DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Waldrep	5-11-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 101435	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Singleton, Deps, CMS file Cleared 8/7/12, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 8-31-12 [ ] FOIA DATE DUE _____ Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			Per Teeshia... need a response date. Due date 8/31/12. See attached e-mail response
2.			
3.			
4.			

Availability of Technical Assistance

CMS is working to improve PASRR nationally through increased technical assistance and oversight. In addition to consultation available from this office and CMS Central Office we have developed a robust PASRR Technical Assistance Center (PTAC). This Center offers consultation ranging from answering technical inquiries to in-person meetings with multiple state agencies for restructuring a state's overall PASRR program design and operation. A major focus of this effort is to assist states in satisfying the federal PASRR requirements in a way that is also highly effective — PASRR systems that are person-centered, emphasize community alternatives, expand treatment options, assist facilities with planning care, connect with other LTC systems including Olmstead planning, and return important information to state agencies.

CMS Collaborative Activities

PASRR is complex, but by interpreting Federal requirements in the context of each State's agency structures and long term care policies and practices, we have been able to identify flexibilities and effective practices that have been very useful to States. Several agencies within the Department of Health and Human Services are taking an interest in and supporting PASRR. We are working with the Substance Abuse and Mental Health Services Administration (SAMHSA) to determine how we can jointly support state PASRR programs, particularly the state mental health authority role. The Administration on Developmental Disabilities is our partner in working with the state DD entities and stakeholders. CMS works with the Office of Civil Rights (OCR) to promote the integration of state PASRR programs in Olmstead planning and compliance efforts. The Administration on Aging (AoA) provides grants to States to operate Long-Term Care Ombudsman Programs, which work at the state and local levels to support the interests of residents, including their interests related to the PASRR process. Finally, the Office on Disability is focused on the opportunity PASRR presents for individualized, person-centered planning for long term care.

Our collaborative approach with States to make PASRR more effective will have the effect of reducing risks to State agencies and nursing facilities. States should be aware that failure to comply with PASRR requirements has been a significant element in recent Olmstead-related litigation. Further, when PASRR is not properly implemented, States may be liable to refund federal financial participation in payments made to nursing facilities for any days of service provided to a resident prior to completion of required PASRR documentation. CMS supports good faith efforts by states to remedy deficiencies in their PASRR programs, and intends to work with states to minimize these risks.

Next Steps

Please jointly review the enclosed documents, assess your state PASRR program (making use of any federal technical assistance you may require, as above), and respond through the state Medicaid Agency to me at the Regional Office with your conclusions about what South Carolina needs to do to bring the PASRR program up to standards and to be more effective. If you find that the report does not accurately reflect your current practice, please provide us with updated program information. If you require more than 60 days to respond, please let us know. We

recognize that coordinating a response among multiple state agencies may be challenging, and we or the PTAC would be happy to arrange a joint telephone conference if that would be helpful A tool that many states have found useful for interagency assessment of PASRR activities is the PASRR Self Assessment for States. This document restates the federal requirements in a programmatic order, with some discussion of policy issues and common trouble points. The self assessment and other resources are available at the PTAC website, www.pasrrassist.org.

You may also wish to review the degree to which South Carolina is obtaining the full 75% FMAP available for PASRR activities. Properly allocated expenditures, by all state authorities and delegated entities involved in administering the PASRR program, should be claimed on lines 10 (for Preadmission Screening) and line 11 (for Resident Review) to obtain the enhanced match. We believe that many states are not fully availing themselves of this opportunity, and that doing so may provide resources for PASRR program improvement.

In the future, CMS intends to periodically update the individual state fact sheets and the national report of PASRR program design. We welcome any updated and revised materials you can provide. Please send these materials to Maria Drake at the Regional Office. CMS is also developing a model for quality oversight of PASRR. This tool should assist states in meeting their statutory and regulatory responsibilities and in holding state Medicaid agencies accountable for ensuring compliance with Federal PASRR requirements.

These actions comport with the increased CMS oversight of PASRR program implementation and effectiveness that was outlined in our response to the 2007 OIG PASRR reports.

For additional information and to request technical assistance you may reach your CMS Regional Office contact Maria Drake at 404-562-3697 or Dan Timmel in the CMS Central Office at 410-786-8518.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Mr. John H. Magill, Director
Dr. Beverly A. H. Buscemi, Director

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Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

May 3, 2012

Mr. Anthony E. Keck, Director
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, South Carolina 29201

Re: Preadmission Screening and Resident Review (PASRR)

Dear Mr. Keck:

This letter is addressed to the state agencies that have statutory responsibility for the Preadmission Screening and Resident Review (PASRR) program in South Carolina. PASRR charges states with preventing inappropriate institutional placements and protecting the interests of vulnerable individuals with serious mental illness or intellectual disability who reside in or apply for admission to Medicaid-certified nursing facilities.

Enclosed are two documents, a fact sheet reviewing your state PASRR program design, and a summary report of all state PASRR programs nationally. The national report includes a description of PASRR requirements. In this review, South Carolina demonstrated PASRR program policies and procedures that meet some but not all federal requirements and standard good practices. CMS provides South Carolina state agencies with this information so that you can jointly revisit your state PASRR process, note areas of strengths and deficits, develop strategies to strengthen your systems, and clarify your program policies and procedures. We wish to hear more about your program strengths. Our PASRR Technical Assistance Center (PTAC) seeks to learn about your effective strategies in order to provide the best practical assistance to other states.

National and State PASRR Reports

The enclosed reports present the first documentation of PASRR program designs in all States and the District of Columbia. Under contract from CMS, Mission Analytics Group, Inc. reviewed State policies and procedures on file in CMS Regional Offices, as well as public information, including state regulations and published policy documents. States were offered a draft fact sheet and given opportunity to update and correct the information. The results of this review represent a snapshot of PASRR systems design at a point in time, and the results capture program design only, not any information on program implementation or performance. In addition, this review evaluates the design as compared to the PASRR requirements specified in the Social Security Act and the corresponding regulations, and does not address the Americans with Disabilities Act or other statutory requirements that may be relevant to the State's service system for individuals with disabilities. The national report confirms earlier findings in 2001 and 2007 by the HHS Office of Inspector General, and others, that state PASRR programs vary in adequacy and effectiveness.

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Enclosures

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Substance Abuse and Mental Health Services Administration (SAMHSA)
Administration on Developmental Disabilities
Administration on Aging (AoA)
HHS Office on Disability
HHS Office of Civil Rights (OCR)
The National Association of Medicaid Directors (NAMD)
The National Association of State Directors of Developmental Disabilities Services (NASDDDS)
The National Association of State Mental Health Program Directors (NASMHPD)

Electronic copy:
Vicki McGahee
Susie Boykin
Brian Hawkins
Nicole Mitchell Threatt

[1] (http://oig.hhs.gov/oei/reports/oei-05-05-00220.pdf and http://oig.hhs.gov/oei-07-05-00230.pdf)

PASRR Process State Fact Sheet: South Carolina

August 15, 2011

The Centers for Medicare and Medicaid Services (CMS) is undertaking an effort to understand how different states design their Preadmission Screening and Resident Review (PASRR) processes, policies, and procedures. This report is a product of the PASRR Technical Assistance Center (PTAC), which is staffed by Mission Analytics Group and other external consultants.

CMS and PTAC have recently reviewed the processes and tools used in each state to identify persons with mental illness (MI) and/or mental retardation and related conditions (MR) who could be diverted or transitioned from nursing facilities. This review, and the report below, should help guide your state to better understand the strengths and weaknesses of its PASRR process and tools and to think about strategies for improving these systems. Ultimately, and in accordance with their intent to reduce the institutional bias in Medicaid long-term care, CMS seeks to ensure that:

- all individuals applying to nursing facilities are evaluated for MI and MR,
- that these individuals are placed in the most appropriate setting according to these evaluations, and
- that these individuals receive the services they need.

Through this review, we aimed to capture and present information as accurately as possible. However, we recognize that we may have misinterpreted your PASRR process or the content of the tools. Therefore, please read your State Fact Sheet carefully and clarify any misconceptions by emailing Ed Kako, ekako@mission-ag.com.

Please note that our use of the terms "mental illness" and "mental retardation" is a strict reflection of the language used in the current Code of Federal Regulations (CFR) regarding PASRR.

Objective

This review is an invitation for you to revisit your PASRR process and identify areas for improvement. Primarily, we aim to determine whether your state meets the Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals requirements detailed in the Code of Federal Regulations (42 CFR 483.100 – 42 CFR 483.138). However, the review is not meant to only address regulation compliance. We also assess whether your state's PASRR process reflects recent developments in clinical practice, which may not be captured in the regulation. For example, although the CFR does not require onset dates of medical diagnoses, good clinical practice entails collecting and using these data in assessments.

The Fact Sheet is a living document. As your state revisits and updates its PASRR system, adopting new tools and streamlining processes, we will incorporate these changes in the assessment and Fact Sheet.

Methodology

Your state's PASRR process was reviewed based on the documentation you provided to your Regional Office PASRR Coordinator. Your state's documentation was reviewed independently by two reviewers working for the PASRR Technical Assistance Center (PTAC); any discrepancies between the two reviews were subsequently reconciled. The review focused on your state's general PASRR process as well as several specific requirements within the process. All reviews attempted to capture the *intent* of the provided documentation, not merely the exact words written on the page. In addition, we focused the review on *current* processes. If your state updates its process, please let us know so we can conduct a new assessment.

We made attempts to collect additional documentation from your state if we discovered that crucial information was missing from your inventory. Attempts to collect additional information included Internet searches and communication with your Regional Office PASRR Coordinator to request or clarify documentation provided. After two weeks, we resumed the review process with or without this information.

Using the CFR and good clinical practice as a basis, the reviewers identified data elements that should be recorded during the PASRR process. The values of these data elements were captured in the tables that follow (see Tables 1 through 4). Where necessary, the reviewers separated these data elements into the categories of mental illness and mental retardation. The degree to which your state fulfills each of the specific requirements of the Level II tool(s) was captured at one of three levels: comprehensive, absent, or partial (see Table 3). Your state's ability to meet a requirement was considered "comprehensive" if the documentation addressed all of the necessary elements of the relevant paragraph of the CFR, in addition to certain good clinical practices. Your state's ability to meet a requirement was considered "absent" if the documentation failed to address any of the necessary elements of the relevant paragraph of the CFR. Your state's ability to meet a requirement was considered "partial" if the documentation did not address 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 the documentation left room for a free response answer related to a data element (i.e. if questions on a Level II PASRR screening tool left room for an open ended answer). Finally, a requirement was also considered "partial" if the documentation solicited, but did not provide, additional documentation related to a data element.

Findings about your State

This section details the findings from the review of the documentation provided by your state. All reviews attempted to capture the intent of the provided documentation. A description of the data elements and possible values in the tables below can be found at the end of this section.

Tables 1 and 2 below reflect the timing and general requirements of the PASRR process in your state. Specifically, Table 1 aims to capture the sequence of events beginning at the determination of nursing facility level of care (NF LOC) through determinations made for Level II review(s). The table also captures critical elements of the NF LOC and Level I tools and processes as well as the requirements of agencies and persons at various stages of the process. Table 2 captures any comments the reviewer would like to convey to the state about the timing and requirements of the NF LOC, Level I and Level II assessments. In many cases, the comment is a section of the state's documentation, indicating from where the reviewer obtained the relevant information.

Table 1: NF LOC, Level I, and Level II Timing and General Requirements

OVERALL TIMING Part I	CFR
Determination of NF LOC	128(f); 132(a)
Level I	**CFR**
Level I evaluation & determination	112(c)
OVERALL TIMING - Level II	**CFR**
Level II evaluation & determination	112
GENERAL REQUIREMENTS - Level II	**CFR**
H&P	132(c)(1)
Mental status	132(c)(2)
Functional status	132(c)(3)

Relative to PASRR	Level of Severity	Document(s)	
Before Admission	Captured	DDHS Form 185	
Relative to Admission	**Entity Completing**	**Entity Determining Need for Level II**	**Alternative Placement Questions**
Before Admission	NF or Hospital	SMHA and SMRA	No
Relative to Admission		**Document(s)**	
Before Admission		Mental Health Authority Determination Form and Mental Retardation Authority Determination Form	
Present/Absent	**Level of Severity**	**Responsible Entity**	**Discipline**
Present	Captured	Both SMHA & SMRA	See Comments
Present	Captured	Both SMHA & SMRA	See Comments
Present	Captured	Both SMHA & SMRA	See Comments

Table 2: Comments Regarding NF LOC, Level I, and Level II Timing and General Requirements

OVERALL TIMING Part I	CFR	Comments
Determination of NF LOC	128(f); 132(a)	According to Medicaid criteria, you meet the medical requirements to receive long-term care at the following level: Skilled or Intermediate.
Level I	**CFR**	**Comments**
Level I evaluation & determination	112(c)	There are no alternative placement questions on Level I but LOC determination instrument has the option of applying for a number of waivers.
OVERALL TIMING - Level II	**CFR**	**Comments**
Level II evaluation & determination	112	Level II MI and MR tools state it must be completed for those seeking NF admission.
GENERAL REQUIREMENTS - Level II	**CFR**	**Comments**
H&P	132(c)(1)	Physician and/or Psychologist/Psychiatrist
Mental status	132(c)(2)	As above
Functional status	132(c)(3)	As above

Table 3 below reflects the degree to which your state fulfills specific requirements detailed in the CFR and requirements related to more recent good clinical practices. The levels of detail below are specific to the PASRR Level II tool(s) provided by your state for mental illness and mental retardation. Requirements of the Level II tool(s) are significant as they represent a core component of the PASRR process. Keywords/phrases in *italics* were directly taken from the CFR. If the keyword/phrase is not in italics, the collection of these data is considered good clinical practice and not necessarily a requirement of the regulation.

Table 3: State PASRR Level II Checklist

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)	Partial
		MR: 136(b)(1)	Partial
Neurological assessment	*motor functioning; gait; communication*	MI: 134(b)(1)(iii)	Partial
		MR: 136(b)(8)(9)	Partial
Medication review	*current medications; allergies; side effects*	MI: 134(b)(2)	Partial
		MR: 136(b)(3)	Partial
Medical Status			
Externalizing and internalizing behaviors	aggressive; disruptive; inappropriate; depression; anxiety; loneliness	MI: 134(b)(4)	Comprehensive
		MR: 136(b)(15)	Comprehensive
Harm to self or others (intentional or unintentional)	*suicidal/homicidal ideation*	MI: 134(b)(4)	Comprehensive
	self-injurious behaviors	MR: 136(b)(15)	Absent
Intellectual functioning	estimated IQ level (MR, low average, average, high average)	MI: 134(b)(4)	Absent
	MR range (mild, moderate, severe, profound)	MR: 136(c)(1)	Absent
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)	Comprehensive
		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)	Comprehensive
ADLs/IADLs in community	*assessment of ability to perform ADLs in the community*	MI: 128 (f), 134 (5)	Comprehensive
		MR:136(4)-136(7)	Comprehensive
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	Absent
	appropriate placement is other setting	MI: 134(b)(5)	Absent

CMS would like to see language in your policies and procedures that demonstrates the importance your state places on transitioning patients into the least restrictive, appropriate care settings. Table 4 below reflects any information in the documentation provided by your state that relates to nursing facility diversion and transition requirements or practices. Because we did not specifically request this type of information, we are aware that a "Not Present" does not necessarily reflect the content of all of your state's related documentation.

Table 4: Diversion and Transition Related Requirements or Practices

Diversion/Transition Related Requirements or Practices	Keywords/Phrases	CFR (MI,MR)	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	Level of Care Certification Letter document
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) 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) 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) 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) 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

In the tables above, data elements and values should be interpreted to mean the following:

- "CFR" is the Code of Federal Regulations. Values in this column represent the Sections of the regulation within which the data element is based. Some are noted as pertinent to the screening process for mental illness "MI" and others for the screening process for mental retardation "MR."
- "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. Reviewers chose among "before admission," "after admission," and answer "not given" for this element.
- "Level of Severity" refers to whether the provided documentation asks about a range (i.e. low, medium, high) of need for nursing facility care or a range of disability (ability) for history and physical, mental status, and functional status. Reviewers chose between "not captured" and "captured" for these elements.
- "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. Reviewers chose among "before admission," "after admission," and "not given" for these elements.

Points for Consideration

- Your state's documentation is well organized. This makes it easy to understand your state's PASRR process and could lay the groundwork for straightforward implementation.
- The review of your state's Level II documentation some comprehensive detail. Data elements that were not considered comprehensive were understood to be partial.
- The review of your state documentation revealed an impressive amount of comprehensive detail, however:
    - Questions pertaining to intellectual functioning and the appropriateness for nursing facility placement or other setting are absent from your state's Level II MI and MR forms. Additionally, questions pertaining to self-injurious behaviors are absent from the Level II MR tool.
    - Questions pertaining to medical history, psychological assessment and medication are only partially covered in your state's Level MI and MR II forms. Additionally, questions regarding support systems needed in the community to perform ADLs are partially covered in the MI tool.

Recommendations

- Consider including data elements within your state's Level II MI and MR forms that satisfy the federal requirement and good clinical practice for an evaluation of intellectual functioning (42 CFR 483.134(b)(4)) and appropriateness for nursing facility placement or other setting (42CFR 483.126 and 134(b)(5).
- Consider adding further data elements within your state's Level II MI and MR forms that satisfy the federal requirement and good clinical practice for a complete medical history (42 CFR 483.134(b)(1)(i) and 136(b)(1), psychological assessment (42 CFR 483.

134(b)(1)(iii) and 36(b)(7)(8) and medication review (42 CFR 483.134(b)(2) and 136(b)(10)).

- Include additional information regarding support systems needed to perform ADLs in the community (42 CFR 483.134(b)(5) in your Level II MI tool.
- Complete the PASRR self-assessment tool. You can access the tool on the PTAC website: http://pasrrassist.org/resources/pasrr-self-assessment"
- Contact your Regional Office Coordinator for more information about your state's review.
- Visit the PASRR Technical Assistance Center (PTAC) at www.PASRRassist.org to help answer any outstanding questions you may have or to request an on-site visit from their team of consultants.
- Please feel free to reach out to us if you have any questions about this report or the review process. You can contact Ed Kako, the Director of PTAC, at ekako@mission-ag.com.

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

May 1, 2012

A joint partnership of

Thomson Reuters Healthcare and

Mission Analytics Group, Inc.

Prepared for the Centers for Medicare and Medicaid Services

ACKNOWLEDGEMENTS

We thank Suman King for her help early in this project in thinking about the compliance framework with an eye toward sound clinical judgment, and Dee O'Connor and Jenn Ingle for proposing many of the data elements related to diversion and transition. We thank Ellie Coombs and Jenn Ingle for their tireless assistance in coding state policies and procedures documents.

We also thank our project team at CMS, Mindy Morrell, Angela Taube, and Dan Timmel for their expert guidance on this project and their careful reading of many drafts.

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

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) MR: .136(b)(1)	Comprehensive Comprehensive
Neurological assessment	*motor functioning; gait; communication*	MI: .134(b)(1)(iii) MR: .136(b)(8)(9)	Absent Partial
Medication review	*current medications;* allergies; side effects	MI: .134(b)(2) MR: .136(b)(3)	Comprehensive Comprehensive
Medical Status			
Externalizing and internalizing behaviors	aggressive; disruptive; inappropriate; depression; anxiety; loneliness	MI: .134(b)(4) MR: .136(b)(15)	Partial Comprehensive
Harm to self or others (intentional or unintentional)	*suicidal/homicidal ideation* self-injurious behaviors	MI: .134(b)(4) MR: .136(b)(15)	Partial Partial
Intellectual functioning	estimated IQ level (MR, low average, average, high average) MR range (mild, moderate, severe, profound)	MI: .134(b)(4) MR: .136(c)(1)	Partial 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) MR: .136(b)(10)	Partial Comprehensive
Functional Status			
ADLs/IADLs	*self-care; self-administration of medication*	MI: .134(b)(5)(6) MR: .136(4)-.136(7), .136(12)	Comprehensive Absent
ADLs/IADLs in community	*assessment of ability to perform ADLs in the community*	MI: .128 (f), .134 (5) MR: .136(4)-.136(7)	Partial 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* *appropriate placement is other setting*	GENERAL: .126 MI: .134(b)(5)	Comprehensive 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) 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) 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) 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) 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.

Brenda James

Log # 435

From: Sam waldrep
Sent: Wednesday, June 27, 2012 12:22 PM
To: Teeshla Curtis; Brenda James
Cc: Richard Kluender; Brenda Hyleman; Nicole Mitchell Threatt
Subject: FW: PASRR Process State Fact Sheet: SC

Can you extend the due date on the CMS log letter that was dated around the first of May? It was concerning PASRR and should have been assigned to Brenda/Nicole. CMS has granted a 30-day extension.

From: Maria (CMS/CMCHO) Drake [mailto:Maria.Drake@cms.hhs.gov]
Sent: Tuesday, June 26, 2012 11:25 AM
To: Mason Smith; Nicole Mitchell Threatt; Sam waldrep
Cc: Brenda Hyleman
Subject: RE: PASRR Process State Fact Sheet: SC

Sam--Thank you for your e-mail requesting a 30 day extension. We grant your request for a 30 day extension until August 6, 2012.

On another note --will staff be attending the training on PASRR in the Atlanta Regional Office on August 2-3, 2012?

Thanks,
Maria

From: Sam waldrep [mailto:Waldrep@scdhhs.gov]
Sent: Monday, June 25, 2012 9:07 AM
To: Nicole Mitchell Threatt; Mason Smith; Drake, Maria (CMS/CMCHO)
Cc: Brenda Hyleman
Subject: RE: PASRR Process State Fact Sheet: SC

Maria- we will need a 30-day extension to respond to the report. That will give us time to digest the information from the call.

Thanks for your consideration.

Sam

From: Nicole Mitchell Threatt
Sent: Sunday, June 24, 2012 10:06 AM
To: Mason Smith; maria.drake@cms.hhs.gov
Cc: bhawkins@ddsn.sc.gov; Elizabeth Coombs; Ed Kako; Susie Boykin; llb44@scdmh.org; Sam waldrep
Subject: RE: PASRR Process State Fact Sheet: SC

Sounds like a plan. Thanks.

From: Mason Smith [mailto:msmith@mission-ag.com]
Sent: Friday, June 22, 2012 7:06 PM
To: maria.drake@cms.hhs.gov; Nicole Mitchell Threatt
Cc: bhawkins@ddsn.sc.gov; Elizabeth Coombs; Ed Kako; Susie Boykin; llb44@scdmh.org
Subject: Re: PASRR Process State Fact Sheet: SC

Hi Nicole,

Thanks for your note. I'm out of the office today and away from my and my team members' calendars. I'll send you our availability after I get back to the office on Monday, but for the meantime we won't plan to meet on Monday at the originally scheduled time.

Speak to you soon,
Mason

Sent from my Verizon Wireless Phone

----- Reply message -----
From: "Nicole Mitchell Threatt" <mitcheln@scdhhs.gov>
Date: Fri, Jun 22, 2012 12:26 pm
Subject: PASRR Process State Fact Sheet: SC
To: "Mason Smith" <msmith@mission-ag.com>, "Maria (CMS/CMCHO)(Maria.Drake@cms.hhs.gov) Drake" <Maria.Drake@cms.hhs.gov>
Cc: "Elizabeth Coombs" <ecoombs@mission-ag.com>, "Ed Kako" <ekako@mission-ag.com>, "llb44@scdmh.org" <llb44@scdmh.org>, "bhawkins@ddsn.sc.gov" <bhawkins@ddsn.sc.gov>, "Susie Boykin" <Boykin@scdhhs.gov>

Good afternoon. I would like to reschedule our conference call scheduled for Monday, June 25 at 1:00 p.m. EST. Mason, can you please suggest other dates. Or, will Thursday, June 28 (1pm-2pm EST) work for the group? Thank you.

Nicole Mitchell Threatt

From: Nicole Mitchell Threatt
Sent: Thursday, May 31, 2012 4:04 PM
To: 'Mason Smith'; Maria (CMS/CMCHO)(Maria.Drake@cms.hhs.gov) Drake
Cc: Elizabeth Coombs; Ed Kako; llb44@scdmh.org; bhawkins@ddsn.sc.gov; Susie Boykin
Subject: RE: PASRR Process State Fact Sheet: SC

Thanks for your prompt response. We will aim for Monday, June 25 at 1:00 PM. We look forward to the call. Conference call info listed below.

Link to a few of our PASRR related forms. Some forms will be revised:
http://www.scdhhs.gov/internet/pdf/manuals/Nursing/Forms.pdf
Select from the list of forms: Form Numbers 247, 248, 249, 250, 234.

Have a great weekend.
****

IT Services & Support has invited you to a Cisco Meeting Place Meeting.

Date/Time: June 25, 2012 at 01:00 PM America/New_York
Length: 120 (minutes)
Frequency: once

Meeting ID: 323786

Phone Number: 8038969993

Number of ports: 10

USE OF THE TELECONFERENCING BRIDGE DURING AN EMERGENCY EVENT

During an emergency event such as a natural disaster, pandemic influenza, violent incident, terrorist act or even during a preparedness training exercise, the South Carolina Budget and Control Board reserves the right to maintain and regulate all ports on the teleconferencing bridge for an undetermined period of time or until the emergency concludes. For the duration of the emergency event, there is the possibility that your conference call could be rescheduled or canceled. The goal of these actions is to protect the lives and properties of the residents of the State of South Carolina.

DIRECTIONS FOR JOINING A MEETING

The following directions are necessary for the successful completion of your requested conference call reservation. Prior to joining a meeting, please forward this document to all conference call participants. Each participant joining the call will dial 803-896-9993 and enter the meeting id number (access code). Please contact the Service Center at 803-896-0001 if you experience any difficulties or have questions regarding the conference bridge.

1.Dial the following conference bridge number 803-896-9993 to join a meeting.
2.The conference bridge will state the following: "Welcome to Meeting Place".
3.To attend a meeting, please press "1".
4.The conference bridge will state the following: "enter the meeting id number followed by the # key."
5.Enter the "meeting id number" followed by the # key.
6.The conference bridge will state the following: "you are about to attend the meeting with the iD number (xxxxx).
7.If the "meeting id number" is correct, please press "1"; otherwise press the * key.
8.The conference bridge will state the following: "at the tone please speak your name or location."
9.When finished, please press the # key.
10.You will hear an audible tone, notifying you that you have successfully entered the meeting.

CALLING CARD PROCEDURES

CALLING INTO THE CONFERENCE BRIDGE

1.Dial calling card telephone number 1-800-294-2322.
2.Enter your calling card access number (located on the back of the calling card).
3.Join the conference call by dialing the audio bridge telephone number (803-896-9993).
4.Enter the access code that has been assigned to your conference call (six digit code).
5.If you are the first person to join the conference call you will not hear an audible tone, do not hang up.
6.Please identify yourself when you join the conference call.

ADDING PARTICIPANTS TO A CONFERENCE CALL

1.Dial calling card telephone number 1-800-294-2322.
2.Enter your calling card access number (located on the back of the calling card).
3.Dial telephone number of participant.
4.Once participant is on the line, press the transfer button and dial the conference number (803-896- 9993) and follow the prompts. Press the transfer button again.
5.Repeat the instructions above until all the participants are connected to the call.

TIPS FOR THE MOST SUCCESSFUL CALLING CONDITIONS

--To stop the music press the * key.

--Move the speakerphone as close as possible to the speaker so it will pick up less background noise.

--Mute the phone if your site is not actively participating in the meeting. Turn the mute function off when someone has a question or comment.

--Save side conversations for after the meeting. Even if they are work related they distract from the speaker and other participants.

--Don't tap pens or shuffle papers. These noises sound louder at remote locations than in your meeting room.

--If it won't make the room too uncomfortable, turn off fans and air conditioning as they sound louder through a speakerphone.

--Shut meeting room doors to keep out background noise from your workplace.

--Only one person at a time should speak.

--Limit the use of a secondary conference phone altogether when practical.

--Use LAN lines rather than mobile phones.

--Please identify yourself when you join the conference call.

You can check the status of this maintenance and in addition hear about any other network outage or disruption in service by calling (803) 734-INFO (4636).

If you have any questions or comments relating to this notification, please contact Information Technology Services and Support at (803) 896-0001, or reply to this email.

Thank you,

Information Technology Services and Support
Division of the State Chief Information Officer
SC Budget and Control Board
Columbia, South Carolina 29210
Email: ciohelpdesk@cio.sc.gov
Phone: (803) 896-0001
Fax: (803) 896-0092

Network Status Line (803) 734-INFO (734-4636) State Online Telephone Directory: www.state.sc.us/directory

From: Mason Smith [mailto:msmith@mission-ag.com]
Sent: Thursday, May 31, 2012 1:51 PM
To: Maria (CMS/CMCHO)(Maria.Drake@cms.hhs.gov) Drake; Nicole Mitchell Threatt
Cc: Elizabeth Coombs; Ed Kako
Subject: PASRR Process State Fact Sheet: SC

Hi Nicole,

I am writing on behalf of Ed Kako from the PASRR Technical Assistance Center (PTAC) to schedule a conference call with you. First, thank you for your interest in your state Fact Sheet and your continued commitment to PASRR in South Carolina.

On our end we are available at the following times. Note that we are in California, though all times below are listed in Eastern time.

Monday, June 18: 1PM-5PM Eastern
Tuesday, June 19: 2PM-5PM Eastern
Wednesday, June 20: 12PM-3PM Eastern, 4PM-5PM Eastern
Thursday, June 21: 3PM-5PM Eastern

Monday, June 25: 1PM-5PM Eastern
Tuesday, June 26: 12PM- 4PM Eastern
Wednesday, June 27: 12PM-5PM Eastern
Thursday, June 28: 12PM-5PM Eastern
Friday, June 29: 4PM-5PM Eastern

Please let me know which one hour window of the above times works best on your end. I am copying my colleague Elizabeth Coombs on this message as I will be out of the office beginning tomorrow and through Friday June 8 – Elizabeth can follow up on scheduling if necessary.

Thanks!
Mason

From: Nicole Mitchell Threatt [mailto:mitchelN@scdhhs.gov]
Sent: Thursday, May 31, 2012 9:33 AM
To: Ed Kako; Maria.Drake@cms.hhs.gov
Subject: PASRR Process State Fact Sheet: SC

Good afternoon!

I would like to schedule a conference call with you (designees) to discuss South Carolina's PASRR Process State Fact Sheet. We are working on our response.
Please e-mail me suggested dates and times for the weeks of June 18 and 25.

Thank you,
Nicole Mitchell-Threatt
SC Department of Health and Human Services

Confidentiality Note

This message is intended for the use of the person or entity to which it is addressed and may contain information, including health information, that is privileged, confidential, and the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED.

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If you have received this in error, please notify us immediately and destroy the related message.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Waldrep	5-11-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10435	[X] Prepare reply for the Director's signature DATE DUE 8-31-12
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Singleton, Deps, CMS file	[ ] Prepare reply for appropriate signature DATE DUE [ ] FOIA DATE DUE Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer)	COMMENT
1.			
2.			
3.			
4.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

May 3, 2012

Mr. Anthony E. Keck, Director
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, South Carolina 29201

Re: Preadmission Screening and Resident Review (PASRR)

Dear Mr. Keck:

This letter is addressed to the state agencies that have statutory responsibility for the Preadmission Screening and Resident Review (PASRR) program in South Carolina. PASRR charges states with preventing inappropriate institutional placements and protecting the interests of vulnerable individuals with serious mental illness or intellectual disability who reside in or apply for admission to Medicaid-certified nursing facilities.

Enclosed are two documents, a fact sheet reviewing your state PASRR program design, and a summary report of all state PASRR programs nationally. The national report includes a description of PASRR requirements. In this review, South Carolina demonstrated PASRR program policies and procedures that meet some but not all federal requirements and standard good practices. CMS provides South Carolina state agencies with this information so that you can jointly revisit your state PASRR process, note areas of strengths and deficits, develop strategies to strengthen your systems, and clarify your program policies and procedures. We wish to hear more about your program strengths. Our PASRR Technical Assistance Center (PTAC) seeks to learn about your effective strategies in order to provide the best practical assistance to other states.

National and State PASRR Reports

The enclosed reports present the first documentation of PASRR program designs in all States and the District of Columbia. Under contract from CMS, Mission Analytics Group, Inc. reviewed State policies and procedures on file in CMS Regional Offices, as well as public information, including state regulations and published policy documents. States were offered a draft fact sheet and given opportunity to update and correct the information. The results of this review represent a snapshot of PASRR systems design at a point in time, and the results capture program design only, not any information on program implementation or performance. In addition, this review evaluates the design as compared to the PASRR requirements specified in the Social Security Act and the corresponding regulations, and does not address the Americans with Disabilities Act or other statutory requirements that may be relevant to the State's service system for individuals with disabilities. The national report confirms earlier findings in 2001 and 2007 by the HHS Office of Inspector General, and others, that state PASRR programs vary in adequacy and effectiveness.

Availability of Technical Assistance

CMS is working to improve PASRR nationally through increased technical assistance and oversight. In addition to consultation available from this office and CMS Central Office we have developed a robust PASRR Technical Assistance Center (PTAC). This Center offers consultation ranging from answering technical inquiries to in-person meetings with multiple state agencies for restructuring a state's overall PASRR program design and operation. A major focus of this effort is to assist states in satisfying the federal PASRR requirements in a way that is also highly effective — PASRR systems that are person-centered, emphasize community alternatives, expand treatment options, assist facilities with planning care, connect with other LTC systems including Olmstead planning, and return important information to state agencies.

CMS Collaborative Activities

PASRR is complex, but by interpreting Federal requirements in the context of each State's agency structures and long term care policies and practices, we have been able to identify flexibilities and effective practices that have been very useful to States. Several agencies within the Department of Health and Human Services are taking an interest in and supporting PASRR. We are working with the Substance Abuse and Mental Health Services Administration (SAMHSA) to determine how we can jointly support state PASRR programs, particularly the state mental health authority role. The Administration on Developmental Disabilities is our partner in working with the state DD entities and stakeholders. CMS works with the Office of Civil Rights (OCR) to promote the integration of state PASRR programs in Olmstead planning and compliance efforts. The Administration on Aging (AoA) provides grants to States to operate Long-Term Care Ombudsman Programs, which work at the state and local levels to support the interests of residents, including their interests related to the PASRR process. Finally, the Office on Disability is focused on the opportunity PASRR presents for individualized, person-centered planning for long term care.

Our collaborative approach with States to make PASRR more effective will have the effect of reducing risks to State agencies and nursing facilities. States should be aware that failure to comply with PASRR requirements has been a significant element in recent Olmstead-related litigation. Further, when PASRR is not properly implemented, States may be liable to refund federal financial participation in payments made to nursing facilities for any days of service provided to a resident prior to completion of required PASRR documentation. CMS supports good faith efforts by states to remedy deficiencies in their PASRR programs, and intends to work with states to minimize these risks.

Next Steps

Please jointly review the enclosed documents, assess your state PASRR program (making use of any federal technical assistance you may require, as above), and respond through the state Medicaid Agency to me at the Regional Office with your conclusions about what South Carolina needs to do to bring the PASRR program up to standards and to be more effective. If you find that the report does not accurately reflect your current practice, please provide us with updated program information. If you require more than 60 days to respond, please let us know. We

recognize that coordinating a response among multiple state agencies may be challenging, and we or the PTAC would be happy to arrange a joint telephone conference if that would be helpful A tool that many states have found useful for interagency assessment of PASRR activities is the PASRR Self Assessment for States. This document restates the federal requirements in a programmatic order, with some discussion of policy issues and common trouble points. The self assessment and other resources are available at the PTAC website, www.pasrrassist.org.

You may also wish to review the degree to which South Carolina is obtaining the full 75% FMAP available for PASRR activities. Properly allocated expenditures, by all state authorities and delegated entities involved in administering the PASRR program, should be claimed on lines 10 (for Preadmission Screening) and line 11 (for Resident Review) to obtain the enhanced match. We believe that many states are not fully availing themselves of this opportunity, and that doing so may provide resources for PASRR program improvement.

In the future, CMS intends to periodically update the individual state fact sheets and the national report of PASRR program design. We welcome any updated and revised materials you can provide. Please send these materials to Maria Drake at the Regional Office. CMS is also developing a model for quality oversight of PASRR. This tool should assist states in meeting their statutory and regulatory responsibilities and in holding state Medicaid agencies accountable for ensuring compliance with Federal PASRR requirements.

These actions comport with the increased CMS oversight of PASRR program implementation and effectiveness that was outlined in our response to the 2007 OIG PASRR reports.

For additional information and to request technical assistance you may reach your CMS Regional Office contact Maria Drake at 404-562-3697 or Dan Timmel in the CMS Central Office at 410-786-8518.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Mr. John H. Magill, Director
Dr. Beverly A. H. Buscemi, Director

Substance Abuse and Mental Health Services Administration (SAMHSA)
Administration on Developmental Disabilities
Administration on Aging (AoA)
HHS Office on Disability
HHS Office of Civil Rights (OCR)
The National Association of Medicaid Directors (NAMD)
The National Association of State Directors of Developmental Disabilities Services (NASDDDS)
The National Association of State Mental Health Program Directors (NASMHPD)

Electronic copy:
Vicki McGahee
Susie Boykin
Brian Hawkins
Nicole Mitchell Threatt

[1] (http://oig.hhs.gov/oei/reports/oei-05-05-00220.pdf and http://oig.hhs.gov/oei-07-05-00230.pdf)

PASRR Process State Fact Sheet: South Carolina

August 15, 2011

The Centers for Medicare and Medicaid Services (CMS) is undertaking an effort to understand how different states design their Preadmission Screening and Resident Review (PASRR) processes, policies, and procedures. This report is a product of the PASRR Technical Assistance Center (PTAC), which is staffed by Mission Analytics Group and other external consultants.

CMS and PTAC have recently reviewed the processes and tools used in each state to identify persons with mental illness (MI) and/or mental retardation and related conditions (MR) who could be diverted or transitioned from nursing facilities. This review, and the report below, should help guide your state to better understand the strengths and weaknesses of its PASRR process and tools and to think about strategies for improving these systems. Ultimately, and in accordance with their intent to reduce the institutional bias in Medicaid long-term care, CMS seeks to ensure that:

- all individuals applying to nursing facilities are evaluated for MI and MR,
- that these individuals are placed in the most appropriate setting according to these evaluations, and
- that these individuals receive the services they need.

Through this review, we aimed to capture and present information as accurately as possible. However, we recognize that we may have misinterpreted your PASRR process or the content of the tools. Therefore, please read your State Fact Sheet carefully and clarify any misconceptions by emailing Ed Kako, ekako@mission-ag.com.

Please note that our use of the terms "mental illness" and "mental retardation" is a strict reflection of the language used in the current Code of Federal Regulations (CFR) regarding PASRR.

Objective

This review is an invitation for you to revisit your PASRR process and identify areas for improvement. Primarily, we aim to determine whether your state meets the Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals requirements detailed in the Code of Federal Regulations (42 CFR 483.100 – 42 CFR 483.138). However, the review is not meant to only address regulation compliance. We also assess whether your state's PASRR process reflects recent developments in clinical practice, which may not be captured in the regulation. For example, although the CFR does not require onset dates of medical diagnoses, good clinical practice entails collecting and using these data in assessments.

The Fact Sheet is a living document. As your state revisits and updates its PASRR system, adopting new tools and streamlining processes, we will incorporate these changes in the assessment and Fact Sheet.

Methodology

Your state's PASRR process was reviewed based on the documentation you provided to your Regional Office PASRR Coordinator. Your state's documentation was reviewed independently by two reviewers working for the PASRR Technical Assistance Center (PTAC); any discrepancies between the two reviews were subsequently reconciled. The review focused on your state's general PASRR process as well as several specific requirements within the process. All reviews attempted to capture the *intent* of the provided documentation, not merely the exact words written on the page. In addition, we focused the review on *current* processes. If your state updates its process, please let us know so we can conduct a new assessment.

We made attempts to collect additional documentation from your state if we discovered that crucial information was missing from your inventory. Attempts to collect additional information included Internet searches and communication with your Regional Office PASRR Coordinator to request or clarify documentation provided. After two weeks, we resumed the review process with or without this information.

Using the CFR and good clinical practice as a basis, the reviewers identified data elements that should be recorded during the PASRR process. The values of these data elements were captured in the tables that follow (see Tables 1 through 4). Where necessary, the reviewers separated these data elements into the categories of mental illness and mental retardation. The degree to which your state fulfills each of the specific requirements of the Level II tool(s) was captured at one of three levels: comprehensive, absent, or partial (see Table 3). Your state's ability to meet a requirement was considered "comprehensive" if the documentation addressed all of the necessary elements of the relevant paragraph of the CFR, in addition to certain good clinical practices. Your state's ability to meet a requirement was considered "absent" if the documentation failed to address any of the necessary elements of the relevant paragraph of the CFR. Your state's ability to meet a requirement was considered "partial" if the documentation did not address 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 the documentation left room for a free response answer related to a data element (i.e. if questions on a Level II PASRR screening tool left room for an open ended answer). Finally, a requirement was also considered "partial" if the documentation solicited, but did not provide, additional documentation related to a data element.

Findings about your State

This section details the findings from the review of the documentation provided by your state. All reviews attempted to capture the intent of the provided documentation. A description of the data elements and possible values in the tables below can be found at the end of this section.

Tables 1 and 2 below reflect the timing and general requirements of the PASRR process in your state. Specifically, Table 1 aims to capture the sequence of events beginning at the determination of nursing facility level of care (NF LOC) through determinations made for Level II review(s). The table also captures critical elements of the NF LOC and Level I tools and processes as well as the requirements of agencies and persons at various stages of the process. Table 2 captures any comments the reviewer would like to convey to the state about the timing and requirements of the NF LOC, Level I and Level II assessments. In many cases, the comment is a section of the state's documentation, indicating from where the reviewer obtained the relevant information.

Table 1: NF LOC, Level I, and Level II Timing and General Requirements

OVERALL TIMING - Level I	CFR
Determination of NF LOC	128(f); 132(a)

Level I	CFR
Level I evaluation & determination	112(c)

OVERALL TIMING - Level II	CFR
Level II evaluation & determination	112

GENERAL REQUIREMENTS - Level II	CFR
H&P	132(c)(1)
Mental status	132(c)(2)
Functional status	132(c)(3)

Relative to PASRR	Level of Severity	Document(s)
Before Admission	Captured	DDHS Form 185

Relative to Admission	Entity Completing	Level(s) of Review Required for Level II	Alternative Placement Question
Before Admission	NF or Hospital	SMHA and SMRA	No

Relative to Admission	Level of Severity	Document(s)	Responsible Entity	Discipline
Before Admission		Mental Health Authority Determination Form and Mental Retardation Authority Determination Form		
Present	Captured		Both SMHA & SMRA	See Comments
Present	Captured		Both SMHA & SMRA	See Comments
Present	Captured		Both SMHA & SMRA	See Comments

Table 2: Comments Regarding NF LOC, Level I, and Level II Timing and General Requirements

OVERALL TIMING: Level I	CFR
Determination of NF LOC	128(f); 132(a)
Level I	**CFR**
Level I evaluation & determination	112(c)
OVERALL TIMING: Level II	**CFR**
Level II evaluation & determination	112
GENERAL REQUIREMENTS: Level II	**CFR**
H&P	132(c)(1)
Mental status	132(c)(2)
Functional status	132(c)(3)

Comments
According to Medicaid criteria, you meet the medical requirements to receive long-term care at the following level: Skilled or Intermediate.
Comments
There are no alternative placement questions on Level I but LOC determination instrument has the option of applying for a number of waivers.
Comments
Level II MI and MR tools state it must be completed for those seeking NF admission.
Comments
Physician and/or Psychologist/Psychiatrist
As above
As above

Table 3 below reflects the degree to which your state fulfills specific requirements detailed in the CFR and requirements related to more recent good clinical practices. The levels of detail below are specific to the PASRR Level II tool(s) provided by your state for mental illness and mental retardation. Requirements of the Level II tool(s) are significant as they represent a core component of the PASRR process. Keywords/phrases in *italics* were directly taken from the CFR. If the keyword/phrase is not in italics, the collection of these data is considered good clinical practice and not necessarily a requirement of the regulation.

Table 3: State PASRR Level II Checklist

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)	Partial
		MR: 136(b)(1)	Partial
Neurological assessment	*motor functioning; gait; communication*	MI: 134(b)(1)(iii)	Partial
		MR: 136(b)(8)(9)	Partial
Medication review	*current medications; allergies; side effects*	MI: 134(b)(2)	Partial
		MR: 136(b)(3)	Partial
Medical Status			
Externalizing and internalizing behaviors	aggressive; disruptive; inappropriate; depression; anxiety; loneliness	MI: 134(b)(4)	Comprehensive
		MR: 136(b)(15)	Comprehensive
Harm to self or others (intentional or unintentional)	*suicidal/homicidal ideation*	MI: 134(b)(4)	Comprehensive
	self-injurious behaviors	MR: 136(b)(15)	Absent
Intellectual functioning	estimated IQ level (MR, low average, average, high average)	MI: 134(b)(4)	Absent
	MR range (mild, moderate, severe, profound)	MR: 136(c)(1)	Absent
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)	Comprehensive
		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)	Comprehensive
ADLs/IADLs in community	*assessment of ability to perform ADLs in the community*	MI: 128 (f), 134 (5)	Comprehensive
		MR:136(4)-136(7)	Comprehensive
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	Absent
	appropriate placement is other setting	MI: 134(b)(5)	Absent

CMS would like to see language in your policies and procedures that demonstrates the importance your state places on transitioning patients into the least restrictive, appropriate care settings. Table 4 below reflects any information in the documentation provided by your state that relates to nursing facility diversion and transition requirements or practices. Because we did not specifically request this type of information, we are aware that a "Not Present" does not necessarily reflect the content of all of your state's related documentation.

Table 4: Diversion and Transition Related Requirements or Practices

Diversion/Transition Related Requirements or Practices	Keywords/Phrases	CFR (MI/MR)	Document
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 document
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) 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) 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) 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) 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

In the tables above, data elements and values should be interpreted to mean the following:

- "CFR" is the Code of Federal Regulations. Values in this column represent the Sections of the regulation within which the data element is based. Some are noted as pertinent to the screening process for mental illness "MI" and others for the screening process for mental retardation "MR."
- "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. Reviewers chose among "before admission," "after admission," and answer "not given" for this element.
- "Level of Severity" refers to whether the provided documentation asks about a range (i.e. low, medium, high) of need for nursing facility care or a range of disability (ability) for history and physical, mental status, and functional status. Reviewers chose between "not captured" and "captured" for these elements.
- "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. Reviewers chose among "before admission," "after admission," and "not given" for these elements.

Points for Consideration

- Your state's documentation is well organized. This makes it easy to understand your state's PASRR process and could lay the groundwork for straightforward implementation.
- The review of your state's Level II documentation some comprehensive detail. Data elements that were not considered comprehensive were understood to be partial.
- The review of your state documentation revealed an impressive amount of comprehensive detail, however:
    - Questions pertaining to intellectual functioning and the appropriateness for nursing facility placement or other setting are absent from your state's Level II MI and MR forms. Additionally, questions pertaining to self-injurious behaviors are absent from the Level II MR tool.
    - Questions pertaining to medical history, psychological assessment and medication are only partially covered in your state's Level MI and MR II forms. Additionally, questions regarding support systems needed in the community to perform ADLs are partially covered in the MI tool.

Recommendations

- Consider including data elements within your state's Level II MI and MR forms that satisfy the federal requirement and good clinical practice for an evaluation of intellectual functioning (42 CFR 483.134(b)(4)) and appropriateness for nursing facility placement or other setting (42CFR 483.126 and 134(b)(5).
- Consider adding further data elements within your state's Level II MI and MR forms that satisfy the federal requirement and good clinical practice for a complete medical history (42 CFR 483.134(b)(1)(i) and 136(b)(1), psychological assessment (42 CFR 483.

134(b)(1)(iii) and 36(b)(7)(8) and medication review (42 CFR 483.134(b)(2) and 136(b)(10)).

- Include additional information regarding support systems needed to perform ADLs in the community (42 CFR 483.134(b)(5) in your Level II MI tool.
- Complete the PASRR self-assessment tool. You can access the tool on the PTAC website: http://pasrrassist.org/resources/pasrr-self-assessment"
- Contact your Regional Office Coordinator for more information about your state's review.
- Visit the PASRR Technical Assistance Center (PTAC) at www.PASRRassist.org to help answer any outstanding questions you may have or to request an on-site visit from their team of consultants.
- Please feel free to reach out to us if you have any questions about this report or the review process. You can contact Ed Kako, the Director of PTAC, at ekako@mission-ag.com.

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."

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				
Determination of NF LOC	.128(f); .132(a)	After PASRR	See Comments	http://www.bock-associates.com/index.html	
Level II	CFR	Relative to Admission	Entity Commencing	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		Documents	
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:

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[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

SCREENING REQUIREMENTS – Level II	Key words/phrases	CFR MI/MR	Level of detail
H&P			
Medical history	diagnosis(es); onset date(s)	MI: .134(b)(1)(i) MR: .136(b)(1)	Comprehensive Comprehensive
Neurological assessment	*motor functioning; gait; communication*	MI: .134(b)(1)(iii) MR: .136(b)(8)(9)	Absent Partial
Medication review	*current medications;* allergies; side effects	MI: .134(b)(2) MR: .136(b)(3)	Comprehensive Comprehensive
Medical Status			
Externalizing and internalizing behaviors	aggressive; disruptive; inappropriate; depression; anxiety; loneliness	MI: .134(b)(4) MR: .136(b)(15)	Partial Comprehensive
Harm to self or others (intentional or unintentional)	*suicidal/homicidal ideation* self-injurious behaviors	MI: .134(b)(4) MR: .136(b)(15)	Partial 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) MR: .136(b)(10)	Partial Comprehensive
Functional Status			
ADLs/IADLs	*self-care; self-administration of medication*	MI: .134(b)(5)(6) MR: .136(4)-.136(7), .136(12)	Comprehensive Absent
ADLs/IADLs in community	*assessment of ability to perform ADLs in the community*	MI: .128 (f), .134 (5) MR: .136(4)-.136(7)	Partial 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	Citation(MR)	Documented
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) 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) 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) 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) 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 Responsible for 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	Key words/ indicators	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

[illegible]	[illegible]	[illegible]
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

[illegible]	[illegible]	[illegible]	[illegible]
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.

Brenda James

From: Teeshla Curtis
Sent: Wednesday, August 08, 2012 9:42 AM
To: Brenda James
Cc: Nancy Sharpe; Stephanie Vincent
Subject: Reponse Log 15
Attachments: SKMBT_28312073114550.pdf; Ref Log 000015 - Response.pdf

Brenda,

Attached is the response for Log 15 including the enclosure.

Teeshla

Stops - Images - Search®

Image Front:

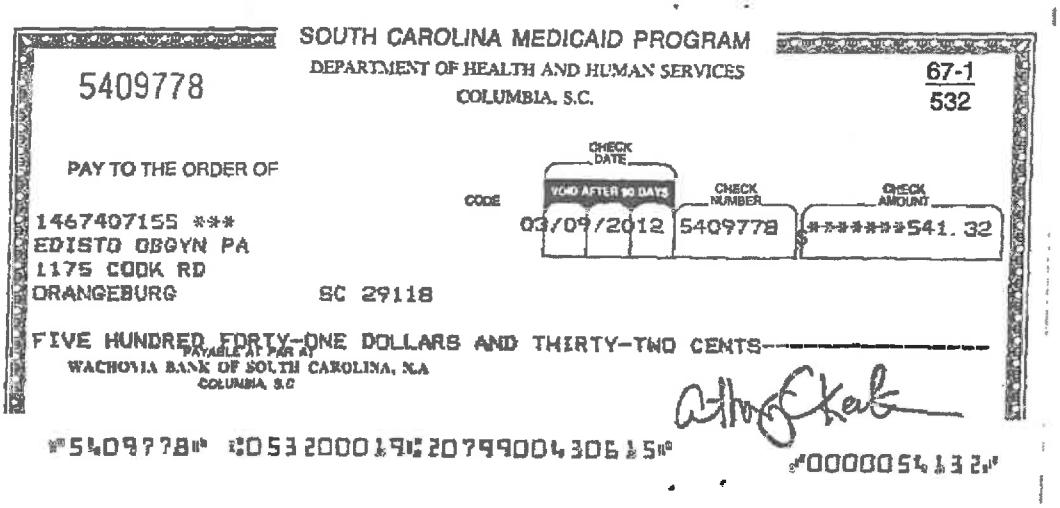
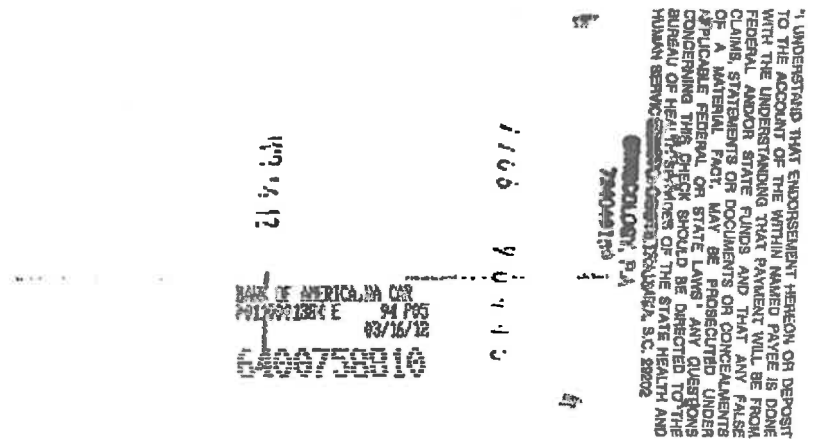


Image Back:



Item Details
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Posting Date: **03/19/2012**
As of Date: **03/19/2012**

Additional Item Details: **0000021 -000000005867141**
CHL **REF#: 0000008183066022**

Account Name: **H AND HS**
Account Number: **2079900430615**
Routing Number: **053101561**
Type Code/Description: **475/CHECK PAID**
Item Sequence Number: **8183066022**

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

August 7, 2012

Jerome Degen, MD
1175 Cook Road, Suite 305
Orangeburg, South Carolina 29118

Dear Dr. Degen:

This letter is in response to your recent correspondence regarding a Medicaid reimbursement you did not receive and our provider customer service. We apologize for the delay in responding to your initial inquiry in May.

The South Carolina Department of Health and Human Services (SCDHHS) recently made very important changes to its provider services, support and relations procedures in order to better serve you. SCDHHS consolidated operations to provide a single point of contact through the Medicaid Provider Service Center (PSC) at (888) 289-0709. This change addresses the specific communication and reimbursement issues your office has recently experienced.

According to our records, check number 5409778 issued to Edisto/Ob/Gyn PA was cashed on March 19, 2012. We have enclosed a copy of the check with bank validation for your records.

It is no longer necessary to direct inquiries or correspondence to an assigned representative; any available PSC Representative will be able to assist you. You can also access provider service requests online by simply submitting an online inquiry at http://www.scdhhs.gov/contact-us and a provider support representative will then respond to you directly.

We believe the recent changes in our provider relations will all us to more effectively respond to your requests and support your office.

Sincerely,

John R. Supra
Deputy Director

JS/pc

Enclosure

Office of Information Management
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2580 • Fax (803) 255-8235