2018 PASRR National Report

A Review of Preadmission Screening and Resident Review (PASRR) Programs

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Mission Analytics Group, Inc.

Prepared for the Centers for Medicare & Medicaid Services

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Executive Summary

This seventh Preadmission Screening and Resident Review (PASRR) National Report provides new data on the expenditures that states claim for the PASRR programs and analyzes aspects of PASRR program operation that may be related to spending patterns. This analysis of claiming data indicates substantial variation in PASRR-related claims that states file on their quarterly CMS-64 reimbursement forms. Moreover, there appears to be substantial variation in key aspects of PASRR program operation (or at least in the aspects of program operation on which states can report).

Section 1 provides a brief overview of the PASRR requirements.

Section 2 lays out the analysis of claims that states have made to be reimbursed for their PASRR activities—both preadmission and post-admission activities. The analysis includes a population-adjusted (per capita) dollar figure for each state. The analysis of the claiming data shows minimal variation from year to year in PASRR expenditures overall, but variation from state to state.

Section 3 identifies aspects of PASRR program operation that are likely related to expenditures—for example, whether Level I or Level II screens are performed by a vendor, whether the state claims the enhanced 75 percent federal match for its activities (as opposed to the standard 50 percent match for administrative activities or nothing at all), or whether the state uses an electronic tracking system. Although more is known about these operational variations than was the case previously, it still is not possible to say with confidence that operational differences drive differences in claiming patterns.

Section 4 provides recommendations for the Centers for Medicare & Medicaid Services to facilitate expansion of these findings and continued improvement in states' PASRR programs.

1 Introduction

Preadmission Screening and Resident Review (PASRR) was added to Title XIX of the Social Security Act in 1987 as part of the Nursing Home Reform Act.[1] PASRR has important and unique implications in Medicaid law. It requires states to (1) identify individuals who might be admitted to a nursing facility (NF) who have a serious mental illness (SMI), an intellectual disability (ID), or a related condition (RC); (2) consider community placement first, and a NF only if appropriate; and (3) identify the PASRR-specific needs that must be met for individuals to thrive, whether in a NF or in the community.

The regulations that govern PASRR (42 CFR 483.100–138) require that states administer a PASRR program with two steps. First, all individuals who apply for admission to a Medicaid-certified NF must be screened for a PASRR disability. The regulation calls this a *Level I screen*. Individuals who test positive at Level I then receive a more in-depth evaluation to determine

[1] Social Security Act, 42 USC 1919(e)(7) (1987).

whether they have such a disability and, if so, whether they need specialized services to address their PASRR-related needs. The regulation calls this a *Level II evaluation.* A positive Level II evaluation produces recommendations for the setting in which services should be received, and recommendations for Specialized Services are intended to inform the individual's plan of care.

To encourage states to conduct the necessary screens, evaluations, and determinations, the law allows states to claim an enhanced federal match of 75 percent for all activities related to the administration of the PASRR program. PASRR is classified as a *mandatory administrative function* rather than as a *direct service function* as outlined in Section 4.39 of a state's Medicaid State Plan.

Aside from the critical components outlined above, program design and implementation are largely at the states' discretion. Accordingly, programs vary widely among the states. To provide states with comprehensive technical assistance, the Centers for Medicare & Medicaid Services (CMS) funded the creation of the PASRR Technical Assistance Center (PTAC). A central aim of the PTAC contract is to help states improve their PASRR programs and ensure that their programs are meeting state-specific needs while also complying with federal regulations.

Additionally, PTAC authors an annual report on behalf of CMS designed to provide both CMS and the states with snapshots of how PASRR is being carried out across the country. For the first time, this year's report analyzes both preadmission and post-admission expenditures that states claim for their PASRR-related activities. It also discusses aspects of state program design and operation, such as whether the state uses one or more vendors or has deployed an electronic tracking system.

PTAC's analyses cannot provide direct information about the *implementation* of a state's PASRR program.

The analysis of these data continues the productive conversations that have taken place over the last several years between (and among) states, CMS, and PTAC about how states can improve the data that they collect about their PASRR programs.

2 Interstate Variation in PASRR Expenditures

To help states meet the PASRR requirement, CMS offers an enhanced 75 percent match. To qualify for this match, states must fulfill the following conditions:

1. The activity or supply must legitimately be considered a cost of administering PASRR.
2. The activity or supply must be properly documented.[2]

[2] PASRR Technical Assistance Center. Enhanced 75% Match for PASRR: An Overview. June 5, 2014. https://www.pasrrassist.org/resources/75-match/enhanced-75-match-pasrr-overview

States can claim the enhanced match on a variety of activities and services related to PASRR in addition to the screens and evaluations themselves and the time it takes state staff members to review them. For example, they also can claim the enhanced match on training, hiring a vendor, and purchasing and maintaining an electronic tracking system. To receive reimbursement for their PASRR activities, states must claim the relevant expenditures on their Form CMS-64, which they transmit to CMS quarterly. One line (Line 10) allows a state to specify the costs it has incurred for preadmission activities, and another (Line 11) allows it to specify the costs it has incurred for its post-admission activities. The state reports its total PASRR expenditures on these lines as appropriate, and CMS returns 75 cents for every dollar claimed.

A state could have low PASRR expenditures because:

1. It has failed to implement or monitor some (or even most) aspects of its PASRR program.
2. It has a working PASRR program in place, but it under-identifies individuals with SMI or ID/RC at the preadmission Level I screen. The state would ultimately conduct too few Level II preadmission evaluations, which are costlier (because they are more in-depth).
3. It fails to conduct post-admission Level II evaluations following a significant change in status.
4. The Medicaid agency has not arranged for the state mental health authority (SMHA) or the state intellectual disability authority (SIDA) to be reimbursed for their PASRR activities. In other words, effective PASRR programs could be in place, but the responsible state authorities are not being paid for their activities. In this case, the claimed expenditures could be as low as zero.
5. The Medicaid agency has information about PASRR expenditures from the SMHA and SIDA, but simply fails to claim those expenditures on the CMS-64. In this case, too, the claimed expenditures could be as low as zero.

Note that these explanations for low expenditures are not mutually exclusive.

A state could have high PASRR expenditures because:

1. It has a large nursing home population relative to other states. In the analysis we present below, we attempt to adjust for this by calculating per-capita PASRR expenditures.
2. It has a robust PASRR program that could include high-quality training for Level I screeners and Level II evaluators; implementation and maintenance of an information technology system that tracks individuals who have had PASRR screens and evaluations; or use of an external vendor that brings expertise to the process.
3. Its PASRR program is inefficient: It could conduct more Level II evaluations than necessary – in other words, the state's program heavily favors false positives in its Level I preadmission screen (leading to many preadmission Level II evaluations), or in the recommendations of the SMHA or SIDA to conduct post-admission Level II evaluations.

Note, again, that these explanations for low expenditures are not mutually exclusive.

The analyses we describe below are preliminary and cannot yet distinguish among these competing explanations. However, in the Findings and Discussion section, we suggest ways to tease them apart.

2.1 Methods

Data used in this analysis came from two sources: Form CMS-64 and the MDS. Three distinct time periods were examined: federal fiscal years (FYs) 2014, 2015, and 2016. Data for the 50 states and the District of Columbia were included.

The MDS contains assessment data for all residents in Medicaid-certified NFs. The number of unique NF residents in the state in that FY (i.e., any individual with at least one admission, assessment, or death record in the MDS in the FY) was extracted from the MDS for each FY.

Using the CMS claiming data and the MDS NF population, PTAC computed the PASRR cost per resident, for both preadmission (Line 10) and post-admission activities (Line 11). This computation produces a per capita cost that lends itself more readily to cross-state comparisons. This analysis included only states that report more than zero dollars of expenditures. Notably, seven (7) states reported *no* PASRR expenditures at all.

To avoid the possible influence of outliers among states that do claim expenditures, states whose costs were more than 50 percent above the national mean also were excluded (again considering only states that report an amount greater than zero). Preadmission and post-admission costs were considered separately and together (in which case the total value is referred to simply as *the PASRR cost*).

2.2 Findings and Discussion

In 2016, the total PASRR expenditures reported across all states and DC on Form CMS-64 was $95,944,443. There were 3,675,635 NF residents in 2016 across the United States (this includes all individuals who resided in NFs at any point during the year). The cost per NF resident was therefore $26.10. Seven states did not report any PASRR costs that year, and 12 states had per capita costs above 150 percent of the U.S. mean ($26.10). PTAC's analysis included the 32 remaining states (that is, the 32 states that did not constitute outliers).

In 2016, the 32 states accounted for $31,500,456 of PASRR spending. The average per capita spending per NF resident for these states was $17.13. The median per capita spending was $15.26. Table 1 shows these figures for all years in the analysis and for each component.

For the last 3 fiscal years examined, there is virtually no variation from one federal FY to the next in per capita PASRR expenditures when looked at nationally (using either the median or the mean as the key statistic). However, some states in some years did not report expenditures on one line or the other and were excluded. Among the states that reported PASRR expenditures

greater than $0 total and were not otherwise outliers, most reported preadmission expenditures (Line 10), but many did *not* report post-admission expenditures (Line 11).

Table 1. Mean and Median Spending per NF Resident, 2014–2016

Year	Preadmission Spending per NF Resident			Post-admission Spending per NF Resident			Total PASRR Spending per NF Resident		
	No. of States Included	Mean, $	Median, $	No. of States Included	Mean, $	Median, $	No. of States Included	Mean, $	Median, $
2014	31	13.16	14.96	11	3.68	2.33	32	16.84	16.77
2015	31	14.89	14.14	10	2.42	2.23	32	17.39	15.45
2016	29	13.23	10.17	8	2.60	2.46	32	17.13	15.26

Abbreviations: NF, nursing facility; PASRR, Preadmission Screening and Resident Review.

PTAC's analysis indicated that there *is* considerable variation among states in total PASRR expenditures, regardless of year. To explore the interstate variation in PASRR expenditures, we focus on a single year – 2016 – and present the table below, which includes the MDS NF Population in CY 2016; the Total Federal Share (for all PASRR Activities); and the Per-Capita Federal Share (again, for all PASRR activities).

Table 2: NF Population, Total Expenditures, and Per Capita Expenditures in 2016

State	MDS NF Population in CY 2016	Total Federal Share	Per Capita Federal Share
AL	58,114	$1,050,320.00	$18.07
AK	1,411	$0.00	$0.00
AZ	50,497	$4,969,249.00	$98.41
AR	38,253	$625,004.00	$16.34
CA	331,169	$0.00	$0.00
CO	39,887	$1,206,570.00	$30.25
CT	65,013	$2,014,425.00	$30.98
DE	12,043	$868,617.00	$72.13
DC	5,724	$0.00	$0.00
FL	256,239	$2,928,756.00	$11.43
GA	80,084	$0.00	$0.00
HI	10,494	$0.00	$0.00
ID	11,976	$425,413.00	$35.52
IL	176,479	$29,463,235.00	$166.95
IN	94,560	$3,298,663.00	$34.88
IA	50,109	$1,999,820.00	$39.91
KS	38,035	$1,211,588.00	$31.85
KY	54,438	$479,030.00	$8.80
LA	46,806	$283,111.00	$6.05
ME	19,360	$196,847.00	$10.17

State	MDS NF Population in CY 2016	Total Federal Share	Per Capita Federal Share
MD	77,662	$202,879.00	$2.61
MA	115,062	$561,781.00	$4.88
MI	122,052	$6,216,349.00	$50.93
MN	71,112	$2,501,386.00	$35.18
MS	32,072	$546,572.00	$17.04
MO	89,033	$706,057.00	$7.93
MT	11,614	$1,330,302.00	$114.54
NE	28,567	$276,309.00	$9.67
NV	20,398	$7,830,124.00	$383.87
NH	17,307	$614,066.00	$35.48
NJ	126,553	$358,263.00	$2.83
NM	16,916	$720,412.00	$42.59
NY	263,925	$377,088.00	$1.43
NC	109,407	$2,804,982.00	$25.64
ND	10,282	$420,290.00	$40.88
OH	205,397	$427,405.00	$2.08
OK	41,529	$1,274,556.00	$30.69
OR	35,668	$1,003,457.00	$28.13
PA	194,038	$873,321.00	$4.50
RI	21,574	$305,997.00	$14.18
SC	43,806	$2,837,166.00	$64.77
SD	12,168	$403,385.00	$33.15
TN	77,198	$6,538,448.00	$84.70
TX	220,302	$1,099,962.00	$4.99
UT	17,629	$1,249,975.00	$70.90
VT	7,715	$0.00	$0.00
VA	85,726	$476,819.00	$5.56
WA	58,992	$1,628,874.00	$27.61
WV	21,906	$64,014.00	$2.92
WI	74,370	$1,273,556.00	$17.12
WY	4,964	$0.00	$0.00

To summarize our findings:

- Again, while some states report zero dollars, others report spending considerably more.
- By and large – although certainly not so consistently as to make a hard and fast rule – states with larger NF populations spend more in total on PASRR than do states with smaller NF populations. Nonetheless, after adjusting for the size of the NF population, we find that there are few clear patterns: Some states spend more per person than others, regardless of nursing home population size.

It is essential to note here that *no* state should be claiming *zero* dollars for its PASRR expenditures. A failure to report any expenses whatsoever could have several possible causes:

1. Improper program implementation.
2. A failure by the SMHA and SIDA to establish the memorandum of understanding (MOUs) with the Medicaid agency that they would need in order to be reimbursed.
3. A failure to aggregate costs at all, even when the necessary MOUs are in place.
4. A clerical error – a failure to enter the data on the relevant lines of the CMS-64.

What about the states that do report expenditures? What can explain the wide variation in per capita costs across states? We turn to that question in the next section.

3 Aspects of PASRR Program Operation

In consultation with CMS, PTAC compiled a list of PASRR operational elements that might influence expenditure patterns. Those elements are listed in Table 2, along with the rationale for including them (i.e., why those operational elements might be associated with a robust PASRR program).

Table 3. PASRR Program Operational Elements and Associated Rationales

PASRR Operational Element	Rationale
Interagency agreement allowing agencies to be reimbursed by Medicaid	Interagency agreements are necessary for non-Medicaid agencies to receive payments from Medicaid agencies, which have the fiduciary relationship with CMS.
Approved cost allocation plan (CAP)	A CAP must be approved to permit agencies to bill an appropriate share of all resources devoted to the PASRR program – staff time, training, quality monitoring, electronic tracking systems, quality monitoring and quality improvement efforts.
Level I screens performed by vendor	Delegating PASRR activities to a third party vendor rather than having them performed by state employees may have an impact on the cost, although the precise nature of that impact is not currently known
Level II evaluations performed by vendor	Delegating PASRR activities to a third party vendor rather than having them performed by state employees may have an impact on the cost, although the precise nature of that impact is not currently known
Electronic tracking system	Electronic tracking systems track whether an individual has had a Level I screen or Level II evaluation. The use of an electronic tracking system may have an impact on overall expenditures and efficiency, although the precise nature of that impact is not currently known.
Made upgrades or changes to electronic tracking system in the past year	Like the introduction of a new electronic system, the maintenance of an existing system can also be paid for under the 75% match. The cost of transitioning to an electronic system could have a discrete impact on a program's expenditures.
75% match claimed for staff time (administration, including determinations)	Staff time should be tracked and reimbursed at the enhanced 75% match.
75% match claimed for information technology systems	As noted earlier, technology services can be reimbursed at the enhanced match of 75%, assuming an approved CAP is in place.

PASRR Operational Element	Rationale
System/mechanism for linking PASRR completion to NF payment	Some states have designed their systems so that NF payments are not approved until the PASRR is complete. This may have a positive impact on PASRR compliance and, in turn, would impact overall PASRR output/expenditures.
Level I screens can be performed by hospital discharge planners	It is very common for hospital discharge planners to administer Level I screens. Anecdotally, it appears that Level I screens may be integrated into hospital discharge activities such that they are not billed separately. While this practice does not have a negative impact on PASRR compliance, it could lead to lower PASRR-specific reimbursements.
Are costs for Level I screens reimbursed individually (Yes) or are they built into other service rates (e.g., other hospital services) (No)?	Costs for Level I screens could be billed individually, in a fee-for-service model, or the cost of the Level I screen could be bundled into another rate (a larger hospital service rate, or the sort of capitated rate that managed care entities typically develop to cover a wide range of costs).
Are regular trainings provided to PASRR screeners/evaluators?	Anecdotally, states have indicated a positive association between training efforts and PASRR compliance. Increased PASRR output could affect PASRR reimbursements.
If yes, are trainings measured for success/impact?	This question was posed in an attempt to more positively identify the association between trainings and PASRR output noted above.
Are regular trainings about PASRR provided to state nursing home surveyors?	Anecdotally, states have noted a positive correlation between Survey activity and PASRR compliance. Increased PASRR compliance may lead to increased PASRR output, which could impact reimbursements.
If yes, are trainings measured for success/impact?	This question was posed in an attempt to more positively identify the association between trainings and PASRR output noted above.

Abbreviations: NF, nursing facility; PASRR, Preadmission Screening and Resident Review.

To determine whether an element was applicable for a particular state and for a particular PASRR population, PTAC first looked for publicly available documents hosted on the web page of the relevant state agency—either mental health or intellectual/developmental disabilities. If relevant information was found, either "yes" or "no" was indicated, as appropriate. If not, the data element was marked as "no information," meaning that information necessary to make the determination was not available. For most states, information was not found for any data element.

To augment the database of PASRR operational information, PTAC composed fact sheets for each state, following a practice that Truven Health has used for other types of analyses. Those fact sheets then were distributed to each state in an email that explained their purpose and gave states the option of responding with updated information. (Fact sheets went out to each staff person listed in the Truven Health database of state PASRR contacts, which PTAC maintains with the help of CMS Regional Office staff.) Each email requested that the staff person acknowledge that he or she had received the fact sheet.

The fact sheets first were distributed in late March of 2018. A reminder was sent four weeks later to any state that did not update or at least acknowledge receiving the fact sheet. Twenty-two states (43.1 percent) updated their fact sheet, 8 states (15.7 percent) acknowledged receiving the fact sheet but did not provide updates, and 21 states (41.2 percent) did not acknowledge receipt. Table 3 contains findings for the 30 states that acknowledged receipt. It was assumed that acknowledging the fact sheet but replying with no updates meant that the state could not provide that information about its own program. Thus, the total number of states reported in Table 3 is 30.

Table 3 breaks the responses down by population type (SMI vs. ID/RC) and by response type ("yes," "no," or "no information"). The total share of responses for each data element adds up to 100 percent.

Table 4. State Responses to PASRR Program Operational Elements Fact Sheet (n=30 states)

Program Design Element	Serious Mental Illness, %			Intellectual Disability or Related Condition			Dual		
	Yes, %	No, %	NI, %	Yes, %	No, %	NI, %	Yes, %	No, %	NI, %
Interagency agreement allowing agencies to be reimbursed by Medicaid	45	23	42	50	23	27	41	27	27
Approved cost allocation plan	55	9	36	50	9	41	45	14	41
Level I screens performed by vendor	32	55	14	27	55	14	27	55	18
Level II evaluations performed by vendor	59	27	14	36	45	14	50	32	18
Electronic tracking system	59	23	14	59	23	18	55	23	23
Made upgrades or changes to electronic tracking system in past year	27	55	18	32	50	18	27	50	23
75% match claimed for staff time (administration, including determinations)	64	9	27	59	14	27	55	18	27
75% match claimed for information technology systems	32	27	41	32	27	41	27	32	41
System/mechanism for linking PASRR completion to NF payment	55	18	27	55	14	27	50	18	27
Level I screens can be performed by hospital discharge planners	59	27	14	59	27	14	55	32	14
Are costs for Level I screens reimbursed individually (Yes) or are they built into other service rates (e.g., other hospital services) (No)?	36	32	32	32	32	36	32	32	36
Are regular trainings provided to PASRR screeners/evaluators?	77	5	18	68	5	27	68	9	23
If yes, are trainings measured for success/impact?	36	32	32	36	32	32	32	36	32
Are regular trainings provided to state nursing home surveyors about PASRR?	45	41	14	41	36	23	41	41	18
If yes, are trainings measured for success/impact?	23	36	41	23	36	41	14	41	41

Abbreviations: NI, no information in PASRR Technical Assistance center files; PASRR, Preadmission Screening and Resident Review.

Note that there is marked variation in the share of states that responded "yes" to the data elements. The following are a few key findings:

- Roughly two-thirds to three-quarters of states indicated that they provide trainings to their PASRR screeners (for Level I) or to their evaluators (for Level II). But only slightly more than one-third of states measure the impact of their trainings.
- About half of states have an approved cost allocation plan that lets them assign costs to PASRR (e.g., share of a staff person's time or share of time that a computer is used for PASRR activities).
- More than half of states claim PASRR-related administrative expenditures at the enhanced match of 75 percent, while significantly less than half claim PASRR-related information technology expenditures at the enhanced match rate. This means that many states either claim it at the regular 50 percent match for standard administrative activities or do not claim it all. It is apparent from Form CMS-64 data that some states do not claim any reimbursements for their PASRR activities—Lines 10 and 11 on the form are simply blank.

Looking state by state, there is no obvious relationship between the per capita expenditures listed in Table 1 and the presence or absence of the operational elements listed in Table 2. However, one cannot conclude that there is *no* relationship. This area requires further study.

4 Recommendations

CMS will use the results of these analyses to have discussion with states about the need to track operational aspects of their PASRR programs, claim the 75 percent enhanced federal match, and ensure that PASRR expenditures are being claimed on the Form CMS-64.

In addition, CMS may wish to—

- Explore factors affecting PASRR output and reimbursement by collecting additional information about PASRR programs through a more comprehensive, formal survey
- Continue providing technical assistance to states wishing to improve their PASRR programs
- Consider developing a series of "promising practices" pieces on states that appear to be operating PASRR programs with strong operational components—for example, by properly claiming PASRR reimbursements on the Form CMS-64, having interagency agreements in place to ensure that the relevant state authorities are reimbursed for their PASRR activities, and having an approved cost allocation plan.

5 About PTAC and Requesting Technical Assistance

PTAC has assembled a team of national experts on PASRR policy and implementation who regularly work directly with states and CMS. Any state agencies working with PASRR may ask a question or request assistance—all PTAC assistance is at no cost to states, including travel if required. PTAC reaches out particularly to the three agencies with statutory responsibility for PASRR: the Medicaid agency, the state mental health authority, and the state intellectual disabilities authority.

PTAC urges these agencies to keep contact information up to date at the PTAC website and with CMS regional offices, so that you will receive notice of monthly PASRR webinars, quarterly PASRR calls with the states in your region, and communications such as this report. You also will receive information on special initiatives such as the work group for states wishing to modernize the ways in which they pay for and provide the PASRR-related supports known as Specialized Services.

Much of the information and training materials assembled since 2009 is available on the Center's website and may be useful to others involved with long-term care, rebalancing and Olmstead initiatives, and services for individuals with SMI or ID/RC.

PTAC's technical assistance to states (1) is free, (2) can include consultations by phone or email, and (3) may include in-person visits (e.g., for strategic planning or to help develop interagency collaboration). States may request technical assistance on any of the topics discussed in this report through the PTAC website or by contacting the Director of PTAC, Ed Kako, at edward.kako@PASRRassist.org.