# Review of State Preadmission Screening and Resident Review (PASRR) Policies and Procedures

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# EXECUTIVE SUMMARY

This report presents the first systematic, empirical effort to document the design of PASRR systems in all States and the District of Columbia. Staff from the PASRR Technical Assistance Center (PTAC) reviewed States policies and procedures kept on file by PASRR Coordinator in CMS Regional Offices.

Documentation was collected in late 2009; the results of this review therefore represent a snapshot of PASRR systems design at that time. This review does *not* capture any information on the *implementation* of these programs.

A review tool was developed by extracting key data elements from the regulations governing PASRR (42 CFR Part 483.100-138). This fundamental set of data elements was augmented with a small number of good, modern clinical practices (e.g., performing a complete medication review). The review covered Level I screens and Level II evaluations and determinations for individuals with serious mental illness (here abbreviated as PASRR/MI) and for individuals with intellectual and developmental disabilities (called "mental retardation" in the CFR; here abbreviated as PASRR/MR). Each data element was evaluated as "comprehensive," "partial," or "absent," depending on how thoroughly the State's assessment tools captured the relevant information.

Major findings from the review included the following:

- The majority of states (74%) conducted level of care determinations prior to, or concurrent with, their PASRR evaluations.
- Most Level I's and Level II's were performed prior to NF admission, though in several cases the documentation was unclear.
- Levels of comprehensiveness were determined for each State's Level II requirements (both PASRR/MI and PASRR/MR), with percentages categorized into three levels: "comprehensive," "partial," and "absent."
- Both "medication review" and "medical history" were the data elements most commonly classified as "partial," again for both populations.
- The level of comprehensiveness for many data elements differs by population. For example, while psychosocial evaluations were comprehensively covered in 67 percent of States' Level II MI tools, they were comprehensively covered in just 45 percent of States' Level II MR tools.

The table below summarizes the extent of inter-state variation in comprehensiveness rates, with States divided into "comprehensiveness quartiles."

| Level of Comprehensiveness | # of States | % of States |
|---|---|---|
| **76%-100%** | 7 | 14% |
| **51%-75%** | 19 | 37% |
| **26%-50%** | 20 | 39% |
| **≤ 25%** | 5 | 10% |

As one can see, most States fall somewhere in the middle range of comprehensiveness. Only a handful of states could be considered outstanding or especially poor. For example, Nevada and Georgia rate squarely in the top quartile, while Arkansas, the District of Columbia, and Pennsylvania fall in the bottom quartile.

To leverage and extend the results of this analysis, we recommend:

- That the national inventory of PASRR design be updated annually, to track changes and trends over time;
- That CMS develop a means to track the implementation and quality of PASRR programs through a system in which states voluntarily report the number of individuals screened, evaluated, admitted to NFs, re-evaluated post-admission, and so on;
- That CMS target technical assistance to States whose systems do not appear robust; and
- That CMS develop training protocols to help Regional Office staff work with the States in their Regions to monitor and improve the design and implementation of their PASRR systems.

# 1. INTRODUCTION

To help ensure that individuals were not inappropriately placed in nursing facilities (NFs), the Omnibus Budget Reconciliation Act of 1987 (OBRA 87, Pub. L. 100-203) introduced Preadmission Screening and Resident Review (PASRR). PASRR requires that all applicants to a Medicaid-certified nursing facility are evaluated for mental illness (MI) and/or mental retardation or related conditions (MR); are placed in the most appropriate setting (whether in the NF or in the community); and receive assessments that identify the services they need in those settings.[1] In 1994, regulations governing PASRR were incorporated into the Code of Federal Regulations at 42 CFR 483.100-138.

PASRR was in many respects ahead of its time. OBRA 87 predated the Americans with Disabilities Act (ADA) by three years, and the PASRR Final Rule, published in 1992 (57 FR 56450), foreshadowed the seminal Supreme Court decision, *Olmstead v. L.C.* (1999, 527 U.S. 581). The *Olmstead* decision held that the ADA applied to individuals with mental and intellectual disabilities, as well as to individuals with physical disabilities, and that all individuals have the right to live in the "least restrictive setting" possible.

In brief, PASRR requires that all applicants to Medicaid-certified NFs be assessed to determine whether they *might* have MI or MR. This is called a "Level I screen." The purpose of a Level I screen is to identify individuals whose total needs require that they receive additional services for their intellectual disabilities or serious mental illness. Those individuals who "test positive" at Level I are then evaluated in depth to confirm the determination of MI/MR for PASRR purposes, and the "Level II" assessment produces a set of recommendations for necessary services that are meant to inform the individual's plan of care.

To assist the States in conducting the necessary evaluations and determinations, CMS allows States to claim an enhanced 75 percent match on all PASRR-related activities. PASRR is not classified as a service, but rather as a special kind of administrative activity, and is a mandatory part of the basic Medicaid State Plan.

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[1] Rosa's Law (2010, Pub. L. 111-256) replaced the phrase "mental retardation" with "intellectual disability" in a large number of existing laws, but not Title XIX of the Social Security Act (Medicaid). Because the PASRR regulations have not been updated to reflect these changes, we will continue to use the phrase "mental retardation."

Because basic State Plan functions (services and administrative activities) do not come up for regular review (unlike, for example, 1915(c) waivers for home and community-based services), evaluation of State PASRR programs is often overlooked both by State and Federal entities. The design and implementation of the programs can thus drift away from requirements and become ineffective.

Many States undoubtedly need to update their PASRR processes. In 2006, Linkins and colleagues published a research paper documenting a lack of compliance in some states with the requirements of PASRR. The Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) also published three detailed reports, one in 2001 and two in 2007, all requiring CMS to attend more closely to PASRR.

While CMS has for some time been committed to helping States improve their PASRR programs, it has not until recently had the ability to provide technical assistance or conduct an empirical analysis of PASRR design and implementation. The findings reported in this paper represent a first, crucial step toward learning more about PASRR in all 50 States and the District of Columbia. Indeed, this report describes the first systematic, empirical effort to document the design of PASRR nationally.

Staff at the PASRR Technical Assistance Center (PTAC) reviewed written State policies and procedures and compared them with the requirements of 42 CFR 483.100-138. The review and the resulting report are intended to help CMS better understand the strengths and shortcomings of State PASRR programs. The State "Fact Sheets" that emerged from this review are intended to invite States to revisit their PASRR process, identify areas for improvement, and develop strategies for strengthening these systems.

Note that our review did not include any aspects of implementation. It is possible that in some States, design and implementation do not align. What looks on paper like a well-designed system could be badly implemented. Conversely, a system that appears not to comply with regulations could be implemented in a way that successfully serves the needs of individuals. Our methodology was not designed to capture any such discrepancies. Note, too, the data we reviewed were collected in late 2009. Our review should thus be seen as a snapshot of State PASRR design at that time.

In what follows, we first describe our methodology, including our processes for collecting documentation, creating a tool to record data systematically across States, reviewing documentation, and receiving and incorporating feedback from States on the

initial reviews. We then present our findings, categorized by three core components of PASRR: 1) timing and general PASRR requirements, 2) requirements of the Level II evaluation, and 3) diversion and transition related efforts. Finally, we discuss limitations of the review and our next steps.

# 2. METHODOLOGY

Our review of PASRR policies and procedures proceeded in four steps:

1. Collection of State PASRR documentation.
2. Development of a tool to compare written policies and procedures against the requirements of the CFR and (to a much lesser extent) good, modern clinical practices.
3. Review of State PASRR documentation.
4. Sharing of our findings with States and soliciting their feedback.

The following four sections detail the efforts undertaken for each of these steps.

## DOCUMENT COLLECTION

CMS Regional Office (RO) PASRR Coordinators provided PTAC with the following documents for the purposes of performing the review that we report here:

Preadmission Screens (PAS)

- Level I screens for serious mental illness
- Level I screens for mental retardation or related conditions
- Level II evaluations and Level II determinations for serious mental illness
- Level II evaluations and Level II determinations for mental retardation or a related condition

Resident Review (RR)

- Level II Resident Review upon significant change in status

General

- Written policies and procedures for completing or interpreting tools or forms

Most documents were submitted in electronic format, though some were submitted in hard copy.

Occasionally we discovered that crucial information was missing from the set of State documents. In these cases, we attempted to collect the missing documentation, first via Internet searches and then by contacting the relevant RO Coordinator. If additional documentation was not obtained after two weeks of reaching out to RO staff, the review process resumed without the additional material.

## CODING SCHEME

In the second half of 2010, the PTAC team worked with CMS staff to develop a tool to compare the contents of State documentation with PTAC regulations. In essence, the tool decomposed the CFR into data elements, which we then looked for in the documents. In addition, CMS and PTAC agreed it would be informative to add several data elements that reflect good, modern clinical practices that have evolved since the regulations were drafted in the early 1990s. For example, although the CFR does not require States to record onset dates of medical diagnoses for PASRR, good clinical practice entails collecting and using these data in assessments. The data elements in the analysis include the overall timing of PASRR procedures relative to NF admission, the entities responsible for various PASRR functions, and the characteristics of tools used for screening and evaluation purposes.

Data elements were coded in a variety of ways, which we describe in detail below. For now, it is enough to note that coding options were rarely binary (present/absent). Instead, we developed a more nuanced coding scheme to capture data as accurately as possible, and to give States partial credit (where appropriate) for complying with the requirements of the CFR.

To test the robustness of our data collection tool, we piloted it using the documentation collected from one State. This initial test ensured that our coding scheme did not omit any crucial data elements and that the coding options for each element were exhaustive. As a result of the pilot review, comments fields were added to the tool to capture the individualized ways in which states administer their PASRR programs. Below, we describe each section of the tool and the intent behind each element. Note that we focus primarily on the Preadmission Screens, and far less on Resident Reviews (largely because States document the former in greater depth than they do the latter).

The data elements in Table 1 reflect the timing and general requirements of a State's PASRR process. Specifically, the data elements aim to capture the sequence of events

beginning at the determination of nursing facility level of care (NF LOC) through the completion of Level II determinations. The data elements also capture critical elements of the NF LOC, Level I and Level II tools and processes, and the requirements of agencies and persons at various stages of the process. The second half of the table captures any comments about the timing and requirements of the NF LOC, Level I screening, and Level II evaluations.[2] In many cases, the comments are excerpts from the State's documentation, indicating where the relevant information was found.

**Table 1: Data Elements for NF LOC, Level I, Level II Timing and General Requirements**

| OVERALL TIMING Part I | CFR | Relative to PASRR | Level of Severity | Document(s) | |
|---|---|---|---|---|---|
| Determination of NF LOC | .128(f); .132(a) | After PASRR | See Comments | http://www.bock-associates.com/index.html | |
| **Level I** | **CFR** | **Relative to Admission** | **Entity Completing** | **Entity Determining Need for Level II** | **Alternative Placement Questions** |
| Level I evaluation & determination | .112(c) | Before Admission | NF | Medicaid | No |
| **OVERALL TIMING - Level II** | **CFR** | **Relative to Admission** | | **Document(s)** | |
| Level II evaluation & determination | 0.112 | Before Admission | | http://www.bock-associates.com/index.html | |
| **GENERAL REQUIREMENTS - Level II** | **CFR** | **Present/Absent** | | **Responsible Entity** | **Discipline** |
| H&P | .132(c)(1) | Present | Not Captured | Both SMHA & SMRA | Not Given |
| Mental status | .132(c)(2) | Present | Captured | Both SMHA & SMRA | Not Given |
| Functional status | .132(c)(3) | Present | Not Captured | Both SMHA & SMRA | Not Given |

| OVERALL TIMING Part I | CFR | Comments |
|---|---|---|
| Determination of NF LOC | .128(f); .132(a) | Unclear whether the (DHS 703) Evaluation of Medical Need criteria is the LOC form. |
| **Level I** | **CFR** | **Comments** |
| Level I evaluation & determination | .112(c) | None |
| **OVERALL TIMING - Level II** | **CFR** | **Comments** |
| Level II evaluation & determination | 0.112 | Bock Associates then issues a determination in writing to the referring agency. If the client is approved for nursing facility admission, they may then transfer to the nursing facility of choice. |
| **GENERAL REQUIREMENTS - Level II** | **CFR** | **Comments** |
| H&P | .132(c)(1) | Once the review is completed by the assessor and returned to Bock Associates, it is reviewed by the Office of Long Term Care. The Office of Long Term Care is the agency responsible for determining if the client meets nursing home criteria and deciding the final outcome of the PASRR. |
| Mental status | .132(c)(2) | |
| Functional status | .132(c)(3) | |

In the table above, data elements and values have the following meanings:

[2] Note that the second half of Table 1 is a continuation of the first, and would be read as such if the two tables were placed side by side. We have segmented the table to help present the data in limited space.

- "Relative to PASRR" refers to the stage at which the nursing facility level of care is determined relative to an individual's PASRR Level I and Level II screenings. For this element, reviewers chose among *before admission*, *after admission*, *concurrent*, and *not given*.

- "Level of Severity" refers to whether the provided documentation asks about a range of need for nursing facility services (low, medium, high), or a range of ability or disability for history and physical, mental status, and functional status. For these elements, reviewers chose between *not captured* and *captured*.

- "Relative to Admission" refers to the stage at which the Level I and Level II tools are completed relative to an individual's admission into a nursing facility. For these elements, reviewers chose among *before admission*, *after admission*, *concurrent*, and *not given*.

The data elements in Table 2 assess the degree to which States fulfill each of the specific requirements of their MI and MR Level II tools. Keywords and phrases in italics were taken directly from the CFR. The remaining keywords and phrases stem from the identification of good clinical practices and are *not* specified in the CFR. The value for each data element was coded as *comprehensive*, *absent*, or *partial* (these terms are defined below).

**Table 2: Data Elements for Level II**

| SPECIFIC REQUIREMENTS - Level II | Keywords/Phrases | CFR (MI; MR) | Level of Detail |
|---|---|---|---|
| H&P | | | |
| Medical history | diagnosis(es); onset date(s) | MI: .134(b)(1)(i) | Comprehensive |
| | | MR: .136(b)(1) | Comprehensive |
| Neurological assessment | *motor functioning; gait; communication* | MI: .134(b)(1)(iii) | Absent |
| | | MR: .136(b)(8)(9) | Partial |
| Medication review | *current medications;* allergies; side effects | MI: .134(b)(2) | Comprehensive |
| | | MR: .136(b)(3) | Comprehensive |
| Medical Status | | | |
| Externalizing and internalizing behaviors | aggressive; disruptive; inappropriate; depression; anxiety; loneliness | MI: .134(b)(4) | Partial |
| | | MR: .136(b)(15) | Comprehensive |
| Harm to self or others (intentional or unintentional) | *suicidal/homicidal ideation* | MI: .134(b)(4) | Partial |
| | self-injurious behaviors | MR: .136(b)(15) | Partial |
| Intellectual functioning | estimated IQ level (MR, low average, average, high average) | MI: .134(b)(4) | Partial |
| | MR range (mild, moderate, severe, profound) | MR: .136(c)(1) | Comprehensive |
| Cognitive functioning | *memory; concentration; orientation; cognitive deficits* | MI: .134(b)(4) | Comprehensive |
| Reality testing | *delusions and hallucinations* | MI: .134(b)(4) | Comprehensive |
| Psychosocial evaluation | *current living arrangements; medical and support systems* | MI: .134(b)(3) | Partial |
| | | MR: .136(b)(10) | Comprehensive |
| Functional Status | | | |
| ADLs/IADLs | *self-care; self-administration of medication* | MI: .134(b)(5)(6) | Comprehensive |
| | | MR: .136(4)-.136(7), .136(12) | Absent |
| ADLs/IADLs in community | *assessment of ability to perform ADLs in the community* | MI: .128 (f), .134 (5) | Partial |
| | | MR: .136(4)-.136(7) | Partial |
| Support systems | *level of support needed to perform activities in the community* | MI: .134(b)(5) | Partial |
| Other | | | |
| Need for NF | *appropriate placement is NF* | GENERAL: .126 | Comprehensive |
| | *appropriate placement is other setting* | MI: .134(b)(5) | Partial |

*Note*: All citations are to 42 CFR Part 483.

The column labeled "CFR" cites the specific section of the Code of Federal Regulations. Values in this column represent the sections of the regulation that specify the data elements, both for PASRR/MI and PASRR/MR.

The data elements in Table 3 reflect language in States' policies and procedures that demonstrate efforts to transition NF residents or divert NF applicants to the least restrictive appropriate settings. This information was not specifically requested from States, but could be included in States' tools or in documents from the State Medicaid agency. As such, it should be noted that a "Not Present" does not necessarily reflect the extent of a State's diversion and transition effort, as information on diversion and transition may be provided in other State documents.

**Table 3: Diversion and Transition-Related Practices**

| Diversion/Transition Related Requirements or Practices | Keywords/Phrases | CFR (MI,MR) | Document(s) |
|---|---|---|---|
| Training or instructions to contractors or evaluators on HCBS waivers | Info in training manuals or in training materials regarding waivers and other HCBS | N/A | Level of Care Certification Letter |
| Mission/vision of state diversion/transition philosophies related to other initiatives (i.e. Olmstead) in PASRR documents | Olmstead; other programs that work to rebalance between institutional and community based care | N/A | Not Present |
| Transition to community for short term or long term residents who need MH services but not NF | Discharge; regardless of the length of stay | MI: .118(1and2)<br>MR: .118(1and2) | Not Present |
| Info given on state plan services or other HCBS waivers for MH and MR services | Info on receiving services in an alternative appropriate setting | MI: .118 (c)(i-iv)<br>MR: .118 (c)(i-iv) | Not Present |
| Definition of specialized services as narrowly interpreted or broadly interpreted by the regulations | Use of specialized services beyond 24 hour inpatient psych and ICF/MR placements | MI: .120(1)<br>MR: .120 (2) and 483.440(a)(1) | MR and MI Authority Determination Forms |
| Recommended services of lesser intensity, MH or MR services while in NF recommended | Recommendations by evaluators regarding what services are needed in NF to help person with MI or MR skill build | MI: .120, .128(h)(i) (4 and 5)<br>MR: .120, .128(h)(i) (4 and 5) | MR and MI Authority Determination Forms |
| Other elements or practices related to diversion/transition | Other practices that states have implemented | N/A | Not Present |

*Note*: All citations are to 42 CFR Part 483.

We developed a coding scheme to characterize the fidelity of State PASRR program design as accurately as possible. For example, a State's ability to meet a Level II requirement was considered "comprehensive" if the documentation addressed all of the necessary elements of the relevant section of the CFR, in addition to certain good clinical practices. A State's ability to meet a requirement was considered "absent" if the documentation the State provided did not address any of the necessary elements of the relevant paragraph of the CFR. A State's ability to meet a requirement was considered "partial" if the documentation addressed some but not all of the necessary elements of the relevant paragraph of the CFR, or if the documentation did not address certain good clinical practices. A requirement was also considered "partial" if a tool specified that the person completing it could provide responses in free text format. Because free text responses are (by design) not constrained, it is difficult to know exactly what information is being captured. It *could* be comprehensive, but we opted to be conservative and categorize free text responses as partial. Finally, a requirement was also considered "partial" if the tool called for the attachment of another document or set of documents.

## CODING PROTOCOL

Because the documents were sometimes challenging to interpret, and because some coding necessarily involved subjective judgment, the documents for each State were reviewed by two members of the PTAC team. Any discrepancies between the two reviewers were subsequently reconciled through discussion. This process helped to ensure both inter-rater reliability and replicability of our coding scheme.

To ensure that States received appropriate credit for their program design, we did not conduct a mechanical process that looked for exact keywords. Instead, we aimed to assess the goals of each question and section of the tools. In other words, we attempted, as much as possible, to look behind the words in the documentation to see the *intent* of its authors.

## DISTRIBUTION OF FINDINGS AND INCORPORATION OF STATE FEEDBACK

To ensure the accuracy of our findings and to engage States in meaningful dialogue about their PASRR programs, we developed a set of "Fact Sheets" that were individualized for each State. Each Fact Sheet includes an introduction to the project and its objectives, a description of the methodology, a summary of State specific findings, points for consideration, and recommendations.

PTAC began distributing Fact Sheets to States through the CMS Regional Office PASRR Coordinators in July 2011. The RO coordinators shared the documents with the States within their region and requested that feedback be submitted to PTAC. States were allotted three weeks to contact the research team, to provide additional documentation, or to make a request for additional time to review the findings. When requested, the research team met with States via telephone to discuss the methodology and findings of the report, and to address any concerns or questions the State might have. Some States corrected minor errors in the Fact Sheets; others provided documentation that had been missing from the set we used for our initial review. For States that provided feedback or additional documentation, we drafted a second, updated Fact Sheet. The Fact Sheets for States that did not provide feedback were assumed to be complete and accurate.

# 3. FINDINGS

Each of the following three sections addresses the findings from a part of our review – which, as noted earlier, represents PASRR system design as of late 2009. The first section reflects the timing and general requirements of the PASRR process across States. The second section assesses the degree to which States fulfilled each of the specific requirements of their MI and MR Level II tools. Finally, the third section reflects language in States' policies and procedures that demonstrated efforts to transition residents or divert applicants to the least restrictive, appropriate settings.

In general, PASRR policies, procedures, and tools varied widely across States. Some States have developed detailed evaluation tools, clear descriptions of process timing, and a clear delineation of the responsibilities of participating agencies. By contrast, the documentation from other States displayed numerous gaps or conflicts with the CFR.

## TIMING AND GENERAL PASRR REQUIREMENTS

As shown in Table 4, approximately 74 percent of States assessed individuals' eligibility for NF LOC before or during PASRR. Only two percent of States determined NF LOC after PASRR Level I and II determinations had been made. Many of the States that determined NF LOC concurrent with PASRR included NF LOC as part of the Level II assessment; this was particularly true for States with automated Level II tools. Documentation from 18 percent of States did not indicate when the NF LOC determinations were made relative to PASRR.

**Table 4: Timing of Nursing Facility Level of Care Determination Relative to PASRR**

| Relative to PASRR | % of States |
|---|---|
| Before PASRR | 37% |
| After PASRR | 2% |
| Concurrent with PASRR | 37% |
| Not Given | 18% |
| See Comments | 6% |

As Table 5 indicates, most States also followed regulations in terms of conducting PASRR *before* an individual was admitted to a nursing home (Table 5); 90 percent administered the Level I screen and 78 percent administered the Level II before admission into a NF or other appropriate care setting. No States administered the initial Level I after admission into a NF. However, four percent conducted Level II evaluations

*after* admission. The documentation from six percent of States did not reveal when the Level I screenings occurred relative to admission into a NF or other care setting. In eight percent of States, it was unclear when the Level II evaluations occurred.

**Table 5: Timing of PASRR Level I and Level II**

| Relative to Admission | Timing of Level I Screen | Timing of Level II Evaluation |
|---|---|---|
| Before Admission | 90% | 78% |
| After Admission | 0% | 4% |
| Not Given | 6% | 8% |
| See Comments | 4% | 10% |

As shown in Table 6, State mental health authorities (SMHAs) and State mental retardation authorities (SMRAs), together, were predominately responsible for the PASRR process. In 43 percent of States, these two entities used the completed Level I screens to determine the need for a Level II evaluation. Seventy-three percent of States relied on SMHAs and SMRAs to oversee the Level II evaluations. These comments provide additional data on the 37 percent of States for which the other main coding options did not apply (i.e., the row in Table 6 labeled "See Comments").

**Table 6: Entities Responsible for Determining the Need for the Level II Evaluation and Conducting the Level II Evaluation**

| Responsible Entity* | Entity Determining Need for Level II Evaluation | Entity Responsible for Level II Evaluation |
|---|---|---|
| SMHA and SMRA | 43% | 73% |
| State Medicaid Agency | 10% | 2% |
| SMHA | 4% | 2% |
| Nursing Facility | N/A | 2% |
| Not Named | 4% | 4% |
| Other | 14% | 6% |
| See Comments | 25% | 12% |

*Note: For the purposes of our review, third-party vendors contracted by the SMHA or SMRA were coded as SMHA and SMRA.*

## ELEMENTS OF LEVEL II

One of the most notable findings of our review is that no States comprehensively collected all required and effective data elements in their Level II evaluation forms. Table 7 presents the breakdown of States' "comprehensive," "partial," and "absent" data elements on their Level II MR tools, while Table 8 presents the same information for the MI tools.

For Level II MR tools, the most complete data element, "need for NF," was considered comprehensive for 71 percent of States. "Medical history" was the least widely captured, at 29 percent comprehensive; it also had the highest partial rate at 59 percent. This is because many State tools did not ask for onset dates, or simply asked that the most recent physical be attached. "Medication review" also had a notably high partial rate at 39 percent, most likely because State tools did not capture allergies or side effects. Because the CFR does not require onset dates, or all aspects of the medication review as we have defined it (e.g., allergies), these finding should be interpreted with some caution. For medical history and medication review, the label "comprehensive" captures both the requirements of the CFR and good clinical practice. A label of "partial" therefore should not be treated as a problem with compliance. It may instead indicate that the State should update its data collection procedures to reflect modern practice.

**Table 7: Percent of States that Met the MR Level II Requirements (Regulatory and Good Clinical Practice)**

| Requirement | Keywords and Key Phrases | Comprehensive | Partial | Absent* |
|---|---|---|---|---|
| Need for NF | appropriate placement is NF | 71% | 14% | 16% |
| Neurological assessment | motor functioning; gait; communication | 53% | 27% | 20% |
| Harm to self or other | Suicidal/homicidal ideation | 49% | 18% | 33% |
| Externalizing and internalizing behaviors | aggressive; disruptive; inappropriate; depression; anxiety; loneliness | 49% | 29% | 22% |
| ADLs/IADLs | self-care; self-administration of medication | 47% | 35% | 18% |
| ADLs/IADLs in community | assessment of ability to perform ADLs in the community | 47% | 29% | 24% |
| Psychosocial evaluation | current living arrangements; medical and support systems | 45% | 31% | 24% |
| Intellectual functioning | estimated IQ level (MR, low average, average, high average) | 39% | 31% | 29% |
| Medication review | current medications; allergies; side effects | 37% | 39% | 24% |
| Medical history | diagnosis(es); onset date(s) | 29% | 59% | 12% |

** "Absent" includes absence of a data element from a submitted document or lack of the entire document.*

For the MI Level II requirements, the data element "harm to self or others" had the highest comprehensive rate at 80 percent. "Medication review," "medical history," and "intellectual functioning" had the lowest comprehensive rates at 33 percent each. "Medication review" and "medical history" both had a high partial rate at 65 percent and 63 percent respectively, due to the reasons discussed above. Finally, "ADLs/IADLs in community" had a partial rate of 37 percent; State tools often did not specify "in the community," or they failed to capture certain ADLs/IADLs that are likely to take place in the community (e.g. taking public transportation, managing finances, and grocery shopping).

**Table 8: Percent of States that Met the MI Level II Requirements (Regulatory and Good Clinical Practice)**

| Requirement | Keywords and Key Phrases | Comprehensive | Partial | Absent* |
|---|---|---|---|---|
| Harm to self or others (intentional or unintentional) | suicidal/homicidal ideation | 80% | 18% | 2% |
| Reality testing | delusions and hallucinations | 76% | 16% | 8% |
| Cognitive functioning | memory; concentration; orientation; cognitive deficits | 76% | 22% | 2% |
| Need for NF | appropriate placement is NF | 71% | 14% | 16% |
| Psychosocial evaluation | current living arrangements; medical and support systems | 67% | 27% | 6% |
| Externalizing and internalizing behaviors | aggressive; disruptive; inappropriate; depression; anxiety; loneliness | 65% | 35% | 0% |
| Neurological assessment | motor functioning; gait; communication | 61% | 33% | 6% |
| Need for NF | appropriate placement is other setting | 61% | 12% | 27% |
| ADLs/IADLs | self-care; self-administration of medication | 59% | 29% | 12% |
| ADLs/IADLs in community | assessment of ability to perform ADLs in the community | 47% | 37% | 16% |
| Support systems | level of support needed to perform activities in the community | 39% | 22% | 39% |
| Medication review | current medications; allergies; side effects | 33% | 65% | 2% |
| Medical history | diagnosis(es); onset date(s) | 33% | 63% | 4% |
| Intellectual functioning | estimated IQ level (MR, low average, average, high average) | 33% | 51% | 16% |

** "Absent" includes absence of a data element from a submitted document or lack of the entire document.*

Notably, there is some consistency in the level of comprehensiveness in data collection across the Level II MI and MR tools. For example, aside from "need for NF," "harm to self or others" was among the top two data element most often captured comprehensively for both the MI and the MR populations. Both "medication review" and "medical history" were the data elements most commonly classified as "partial," again for both populations. Nonetheless, the level of comprehensiveness for many data elements does differ by population. For example, while "externalizing and internalizing behaviors" was comprehensively covered in 65 percent of States' Level II MI tools, it was covered comprehensively in only 49 percent of States' Level II MR tools. This is a

surprising finding, one that raises important questions about how States are assessing individuals' behaviors for PASRR/MR.

Table 9 shows the breakdown of states into "comprehensiveness quartiles." The most heavily populated quartile is the 26%-50% range, which contains 20 states (39 percent). The second most heavily populated quartile is the 51%-75% range, with 19 states (37 percent). Thus, most states fall somewhere in the middle range of comprehensiveness. Only a handful of states could be considered outstanding or especially poor.

**Table 9: Frequency and Share of States in Each Range of Comprehensiveness**

| Level of Comprehensiveness | # of States | % of States |
|---|---|---|
| **76%-100%** | 7 | 14% |
| **51%-75%** | 19 | 37% |
| **26%-50%** | 20 | 39% |
| **≤ 25%** | 5 | 10% |

Table 10 lists States by comprehensiveness quartile.

**Table 10: States Listed by PASRR Comprehensiveness Quartile**

| States by Level of Comprehensiveness | | | |
|---|---|---|---|
| **76%-100%** | **51%-75%** | **26%-50%** | **0-25%** |
| Alabama | Arizona | Alaska | Arkansas |
| Georgia | Colorado | California | Dist. of Columbia |
| Missouri | Connecticut | Delaware | New Hampshire |
| Nevada | Florida | Hawaii | Pennsylvania |
| North Carolina | Idaho | Indiana | South Dakota |
| Tennessee | Illinois | Iowa | |
| Virginia | Kansas | Maine | |
| | Kentucky | Mississippi | |
| | Louisiana | Montana | |
| | Maryland | New Jersey | |
| | Massachusetts | Ohio | |
| | Michigan | Oklahoma | |
| | Minnesota | Oregon | |
| | Nebraska | Rhode Island | |
| | New Mexico | South Carolina | |
| | New York | Texas | |
| | North Dakota | Utah | |
| | Washington | Vermont | |
| | Wisconsin | West Virginia | |
| | | Wyoming | |

Some caution should be exercised in interpreting the results of the comprehensiveness tables. Notably, because our coding scheme included both regulatory requirements and good clinical practices, degree of comprehensiveness should not be equated with degree of compliance with minimum requirements.

## DIVERSION AND TRANSITION-RELATED EFFORTS

PASRR provides perhaps the most powerful lever in all of Medicaid law to encourage diversion and transition. It is therefore worth knowing whether States have explicitly connected their PASRR efforts to the mandate of *Olmstead* planning.

Table 11 shows the percentage of States whose documentation contains language on diversion/transition related requirements. The extent to which the States had all of these requirements or practices varies widely. Only 18 percent of states have mission statements or visions for diversion and transition in their PASRR documentation.

**Table 11: Diversion/Transition Related Requirements or Practices of States**

| Diversion/Transition Related Requirements or Practices | # of States | % of States |
|---|---|---|
| Training or instructions to contractors or evaluators on HCBS waivers | 16 | 31% |
| Mission/vision of state diversion/transition philosophies related to other initiatives (i.e. Olmstead) in PASRR documents | 9 | 18% |
| Transition to community for short term or long term residents who need MH services but not NF | 9 | 18% |
| Info given on state plan services or other HCBS waivers for MH and MR services | 18 | 35% |
| Recommended services of lesser intensity, MH or MR services while in NF recommended | 24 | 47% |
| Other elements or practices related to diversion/transition | 19 | 37% |

# 4. Discussion and Next Steps

This review of PASRR design had two objectives. The first objective was to collect data that would help CMS better understand the strengths and shortcomings of PASRR processes and procedures nationally. The second and equally important objective was to create, through our Fact Sheets, an invitation to States to revisit their PASRR process, identify areas for improvement, and develop strategies for strengthening these systems.

The PTAC team has already been encouraged by the volume of feedback we have received from States in response to their Fact Sheets. The review team has held several conference calls with State PASRR representatives to review or clarify our objectives, methodology, or findings. As a result, many States have submitted more up-to-date and complete documents, corrected misinterpretations, validated findings, and/or started to make improvements to their PASRR systems. Our review team continues to collect State feedback and additional documentation and plans to incorporate this information into an updated Fact Sheet for each State that requests one. Some States have undertaken dramatic systems change since the documents were first obtained from the Regional Offices in 2009. Future versions of this report will capture those systems changes.[3]

Our conversations with States have made us even more acutely aware of the limitations of our methods. Our document review was intended to capture elements of States' policies and procedures as they are written. As we noted in the Introduction, our review assessed program design, but it did not address the *implementation* of these programs. As such, while our findings might suggest that a State has a comprehensive and compliant PASRR process by design, it may be poorly implemented. This limitation works in reverse as well: Although our review may have found flaws in the way a State has designed its PASRR system, its implementation of that system may be more effective than is reported here. Any assessment of how a State implements PASRR – and how implementation relates to the written policies and procedures reviewed here – is ultimately a quality improvement function, and therefore an oversight responsibility for

[3] The following states will be reassessed for the subsequent version of this report: Arkansas, Florida, Georgia, Idaho, Iowa, Maine, Massachusetts, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Washington, and Wyoming.

CMS. PTAC will be working with CMS to provide technical assistance and quality tools to states to follow up this initial analysis of program design.

# ERRATUM

In: Kako, E. and Smith, M. (May 2012). Review of State Preadmission Screening and Resident Review (PASRR) Policies and Procedures. Reported to the Centers for Medicare and Medicaid Services (CMS). Page 20.

The information about Arkansas in the National Report was based on an incomplete set of 2009 documents. After reviewing a draft version of the State Fact Sheet, Arkansas staff sent updated documents to PTAC, but these were not consistently marked as "pre-2009" documents versus "post-2009" documents. As a result, the State was classified as a "post-2009" redesign State.

PTAC has since conducted a re-review of the State, which has resulted in significant changes in the findings – all absents and partials have moved to comprehensive. An updated Table 10 below reflects these changes within the context of the national review. Future versions of the National Report will also contain this information.

**Table 12: States Listed by PASRR Comprehensiveness Quartile**

| States by Level of Comprehensiveness | | | |
|---|---|---|---|
| **76%-100%** | **51%-75%** | **26%-50%** | **0-25%** |
| Alabama | Arizona | Alaska | Dist. of Columbia |
| Arkansas | Colorado | California | New Hampshire |
| Georgia | Connecticut | Delaware | Pennsylvania |
| Missouri | Florida | Hawaii | South Dakota |
| Nevada | Idaho | Indiana | |
| North Carolina | Illinois | Iowa | |
| Tennessee | Kansas | Maine | |
| Virginia | Kentucky | Mississippi | |
| | Louisiana | Montana | |
| | Maryland | New Jersey | |
| | Massachusetts | Ohio | |
| | Michigan | Oklahoma | |
| | Minnesota | Oregon | |
| | Nebraska | Rhode Island | |
| | New Mexico | South Carolina | |
| | New York | Texas | |
| | North Dakota | Utah | |
| | Washington | Vermont | |
| | Wisconsin | West Virginia | |
| | | Wyoming | |