REQUIREMENTS AND LIMITS

06-87 APPLICABLE TO SPECIFIC SERVICES 4130

4130. COMPARABILITY OF SERVICES

A. Background.--Under §1902(a)(10)(B) of the Social Security Act (the Act) and implementing regulations at 42 CFR 440.240, services available to any categorically needy recipient under a State plan must not be less in amount, duration, and scope than those services available to a medically needy recipient. Services available to any individual in the categorically needy group or a covered medically needy group must be equal in amount, duration, and scope for all recipients within the same group. Comparability requirements ensure that coverage of services for the categorically needy continue to be the primary objective of the Medicaid program and prevent the coverage of selected services for the medically needy from diverting resources from the categorically needy. Also, these requirements ensure that each Medicaid individual receives a fair and equitable share of services covered under the State Medicaid plan, and that no individual is prevented arbitrarily from receiving a service once determined to be a member of an eligible coverage group.

In the past, various legislative provisions have been enacted to permit or require that exceptions be made to these comparability requirements. The purpose was to permit flexibility in targeting needed medical services to those individuals who required them while, at the same time, ensuring that the intent of the Medicaid program was upheld.

B. Exceptions.--Effective April 7, 1986, §9501(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law 99-272) provides an exception to the comparability requirements with respect to additional services made available to pregnant women. Under this exception, you may elect to provide additional services (expansion of coverage) to pregnant women eligible for receiving Medicaid without violating comparability requirements. The only stipulation is that these additional services must be available to all Medicaid pregnant women, however, you do not have to extend them to other individuals or groups.

Additional services for pregnant women would be directed toward the rendition of pregnancy-related services (prenatal, delivery and post-partum) and services for conditions which may complicate pregnancy. These additional services may be comprised of the following:

o greater coverage of existing plan services (required or optional); and

o coverage of optional services not otherwise covered under the plan.

Accordingly, you may establish less restrictive limitations on existing plan services which would allow for increased medical care being made available only to Medicaid pregnant women (e.g., you may wish to provide additional inpatient hospital care or physician care by allowing coverage for additional inpatient days or physician visits). You may also extend coverage for preventative and curative services not presently covered under your Medicaid plan only to your Medicaid pregnant women. These may be services which are currently optional under §§1905(a)(9) and (13) of the Act, including health education and outreach services, clinic services, nutrition counseling, vitamins and other over-the-counter medications, etc.

Rev. 28 4-131

REQUIREMENTS AND LIMITS

4130(Cont.) APPLICABLE TO SPECIFIC SERVICES 06-87

The following example is an illustration of the use of the comparability exception to expand coverage for pregnant women: If you wish to provide prescribed drugs (an optional service not otherwise available under your plan) and 10 additional days of inpatient hospital care (expansion of a plan limitation on a required service) to your medically needy pregnant women, you would be required to provide comparable benefits to your categorically needy pregnant women, but would not be required to provide these benefits to the entire medically needy and categorically needy populations.

4-132 Rev. 28

REQUIREMENTS AND LIMITS

11-88 APPLICABLE TO SPECIFIC SERVICES 4201

4201. ORGAN TRANSPLANTS

A. Background.--Section l903(i) of the Social Security Act requires the denial of Federal Financial Participation (FFP) for organ transplants unless the State plan provides written standards concerning the coverage of such procedures. The statute does not list the transplant procedures for which standards must be written, but the organs about which questions are most commonly asked are: cornea, kidney, heart, liver, bone marrow, pancreas and combined heart-lung. You can choose to cover no organ transplant procedures, some types of transplants and not others, or all transplants. You should specify in the written standards which organs you cover and any special conditions or limitations which apply to them.

B. Standards for Coverage.--If you choose to cover organ transplant procedures, furnish written standards for the coverage of these procedures which provide that:

o similarly situated individuals are treated alike;

o any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; and

o services are reasonable in amount, duration, and scope to achieve their purpose.

1. Similarly Situated Individuals.--Similarly situated does not mean that anyone with end-stage organ disease, regardless of the etiology, must be covered. Apply transplant criteria fairly and uniformly to all individuals eligible for Medicaid. There is no justification for approving payment for a particular transplant procedure for one eligible recipient and denying payment for that same procedure for another similarly situated eligible recipient needing the same transplant procedure. You may, however, place limitations on coverage. For example, you can choose to cover transplants for the categorically needy, and not cover them for the medically needy. You can also choose to limit coverage to certain clinical conditions or to reasonable patient selection criteria. However, include these conditions in your standards. Do not list general statements such as "coverage is limited to those conditions for which the safety and efficacy of the transplant have been established," or "coverage is limited to nonexperimental procedures," as coverage standards.

2. Facility and Practitioner Restrictions.--In view of the extraordinary expense and complexity of transplant procedures, you can decide to commit your resources only to those facilities and practitioners of demonstrated excellence with regard to a particular procedure, whether located in your State or not. If you choose to restrict the facilities or practitioners, assure that the designated providers render high quality care and that they are accessible, through transportation arrangements made or paid for by the State, to all eligible Medicaid recipients throughout the State.

Rev. 39 4-203

REQUIREMENTS AND LIMITS

4201 (Cont.) APPLICABLE TO SPECIFIC SERVICES 11-88

3. Sufficiency of Services.--Under regulations at 42 CFR 440.230, you are prohibited from "arbitrary" denial or reduction of an eligible recipient’s benefits, but you are permitted to place appropriate limits based on medical necessity. You may cover transplants up to a dollar or day limit, and may refuse to continue coverage beyond such limits, even if the patient is currently in a transplant program. However, any limits applicable to transplants, whether in terms of dollars or days, should be reasonably related to the dollars or days necessary to cover the particular type of transplant for most transplant patients in the Medicaid-eligible population. For example, if the average hospital stay for a type of transplant is 30 days, a limit of l4 days would not be considered reasonable, even though such a limit might be acceptable for nontransplant patients.By the same token, you may provide additional coverage for transplant patients above normal State plan limits, and this would not constitute an arbitrary denial or reduction in services for other (nontransplant) recipient groups.

4-204 Rev. 39

REQUIREMENTS AND LIMITS

07-85 APPLICABLE TO SPECIFIC SERVICES 4221

4221. OUTPATIENT PSYCHIATRIC SERVICES.

A. General.--Medicaid provides coverage of various types of organized outpatient programs of psychiatric treatment. These programs are covered primarily as either outpatient hospital services (42 CFR 440.20(a)) or as clinic services (42 CFR 440.90). Problems have sometimes arisen regarding outpatient programs which inappropriately billed Medicaid for chance, momentary social encounters between a therapist and a patient as if they were valid therapeutic sessions. There have also been instances of billing for services without sufficient documentation to establish that the services were clearly related to the patient’s psychiatric condition. With the ongoing effort to encourage furnishing psychiatric treatment in the least restrictive setting possible, there is an increasing need for coverage guidelines specifically directed at outpatient programs. The following guidelines can help to ensure appropriate utilization with regard to outpatient psychiatric programs.

B. Outpatient Program Entry.--An intake evaluation should be performed for each recipient being considered for entry into an outpatient psychiatric treatment program. This applies to any organized program or course of treatment that a recipient enters or attends to receive scheduled or planned outpatient psychiatric services. The evaluation is a written assessment that evaluates the recipient’s mental condition and, based on the patient’s diagnosis, determines whether treatment in the outpatient program would be appropriate.

The evaluation team should include, at a minimum, a physician and an individual experienced in diagnosis and treatment of mental illness (both criteria can be satisfied by the same individual, if appropriately qualified). For each recipient who enters the program, the assessment should include a certification by the evaluation team that the program is appropriate to meet the recipient’s treatment needs. The assessment should be made a part of the patient records.

C. Treatment Planning.--For each recipient who enters the outpatient program, the evaluation team should develop an individual plan of care (PoC). This consists of a written, individualized plan to improve the patient’s condition to the point where the patient’s continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The PoC is included in the patient records, and contains a written description of the treatment objectives for that patient. It also describes:

1. the treatment regimen--the specific medical and remedial services, therapies, and activities that will be used to meet the treatment objectives;

2. a projected schedule for service delivery--this includes the expected frequency and duration of each type of planned therapeutic session or encounter;

3. the type of personnel that will be furnishing the services; and

4. a projected schedule for completing reevaluations of the patient§s condition and updating the PoC.

Rev. 15 4-221

REQUIREMENTS AND LIMITS

4221 (Cont.) APPLICABLE TO SPECIFIC SERVICES 07-85

D. Documentation.--The outpatient program should develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. This documentation, at a minimum, should consist of material which includes:

1. the specific services rendered;

2. the date and actual time the services were rendered;

3. who rendered the services;

4. the setting in which the services were rendered;

5. the amount of time it took to deliver the services;

6. the relationship of the services to the treatment regimen described in the PoC and

7. updates describing the patient’s progress.

For services that are not specifically included in the recipient’s treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient’s PoC should be submitted with bills. Similarly, a detailed explanation should accompany bills for a medical or remedial therapy, session, or encounter that departs from the PoC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives.

E. Periodic Review.--The evaluation team should periodically review the recipient’s PoC in order to determine the recipient’s progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the recipient’s continued participation in the program. The evaluation team should perform such reviews on a regular basis (i.e., at least every 90 days) and the reviews should be documented in detail in the patient records, kept on file and made available as requested for State or Federal assessment purposes.

4-221.1 Rev. 15

REQUIREMENTS AND LIMITS

04-90 APPLICABLE TO SPECIFIC SERVICES 4231

4231. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) AND OTHER AMBULATORY SERVICES

A. Background.--Section 6404 of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) amended §§1905(a) and (l) of the Social Security Act to provide for coverage and definition of Federally Qualified Health Center (FQHC) services and other ambulatory services offered by an FQHC under Medicaid. Payment for services added by §6404 is effective for services provided on or after April 1, 1990. Payment for FQHC services is discussed in §6303.

B. FQHC Services and Other Ambulatory Services.--FQHC services are defined the same as the services provided by rural health clinics (RHCs) and generally described as RHC services. These services include physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician’s services. In certain cases, services to a homebound Medicaid patient may be provided. For a discussion of RHC services, see the Medicare Rural Health Clinic Manual, Chapter IV. Any other ambulatory service included in a State’s Medicaid plan is considered a covered FQHC service, if the FQHC offers such a service.

C. Qualified FQHCs.--FQHCs are facilities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. For purposes of providing covered services under Medicaid, FQHCs may qualify as follows:

o The facility receives a grant under §§329, 330, or 340 of the Public Health Service (PHS) Act;

o The Health Resources and Services Administration (HRSA) within the PHS recommends, and the Secretary determines that, the facility meets the requirements for receiving such a grant; or

o The Secretary determines that a facility may, for good cause, qualify through waivers of the requirements described above. Such a waiver cannot exceed a period of 2 years.

A list of facilities receiving grants under §§329, 330, and 340, and thereby automatically qualified for provision of and payment for services provided under this section, is found in Exhibit I immediately following this section. The PHS advises HCFA timely of changes in status of grantees and other qualified FQHCs.

Rev. 47 4-231

REQUIREMENTS AND LIMITS

4231 (Cont.) APPLICABLE TO SPECIFIC SERVICES 04-90

Any entity seeking to qualify under this section which does not qualify as a grant receiving facility should contact the PHS for consideration. The PHS is responsible for determining whether an applicant meets eligibility requirements. Applicants for consideration generally must be free-standing entities providing ambulatory care which otherwise qualify under §§329, 330 or 340 of the PHS Act. PHS forwards to HCFA, as determinations are made, a list of qualified entities. HCFA is responsible for the final determination that a facility (other than a grant recipient) can receive payment for services under Medicaid, and will notify states accordingly. Applicants apply to:

Director, Division of Primary Care Services

Bureau of Health Care Delivery and Assistance

U. S. Public Health Service

Room 7A55

5600 Fishers Lane

Rockville, MD 20857

Additionally, an FQHC which is not physician-directed may make certain arrangements similar to those entered into by RHCs, as provided for in § 1861(aa)(2)(B) of the Act. These arrangements concern reviews, supervision and guidance of non-physician staff, preparation of treatment orders, consultation, medical emergencies, and certain other certifying requirements for such facilities. The PHS assures the non-physician directed FQHCs comply with the requirements of §1861 (aa)(2)(B) of the Act.

D. Effective Date.--April 1, 1990 is the effective date for services provided under §6404 of OBRA-89. Submit State plan amendments to the HCFA regional offices no later than June 30, 1990, in order to obtain approval for services provided on or after the effective date. However, when the Secretary determines that State legislation (other than for funding) is necessary in order for the plan to meet the additional requirements of §6404, the State plan is out of compliance only if it fails to comply with such additional requirements after the first day of the first calendar quarter beginning after the close of the first regular session of a State legislature that begins after the date of the enactment of OBRA-89 (December 19, 1989). In a State that has a 2 year legislative session each year of the session is deemed to be a separate regular session of the State legislature.

4-231.1 Rev. 47

REQUIREMENTS AND LIMITS

04-90 APPLICABLE TO SPECIFIC SERVICES 4231 (Cont.)

Exhibit I

FY 1990 CH/MHC Grantee List

90

R BDT

E ST

G MO BCRR PROG NAME CITY ST

==============================================================

01 08 010810 U SW Community Bridgeport CT

01 03 011270 U Bridgeport Comm Bridgeport CT

01 03 011260 U Community Health Hartford CT

01 01 011830 U Charter Oak Terrace Hartford CT

01 06 010070 U Hill Health Corp New Haven CT

01 04 010060 U Fairhaven Comm Health New Haven CT

01 08 010290 U Roxbury Comp Comm. Boston MA

01 07 010160 U North End Comm Hlth Boston MA

01 02 011890 U Joseph Smith CHC Boston MA

01 07 010170 U Harbor Health Svcs Boston MA

01 04 012010 U Mattapan Comm Hlth Boston MA

01 07 010710 U South Cove Comm. Boston MA

01 02 010030 U Holyoke Health Ctr, Holyoke MA

01 07 012160 U Greater Lawrence Lawrence MA

01 08 011460 U Lowell Community Lowell MA

01 03 011430 U Lynn Community Lynn MA

01 07 011930 U Greater New Bedford New Bedford MA

01 08 010860 U North Shore Comm Hlth Peabody MA

01 03 011190 R Outer Cape Health Provincetown MA

01 06 011640 U Manet Comm Hlth Ctr Quincy MA

01 08 010800 U Family Health & Worcester MA

01 06 010830 U Great Brook Valley Worcester MA

01 06 010330 R Worthington Health Worthington MA

01 07 010040 R Rural Health Centers Augusta ME

01 02 012030 R Bethel Area HC Bethel ME

01 07 010340 R Bucksport Reg Hlth Bucksport ME

01 06 011230 R Sacopee Valley Kezar Falls ME

01 12 010380 R Reg. Medical Center Lubec ME

01 12 010420 R Northern ME Rural Presque Isle ME

01 07 010460 R Kennebec Valley Waterville ME

01 05 011580 R Lamprey Health Care New Market NH

01 12 012230 R Wood River Hlth Hope Valley RI

01 01 012240 U Blackstone Valley Pawtucket RI

01 12 010580 U Providence Ambul. Providence RI

01 03 011820 R Thundermist Hlth Assoc, Woonsocket RI

01 07 010640 R Northern Co. Health St. Johnsbury VT

02 01 021270 R/MH Bridgeton Area Bridgeton NJ

02 01 021280 U Camcare Health Camden NJ

02 03 020930 R/MH Sa-Lantic Health Hammonton NJ

Rev. 47 4-231.2

REQUIREMENTS AND LIMITS

4231 (Cont.) APPLICABLE TO SPECIFIC SERVICES 04-90

Exhibit I(Cont.)

02 04 022290 U Jersey City Medical Jersey City NJ

02 12 020500 U Newark Comm Hlth Ctr Newark NJ

02 01 021300 U Paterson CHC Network Paterson NJ

02 07 021230 U Plainfield Health Plainfield NJ

02 04 020070 U Henry J. Austin Trenton NJ

02 04 020110 U Whitney M. Young Albany NY

02 01 020180 R/MH Oak Orchard Comm. Brockport NY

02 08 021950 U Soundview Health Bronx NY

02 06 021610 U Morris Heights Bronx NY

02 02 020760 U Bronx Ambulatory Bronx NY

02 01 020270 U Sunset Park Brooklyn NY

02 12 021210 U ODA Primary Care Brooklyn NY

02 01 020610 U CHC East New York Brooklyn NY

02 12 022050 U L B Johnson Health Brooklyn NY

02 04 021980 U Brooklyn Plaza Brooklyn NY

02 01 020010 U North West Buffalo Buffalo NY

02 08 021310 R North Jefferson Clayton NY

02 12 021240 R Cortland Co. Rural Cortland NY

02 08 021530 U Greenburgh Neigh§bd HC Greenburg NY

02 08 021500 U Mt. Vernon N.H.C Mt. Vernon NY

02 08 021080 U Settlement Hlth and New York NY

02 12 020390 U East Harlem Cl. for New York NY

02 12 020490 U William F. Ryan New York NY

02 05 021390 U Chinatown CHC New York NY

02 06 020620 U/MH Fam HC of Orange & Newburgh NY

02 08 021520 U Ossining Open Door HC Ossington NY

02 08 021510 U Peekskill Hlth Ctr Peekskill NY

02 01 020870 R Northern Oswego Pulaski NY

02 04 022110 U Joseph P. Addabbo Queens NY

02 01 022070 U Anthony L. Jordan Rochester NY

02 01 020560 U Rochester Primary Rochester NY

02 06 021830 U Carver Community Schenectady NY

02 01 020570 MH Rochester Gen. Hosp Sodus NY

02 04 020160 U Syracuse Community Syracuse NY

02 01 021790 R Hudson Headwaters Warrensburg NY

02 07 021870 R Barceloneta RH Barceloneta PR

02 02 020910 R Camuy RHI Camuy PR

02 05 020660 R/MH Hosp General de Castaner PR

02 03 021250 R Ciales Health Ctr Ciales PR

02 03 020730 MH Cidra Migrant Cidra PR

02 01 021400 R Florida RHI Hlth Ctr Florida PR

02 03 021260 R Hatillo RHI Hatillo PR

02 05 022090 R Lares Health Center Lares PR

4-231.3 Rev. 47

REQUIREMENTS AND LIMITS

04-90 APPLICABLE TO SPECIFIC SERVICES 4231 (Cont.)

Exhibit I(Cont.)

02 07 020670 R/MH Loiza Comprehensive Loiza PR

02 03 021040 MH Mayaguez Migrant Hlth Mayaguez PR

02 06 020650 R/MH Central Areawide Naranjito PR

02 04 020890 R/MH Patillos RHI Patillas PR

02 12 020680 U/MH Ponce Diagnostic Playa Ponce PR

02 05 021030 R Rincon RH Project Rincon PR

02 05 020700 U Dr. J. S. Belaval Rio Piedras PR

02 06 021350 R Fredericksted Hlth St. Croix VI

03 02 031860 U Community Health Care Washington DC

03 04 030070 MH Delmarva Rural Dover DE

03 03 031260 U Southbridge Medical Wilmington DE

03 02 033180 U Baltimore Medical Baltimore MD

03 04 031270 U South Baltimore Baltimore MD

03 07 032810 U Assoc. Program for Baltimore MD

03 12 030150 U West Baltimore Baltimore MD

03 12 030130 U Parkwest Health Baltimore MD

03 07 032750 R Caroline Hlth Goldsboro MD

03 12 031600 R Tri-State CHC Hancock MD

03 06 030170 R Somerset Co for Princess Anne MD

03 06 031220 R North Penn Comp Blossburg PA

03 03 030220 R Broadtop Area Broad Top City PA

03 03 030230 R Comm. Medical Ctr Burgettstown PA

03 02 033930 U Ches Penn Health Chester PA

03 08 032430 R Glendale Area Med. Coalport PA

03 04 032300 R Keystone Rural Emporium PA

03 07 034230 U Primary Hlth Svcs of Erie PA

03 03 034060 R Shenango Valley Pri. Farrell PA

03 02 031700 R Centerville Clinics Fredericktown PA

03 04 033090 R SE Greene Community Greensboro PA

03 04 030290 U Hamilton Health Ctr Harrisburg PA

03 05 031880 MH Rural Opport.,Inc Harrisburg PA

03 03 032440 R Hyndman Area Medical Hyndman PA

03 04 033620 U SE Lancaster Primary Lancaster PA

03 12 032230 U F.O.R. Sto-Rox NHC McKees Rocks PA

03 03 034140 U Spectrum Health Philadelphia PA

03 06 032900 U Philadelphia Health Philadelphia PA

03 06 033780 U Quality Health Philadelphia PA

03 06 033200 U Greater Philadelphia Philadelphia PA

03 12 032220 U Covenant House Hlth Philadelphia PA

03 02 030440 U Primary Care Health Pittsburgh PA

03 12 032560 U Scranton Primary Scranton PA

03 05 030480 R Barnes Kasson Health Susquehanna PA

03 07 030560 R Rural Hlth Corp of NE Wilkes Barre PA

Rev. 47 4-231.4

REQUIREMENTS AND LIMITS

4231 (Cont.) APPLICABLE TO SPECIFIC SERVICES 04-90

Exhibit I(Cont.)

03 04 031160 U York Health Corp. York PA

03 06 030720 R Eastern Shore Rural Accomac VA

03 03 031970 R Brunswick Health Alberta VA

03 03 032380 R Tri County Medical Aylett VA

03 03 032650 R Bland County Medical Bastian VA

03 08 034170 R Boydton Comm Hlth Boydton VA

03 06 031230 R Clinch River Health Dungannon VA

03 05 033030 R Western Lee County Ewing VA

03 05 032840 R Ivor Community Ivor VA

03 08 034180 R Lunenburg Co. Health Kenbridge VA

03 08 033230 R Tri - Area Laurel Laurel Fork VA

03 08 034050 R Blue Ridge Health Lovington VA

03 08 030700 R Central Virginia New Canton VA

03 05 032240 U Peninsula Institute Newport News VA

03 03 031810 R Saltville Medical Saltville VA

03 06 030740 R St Charles Council St Charles VA

03 03 031760 R Stony Creek CHC Stony Creek VA

03 06 033130 R E.A. Hawse Retirement Baker WV

03 06 030880 R Valley Hlth Systems, Barboursville WV

03 06 030800 R Clay-Battelle Hlth Blacksville WV

03 12 033100 R Camden-on-Gauley Camden-on-Gauley WV

03 12 034090 R Clay Co Primary Hlth Clay WV

03 12 031820 R Cabin Creek Health Dawes WV

03 02 030820 R Monongahela Valley Fairmont WV

03 03 031000 R Tug River Health Gary WV

03 07 034190 R Minnie Hamilton Hlth Grantsville WV

03 06 032580 R No. Greenbrier/South Hillsboro WV

03 06 030890 R Preston-Taylor CHCs Kingwood WV

03 07 030900 R/MH Intercounty Hlth, Martinsburg WV

03 06 031250 R Bluestone Health Princeton WV

03 12 033080 R Rainelle Medical Center Rainelle WV

03 12 034210 R Tri-County Health Rock Cave WV

03 12 032600 R New River Health Scarbro WV

03 02 034120 R Roane County Family Spencer WV

03 04 030790 R Community Hlth System Spraque WV

03 08 030990 R Monroe Co. Hlth Bd Union WV

04 04 042210 R Autaugaville Medical Autaugaville AL

04 02 040070 R West Alabama Neigh- Eutaw AL

04 02 042830 R Conecuh Medical Evergreen AL

04 04 044120 U Etowah Quality of Gadsden AL

04 03 044700 U Area Health Dev. Bd Irvington AL

04 03 048190 U Central North Ala. Madison AL

04 08 044710 U Franklin Memorial Mobile AL

04 06 047080 U Mobile Co Hlth Dept Mobile AL

04 02 040130 U Montgomery Hlth Svcs Montgomery AL

04 12 042180 R Southern Rural Hlth Russellville AL

04 06 045710 R Jackson Co Primary Scottsboro AL

4-231.5 Rev. 47

REQUIREMENTS AND LIMITS

04-90 APPLICABLE TO SPECIFIC SERVICES 4231 (Cont.)

Exhibit I(Cont.)

04 07 042850 R Rural Hlth Medical Selma AL

04 05 048950 R SE Alabama RHA Troy AL

04 12 042450 R Maude L. Whately Tuscaloosa AL

04 08 040040 R Health Development Tuscaloosa AL

04 04 040160 R Central Alabama Tuskegee AL

04 02 041660 R/MH West Orange Farm Apopka FL

04 07 040200 R Family Medical Cross City FL

04 03 045500 R/MH East Pasco Hlth Ctr, Dade City FL

04 02 040210 R/MH Florida Rural Hlth Frostproof FL

04 03 041680 R/MH Southwest FL Hlth Ctr Ft Myers FL

04 02 048960 R Tri County Health Greenville FL

04 04 041700 R/MH Collier Health Immokalee FL

04 08 048970 U Columbia Co. Health Lake City FL

04 05 040290 R Lafayette Co. Mayo FL

04 08 041630 U Coconut Grove Family Miami FL

04 02 040330 U Economic Opport. Miami FL

04 02 040320 U/MH Community Hlth Miami FL

04 02 040310 U Borinquen Hlth Care Miami FL

04 04 044130 U Stanley C. Myers Miami Beach FL

04 12 040340 R/MH Rural Health Care, Palatka FL

04 12 044310 R/MH Manatee Co. Rural Parrish FL

04 01 041670 U Sunshine Health Pompano Beach FL

04 12 044780 R/MH Gadsden Primary Care Quincy FL

04 04 041750 R/MH Ruskin Migrant & CHC Ruskin FL

04 01 041720 R Central Florida Sanford FL

04 06 049070 R Johnnie Ruth Clark St. Petersburg FL

04 04 040250 R Project Health, Inc. Sumterville FL

04 04 0412810 R Tampa Community Hlth Tampa FL

04 07 042710 R Trenton Medical Trenton FL

04 04 040370 R/MH Florida Comm Hlth West Palm Beach FL

04 01 041740 R/MH Bd of Co Commiss. West Palm Beach FL

04 08 040380 R Wewahitchka Medical Wewahitchka FL

04 06 044150 U Albany Area Primary Albany GA

04 06 040400 U Health South, Inc. Atlanta GA

04 07 040410 U West End Medical Ctr Atlanta GA

04 04 040390 R Northeast Georgia Crawford GA

04 08 047430 R Georgia Highlands Cumming GA

04 01 046900 U Oakhurst Community Decatur GA

04 08 049170 MH Candler County Hlth Metter GA

04 06 045260 U Palmetto Health Palmetto GA

04 03 043340 R Stewart-Webster Richland GA

04 08 040490 U Westside-Urban Hlth Savannah GA

04 03 048160 R Hancock Co Primary Sparta GA

04 12 042110 R Georgia Mountains Suches GA

04 02 044790 R Primary Hlth Care Trenton GA

04 05 042390 R Tri-County Health Warrenton GA

Rev. 47 4-231.6

REQUIREMENTS AND LIMITS

4231 (Cont.) APPLICABLE TO SPECIFIC SERVICES 4-90

Exhibit I(Cont.)

04 08 046980 R Pike Co. Primary Zebulon GA

04 03 044090 U Northern Kentucky Covington KY

04 08 048140 U Lexington-Fayette Co Lexington KY

04 12 046840 U Louisville Mem Prim Louisville KY

04 12 040650 U Park Duvalle Hlth Louisville KY

04 06 044820 R Health Help, Inc. McKee KY

04 02 040670 R Big Sandy Health Prestonsburg KY

04 12 048980 R Lewis County Primary Vanceburg KY

04 05 040600 R Mountain Comp Whitesburg KY

04 05 049100 R North Benton Co. Ashland MS

04 01 042430 R Coastal Fam Hlth Biloxi MS

04 03 042440 U Rankin Urban Hlth Brandon MS

04 05 043060 R NE Mississippi Byhalia MS

04 06 040760 R Madison Yazoo Leake Canton MS

04 06 046150 R Aaron E. Henry Clarksdale MS

04 06 048800 R Jefferson Compre. Fayette MS

04 08 040750 U Jackson-Hinds Comp Hlth Jackson MS

04 05 040570 R South Mississippi CHC Laurel MS

04 08 044470 R Greene Area Medical Leaksville MS

04 03 045780 R Amite County Med. Liberty MS

04 04 042070 R Greater Meridian Meridian MS

04 03 040780 R Delta Health Center Mound Bayou MS

04 07 040770 R South Central MS New Hebron MS

04 07 048420 R Claiborne Co. Comm. Port Gibson MS

04 04 042720 R East Central MS Hlth Sebastopol MS

04 03 045770 R SE Mississippi RHI, Seminary MS

04 06 048870 R Outreach Health Shubuta MS

04 03 046860 R Three Rivers Area Smithville MS

04 12 047330 R S. W. Hlth Agency Tylertown MS

04 04 040840 R Vicksburg-Warren CHC, Vicksburg MS

04 12 041940 R Tri-County Hlth Aurora NC

04 12 040890 R Orange Chatham Comp Carrboro NC

04 05 047770 U Metrolina Comp Charlotte NC

04 07 040910 U Lincoln CHC/Durham Durham NC

04 01 045800 R/MH Goshen Medical Faison NC

04 04 040940 R/MH Migrant Family Hlth Hendersonville NC

04 07 046610 R Twin Co Rural Health Hollister NC

04 12 045200 R Western Med Group/Boone Mamers NC

04 06 045810 R Morven Area Medical Morven NC

04 04 040900 R/MH Tri-County Comm. Newton Grove NC

04 08 049000 R Robeson Health Pembroke NC

04 03 040860 MH Migrant Hlth Program Raleigh NC

04 12 041000 U Wake Hlth Svcs, Inc. Raleigh NC

4-231.7 Rev. 47

REQUIREMENTS AND LIMITS

04-90 APPLICABLE TO SPECIFIC SERVICES 4231 (Cont.)

Exhibit I(Cont.)

04 06 046800 R Person Fam Med Ctr Roxboro NC

04 12 041020 R Greene Co. Hlth Care, Snow Hill NC

04 03 041060 R Vance Warren Comp. Soul City NC

04 03 046910 R Stedman Wade Hlth Wade NC

04 05 049190 R Bertie County Rural Windsor NC

04 08 044920 R Caswell Family Yanceyville NC

04 02 042310 R Calhoun Falls Area Calhoun Falls SC

04 05 041110 U Franklin C. Fetter Charleston SC

04 08 045220 R Rural Health Svcs, Clearwater SC

04 05 041090 MH SC Mig. Hlth Proj. Columbia SC

04 05 047000 R Britton§s Neck Hlth Conway SC

04 02 040110 R Midlands Primary Eastover SC

04 05 043770 R Allendale Co.- Rural Fairfax SC

04 06 047060 R Little River Medical Little River SC

04 07 045050 R Sandhills Medical McBee SC

04 05 048430 R St James - Santee McClellanville SC

04 03 046930 R Black River Olanta SC

04 12 041180 R Orangeburg Co. Orangeburg SC

04 06 041190 R Beaufort Jasper Ridgeland SC

04 06 045230 R Society Hill Family Society Hill SC

04 06 042780 R/MH Megals Rural Hlth Trenton SC

04 02 041230 R/MH Benton Medical Benton TN

04 12 041260 U Chattanooga Hamilton Chattanooga TN

04 02 042160 R Laurel Fork - Clear Clairfield TN

04 04 041780 R Upper Cumberland Cookville TN

04 07 041440 R Mountain Peoples Huntsville TN

04 05 041370 R Perry County Linden TN

04 04 047820 R Union Grainger Maynardville TN

04 01 041410 U Memphis Health Memphis TN

04 05 049040 R Stewart Co./Tenn Dpt Nashville TN

04 02 041420 U Matthew Walker Nashville TN

04 02 044110 U United Neighborhood Nashville TN

04 04 046810 R Rural Community Parrotsville TN

04 05 0412790 R Rural Hlth Svcs Cons. Rogersville TN

04 03 045420 R Citizens of Lake Co. Tiptonville TN

04 01 041290 R Morgan Co. Hlth Wartburg TN

05 03 052180 R Rural Health Inc. Anna IL

05 07 050030 R Community Health Cairo IL

05 01 053320 R Southern Illinois Centerville IL

05 12 051870 U Frances Nelson Champaign IL

05 02 051720 U New City Health Ctr, Chicago IL

05 02 050080 U KOMED Health Center Chicago IL

05 03 050060 MH Illnois Migrant Chicago IL

Rev. 47 4-231.8

REQUIREMENTS AND LIMITS

4231 (Cont.) APPLICABLE TO SPECIFIC SERVICES 04-90

Exhibit I(Cont.)

05 06 051050 U Claretian Chicago IL

05 01 053280 U Near North Health Chicago IL

05 07 053210 U Erie Family Hlth Ctr Chicago IL

05 04 052130 R Christopher Greater Christopher IL

05 05 053150 U Community Health Decatur IL

05 04 05004D R/MH Shawnee Hlth Svcs Murphysboro IL

05 01 052140 R Henderson Co Rural Oquawka IL

05 12 052760 U Crusaders Central Rockford IL

05 06 051020 U People§s Hlth Ctr Indianapolis IN

05 12 053200 U Community Health Indianapolis IN

05 05 053110 R/MH Indiana Health Indianapolis IN

05 06 052200 R Downriver Community Algonac MI

05 12 050210 R Regional Health Baldwin MI

05 04 050220 R/MH MARCHA Bangor MI

05 12 052820 R Monway Citizens Carleton MI

05 02 052070 U Cass CHC Detroit MI

05 01 051990 U Detroit Health Dept Detroit MI

05 04 051680 R East Jordon Family East Jordon MI

05 04 053300 U Hamilton Area Flint MI

05 04 052030 Cherry Street Services Grand Rapids MI

05 03 053160 R Thunder Bay, CHC Hillman MI

05 01 050290 R Northern Michigan Houghton Lake MI

05 03 056230 U Family Health Center Kalamazoo MI

05 05 051980 R Alcona Medical Lincoln MI

05 03 051440 R Upper Pennisula Newberry MI

05 04 052510 R/MH Pullman Health Pullman MI

05 04 050360 R/MH Health Delivery Inc. Saginaw MI

05 03 050380 MH Sparta Health Ctr Sparta MI

05 04 052250 R Sterling Area Health Sterling MI

05 04 052910 R Citizens Health Temperance MI

05 03 050390 MH Northwest Michigan Traverse City MI

05 06 052710 R Cook Area Hlth Cook MN

05 06 052700 R Cook Co Clinic Grand Marais MN

05 04 051770 U Indian Hlth Board Minneapolis MN

05 03 050320 MH Migrant Health Moorehead MN

05 03 053020 U Westside Community St. Paul MN

05 12 052730 U Model Cities Health St. Paul MN

05 03 050560 R Barnesville Hlth Barnesville OH

05 03 052270 R P.R.A.V. Health Svcs, Chillcothe OH

05 01 051570 U Cincinnati Health Cincinnati OH

05 01 050990 R South. Ohio Hlth Svcs Cincinnati OH

05 01 050580 U Hough Norwood Fam Cleveland OH

05 04 050960 R/MH Community Hlth Svcs Freemont OH

4-231.9 Rev. 47

REQUIREMENTS AND LIMITS

04-90 APPLICABLE TO SPECIFIC SERVICES 4231 (Cont.)

Exhibit I(Cont.)

05 04 050640 R/MH Family Hlth Service Greenville OH

05 05 051660 R Ironton-Lawrence Co Ironton OH

05 02 052900 R Community Action Piketon OH

05 05 053010 U Toledo Family Toledo OH

05 12 051780 U Cordelia Martin HC/ Toledo OH

05 08 051490 R Northern Health Ctrs, Lakewood WI

05 06 050840 R Marshfield Medical Marshfield WI

05 04 053060 U 16th Street Clin/HOPE Milwaukee WI

05 03 056220 U Milwaukee Comprehens. Milwaukee WI

05 01 052670 U Indian Hlth Bd of Milwaukee WI

05 06 052810 R North Woods Medical Minong WI

05 04 050900 MH La Clinica De Los Wildrose WI

06 01 060940 R White River Rural Augusta AR

06 06 062090 R Mid-Delta Rural Hlth Clarendon AR

06 05 062140 R CABUN Rural Hlth Hampton AR

06 12 060060 R Lee Co Cooperative Marianna AR

06 08 060080 R Rural Health Inc. Paragold AR

06 06 060110 U Jefferson Comp Care Pine Bluff AR

06 02 062730 R Mainline Health Portland AR

06 12 060140 U East Arkansas Family West Memphis AR

06 06 060180 R Teche Action Board Franklin LA

06 08 063380 U Bayou Comprehensive Lake Charles LA

06 08 060190 R Natchitoches Area Natchitoches LA

06 01 062480 R Catahoula Parish Sicily Island LA

06 01 060240 U Albuquerque Family Albuquerque NM

06 07 060330 R Health Centers of Espanola NM

06 08 060360 R Gallup/Thoreau/Grants Gallup NM

06 05 060370 R Ben Archer Health Hatch NM

06 02 062160 R Centro Rural de Loving NM

06 08 061290 R/MH La Casa de Bueno Portales NM

06 07 063010 R/MH La Clinica de San Miguel NM

06 01 063450 R Presbyterian Med Santa Fe NM

06 07 063920 U La Familia Medical Santa Fe NM

06 07 060490 MH Oklahoma State Altus OK

06 08 063930 R Konawa Community Konawa OK

06 02 060530 U Community Hlth Ctrs Oklahoma City OK

06 05 063890 U Morton Health Center Tulsa OK

06 02 062650 R Panhandle Rural Amarillo TX

06 08 061000 R Chapparral Hlth Clinic Benavides TX

06 08 061510 U/MH Brownsville Comm. Brownsville TX

06 04 062120 R/MH South Texas Rural Cotulla TX

06 05 060670 R/MH Vida y Salud Crystal City TX

06 12 061010 U Martin L. King, Jr., Dallas TX

06 07 060680 U Los Barrios Unidos Dallas TX

Rev. 47 4-231.10

REQUIREMENTS AND LIMITS

4231 (Cont.) APPLICABLE TO SPECIFIC SERVICES 04-90

Exhibit I(Cont.)

06 12 060710 R/MH Cross Timbers De Leon TX

06 07 060740 R/MH United Medical Svc Eagle Pass TX

06 02 063520 R Centro Medico Del El Paso TX

06 12 061230 U Centro de Salud El Paso TX

06 12 060810 R Gonzales County Gonzales TX

06 08 060820 R Comm Hlth Svc Agency Greenville TX

06 05 060840 R/MH Su Clinica Familiar/ Harlingen TX

06 05 061610 U Galveston Co. Coord. La Marque TX

06 04 060900 U/MH Laredo-Webb Co Hlth Laredo TX

06 06 061220 R/MH South Plains Rural Levelland TX

06 08 061260 R East Texas Community Nacogdoches TX

06 08 061190 R Jasper-Newton Comm Newton TX

06 01 060750 R/MH Hidalgo Co. Health Pharr TX

06 06 060950 R/MH South Plains Health Plainview TX

06 08 062390 R Atascoso RHI Health Pleasanton TX

06 04 063190 U City of Port Arthur Port Arthur TX

06 02 060970 R/MH Comm Action Council Rio Grande City TX

06 04 063940 U Ella Austin Comm. San Antonio TX

06 03 062360 U/MH Barrio Comp Family San Antonio TX

06 05 063250 U Centro Del Barrio San Antonio TX

06 08 063910 R/MH Uvalde Co.-Clinic, Uvalde TX

07 03 071170 U Community Hlth Care Davenport IA

07 08 071790 U Broadlawns Medical Des Moines IA

07 02 070050 MH Muscatine Migrant Muscatine IA

07 02 071410 U Peoples Comm Hlth Waterloo IA

07 05 071800 MH Kansas City Wyandott Kansas City KS

07 07 070090 MH Kansas State Dept Topeka KS

07 08 070150 U Hunter Health Clinic Wichita KS

07 12 071660 R Caldwell Co Medical Hamilton MO

07 08 070290 U Samuel U. Rodgers Kansas City MO

07 05 070270 U Swope Pkwy Comp Kansas City MO

07 05 070300 R NE Missouri Hlth & Kirksville MO

07 03 072130 R Northwest Missouri Mound City MO

07 08 071370 R New Madrid Group New Madrid MO

07 12 071670 R Central Ozark Richland MO

07 02 071700 U Family Care Center St. Louis MO

07 06 072100 U Peoples Clinic St. Louis MO

07 02 070370 U St. Louis Compre St. Louis MO

07 03 071190 U Neighborhood HC, Inc St. Louis MO

07 06 070430 R Big Springs Medical Van Buren MO

07 04 070450 MH Nebraska State Dept Lincoln NE

07 03 072110 U Charles Drew Medical Omaha NE

08 12 080030 R/MH Valley Wide Health Alamosa CO

4-231.11 Rev. 47

REQUIREMENTS AND LIMITS

04-90 APPLICABLE TO SPECIFIC SERVICES 4231 (Cont.)

Exhibit I(Cont.)

08 07 081260 R Gilpin/Columbine Black Hawk CO

08 01 081460 U Comm Hlth of Colorado Springs CO

08 01 080010 MH Colorado Dept. of Denver CO

08 01 080060 U Denver Dept of Hlth Denver CO

08 07 080100 R Dolores Co. Hlth Dove Creek CO

08 06 080130 R/MH Plan de Salud del Fort Lupton CO

08 04 080140 R/MH Sunrise Community Greeley CO

08 02 081650 R La Clinica Campesina Lafayette CO

08 08 081740 R Uncomphadre Combined Norwood CO

08 06 080170 U Pueblo Comm Hlth Pueblo CO

08 05 082500 U Yellowstone City/ Billings MT

08 02 082160 MH Montana Migrant Billings MT

08 08 083270 R Butte CHC-Silver Bow Butte MT

08 01 082110 R Mercer-Oliver Center ND

08 05 080890 R Union County Health Elk Point SD

08 02 080500 R NW South Dakota Faith SD

08 12 081030 R East River Health Howard SD

08 04 082100 R Isabel Comm RHI Isabel SD

08 08 080590 R South Dakota Rural Pierre SD

08 01 081450 U Sioux River Valley Sioux Falls SD

08 08 081690 R Tri-County Hlth Care, Wessington Spring SD

08 07 082240 R Wayne Co. Medical Bicknell UT

08 08 082480 R Enterprise Valley Enterprise UT

08 08 082490 R Green River CHC Green River UT

08 05 080510 MH Utah Rural Dev. Corp. Midvale UT

08 05 082050 U Weber County Comm. Ogden UT

08 01 080220 U Salt Lake City Comm Salt Lake City UT

08 03 080830 MH Tri-County Dev. Corp. Guernsey WY

08 03 080710 MH Northwestern Comm. Worland WY

09 06 090030 R West Pinal Family Casa Grande AZ

09 12 093030 R/MH Clinica Adelante, El Mirage AZ

09 06 090090 R Mariposa Community Marana AZ

09 07 091300 R Lake Powell Family Page AZ

09 12 093070 U Memorial Family Phoenix AZ

09 08 090130 R/MH Valley Health Ctr, Somerton AZ

09 01 090160 U El Rio Santa Cruz NHC Tucson AZ

09 03 093590 R United Community Tuscon AZ

09 05 090210 R Family Health Fnd. of Alviso CA

09 01 093660 U Inland Empire CHC Bloomington CA

09 06 090250 R/MH Clinicas de Salud Brawley CA

09 12 090260 R Intermountain Comm. Brownsville CA

09 04 091600 R/MH Buttonwillow Health Buttonwillow CA

09 12 093150 R/MH El Progresso del Coachella CA

Rev. 47 4-231.12

REQUIREMENTS AND LIMITS

4231 (Cont.) APPLICABLE TO SPECIFIC SERVICES 4-90

Exhibit I(Cont.)

09 04 090290 U Drew Hlth Foundation East Palo Alto CA

09 02 093320 U/MH Sequoia Comm Health Fresno CA

09 01 091050 R/MH La Clinica Popular King City CA

09 04 090390 R/MH Clinica Sierra Vista Lamont CA

09 07 091650 R Long Valley Hlth Ctr, Laytonville CA

09 04 093160 U Arroyo Vista Family Los Angeles CA

09 02 091040 U Asian Pacific Venture Los Angeles CA

09 12 093110 U Altamed Los Angeles CA

09 01 090490 U Community Hlth Fdn Los Angeles CA

09 12 090440 U Watts Health Los Angeles CA

09 12 093210 R/MH El Concilio de Madera Madera CA

09 04 090470 R/MH Merced Family Merced CA

09 07 090710 R/MH Nipomo Comm Med Ctr, Nipomo CA

09 04 090540 U West Oakland Health Oakland CA

09 04 091030 U Asian Health Svcs Oakland CA

09 05 091230 U La Clinica de la Oakland CA

09 07 090850 MH North Sacramento Olivehurst CA

09 12 091000 U Northeast Valley Pacoima CA

09 06 090560 R/MH United Health Ctrs of Parlier CA

09 03 093640 MH Porterville Family Porterville CA

09 04 091240 U West Contra Costa Richmond CA

09 01 093120 U Logan Heights Family San Diego CA

09 04 090530 U San Francisco Med. San Francisco CA

09 03 090660 U Mission Neighborhood San Francisco CA

09 01 090670 U North East Medical San Francisco CA

09 01 090720 R/MH North County Hlth San Marcos CA

09 01 091080 U San Ysidro Health Ctr San Ysidro CA

09 07 093080 U UC Irvine (CCOC) Santa Ana CA

09 05 093650 MH Clinicas del Camino Saticoy CA

09 12 090780 R/MH Agricult§l. Workers Stockton CA

09 07 091960 R Northeast Rural Susanville CA

09 01 093190 U Tiburcio Vasquez Union City CA

09 02 091760 R Commonwealth of Saipan Saipan CM

09 05 093530 R Guam Health Dept. Agana GU

09 04 093410 R K K V Comprehensive Honolulu HI

09 03 090990 R Waianae Coast Waianae HI

09 08 091570 R Central Nevada Rural Babbitt NV

09 04 090820 U CHC of S. Nevada Las Vegas NV

09 01 093680 R Republic of Palaui Koror PW

09 02 093570 R Ministry of Health Marshall Islands TT

09 01 091920 R Ponape State Hosp. Ponape TT

10 07 100020 U Anchorage Neighborhd Anchorage AK

10 07 101610 R Glenns Ferry Area Glenns Ferry ID

10 04 100160 R Terry Reilly Health Nampa ID

4-231.13 Rev. 47

REQUIREMENTS AND LIMITS

04-90 APPLICABLE TO SPECIFIC SERVICES 4231 (Cont.)

Exhibit I(Cont.)

10 04 100280 R Mountain Health Nampa ID

10 03 101630 R/MH Valley Family Health Payette ID

10 07 100180 R Health West Inc. Pocatello ID

10 03 101650 R/MH Family Health Svcs, Twin Falls ID

10 08 100790 MH Clinica Del Valle OR

10 07 100010 R Southeast Oregon Chiloquin OR

10 04 101230 MH Virginia Garcia Mem Cornelius OR

10 03 102080 R/MH La Clinica del Carino Hood River OR

10 07 101120 U Multnomah Co Dept. Portland OR

10 12 100760 U NW Human Svcs, Inc. Salem OR

10 04 100340 R/MH Salud Medical Center Woodburn OR

10 03 100360 R N E W Health Programs Chewelah WA

10 08 100270 R West Coast Health Copalis Beach WA

10 04 101770 MH Okanogan Farmworkers Okanogan WA

10 12 100460 R Columbia Basin Hlth Othello WA

10 08 101520 R/MH La Clinica/South Pasco WA

10 03 100640 U Puget Sound Neighbor Seattle WA

10 04 101020 U/MH Sea-Mar Community Seattle WA

10 03 100630 U Central Seattle Seattle WA

10 06 100450 U Community Health Care Tacoma WA

10 04 101030 R/MH Yakima Valley Farm Topennish WA

10 04 100570 R/MH N C WASH Mig Health Wenatchee WA

Rev. 47 4-231.14

REQUIREMENTS AND LIMITS

4231 (Cont.) APPLICABLE TO SPECIFIC SERVICES0 4-90

Exhibit I(Cont.)

1990 HOMELESS GRANTEES

SECTION 340 HEALTH CARE FOR THE HOMELESS

Project Name: City: State:

Charter Oak Terrace/Rice

Heights Health Center Hartford CT

Hill Health Center New Haven CT

Southwest Bridgeport Comm. Hlth Ctr. Bridgeport CT

Windham Area Comm. Action Prog., Inc. Danielson CT

Boston Health Care for Homeless Project Boston MA

Springfield Hlth Svs. for the Homeless Springfield MA

Worcester Area Community

Mental Health Center, Inc. Worcester MA

City of Manchester Public Health Dept. Manchester NH

Providence Ambulatory Hlth Care Found Providence RI

Community Hlth Ctr. for Burlington, Inc. Burlington VT

William F. Ryan CHC New York NY

United Hospital Fund New York NY

Bowery Residents Committee

Human Services, Corp. New York NY

Westchester Health Network Neighborhood

Health Association of Mt. Vernon White Plains NY

Newark Homeless Health Care Project Newark NJ

Under 21 - Covenant House New York NY

St Vincent§s Hospital New York NY

NY Childrens Health Project New York NY

Jersey City Family Hlth Ctr Jersey City NJ

San Juan Department of Health San Juan PR

Henry J. Austin Hlth Ctr. HCH Trenton NJ

Health Care for the Homeless Proj., Inc. Washington DC

Health Care for the Homeless Baltimore MD

Primary Health Care Services Erie PA

Philadelphia Health Mgmt. Corporation Philadelphia PA

Primary Care Health Services Pittsburgh PA

Rural Health Corporation of NE PA Wilkes-Barre PA

The Daily Planet Richmond VA

Peninsula Institute for Comm. Hlth Hampton VA

Valley Health Systems, Inc. Huntington WV

Georgia Hill Street Neighborhood Fac. Atlanta GA

Birmingham Hlth Care for the Homeless Birmingham AL

Charleston Interfaith Crisis Ministry Charleston SC

Chattanooga Hamilton County Hlth Dept. Chattanooga TN

4-231.15 Rev. 47

REQUIREMENTS AND LIMITS

04-90 APPLICABLE TO SPECIFIC SERVICES 4231 (Cont.)

Exhibit I(Cont.)

Lincoln Community Health Center, Inc. Durham NC

Midlands Center for the Homeless Eastover SC

Broward County HCH Ft. Lauderdale FL

Jackson-Hinds Comprehensive HC Jackson MS

Lexington-Fayette County Hlth Dpt Lexington KY

Seven Counties Services, Inc. Louisville KY

Memphis Health Center, Inc. Memphis TN

Camillus Health Concern Miami FL

Pinellas County Department St. Petersburg FL

Metropolitan Health Dept. Nashville TN

Wake Health Services, Inc. Raleigh NC

Tampa Community Health Tampa FL

Travelers and Immigrants Aid Chicago IL

Crusaders Central Clinic Rockford IL

Indiana Health Centers, Inc. Indianapolis IN

East Side Promise, Inc. Indianapolis IN

Visiting Nurse Services of So. Mich. Battle Creek MI

Ingham County Health Dept. Lansing MI

St. Mary§s Health Services Grand Rapids MI

Family Health Center, Inc. Kalamazoo MI

Detroit Health Care for the Homeless Detroit MI

Downriver Community Services Algonat MI

Hamilton Family Health Ctr. Flint MI

Hennepin Cty Homeless Assistance Proj. Minneapolis MN

West Side Health Center, Inc. St. Paul MN

ECCO Family Health Center Columbus OH

Cordelia Martin Health Center Toledo OH

Cincinnati Health Network Cincinnati OH

Federation for Community Planning Cleveland OH

Coalition for Comm. Hlth Care Milwaukee WI

New Orleans Health Department New Orleans LA

Albuquerque Hlth Care for the Homeless Albuquerque NM

Community Health Center, Inc. Oklahoma City OK

Morton Comprehensive Health Serv. Inc. Tulsa OK

Amarillo Hospital District Amarillo TX

Dept of Hlth & Human Serv. - Dallas Dallas TX

City of Forth Worth Health Department Fort Worth TX

Harris County Hospital Dist. Houston TX

Guadalupe Economic Services Group Lubbock TX

The United Way of San Antonio & Bexar Cty San Antonio TX

Community Health Care, Inc. Davenport IA

Polk County Health Services Des Moines IA

Rev. 47 4-231.16

REQUIREMENTS AND LIMITS

4231 (Cont.) APPLICABLE TO SPECIFIC SERVICES 04-90

Exhibit I(Cont.)

People’s Community Health Clinic, Inc. Waterloo IA

Hunter Health Clinic, Inc. Wichita KS

Charles Drew Health Center Omaha NE

Swope Parkway Health Center Kansas City MO

Grace Hill Neighborhood Health Center St. Louis MO

Colorado Coalition for the Homeless Denver CO

Community Hlth Ctr of Colorado Springs Colorado Spgs CO

Health Care for the Homeless Rapid City SD

Salt Lake Community Health Ctrs, Inc. Salt Lake City UT

El Rio Santa Cruz Neighborhood Hlth Ctr Tucson AZ

Maricopa County Dept. of Hlth Services Phoenix AZ

The Family Health Foundation Alviso CA

Drew Health Foundation E. Palo Alto CA

Clinica Sierra Vista, Inc. Lamont CA

Logan Heights Family Health Center San Diego CA

Merced Family Health Centers, Inc. Merced CA

San Francisco Community Clinic San Francisco CA

Northeast Valley Health Corp. Pacoima CA

Nipomo Community Medical Nipomo CA

Sequoia Community Health Fresno CA

West Contra Cost HC Corp. Richmond CA

WCDCH Hosp. Board, Inc. Waianae HI

Sacramento County Health Dept. Sacramento CA

Santa Cruz Co. Hlth Svcs Agency Santa Cruz CA

Alameda Co. Health Care Svcs Agency Oakland CA

Santa Barbara County Hlth Care Svcs Santa Barbara CA

Terry Reilly Health Services Nampa ID

White Bird Clinic Eugene OR

Sea Mar Community Health Ctr. Seattle WA

Multnomah County Health Portland OR

Metropolitan Development Tacoma WA

Central Seattle Community Hlth Ctrs Seattle WA

Northwest Human Services Salem OR

4-231.17 Rev. 47

REQUIREMENTS AND LIMITS

05-89 APPLICABLE TO SPECIFIC SERVICES 4250

4250. MINIMUM FEDERAL CRITERIA FOR STATES TO USE IN MAKING PREADMISSION AND ANNUAL REVIEW DETERMINATIONS ABOUT ADMISSION TO OR CONTINUED RESIDENCE IN NURSING FACILITIES FOR INDIVIDUALS WHO HAVE MENTAL ILLNESS OR MENTAL RETARDATION

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) sets forth three sections that address preadmission screening and annual resident review (PASARR) requirements:

o With respect to new admissions occurring on or after January 1, 1989, §1919(b)(3)(F) prohibits a nursing facility (NF) from admitting any new resident who has mental illness (MI) or mental retardation (MR) (or a related condition), unless the State mental health or State mental retardation authority has determined that, because of his/her physical and mental condition, the prospective resident requires the level of services provided by a NF. In addition, where it is determined that admission to the NF is appropriate, a determination must be made as to whether active treatment is required.

o With respect to all current residents who have MR or MI and who were admitted prior to January 1, 1989, §1919(e)(7)(B) requires the State mental health or the State mental retardation authority to have reviewed and determined by April 1, 1990:

-- Whether or not the resident, because of his/her physical and mental condition, requires the level of services provided by a NF or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 or of an institution for mental diseases (IMD) providing medical assistance to individuals 65 years or older in the case of residents with MI or the level of services of an ICF/MR in the case of residents with MR. In the case of residents with MI, the statute further specifies that the determination made by the State mental health authority must be based on an evaluation performed by an independent person or entity; and

-- Regardless of the outcome of the NF level of care determination, whether or not the resident requires active treatment for his/her MI or MR.

Section 1919(e)(7)(B)(iii) requires that PASARR reviews and determinations be repeated on at least an annual basis on all NF residents who have MI or MR.

o Section 1919(f)(8) requires the the Secretary to develop, by not later than October 1, 1988, minimum criteria for the States to use in making the required determinations on new admissions and current residents and in permitting individuals adversely affected to appeal such determinations. However, §1919(e)(7)(A) requires the States to have a PASARR program in operation by the effective dates regardless of whether the Federal criteria are available.

We have been advised that the plain reading of the statute’s language and the absence of any apparent limitations mean that any person with MI or MR must be screened if he or she already resides in or is to be admitted to a NF. Furthermore, the statute does not provide any basis for limiting preadmission screening or annual reviews to only those

Rev. 42 4-241

REQUIREMENTS AND LIMITS

4250 (Cont.) APPLICABLE TO SPECIFIC SERVICES 05-89

individuals who have a "known diagnosis" of MI or MR. In order for facilities and States to protect themselves from the imposition of possible sanctions for failure to identify some individuals who have MI or MR, all individuals applying to or residing in a Medicaid-certified NF should be screened in some fashion to determine if they have MI or MR regardless of the "known diagnosis."

We would note that the statute makes preadmission screening requirements applicable to "new admissions." Thus a screening system which differentiates from admissions to an NF those which are "new" (as opposed, for example, to admissions of individuals who had been inpatients but were admitted to a hospital and are now being readmitted) would comply with the law.

We have also been advised that the statute provides no basis for limiting preadmission screening or annual reviews by method of payment. Therefore, all individuals, regardless of whether they are private payers, Medicare beneficiaries, or Medicaid-eligible individuals, must be screened if they reside in or apply to a Medicaid-certified NF. These requirements do not apply to a facility participating solely in Medicare as an skilled nursing facility (SNF).

Because an IMD can be a NF, and all NFs are subject to the PASARR requirements, we have been advised that NFs which participate in Medicaid as IMDs are subject to PASARR. We note that the definition of a NF set forth in §1919(a) appears to be somewhat inconsistent with the definition of an IMD in that it states that a NF is an institution that "is not primarily for the care and treatment of mental diseases." We believe, however, that the best reading of these two definitions is that a NF can be both a NF and an IMD. In such situations, the NF maintains its status as a certified NF, but the IMD classification applies. That is, when NFs provide IMD services for persons over 65 years of age or inpatient patient psychiatric services for individuals under 21, we consider these facilities in the context of these benefits even though they meet NF requirements. For individuals aged 22 to 64, residence in an IMD precludes them from receiving any Medicaid benefits.

The PASARR requirements do not currently apply to swing beds because the existing swing bed regulations at 42 CFR 482.66(b) list those SNF requirements which swing beds must meet and would need to be revised to include PASARR requirements before they would be applicable. When we revise these regulations, we anticipate requiring that PASARR apply to swing beds.

The statutory PASARR requirements make no specific reference to time frames within which the State mental health and mental retardation authorities must perform the required screenings and make the required determinations.We intend to specify in forthcoming regulations that determinations must be made in a timely manner. We believe that timely action is necessary in order to prevent unnecessary extensions of inpatient hospital stays or inappropriate delays in providing needed services to individuals with MI or MR while they await screening by the State.

4-242 Rev. 36

REQUIREMENTS AND LIMITS

05-89 APPLICABLE TO SPECIFIC SERVICES 4250 (Cont.)

To the greatest degree possible a State should interface the PASARR process with other existing or future NF preadmission screening and resident assessment procedures. For example, data compiled as part of the preadmission screening (PAS), which, by definition, takes place prior to admission, may be used in conducting the initial assessment which must be performed on a new resident. Currently, these initial assessments must be performed no later than 14 days after the date of admission. As of October 1, 1990, they will have to be performed within the first 4 days after the date of admission. Similarly, the results of the routine annual resident assessment (or more frequent assessments which are precipitated by a change in the resident’s status) may be used for purposes of identifying residents with MI or MR who must be referred to the State mental health or mental retardation authorities for the annual resident reviews (ARRs).

Residents who are subject to annual reviews fall into two groups: 1) all who were previously identified as having MI or MR through preadmission screening or initial reviews and who were, for one reason or another, permitted to enter or remain in a nursing facility; and 2) any other residents who are later discovered to have MI or MR. If a resident, who was either not identified as having MI or MR (and therefore was not referred for further screening) or was found not to have MI or MR as a result of the preadmission screening or initial resident review, is later found to have a previously undiagnosed or a new condition of MR or MI, that individual should be referred to the State authorities for screening and a determination.

We envision that discovery of "new" cases of MR or MI will occur in one of two ways. Unlike MR which has a constant nature, MI frequently has an episodic character. Some NF residents may develop MI while in the NF. Development of a new condition or a significant worsening of an existing condition would be a change in the resident’s health status which should trigger a reassessment under current regulations (483.20(b)(4)(iv)). We also anticipate that once the uniform data set is in use for routine annual resident assessments (as required by OBRA §87 as of October 1, 1990), some conditions which had previously been inadequately or incorrectly diagnosed may be detected.

The facility should immediately refer "new" cases of MR or MI to the State mental health or mental retardation authorities. At the State’s option, the actual screening may be postponed until the next scheduled resident review session at that facility. If the facility is willing to accept responsibility for meeting the resident’s new treatment needs in the short term, it may retain the resident until a State determination has been made. However, if the facility believes it cannot meet the resident§s needs, that inability would serve as grounds for a more immediate transfer of the individual to a more appropriate setting.

States should be aware that they are responsible if they fail to screen or review any individuals who genuinely have MI or MR. Facilities are also accountable if they admit or allow any individuals to stay who should have been screened or reviewed but were not (unless, in the case of a continuing resident, the facility has notified the State authorities and is awaiting screening). Therefore, in order to ensure that no one who actually has MI or MR is missed, we would advise the State mental health and mental retardation authorities to perform screenings and make determinations on any individuals when they learn that they are suspected of having MI or MR.

Rev. 42 4-243

REQUIREMENTS AND LIMITS

4250 (Cont.) APPLICABLE TO SPECIFIC SERVICES 05-89

For discussion purposes, these Federal minimum criteria present a two-step process. The first step, which is referred to as Level I, involves identification of individuals who are suspected of having MI or MR and need to be subjected to further screening (through Level II). (See §4250.1.) The second step, Level II, is the actual PASARR process by which determinations are made by the State as to whether the individual requires the level of services provided by a NF or another type of facility and (if required) whether the individual requires active treatment. (See §4250.2.) This discussion of the Level II process is, in turn, broken down into three components: PASARR/NF, PASARR/MI, and PASARR/MR which should provide answers to both statutory questions. (See §§4251-4253.) However, as will be explained in these sections, some of the determinations which are required may be made categorically by the State rather than with respect to individuals.

As noted above, the statute requires that a determination be made as to the need for active treatment for all current residents who have MI or MR, regardless of whether they do or do not need the level of services provided by a NF. For new admissions on or after January 1, 1989, a determination as to active treatment needs is only required if the individual is determined to require NF level of services. Under each level (Identification and PASARR) we are providing criteria for both evaluating residents and making determinations based on the data complied through the evaluation. (See Evaluation Criteria and Determination Criteria under both levels.)

We are outlining criteria, not process. We propose that each State may develop its own process. If the State chooses, it may require facilities or hospital discharge planners to do the Level I screening and make referrals to the State. Alternatively, the State may retain the Level I function or delegate/contract it to another entity. The statute clearly requires, however, that the administration of the Level II screening, the actual PASARR, is a responsibility of the State mental health and mental retardation authorities although they may do so under contract or by delegation. In the case of individuals with MI, the evaluation phase of Level II must be delegated/contracted to a person or entity independent of the State mental health authority.

This discussion treats this screening process as a whole; however, screening need proceed only so far as is necessary to make the determinations required by the law. Thus, if screening quickly reveals that an individual does not have MI or MR, further evaluation is not necessary to meet the statutory requirement.

We believe that decisions as to appropriate placement for current or prospective residents who have MI or MR are not governed by the availability of placement alternatives. If availability of placements were to be considered, there would have been no purpose for Congress to have allowed States the option of submitting Alternative Disposition Plans (ADPs), as provided for in the statute at §1919(e)(7)(D). The purpose of the ADP provision is to give those States which need additional time to create the alternative placement slots and arrange for the provision of active treatment services the opportunity to continue to be in compliance so long as they are making adequate progress toward developing the needed placement slots and services. Placement by the State of individuals with MI or MR in NFs as a means of avoiding responsibility for provision of the active treatment these individuals need will no longer be tolerated.

4-244 Rev. 42

REQUIREMENTS AND LIMITS

05-89 APPLICABLE TO SPECIFIC SERVICES 4250.1

4250.1 Level I - Identification (ID) of Individuals With Mental Illness or Mental Retardation.--

A. Purpose.--The purpose of the ID screen is to determine which NF applicants or residents have MI or MR and are subject to PASARR. Because the statute excludes dementias from the definition of MI, individuals with a supportable primary diagnosis of dementia (including Alzheimer’s disease or a related disorder) are not subject to PASARR (unless they have a concurrent diagnosis of MR). These individuals with dementia will also be detected through this ID screen.

In using these criteria, States are encouraged to develop and to coordinate this screening process with existing State procedures to identify the needs of individuals who have a diagnosis of MI or MR. Because a large proportion of new NF admissions come from hospitals, States may find it practical to have hospitals perform the Level I screening for prospective residents as part of discharge planning. Alternatively, as States determine appropriate, they may elect to have NFs perform the Level I screening on new admissions as well as on their current residents who must be identified for purposes of referral for annual resident review. However the State chooses to design its Level I process, a system must be in place for identifying all individuals with MI or MR so that the required determinations by the State mental health or mental retardation authority can be made.

B. Definitions.--The following definitions of MI, dementia, and MR are applicable for the Level I (ID) process:

1. Mental Illness.--An individual is considered to have MI if he/she has a current primary or secondary diagnosis of a mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III-R)) and does not have a primary diagnosis of dementia (including Alzheimer’s disease or a related disorder).

2. Dementia.--An individual is considered to have dementia if he/she has a primary diagnosis of dementia (as described in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III-R). As described in DSM-III-R, diagnostic criteria for dementia include:

(a) Demonstrable evidence of impairment in short- or long-term memory;

(b) At least one of the following:

(1) Impairment of abstract thinking;

(2) Impaired judgment;

(3) Other disturbances of higher cortical function; and

(4) Personality change.

(c) The disturbance in (a) or (b) significantly interferes with work or usual social activities or relationships with others;

(d) Not occurring exclusively during the course of delirium;

(e) Either (1) or (2):

Rev. 42 4-245

REQUIREMENTS AND LIMITS

4250.1 (Cont.) APPLICABLE TO SPECIFIC SERVICES 05-89

(1) Evidence from the history, physical examination, or laboratory tests, of a specific organic factor that is is judged to be etiologically related to the disturbance; or

(2) In the absence of such evidence, an etiologic organic factor can be presumed if the disturbance cannot be accounted for by any nonorganic mental disorder.

3. Mental Retardation and Related Conditions.--An individual is considered to have MR if he/she has a level of retardation (mild, moderate, severe or profound) as described in the American Association on Mental Deficiency’s Manual on Classification in Mental Retardation (1983), page 1:

Mental Retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

The provisions of this section also apply to persons with "related conditions," as defined by 42 CFR 435.1009, which states: "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to-

(1) Cerebral palsy or epilepsy; or

(2) Any other condition, other than MI, found to be closely related to MR because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR, and requires treatment or services similar to those required for these persons.

(b) It is manifested before the person reaches age 22;

(c) It is likely to continue indefinitely; and

(d) It results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Self-care;

(2) Understanding and use of language;

(3) Learning;

(4) Mobility;

(5) Self-direction; and

(6) Capacity for independent living.

Any other condition includes autism. (See §4398.)

C. ID Evaluation Criteria.--The State should assure that the ID screening process is in place for determining whether each resident in and each applicant to a NF has MI or MR. The process must meet the following evaluative criteria.

1. For MI.--The individual has a primary or secondary diagnosis of MI and does not have a primary diagnosis of dementia. (See definitions of MI and dementia in §4250.1B).

4-246 Rev. 42

REQUIREMENTS AND LIMITS

05-89 APPLICABLE TO SPECIFIC SERVICES 4250.1 (Cont.)

Because the statutory definition refers to DSM-III-R, we cannot use a MI definition more limited than one which includes all mental disorders listed in DSM-III-R. Therefore, all individuals having a mental disorder listed in DSM-III-R will have to have the required PASARR determinations made with respect to them.

In determining whether an individual has a primary or secondary diagnosis of MI and does not have a primary diagnosis of dementia, the evaluator should use discretion in reviewing patient data. For example, in determining an individual’s diagnosis, the evaluator should look behind the diagnostic labels used in the patient records. When no MI diagnosis is indicated, the evaluator should look to see if there is any presenting evidence of MI, including possible disturbances in orientation, affect, or mood. A recent (within the last 2 years) history of MI, if known, should also serve as a clue to the evaluator that he or she should investigate further to see whether the MI is, in fact, a current primary or secondary problem. On the other hand, when evidence of current nonpsychiatric primary and secondary problems is clearly present, an individual should not be labeled MI and be needlessly put through the Level II determination process simply as a result of a past MI. The evaluator should also consider the prescription of a major tranquilizer or psychoactive drug on a regular basis in the absence of a justifiable neurological disorder as an indication that further screening is advisable to uncover masked symptoms. Again, however, such medications may be properly used for patients without a mental disorder; and evidence of drug use need not be taken as an indication that further review is needed when there is a medical justification for its use that is not in connection with a mental disorder.

Because dementias are sometimes misdiagnosed as MI (or vice-versa), the evaluator should examine the charts of individuals diagnosed as having MI or suffering from dementia for the possibility of a misdiagnosis. A diagnosis of dementia should be supported by positive evidence from a thorough mental status examination which focuses especially on cognitive functioning and which is performed in the context of a complete neurological or neuro-psychiatric examination. A neurological examination on its own may corroborate a diagnosis of dementia but is not determinative.

2. For MR or Persons With Related Conditions.--The individual has a diagnosis of MR. (See definition of MR in 4250.1B.)

In evaluating whether an individual has a diagnosis of MR, the person performing the Level I (ID) should investigate whether there is any history of MR or developmental disability in the individual’s past. The evaluator should also look for any presenting evidence (cognitive or behavioral functions) that may indicate that the person has MR or developmental disability. Referral by an agency which serves persons with MR (or other developmental disabilities) and which has deemed the individual to be eligible for that agency’s services should also be an indication that a State (PASARR) determination is needed.

Rev. 42 4-247

REQUIREMENTS AND LIMITS

4250.1 (Cont.) APPLICABLE TO SPECIFIC SERVICES 05-89

D. ID Determination Criteria.--The findings of the ID evaluation and interpretation should be used in making a determination as to whether or not the individual has (or is suspected of having) MR or MI and, if so, should be subjected to a Level II (PASARR) screening. There are three possibilities:

1. Criterion - IS MI/MR.--Any individual for whom there is a positive response to the evaluation criteria described in §4250.1C, must not be admitted to or allowed to continue to reside in a Medicaid-certified NF without being determined appropriate for nursing facility placement through the Level II (PASARR) process.

2. Criterion - Dementia.--Individuals who are found to have a primary diagnosis of dementia (including Alzheimer’s disease or a related disorder) as defined in §4250.1B, as a result of the evaluation criteria described in §4250.1C, are not subject to the Level II (PASARR) process for admission to or continued residence in a Medicaid-certified NF, unless they are also MR.

o Explanation: Section 1919(b)(3)(f)(i) and (e)(7)(G)(i) exclude persons with a primary diagnosis of dementia (including Alzheimer’s disease or a related disorder) in defining individuals considered to have MI. This exclusion, however, does not apply to individuals with a primary diagnosis of dementia and a secondary diagnosis of MR because the definition of MR in the statute simply refers to a diagnosis of MR and makes no mention of an exclusion for dementia.

3. Criterion - IS NOT MI/MR.--Any individual for whom there is a negative response to all ID evaluative criteria for MR or MI and for whom there is no other evidence of a condition of MI or MR may be admitted or continue to reside in a Medicaid-certified NF without being subjected to a review and determination through the Level II (PASARR) process.

E. Recording Determinations.--There should be a record of the ID determination and the evaluation and interpretation upon which the determination was based in the nursing facility resident’s record.

4250.2 Level II - Preadmission Screening and Annual Review (PASARR) for Individuals with MR or MI.--

A. Purpose.--The purpose of the PASARR process is to determine: (1) in the case of each nursing facility applicant with MI or MR, whether the applicant requires the level of services provided by a NF, and (2) in the case of NF resident, whether the resident requires the the level of services provided by a NF or an intermediate care facility for the mentally retarded (ICF/MR), inpatient psychiatric hospital for persons under 21, or an institution for mental diseases (IMD) for individuals 65 and older. For applicants with MR or MI who are found to require the level of services provided by a NF and for all current residents with MR or MI, a second determination must also be made as to whether or not the resident requires active treatment.

4-248 Rev. 42

REQUIREMENTS AND LIMITS

05-89 APPLICABLE TO SPECIFIC SERVICES 4250.2 (Cont.)

As noted in §4250 of this manual, responsibility for Level II (PASARR) determinations rests with the State mental health and State mental retardation authorities although we have been advised that they may delegate the screenings or perform them directly. In the case of individuals with MI, the evaluation phase of Level II must be delegated/contracted to a person or entity independent of the State mental health authority.

Also as noted in §4250 of this manual, we intend to specify in forthcoming regulations that preadmission screenings and determinations must be performed timely in order to prevent unnecessary extensions of inpatient hospital stays or inappropriate delays in providing needed services to individuals with MI or MR while they await screening by the State.

These required determinations only address the appropriateness of placement and the need for services, not the provision of services. Even though §1919(e)(7)(B), which describes the determinations which must be made, refers only to institutional settings, it does not preclude alternative placements. Section 1919(e)(7)(C), lists the choices that must be offered to residents who have resided in a NF for 30 months or more and who are found not to need a NF level of services but to require active treatment. This section clearly envisions the possibility of alternative placement in noninstitutional settings. For those residents who have resided in a NF for less than 30 months and are found to require only active treatment, some other placement (whether institutional or community-based) must be arranged. As noted in §4250, we believe that determinations as to appropriate placement for current or prospective residents who have MR or MI are not governed by the availability of placement alternatives.

B. Definitions.--The following definitions and discussions may assist States in making Level II determinations.

1. Active Treatment.--A continuous program for each client with MR or MI which includes aggressive, consistent implementation of a program of specialized and generic training, specific therapies or treatments, activities, health services and related services, as identified in an individualized plan of care, which has the following characteristics:

o For individuals with MI, the plan must be developed under and supervised by a physician. The prescribed components of the individualized active treatment program must be provided by a physician or other qualified mental health professionals.

o For individuals with MR, the individual program plan must be developed and supervised by an interdisciplinary team that represents areas that are relevant to identifying the client§s needs and to designing programs that meet the client’s needs.

Rev. 42 2-249

REQUIREMENTS AND LIMITS

4250.2 (Cont.) APPLICABLE TO SPECIFIC SERVICES 05-89

The purpose of the active treatment is--

o For individuals with MR, to direct them toward the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; to prevent or decelerate regression or loss of current optimal functional status.

o For persons with MI who are experiencing an acute episode of severe MI which necessitates 24-hour supervision by trained mental health personnel, to diagnose or reduce the recipient’s psychotic or neurotic symptoms which necessitated institutionalization, to improve his/her level of functioning and, whenever possible, to achieve the recipient’s discharge from inpatient status at the earliest possible time.

Active treatment for a persons with MR does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program. For persons with MI, active treatment does not include intermittent psychiatric services to clients who do not require 24-hour supervision by trained mental health personnel. For both groups, the term active treatment does not include, in the case of a resident of a NF (including residents with MI or MR who are determined to require the level of care provided by a NF), services the facility must provide or arrange for its residents under §1919(b)(4) of the Act (though some of these services clearly would become an integral part of an active treatment regimen if one were required).

Persons with MR or MI who need active treatment should be considered for placement in facilities which most appropriately suit the level of services they need. While NF placement is not prohibited, settings such as an IMD, an inpatient psychiatric hospital, an ICF/MR, or an appropriately supervised community setting must also be considered.

**NOTE:** Currently we have separate Medicaid definitions for active treatment in the ICF/MR and the psych under 21 contexts (42 CFR §§435.1009 and 483.440 for the ICF/MR benefit and 441.154 for the psych under 21 benefit). Active treatment is also required to be provided in psychiatric hospitals under Medicare. In forthcoming regulations we will need to establish a generic definition or descriptive statement about active treatment because the statute clearly excludes active treatment from NF services. As a result, someone who requires active treatment while in a NF requires something the NF usually would not provide and which the statute considers to be distinct from NF services. Until such time as regulations are promulgated, the above given definition is advisory.

We believe that active treatment is a concept which embraces a wide range of services and involves a complex set of competent interactions among the facility’s staff and between the staff and the resident. While some components of an active treatment program may be identified as NF services, other components are services which are more

4-250 Rev. 42

REQUIREMENTS AND LIMITS

05-89 APPLICABLE TO SPECIFIC SERVICES 4250.2 (Cont.)

specialized than those which a NF usually provides. Active treatment, however, is not simply a collection of disparate services: it is a concept that embraces the whole range of services a patient needs. The total effect of active treatment is that the individual components are integrated and directed toward achieving the goals established in each individual resident’s plan of care.

The need for integration of services may be best illustrated by specific example. If the plan of care for a particular resident contains a program to modify a certain behavior, every staff member in the facility who interacts with that resident during a 24-hour period must be aware of that program and skilled in implementing it so that he or she can appropriately deal with the undesirable behavior whenever it is manifested and can consistently reinforce the new behavior. It would do the resident with MR or MI little good to have only the psychologist who designed the program and who spends only a fraction of the day with the resident versed in administering the program.

It should be noted that individuals who need mental health services and who are admitted to or retained in a NF must receive them whether or not the State determines they constitute "active treatment" or are of a lesser intensity.

2. Appropriate Placement.--Placement of an individual in a NF may be considered "appropriate" when the individual’s needs are such that he/she meets the minimum standards for admission and the individual’s needs for treatment do not exceed the level of services which the facility is capable of providing.

**NOTE:** As stipulated by §1919(e)(7), the first question which must be answered concerning an applicant to or a resident of a NF is whether or not he/she needs the level of services provided by a NF. Section 1919(a)(1) defines a NF as "An institution . . . which is primarily engaged in providing to residents: (1) skilled nursing services . . .; (2) rehabilitation services . . .; or (3) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities." In other words, an individual requiring health-related care and services above the level of room and board could be considered to meet this definition.

If meeting the minimum criterion for entrance or residence were the only consideration, few individuals in need of some type of supervision would fail to qualify for NF level of services. However, both the old and new regulations relating to long-term care facilities require that a facility be capable of meeting the total needs of any individual which it admits or retains (the existing regulations are at 42 CFR 442.306 while the new regulations are at 42 CFR 483.25). We also believe that the intent of Congress was both to ensure placement of individuals with MR or MI where their total needs would be best served as well and to provide active treatment to those individuals with MR and MI for whom NF placement is appropriate, either because they have medical

Rev. 42 4-251

REQUIREMENTS AND LIMITS

4250.2 (Cont.) APPLICABLE TO SPECIFIC SERVICES 05-89

needs, as identified by a prioritized needs assessment, which, despite the need for active treatment, require a NF level of services, or because they fall into the group of long-term residents to whom Congress allowed the choice of staying in the NF even though they do not need the NF level of services but do need active treatment.

Because the provision of active treatment requires a high degree of cross-disciplinary competence for staff to interact with each of these individuals with MR or MI around the clock, as needed, it continues to be our experience that long-term care facilities which are not organized to meet the unique needs of the population with MR or MI exclusively cannot readily provide continuous active treatment. Some NFs, however, may need to develop this capability to meet the active treatment needs of individuals with MR or MI. This may be possible if they were to do so with increased staffing and funding, by the State or some other source. The specialized facilities which normally provide active treatment, such as ICFs/MR and psychiatric hospitals, are equipped, staffed, and funded on an enriched basis so that they can provide it. Since the statute clearly envisions that active treatment can and must be provided in NFs under some circumstances, increased funding will, in most cases, be required to enable the facility to provide the specialized services that these residents with MR or MI need. The statute also clearly distinguishes active treatment from NF services and indicates that FFP cannot be made available for active treatment as NF services.

Although Medicaid payment may not be made for active treatment services as NF services, States may use other Medicaid benefits to fund aspects of active treatment programs for individuals with MI or MR who are in a NF. For example, services provided in the context of the rehabilitation services, clinic services, or physical, occupational, or speech therapy services optional benefits might be used to meet some of the more discrete services required by the resident’s active treatment program if these optional services are available under the State plan or the State wishes to add them (subject to the amount, duration and scope and comparability requirements listed in 42 CFR 440, subpart B). Similarly, in providing active treatment for short-term residents who are determined to be inappropriate for continued residence in a NF, the States could use other optional Medicaid services such as case management or personal care services to coordinate some components of an active treatment program or to provide the support services needed for community placement. However, the package of services comprising an active treatment program is not able to be funded as "active treatment" and, as noted above, aspects of the package that fall outside the scope of established Medicaid benefits may not be eligible for FFP.

States should bear in mind that for any individuals with MR or MI who are permitted to enter or allowed to stay in a NF (whether under the PASARR process or by failure to be subjected to PASARR) and who need active treatment:

4-252 Rev. 42

REQUIREMENTS AND LIMITS

05-89 APPLICABLE TO SPECIFIC SERVICES 4250.2 (Cont.)

o FFP will not be available for active treatment services which are billed as NF services; and

o facilities will be held responsible for provision of all services which the resident needs (including active treatment needs) through the State’s survey and certification processes and Federal oversight surveys.

C. PASARR Evaluation Criteria.--Each State’s mental health authority and mental retardation authority should assure that a PASARR evaluation process is established that meets the following criteria:

o PASARR should be adapted to the cultural background, language, ethnic origin and means of communication used by the person.

o PASARR programs should contain the minimum Federal evaluative criteria included in:

-- PASARR/NF - Minimum criteria for determining level of nursing care service needs for individuals with MI or MR. (See §4251.);

-- PASARR/MI - Minimum criteria for determining active treatment needs for individuals with MI. (See §4252.);

-- PASARR/MR - Minimum criteria for determining active treatment needs for individuals with MR. (See §4253);

-- PASARR/MI/MR - Minimum criteria for determining active treatment needs for individuals with a dual diagnosis of MI and MR. (See §§4252-4253.)

o Information that is necessary for determining whether it is appropriate for the individual with MI or MR to be placed in a NF or in another appropriate residential and program setting (if a NF resident) should be gathered throughout all applicable portions of the PASARR evaluation. (See discussion on interrelatedness of the three instruments in §4251).

o Current and relevant assessment information obtained prior to the initiation of the PASARR may be used (e.g., prior evaluations of mental and physical status) if this assessment information is considered to be valid and accurate.

o As appropriate for individuals with MR or MI, PASARR findings should be:

-- accurate and correspond to the person’s current functional status;

-- descriptive (i.e., the presence of diagnosis, numerical test scores, intelligence quotients, developmental levels, etc., in the absence of specific statements which interpret what the diagnosis, scores, quotients, and levels mean in terms of the person’s functional status should not be acceptable); and

-- interpreted to the person (or a designated legal representative of the person if he/she is incapable of understanding the PASARR findings), to the family, and to the parent or legal guardian of a minor person, if available.

o The results of the PASARR evaluation should be described in a report which includes:

Rev. 42 4-253

REQUIREMENTS AND LIMITS

4250.2 (Cont.) APPLICABLE TO SPECIFIC SERVICES 05-89

-- identification of the name and professional title of the person(s) performing the evaluation(s) and the date on which each portion of the evaluations or assessments was administered;

-- a summary of the person’s positive traits or developmental strengths and weaknesses or developmental needs; and

-- if active treatment is needed, identification of the MR and/or mental health services required to meet the person’s identified active treatment needs, regardless of the availability of those services.

o Findings from this evaluation should be used by the State mental health or mental retardation authorities in making the required determinations about whether the individual with MI or MR requires the level of services provided by a NF and whether active treatment is needed.

o If a determination is made to permit admission of an individual who requires active treatment, the determination should be supported by specific findings that the NF to which the individual is to be admitted can meet the active treatment needs he or she has.

o The PASARR process should be stopped if at any time during the PASARR it is found that the individual does not have MI or MR or that he/she has a primary diagnosis of dementia (including Alzheimer’s disease or a related disorder) and does not have a diagnosis of MR or a related condition.

D. PASARR Determination Criteria.--The relevant statutory provisions require determinations, based on the preadmission screening or annual review evaluation findings, as follows:

1. Can be Admitted to a NF.--Any individual with MR or MI who requires the level of services provided by a NF, whether or not he/she also requires active treatment, can be admitted, if appropriate. (See definition of appropriate placement in §4250.2B for this and all following classifications.) If active treatment is also required, these services will have to be provided in addition to the nursing facility services. These active treatment services will have to be provided largely at other than Federal expense.

2. Cannot be Admitted to a NF.--Any individual with MR or MI who does not require the level of services provided by a NF, regardless of whether or not he/she needs active treatment, should be considered inappropriate for placement and cannot be admitted. (The PASARR/MR and/or PASARR/MI portions of the evaluation which investigate the need for active treatment do not have to be done for this group if NF care is not needed.)

3. Can be Considered Appropriate for Continued Placement in a NF.--Any resident with MR or MI who requires the level of services provided by a NF, regardless of the length of his/her previous stay or whether he/she needs active treatment, can continue to reside there, if appropriate. If active treatment is also required, these services will have to be provided in addition to the NF services. These active treatment services will have to be provided largely at other than Federal expense.

4-254 Rev. 42

REQUIREMENTS AND LIMITS

05-89 APPLICABLE TO SPECIFIC SERVICES 4250.2 (Cont.)

4. May Choose to Remain in the NF Even Though Placement Would Otherwise be Considered Inappropriate.--Any resident with MR or MI who does not require the level of services provided by a NF but does require active treatment and who has resided in a NF at least 30 months may choose to continue to reside in the facility or he/she may choose to receive covered services in an alternative appropriate institutional or noninstitutional setting. Wherever the individual chooses to reside, he/she must be provided with the active treatment services which he/she needs, largely at other than Federal expense. If the resident chooses to stay in the NF, FFP will be available for the NF level of services.

5. Cannot be Considered Appropriate for Continued Placement and Must be Discharged (Short-Term Residents).--Any resident with MR or MI who does not require the level of services provided by a NF but does require active treatment and who has resided in the facility less than 30 months must be discharged in accordance with the transfer and discharge requirements of §1919(c)(2). Active treatment services must be provided by the State to the individual in an alternative setting, largely at other than Federal expense.

6. Cannot be Considered Appropriate for Continued Placement in a NF and Must be Discharged (Long-Term Residents).--Any resident with MR or MI, even though he/she has resided in the NF for 30 months or more, who requires neither NF level of services nor active treatment must be discharged in accordance with the requirements of §1919(c)(2).

The decision trees for the preadmission screening (PAS) and annual resident review (ARR) processes, which are presented on the following page, diagram these statutory placement determinations.

Rev. 42 42-255

REQUIREMENTS AND LIMITS

4250.2(Cont.) APPLICABLE TO SPECIFIC SERVICES 05-89

THIS IS SPACE FOR PAS CHART

4-256 Rev. 42

REQUIREMENTS AND LIMITS

05-89 APPLICABLE TO SPECIFIC SERVICES 4251

4251. MINIMUM EVALUATION CRITERIA SPECIFIC TO SCREENING PERSONS WITH MR OR MI FOR THE NEED FOR NF LEVEL OF SERVICES - (PASARR/NF)

The purpose of the PASARR/NF process should be to determine, as a result of a review of the data obtained, whether or not the person with MR or MI, because of his/her physical and mental condition, needs the level of services provided by a NF. (See the definition of "appropriate placement" in §4250.2.)

DATA COMPILATION

The PASARR/NF instrument should assess whether the individual’s total needs are such that they can only be met on an institutional basis and, if so, whether the NF is the appropriate institutional setting for meeting those needs. At a minimum the PASARR/NF instrument should include:

o evaluation of physical status;

-- diagnoses;

-- date of onset;

-- medical history; and

-- prognosis.

o evaluation of mental status; and

-- diagnoses;

-- date of onset;

-- medical history;

-- medical history; and

-- prognosis.

o functional assessment (Activities of Daily Living).

DATA INTERPRETATION

The data interpretation phase of the PASARR/NF should attempt to prioritize the residents physical and mental needs and assess the severity of each condition. While the PASARR/MR and PASARR/MI portions of Level II will specifically address the individual’s need for active treatment, the presence of certain diagnoses or prognoses under the physical and mental evaluations should serve as indicators during the PASARR/NF process that NF placement is or is not appropriate.

The PASARR/NF and PASARR/MI and/or PASARR/MI processes, while being separate instruments with separate purposes, should not be considered to be mutually exclusive determination processes and should not be conducted in isolation of each other (if both determinations as to placement and active treatment are required). The PASARR process taken as a whole should lead to placement decisions which make sense both by providing individuals who need active treatment with these services and by allowing for delivery of

Rev. 42 4-257

REQUIREMENTS AND LIMITS

4251 Cont.) APPLICABLE TO SPECIFIC SERVICES 05-89

needed services in the most logical and cost effective manner through specialization (except for the long-term residents who are allowed to stay in NFs). Establishing a hierarchy of patient needs is essential to the placement process. For example, a secondary need for active treatment should not preclude admission or residence in a NF if there is a medical need which requires intensive skilled nursing interventions and the NF is capable of adequately meeting the individual’s active treatment needs. Nor should a primary need for a rigorous course of active treatment, which is of such an intensity that it can only be provided in a specialized facility, be subordinated to lesser physical needs which could be met in a NF but could also be served as adequately in a specialized inpatient setting such as an ICF/MR, a psychiatric hospital, or an IMD as they could be dealt with in a NF.

In evaluating the data concerning a client’s mental status, the evaluator should bear in mind that not all mental disorders described in DSM-III-R will require active treatment. DSM-III-R describes eight diagnoses under Axis I which, by definition, presents psychiatric diagnoses. Axis II presents patterns of personality defenses and/or developmental problems that one brings to a situation. Axis II diagnoses are not clinical syndromes. When a psychiatric diagnosis is assigned, Axis I represents the clinical syndrome, and Axis II represents those things that should be kept in mind while dealing with the Axis I diagnosis. Many psychiatrists do not consider the Axis II items to be mental illnesses at all.

We believe that minor mental disorders, such as Axis II diagnoses on their own, which do not require active treatment, should not keep people out of NFs. We believe that the determinations as to MI a State is required to make need not all be made with respect to specific individuals. A State could, for example, formally determine that certain minor psychiatric diagnoses such as nail-biting, tobacco abuse (smoking), mild depression, inhibited sexual desire, or hypochondriasis are diagnoses for which active treatment is not needed and that individuals who have these diagnoses are not in need of active treatment. If a State did this, individuals with such diagnoses who need NF care could be admitted to NFs without the need for a further specific individual determination by the State mental health authority as to the need for active treatment.

The State could presumably also determine that certain diagnoses always warrant active treatment and indicate that individuals evidencing these latter diagnoses should always be subjected to an individual PASARR/MI evaluation and determination as to the need for active treatment. We will consider whether to specify in regulations conditions such as the five major mental illnesses on Axis I which require active treatment (i.e., schizophrenic, paranoid, major affective, schizoaffective disorders and atypical psychosis) for which individual screening would always be needed.

The State could also make categorical determinations that certain mental conditions would normally require active treatment services of such an intensity that most, although not all, NFs would be incapable of meeting these needs. In such cases, a more specialized care setting would be the more appropriate placement; and the plan of care in that facility would have to address the totality of the resident’s physical and mental needs.

4-258 Rev. 42

REQUIREMENTS AND LIMITS

05-89 APPLICABLE TO SPECIFIC SERVICES 4251 (Cont.)

The State should recognize, however, that all DSM-III-R mental illnesses are mental illnesses under any approvable screening system and require determinations, either categorically or individually. All Level II determinations, regardless of how they are arrived at, must be recorded in the resident’s record.

Just as the State may make certain advance categorical determinations concerning diagnoses which will or will not require active treatment, the State may also make categorical determinations under Level II concerning certain physical conditions which would normally indicate that the individual would require NF level of services. For example, the State could specify that the presence of certain physical conditions such as terminal illness, convalescence from an acute physical illness, or severe illness (i.e. conditions such as comatose, ventilator dependent, or functioning at a brain stem level; or diagnoses such as chronic obstructive pulmonary disease, Parkinson’s disease, Huntington’s disease, amyotrophic lateral sclerosis, congestive heart failure, or similarly debilitating physical illnesses) normally would require NF level of services. Screening to determine active treatment needs for individuals in these physical need groups (through the PASARR/MI or PASARR/MR components of Level II) should not, however, be categorically waived. To the extent that the resident falling into one of these categories could also benefit from active treatment services while in the NF, these secondary active treatment needs would also have to be met; and the plan of care would need to address all the resident’s needs.

There are also cases in which the patient’s condition upon screening is such that a definitive determination for placement purposes cannot be made. For example, many individuals with delirium arising as a result of treatment provided during a prior hospital stay may or may not have a diagnosis of mental illness or mental retardation which could affect a placement decision. A State may approve provisional admissions and subsequent reassessment where such cases make an effective preadmission determination impossible and the individual is manageable in the NF setting.

The State could also make an advance determination that individuals "of advanced years" who need both NF level of services and active treatment and who are not a danger to themselves or others may be allowed to decline active treatment in a NF. A decision to provide the resident an option to forego active treatment is left open as to age because some elderly persons with MI or MR can benefit greatly from continued active treatment services. Such a decision should, therefore, be made by the client or his/her representative in consultation with his/her caregivers.

States should note that the "advanced years" option can only apply as a practical matter to individuals with concomitant NF needs. The statute accords long-term residents with MI or MR (those who have resided in a facility for 30 months or more) who do not need NF level of services but do need active treatment the choice of remaining in the NF to receive it. Because the need for active treatment is the only qualifying reason for a continued stay, we believe that individuals in this group should not have an unqualified option of declining active treatment. If a resident in this group were to decline active

Rev. 42 4-259

REQUIREMENTS AND LIMITS

4252 APPLICABLE TO SPECIFIC SERVICES 05-89

treatment, he/she would require no needed services. The resident should understand that if he/she refuses active treatment, the facility would have grounds for discharge since none of the resident’s needs require NF care. Most elderly residents with MI or MR, however, are likely to have some need for NF level of services in addition to a need for active treatment and, therefore, would have a choice if the State elected to offer this option.

Finally, a State could make an advance determination with respect to very short stays, for example, for respite purposes or in order to permit alternative arrangements for longer term care to be made that NF care is appropriate. In such cases, as in all others, appropriate treatment would need to be provided during the person’s stay in the NF.

4252. MINIMUM CRITERIA SPECIFIC TO THE SCREENING OF PERSONS WITH MI -(PASARR/MI)

The purpose of the PASARR/MI process should be to determine, as a result of the data obtained, whether or not the person with MI needs the implementation of an active treatment program for mental illness.

DATA COMPILATION

A. The PASARR/MI process should include a comprehensive history and physical examination of the person. At a minimum, the examination must address the following areas (if not previously addressed):

o complete medical history;

o review of all body systems;

o specific evaluation of the person’s neurological system in the areas of:

-- motor functioning;

-- sensory functioning;

-- gait;

-- deep tendon reflexes;

-- cranial nerves; and

-- abnormal reflexes.

o In case of abnormal findings which are the basis for a NF placement, additional evaluations should be conducted by appropriate specialists; and

o If the history and physical examination of the PASARR/MI process are not performed by a physician, then a physician’s review and concurrence with the conclusions should be required.

B. The PASARR/MI process should provide a comprehensive drug history of all current or immediate past utilization of medications that could mask symptoms or mimic MI.

4-260 Rev. 42

REQUIREMENTS AND LIMITS

05-89 APPLICABLE TO SPECIFIC SERVICES 4252 (Cont.)

C. The PASARR/MI process should include a psychosocial evaluation of the person. At a minimum, this should include an evaluation of the following:

o current living arrangements;

o medical and support systems; and

o If the psychosocial evaluation is not conducted by a social worker, then a social worker’s review and concurrence with the conclusions should be required.

D. The PASARR/MI process should include a comprehensive psychiatric evaluation. At a minimum, this evaluation should address the following areas:

o complete psychiatric history;

o evaluation of intellectual functioning, memory functioning, and orientation;

o description of current attitudes and overt behaviors;

o affect;

o suicidal/homicidal ideation;

o degree of reality testing (presence and content of delusions) and hallucinations; and

o If the psychiatric evaluation is not performed by a physician, then a board-certified psychiatrist’s review and concurrence with the conclusions should be required.

E. The PASARR/MI process should include a functional assessment of the individual’s ability to engage in activities of daily living and the level of support which would be needed to assist the individual to perform these activities while living in the community. The assessment should determine whether this level of support can be provided to the individual in an alternative community setting or whether the level of support needed is such that NF placement is required. At a minimum, this evaluation should address the following areas:

o self-monitoring of health status;

o self-administering and/or scheduling of medical treatments, including medication compliance;

o self-monitoring of nutritional status;

o handling money;

o dressing appropriately; and

o grooming.

DATA INTERPRETATION

The PASARR/MI process should insure that, based on the data compiled, a board-certified psychiatrist validates the diagnosis of MI and determines whether a program of psychiatric active treatment is needed.

Rev. 42 4-261

REQUIREMENTS AND LIMITS

4253 APPLICABLE TO SPECIFIC SERVICES 05-89

4253. MINIMUM CRITERIA SPECIFIC TO THE SCREENING FOR PERSONS WITH MR (PASARR/MR)

The purpose of the PASARR/MR process should be to determine, as a result of the data obtained in this section, whether or not the person with MR or a related condition needs the implementation of a continuous active treatment program, as defined at 42 CFR 435.1009, "Active Treatment in Intermediate Care Facilities for the Mentally Retarded."

DATA COMPILATION

A. The PASARR/MR process should review the individual’s comprehensive history and physical examination results so that the following minimum information can be identified:

o a list of the individual’s medical problems;

o the level of impact these problems have on the individual’s independent functioning;

o a list of all current medications used by the individual; and

o current response of the individual to any prescribed medications in the following drug groups:

-- hypnotics;

-- antipsychotics (neuroleptics);

-- mood stabilizers and antidepressants;

-- antianxiety-sedative agents; and

-- anti-Parkinsonian agents.

B. The PASARR/MR process should assess:

o self-monitoring of health status;

o self-administering and/or scheduling of medical treatments; and

o self-monitoring of nutritional status.

C. The PASARR/MR process should assess:

o self-help development (such as toileting, dressing, grooming, and eating);

o sensorimotor development (such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor/perception, fine motor dexterity, eye-hand coordination, and extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual’s functional capacity);

o speech and language (communication) development (such as expressive language (verbal and nonverbal), receptive language (verbal and nonverbal), extent to which nonoral communication systems can improve the individual’s function capacity, auditory functioning, and extent to which amplification devices (e.g., hearing aid) or a program of amplification can improve the individual’s functional capacity);

4-262 Rev. 42

REQUIREMENTS AND LIMITS

05-89 APPLICABLE TO SPECIFIC SERVICES 4253(Cont.)

o social development, such as interpersonal skills, recreation-leisure skills, and relationships with others;

o academic/educational development, including functional learning skills;

o independent living development (such as meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to the neighborhood, town, city), laundry, housekeeping, shopping, bedmaking, care of clothing, and orientation skills (for individuals with visual impairments);

o vocational development, including present vocational skills;

o affective development (such as interests, and skills involved with expressing emotions, making judgments, and making independent decisions); and

o presence of identifiable maladaptive or inappropriate behaviors of the individual based on systematic observation (including, but not limited to, the frequency and intensity of identfied maladaptive or inappropriate behaviors).

DATA INTERPRETATION

D. The PASARR/MR process should insure that a psychologist who meets the qualifications of a Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a):

o identifies the individual’s intellectual functioning measurement; and

o validates that the individual has MR or is a person with a related condition.

E. The PASARR/MR process should review the data collected from this section and identify to what extent the person’s status compares with each of the following characteristics commonly associated with a need for active treatment:

o inability to take care of most personal care needs;

o inability to understand simple commands;

o inability to communicate basic needs and wants;

o inability to be employed at a productive wage level without systematic long-term supervision or support;

o inability to learn new skills without aggressive and consistent training;

o inability to apply skills learned in a training situation to other environments or settings without aggressive and consistent training;

o inability to demonstrate behavior appropriate to the time, situation or place without direct supervision;

o demonstration of severe maladaptive behavior(s) which place the person or others in jeopardy to health and safety;

o inability or extreme difficulty in making decisions requiring informed consent; and

o presence of other skill deficits or specialized training needs which necessitates the availability of trained MR personnel, 24 hours per day, to teach the person functional skills.

Rev. 42 4-263