Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

YOUNGER NURSING FACILITY RESIDENTS WITH MENTAL ILLNESS:

Preadmission Screening and Resident Review (PASRR) Implementation and Oversight

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EXECUTIVE SUMMARY

PURPOSE

To examine the safeguards that ensure the appropriate admission and mental health treatment of younger Medicaid beneficiaries, ages 22 to 64, who have a serious mental illness and reside in nursing facilities.

BACKGROUND

This inspection is one in a series of Office of Inspector General reports on individuals with mental illness in nursing facilities. A follow-up inspection to this report, "Younger Nursing Facility Residents with Mental Illness: A Population Unidentified" (OEI-05-99-00701) is an attempt to determine the extent to which younger individuals with mental illness reside in nursing facilities.

Preadmission Screening and Resident Review (PASRR) -- Nursing Facility Admission Requirements

The Social Security Act does not allow a nursing facility to admit any resident who has a serious mental illness unless the State mental health authority has determined that the individual, because of a physical and mental condition, requires the level of services provided by a nursing facility. In addition, the State mental health authority must determine whether an individual requires "specialized services" for their mental illness, and must provide such services.

The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) mandated Preadmission Screening and Resident Reviews (PASRR). The intent of the PASRR process is to ensure that only individuals with serious mental illness who are in need of nursing facility care be admitted and continue to reside in nursing facilities, and to determine whether persons with serious mental illness need specialized mental health services.

The Olmstead Decision

The 1999 Olmstead Supreme Court decision mandates that States "provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate." States must take into consideration their resources and the needs of other people with mental disabilities in making such determinations.

We collected information and data from Medicaid programs and from surveys of State officials involved in mental health services and nursing home care. We made onsite visits to 19 purposively-selected nursing facilities in five States.

We reviewed detailed information about 187 nursing facility resident Medicaid beneficiaries, ages 22 to 64, with a serious mental illness.

FINDINGS

Preadmission Screening and Resident Reviews are not in compliance with Federal requirements

The PASRR system is the primary mechanism by which individuals with mental illness in nursing facilities are monitored. We found little evidence that Level I PASRRs, which are screens to identify an individual's mental illness, are completed. Only 47 percent (88 of 187) of residents we sampled in the five case study States had a Level I PASRR screen in their nursing facility records. An initial Level II PASRR confirms the existence of a serious mental illness, the need for nursing facility services and the "specialized services" a resident may need. Our case file review revealed that only 41 percent (77 of 187) files had any evidence of a Level II PASRR. Most of these residents had only a determination letter or a form with the signature from a State contracted physician, not the actual assessment in their record.

Level II PASRR reviews, hereafter referred to as reassessments, are triggered by a significant change in a resident's mental health condition. These reassessments rarely occur. Sixteen of the 19 nursing facilities we visited had never contacted the appropriate State agency about a significant change in a resident's mental health status. Our case file review indicated that only 29 percent (22 of 77) of individuals with an initial Level II PASRR, also had a Level II PASRR reassessment. All of these reassessments were completed at the time when an annual reassessment requirement was still in effect. The annual reassessment requirement was repealed in 1996.

PASRR does not ensure that mental health needs are assessed

The Federal definition of "serious mental illness" puts forth multiple conditions to be met to classify an individual as requiring a Level II PASRR mental health assessment. This may enable States to avoid assessment of some residents with serious mental illness.

Nursing facilities have their own admissions process to determine their ability to care for an applicant, which may not incorporate the PASRR assessment.

The Level I PASRR screen is viewed by many nursing facilities in all five States we visited primarily as an indication of eligibility for Medicaid reimbursement, not as an evaluation tool.

States may violate the intent of the Federal requirement to provide mental health services

States' definitions of "specialized services" may enable them to avoid their responsibility to provide mental health services. Four of the 5 States we visited and 15 of the States responding to our survey define "specialized services" as 24-hour inpatient psychiatric treatment. Under this definition, a nursing facility is not a 24-hour psychiatric treatment facility and residents in nursing facilities are excluded from receiving "specialized services." Limiting the definition in this way excludes the provision of certain mental health services to individuals in nursing facilities and relieves States of their responsibility to provide this care.

Nursing facilities receive little information from the State regarding the Level II PASRR mental health evaluations. In the few cases where nursing facilities receive specific information, it is in the form of "recommended services" which the State does not require them to provide.

Many respondents, including State agencies, Long-Term Care Ombudsmen, mental health advocates and nursing facilities, indicated that they are concerned that younger individuals with mental illness are not receiving mental health treatment in nursing facilities.

PASRR systems function with little State and Federal oversight

States do not routinely ensure that Level I PASRR identification forms accurately reflect an applicant's mental health status. States do not have a systematic process to ensure that an individual is getting the mental health services that were indicated as necessary or "recommended" on the Level II PASRR or Level II PASRR reassessment.

Most States rely on the nursing facility survey agency to monitor the PASRR process. However, surveyors reported that monitoring the PASRR process is not their responsibility. The OBRA 87 survey requirements do not include a review of PASRR forms or process. Most State mental health authorities in our case study States do not consider it their responsibility to monitor or provide treatment for residents of nursing facilities with mental illness.

States do not have a mechanism to ensure that PASRR Level II reassessments are appropriately triggered. Many nursing facilities, surveyors and State agencies indicate that the definition of "significant change" for nursing facility residents with mental illness and the criteria to trigger a Level II PASRR reassessment are unclear.

The Health Care Financing Administration (HCFA) regional offices and headquarters do not currently monitor the PASRR process or provide related guidance to the States. State Long-Term Care Ombudsmen report that they primarily focus attention on the needs of geriatric nursing facility residents, not the younger population with mental illness.

RECOMMENDATIONS

Improve States' capacity to identify individuals with mental illness and determine appropriate facility placement

We recommend that HCFA:

- ensure completion of the Level I PASRR screens prior to nursing facility admission;
- require that Level II PASRR evaluations be triggered if at least one indicator of serious mental illness is identified; and
- outline and enforce State requirements for Level II PASRR evaluation summary reports that are to be shared with the admitting nursing facility.

Improve oversight of the PASRR process and access to mental health treatment

We recommend that HCFA:

- provide regional PASRR training to surveyors and add a PASRR component to survey requirements;
- require the use of the Level II PASRR evaluation in care planning;
- require that State surveyors monitor to ensure care plan compliance; and
- provide States with technical assistance to develop an additional mechanism to monitor the PASRR process.

Ensure that placement of an individual with mental illness in a nursing facility is not a means of avoiding responsibility for the provision of specialized mental health services

We recommend that HCFA:

- define specialized services that are to be provided by the State and made available to individuals with mental illness in nursing facilities.

Improve ability of nursing facilities to identify significant change and to make appropriate referrals

We recommend that HCFA:

- clarify the definition of significant change and implement a mechanism to ensure a Level II PASRR reassessment is completed.

Improve Federal monitoring and oversight

We recommend that HCFA:

- clarify the role and responsibilities of the regional HCFA PASRR contact;
- require a standardized annual State report to include data regarding the number of Level I and II PASRRs completed and the placement and treatment results, by age; and

- specify which unit(s) within HCFA have responsibility for ensuring appropriate implementation, completion and compliance.

Improve the Level II PASRR process and ensure compliance with the Olmstead Decision

We recommend that HCFA:

- require that State Medicaid agencies collaborate with State mental health authorities to identify and maintain a list of alternative community based treatments and to track the level of need and availability of such resources.

We recommend that the Substance Abuse and Mental Health Services Administration (SAMHSA):

- provide annual guidance to State mental health authorities on appropriate treatment, needed specialized and other mental health services;
- periodically review State mental health authorities' Level II determinations; and
- provide annual guidance to State mental health authorities to identify alternative treatment options for individuals being considered for nursing facility placement.

Clarify Agencies' roles and responsibilities within the Department in overseeing the PASRR process

To improve implementation and oversight of the PASRR process, the Department should determine and delineate HCFA and SAMHSA's responsibilities in overseeing the PASRR process.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration and the Substance Abuse and Mental Health Services Administration. The HCFA and SAMHSA concur with the majority of our recommendations. We feel that HCFA and SAMHSA's commitment to the effectiveness of the PASRR process is of particular importance in light of the recent Olmstead Decision. Where appropriate, we changed the report to reflect both HCFA and SAMHSA's comments. The full text of the comments are contained in Appendix B.

The HCFA believes our recommendations will "help [them] make sound policy decisions about how best to protect the interests of younger Medicaid beneficiaries who have a serious mental illness...and reside in nursing facilities." In addition, HCFA will "attempt to augment [our] recommendations with companion efforts that would expand community alternatives and will coordinate planning for PASRR improvements with those community service improvement efforts." We would like to thank HCFA for their assistance in conducting this study and for providing us with substantive and insightful comments.

The HCFA concurred in full with 24 of the 30 ways to achieve our recommendations. The agency proposes an alternative solution or will further consider six recommendations with which they do not concur. A discussion of HCFA's comments are contained on pages 28 and 29 of the report.

We would also like to thank SAMHSA for their assistance in conducting this study and for their supportive comments. The agency agrees in full with 5 of the 6 specific recommendations that apply to them. In addition, it concurs with our broader recommendation to determine and delineate HCFA and SAMHSA's responsibilities in overseeing PASRR determinations. The SAMHSA is working together with HCFA in addressing the Olmstead Decision and other key areas regarding behavioral health services. A discussion of SAMSHA's comments are contained on page 30 of the report.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

To examine the safeguards that ensure the appropriate admission and mental health treatment of younger Medicaid beneficiaries, ages 22 to 64, who have a serious mental illness and reside in nursing facilities.

BACKGROUND

In 1955, State mental health hospitals began reducing their resident populations and many patients were transferred to nursing facilities and other residential facilities.[1] In 1987, legislation was enacted to prevent the inappropriate admission and retention of people with serious mental illness and determine their need for specialized services. The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) mandated preadmission screening to ensure that only individuals with serious mental illness in need of nursing facility care be admitted to nursing facilities, that these individuals' need for specialized services be determined, that facilities provide active mental health treatment to residents with a primary mental illness and that yearly reviews be conducted for each resident.[2] The preadmission screening and resident review (PASRR) is the primary mechanism that is used to ensure appropriate nursing facility placement and that mental health needs are addressed.

We focus our attention in this report on younger individuals with mental illness who are ages 22 to 64. Both Medicaid and Medicare impose limitations on coverage for the long-term care of individuals with mental illness in this age group.[3] They may be more vulnerable to difficulties in accessing mental health treatment due to these restrictions. In addition, according to the Surgeon General's report, adults with mental illness in mid-life may confront many special service delivery problems, including proper identification and treatment.

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1 Psychiatric Services 51:354-358, March 2000.

2 The Nursing Home Facility Resident Reform Act, P.L. 104-315 in 1996, repealed the annual review requirement.
OBRA 1990 replaced the term "active mental health treatment" with "specialized services."

3 42 C.F.R. 1905(h)(1)(C). The 21st birthday is the cut off point for benefits unless the beneficiary is under psychiatric care prior to and following his/her 22nd birthday — whichever comes first.

Funding for Mental Health Services

Medicaid funds both outpatient and inpatient services including long-term service through hospitalization and residential treatment for individuals with mental illness under 21.[4] Certain mental health services are covered by Medicare for individuals with mental illness 65 and over.

The primary financial responsibility to cover the long-term care of individuals with mental illness ages 21 to 64 lies with the State mental health authorities (SMHA). The Social Security Act states that services provided in an Institution for Mental Disease (IMD) will not be covered by Medicaid for individuals ages 21 to 64. The Act defines such institutions as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services."[5] Medicaid ruled that it would pay for the care of individuals with mental illness in nursing facilities where 50 percent or less of the facility's beds were filled by residents with mental illness. Therefore, there are financial incentives to place a younger individual with mental illness into a nursing facility in order to receive payment from Medicaid rather than the State mental health authority.

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Community Mental Health Services Block Grant is given to States to provide mental health services to individuals with mental diseases. The SAMHSA's Center for Mental Health Services is mandated to assume a leadership role in delivering mental health services, generating and applying new knowledge, and establishing national mental health policy.[6] The Center helps States improve and increase the quality and range of their treatment, rehabilitation, and support services for people with mental illness.

Placement for Individuals with Mental Illness

Nursing facilities have traditionally been "the last refuge" for individuals with mental illness. Individuals with mental illness may find themselves in a nursing facility because of physical and behavioral problems, the lack of caretakers, or insufficient community services, including long-term care."[7] Federal nursing facility regulations stipulate that when evaluating an individual with mental illness for nursing facility placement, evaluators must first assess whether the individual's total needs are such

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4 1999 Surgeon General's Report

5 SSA Section 1905 (h)(2)(i)

6 ADAMHA Reorganization Act, Public Law 102-321(1992).

7 American Psychiatric Association, *Psychiatric Services* 51:354-358, (March 2000).

that they can be met in an appropriate community setting. If not, the evaluation must determine if inpatient care is appropriate and desired, and whether a nursing facility or another institution such as a psychiatric hospital would be an appropriate placement.[8] The availability of long-term care community mental health services varies widely by State and community.

Olmstead Decision

The Administration has recently brought into question the long-term care of individuals with mental illness in nursing facilities. The 1999 Olmstead Supreme Court decision mandates that States "provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate." States must take into consideration their resources and the needs of other people with mental disabilities in making such determinations. In response to the decision, the Secretary issued a letter to all governors in January 2000, stating that "no person should have to live in a nursing facility or other institution if he or she can live in his or her community." Moreover, the Secretary said that "unnecessary institutionalization of individuals with disabilities is discrimination under the Americans with Disabilities Act."[9]

Surgeon General's Report

Additional recent attention to the care of individuals with mental illness in nursing facilities was initiated by the 1999 U.S. Surgeon General's report on Mental Health which indicates that there are "major barriers" that prevent the delivery of appropriate care to residents of nursing facilities who have mental illness.[10] Researchers have found that, despite a high prevalence of individuals with mental illness residing in nursing facilities, these facilities are ill equipped to meet their needs.[11] Further, experts believe that the placement of non-elderly residents with mental illness in nursing facilities with elderly residents raises questions regarding the ability of nursing facilities to provide appropriate care to both populations. There are significant differences between the needs of the geriatric population and of younger adults with mental illness that reside in nursing facilities.

The number of individuals with serious mental illness who are residents of nursing facilities is unknown. We examined various data sources to determine

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8 42 C.F.R. §483.132 (a) (1999).

9 "U.S. Seeks More Care for Disabled Outside Institutions. *New York Times*, February 13, 2000

10 Mental Health: A Report of the Surgeon General, 374 (1999).

11 Lombardo, N.E. *Barriers to mental health services for nursing home residents*. Washington, DC: American Association of Retired Persons (1994).

the number of individuals and costs pertaining to the care of persons with mental illness in nursing facilities, primarily focusing of individuals ages 22 to 64.

Preadmission Screening and Resident Reassessment -- Nursing Facility Admission Requirements

The Social Security Act [Section 1919(b)(3)(F)(i)] does not allow a nursing facility to admit any resident who has a mental illness unless the State mental health authority has determined that the individual, because of a physical and mental condition, requires the level of services provided by a nursing facility. In addition, the State mental health authority must determine whether an individual requires "specialized services" for his/her mental illness.

In order to identify individuals who may have a serious mental illness, the Nursing Home Reform Act of 1987 required that all nursing home applicants, regardless of payment source, be given a preadmission screening and annual resident review (PASARR).[12] Effective in October 1996, the Federal requirement for annual resident review or reassessment was eliminated and the screen is now referred to as the preadmission screening and resident review (PASRR).[13] The screening to identify an applicant's mental illness is referred to as the Level I PASRR or Level I PASRR screen. Under Federal regulations, an individual is considered to have a serious mental illness if they meet requirements on diagnosis, level of impairment and duration of illness.[14] Specifically, an individual must have a major mental illness diagnosis, not including dementia and organic brain disorders including Alzheimer's disease, (unless the primary diagnosis is a serious mental illness), a functional limitation within the past 3 to 6 months and have had psychiatric treatment more intensive than outpatient care in the past 2 years. Although there are minimum Federal PASRR requirements, States may design their own PASRR forms and may choose a more inclusive criteria for identifying a serious mental illness.

An "independent physical and mental evaluation" referred to as the Level II PASRR must be completed for individuals who meet the requirements of serious mental illness, as indicated on the Level I PASRR screen. The Level II PASRR evaluation must be completed by an independent entity with whom the State Medicaid agency contracts.[15] The Level II PASRR evaluation objectives are to:

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[12] Omnibus Budget Reconciliation Act of 1987, P.L. 100-203. The PASRR requirement also applies to individuals with mental retardation or developmental disabilities.

[13] The Nursing Home Facility Resident Act, P.L. 104-315.

[14] 42 C.F.R. §483.102 (b)(1)(1999).

[15] The Level II PASRR may be contracted to a private entity or may be contracted to another State agency. In 2 of the 5 States we visited, the completion of the Level II PASRR and the determination for nursing facility placement is contracted to the State Department on Aging.

- confirm whether or not applicants have a serious and persistent mental illness,
- determine whether such applicants require nursing facility services, and
- determine whether such applicants require specialized services for their mental illness.

The SMHA, based upon the independent physical and mental evaluation, makes the final determination on whether a person requires nursing facility placement and specialized services. The SMHA may verbally convey Level II PASRR determinations to nursing facilities and individuals and must subsequently confirm the determination in writing.[16]

Further, once an individual with mental illness is admitted to a nursing facility, if there is a "significant change" in his/her physical or mental condition "which has a bearing on their active treatment needs," the nursing facility is required to promptly notify the SMHA. The Health Care Financing Administration has instructed that "significant change" should be identified when a resident's Minimum Data Set (MDS) assessment indicates that "a more immediate annual resident review is warranted."[17] The SMHA is then required to conduct a Level II resident review or reassessment.[18]

Mental Health Services for Nursing Facility Residents with Mental Illness

When notifying individuals and nursing facilities of approval for nursing facility level of care, State mental health authorities must also include whether "specialized services" are necessary. The SMHA must consider the need for specialized service when making the determination concerning the need for nursing facility service. "Specialized services" are defined as "services specified by the State which, combined with services provided by the nursing facility result in the continuous and aggressive implementation of an individualized plan of care."[19] The SMHA must provide or arrange for the provision of specialized services to all nursing facility residents with mental illness "whose needs are such that continuous supervision, treatment and training by qualified mental health professionals is necessary."[20]

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16 42 C.F.R. §483.112(c)(2)(1999).

17 HCFA December 1996 memorandum to the Division of Medicaid Regional Administrators.

18 The Nursing Home Facility Resident Act, P.L. 104-315.

19 42 C.F.R. §483.112(a)(2)(1999).

20 42 C.F.R. §483.112(b)(1999).

Mental health services of "lesser intensity than specialized services" must be provided by nursing facilities. The Omnibus Reconciliation Act of 1990 added mental health services that are not the responsibility of the State to provide, to the list of services a nursing facility is required to provide.[21] This was to clarify that any medically necessary mental health service a resident needs that is not a "specialized service" is the responsibility of the nursing facility to provide. These services are not reimbursed separately by Medicaid, rather they are considered a condition of participation and must be paid for by the nursing facility or under some other arrangement with the State.

Although Federal admission criteria mandates that facilities accept only those residents they are qualified to care for, no clear criteria exist for making such judgements. To meet requirements for treating individuals with mental illness, nursing facilities must have the capacity to deliver mental health care by trained mental health professionals. However, the Surgeon General's report indicates that Medicaid reimbursements for nursing facility residents have been too low to provide a strong incentive for participation by highly trained mental health providers.[22]

Monitoring, Survey and Certification Requirements

Responsibility for enforcing PASRR requirements is shared by the State Medicaid agency and HCFA. State Medicaid agencies are required to deny Medicaid payments to nursing facilities if they provide services to individuals who have not been determined by PASRR to need nursing facility services. The HCFA is responsible for monitoring States' compliance with Federal PASRR requirements. Specifically, HCFA is required to review a sufficient number of cases to allow reasonable inferences in regard to each State's compliance with PASRR requirements regarding the discharge and placement of residents with specialized service needs and to report annually to Congress on the extent of State compliance with PASRR requirements.[23]

Medicaid/Medicare nursing facility surveyors may, through the course of their survey and certification program, monitor the treatment of nursing facility residents with mental illness. The Nursing Home Reform Act of 1987 amended the Medicaid program to establish a set of survey and certification requirements for all nursing facilities.[24] States are responsible for surveying and certifying that nursing facilities comply with Medicaid nursing facility requirements. Certification of facilities must be conducted by a multi-disciplinary team of professionals on an unannounced basis

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21 Section 1919(b)(4)(vii) of the Social Security Act

22 Mental Health: A Report of the Surgeon General (1999).

23 42 U.S.C. 1396r(f)(8)(B) and OBRA 1990, §4801(b)(5)(B).

24 OBRA 1987, P.L. 100-203.

at least every 15 months. The Act also requires States to establish a process for the receipt, review and investigation of allegations of resident neglect and abuse.

Each State has a Long-Term Care (LTC) Ombudsman office which in conjunction with local Area Offices on Aging oversee local Long-Term Care Ombudsmen who are advocates for residents of nursing facilities, board and care homes, assisted living facilities and similar adult care facilities. The LTC Ombudsman program, established under the Older Americans Act, is administered by the Administration on Aging (AoA). Nationally, thousands of volunteer LTC Ombudsmen regularly visit long-term care facilities and monitor conditions and care. Any resident of a nursing facility, including those with mental illness, may fall under the auspices of the LTC Ombudsman program responsibilities.

SCOPE

This report evaluates State and Federal safeguards that ensure the appropriate admission and mental health treatment of individuals with mental illness residing in nursing facilities. We focused our study population on Medicaid recipients between the ages of 22 and 64 with a "severe and persistent mental illness" as their primary or secondary diagnosis. We did not evaluate residents with dementia, Alzheimer's disease or other organic brain disorders. We focused on this population because evidence suggests there are fundamental features of care and protection unique to younger adults, ages 22 to 64, with severe and persistent mental illness residing in the nursing facilities.

We examined States' PASRR processes which are designed to determine appropriate nursing facility placement and necessary mental health services for nursing facility applicants with mental illness. The PASRR process also identifies and evaluates nursing facility applicants with mental retardation and developmental disabilities. We have limited our study to the process as it relates to individuals with mental illness.

We examined the systems in place to monitor the care of persons with mental illness in long-term care facilities including Federal and State survey and certification requirements. We examined coordination between State agencies regarding the oversight and treatment of this population. We did not conduct a medical review of resident records.

This inspection is one in a series of Office of Inspector General reports on individuals with mental illness in nursing facilities. A follow-up inspection to this report, "Younger Nursing Facility Residents with Mental Illness: A Population Unidentified" (OEI-05-99-00701) is an attempt to determine the extent to which younger individuals with mental illness reside in nursing facilities.

METHODOLOGY

We made onsite visits to five States -- California, Florida, Kansas, Minnesota and Pennsylvania -- to conduct State agency interviews, visit nursing facilities and conduct case file reviews. We selected these States based on the high percentage of residents with a serious mental illness as their primary or secondary diagnosis in individual nursing facilities as identified by the Federal Online Survey and Certification Reporting System (OSCAR) data. In addition, we selected States based on their submission of data to the Federal Medicaid Statistical Information System (MSIS) data system as of Fiscal Year 1998 and geographic location.[25] In each of the 5 case study States, we selected 4 nursing facilities based on the high percentage of residents ages, 22 to 64, with a primary or secondary diagnosis of mental illness being cared for in that facility and geographic proximity. One sampled nursing facility prohibited our entry.

In the 5 case study States, we visited 19 nursing facilities and reviewed 187 resident case files of current nursing facility Medicaid residents between the ages of 22 and 64 with a major mental illness diagnosis from the International Classification of Diseases, 9th Revision (ICD-9) codes 293-301, 311, 312. At each of the nursing facilities we visited, we determined if a Level I and Level II PASRR existed for each resident with a mental illness. In addition, we interviewed the facility director, social service staff and other staff as available.

We interviewed State representatives from Departments of Mental Health, Medicaid and Medicare/Medicaid Survey agencies and Long-Term Care Ombudsmen agencies, as well as mental health protection and advocacy representatives and nursing home associations. We also interviewed HCFA regional survey and certification staff and PASRR contacts.

For the 39 States that submitted Medicaid claims and eligibility information to HCFA's MSIS system in 1998, we identified the number of nursing facility residents between the ages of 22 and 64 with a primary or secondary diagnoses of severe mental illness that had a Medicaid claim.

We used the Federal Minimum Data Set (MDS) to examine the number of assessments of nursing facility residents, ages 22 to 64, with a psychiatric diagnosis conducted during January through June 1999. Nationally, during this period, there were 116, 287 assessments of Medicaid nursing facility residents, ages 22 to 64. Of these, 73,586 (63 percent) were for residents with a psychiatric diagnosis. Of these, 17,553 (15 percent) were initial assessments for individuals with a psychiatric diagnosis admitted during this time period. There were 45,710 Medicaid nursing facility residents with a mental illness, ages 22 to 64, during this period.

[25] All 5 States we visited submitted data to the Federal MSIS as of 1998.

We also conducted a survey of all 50 States for each of the 4 different entities -- Mental Health, Medicaid and State Medicare/Medicaid Survey agencies and State Long Term Care Ombudsmen. The intent of the survey was to understand the extent to which individuals with serious mental illness are being cared for in nursing facilities in each State, as well as the extent to which State regulations pertain to this population. We received 129 out of 200 (64.5 percent) surveys — 42 from Departments of Mental Health, 36 from Medicaid agencies, 29 from State Medicare/Medicaid Survey agencies and 22 from the State LTC Ombudsmen.

We conducted a purposive sample in order to give us greater understanding of individuals with mental illness, ages 22 to 64 who are nursing facility residents. We do not project our findings.

We conducted our review in accordance with the Quality Standards for Inspections issued by the President's Council on Integrity and Efficiency.

FINDINGS

PASRR screenings and assessments are not in compliance with Federal requirements

Only 47 percent (88 of 187) of the residents we sampled in the five case study States had a Level I PASRR screen in their nursing facility records

Level I PASRR screens do not ensure that residents with mental illness are identified. Level I PASRR screens were found infrequently at nursing facilities. Although required for all residents of nursing facilities, only 47 percent (88 of 187) of residents we sampled in the five case study States had a Level I PASRR screen in their case file or at the nursing facility. For the case study States, the average rate of Level I PASRR screens in the case files that we sampled ranged from 11 to 100 percent by State. Seventeen percent (15 out of 88) of the Level I PASRR screens we found were not completed prior to or on the date of admission to the nursing facility. Fourteen Level I PASRR screens were dated more than 2 months after admission.

There is little evidence that initial Level II PASRRs were conducted, and Level II reassessments rarely occurred for resident case files we reviewed

Only 41 percent (77 of 187) of the resident files we reviewed had evidence of a Level II PASRR. Our case file review revealed that most of these residents had only a determination letter or a form with the signature from a State contracted physician, not the actual assessment.

Our case file review indicated that only 29 percent (22 of 77) of individuals with an initial Level II PASRR, also had an additional Level II PASRR reassessment. All of the 22 Level II PASRR reassessments we encountered were completed while the annual reassessment requirement was still in effect.[26] All five case study States eliminated the annual Level II PASRR review requirement for nursing facility residents, although States have the option of continuing it. Seven States in our 50 State survey indicated that they still require an annual PASRR review or reassessment. Sixteen out of 19 nursing facilities indicated that Level II PASRR reassessment of their residents have never been conducted.

Sixteen of 19 nursing facilities are unclear what qualifies as a "significant change" and could not identify how a "significant change" should trigger a Level II PASRR reassessment. Since the repeal of the annual review or reassessment, nursing facilities

[26] In 1996 the **annual** requirement for the Level II PASRRs was eliminated.

must notify the State mental health authority when a resident with mental illness has a "significant change" in his/her physical or mental condition.

Sixteen of the 19 nursing facilities we visited had never contacted the appropriate State agency about the significant change in residents' mental health status. Ten of the nursing facilities we visited were aware of the Level II reassessment process if a "significant change" occurred. In two of our case study States, we found no evidence that the Level II PASRR reassessment was completed out of the 72 reviewed files in those States. In two other States, we found only one reassessment in each State out of a total of 62 reviewed files for those States. In the fifth State, we found 20 reassessments (37 percent) in the 53 files we reviewed. In two nursing facilities, in two different States, the Director of Nursing said that a Level II PASRR reassessment was not triggered for residents who were diagnosed with bipolar disorders after admission.

Some State respondents and nursing facilities identified the Minimum Data Set (MDS) assessments as the primary mechanism by which a Level II PASRR reassessment would be triggered. However, while HCFA has suggested the use of the MDS to trigger Level II PASRR reassessments, the MDS captures an "overall change in care status" which is not necessarily an indicator for a mental health status change. Our case file review revealed that none of the 21 residents, with an "improved" or "deteriorated" care status on either their most recent MDS assessment or one completed between April and June 1999, had a Level II PASRR reassessment. One case study State reported that there is a movement to begin developing a pilot MDS protocol that contains criteria specific to individuals with mental illness.

Case File Review — Evidence of PASRRs in Resident Files or Nursing Facility

State	Total Case File Reviews	Level Is	Level IIs	Level II Reassessments
1	39	32	10	0
2	33	6	1	0
3	53	6	31	20
4	40	22	22	1
5	22	22	13	1
Total	**187**	**88**	**77**	**22**

PASRR does not ensure that mental health needs are assessed

Federal definition of "serious mental illness" may limit Level II PASRR assessments

State Level I PASRR screens may not trigger a Level II PASRR mental health assessment for an individual with a severe and persistent mental illness. Our case file review revealed that 41 percent (77 of 187) individuals with a serious mental illness diagnosis had a Level II PASRR. The Federal definition of "serious mental illness" may enable States to avoid assessment of some residents with a serious mental illness by requiring that multiple conditions be met to classify them as requiring a Level II PASRR assessment. An individual is considered to have a serious mental illness if they have a major mental illness diagnosis, a functional limitation within the past 3 to 6 months **and** have had psychiatric treatment more intensive than outpatient care in the past 2 years.[27]

The Federal definition of serious mental illness limits those individuals who are required to undergo a Level II PASRR mental health evaluation. For example, individuals with a serious mental illness diagnosis, but no history of hospitalization in the past 2 years, are not required to be screened for needed mental health treatment or services before they are admitted to a nursing facility. Individuals with no treatment history, such as homeless individuals with a mental illness or applicants who have avoided mental health treatment due to stigma, may continue to have their mental health needs ignored.

Although there are minimum Federal PASRR requirements, States may design their own PASRR forms and may adopt a more inclusive definition of serious mental illness to facilitate referring more individuals to a Level II PASRR.[28] However, most States infer from the Federal requirement that all three conditions must be met to warrant a Level II PASRR mental health assessment. Fifty percent (15 of 30) State Level I PASRR forms that we reviewed require that all three conditions related to mental illness must be met to necessitate triggering a mental health assessment. Twenty-six percent of the States (8 of 30) require that only one or two criteria be met to trigger the Level II assessment.

One State reported that they require individuals who meet the Federal definition of serious mental illness to have a Level II PASRR, but they also require applicants who are considered a danger to self or others to have a Level II whether or not they have a mental illness diagnosis. This State also gives nursing facilities the latitude to request

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[27] 42 C.F.R. §483.102(b)(1)(1999).

[28] HCFA

that a Level II be done prior to admission or at any point during their stay at the nursing facility, if there are indicators of a serious mental illness, but may not fully meet the Federal definition. For seven of the forms that we reviewed, it was unclear what conditions needed to be met to trigger the Level II PASRR assessment.

Nursing facilities may not incorporate PASRR into their admissions process; PASRR is viewed as an eligibility indicator, not an evaluation tool

Nursing facilities have their own individual admissions process to determine their ability to care for an applicant, which may not take into consideration the PASRR assessment. Seven of the 19 facilities we visited reported that they did not use the PASRR to determine if they could accept a resident. Many facilities reported that their process is more in-depth and accurate than the Level I PASRR forms which only asks for "minimal information" and is "only a snap shot" of the clinical needs that an individual may have. Many facilities interview potential residents face to face, as opposed to the Level I PASRR screen which they view as only a "paper review." A nursing facility that we visited reported that they never look at the PASRRs and that they are filed in a folder separate from the residents' files. When we requested reviewing Level I and Level II PASRRs for sampled residents, this facility could not locate any of them. One facility thought that the State had discontinued the PASRR process.

State and nursing facility respondents indicate that the PASRR is what the States use to determine residents' nursing facility eligibility. In some States, the Level I PASRR is sent to the Medicaid office along with the Medicaid reimbursement form, and in others it is used to determine case mix reimbursement. As such, most nursing facilities we visited view the Level I PASRR as a tool to determine Medicaid eligibility rather than as an evaluation tool. These nursing facilities view the Level I PASRR as a formality and, more specifically, as an affirmation of applicant eligibility from the State. The Level I PASRR authorizes a short stay until the Level II is completed.

One facility reported that they would not be paid without the Level I PASRR screen, but rely more on a psychological profile than the PASRR. Another State agency respondent stated that the Level I PASRR is "not a medical instrument and anyone with knowledge of the applicant may complete it." A respondent from a State mental health authority reported that they "don't know that [the] Level I PASRR [process] is a good way of matching what a person needs with placement [because it is] structured more on eligibility versus needed resources."

States may violate the intent of the Federal requirement to provide mental health services

Implementation of the PASRR process may limit younger residents of nursing facilities access to mental health services due to: 1) a definition of "specialized services" that excludes residents of nursing facilities; 2) nursing facilities' inability to address Level II PASRR recommendations, when available, in treatment and care planning process; and 3) a lack of coordination between States and nursing facilities to provide recommended mental health services.

States' definitions of "specialized services" may enable them to avoid their responsibility to provide mental health services

An individual admitted to a nursing facility may require specialized services as determined by the Level II PASRR. States may adopt their own definition of specialized services. The HCFA describes specialized services as "services specified by the State which combined with services provided by the nursing facility, result in the continuous and aggressive implementation of an individualized plan of care."[29] Four of the five States we visited and 15 of 42 State mental health authorities responding to our survey define "specialized services" as 24-hour inpatient psychiatric treatment for an acute episode of mental illness. Under this definition, a nursing facility is not a 24-hour psychiatric treatment facility and thus nursing facility residents are excluded from receiving "specialized services."

By defining specialized services as 24-hour inpatient psychiatric treatment, States may avoid providing necessary mental health services to nursing facility residents with mental illness and shift this responsibility onto nursing facilities. In narrowing the scope of specialized services that the State is required to provide, States broaden the scope of services of "lesser intensity" that nursing facilities are required to provide. All of the States we visited indicated that if an individual requires the level of care identified as a specialized service, the individual would not be approved for nursing facility residence.

In 3 of the 5 case study States, the State makes "recommendations" for mental health services for an individual when notifying a nursing facility of approval for placement as part of the Level II PASRR process. Because they are not defined as "specialized services," the States are not required to, nor did we find that they provide or pay for these recommended services. Further, States do not follow up to ensure that nursing facilities are meeting or attempting to implement these recommendations. States' "recommendations" include "group therapy," "individual psychotherapy," "continuing psychiatric evaluations," "independent living training" and "vocational training."

[29] 42 C.F.R. §483.120 (1999).

Nursing facility residents with mental illness may have difficulty accessing more intensive "specialized services"

Even when a nursing facility resident with mental illness is determined to require "specialized services," these individuals are not always able to access such services. Our case file review revealed that 5 of the 77 residents (7 percent) who had a Level II PASRR assessment were identified as needing specialized services. Due to the States' definition of specialized services as 24-hour inpatient care or a level of mental health care more intensive than a nursing facility, these five residents may need 24-hour care and may have been inappropriately placed in a nursing facility. These residents may also have had a difficult time accessing more appropriate care and were thus unable to leave the facility, despite the States' PASRR recommendation.

In 3 of the 5 case study States, nursing facilities reported that they have difficulty linking their residents to specialized services when a resident is experiencing an acute episode of mental illness and requires a more specialized setting or 24-hour inpatient treatment.

Thirty percent (23 of 76) of State mental health authority and Medicaid agency respondents indicated that access to specialized services was an issue of great concern regarding the treatment of individuals with mental illness in nursing facilities. One nursing facility indicated that one of its residents was identified by the State as inappropriate for a nursing facility and instead needed to be placed in a State institution for mental diseases. However, the nursing facility was unable to find a facility willing to accept their resident into the program.

The Level II PASRR evaluation does not appear to be used in care planning

Most nursing facility respondents indicated that Level II PASRR evaluations are not used in the treatment or care planning process. The actual physical and mental evaluation upon which the determination is based, is rarely sent to nursing facilities. Most nursing facilities responded that they never see the results of the Level II PASRRs. Four of the five States we visited send out a letter documenting completion of the Level II PASRR and informing the nursing facility of the determination for placement. In the one case study State where nursing facilities may receive a copy of the evaluation, one nursing facility indicated that their procedure is to send the Level II evaluation directly to the medical records unit without the staff social worker's review.

Other than the Level II PASRR determination letters with "recommended" mental health services, nursing facilities get little information from the State regarding the treatment needs of an individual based on the PASRR process. In one State, a contracted physician visits a nursing facility and signs a standardized form in the residents file, logging that it has been completed. In this State, nursing facilities report that State-contracted Level II PASRR evaluators complete the Level II PASRR

mental health evaluation for approximately two of every five residents with a mental illness. One nursing facility reported that "aside from the letter from the State indicating that the Level II had been completed, the nursing facility doesn't get feedback" or additional information regarding the Level II PASRR mental health evaluation.

Respondents are concerned that younger nursing facility residents with mental illness may not have access to mental health services

Respondents from 40 States, including State agencies, LTC Ombudsmen, mental health advocates and nursing facilities, indicated that they are concerned that individuals with mental illness are not accessing mental health treatment in nursing facilities. Twenty-seven of 76 State Mental Health and Medicaid agency survey respondents indicated that access to necessary mental health care was an issue of great concern. Eight respondents from four case study States indicated that nursing facilities primarily provide medication management for their residents with mental illness.

State agency respondents in the five case study States indicated that some nursing facilities are more capable of providing linkages to mental health services than others. However, most nursing facilities reported that they do not have funding to provide necessary mental health services, bring in additional staff and/or arrange for transportation. One State indicated that community psychiatric interventions funded by State funds are not permitted in a nursing facility since nursing facility psychiatric care in that State is considered to be "a self-contained program appropriate and complete for clients at this level of care."

Federal Financial Participation (FFP) is not available for specialized [mental health] services furnished to nursing facility residents as nursing facility services.[30] States, however, receive FFP for services that are Medicaid optional benefits under their State plan services. For example, States may choose to cover psychologist, rehabilitative, case management, clinic and medical social worker's services for nursing facility residents.

States and nursing facilities we visited rarely coordinate to provide mental health services to nursing facility residents. This lack of coordination may limit residents' access to mental health services. Most nursing facility respondents indicate that there is little cooperation from the State in linking their residents to State or county mental health services. In one State, individuals with mental illness who have a case manager prior to admission may retain them to assist in accessing additional mental health services. In another State, the protection and advocacy agency indicated that if a resident with mental illness has a case manager when s/he enters a nursing facility

[30] 42 C.F.R. §483.124 (1999).

they lose their case manager. The State believes that once a resident with mental illness is in a nursing facility, they no longer need the case manager, seeing him/her as duplicative of the services the nursing facility should provide.

Most of the protection and advocacy respondents in our case study States expressed concern about the mental health treatment received by individuals with mental illness in nursing facilities. They were also concerned with the State's ability to monitor these individuals, but were not particularly focused on this issue. Three of five advocates reported their concern about the lack of mental health background and training of nursing facility employees working with this population. A few advocates stated that they believe that if there were other mental health supports available in the community, then States would not be placing younger individuals with mental illness in nursing facilities. Many State and nursing facility respondents reported that individuals with mental illness lack the strong type of advocacy community that helps individuals with developmental disabilities.

While most State protection and advocacy agencies are not focused on nursing facility residents with mental illness, one case study State protection and advocacy agency has frequently been involved with this population. Currently this State's protection and advocacy agency is involved in a law suit regarding individuals with mental illness who are residents of a nursing facility who are not being informed of, assessed for, or provided with long-term care services at home or in the community.

PASRR systems function with little State and Federal oversight

In four of the five case study States, State agency respondents reported they were not aware of younger individuals with mental illness, ages 22 to 64, who were residing in nursing facilities without a physical co-morbidity and if there were, that it was a negligibly small population. However, we found that all five case study States housed residents with mental illness without a co-existing physical illness in nursing facilities. In two of the five States, the majority of files we reviewed consisted of individuals with mental illness without a physical diagnosis. We visited nursing facilities in three States where the majority of individuals in that facility had only a mental illness.

States do not systematically monitor the PASRR process

States do not routinely ensure that Level I PASRR forms accurately reflect an applicant's mental health status. States are relying on Level I PASRR screens that are completed by individuals who may not have any mental health training or background. In three of the five States we visited, those who complete the Level I PASRR screen, e.g. nursing facility and hospital staff, may not have a mental health

background or training.[31] In completing the Level I PASRR screen, nursing facilities may rely on mental health background information received from the applicant or a family member.

Minimal State oversight of the accuracy of the Level I PASRR form enables the placement of individuals with mental illness in nursing facilities without the placements being scrutinized. One facility reported that they heard that the county who administers the PASRR admissions process was "going to be selective [about admissions], but we have only had one case denied for admission in the past 9 months." One State Medicaid agency believes the PASRR process is adequate based on the absence of identified or perceived problems.

States do not have a systematic process to ensure that individuals are getting the mental health services that were indicated as necessary or "recommended"on the Level II PASRR or a Level II PASRR reassessment. Services are written on Level IIs as recommendations, not requirements. States believe they are not obligated to follow up to ensure nursing facility compliance. One State is currently undergoing a pilot tracking program to determine if they need to oversee mental health treatment delivered to individuals whom the State recommends receive specific services. A respondent from that State's Medicaid Agency reported that they have not reviewed their system in 12 years and believe that it is "alarming that no one knows what happens once the letter [with treatment recommendations] is sent." A respondent from another State reported that they have "never tested the [PASRR] process enough" and "never bothered to enforce legislation." In addition, the respondent felt that the PASRR is "politically unpopular with the State's legislature" who "do not see the need" for the process and think that the PASRR is "too paper heavy."

States rely on surveyors to monitor PASRR process; surveyors report that it is not their responsibility

In four of the five case study States, State mental health authorities and Medicaid Agencies said they relied on the State nursing home survey agency to monitor the PASRR process. One SMHA relies on surveyors to ensure that Level II recommendations of treatment are implemented. However, the surveyors we interviewed from this State reported that they did not follow up to review the implementation of treatment recommendations and were not familiar with the PASRR process. Surveyors in all case study States reported that monitoring the Level I PASRR process was not their responsibility. Only 1 out of 25 survey agencies in our larger sample reported that they had responsibility to monitor the Level I PASRR process.

In addition, State agencies rely on surveyors to monitor whether an individual with mental illness has undergone a significant change in their mental health status and has

[31] In KS and MN trained Area on Aging staff complete the Level I PASRR screen.

a Level II reassessment. Most surveyors, however, report that they do not look for instances of "significant change" in a resident's mental illness status and then to see if a Level II PASRR has been appropriately triggered. In addition, the Level II PASRR reassessment is not an element of the OBRA 1996 survey. While some State surveyors are aware of the need for a Level II reassessment in certain circumstances, they are unclear what these circumstances are and what mechanism should be used by the nursing facility to trigger the reassessment. In four of the five case study States, surveyors indicated that there are no guidelines for them with reference to the PASRR to indicate when there is a significant change that should warrant reassessment. In one case study State, surveyors indicated that they check to see if a Level II PASRR reassessment should have been completed for sampled residents with a mental illness. These surveyors were specifically trained by the regional HCFA office on PASRR and mental health issues in nursing facilities.

In most case study States, both surveyors and nursing facilities expressed concern that the surveyors were not adequately trained to assess the appropriate care needs of younger residents with mental illness. Surveyors do not usually have a mental health background or mental health training, nor are they accustomed to evaluating the needs of younger individuals. Most case study surveyors we spoke with report that they are not trained to review PASRR forms, primarily because it is not part of the OBRA 1987 survey process. Some nursing facility respondents in facilities with a significant number of individuals with mental illness, report that they are more knowledgeable than the surveyors about treating these individuals. One facility reported that they "would like more feedback and suggestions from the surveyors."

Survey requirements do not include review of PASRRs forms or process

The current State Operations Manual sampling criteria requires that surveyors sample only one resident with mental illness per nursing facility.[32] For the most part, surveyors use a geriatric model when conducting a survey and reviewing their sample files. In case study States, surveyors report that they focus on traditional issues and services offered to nursing facility residents such as dehydration, medication reduction, and group social activities. One State respondent believes that surveyor reviews mainly look at what medications rather than mental health services are provided to residents. In one State, surveyors reported that "it was no longer a [Federal] mandate to include any individuals with mental illness in their sample."

Surveyors may be unaware of recent regulations in the State Operations Manual citing the requirement to look at PASRRs if available during the pre-site stage of their survey. According to the State Operations Manual, the PASRR is one of eight information sources used to focus the survey for Offsite Survey Preparation. If the PASRRs are available," surveyors are directed to "evaluate if there are any potential concerns and note names of residents for possible inclusion in the sample."

[32] State Operations Manual, Appendix P Survey Protocol for Long-term care.

Surveyors report that there is not a survey category in which to cite that an individual with mental illness is inappropriately placed in a nursing facility. Due to already stringent OBRA 1987 survey requirements, surveyors from one State reported they would need to have a larger sample size if they were going to purposively sample younger residents with mental illness. One State surveyor reported that she can cite the facility only for not providing appropriate mental health services. She cannot cite an inappropriate placement.

Surveyors do not focus on whether a resident's care plan incorporates Level II PASRR recommendations for mental health services. Four of the five surveyor teams we interviewed were aware of the Level I PASRR forms and the Level II determination letters, but did not routinely review them. One State surveyor team, in a State with one of the highest national placement rates of individuals with mental illness in nursing facilities, was unfamiliar with the PASRR process. These surveyors reported that they had been handed a folder labeled "PASRR" by their supervisor before their current site visit, but had not reviewed the included information. They did not modify their review procedures despite being at a facility where every resident had a mental illness diagnosis and most were under age 55.

Three of the four survey teams we interviewed mentioned issues related to the PASRR as part of their review including: whether individuals were identified as needing specialized services; that they could not locate some of the forms or that they were incomplete; and that they differed by county. One State surveyor reported that surveyors from their State do not review the PASRR because they assume that the PASRR has already been properly completed and is in place. Surveyors from this State further assume without verification, that if a resident has been accepted by the facility, then the facility is capable of providing the needed mental health care.

States do not ensure that PASRR Level II reassessments are appropriately triggered

States do not have a mechanism to ensure that Level II PASRR reassessments are appropriately triggered. Nursing facilities are required to "promptly" notify the State mental health authority if there is a "significant change in the resident's physical or mental condition."[33] Respondents from four case study States question a nursing facility's incentive to notify the State mental health authority about the change in status of a resident if, for example, their case mix is determined on a 6 month basis or if they rely on the resident remaining in the facility as a valuable income source. Other State respondents believe that nursing facilities have an incentive to report a resident's change rather than face potential penalties from deficiencies identified through the survey process or face treatment difficulties of a resident whose behavior has become difficult to manage. Many nursing facilities, surveyors and State agencies

[33] The Nursing Home Facility Resident Act, P.L. 104-315

indicate that the definition of "significant change" for nursing facility residents with mental illness and the criteria to trigger a Level II PASRR reassessment are unclear.

Four case study States and one survey State expressed frustration that there has been minimal guidance or directive from HCFA on what defines significant change and what should trigger a Level II PASRR reassessment since the repeal of the annual review requirement. The HCFA has not provided a specific definition for significant change for PASRR purposes, nor do they believe that it is necessary.

In 1996, HCFA offered clarification to the States concerning the need for a resident reassessment when there is a "significant change in a resident's physical or mental condition," but left States the flexibility to establish their own criteria.[34] In earlier guidance, HCFA indicated that States may establish criteria that will determine whether a resident's "significant change" could effect the determination of appropriate nursing facility placement and/or the resident's need for specialized services, and thus trigger a Level II PASRR reassessment.[35] As a follow-up, HCFA indicated "that when the nursing facility resident assessment (the MDS) indicates that a more immediate annual resident review is warranted, the facility should alert the SMHA. The HCFA further directed the States to consider that "judgment is... required in determining when reviews [reassessments] are appropriate and when a more thorough annual resident review is required."[36]

State mental health authorities do not accept oversight responsibility

Survey respondents from 22 States report that Level II PASRR responsibility rests with the State mental health authorities. However, most SMHAs in our case study States do not consider it their responsibility to monitor or provide treatment for residents of nursing facilities with mental illness. Despite having primary responsibility for providing treatment and long term care options to individuals with mental illness, most SMHA decline responsibility for residents with mental illness in nursing facilities and instead rely on facilities to provide needed services without their oversight. One SMHA reported that Federal regulations do not connect nursing facilities to State mental health authorities. Subsequently, this SMHA is not involved in ensuring that a Level II PASRR reassessment is completed when necessary. Some of the SMHA representatives that we interviewed were not able to answer basic process questions regarding the PASRR process.

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[34] December 23, 1996 HCFA, Office of Long-Term Care Services, Medicaid Bureau Memorandum to All Associate Division of Medicaid Regional Administrators

[35] March 23, 1990 Federal register proposed rule.

[36] December 23, 1996 HCFA, Office of Long-Term Care Services, Medicaid Bureau Memorandum to All Associate Division of Medicaid Regional Administrators

A few States violate Federal regulations by inappropriately delegating the authority both to conduct the Level II PASRR evaluations and make determinations regarding appropriate placement and specialized services. Responsibility for the Level II PASRR mental health evaluation and determinations rests with the State Medicaid agency who most frequently delegate this responsibility to the SMHA.[37] Determinations must be made by the SMHA based on an independent evaluation performed by an entity other than the State mental health authority. Three States responding to our survey report that nursing facilities complete the Level II PASRR evaluation. This directly violates regulations that prohibit the State from delegating this responsibility to a nursing facility or any entity that has a direct or indirect affiliation with a nursing facility.[38] In addition, in one of the five States we visited, the Level II placement determination is made by the State Agency on Aging, without the State mental health authority's approval.

Two case study States report that the county mental health authority has responsibility for ensuring individuals are getting services either from the nursing facility or through county-contracted services. States with county-run mental health systems, report there is little oversight over the activities of the counties. In one case study State, counties can even design their own forms. Two States indicated that the county mental health programs review PASRRs and "pull a sample of charts." However, the State Agencies do not monitor the county's activities and many nursing facilities were not aware of the review process.

One State Medicaid agency reported that they "should be asking counties about numbers of referrals." In addition, they stated that they "did not know about the adequacy of services being provided, because they don't get enough feedback. The [PASRR] system is designed to prevent admission, [not to inform the State if residents are] getting psychological therapy." Surveyors report seeing Statewide variation in the involvement of community mental health centers in nursing facilities. Nursing facilities report that, although it rarely occurs, some counties provide mental health services to residents who were county clients before nursing facility admission.

HCFA does not monitor the PASRR process

The HCFA regional offices and headquarters do not monitor the PASRR process or provide guidance to the States. All of the HCFA regional office PASRR contacts reported that they have limited knowledge of current State PASRR processes. Despite an annual report requirement, HCFA regional offices report that they are not collecting an annual report from States. The HCFA headquarters reported that it never made the required report to Congress. In the statute, State reporting requirements are minimal and focus on discharge of this population from nursing

[37] 42 C.F.R. §483.112 (1999).

[38] 42 C.F.R. §483.106(d)(1)(iii) (1999).

facilities. There is no standard report form and HCFA respondents indicated that when the reports were being collected, in the early 1990s, the little information they did receive was not particularly useful.

Some regional office staff report that monitoring visits that were made during the early 1990's enabled them to better assist the States with the provision of technical assistance. Recent agency reorganization, downsizing and shifting priorities eliminated the regional office monitoring component. One regional office provided training for surveyors specifically covering techniques for reviewing the PASRR process. Both surveyor agency staff and on-site surveyors from a case study State in this region report this training was beneficial.

State Long-Term Care Ombudsmen primarily focus on geriatric residents

State Long-Term Care Ombudsmen report that they primarily focus their attention on the needs of geriatric nursing facility residents. In our case study States, LTC Ombudsmen report that they have not received a sufficient number of complaints to warrant their concern for younger individuals, ages 22 to 64, with mental illness or geriatric residents regarding issues related to this population. Federal LTC Ombudsman reporting system complaint categories include PASRR, mental health services and three other general categories which the Federal Agency on Aging indicated "might also pick up problems due to mental health." However, State LTC Ombudsmen indicated that younger individuals with mental illness are not generally a population whose concerns they normally address. Fourteen of 22 State LTC Ombudsmen could not report how many complaints they had received either from geriatric residents or individuals with mental illness regarding issues related to mental illness.

RECOMMENDATIONS

We based our findings on a purposive sample and have not made a statistical projection. Nonetheless, our findings raise serious concerns that warrant further attention. States make placement decisions and nursing facilities provide care with little oversight for younger individuals with mental illness. State implementation of preadmission screening and resident review (PASRR) systems, the primary mechanism to ensure appropriate nursing facility placement and address mental health needs, is inadequate. The Federal definition of serious mental illness and the commonly held perception that the PASRR is more of an eligibility indicator than an evaluation tool, contribute to the ineffectiveness of States to identify an individual's mental health status, make necessary mental health assessments and oversee needed mental health treatment. Finally, States' definitions of specialized services may limit the opportunity for individuals to access mental health services.

The PASRR process functions with little State or Federal oversight to ensure that younger individuals, ages 22 to 64, with mental illness are appropriately screened, evaluated and placed in nursing facilities. States do not systematically monitor the PASRR process, instead they rely on surveyors, whose guidelines do not include the review of PASRR forms or processes, to assess the issues facing this population.

Improve States' capacity to identify individuals with mental illness and determine appropriate facility placement

To improve the effectiveness of the PASRR process to identify individuals with mental illness and determine appropriate facility placement, we recommend that HCFA:

- ensure completion of the Level I PASRR screens and that they completed prior to nursing facility admission;
- develop guidance under which the Level I PASRR screen should be completed by a mental health professional;
- require that Level II PASRR be triggered if at least one indicator of serious mental illness is identified, per a standard definition provided by SAMHSA (through the Center for Mental Health Services). In particular, HCFA should eliminate the Federal requirements that an individual has been hospitalized in the past 2 years, and that they have had a functional limitation in the past 3 to 6 months due to their mental illness;
- outline and enforce State requirements for Level II PASRR evaluation summary reports that are to be shared with the admitting nursing facility; and
- provide technical assistance to help States develop a formal mechanism to share the results of PASRR screens with the survey agency. This will facilitate surveyors' ability to evaluate whether there are any potential

concerns and note names of residents for possible inclusion in their sample of nursing facility residents.

Improve oversight of the PASRR process and access to mental health treatment

To improve the oversight of and access to mental health treatment, we recommend that HCFA:

- provide regional PASRR training to surveyors;
- require surveyors to ensure that PASRR Level I identification screen is completed for all nursing facility residents;
- require nursing facilities to use the Level II PASRR assessment and recommendations in care planning and provide findings to the State Medicaid agency. The State Medicaid agency should ensure that technical assistance is provided to nursing homes or designate the State mental authority to provide such technical assistance;
- provide States with technical assistance to develop additional mechanism(s) to monitor the PASRR process both at admission and throughout a resident's stay at a nursing facility (see Appendix for example);
- add survey regulations that require State surveyors to ensure care plan compliance with all Level II PASRR recommendations; and
- convene regular stakeholder meetings with State Agencies, regional offices, Ombudsmen, and Protection and Advocacy agencies, to discuss the effectiveness of the PASRR process.

Ensure that placement of an individual with mental illness in a nursing facility is not a means of avoiding responsibility for the provision of specialized mental health services

To ensure that placement of an individual with mental illness in a nursing facility is not a means of avoiding responsibility for provision of specialized services, HCFA should:

- define specialized services, with mental health provider input, that is to be provided by the State and made available to individuals with serious mental illness residing in nursing facilities.

Improve ability of nursing facilities to identify significant change and to make appropriate referrals

To improve nursing facilities ability to identify and appropriately refer nursing facility residents whose mental health condition changes, HCFA should:

- clarify the definition of significant change and implement a mechanism to ensure a Level II PASRR is completed;

- modify the MDS form to identify a significant change in mental health status, triggering a Level II PASRR reassessment;
- update the State Medicaid Manual to provide related guidance on triggering a Level II PASRR reassessment; and
- develop a Resident Assessment Protocol (RAP) for mental health status.

Improve Federal monitoring and oversight

To improve Federal monitoring and oversight, we recommend that HCFA:

- clarify the role and responsibilities of regional HCFA PASRR contacts;
- require the annual PASRR report to include data regarding the number of Level I and II PASRRs completed and the placement and treatment results by age;
- standardize the annual report and ensure that it is completed and monitored annually by the HCFA regional office; and
- reconsider adding a PASRR compliance and enforcement component to State nursing facility report cards for inclusion on HCFA's Nursing Home Compare web site if further study indicates the need to report this information to the public.

To improve implementation and oversight of the PASRR process, HCFA should specify which unit(s) within HCFA have responsibility for ensuring that:

- States are appropriately implementing PASRR;
- all appropriate PASRR paperwork and, consequently the justification for nursing facility placement, specialized services and other mental health treatment if applicable, is properly completed; and
- nursing facilities and States comply with PASRR determinations and recommendations for mental health services.

Improve Level II PASRR process and ensure compliance with Olmstead Decision

To improve State Medicaid agencies ability to ensure compliance with the Olmstead Decision HCFA should:

- require that State Medicaid agencies collaborate with State mental health authorities to identify and maintain a list of alternative community based treatments, including the Medicaid and Community-Based Waiver, and to track the level of need and availability of such resources.

To improve State mental health authorities' ability to make appropriate Level II PASRR placement, specialized service and mental health treatment determinations, SAMHSA should within its statutory authority over SMHAs:

- provide guidance to SMHAs including model practices and standards on appropriate treatment, specialized and other mental health services;
- emphasize the importance of supporting this population to the Protection and Advocacy agencies; and
- periodically review SMHA Level II determinations and provide technical assistance to SMHAs.

To improve nursing facilities' ability to identify and appropriately refer nursing facility residents whose mental health conditions change, SAMHSA should:

- provide guidance to SMHAs regarding identifying alternative treatment options for individuals being considered for placement in nursing facilities.

Clarify Agencies' roles and responsibilities within the Department in overseeing the PASRR process

To improve implementation and oversight of the PASRR process, the Department should determine and delineate HCFA and SAMHSA's responsibilities in overseeing PASRR determination.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration and the Substance Abuse and Mental Health Services Administration. The HCFA and SAMHSA concur with the majority of our recommendations. We feel that HCFA and SAMHSA's commitment to the effectiveness of the PASRR process is of particular importance in light of the Olmstead Decision. Where appropriate we changed the report to reflect both HCFA and SAMHSA's comments. The full comments received from HCFA and SAMHSA are contained in Appendix B.

The HCFA believes our recommendations will "help [them] make sound policy decisions about how best to protect the interests of younger Medicaid beneficiaries who have a serious mental illness...and reside in nursing facilities." In addition, HCFA will "attempt to augment [our] recommendations with companion efforts that would expand community alternatives and will coordinate planning for PASRR improvements with those community service improvement efforts."

We would like to commend HCFA on their assistance in conducting this study and for providing us with substantive and insightful comments.

The HCFA concurred in full with 24 of the 30 ways to achieve our recommendations. The agency proposes an alternative solution or will take under further consideration the following 6 recommendations with which they do not concur:

The HCFA does not concur with our recommendation to develop guidance under which the Level I PASRR screen should be completed by a mental health professional. The HCFA does not believe it is necessary for a mental health professional to conduct the Level I screen that identifies persons who are suspected of having a mental illness. We believe that at present, there is little evidence that these screens are being completed by individuals who are trained to diagnose possible mental illness and subsequently trigger the necessary Level II PASRR mental health evaluation. We have kept the recommendation as previously stated.

The HCFA does not concur in whole with our recommendation that a Level II PASRR be triggered if at least one indicator of serious mental illness is identified. They agree with our recommendation to eliminate the requirement that a person has been hospitalized in the past 2 years. However, they believe that a person who does not have a functional limitation should be permitted access to a nursing facility if they meet that level of care criteria. While we agree that individuals with a serious mental illness diagnosis who do not have a functional limitation may be appropriate for nursing facility residency, we still believe that based on their serious mental illness diagnosis these individuals should still have a Level II PASRR evaluation to determine needed mental health services.

The HCFA proposes an alternative to our recommendation to require that States share the Level II PASRR mental health evaluation with the admitting nursing facility. The HCFA believes it would be an unnecessary burden to require such documentation be copied and sent for every person evaluated. Instead, they propose to take action through a State Medicaid Director letter and subsequent changes in the State Medicaid Manual. We support HCFA's proposed actions and agree that if the current regulations requiring a detailed summary report are enforced, as outlined in HCFA's comments, then nursing facilities should have sufficient information regarding the outcome of the Level II PASRR mental health evaluation.

The HCFA does not concur with our recommendation to define specialized services, with mental health provider input, to be provided by the State and made available to individuals with serious mental illness in nursing facilities. They believe that States should define specialized services as 24-hour inpatient psychiatric treatment in order to prevent individuals needing intensive mental health services from residing in nursing facilities. While we agree that intensive mental health services are difficult to provide in a nursing facility, our recommendation speaks to those individuals with serious mental illness who are already residents of a nursing facility or who require nursing facility care because of a comorbid physical condition. We believe that appropriateness of nursing facility placement does not preclude an individual's need for intensive mental health services in that setting. Therefore, we are keeping the recommendation as written.

The HCFA does not concur with our recommendation to add a PASRR compliance and enforcement component to State nursing facility report cards for inclusion on HCFA's Nursing Home Compare web site. We support HCFA in their willingness to reconsider adding this component if further study indicates the need to report this information to the public.

The HCFA would like to further review our recommendations pertaining to the MDS and "significant change" requirements for PASRR. Specifically they would like to consider further our recommendations to: 1) clarify the definition of significant change and implement a mechanism to ensure a Level II PASRR is completed; 2) modify the MDS form to identify change in mental health status, triggering a Level II PASRR reassessment; and 3) develop a Resident Assessment Protocol (RAP) for mental health status. We request that at the time HCFA submits the action plan, they provide us with an updated assessment of these items.

Our recommendation to improve the Level II process and ensure compliance with the Olmstead Decision directs specific recommendations to SAMHSA. The SAMHSA agrees in full with 5 of the 6 specific recommendations that apply to them. In addition, SAMHSA concurs with our Departmental recommendation to determine and delineate HCFA and SAMHSA's responsibilities in overseeing PASRR determinations.

We would like to thank SAMHSA for their assistance in conducting this study and for providing us with supportive comments.

The SAMHSA agrees that there are problems with Level I and II PASRR documentation and implementation and is committed to insuring a common understanding of the PASRR requirements, goals and objectives. The SAMHSA is working together with HCFA in addressing the Olmstead Decision and other key areas regarding behavioral health services. The SAMHSA looks forward to utilizing their partnership to address how SAMHSA can support HCFA in implementing the PASRR process.

The SAMHSA concurs with our specific recommendations for their role in improving the ability of State mental health authorities (SMHAs) to make appropriate Level II PASRR placement, specialized service and mental health treatment decisions. They further agree that they should provide guidance to SMHAs to identify alternative treatment options for individuals being considered for placement in nursing facilities.

The SAMHSA does not concur with our recommendation that they annually review SMHA Level II determinations. They believe this recommendation overstates their statutory responsibility for the PASRR process as the regulations do not require such a review. We agree that SAMHSA does not have the authority to make administratively binding assessments of the acceptability of these determinations, nor the resources to conduct annual reviews of each. We have therefore, changed the recommendations to reflect their broader mandate to provide guidance and support to SMHAs in providing care to all individuals with mental illness in any treatment setting.

We feel that SAMHSA's commitment to the effectiveness of the PASRR process is of particular importance in light of the recent Olmstead Decision. We believe SAMHSA has a responsibility to ensure the appropriate care for individuals with mental illness in any treatment setting and should use its expertise to support the Level II PASRR process. In this vein, we believe that periodic reviews of some or all such determinations could serve as a useful basis for developing appropriate guidance.

We support SAMHSA's proposed actions for meeting our recommendations.

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APPENDIX A

One State has a special oversight branch to monitor the PASRR process

One case study State has a special oversight branch to monitor the PASRR process. In Pennsylvania, the Utilization Management Review (UMR) Section, during quarterly onsite visits, verifies that Level I PASRRs exist for all new admissions and that they are completed correctly. During their facility visits, UMR representatives monitor the Level I PASRRs, Minimum Data Set (MDS) and the determination letters from the Mental Health, Mental Retardation or Social Services Program offices. This ensures that residents require nursing facility care and the nursing facility can provide any specialized services that are required. The UMR also monitors the Level II assessments in conjunction with contracted mental health specialists who are brought in on a case by case basis. In addition, the UMR representatives do an "in-depth chart review" to ensure documentation is present to support MDS entries. Review of the MDS could result in a Level II reassessment.

For further information please contact:
The Pennsylvania Department of Health
Division of Nursing Care Facilities
717-787-1816

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: SEP 27 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Younger Nursing Facility Residents with Mental Illness: Preadmission Screening and Resident Review Implementation and Oversight," (OEI-05-99-00700)

Thank you for the opportunity to review and comment on the above-referenced draft report. The information gathered by the OIG will help us make sound policy decisions about how best to protect the interests of younger Medicaid beneficiaries who have a serious mental illness or mental retardation and reside in nursing facilities.

Preadmission screening and resident review (PASRR) is a Medicaid program that was enacted as part of the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 to ensure that people who have a serious mental illness or mental retardation are not "warehoused" in Medicaid nursing facilities. The PASRR program assesses the service needs of nursing facility applicants and residents, and considers appropriate alternatives to nursing home placement. When a person who has mental illness or mental retardation needs nursing facility services and is admitted, the mental health and mental retardation services a person needs must be provided. If a nursing facility resident needs less intensive mental health services, the nursing facility is required to provide that level of service. Likewise, states are required to provide more intensive specialized mental health services that a resident is determined to need. Persons with mental retardation must receive the same services they would receive under the Medicaid program for that population.

States were required to develop PASRR programs in a relatively short timeframe, and before HCFA would be able to publish regulations. In May, 1989, responding to states' request, HCFA provided guidelines in Transmittal number 42 of the State Medicaid Manual. We published proposed rules March 23, 1990, and final rules, November 30, 1992. HCFA staff has also regularly worked with state mental health program directors, providing clarifications and updates on PASRR. Regional offices initially conducted regularly scheduled oversight reviews of state PASRR programs, including record reviews at a sampling of nursing facilities. Due to regional office staffing and budget shortages, regional office oversight reviews are now done when staffing schedules and budgets allow.

Nursing home residents deserve and expect access to safe, quality care. In 1998, the Clinton Administration began an aggressive initiative to improve enforcement of Federal and state nursing home standards and to promote quality care for nursing home residents. The Health Care Financing Administration (HCFA) now requires states to crack down on homes that repeatedly violate health and safety standards and has strengthened the inspection process to

Agency Comments

increase its focus on preventing bedsores, malnutrition, and abuse. In addition, HCFA has created Nursing Home Compare, a searchable database available at www.medicare.gov, to give consumers access to comparative information about nursing homes, including annual inspection results and the health status of residents. HCFA is taking these actions to make sure that residents get the quality care and safe environment that they deserve.

At the same time, stronger enforcement in isolation is likely to lead to wasted effort until states develop improved community alternatives for people with severe and persistent mental illness. We recognize our responsibility to work with states, the Administration, and Congress to make such improvements possible. We will, therefore, attempt to augment the OIG recommendations with companion efforts that would expand community alternatives and will coordinate planning for PASRR improvements with those community service improvement efforts.

The report states that states may be violating the intent of the Federal requirement to provide mental health services. It also suggests that the PASRR system could be used as a positive tool in a state's compliance efforts with the Olmstead Supreme Court decision since, ideally, PASRR would assure that those who enter nursing homes are being served in appropriate settings qualified to care for them. Additionally, significant changes in patients' levels of needed care would be identified if Level II PASRR screens were used. Ideally, in states with single point of entry systems, which have been shown to decrease unnecessary institutionalization, PASRR would work in tandem with the single point of entry systems. Each of these measures would be expected to have a protective effect if a state were challenged under Olmstead. Conversely, states may be putting themselves in jeopardy with regard to Olmstead, such as legal challenges by having a screening tool in place to monitor appropriate institutionalization and service delivery but then not using it.

HCFA has taken its role in issuing Olmstead compliance guidance to states very seriously. The State Medicaid Directors and Governors have received two letters in an ongoing series of guidance materials designed to assist states in ensuring that people are served in the least restrictive environment appropriate for their needs. As a component of this guidance, we recommended that states have comprehensive effectively working plans in place to transition people who are unjustly being served in institutional settings into the community. The findings of this report support the need for continued work on the front end of this planning process to identify the eligible population of individuals that could benefit from community-based care The PASRR screens, if completed should provide much of this information.

While we strongly support Olmstead planning activities, the OIG recommends that HCFA mandate that state Medicaid agencies collaborate with state mental health authorities to identify and maintain a listing of available community-based alternatives. While this is an admirable goal, and HCFA can recommend this kind of activity, Olmstead does not give HCFA authority to mandate cross-collaboration among state agencies.

We appreciate the effort that went into the audit report and the opportunity to review and comment on the issues it raises. Our response to your recommendations and technical comments on the report are attached.

Attachment

Agency Comments

**Response of the Health Care Financing Administration (HCFA)
Regarding Office of Inspector General (OIG) Draft Report:
"Younger Nursing Facility Residents with Mental Illness:
Preadmission Screening and Resident Review
Implementation and Oversight," (OEI-05-99-00700)**

Responses to Specific OIG Recommendations

OIG Recommendation

To improve the effectiveness of the preadmission screening and resident review (PASRR) process to identify individuals with mental illness and determine appropriate facility placement, we recommend that HCFA:

1. *ensure completion of the Level I PASRR screens;*
2. *ensure completion of the Level I PASRR screens prior to nursing facility admission;*
3. *develop guidance under which the Level I PASRR screen should be completed by a mental health professional;*
4. *require that Level II PASRR be triggered if at least one indicator of serious mental illness is identified. In particular, HCFA should eliminate the Federal requirements that an individual has been hospitalized in the past 2 years, and that they have had a functional limitation in the past 3 to 6 months due to their mental illness;*
5. *require that states share the Level II PASRR mental health evaluation with the admitting nursing facility; and*
6. *provide technical assistance to help states develop a formal mechanism to share the results of PASRR screens with the survey agency. This will facilitate surveyors' ability to evaluate whether there are any potential concerns and note names of residents for possible inclusion in their sample of nursing facility residents.*

HCFA Response

We concur with *1. (ensure completion of the Level I PASRR screens)* and *2. (ensure completion of the Level I PASRR screens prior to nursing facility admission)* above with the following clarifications:

HCFA currently has regulations governing the requirements for ensuring the completion of Level I screening for all admissions to nursing homes. The following will be emphasized and reinforced in regional offices and state agencies:

- The law precludes Medicaid participating nursing facilities from admitting any person who has mental illness, regardless of payment source, unless the state PASRR program has determined that the person needs the level of service provided by a nursing facility. Furthermore, Federal payment cannot be paid for a Medicaid resident's care unless such a determination has been made. To protect nursing facilities from admitting persons who have not received such a determination, it is imperative to identify all applicants who might have mental illness. Thus, Federal regulations require every applicant to be given an identification screen. Called a

Agency Comments

Level I, this pre-PASRR activity must be done prior to nursing facility admission and it is the responsibility of the state Medicaid agency to assure compliance.

- State surveyors are expected to determine nursing facility compliance with regulatory requirements for a Level I screen. The regulation at 42 CFR 483.20(m) requires preadmission screening for individuals with mental illness and guidance to surveyors is found in Appendix PP on page PP-82.7 for Tag F285. In addition, Appendix P, Survey Protocol for Long Term Care Facilities, directs surveyors in the process of how to consider the inclusion of residents with mental illness in the resident sample.

During future long term care basic training, surveyors will be provided additional guidance on how to determine facility compliance with PASRR requirements for Level I identification screens for residents who are identified with a diagnosis of mental illness.

We will also issue a State Medicaid Director letter to reinforce each state's awareness of its responsibility to ensure that a Level I is completed prior to each nursing facility admission. Through written communication, regional offices and state agency surveyors will be reminded to review records of individuals with a diagnosis of mental illness in their selected sample, for the presence and completion of a Level I identification screen, as required.

We do not concur with *3. (develop guidance under which the Level I PASRR screen should be completed by a mental health professional)* for the following reasons:

Our goal is to provide people with the services they need. To require a mental health professional to screen every nursing facility applicant and resident for possible mental illness would seriously delay residents from receiving needed services. Furthermore, we do not believe it is necessary to use a mental health professional for the pre-PASRR Level I screen that identifies persons who are suspected of having a mental illness and need the Level II PASRR evaluation. To assure that persons with health needs quickly receive needed services, our guidelines to states are clear that the Level I screen must identify symptoms of possible mental illness and not limit the identification to a known diagnosis of mental illness.

We propose to include clarifying guidelines concerning Level I criteria in our State Medicaid Director letter and subsequent State Medicaid Manual guidelines.

We concur in part with *4. (require that Level II PASRR be triggered if at least one indicator of serious mental illness is identified. In particular, HCFA should eliminate the Federal requirements that an individual has been hospitalized in the past 2 years, and that they have had a functional limitation in the past 3 to 6 months due to their mental illness).*

We agree with the OIG's recommendation to eliminate the part of the mental illness definition, which requires that a person has been hospitalized in the past 2 years. We will draft a regulation change to effect the recommended removal of the hospitalization threshold.

Agency Comments

We do not agree that the requirement for a Level II evaluation should be based upon diagnosis alone. We feel that a person who has a diagnosis of a major mental illness, whose illness has been controlled by medication so as not to have functional limitations in major life activities within the past 3 to 6 months, should be permitted access to nursing facility services without a Level II evaluation if they meet the nursing facility level of care criteria.

We would like to propose an alternative to ***5. (require that states share the Level II PASRR mental health evaluation with the admitting nursing facility).***

The Level II documentation is extensive and it would be an unnecessary burden to require such documentation to be copied and sent for every person evaluated. We feel the problem may be that evaluators may not be meeting the informational requirements when preparing the PASRR evaluation reports.

Regulations currently require each Level II evaluator to issue Level II findings in a written PASRR evaluation report. This PASRR evaluation report is required to be sent to the person evaluated and his or her legal representative; the state authority that makes the determinations; the admitting or retaining nursing facility; the individual's attending physician; and the discharging hospital, if the person is seeking nursing facility admission from a hospital.

For an individualized evaluation, the report must:

- include the name and professional title of the person(s) who performed the evaluations and the date on which each portion of the evaluation was administered;
- provide a summary of the medical and social history, including the positive traits or developmental strengths and weaknesses or developmental needs of the person;
- if nursing facility services are recommended, must identify the specific services which are required to meet the person's needs;
- if specialized services are not recommended, must identify any specific mental health services which are of a lesser intensity than specialized services that are required to meet the evaluated person's needs;
- if specialized services are recommended, must identify the specific mental health services the state must provide or arrange for to meet the person's needs; and
- it must include the basis for the report's conclusions.

Categorical PASRR determination findings must be issued in an abbreviated written report. If a resident's condition requires additional information, the nursing facility has the option of calling the state mental health authority and requesting a copy of the evaluation, or the particular part of the evaluation the nursing facility requires.

Agency Comments

HCFA will, therefore, undertake the following actions in a State Medicaid Director letter and subsequent State Medicaid Manual section:

1. Clarify that the full evaluation documentation must be sent if the facility requests it;
2. Clarify the PASRR evaluation report content requirements; and
3. Clarify the requirement that the PASRR evaluation report be placed in the nursing facility resident's medical record.

We concur with ***6. (provide technical assistance to help states develop a formal mechanism to share the results of PASRR screens with the survey agency. This will facilitate surveyors' ability to evaluate whether there are any potential concerns and note names of residents for possible inclusion in their sample of nursing facility residents).***

HCFA will work with state Medicaid agencies and survey agencies to develop a process for sharing PASRR results. Currently, some states are receiving this information and it is used in preparation for surveying a nursing facility, as prescribed in Task 1, Off Site Preparation, found in Appendix P Survey Protocol for Long Term Care Facilities. The task directs surveyors to review PASRR information that the state survey agency may have received for potential concerns and for possible inclusion in the sample.

OIG Recommendation

To improve the oversight of and access to mental health treatment, we recommend that HCFA:

1. *provide regional PASRR training to surveyors;*
2. *require surveyors to ensure that PASRR Level I identification screen is completed for all nursing facility residents;*
3. *require nursing facilities to use the Level II PASRR assessment and recommendations in care planning;*
4. *provide states with technical assistance to develop additional mechanism(s) to monitor the PASRR process both at admission and throughout a resident's stay at a nursing facility (see Appendix for example);*
5. *add survey regulations that require state surveyors to ensure care plan compliance with all Level II PASRR recommendations; and*
6. *convene regular stakeholder meetings with state agencies, regional offices, ombudsmen, and protection and advocacy agencies, to discuss the effectiveness of the PASRR process.*

HCFA Response

We concur with ***1. (provide regional PASRR training to surveyors), 2. (require surveyors to ensure that PASRR Level I identification screen is completed for all nursing facility residents) and 3. (require nursing facilities to use the Level II PASRR assessment and recommendations in care planning).***

HCFA will provide regional PASRR training to surveyors, require surveyors to ensure that a Level I identification screen is completed for individuals in the selective sample who have

Agency Comments

mental illness, and require nursing facilities to consider the Level II PASRR assessment and recommendations in care planning.

New surveyors will be provided guidance on surveying the PASRR process during Basic Long Term Care Training. In addition, during the standard survey, surveyors will review residents identified with mental illness for possible inclusion in the selected sample, as noted earlier. During the review of a resident's records, surveyors will check for the presence of the Level I screens and the incorporation of the resident's Level II PASRR evaluation/assessment with recommendations in the care planning process, as appropriate. The Level II PASRR assessment should be considered during the care planning process in order to provide quality care to the resident. Level II PASRR recommendations should be evaluated by the appropriate professionals on the interdisciplinary team for inclusion in the care plan.

We concur with ***4. (provide states with technical assistance to develop additional mechanism(s) to monitor the PASRR process both at admission and throughout a resident's stay at a nursing facility (see Appendix for example)).***

The referenced Appendix describes Pennsylvania's special oversight branch, which monitors the PASRR process. We agree that states should be provided examples of ways other states are monitoring the PASRR process. We will reference Pennsylvania's oversight branch in our State Medicaid Director letter and attach the OIG's summary/appendix. Further, we will ask states to provide HCFA with a description of their monitoring systems to share with the states.

We concur with ***5. (add survey regulations that require state surveyors to ensure care plan compliance with all Level II PASRR recommendations).***

HCFA has promulgated regulations that address care planning and coordination of assessments. While we do not see a need for further regulation changes, we agree that the survey process should be changed to assure residents are receiving needed services, the survey process is being revised. Surveyors will be expected to review the care plan to assure that information relevant to a resident's needs, including the PASRR evaluator's mental health services recommendations, has been considered by the nursing facility interdisciplinary team. As recommended by the OIG, we will add this element to future surveyor training.

We concur with ***6. (convene regular stakeholder meetings with state agencies, regional offices, ombudsmen, and protection and advocacy agencies, to discuss the effectiveness of the PASRR process).***

We agree that a forum is needed to involve all entities concerned with the PASRR program, to provide guidance; to provide a time and place for states to share their successes, ask for assistance and discuss best practices; and to raise issues of policy and practice. We will add PASRR to the agenda of a regularly scheduled meeting with protection and advocacy agencies and/or arrange for a specialty conference. We will also conduct PASRR conference calls.

Agency Comments

OIG Recommendation

To ensure that placement of an individual with mental illness in a nursing facility is not a means of avoiding responsibility for provision of specialized services, HCFA should define specialized services, with mental health provider input, that is to be provided by the state and made available to individuals with serious mental illness in nursing facilities.

HCFA Response

We do not agree. We believe that persons experiencing an acute episode of major mental illness need intensive mental health services provided with a frequency that is difficult to provide in a nursing facility setting. That is why HCFA encouraged states, through guidance in preambles to regulations, to define specialized services as 24-hour inpatient psychiatric treatment. States do not avoid their responsibility for providing mental health services for these individuals, but in fact, provide needed mental health services in a setting that is more appropriate than in a nursing facility. At the same time, individuals needing less than 24-hour treatment must still receive such services as part of the nursing facility responsibilities under Section 1919(b)(4)(A)(i) and (vii). States that define specialized services more broadly and admit persons who need specialized services to nursing facilities, must provide specialized services to residents who are determined to need them.

We will clarify, in a State Medicaid Director's letter, the nursing facility's responsibility to provide needed mental health services.

OIG Recommendation

To improve nursing facilities' ability to identify and appropriately refer nursing facility residents whose mental health condition changes, HCFA should:

1. *clarify the definition of significant change and implement a mechanism to ensure a Level II PASRR is completed;*
2. *modify the Minimum Data Set (MDS) form to identify change in mental health status, triggering a Level II PASRR reassessment;*
3. *update the State Medicaid Manual to provide related guidance on triggering a Level II PASRR reassessment; and*
4. *develop a Resident Assessment Protocol (RAP) for mental health status.*

HCFA Response

Recommendation *1. (clarify the definition of significant change and implement a mechanism to ensure a Level II PASRR is completed)* requires further review.

The nursing facility process for determining when there has been a significant change in a resident's physical or mental condition is clearly defined and a procedure clearly explained and documented in the Long Term Care Resident Assessment Instrument User's Manual, version 2.0 (RAI User's Manual). The RAI User's Manual lists examples of MDS item categories, identified by empirical analysis of MDS data sets, in which a resident's decline or improvement would warrant a Significant Change in Status MDS
assessment. This list is not exhaustive. Facility clinical staff should exercise clinical judgment on determining whether a significant Change in Status Assessment is warranted.

Agency Comments

There may be other areas of decline or improvement that have such a profound impact on the resident and his or her needs for care that they would also appear to warrant a comprehensive reassessment. Facility staff should also know to call the state authority, following procedures provided by the state to trigger a possible Level II resident review, when the state decides a Level II PASRR evaluation is needed.

While we believe that nursing facilities understand how to identify when a resident has experienced a significant change in status and they document it in the MDS, we will review and consider the definition and procedures as they relate to required nursing facility notification and subsequent Level II PASRR evaluations, as appropriate. However, we believe the OIG's finding that nursing facilities did not understand about PASRR in relation to a significant change in condition is an indication that some states have not fulfilled their responsibilities to provide nursing facilities with a notification procedure.

To ensure that states understand their responsibility to provide nursing facilities with a notification procedure when there is a significant change in status, HCFA will include clarification of this requirement in a State Medicaid Director's letter and subsequent State Medicaid Manual guidelines.

Recommendation ***2. (modify the MDS form to identify change in mental health status, triggering a Level II PASRR reassessment)*** **requires further review.**

Although HCFA believes the recommendation would be repetitive of what is already in place, we agree to review the MDS, as it relates to PASRR requirements.

We also believe that nursing facilities must understand their legal notification requirement and that states must provide training to the nursing facilities on the procedures the nursing facility is required to follow pertaining to PASRR and notification of the appropriate state authority.

We clearly understand the need for HCFA to remind states of their responsibility to provide nursing facilities with a procedure, detailing when and how to notify the state mental health mental retardation authorities (SMHMRAs) when there has been a significant change in the physical or mental condition of a resident who has been determined, by the PASRR program, to need nursing facility and/or specialized services. Reinforcement of this awareness will be accomplished via a letter to State Medicaid Directors and SMHMRA Directors.

We concur with ***3. (update the State Medicaid Manual to provide related guidance on triggering a Level II PASRR reassessment).***

We will immediately begin making the changes made necessary by the change in the law and will seek a fast track to provide states with needed clarifications.

Recommendation ***4. (develop a Resident Assessment Protocol (RAP) for mental health status)*** **requires further review.**

Agency Comments

The development of a RAP for mental health status will be considered during version 3, a revision of the current Long Term Care Resident Assessment Instrument version 2.0. Currently there is a variety of the RAPs that guide facility staff through additional assessment when the MDS indicates clinical manifestations that may be related to health status. These include a RAP for "psychosocial wellbeing"; "mood state"; "behavioral symptoms"; and "psychotropic drug use."

OIG Recommendation

To improve Federal monitoring and oversight, we recommend that HCFA:

1. *clarify the role and responsibilities of regional HCFA PASRR contacts;*
2. *require the annual PASRR report to include data regarding the number of Level I and II PASRRs completed and the placement and treatment results by age;*
3. *standardize the annual report and ensure that it is completed and monitored annually by the HCFA regional office; and*
4. *add a PASRR compliance and enforcement component to state nursing facility report cards for inclusion on HCFA's Nursing Home Compare web site.*

HCFA Response

We concur with *1. (clarify the role and responsibilities of regional HCFA PASRR contacts).*

HCFA will clarify the role and responsibilities of the regional office PASRR coordinators. Early in the PASRR program, regional offices conducted reviews of state PASRR programs on a regularly scheduled basis. Responsibility for state PASRR program oversight, at that time, was with the Medicaid Bureau and is now with the Center for Medicaid and State Operations. Lack of regional office staff and travel money created a burden and the regional offices, while still responsible for conducting PASRR reviews, were relieved of doing reviews on a scheduled basis. We will review our responsibility for Federal oversight of the state programs, what the regional office responsibilities are, and what responsibilities for PASRR monitoring are with the survey process.

We concur with *2. (require the annual PASRR report to include data regarding the number of Level I and II PASRRs completed and the placement and treatment results by age).*

We agree that the requested information would provide meaningful data. We will consider whether a requirement for providing this information would place a substantial burden on nursing facilities and states and look at ways we may be able to provide assistance in accomplishing such a requirement. A request for this information will require approval by the Office of Management and Budget (OMB) and is subject to the Paperwork Reduction Act.

We concur with *3. (standardize the annual report and ensure that it is completed and monitored annually by the HCFA regional office).*

Agency Comments

HCFA will create a standardized annual report form and obtain approval through the OMB. Furthermore, we recognize our responsibility to ensure state compliance with this statutory requirement and will work with the regional office to this end.

We do not concur with *4. (add a PASRR compliance and enforcement component to state nursing facility report cards for inclusion on HCFA's Nursing Home Compare web site).*

HCFA is currently working on expanding Nursing Home Compare to include the release of previous inspection results and quality indicators from the MDS. The addition of PASRR compliance and enforcement information is beyond the current scope of the web site at this time and beyond current resource levels. However we will reconsider adding a PASRR compliance and enforcement component if further study indicates the need to report this information to the public.

OIG Recommendation

To improve implementation and oversight of the PASRR process, HCFA should specify which unit(s) within HCFA have responsibility for ensuring that:

1. *states are appropriately implementing PASRR;*
2. *all appropriate PASRR paperwork and, consequently the justification for nursing facility placement, specialized services and other mental health treatment if applicable, is properly completed; and*
3. *nursing facilities and states comply with PASRR determinations and recommendations for mental health services.*

HCFA Response

We concur with this entire recommendation.

The OIG's study suggests the need for increased oversight of state PASRR programs and for reminding specific units of their implementation and oversight responsibilities. As indicated above, HCFA will further specify each unit's responsibility for PASRR implementation and oversight. Initially, we will use a State Medicaid Director's letter, followed by State Medicaid Manual guidelines, to ensure that the state understands its responsibilities and will ensure that regional office and central office fully understand their respective oversight and monitoring responsibilities. As indicated in our response to the earlier recommendation *1. (ensure completion of the Level I PASRR screens)*, we will ensure that nursing facilities and survey agencies understand their PASRR responsibilities.

OIG Recommendation

To improve state Medicaid agencies' ability to ensure compliance with the Olmstead Decision, HCFA should require that state Medicaid agencies collaborate with state mental health authorities to identify and maintain a list of alternative community based treatments and to track the level of need and availability of such resources.

Agency Comments

HCFA Response

We concur. State Medicaid agencies are already required, when making the determination concerning whether a person needs nursing facility services, to consider appropriate alternatives, including services provided in the community. To make the determination concerning need for nursing facility services, they must know where community services are available. We will provide further clarification concerning a state's role to assist each nursing facility applicant and resident, during the PASRR process, to understand all alternatives available for receiving needed services, as well as his or her options, when appropriate. We will also actively engage with the Substance Abuse and Mental Health Services Administration to coordinate these responsibilities.

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
Rockville MD 20857

OCT 20 2000

TO: June Gibbs Brown
Inspector General

FROM: Administrator

SUBJECT: Revised SAMHSA Comments on OIG Draft Report: *Younger Nursing Facility Residents with Mental Illness: Preadmission Screening and Resident Review (PASRR) Implementation and Oversight*.

Thank you for the opportunity to review and comment on the Office of the Inspector General draft report titled: *Younger Nursing Facility Residents with Mental Illness: Preadmission Screening and Resident Review (PASRR) Implementation and Oversight*. This report is timely in light of the the Olmstead Supreme Court Decision. It helps to clarify the Health Care Financing Administration (HCFA) and the Substance Abuse and Mental Health Services Administration's roles in meeting respective PASRR responsibilities.

As a result of the OIG study and our own preliminary background research and study, we agree with the OIG that there is a need for greater oversight of the screening, treatment, and oversight of younger persons residing in nursing facilities. Our literature review concerning the current PASRR process illuminated several areas of ambiguity that are open to interpretation among the States. We agree that there are problems in the Level I and II screens that highlight a lack of adequate documentation or lack of implementation of the PASRR process.

As SAMHSA and HCFA are working together in addressing the Olmstead Decision, Medicaid waiver reviews, the Children's Health Insurance Program (CHIP) and other key areas regarding behavioral health services, we look forward to utilizing this collaborative partnership to focus on how SAMHSA can support HCFA in implementing the PASRR process. If it would be useful, we can also provide copies of our annual State reports from the program of Protection and Advocacy of the Mentally Ill.

Attached are our comments on the OIG's recommendations for SAMHSA. If you have any questions about these comments, please contact Richard Kopanda on 301-443-3875.

Nelba Chavez, Ph.D.

Attachment

Office of the Administrator—Office of Applied Studies—Office of Communications—Office of Equal Employment Opportunity & Civil Rights—Office of Managed Care—Office of

Agency Comments

COMMENTS OF THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA) ON THE OFFICE OF THE INSPECTOR GENERAL (OIG) DRAFT REPORT, "Younger Nursing Facility Residents with Mental Illness: Preadmission Screening and Resident Review (PASRR) Implementation and Oversight"

One of the major issues with PASRR implementation and oversight is the inconsistency across States in how it is addressed. SAMHSA is committed to insuring a common understanding of the PASRR requirements, goals, and objectives. Therefore, SAMHSA will undertake the following, consistent with the recommendations on pages 32-33 of the OIG report. It should be noted that SAMHSA does not have the statutory authority to comply with the OIG recommendation to "annually review State Mental Health Authorities (SMHA) Level II determinations."

- **OIG Recommendation (Pages 32)**

  To improve State mental health authorities' ability to make appropriate Level II PASRR placement, specialized service and mental health treatment determinations, SAMHSA should:

  --provide guidance annually to SMHAs including model practices and standards on appropriate treatment, specialized and other mental health services;

  SAMHSA Response: SAMHSA will, in consultation with the National Association of State Mental Health Program Directors (NASMHPD), develop guidance to the SMHAs, including model practices and standards on appropriate treatment for those with mental health disorders. Additionally, SAMHSA will assist HCFA to ensure that the appropriate treatment information is made available to nursing facilities.

- **OIG Recommendation (Pages 33)**

  --emphasize the importance of supporting this population to the Protection and Advocacy agencies; and

  SAMHSA Response: SAMHSA will emphasize the importance of supporting this population to Protection and Advocacy agencies. We will also provide HCFA with information on nursing home issues from annual State reports from the program of Protection and Advocacy for the Mentally Ill (PAMI).

- **OIG Recommendation (Pages 33)**

  --annually review SMHA Level II determinations.

  SAMHSA Response: SAMHSA is unable to comply with this recommendation as it does not have statutory authority.

Agency Comments

- **OIG Recommendation (Pages 33)**

  To improve nursing facilities' ability to identify and appropriately refer nursing facility residents whose mental health conditions change, SAMHSA should:

  --provide guidance annually to SMHAs regarding identifying alternative treatment options for individuals being considered for placement in nursing facilities.

  SAMHSA Response: SAMHSA will develop guidance, inclusive of materials and technical assistance, to the SMHAs in consultation with HCFA and NASMHPD,

- **OIG Recommendation (Page 33)**

  Clarify Agencies roles and responsibilities within the Department in overseeing the PASRR Process

  --To improve implementation and oversight of the PASRR process, the Department should determine and delineate HCFA and SAMHSA's responsibilities in overseeing PASRR determination.

  SAMHSA Response: SAMHSA will initiate discussions with HCFA to clarify our respective roles and responsibilities with respect to persons with mental illness to ensure these persons receive adequate PASRR determinations, placements, and treatment.