While PASRR has existed since 1987, recent developments have shined a spotlight on the crucial role that PASRR can play in the lives of individuals with intellectual disability (ID) and mental illness (MI), and, importantly, how PASRR can be a tool for both diversion and deinstitutionalization, helping states to meet their obligations under the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision.

As it is a tool, it is also a state obligation, and the Department of Health and Human Services (HHS) is increasingly holding states accountable for its effective operation. The Office of the Inspector General (OIG) for HHS published three detailed reports, one in 2001 and two in 2007, all requiring CMS to attend more closely to PASRR. Since that time, the Centers for Medicare & Medicaid Services (CMS) built the PASRR Technical Assistance Center (PTAC) to assist state agencies. CMS has also increased enforcement, issued a disallowance in one state, and corrective actions in others for failure to comply with the applicable statutory and regulatory provisions. In addition, the U.S. Department of Justice (DOJ) has increasingly looked to PASRR practices in ascertaining a state's compliance with the *Olmstead* decision, and has pursued settlement agreements including obligations related to PASRR.

PASRR was created in 1987 as part of nursing home reform, through language in the Omnibus Budget Reconciliation Act (OBRA ‘87). It has three goals:

1. to identify individuals with mental illness (MI) and/or intellectual disability (ID) or a related condition (this includes children and adults);
2. to ensure they are placed appropriately, whether in the community or in a Nursing Facility (NF); and
3. to ensure that they receive the services they require for their MI or ID.

PASRR is unique within Medicaid in that the statute obligates the state ID and MI agencies as well as the Medicaid agency to perform certain functions. This represents an important recognition of the role and partnership these agencies have in the delivery of services through the Medicaid program.

This *Directors Alert Bulletin* will provide key information regarding PASRR requirements, obligations of state ID agencies, and implications for state directors.

**BACKGROUND**

Each state is required to have a Preadmission Screening and Resident Review (PASRR) process in place to screen all individuals with ID (or a related condition) and individuals with MI, regardless of Medicaid eligibility, who apply for admission to a Medicaid certified nursing facility (NF). The intent of PASRR is to both make sure only those who truly need NF services are admitted and that those with MI and DD who need NF services, but also need specialized services to supplement them, receive a person-centered assessment, and get the needed services.
Statutory and Regulatory History

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87, Pub. L. 100-203) introduced Preadmission Screening and Resident Review (PASRR). PASRR is codified in Sections 1919(b)(3)(F) and 1919(e)(7) of the Social Security Act. Regulations governing these provisions were published in 1992, after the passage of the landmark Americans with Disabilities Act, and are located at 42 CFR 438.100 through 138.

Often noted as being "ahead of its time," PASRR set forth an expectation that institutionalization should not be a default, and should instead be carefully considered in light of the totality of individuals' needs. While the PASRR statute relates specifically to individuals with ID and MI, it foreshadowed expectations set forth in the 1990 Americans with Disabilities Act, and the 1999 Olmstead decision by the Supreme Court, that individuals with disabilities should receive services in the most integrated setting appropriate to meet their needs. The regulations for PASRR, published in 1992, further reinforce this principle.

Importantly, the regulation utilizes specific definitions of mental illness and intellectual disability to define those to whom PASRR applies. States are obligated to conduct the PASRR process based upon a crosswalk of current standards against these historical definitions, which may differ from the state's own definition for MI or ID.

The federal definition of ID adopted for PASRR was the definition published in 1983 by the American Association on Intellectual and Developmental Disabilities (AAIDD), formerly called the American Association on Mental Retardation (AAMR). Typically this definition requires an IQ score of less than 70, as measured by a standardized, reliable test of intellectual functioning. ID encompasses a wide range of conditions and levels of impairment. To qualify as having ID for the purposes of PASRR, an individual must also have concurrent impairments in adaptive functioning. Whatever form it takes, ID must have emerged before the age of 18, and must be likely to persist throughout a person's life.

PASRR is also intended to identify and evaluate individuals with "related conditions" — conditions that are not a form of intellectual disability. Related conditions must emerge before the age of 22; they must be expected to continue indefinitely; and they must result in substantial functional imitations in three or more of the following major life activities:

1. Self-Care
2. The Understanding and Use of Language
3. Learning
4. Mobility
5. Self-Direction
6. Capacity for Independent Living

Related conditions could include autism, cerebral palsy, Down syndrome, fetal alcohol syndrome, muscular dystrophy, seizure disorder, and traumatic brain injury. Note that this is not an exhaustive list.

The statute also provides that, for activities attributable to PASRR, states can claim a federal administrative match rate of 75 percent. This includes all of the activities of the state ID authority necessary to carry out PASRR. Many states are not taking full advantage of the extra 25 percent of administrative match, but technical assistance is available on this matter from CMS' PASRR technical assistance provider (PTAC).

The PASRR regulations are complex, but also afford great interpretive flexibility for states in their implementation. Consequently, there is great variation from state to state on how PASRR is
operationalized. CMS has been emphasizing that PASRR should be an effective program, not a bureaucratic exercise, and is always happy to discuss ways of reading the requirements to accomplish that.

**Role and Responsibility of I/DD Agencies in PASRR**

It is the role of the Medicaid agency to oversee the PASRR process. However, the role of the state I/DD agency and the state MI agency in the performance of PASRR is critical, and entirely unique in Medicaid law. Unlike other provisions of Title XIX of the Social Security Act (the Act) that reinforce the authority of the single state Medicaid agency to administer or supervise the administration of the Medicaid state plan (§1902(a)(5) of the Act), the PASRR provisions bestow responsibilities and decision-making authority on the ID and MI agencies that cannot be countermanded by the state Medicaid agency.

While the ID and MI agency responsibilities are similar within PASRR, they are not identical. State ID agencies are responsible for both the Level II evaluation and determination (described in more detail below), while the state MI agency is only responsible for the Level II determinations (the statute requires that the evaluations for MI be performed by an entity independent from the state MI agency). State ID and MI agencies are permitted to delegate their activities (but not their responsibilities), so the state ID agency may elect to delegate the evaluation and determination elements to another entity, with strong oversight of the performance of the requisite activity.

The statute and regulations do not prescribe who or what entities conduct the Level I screens (also described more below).

As CMS and its technical assistance providers (PTAC) have spotlighted, the most effective PASRR strategies include strong collaboration, communication and accountability among all of the PASRR-involved state agencies. States such as Delaware, Ohio, Tennessee, Wyoming, Nebraska, Indiana, and others have been highlighted as having positive practices through webinars hosted by CMS’ technical assistance contractor at [www.PASRRassist.org](http://www.PASRRassist.org).

Increasingly, state ID agencies are seeing the PASRR process as a strong tool for diversion and deinstitutionalization, particularly when coordinated with available Medicaid state plan services (including case management) and home and community-based services (HCBS) programs.

**PASRR Processes**

At its root, PASRR is intended to ensure the appropriate placement and appropriate services for individuals with ID and MI. This simple objective is not always easily achieved, and requires well-structured processes and policies to undergird them. The PASRR regulations set forth two important levels of screening/evaluation and determination. Though seemingly straightforward, this process has multiple layers of consideration and complexity.

1. **Level I Screen**

   Every individual, regardless of payer, must receive a Level I screen, to see if a Level II evaluation is needed before admission to a Medicaid certified NF. If a current nursing facility resident experiences a significant change in his or her mental or physical condition, the individual bypasses Level I and immediately moves on to a Level II evaluation.
The Level I screen is intended to identify individuals who may have an ID or MI. There are not strict requirements for the contents of the Level I screen, but the screen should err on the side of including more individuals than fewer to ensure that all individuals likely to be ultimately evaluated and determined as having an ID or MI through the Level II screening process are referred onto the next phase. CMS has noted that a robust Level I screen will likely result in false positives. (See 2014 Review of State PASRR Policies and Procedures National Report.)

As noted above, state Medicaid agencies are responsible for overseeing the Level I process (and the entirety of PASRR); however, there are no specific requirements for the entities who can conduct the Level I screens on behalf of the state. Entities including hospital discharge planners, NFs themselves, state agencies, or an independent entity such as a contractor could conduct Level I screens, as long as they are conducted properly, by examining information documented by qualified professionals. The Level I screener does not make diagnostic judgments; the screener identifies individuals who need a Level II to do so. If an individual appears to have an ID or MI, or possibly could have, they are referred on for a Level II evaluation. An individual who tests positive on both MI and ID screens must undergo a Level II for mental illness and a Level II for intellectual disability. This reinforces the need for strong coordination and collaboration among all state agencies responsible for the PASRR program.

2. Level II Evaluation

The Level II evaluation has three primary objectives:

**Confirm the Presence of ID and/or MI**
In confirming the presence of an ID, the evaluation must include a comprehensive history and physical that provide information on a number of items related to the individual's medical history, ability to self-administer medications, communication, social development, and educational and vocational considerations, among others. These elements are specified at 42 CFR 483.132 and 42 CFR 483.136.

The federal regulations place very few restrictions on who states can specify to perform the Level II, except that Level II evaluators cannot be employed in any way by a nursing facility. The conflict of interest would be too severe.

**Determine Need for NF Services**
The presence of an ID and/or MI is not sufficient to require a NF level of care. An individual's needs, often resulting from concomitant medical conditions rather than ID or MI alone, must be significant enough to warrant NF services. The determination may be that an individual has needs: greater than can be accommodated in a NF, (for example, HCBS or inpatient services at an ICF/IID level of care) and NF is denied; that can be met only in a NF (HCBS meeting the need are not available); that can be met in either NF, or preferably HCBS; or, are less than NF and NF is denied.

This determination is made by the state ID agency. Each state has different thresholds for NF level of care. It is important that state ID agencies understand this threshold in the conduct of this function. However, the point of the PASRR NF determination is that taking into account the individual's ID or related condition may yield a different determination than the state's standard level of care.

**If Individual Does Require NF Services, Identify Whether and Which Specialized Services May Be Needed**
A key element of PASRR is the need for and availability of specialized services. Through the Level II
evaluation, a determination is made regarding specialized services. The evaluation report describes individualized and person-centered considerations to reflect the unique and specific needs of the individual. The Level II document should reflect what is important to the individual as well as what is important for the individual, to guide the NF in deciding whether to admit the person, and in the case of admission, to guide care planning. The Level II documentation is crucial information about ID that the NF staff would otherwise completely lack.

To meet the identified needs, the Level II determination recommends specific categories of specialized services, which both the ID authority and the NF must assure are practically available before NF admission is recommended. Put simply, PASRR should prevent individuals from being placed where they cannot access a needed type of service.

Note that 'specialized services' differ from 'specialized rehabilitative services' which are provided by the NF and already included in the NF's reimbursement. Specialized services are by definition above and beyond what NF provides. The Level II determination should list both levels of needed service, as it is this complete package that will address the PASRR disability. Whether a particular type of service or support is considered a specialized service or a specialized rehabilitative service will vary by state and is influenced by state-specific and widely varying Medicaid service definitions.

"If...a resident or applicant for admission requires both a NF level of services and Specialized Services for the mental illness or intellectual disability....The State must provide or arrange for the provision of the Specialized Services needed by the individual while he or she resides in the NF." [42 CFR 483.116(b)].

CMS has been providing guidance through its technical assistance providers/resources to assist states in determining strategies for paying for specialized services. Federal match is available for many types of specialized services that can be defined under Medicaid. These can take the form of state plan services available to individuals while they are in the NF, or could include defining add-on payments in the Medicaid NF reimbursement methodology for specially qualified providers of specialized services. Managed LTC contracts that include NF services can also include requirements related to specialized services the state defines. Particularly useful are services heretofore not covered by Medicaid, such as skill building and transition services, and habilitation services. Some states will be able to use this guidance to get federal match for services funded currently through state-only dollars.

3. Level II — Determinations

Once the Level II evaluation is complete, the state ID agency or state MH agency must produce a Level II determination. The determination is a legal document with important ramifications for the individual's care. The determination document:

- Summarizes the individualized evaluation information in a rich individualized and personalized description of strengths, needs, and preferences;
- Specifies which PASRR "target condition" was present, if any (i.e., MI, ID, or a related condition);
- Recommends what services would be needed to be provided in the community, and for or against NF.
- Says "yes" or "no" to whether specialized services (more than NF services) are needed; and
- Makes specific and clear recommendations for both specialized services and specialized rehabilitative services (if the person was approved for NF stay).

The determination summary and the notice indicating a right to appeal are provided and explained to
the individual. State agencies may delegate their activities, and some have utilized partners such as PASRR contractors, counties, or managed care entities to carry out some of the functions, with specific instruction on the execution of the functions and strong oversight strategies.

**Exemptions/Categorical Determinations**

PASRR is particularly meant to protect long-term NF residents. If an individual is being discharged from a hospital and their stay is expected to last fewer than 30 days, the state may elect to exempt them from the PASRR process. In addition, the rules describe some circumstances where states may be permitted to perform a less individualized Level II for certain "categorical determinations."

**4. Resident Review**

To ensure that individuals are having their total needs met, the state must periodically review the MI/ID status of NF residents.

Level II evaluations must also be conducted on NF residents with MI/ID any time there is a change in condition (CMS recommends that states use Section 2.6 of the MDS 3.0 Manual change of condition protocol, which is attached below. The MDS is the highly structured assessment instrument required of all nursing homes). If a PASRR Level II resident triggers the MDS significant change in status assessment, or detects newly suspected MI/ID, the NF must notify the DD/MH agency or its designee, which must then arrange a Level II Resident Review (RR) if indicated.

**PASRR as a Tool in Community Balancing**

States are increasingly viewing PASRR as a component of their overall community-based system of supports, a tool for ensuring that individuals are receiving the services appropriate to meet their needs in the most integrated setting.

States are using the PASRR process as a diversion strategy. When individuals must receive services in a NF due to their needs, states are using PASRR as a critical transition component. Specialized services can include building skills needed for successful community living. Provider qualifications for the services can include being an HCBS provider, which can build an extremely effective bridge between the NF and community and potentially excellent continuity of care at discharge. States are also beginning to utilize information available through MDS and other data sources to identify current residents of NFs who may be better served in the community. In thinking of PASRR as an integrated component of the service delivery system, states are exploring how to bridge transitions seamlessly.

Notably, DOJ has also seen the potential of PASRR for state strategies to comply with the *Olmstead* decision, and has included requirements related to PASRR in at least two settlement agreements while highlighting states’ failures at PASRR implementation in numerous findings letters. Protection and Advocacy organizations are monitoring PASRR and have brought several critical complaints that spurred CMS action.

**How States Are Doing**

As noted above, there is great variability in the manner in which states operate their PASRR processes. HHS/OIG published three detailed reports, one in 2001 and two in 2007, all requiring CMS to attend
more closely to PASRR. For the past three years, CMS has commissioned an annual report of national practices in PASRR, spotlighting areas requiring improvement on a state by state and national level.

The reports identify areas for improvement, and PTAC provides technical assistance to states to make improvements. For example, the 2012 report noted lack of comprehensiveness in Level II tools, with the 2013 report demonstrating improvement. The 2014 report reviews the Level I screens for efficacy and reviews the data and information that states can gain and use from the MDS.

CMS, recognizing that states are emerging in their practices, is providing an abundance of technical assistance and guidance to assist. CMS' Technical Assistance contractor hosts a website with significant resources dedicated to the proper administration of PASRR (www.PASRRassist.org). Any state agency engaged in PASRR may request technical assistance at no cost, from on-site multi-agency system redesign to informal questions from individual state employees implementing PASRR.

While CMS has taken a supportive stance with states wishing to improve their PASRR programs, they are also pursuing areas of non-compliance when identified. As an example, CMS has issued a multi-million dollar disallowance in at least one state for failing to comply with their PASRR obligations.

Implications for State Directors

PASRR has significant importance for state ID directors. In addition to providing opportunities for early identification, diversion and transition of individuals from NFs to the community, it is also an obligation with implications for Federal Financial Participation (FFP) and potential litigation.

Be Familiar with PASRR Obligations

Because PASRR requirements for the ID and MH authorities are written in Medicaid law and regulation rather than in sections of federal requirements more familiar to ID and MH administrators, many do not fully appreciate their statutory level of responsibility for conducting these activities. It is important to understand these issues, to work collaboratively within your state to develop strong processes and working relationships, and to seek available technical assistance from PTAC or NASDDDS.

PASRR has its own set of definitions and specific requirements, so it is important to keep in mind the following:

- Federal PASRR ID/MI definitions may not align with state definitions, yet the population to which PASRR applies is governed by the federal statute and regulations.
- PASRR functions (including the provision of Specialized Services) are not limited to individuals who are Medicaid eligible or who may otherwise meet the state’s service priorities.
- State ID agencies are directly responsible for the provision of both Level II evaluations and determinations, but can delegate those functions with oversight.
- State ID agencies can (and should) receive 75 percent administrative claiming for all PASRR related activities, and should work with their state Medicaid agencies to gain the appropriate authority for this claiming.
- States are increasingly gaining FFP for specialized services provided to individuals in NFs. Potential options for drawing FFP include using state plan benefits (not covered as part of the NF benefit) as the Specialized Services or adjusting the services included in the NF reimbursement.

Strong working relationships, role identification and accountability is essential across the three key agencies administering PASRR activities — particularly for individuals who may have co-occurring ID/MI
support needs. If you are not already doing so, set up a regularly scheduled inter-agency PASRR coordination group.

Because state ID agencies often do not work frequently with NFs, it is important to ensure strong understanding of the NF admission practices and policies within your state. This will include gaining familiarity with the state's NF level of care threshold and tools for its determination, understanding the admission patterns within your state and understanding the data available to you in identifying individuals for whom PASRR applies. PTAC consultants include individuals with NF experience and can help with this.

According to the 2012 Residential Information Systems Project, nearly 30,000 individuals with I/DD were living in NFs nationally. This illustrates the importance of devising strong strategies to fully comply with PASRR to ensure individuals are receiving services appropriate to their needs, to ascertain whether their needs could be more effectively met in the community, and to protect the state from administrative or judicial actions that may stem from lack of PASRR performance.

SOURCES

- Title XIX of the Social Security Act.
- Reference documents, FAQs, presentations, and other resources available at www.PASRRassist.org.
- U.S. Department of Justice Olmstead Enforcement website at www.ada.gov/olmstead.