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

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PTAC
PASRR Technical Assistance Center

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Edward Kako, Ph.D., Director, and Mason Smith, B.A.
Authors, PASRR Technical Assistance Center

Executive Summary

In 2010-2012, the PASRR Technical Assistance Center (PTAC) conducted the first systematic, empirical effort to document the design of PASRR systems in all States and the District of Columbia. PTAC reviewed States' 2009 policies and procedures kept on file by PASRR Coordinators in CMS Regional Offices. A summary of findings was published in May 2012.

Since 2009, many States have updated their PASRR policies and procedures. Therefore, PTAC accepted and reviewed revised documentation from States from May 2012 through February 2013. The results of this review – offering a snapshot of 2013 PASRR policies and procedures – are captured in this report. This review does *not* capture any information on the implementation of these policies or procedures.

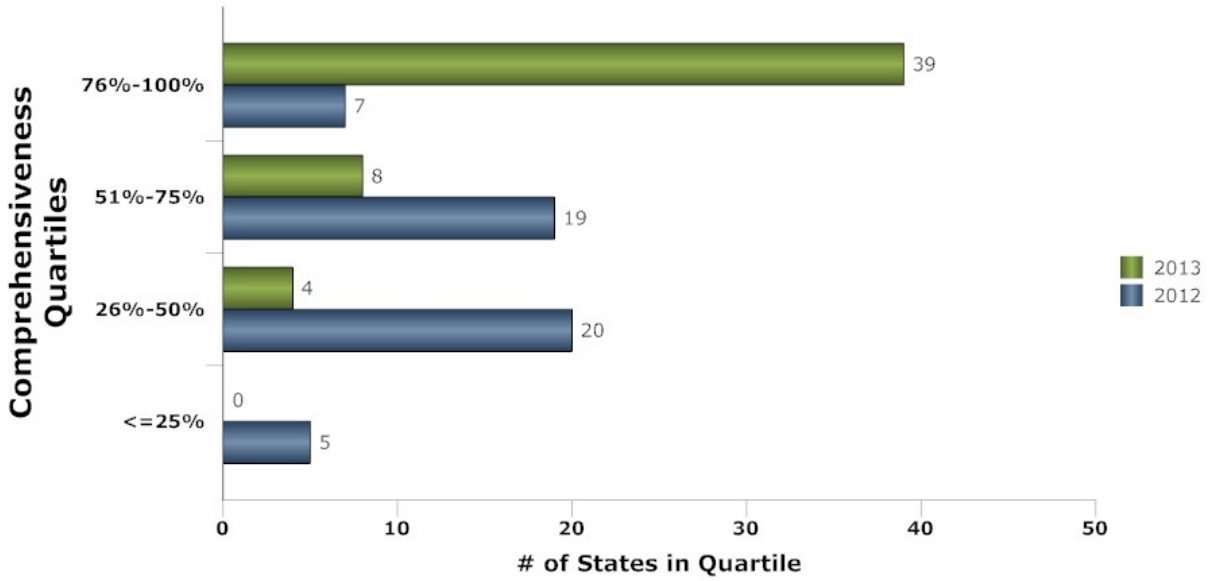
A review tool was developed by extracting key data elements from the regulations governing PASRR (42 CFR Part 483.100-138). This fundamental set of data elements was augmented with a small number of good, modern clinical practices that collectively reflect adherence to federal requirements (e.g., performing a complete medication review). The review covered Level I screens and Level II evaluations and determinations for individuals with serious mental illness (PASRR/MI) and for individuals with intellectual and developmental disabilities (PASRR/ID).

Data elements related to Level II assessments were evaluated as comprehensive, partial, or absent, depending on how thoroughly the State's assessment tools captured the relevant information. States were then assigned a "level of comprehensiveness" based on the percent of total data elements that were considered comprehensive.

Major findings from the review include the following:

- Average State comprehensiveness scores increased by 59 percent between 2012 (52 percent comprehensive) and 2013 (83 percent comprehensive).
- Across States, the level of comprehensiveness for each Level II MI and ID data element increased dramatically between 2012 and 2013.
- As indicated by the Figure below, 76 percent of States (39) fell within the top quartile of comprehensiveness, compared to 14 percent (7) in 2012.
- In 2013, no States fell within the bottom quartile, whereas 10 percent (5) did so in 2012.
- In 2013, only a handful of States were less than 50 percent comprehensive, compared to half of all States in 2012.

Number of States by Comprehensiveness Quartile, 2013 vs. 2012



- The level of comprehensiveness for many data elements differed by population. For example, while identifying "harm to self or others" was comprehensively covered in 98 percent of States' Level II MI tools, it was covered comprehensively in 88 percent of States' Level II ID tools.
- For the second consecutive year, both "medication review" and "medical history" were the data elements least commonly captured comprehensively and most commonly captured partially, both for the MI population and for the ID population.
- Most Level I's and Level II's were performed prior to NF admission, though in several cases the documentation was unclear.
- The majority of States (88 percent) conducted nursing home level of care determinations prior to, or concurrent with, their PASRR evaluations.

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

- That the national inventory of PASRR design continue to be updated annually, to track changes and trends over time;
- That the national review of PASRR design more deeply assess certain aspects of the PASRR process, including States' Level I screens;

- 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; and
- That CMS Central and Regional Office staff continue to jointly develop protocols and resources that will improve monitoring and oversight, to help States 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 all applicants to a Medicaid-certified nursing facility to be evaluated for mental illness (MI) and/or intellectual disability or related conditions (abbreviated here as ID, formerly called mental retardation or 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. In 1994, regulations governing PASRR were incorporated into the Code of Federal Regulations at 42 CFR 483.100-138.

PASRR requires that all people entering Medicaid-certified nursing facilities are evaluated for MI and ID, are placed in the most appropriate setting, and receive assessments to identify their service needs.

This report evaluates the policies, procedures, and tools that demonstrate States' adherence to PASRR requirements and good clinical practice.

PASRR was in many respects ahead of its time. OBRA 87 predated the Americans with Disabilities Act (ADA, Pub. L. 101-336) 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 ID. 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 disability or serious mental illness. Those individuals who "test positive" at Level I are then evaluated in depth to confirm the determination of MI/ID 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, the law allows States to claim an enhanced 75 percent federal match on all activities related to the administration of PASRR. PASRR is not classified as a service to the beneficiary, but rather as a special kind of administrative activity, and is a mandatory part of the basic Medicaid State Plan.

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

In 2006, Linkins and colleagues published a research paper through a grant from the Department of Health and Human Services (HHS), documenting a lack of compliance in some States with the requirements of PASRR. The Office of the Inspector General (OIG) for the HHS also published three detailed reports, one in 2001 and two in 2007, all directing 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 had the ability until recently to provide technical assistance or conduct an empirical analysis of PASRR design and implementation. The findings reported in the 2012 paper represented a first crucial step toward learning more about PASRR in all 50 States and the District of Columbia. This 2013 report is an update to that first systematic, empirical effort to document the policies and procedures of PASRR programs nationally. It demonstrates marked improvement in the degree to which States capture the data elements laid out in the 2012 report.

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, States, and other stakeholders better understand the strengths and shortcomings of State PASRR programs. The more detailed “Fact Sheets” that we provide to states from this review are intended to invite States to revisit their PASRR process, identify areas for improvement, and develop strategies for strengthening their 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, that the data we reviewed were collected between late 2009 and February 2013. We corresponded with every State to ensure that we analyzed the most recent program information. Our review should thus be seen as a snapshot of State PASRR design as of February 2013.

In what follows, we first describe our methodology for the 2013 report. (A detailed methodology of the 2012 baseline report can be found in Appendix A: Baseline Methodology.)

We then present our findings, categorized by three core components of PASRR: 1) requirements of the Level II evaluation; 2) diversion and transition related efforts; and 3) timing and general PASRR requirements. This 2013 report also presents data on the degree to which States have improved their policies and procedures since the previous report. (Additional findings can be found in Appendix B.) We conclude by discussing limitations of the review and describe plans for analyzing States' Level I screening instruments. A glossary of terms can be found in Appendix C.

2 Methodology

The first version of the national report was released in May of 2012 and proceeded in four main steps:

1. Initial assembly of State PASRR documentation.
2. Development of a tool to compare written policies and procedures against the requirements of the CFR and good, modern clinical practices for implementing them.
3. Review of State PASRR documentation.
4. Sharing of our findings with States and soliciting their feedback and additional documentation.

Our methodology for this 2013 report closely resembled that of the 2012 report. (For details on the methodology of the 2012 report, see Appendix A.) Steps 1 and 2 above were unnecessary this year because we already had PASRR documentation from each State; we chose to continue using the evaluation tool as designed for the 2012 report; and we did not make changes to our coding scheme or coding protocol. Following the release of the 2012 report, many States submitted feedback or additional PASRR documentation for review by the PASRR Technical Assistance Center (PTAC). As such, the analysis reported here proceeded in two main steps:

1. Review of State feedback and additional or updated State PASRR documentation; and
2. Sharing of our findings with States and soliciting their feedback to ensure that our documentation was complete and that our findings were accurate.

For this report, PTAC interacted directly with State PASRR staff to discuss their feedback on the 2012 report and to solicit additional or updated documentation. The PTAC team was encouraged by the volume of feedback we received from States in response to their Fact Sheets issued with the 2012 report. Many States appreciated both the national data and their State-specific information. After May 2012, the review team held numerous conference calls with State PASRR representatives to review or clarify our objectives, methodology, or findings. As a result, many States submitted more up-to-date and complete documents, corrected misinterpretations, or verified findings.

As with the 2012 report, individualized Fact Sheets were created for each State to summarize State-specific findings, points for consideration, and recommendations. PTAC met with States and incorporated up-to-date information about State PASRR programs through February 15, 2013. Thus, this report captures the state of State PASRR systems as of February 2013.

3 Findings

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

In general, PASRR policies, procedures, and tools varied widely across States. Many States have developed detailed evaluation tools, clear descriptions of process timing, and a clear delineation of the responsibilities of the participating agencies. By contrast, the documentation from some States was unclear or displayed gaps in the CFR requirements.

Comparisons to the May 2012 report are included where differences reveal a notable improvement over previous results. Some especially striking differences between 2012 and 2013 include the degree to which Level II MI and ID assessment tools meet the criteria of our review, and the degree to which the language in States' policies and procedures reflect diversion and transition efforts.

3.1 Elements of Level II Tools

Table 1 presents the breakdown of States' comprehensive data elements on their Level II ID tools and the percent change from 2012 to 2013 for each of the Level II requirements. Table 2 presents the same information for the MI tools. In the interest of brevity, we describe the breakdown of States' partial and absent data elements, as well as the percent change from 2012 to 2013, in Appendix B. Across States, comprehensiveness increased for each Level II data element between 2012 and 2013 for both Level II ID and MI tools. In generals, data elements with lower comprehensiveness scores saw larger increases between 2012 and 2013. For Level II ID tools, the most complete data element, "need for NF," was considered comprehensive for 94 percent of States. "Medical history" remained the least widely captured for the second year, although improved at 67 percent comprehensive in 2013. This data element also had the highest partial rate for the second consecutive year, at 31 percent. This is because many State tools did not ask for onset dates, or simply asked that the most recent physical be attached.

The number of States that received a comprehensive for "medical history" increased by 130 percent between 2012 and 2013, which is the largest percent change for any Level II ID data element. The percent change for each data element was calculated by subtracting the 2012 comprehensiveness score from the 2013 comprehensiveness score, then dividing this figure by the 2012 comprehensiveness score. For example, in the case just mentioned:

(66.6% - 29%)/ 29% = +130%

For the second consecutive year, "medication review" had the second highest partial rate, at 24 percent, most likely because State tools did not explicitly 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, these findings 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 necessarily 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 1: Percentage of States That Comprehensively Met the ID Level II Requirements (Regulatory and Good Clinical Practice) and Percentage Change from 2012

Requirement	Keywords and Key Phrases	Percentage Comprehensive 2013	Percent Change 2012 to 2013
Need for NF	appropriate placement is NF	94%	**+33%**
Neurological assessment	motor functioning; gait; communication	92%	**+74%**
Externalizing and internalizing behaviors	aggressive; disruptive; inappropriate; depression; anxiety; loneliness	88%	**+80%**
Harm to self or others	suicidal/homicidal ideation	88%	**+80%**
ADLs/IADLs	self-care; self-administration of medication	88%	**+88%**
ADLs/IADLs in community	assessment of ability to perform ADLs in the community	86%	**+84%**
Intellectual functioning	estimated IQ level (ID, low average, average, high average)	84%	**+116%**
Psychosocial evaluation	current living arrangements; medical and support systems	78%	**+74%**
Medication review	current medications; allergies; side effects	69%	**+85%**
Medical history	diagnosis(es); onset date(s)	67%	**+130%**

Among the MI Level II requirements, the data element "harm to self or others" had the highest comprehensive rate for the second consecutive year, at 98 percent (Table 2). "Medical history" had the lowest comprehensive rates at 73 percent, followed by "medication review" with a comprehensive rate of 76 percent. "Medical history" and "medication review" both had a relatively high partial rate at 27 percent and 24 percent respectively, due to the reasons discussed above. No State received an absent for either of these data elements. Between 2012

and 2013, the number of States that received a comprehensive for “medical history” and “medication review” increased by 120 percent and 132 percent, respectively. In no case was a Level II MI data element absent in more than 10 percent of States.

Table 2: Percent of States that Comprehensively Met the MI Level II Requirements (Regulatory and Good Clinical Practice) and Percent Change from 2012

Requirements	Keywords and Key Phrases	Percentage Comprehensive 2013	Percent Change 2012 to 2013
Harm to self or others (intentional or unintentional)	suicidal/homicidal ideation	98%	**+23%**
Reality testing	delusions and hallucinations	96%	**+26%**
Cognitive functioning	memory; concentration; orientation; cognitive deficits	96%	**+26%**
Need for NF	appropriate placement is NF	94%	**+33%**
Externalizing and internalizing behaviors	aggressive; disruptive; inappropriate; depression; anxiety; loneliness	92%	**+42%**
Need for NF	appropriate placement is other setting	92%	**+51%**
Neurological assessment	motor functioning; gait; communication	90%	**+48%**
ADLs/IADLs in community	assessment of ability to perform ADLs in the community	90%	**+92%**
ADLs/IADLs	self-care; self-administration of medication	88%	**+50%**
Psychosocial evaluation	current living arrangements; medical and support systems	86%	**+29%**
Support systems	level of support needed to perform activities in the community	78%	**+101%**
Intellectual functioning	estimated IQ level (ID, low average, average, high average)	78%	**+138%**
Medication review	current medications; allergies; side effects	76%	**+132%**
Medical history	diagnosis(es); onset date(s)	73%	**+120%**

There is some notable consistency in the level of comprehensiveness in data collection across the Level II ID and MI tools. For example, “need for NF (appropriate placement is NF)” was comprehensively captured in 94 percent of States’ Level II ID and MI tools. Similarly, assessment information regarding “ADLs/IADLs” was comprehensively captured in 88 percent of States’ Level II ID and MI tools. Both “medication review” and “medical history” were the data elements least commonly captured comprehensively and most commonly classified as partial, for both the ID and MI populations. These patterns were also found in the 2012 report. In addition, the percent change between 2012 and 2013 in comprehensiveness for “intellectual functioning” was higher than any other data element for both Level II ID and Level II MI tools.

The share of States that received a comprehensive for “intellectual functioning” increased by 116 percent between 2012 and 2013 in Level II ID tools and 138 percent in Level II MI tools.

The level of comprehensiveness for many data elements differs by population. For example, while “harm to self or others” was comprehensively covered in 98 percent of States’ Level II MI tools, it was covered comprehensively in only 88 percent of States’ Level II ID tools. Comprehensiveness levels also differed between the Level II MI and ID tools for “medication review” and “psychosocial evaluation.” Although there may be valid clinical reasons to use different tools and procedures for the two populations, differences may be primarily due to multiple agencies within a State being responsible for the PASRR process (i.e., SMHA for the MI population and SIDA for the ID population). Throughout PTAC’s review, we found that the agencies that administer PASRR are often not coordinated. While it is understandable that each agency might develop processes that meet the unique needs of its corresponding population, agencies could benefit from sharing information and aligning their efforts.

Figure 1 shows the breakdown of States into “comprehensiveness quartiles” for 2012 and 2013. The level of comprehensiveness across States increased markedly between 2012 and 2013. The most heavily populated quartile in 2013 was the 76%-100% range, with 39 States (76 percent), compared to 7 States (14 percent) in 2012. The most heavily populated quartile in 2012 was the 26%-50% range, with 20 States (39 percent). Similar to 2012, the second most heavily populated quartile in 2013 was the 51%-75% range, with 8 States (16 percent). Thus, in 2013, 92 percent of States fell somewhere in the upper two comprehensiveness quartiles, compared to 51 percent in 2012. In 2013, no States fell within the bottom quartile, and only a handful were less than 50 percent comprehensive.

Figure 1: Number of States in Each Comprehensiveness Quartile, 2013 vs. 2012

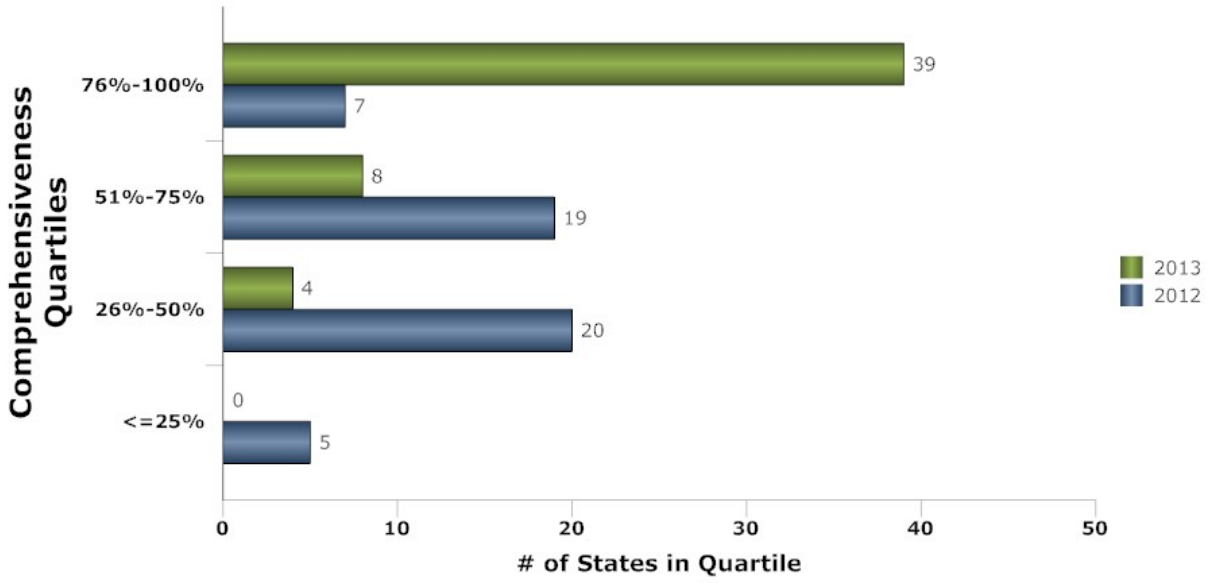


Table 3 lists States by quartile according to the comprehensiveness of Level II tools and procedures as described in the methods section of this report. We reiterate that the percentage value is an indication of program design and not a measure of program implementation.

Table 3: States Listed by PASRR Level II Tools Comprehensiveness Quartile

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

3.2 Olmstead Implications: 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 4 shows the percentage of States whose documentation contained language on diversion/transition related requirements in both 2012 and 2013. In 2013, 65 percent of States had mission statements or visions for diversion and transition in their PASRR documentation whereas 98 percent of States remarked on recommended services of lesser intensity while in the NF. Between 2012 and 2013, the share of States whose documentation contained language about diversion/transition efforts increased. The largest increases were seen in “transition to community for short term or long term residents who need MH or ID services but not NF” and in “mission/vision of State diversion/transition philosophies related to other initiatives (i.e., Olmstead) in PASRR documents."

Table 4: Diversion/Transition Related Requirements or Practices of States

Diversion/Transition Related Requirements or Practices	Percentage of States 2012	Percentage of States 2013	Percentage Change 2012-2013
Training or instructions to contractors or evaluators on HCBS waivers	31%	71%	**+125%**
Mission/vision of State diversion/transition philosophies related to other initiatives (i.e. Olmstead) in PASRR documents	18%	65%	**+267%**
Transition to community for short term or long term residents who need MH or ID services but not NF	18%	67%	**+278%**
Info given on State plan services or other HCBS waivers for MH and ID services	35%	71%	**+100%**
Recommended services of lesser intensity, MH or ID services while in NF recommended	47%	51%	**+8%**

3.3 Timing of Level of Care and PASRR

Medicaid eligible individuals may be admitted to a NF only if they are assessed to need NF level of care (LOC). For persons with MI or ID to be admitted, PASRR Level II must also determine whether their disability-specific needs can be met in a NF. States coordinate the LOC process and the PASRR process in various ways, as there is no federal requirement about how the two are related or integrated.

As shown in Table 5, approximately 88 percent of States assessed individuals' eligibility for NF LOC before or during PASRR. Only one State 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 six percent of States did not indicate when the NF LOC determinations were made relative to PASRR.

Table 5: Timing of Nursing Facility Level of Care Determination Relative to PASRR

Relative to PASRR	% of States
Before PASRR	35%
After PASRR	2%
Concurrent with PASRR	53%
Not Given	6%
See Comments	4%

As Table 6 indicates, most States also followed regulations in terms of conducting PASRR before an individual was admitted to a nursing home; 94 percent administered the Level I screen and 86 percent administered the Level II before admission into a NF or other appropriate care setting. One State reported administering the initial Level I after admission into a NF. However, six percent conducted Level II evaluations after admission. The documentation from one State did not reveal when the Level I screenings occurred relative to admission into a NF or other care setting. In one State, it was unclear when the Level II evaluations occurred.

Table 6: Timing of PASRR Level I and Level II

Relative to Admission	Timing of Level I Screen	Timing of Level II Evaluation
Before Admission	94%	86%
After Admission	2%	6%
Not Given	2%	2%
See Comments	2%	6%

4 Discussion and Next Steps

The first review of State PASRR policies and procedures and the corresponding report released in May 2012 had two objectives. The first was to collect data that would help CMS better understand the strengths and weaknesses of PASRR processes and procedures nationally. The second, 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.

As illustrated in the previous section, many States have undertaken changes to their PASRR forms and processes since the release of the previous version of this report. Our review team continues to collect State feedback and additional documentation and incorporate this information into an updated Fact Sheet for each State.

Our conversations with States have highlighted 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 CMS. PTAC will be working with CMS to continue to provide technical assistance and quality tools to States to follow up this analysis of program design.

Since the release of the 2012 report, PTAC has been working with CMS to identify additional aspects of PASRR programs to be analyzed in subsequent reports. The 2014 report will include a more detailed analysis of the content of Level I screening tools and corresponding guidance. Our analysis for subsequent reports will focus on other components of Level I programs, including best practices for Level I tools and quality monitoring. The following two sections provide States with our objectives for future reviews so that they can assess their programs in advance of these analyses and request appropriate technical assistance, as needed.

In reviewing their Level I screening tools in the coming year, States should be mindful of additional aspects that contribute to an effective Level I program. Beginning with the 2014 report, our analysis will include the following five additional components of an effective Level I program:

1. Identifying Individuals with MI or ID
2. Screener Training
3. Program Fidelity
4. Program Structure
5. Hospital Discharge Exemptions and Categorical Determinations

Below we describe the data elements we intend to examine for each of these components, along with citations to relevant portions of the CFR.

4.1 Identifying Individuals with MI or ID

The State's PASARR program must identify all individuals who are suspected of having MI or ID as defined in Sec. 483.102. [§ 483.128(a)]

Level I processes must consider information beyond that which is reported in the record. [§ 483.128(g)]

To meet these requirements of the CFR, the Level I tool/process:

1. Contains questions to assist in identifying previously unreported disabilities.
2. Captures key symptoms or behavioral indicators.
3. When co-morbid dementia and mental illness are present, captures presenting and collateral information to determine which condition is primary.

4.2 Screener Training

There are written procedures designating responsibility for performing Level I screens, specified forms or instruments, and training requirements for screeners. [§ 483.100, 483.122]

To meet these requirements of the CFR, the Level I tool/process:

1. Specifies screening procedures clearly describing federal intent for identifying MI and ID.
2. Includes procedures and training for NF staff that emphasize responsibility for notifying when a NF resident not previously identified as having SMI/ID displays behaviors that indicate need for a Level II evaluation (Resident Review), and a means to evaluate whether the procedures are followed.
3. Explains Level I screeners' responsibility to look beyond diagnoses.

4. Describes qualifications of Level I screeners.
5. Requires that individuals with co-morbid dementia and other behavioral health conditions must be evaluated through the Level II process.
6. Requires that Level I/II processes are completed prior to NF admission.
7. Requires that PASRR be completed regardless of insurance type (Medicaid, Medicare, private pay).
8. Requires ongoing screener training.
9. Indicates the method by which a Level I is determined to be positive versus negative (i.e., scoring methods and role for judgment).

4.3 Program Fidelity

All individuals with SMI or ID to be admitted to a Medicaid-certified NF (regardless of payment source) are subject to PAS. Requires that no person be admitted to a Medicaid certified NF without a PASRR Level I screen. [§ 483.106(b)]

Every new admission to a Medicaid-certified NF (or distinct part), regardless of payment source and known diagnosis, receives a Level I screen before admission [§ 483.102(a), 483.106(a), 483.122(b)] including those who meet the hospital discharge exemption from Level II. [§ 483.106(b)(2)]

The Medicaid Authority must withhold Medicaid payment for any resident with SMI/ID who enters or remains in a NF contrary to PASRR rules. [§ 483.122(b)]

To meet these requirements of the CFR, the State:

1. Assures that it can report on the number of Level I screens.
2. Assures that the number of completed Level I screens matches the number of NF admissions.
3. Assures that the proportion of Level I screens for individuals who are Medicaid versus non-Medicaid matches demographics of the State's NF population.
4. Assures that the percentage of Level I screens leading to Level II evaluations reflects the prevalence of disabilities in NF settings.

5. Assures that it can report on the percentage of Level II determinations that indicate a) that an individual has a PASRR condition and b) that an individual does not have a PASRR condition (as a share of the total NF population).

6. Assures that Medicaid payment mechanisms or payment procedures require evidence of completion of the Level I (and Level II if indicated) prior to authorizing payment for NF services.

4.4 Program Structure

For first time identifications, written notice is provided to the individual (and legal representative) that SMI or ID/DD is suspected or known, and referral is being made to the SMHA or SIDA for Level II. [§ 483.128(a)]

To meet these requirements of the CFR, the Level I tool/process meets the following requirements:

1. Level I screeners notify the State MH or ID authorities when a person is suspected of having SMI or ID. Both agencies are notified when both SMI and ID are suspected.

2. A protocol is in place for notification of individual or guardian of Level I and Level II determinations (as appropriate).

3. Written notification is provided to the applicant or resident when it is determined that a PASRR Level II evaluation is required.

4. If categorical determinations are applied by Level I screeners, the final determination is made by the appropriate State MH/ID authority (or designee).

4.5 Hospital Discharge Exemptions and Categorical Determinations

Individuals may be exempted from PASRR if they are discharged from a hospital for a short-term stay in a NF to recover from the illness for which they received treatment – provided the attending physician has certified that the stay will last less than 30 days. If the stay exceeds 40 calendar days, PASRR must be administered. [§ 483.106(b)]

Individuals who fall into certain categories as determined by the State may be given an "abbreviated" Level II evaluation because they need NF placement for a short period of time (provisional admissions) or because they are unlikely to need Specialized Services. In all cases, a Level II determination must still be issued. [§ 483.130]

To meet these requirements of the CFR, the Level I and Level II tool/process meets the following requirements:

1. Categorical determinations and exempted hospital discharge decisions are approved by the State MH/ID authority.

2. State MH/ID authority maintains a process for tracking persons admitted under categorical determinations and hospital discharge exemptions (monitoring admission location and authorization end dates).

3. State MH/ID authority process ensures initiation of PASRR evaluation by or before end-dates for residents remaining in NFs beyond categorical and exempted hospital discharge decision end dates.

4. Continued NF payment is tied to completion of a PASRR Level II evaluation (Resident Review) for residents remaining in NFs beyond categorical and exempted hospital discharge decision end dates.

5. The State has a system that reliably notifies the MH/ID authorities when the time limit of the categorical determination or hospital discharge exemption expires, and the individual needs a Level II (Resident Review).

5 Requesting Technical Assistance

To assist you in reviewing your Level I tool and process, a webinar recording and presentation slides about PASRR Level I screening requirements and best practices has been posted on the PTAC website (www.PASRRassist.org). A forthcoming white paper providing further guidance on effective Level I program design and operation will be added to the PTAC website in the the near future. Please check our website then to access this useful supplemental guidance.

PTAC's technical assistance:

- Is free to States;
- Is confidential (except in cases where the health and welfare of individuals may be jeopardized);
- May include in-person visits (e.g., for strategic planning or to help develop interagency collaboration).

States may request technical assistance on any of the topics discussed in this report through the PTAC website (www.PASRRassist.org) or by contacting the Director of PTAC, Ed Kako, at ekako@mission-ag.com.

6 Appendix A: Baseline Methodology

Our 2012 review of PASRR policies and procedures proceeded in four steps:

1. Initial 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 lesser extent) good, modern clinical practices for implementing the requirements.
3. Review of State PASRR documentation.
4. Sharing of our findings with States and soliciting their feedback and additional documentation.

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

6.1 Initial Document Collection

For the first National Report, CMS Regional Office (RO) PASRR Coordinators provided PTAC with the following documents:

Preadmission Screens (PAS)

- Level I screening tools for serious mental illness.
- Level I screening tools for intellectual or developmental disabilities or related conditions.
- Level II evaluation and Level II determination requirements or tools for serious mental illness.
- Level II evaluation and Level II determination requirements or tools for intellectual disability or a related condition.

Resident Review (RR)

- Level II Resident Review procedures 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.

6.2 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. A complete evaluation of the individual is not possible without knowing when diagnosed issues have arisen. 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, comment 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 7 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. In many cases, the

comments are excerpts from the State's documentation, indicating where the relevant information was found.

Table 7: Data Elements for NF LOC, Level I, Level II Timing and General Requirements[1] with Example Data

OVERALL TIMING Part I	**CFR**	**Relative to PASRR**	**Level of Severity**	**Document(s)**		**Comments**
Determination of NF LOC	.128(f); .132(a)	Before PASRR	Not captured	PASRR Manual for NF		Unclear whether the Evaluation of Medical Need Criteria (DHS 703) is the LOC form.
Level I	**CFR**	**Relative to Admission**	**Entity Completing**	**Entity Determining Need for Level II**	**Alternative Placement Questions**	**Comments**
Level I evaluation & determination	.112(c)	Before Admission	NF	SMHA and SIDA	No	Level I tool unavailable
OVERALL TIMING - Level II	**CFR**	**Relative to Admission**		**Document(s)**		**Comments**
Level II evaluation & determination	.112	Before Admission		PASRR Manual for NF		
GENERAL REQUIREMENTS - Level II	**CFR**	**Present/Absent**	**Level of Severity**	**Responsible Entity**	**Discipline**	**Comments**
H&P	.132(c)(1)	Present	Captured	SMHA and SIDA	RN	Once the review is completed by the assessor and returned to PASRR 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 the nursing home criteria and deciding the final outcome of the PASRR.
Mental status	.132(c)(2)	Present	Captured	SMHA and SIDA	QMHP or QIDP	
Functional status	.132(c)(3)	Present	Captured	SMHA and SIDA	Not given	

Note: All citations are to 42 CFR Part 483.

[1] A glossary of terms used in this table can be found in Appendix C.

The data elements in Table 8 assess the degree to which States fulfill each of the specific requirements of their MI and ID 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).

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/ID.

Table 8: Data Elements for Level II with Example Data

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

Note: All citations are to 42 CFR Part 483.

The data elements in Table 9 reflect language in States' policies and procedures that demonstrate efforts to transition NF residents or divert NF applicants to the least restrictive appropriate settings. Some of this information may not be contained in the PASRR program data specifically requested from States; it could be included in other State tools or program documents from the State Medicaid agency. As such, it should be noted that a value of "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 9: Diversion and Transition-Related Practices with Example Data

Diversion/Transition Related Requirements or Practices	Keywords/Phrases	CFR (MI; ID)	Documents
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	Not present
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	PASRR Manual for Mental Illness for Nursing Facilities
Transition to community for short term or long term residents who need MH or ID services but not NF	Discharge; regardless of the length of stay	MI: .118(b)(1); .118(b)(2) ID: .118(b)(1); .118(b)(2)	Not present
Info given on State plan services or other HCBS waivers for MH and ID services	Info on receiving services in an alternative appropriate setting	MI: .118(c)(i-iv); ID: .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//IID placements	MI: .120(a)(1); ID: .120(a)(2); .440(a)(1)	PASARR FORM 103 07 REVISION
Recommended services of lesser intensity, MH or ID services while in NF recommended	Recommendations by evaluators regarding what services are needed in NF to help person with MI or ID skill build	MI: .120, .128(h)(i)(4); .128(h)(i)(5) ID: .120; .128(h)(i)(4); .128(h)(i)(5)	Not present
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 that are necessary to implement the requirements. 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 data element was labeled "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.

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 the robustness 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.

6.3 Dissemination of Findings and Incorporation of State Feedback and Additional Documentation

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. Finally, some States provided documents that were revised since 2009. We drafted an additional, updated Fact Sheet for each State that provided feedback or additional

documentation. We assumed that the Fact Sheets for States that did not provide feedback were accurate and complete.

The initial version of this report was disseminated to States in May 2012. States were encouraged to respond to the research team with feedback, to request corrections, or to provide updated documentation. Many States undertook revisions to their PASRR forms and processes as a result of the initial National Review. The 2013 report captures corrections and systems changes States made between May 2012 and February 2013.

7 Appendix B: Additional Findings

Table 10: Percent of States that Met the ID Level II Requirements (Regulatory and Good Clinical Practice) and Percent Change from 2012

Requirement	Keywords and Key Phrases	2013 Absent*	Percent Change Absent 2012-2013	2013 Partial	Percent Change Partial 2012-2013
Need for NF	appropriate placement is NF	2%	**-88%**	4%	**-72%**
Neurological assessment	motor functioning; gait; communication	2%	**-90%**	6%	**-78%**
Externalizing and internalizing behaviors	aggressive; disruptive; inappropriate; depression; anxiety; loneliness	2%	**-91%**	10%	**-66%**
Harm to self or others	suicidal/homicidal ideation	6%	**-82%**	6%	**-67%**
ADLs/IADLs	self-care; self-administration of medication	2%	**-89%**	10%	**-72%**
ADLs/IADLs in community	assessment of ability to perform ADLs in the community	4%	**-84%**	10%	**-66%**
Intellectual functioning	estimated IQ level (ID, low average, average, high average)	6%	**-80%**	10%	**-68%**
Psychosocial evaluation	current living arrangements; medical and support systems	4%	**-84%**	18%	**-43%**
Medication review	current medications; allergies; side effects	8%	**-67%**	24%	**-40%**
Medical history	diagnosis(es); onset date(s)	2%	**-84%**	31%	**-47%**

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

Table 11: Percent of States that Met the MI Level II Requirements (Regulatory and Good Clinical Practice) and Percent Change from 2012

Requirement		2013 Absent*	Percent Change Absent 2012-2013	2013 Partial	Percent Change Partial 2012-2013
	Keywords and Key Phrases				
Harm to self or others (intentional or unintentional)	suicidal/homicidal ideation	0%	**-100%**	2%	**-89%**
Reality testing	delusions and hallucinations	4%	**-51%**	0%	**-100%**
Cognitive functioning	memory; concentration; orientation; cognitive deficits	4%	**+96%**	0%	**-100%**
Need for NF	appropriate placement is NF	2%	**-88%**	4%	**-72%**
Externalizing and internalizing behaviors	aggressive; disruptive; inappropriate; depression; anxiety; loneliness	0%	**N/A**	8%	**-78%**
Need for NF	appropriate placement is other setting	6%	**-78%**	2%	**-84%**
Neurological assessment	motor functioning; gait; communication	4%	**-35%**	6%	**-82%**
ADLs/IADLs in community	assessment of ability to perform ADLs in the community	6%	**-63%**	4%	**-89%**
ADLs/IADLs	self-care; self-administration of medication	2%	**-84%**	10%	**-66%**
Psychosocial evaluation	current living arrangements; medical and support systems	2%	**-67%**	12%	**-56%**
Support systems	level of support needed to perform activities in the community	10%	**-75%**	12%	**-47%**
Intellectual functioning	estimated IQ level (ID, low average, average, high average)	4%	**-75%**	18%	**-65%**
Medication review	current medications; allergies; side effects	0%	**-100%**	24%	**-64%**
Medical history	diagnosis(es); onset date(s)	0%	**-100%**	27%	**-56%**

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

8 Appendix C: Glossary

Activities of Daily Living (ADLs): daily, fundamental self-care activities assessed through PASRR used to measure an individual's functional status.

Alternative Placement Questions: questions or fields in a Level I screen that inform whether an individual can be better served in a setting other than the one to which he or she applied. For this element, reviewers chose between yes, see comments, and no.

History and Physical (H&P): evaluation of an individual's physical status, including diagnoses, date of onset, medical history, and prognosis.

Home and Community-Based Services (HCBS): services provided to Medicaid beneficiaries in their own home or community.

Instrumental Activities of Daily Living (IADLs): daily self-care activities assessed through PASRR used to measure an individual's functional status.

Level of Severity: an indication of an individual's 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.

Nursing Facility Level of Care (NF LOC): criteria for determining Medicaid reimbursement of nursing facility services as well as home and community-based services (HCBS) offered as an alternative to people who would otherwise qualify to receive nursing facility care.

Olmstead: 1999 Supreme Court decision that holds that the Americans with Disabilities Act (ADA) applies 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.

Qualified Intellectual Disability Professional (QIDP): professional designated by the State as qualified to oversee and approve medical findings related to individuals' intellectual disability status.

Qualified Mental Health Professional (QMHP): professional designated by the State as qualified to oversee and approve medical findings related to individuals' mental health status.

Registered Nurse (RN): a fully trained nurse with an official certificate of competence.

Relative to PASRR: 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 PASRR, after PASRR, concurrent with PASRR, and not given.

Relative to Admission: 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.

State Intellectual Disability Authority (SIDA): State-level entity responsible for evaluation and determination functions for individuals with intellectual disability.

State Mental Health Authority (SMHA): State-level entity responsible for determination function for individuals with mental illness.