DMH and begins outreach to individual and SNF ▪ Individual, or individual's guardian on behalf of the individual, accepts BH CP services
5	**Comp. Assessment, Care Planning and Care Coordination**	▪ BH CP completes Comprehensive Assessment and Care Plan to assess and plan for care coordination needs ▪ BH CP provides enhanced care coordination and coordinates necessary BH and specialized services for SMI
6	**MassHealth Issues Payments and Reports to BH CPs**	▪ MassHealth verifies individual's eligibility, benefits, and payments (payments are pro-rated) ▪ MassHealth issues payments retrospectively based on enrollment panel

BH CP’s Role in Enrollment and Outreach Process

BH CPs play a critical role in connecting potential individuals who reside in SNFs.



Disenrollment Process

Individual's disenrollment from BH CP can be triggered by one of five events[1].

- Individual has PASRR redetermination under 90 days which makes them ineligible.[2] The DMH Transition Case Manager has opportunity to extend BH CP.
- Individual is enrolled in Integrated Care Services (OneCare, SCO, or PACE)
- Individual decides they no longer want to receive CP Supports
- Individual discharged from SNF
- Individual no longer requires BH CP Supports[3]

Individual is disenrolled. The BH CP is notified. The DMH Transition Manager receives updates via weekly DMH roster change status report.

[1] In the future-state, information about individual disenrollment will be pulled from PASRR Portal.
[2]The individual will instead be assigned a DMH transition case manager. Disenrollment/ineligibility will not result in disenrollment/stopping of necessary BH/specialized services.
[3]For example, an individual resides in a SNF for an extended period of time, the individual met goals and no longer has need for care coordination. If the need arises and the individual is determined appropriate for SNF care for 12 months through a new PASRR Level II evaluation, the individual can be referred again to the BH CP for CP Supports.

Program Definitions

Graduation

- An individual is considered graduated from the BH CP Program when they have completed and sustained maintenance of the goals in their Care Plan, as determined by the individual and the BH CP, in consultation with the individual's ACO or MCO, or with DMH, as applicable.
- An individual who has graduated will be disenrolled from the BH CP.

Disenrollment[1]

- An individual who is no longer receiving BH CP Supports has been disenrolled.
- The BH CP shall no longer receive payment for a disenrolled individual.

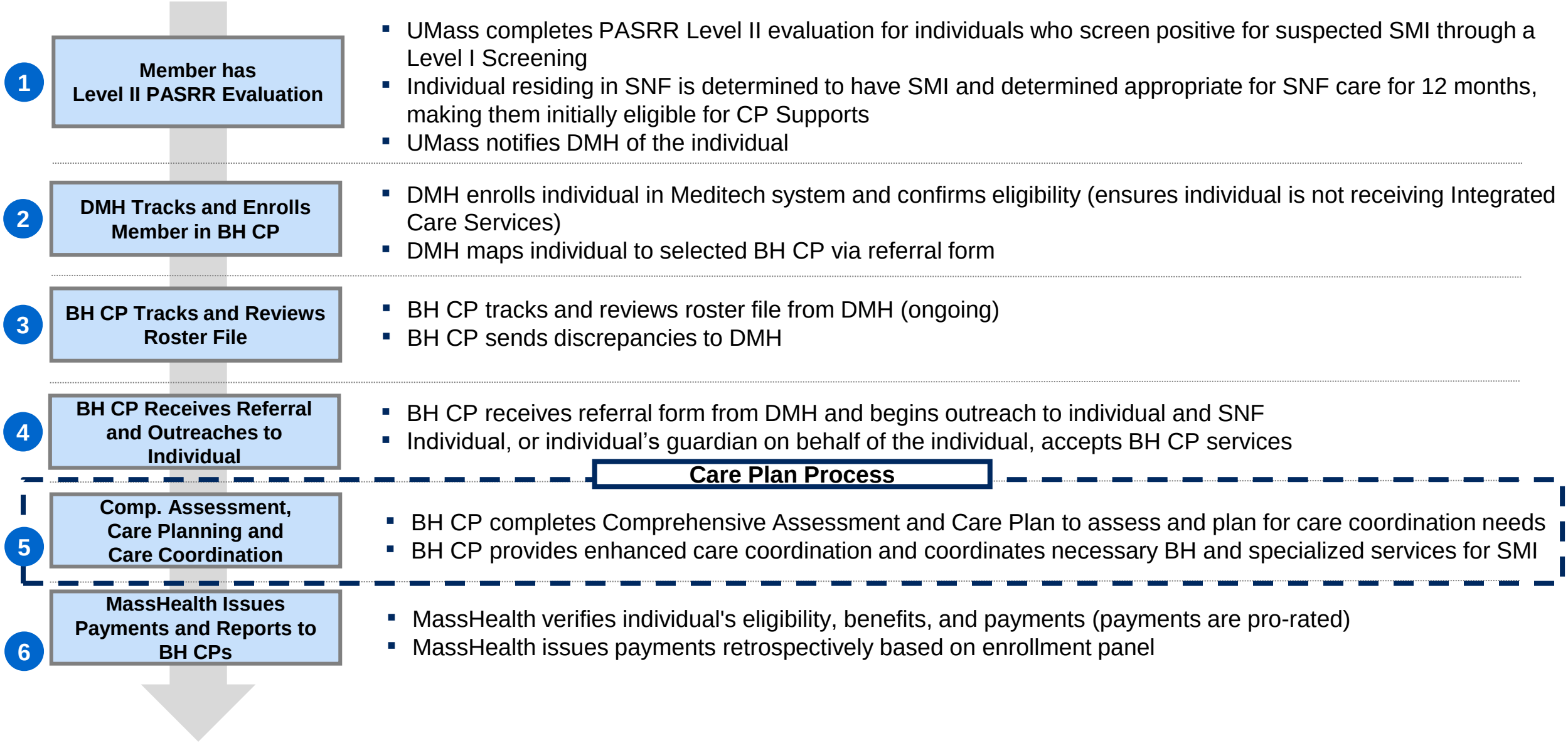
Discharge

- An individual is considered discharged when they no longer receive services in a SNF.

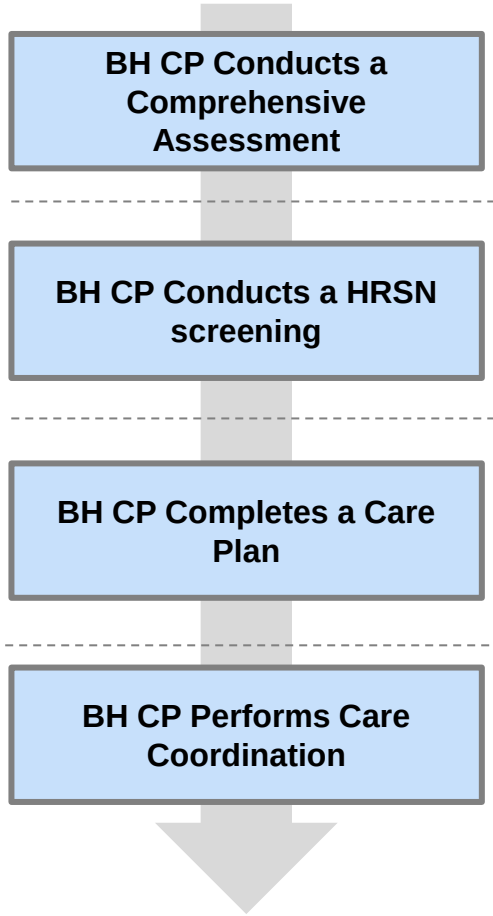
[1]Following disenrollment, an individual may transition to the community and subsequently enroll in the BH CP if they are otherwise eligible as described in the BH CP Contract. Disenrollment does not mean stoppage of necessary BH/specialized services.

Comprehensive Assessment and Care Plan Process

Assessment and Care Plan Process



BH CPs Conduct Comprehensive Assessments and Care Plan



The **BH CP conducts a comprehensive assessment**, using an approved tool. **Assessments may incorporate additional information** received from providers that is confirmed with the individual.

The **BH CP conducts a HRSN screening**, using an approved tool. **Screenings may incorporate additional information** received from providers that is confirmed with the individual.

The **BH CP completes a Care Plan** with the individual that is based on the comprehensive assessment and HRSN screening results; reflects the preferences, goals, and needs of the individual; and is approved and signed by the individual or individual's guardian on behalf of the individual, and the BH CP Clinical Care Manager (CCM).

The BH CP **forms a Care Team** for the Member, **facilitates communication** across providers, **assists the individual in accessing services**, including specialized and other BH services, and **implements the care plan** with the individual.

Q&A