Policy Report

SCREENING *for* MENTAL ILLNESS *in* NURSING FACILITY APPLICANTS:

Understanding Federal Requirements

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Executive Summary

Medicaid law and regulations require States to have a Preadmission Screening and Resident Review (PASRR)[1] program to determine whether nursing facility applicants and residents require nursing facility services and specialized mental health care. Congress developed the PASRR program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities, as part of the Omnibus Budget Reconciliation Act (OBRA) 1987. Several recent studies raise questions concerning the effectiveness of the PASRR program, suggesting that the program creates barriers for persons requiring nursing facility placements and does not ensure access to appropriate psychiatric services.

As part of a larger evaluation of the PASRR program, this paper reviews the literature concerning PASRR and mental health services for persons in nursing facilities. It details the Federal laws and regulations concerning PASRR, reviews key policy issues from the literature, clarifies frequently asked questions regarding the process, and identifies additional policy questions to be studied.

The following is a summary of the findings of the literature review and the key issues concerning the implementation of PASRR.

PASRR Process

- Under the PASRR program, the Medicaid statute prohibits nursing facilities (NFs) from admitting any individual with a serious mental illness (SMI) unless the State Mental Health Authority (SMHA) has determined that the individual requires the level of services the facility provides. Further, the SMHA must determine whether the individual requires specialized services to treat his/her mental illness. If placing the individual in an NF is deemed appropriate and the individual requires specialized mental health services, the State Medicaid agency must provide or arrange

[1] This program was enacted as part of the Nursing Home Reform Act under the Omnibus Budget Reconciliation Act OBRA 1987, as amended by OBRA 1990, 42 U.S.C. 1396r(e)(7). Originally the program included an annual resident review and was referred to as the Preadmission Screening and Annual Resident Review (PASARR) program. Under the Balanced Budget Amendment of 1996, P.L. 104-315, or 42 USC 1396r, the requirement for "annual" resident review, however, was eliminated and replaced with a requirement to screen when "there is a significant change in physical or mental condition." Therefore, the current program acronym of PASRR will be used to refer to the program throughout this paper.

for provision of such services. SMHAs also must review the needs of NF residents with SMIs for NF services and specialized care.

- To determine the universe of NF applicants who must have a PASRR (i.e., Level II) evaluation, regulations require that States conduct a Level I screening to identify individuals suspected of mental illness. The Level I identification may be conducted by the State Medicaid agency, the nursing home, or any other agent specified by the State. If Level I identification screening indicates the individual may have a mental illness, a Level II screening must be conducted. The Level II screening requires a two-pronged determination by the State Mental Health Authority: (1) whether the individual requires NF services and (2) whether the individual requires specialized mental health services. Determinations must be based on an independent evaluation conducted by an entity other than the State Mental Health Authority or a nursing home. People with SMI who do not require NF services may not be admitted to the NF. If the individual with SMI needs NF services and specialized services, the State Medicaid agency must provide or arrange for such specialized services.

State Variations in PASRR Implementation

- Under OBRA 1987 and the resulting 1990 and 1992 regulations, no mandated process existed for preadmission screening and no required screening tools were identified for the States to implement. The 1990 and 1992 regulations granted States enormous flexibility in implementing even the most basic operational aspects of PASRR, such as the criteria that trigger a PASRR screen and the very definition of what constitutes specialized services. Consequently, any comparison among States must explicitly identify such differences.

Current Issues and Concerns

- Funding PASRR screens and specialized treatment is a challenge for States. If individuals need specialized services to treat their mental illnesses, the State Medicaid agency ultimately is responsible for providing or arranging for provision of those specialized services. To prevent duplicate payment, no Federal financial participation (FFP) is available to reimburse specialized services that are NF services (other than NF services). However, FFP is available for specialized services that are state plan services. Although the Federal Government will match State expenditures to meet PASRR requirements, it does not fund alternative placements.
- The statutory definition of mental illness (for PASRR) does not include persons with dementia, including Alzheimer's disease and other organic brain disorders, unless their primary diagnosis is an SMI. As a result, the identification and provision of specialized mental health service needs for this population becomes the responsibility of the NF within the nursing facility payment.
- Although diagnosing SMI is subject to Federal minimum requirements, States are allowed to administer their own instruments to screen for suspected mental illness. Hence, an individual might be identified as experiencing an SMI in one State but not in another. Similarly, with no standardized definition for "specialized mental health services," some States limit these services to acute inpatient care; others include a combination of inpatient and community-based services.

II. Introduction

The process of screening and determining whether nursing facility (NF) services and specialized mental health care are needed by nursing facility applicants and residents is called the Preadmission Screening and Resident Review (PASRR) program. The PASRR program is a required component of each State's Medicaid plan. State Medicaid agencies bear the ultimate responsibility for PASRR program operations, although State Mental Health Authorities have specific responsibilities under Federal statute and regulations.

More than a decade after Congress enacted the PASRR program to prevent the inappropriate admission and retention of people with mental disabilities in nursing facilities, many concerns regarding the efficacy and effectiveness of the legislation remain. In fact, organizations such as the Society for Social Work Leadership in Health Care, the American Psychiatric Association, and the American Association for Geriatric Psychiatry conclude that while the program's goals are laudable, PASRR creates logistical barriers for persons requiring nursing facility placements and does not ensure access to appropriate (i.e., medically necessary) psychiatric services.

This literature review is part of a larger study, "An Evaluation of PASRR and Mental Health Services for Persons in Nursing Facilities," funded by the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration. The purpose of the study is to conduct research and analysis on the (1) intent, scope, and jurisdiction of PASRR; (2) implementation of PASRR at the State and nursing facility level; and (3) effect PASRR has had on the identification of people with serious mental illness in nursing facilities.

A number of resources were searched for literature on treatment of people with mental illness residing in nursing homes, PASRR, and related issues such as the use of the Minimum Data Set (MDS) and the status of Institutions for Mental Diseases (IMDs). The search covered a variety of electronic bibliographic databases, including Medline, HealthStar, PsycINFO, Mental Health Abstracts, Ageline, Social SciSearch, Dissertation Abstracts, Embase, and the Health & Wellness Database. In addition, the library collection of the Mental Health Policy Resource Center, developed between 1988 and 1996, was searched. The collection contains an extensive compilation of published and unpublished literature on issues related to all aspects of

mental health policy, including mental illness and nursing homes. In addition, the Centers for Medicare and Medicaid Services (CMS) provided technical consultation.

This literature review provides a base of information for the larger study and identifies key policy issues concerning PASRR legislation as it exists today and, more generally, individuals in need of mental health services in nursing facilities. This paper details the PASRR policy as specified in the statute and regulations. It examines several key policy issues discussed in the literature, clarifies some of the most frequently asked questions regarding PASRR, and highlights many of the pervasive policy questions that remain unanswered in the research.

This paper is limited in several important ways. Although an extensive general literature details the implementation and impact of nursing home reform under the Omnibus Budget Reconciliation Act of 1987 (OBRA, 1987), literature that addresses PASRR specifically is less developed (Alexakos et al., 1995; Colenda et al., 1999; Marek et al., 1996; Snowden and Roy-Byrne, 1998). For example, studies that examine the effect of OBRA 1987 on the use of psychotropic drugs and physical restraint in nursing facilities only indirectly address the effect of PASRR on the appropriateness of mental health services in nursing facilities.[2] Additionally, little formal research has been conducted on the implementation of PASRR across States. In 2001, the Office of the Inspector General (OIG), U. S. Department of Health and Human Services, released two reports concerning mental illness in nursing facilities for the non-elderly adult population. One report (OIG, *An Unidentified Population,* 2001) attempted to determine how many younger individuals with mental illness reside in nursing facilities. A companion report (OIG, *PASRR Implementation and Oversight,* 2001) explored the PASRR screening process for younger Medicaid beneficiaries in five States.

As a result, the implementation experience described in this literature review relies heavily on findings from a study conducted by the Bazelon Center[3] (1996), supplemented by other relevant studies of PASRR and mental health issues in nursing facilities. Although the Bazelon Center study surveyed Medicaid directors in all 50 States, the District of Columbia, and Puerto Rico, the response rate was only 63 percent. Therefore, no information is available on the States that chose not to participate in the study. In addition, inconsistencies arose in the way States reported (or did not report) data, affecting the item response rates for the survey. Despite these limitations, the Bazelon Center study provides valuable data for understanding how States vary in their implementation of PASRR.

[2] The Office of Inspector General conducted PASRR-related studies in Chicago and New York. The Chicago study surveyed all States regarding their systems for treating Medicaid recipients with mental illness in nursing facilities. The New York study assessed the appropriateness of Medicare Part B payments to Medicare beneficiaries living in nursing facilities.

[3] The Judge David L. Bazelon Center for Mental Health Law is a nonprofit legal advocacy organization based in Washington, DC. Judge Bazelon was the Federal appeals court judge whose landmark decisions pioneered the field of mental health law.

III. Background

To address the effectiveness of PASRR, the historical factors that served as catalysts for the legislation must be understood.

History of PASRR

Congress created the PASRR program under OBRA 1987 out of concern that, as a result of the deinstitutionalization movement, many people with SMI or mental retardation were inappropriately placed in nursing homes, where they would not receive the care or specialized services needed. Based on both advocacy concerns and empirical data, Congress became increasingly aware that some States were using NF placements as a way to reduce overcrowding in State facilities for people with SMI. States had a financial incentive to place people with SMI in nursing facilities rather than in institutions for the mentally ill because Medicaid does not pay for mental hospital care for persons aged 22 to 64 (Buck et al., 1995).[4] By transferring State hospital residents to Medicaid-certified nursing homes, States were able to shift approximately 50 percent of the cost of care to the Federal Government (Goldman & Frank, 1990). Moreover, under the prevailing rules for community mental health center (CMHC) reimbursement under Medicaid, CMHCs could only be reimbursed for services provided in the CMHC. As a result, many nursing homes were left without the resources to provide appropriate care for this new category of residents (Emerson Lombardo, 1994; U.S. General Accounting Office, 1982).

Congress responded to these concerns by directing the Centers for Medicare and Medicaid Services (CMS) and the General Accounting Office (GAO) to investigate nursing home quality. CMS funded an Institute of Medicine (IOM) study that reported widespread quality problems and recommended strengthening Federal regulations for nursing

[4] Medicaid was created in 1965 as an insurance system for the indigent and medically needy. It covered both treatment in doctors' offices and in general hospitals, as well as long-term care in nursing facilities. In 1994, Medicaid contributed 47 percent of the expenditures on nursing home services (Feder et al., 1997). One exception was its prohibition of covering patients in psychiatric hospitals. The drafters of the legislation feared that the cost of covering such patients would be too great. At the time, State hospital populations numbered in the thousands. To prevent Medicaid from assuming State costs, Congress included the Institutions for Mental Diseases (IMD) exclusion provision. Psychiatric hospitals were not considered covered services. Later, Congress amended the IMD rule to permit States the option of Medicaid reimbursement for individuals under the age of 22 and over the age of 64 residing in psychiatric hospitals.

homes (IOM, 1986). Imbedded in the IOM report was an explicit request that Federal regulations address patients' rights, quality of care, and quality of life in nursing facilities (Morford, 1988). This recommendation became an especially important catalyst for nursing home reform.

The GAO (1987) report corroborated the IOM study findings, indicating that more than one-third of U.S. nursing homes were operating at a level below minimum Federal standards. The report cited evidence of untrained staff, inadequate health care, unsanitary conditions, poor food, unenforced safety regulations, and many other problems related to quality and safety. This report further convinced Congress to pursue nursing home reform.

In response to the recommendation of the IOM study to strengthen Federal regulation of nursing facilities, CMS proposed and published two rules in the Federal Register, one identifying requirements for nursing homes to participate in Medicare and Medicaid (CMS, *Federal Register*, 1987a) and the second delineating the Federal processes to enforce compliance with the requirements (CMS, *Federal Register*, 1987b). However, concurrent with and independent of CMS's rule development process, Congress enacted nursing home reform under the 1987 Omnibus Budget Reconciliation Act. Morford (1988) posits three reasons why Congress passed legislation despite publication of CMS's two proposed rules. First, the proposed rules did not offer sufficient assurance that the Federal Government would publish final rules. After IOM published its recommendations, it took more than a year for CMS to produce the proposed rules. Second, the proposed rules were a practical but not identical translation of the IOM recommendations into regulation. Critical differences remained. Therefore, Congress believed that legislation could ensure more comprehensive implementation of the IOM recommendations. Third, because of IOM's prestige, implementing its recommended nursing home reforms was perceived to be politically viable.

OBRA 1987's nursing home reform legislation exceeded the scope of CMS's proposed rules and offered assurance that final Federal regulations would be published and implemented. The statute contained detailed requirements concerning patients' rights, patient assessments, and staffing criteria. The law added requirements that all States implement new sanctions for NF noncompliance and granted new authority to the Federal Government to enforce three types of noncompliance penalties (denial of payment; fines; and appointment of temporary management to ensure improvements or orderly closure) (Morford, 1988). The legislation also included several provisions that pertained directly to the problem of inappropriate placements and inadequate treatment of people with serious mental illness in nursing facilities. These provisions included regulation of the use of antipsychotic medications and physical restraints, as well as preadmission screening of individuals with mental illness to determine if they need the level of care provided by a nursing facility.

IV. Understanding Medicaid Policy

Medicaid policy is a complex framework of State and Federal laws, regulation, guidance, and court decisions that begins with the laws passed by Congress under Title XIX of the Social Security Act. Congress delegates some of its lawmaking powers to the Secretary of the Department of Health and Human Services (HHS), who promulgates Medicaid regulations that carry the weight of law. CMS issues guidance to States through the State Medicaid Manual, letters to State Medicaid agencies, and other communications. CMS guidance translates Federal requirements in statute and regulations, providing practical direction for State Medicaid program operations. Since States are given wide latitude in Medicaid program design, State statutes and regulations further spell out how individual State Medicaid programs work. State laws and regulations are reflected in State Medicaid plans, submitted to CMS to ensure they fulfill Federal requirements. Courts, at the Federal and State level, also make decisions about how Medicaid laws and regulations should be interpreted, potentially affecting how they are carried out. Over time, Congress changes statutes, HHS publishes new regulations, and CMS and courts reinterpret the meaning of laws and regulation. Thus, Medicaid policy is best characterized as a patchwork of laws, rules, and interpretations rather than as a seamless monolithic policy authorized by law, elaborated by regulations, interpreted by guidance, and executed by States.

Likewise, Medicaid policy regarding PASRR is fragmented and complex. Congress established PASRR in 1987. PASRR regulations were not published initially by HHS. Instead, CMS helped States implement PASRR statutory requirements by issuing interim guidance in the State Medicaid Manual. In 1990, Congress made several changes to PASRR law.[5]

Though these changes made the guidance in the interim State Medicaid Manual moot, CMS still plans to revise and update the State Medicaid Manual sections concerning PASRR. In 1992, HHS published final PASRR regulations that reflected the 1990 statutory changes (CMS, *Federal Register,* 1992). In 1996, Congress revisited the PASRR program and removed the requirement for *annual* resident review, replacing it with a requirement to

[5] For an overview of the 1990 legislative changes, see Mental Health Law Project, 1991.

conduct reviews when a resident's physical or mental status changes. Neither Federal regulations nor State Medicaid Manual sections have been changed to reflect the 1996 statutory amendments. Regulations and the State Medicaid Manual offer no guidance on how to implement the 1996 amendments.

Title XIX provisions concerning PASRR must be examined to understand what Federal policy requires of State Medicaid agencies, Mental Health Authorities, and nursing facilities. PASRR regulations also have the force of law, but regulations concerning the annual frequency of resident reviews were superseded by 1996 statutory changes and may be ignored. The State Medicaid Manual does not carry the force of law and can be consulted only to interpret PASRR provisions not superseded by the statutory changes in 1990 and 1996 and by regulations published in 1992. The following analysis of PASRR policy is based on a review of current law, regulations, and guidance. It is not a legal analysis and does not examine congressional intent or statutory construction. Thus, it does not necessarily reflect how a court may interpret the law and regulations.

V. The PASRR Process

Table 1 (Appendix) provides detail and definitional sources for the elements of the PASRR program. All Medicaid recipients applying for new admission to a nursing facility must be screened to identify those suspected of having a mental illness. The Medicaid statute does not specifically require that all NF applicants be screened for mental illness. Rather, it requires that all applicants who have mental illness be screened for their need for NF services and specialized services to treat their mental illness. However, to determine the universe of nursing facility applicants suspected of having a mental illness, some form of screening must be conducted on *all* applicants. Regulations mandate this preliminary screening and refer to it as a Level I screening. Because Federal regulations provide no rules about the tools used or personnel involved in Level I screening, the screening may be conducted by nursing facilities, hospitals, physicians, or any other entity specified by the State's Medicaid program.

Patients who are admitted to an NF directly from a hospital after receiving acute inpatient care; who require NF services for the condition for which they received hospital care and whose attending physician has certified prior to admission to the NF that they are expected to stay in the nursing facility for less than 30 days are exempt from preadmission screening requirements. Patients being readmitted to a nursing facility or being transferred from one nursing facility to another are not considered new admissions and, thus, resident review requirements apply.

Applicants suspected of having a mental illness (who rated "positive" in the Level I screen) undergo a more extensive preadmission review called Level II screening. Level II screening requires an independent evaluation of applicants' physical and mental health status. Independent evaluators must not have any ties to nursing facilities, nor may they be part of a State Mental Health Authority (SMHA). The independent evaluator must verify whether the applicant has a serious mental illness. Applicants without serious mental disorders may be admitted to the nursing facility without further PASRR review.

A serious mental illness is defined as a mental disorder that may lead to a chronic disability and is diagnosable under the DSM-III-R other than dementia, unless the primary diagnosis is a major mental

disorder. The disorder must have resulted in functional limitations in major life activities within the past 3 to 6 months. In addition, the applicant must experience at least one of the following: (1) psychiatric treatments more intensive than outpatient care or (2) significant disruption to the normal living situation requiring supportive services or intervention by housing or law enforcement personnel.

For applicants diagnosed with a serious mental illness, SMHAs must use the independent evaluation to determine whether the applicant requires the level of care offered by the nursing facility and whether specialized services are necessary to treat the applicant's mental illness. Applicants with SMI may be admitted only if they are determined to require the level of nursing care the facility provides. Applicants who do not need NF services cannot be admitted to the facility.

If it is determined that an applicant also needs specialized services to treat a mental illness, the State Medicaid agency ultimately is responsible for providing or arranging for the provision of those services. Congress authorized HHS to define specialized services through regulations. In turn, HHS published regulations defining specialized services as those "specified by the State" for the continuous and aggressive treatment of a nursing facility resident's mental illness. Thus, Federal law and regulations provide no specific definition of the specialized services that must be provided to nursing home residents with SMI. The mandate to provide such services extends only to those specialized services a State includes in its definition.

Furthermore, Medicaid statute requires nursing facilities to provide treatment and services "not otherwise provided or arranged for (or required to be provided or arranged for) by the State." This requirement is interpreted in regulations to include all "services of lesser intensity than specialized services." The absence of a definition of specialized services in either Federal law or regulations has resulted in considerable confusion about the services to be provided by States and those to be provided by nursing facilities. If a State chooses to limit its definition of specialized services to reduce the scope of this unfunded mandate, it shifts a greater burden onto nursing facilities to provide or arrange for psychiatric services.

Before the 1996 amendments (Public Law 104-315), individuals residing in nursing facilities were required to be screened for mental illness at least annually as if they were new admissions. Current law does not require that NF residents be screened on an annual basis for mental illness. Instead, the statute requires nursing facilities to report significant changes in a resident's mental condition promptly to the State Mental Health Authority. Regulations specify that SMHAs must conduct a Level II screen to evaluate such residents and determine if their placements continue to be appropriate and whether their specialized services needs have changed.

All NF residents determined by State Mental Health Authorities to require NF services may continue to reside there. Residents who do not need NF services may choose to continue residing in the facility only if they both need specialized services and have continuously lived in a nursing facility for at least 30 months. All other residents with mental illness must be discharged. States must provide specialized services to residents found to need such services, regardless of whether they may stay in the nursing facility.

VI. Responsibilities of Nursing Facilities, State Medicaid Agencies, and Mental Health Authorities

In general, the Medicaid statute can be described as a series of State Medicaid plan requirements. States must designate a single State agency to administer and manage the State Medicaid program. Thus, State Medicaid agencies bear the ultimate responsibility for fulfilling all Medicaid requirements, including those associated with PASRR.

Regulations specifically require State Medicaid agencies to include a PASRR program in their State plan and to develop a written agreement with the State Mental Health Authority detailing the operation of the PASRR program. State Medicaid agencies also bear the final responsibility for providing or arranging for specialized services to NF residents with mental illness or residents discharged from nursing facilities because of PASRR. Medicaid agencies may delegate the function of providing or arranging for specialized services to the SMHA or another agency, but the ultimate responsibility remains with the Medicaid agency. State Medicaid agencies may not claim any nursing facility services provided to individuals with mental illness not screened by PASRR as Medicaid expenditures eligible for Federal financial participation. In addition, State Medicaid agencies must protect patients' rights by establishing an appeals system, providing culturally/linguistically/ethnically appropriate notices to persons with SMI and their families, retaining records, and tracking persons to ensure that appeals are heard and that future reviews are performed.

Federal regulations articulate the required elements of written agreements between State Medicaid agencies and State Mental Health Authorities. The agreement must specify the respective responsibilities of the State Medicaid agency and the Mental Health Authority for

- conducting joint planning;
- providing access by the Medicaid agency to SMHA records;

- recording, reporting, and exchanging medical and social information about individuals subject to PASRR;
- ensuring that preadmission screenings and resident reviews are performed in a timely manner;
- ensuring that if the SMHA delegates its determination responsibility, this delegation complies with regulations;
- ensuring that PASRR determinations made by the SMHA are not countermanded by the Medicaid agency;
- designating the independent person or entity that performs Level II PASRR evaluations for individuals with mental illness; and
- ensuring that all requirements of PASRR are met.

Nothing prohibits States from addressing other issues such as the provision of specialized services in these written agreements; nor do Federal law and regulations spell out the division of functions between State Medicaid agencies and SMHAs. Thus, States are granted considerable flexibility to design the operations of their PASRR program.

Federal law and regulations require State Mental Health Authorities to perform certain PASRR duties. SMHAs must determine whether persons with mental illness need nursing facility services and whether they need specialized services. SMHAs must base their determinations on independent evaluations that are in no way connected to a nursing facility. Determinations must be made on an annual average of 7 to 9 working days after an applicant is referred for a Level II screening. Anticipating that State Mental Health Authorities may delegate or contract determination decisions to others, the statute and regulations prohibit delegation to entities related to nursing facilities.

Nursing facilities are obligated to perform certain duties under PASRR as well. The Medicaid statute bars nursing facilities from admitting any new resident who has a mental illness unless the State Mental Health Authority has conducted a Level II (PASRR) assessment and determined that NF services are needed. The law also requires that nursing facilities notify the SMHA promptly after a significant change in the physical or mental condition of a resident. Forthcoming regulations will elaborate further on NF duties with regard to resident review and changes in a resident's condition. The statute also requires nursing facilities to provide services of lesser intensity than specialized services to their residents with mental illness. The scope of this requirement is not articulated fully by Federal law and regulations, and depends on the definitions and policies adopted at the State level regarding specialized services.

PASRR Screens	*Responsibility for Oversight*	*Eligible to Conduct Screen*
Level I	■ State Medicaid Agency	All involved parties, including nursing facilities, State Mental Health Authority, or an independent entity
Level II	■ State Mental Health Authority for mental illness	Independent entity (other than the State Mental Health Authority) without ties to a nursing facility
Change in condition assessment	■ State Mental Health Authority, after NF identifies change	Independent entity (other than the State Mental Health Authority) without ties to a nursing facility

Regulations also require that nursing facilities transfer PASRR reports when residents with mental illness are transferred to a hospital or another nursing facility. Because States have great flexibility in designing their PASRR programs, they may place additional responsibilities on nursing facilities.

VII. Frequently Asked Questions

1. Under PASRR, can an applicant with only mental illness be admitted to a nursing facility?

Yes. An applicant with mental illness may be admitted to a nursing facility if the State Mental Health Authority determines that the applicant requires the level of services provided by the facility. Regulations require that the SMHA, when making the determination of whether NF services are needed, assess whether the total needs of an applicant with mental illness can be met in a community setting or must be met on an inpatient basis. If inpatient care is appropriate, the SMHA must assess whether a nursing facility is an appropriate setting. NF placement may be considered appropriate if the applicant meets the minimum standards of admission and if the applicant's treatment needs do not exceed the level of services that can be delivered by the NF—combined with any required specialized services provided or arranged for by the State.

2. Can nursing facilities conduct any part of the Level I or II screens?

Nothing in Federal law or regulations precludes NF involvement in Level I screens to identify applicants or residents suspected of having a mental illness. However, nursing facilities may not conduct Level II evaluations or determinations, although they may ascertain whether existing data are sufficient to determine that an applicant fits a category established by the State for an advance group determination. Evaluations for mental illness must be conducted by an independent entity (other than the State Mental Health Authority) with no direct or indirect relationship with any nursing facility. Determinations are the responsibility of State Mental Health Authorities, but SMHAs may delegate or contract that responsibility to any entity without direct or indirect ties to any nursing facility.

3. Under what circumstances can an applicant be admitted to a nursing facility before the Level I or II screens are completed?

None. Regulations require a Level I screen prior to admission for every nursing facility applicant, including private pay. The Level I screen identifies applicants who may have mental illness and thus will require the Level II evaluation. Federal law bars nursing facilities from admitting new applicants with mental illness unless the State Mental Health Authority has determined, on the basis of a PASRR Level II evaluation, that the person needs NF services. States cannot seek Federal Medicaid reimbursement for eligible NF services provided to residents with mental illness who were not determined by a PASRR program to require such services. CMS is prohibited from providing Federal financial participation until a PASRR screen is conducted.

However, regulations allow States to expedite certain nursing facility admissions through advance group determinations—Level II determinations based on categories for which NF services are normally needed. Some examples in regulation include provisional admissions pending further assessment in cases of delirium and emergency protective services. States must specify an appropriate time limit for provisional admissions. Further, a person later determined to need a longer stay must be given an individualized Level II resident review before continuation of the stay is permitted and payment made for care beyond the State's time limit. In cases of delirium in which an accurate diagnosis cannot be made until the delirium resolves and in emergency situations requiring protective services, patients may be admitted provisionally pending further assessment. An emergency admission must not exceed 7 days. Most persons who meet the criteria for a categorical NF determination must still have an individualized evaluation for the need for specialized services. In only two circumstances are specialized services categorical determinations permitted: in the provisional admissions categories for emergencies requiring protection and respite.

4. Can the state mental health authority delegate determinations?

Yes. Federal statute and regulations anticipate that State Mental Health Authorities may delegate or contract determination decisions to others by prohibiting delegation to entities related to nursing facilities. SMHAs may delegate admission and continued stay determinations to any entity without direct or indirect ties to a nursing facility. However, SMHAs retain ultimate control and responsibility for the determinations.

5. Are nursing facilities obligated to provide services recommended by the State Mental Health Authority on the basis of Level II screens?

Yes, but only those services of lesser intensity than specialized services. State Mental Health Authorities are required to determine whether nursing facility applicants and residents with mental illness need specialized services, and the State must provide or arrange for those services. The Medicaid statute mandates that nursing facilities provide treatment and services required by residents with SMI that are not otherwise provided or arranged for (or required to be provided or arranged for) by the State. Regulations interpret the statutory language to require provision of mental health services of lesser intensity than specialized services to all residents who need such services. However, if the treatment needs of an applicant or resident with SMI cannot be met by the nursing facility or through specialized services provided by the State, placement is not considered appropriate and the individual may not stay in the nursing facility.

6. What constitutes specialized services? Can they be defined any way a state chooses?

Congress authorized HHS to define specialized services in regulation. The resulting HHS regulations define specialized services as those "specified by the State" that, combined with services provided by the nursing facility, result in the continuous and aggressive implementation of an individualized plan of care. The plan of care must be developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professional, and other professionals as appropriate. It must prescribe specific therapies and activities for the treatment of acute episodes of serious mental illness. The plan must also be directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving independent functioning, and achieving a level of function that enables the elimination of specialized services at the earliest possible time. Within the definition of specialized services articulated in Federal regulations, States maintain considerable flexibility in the definition of specific services and treatment.

7. Can specialized services be defined as those services provided in a psychiatric hospital or psychiatric unit of a general hospital?

Yes. PASRR's purpose is to determine whether NF care for persons with SMI is appropriate and whether specialized services are needed. In States that define specialized services as intensive mental health services provided in an inpatient psychiatric hospital or general hospital, PASRR determinations that specialized services are needed mean that NF services are not needed. The State then becomes involved in the person's placement in an appropriate alternative setting (e.g., an inpatient psychiatric hospital, an IMD, or a psychiatric wing of a general hospital).

VIII. State Variations in PASRR Implementation

Medicaid is a State/Federal program that provides each State a great deal of flexibility in the design and administration of its program within broad Federal guidelines. Neither OBRA 1987 nor the resulting 1990 and 1992 regulations mandated a process for States to implement preadmission screening or stipulated the use of specific screening tools. The 1990 and 1992 regulations granted States great flexibility to implement even the most basic operational aspects of PASRR, such as the PASRR screening criteria and the definition of mental illness. Therefore, a great deal of variation exists in how PASRR is implemented across the States. The following section describes the various ways in which States have interpreted and implemented the program, including screening, specialized services, and alternative placements.

Screening Process

Level I Screens

The Bazelon Center (1996) found that approximately 70 percent (22 of 31) of the States responding to questions on Level II screening rely on Federal criteria specified under PASRR regulations to determine whether an individual is suspected of having a mental illness and qualifies for a Level II screen. States that did not use Federal criteria (9 of 31) reported they applied broader definitions to determine the presence of mental illness (see Table 2 in Appendix).

States also differ in determining who is responsible for conducting the Level I screen and who is qualified to administer it (Table 3 in Appendix). According to the Bazelon Center study (1996), only 2 of the 31 reporting States retained responsibility for the reviews. The majority (45 percent) use a mix of State agencies and private providers. The other States use an array of contracting arrangements, including a mix of individual private health care providers (16 percent), private agencies (13 percent), treating physicians (6 percent), nursing facilities (6 percent), and a combination of nursing facilities and hospitals (6 percent).

With regard to personnel qualified to administer the Level I screen, there is

variation in terms of professional background (e.g., registered nurse, social worker, doctor, mental health professional, or discharge planner) and organizational affiliation (e.g., nursing facility; State Agency on Aging; or a State department, hospital, or independent entity contracted to conduct PASRR screens). For example, in Washington State staff at the admitting NF complete Level I screens, while in Maine screens may be completed by the hospital discharge planner, social worker, registered nurse, psychologist, psychiatrist, doctor, or nursing facility staff (Borson, Loebel, Kitchell, Domoto, & Hyde, 1997; Maine Department of Human Services, 1997). According to the Society for Social Work Leadership in Health Care (SSWLHC) report (1995), the amount of flexibility in who is authorized to complete a Level I screen is correlated with the complexity and bureaucracy involved in a State's PASRR process.

States also vary considerably in the type and complexity of screening tools used for Level I screens. For example, Washington State relies on three separate sources of data in Level I: admission and medical records, staff interviews with an aide or nurse (depending on whether the individual is being discharged from a hospital or currently resides in the NF), and a complete resident examination (including a psychiatric diagnostic interview, the Mini-Mental State Examination, the Hamilton Depression Rating Scale, and the Brief Psychiatric Rating Scale) (Borson et al., 1997). In Maine, Level I screens are much less complex; screeners are required to complete only one instrument, the Med '96 Module V (Maine Department of Human Services, 1997). Some States, such as Oklahoma, include the Minimum Data Set (MDS) as an instrument for the Level I screen since the MDS already is part of the assessment process for individuals applying for NF placement (Oklahoma Department of Mental Health and Substance Abuse Services [DMHSAS], 1997).

Level II Screens

As with the Level I screen, States vary in their implementation of the Level II screen. Definitions, responsibilities, and personnel qualifications for conducting the screen vary, as do the screening instruments used.

Not all individuals identified as meeting a State's criteria for mental illness are referred for Level II screens. Hospital discharges are exempt from PASRR prior to an NF admission when they meet certain criteria and their attending physician certifies (prior to admission) that fewer than 30 days of convalescent care is needed for the condition for which they were hospitalized. SMHAs can make determinations in advance for certain categories that have been approved by CMS and included in the State plan. The approved categories are based upon the fact that certain diagnoses, severity of illness, or need for a particular service indicate that NF admission is appropriate. For MI, a category can indicate that specialized services are *not* needed only for provisional emergency admissions (limited to 7 days) and short-term respite stays. All other categorical determinations that a person needs NF services *must still have an individualized Level II evaluation for specialized services*. There cannot be an advance determination that specialized services *are* needed. Other examples of categorical determinations are persons with a terminal illness and severe medical conditions prohibiting mental health treatment, including coma. The number of

advance determinations made by category (aka categorical determinations) established by States varies, ranging from none to eight (Snowden, Piacitelli, & Koepsell, 1998; SSWLHC, 1995). States vary in the criteria used to make categorical determinations as well.

With regard to the determination of need for NF-level care, CMS permits each State to develop its own medical necessity criteria for nursing facility admissions and Federal guidelines require the SMHA to use the State criteria when making its PASRR determinations. The Bazelon Center (1996) found that 91 percent (30 of 33 responses) of the States defined specialized services as 24-hour inpatient psychiatric care (Table 6 in Appendix). The other three States defined specialized services as a broad spectrum of rehabilitative services designed to develop skills necessary for living independently in the community.

States vary regarding who is responsible for conducting Level II screens and who is qualified to administer the screen (see Table 7 in Appendix). Most State Medicaid agencies authorize private entities to complete Level II screens. The Bazelon Center (1996) found that 52 percent of States (26 States) contract with private entities, 24 percent use community mental health agencies, and 15 percent delegate screening to an independent State agency. In most cases, the referring individual contacts the designated entity only if a Level II screen is required (SSWLHC, 1995). For example, in Oklahoma, the Level II screens can only be completed by a CMHC that is not owned by the State. Individuals identified as requiring a Level II screen are referred to the Oklahoma Health Care Authority PASRR Unit, which in turn refers them to a State psychiatric consultant. The consultant refers individuals to an authorized CMHC, which completes the screen and sends it to the Oklahoma Department of Mental Health and Substance Abuse Services for review (Oklahoma DMHSAS, 1997). Often, the Level II screen involves input from interdisciplinary teams, including physicians, social workers, and licensed professional counselors or family therapists (Oklahoma DMHSAS, 1997). In Washington State, the Mental Health Division contracts with certified mental health professionals to conduct Level II PASRR screens. Licensed psychiatrists are required to review and sign each screen (Snowden et al., 1998). In Maine, Level I screens that meet the criteria are submitted to the Mental Health Authority, which is the final authority on whether individuals should be referred for a Level II screen. The Mental Health Authority then refers the individual to an independent assessor from a local CMHC to conduct the Level II screen (Maine Department of Human Services, 1997).

The way in which screens are conducted also differs among the States. For example, a few States, such as Hawaii, require discharging hospitals to gather and send all required information for individuals requiring Level II screens to the State Mental Health Agency or contracted agency for review. Other States, such as Kentucky, require a face-to-face psychiatric assessment conducted by the agency contracted to perform Level II screens (SSWLHC, 1995).

Screening tools also vary across States. Some States, such as Nebraska, require as many as nine different forms to be completed; other States only require one or two. Although some States do not require the use of standard forms for the Level II screen,

most States do collect common data elements (SSWLHC, 1995) as required in Federal regulations. For example, Maine and Oklahoma have similar requirements for Level II screens, including the mandatory information on medical history, neurological systems, comprehensive drug history, psychosocial evaluation, psychiatric history, and an evaluation of the need for specialized services (Maine Department of Human Services, 1997; Oklahoma DMHSAS, 1997).

Specialized Services

Another area of State variation concerns the type and availability of alternative placement options, as well as the mental health services available in nursing facilities. While PASRR regulations mandate that States arrange for the provision of specialized mental health services to individuals requiring clinical intervention for acute manifestations of mental illness, CMS allows each State to create its own requirements for the kinds of services that would qualify as "specialized." For example, Maine and Oklahoma specify a range of specialized services, such as special staffing; diagnostic assessment by an interdisciplinary team that includes a psychiatrist; emergency detention (provided only for patients in danger of harming themselves or others); intensive one-to-one supervision; seclusion or physical restraint (if providing less intensive treatment fails); psychotropic medication; group therapy; individual therapy; psychiatric testing; recreation therapy; and neurological exams (Maine Department of Human Services, 1997; Oklahoma DMHSAS, 1997). Some States contract with entities or mental health professionals for a variety of reasons. For example, several services, such as emergency detention, are difficult for nursing facilities to provide and still comply with the nursing home residents' rights regulations. Because many facilities choose not to make the necessary modifications, the State is unable to contract with the facility to provide certain specialized services. Another reason States might choose not to provide specialized services in nursing facilities is because of the risk that a facility might unintentionally become an IMD and lose its Medicaid payment for persons age 22–64. A third reason is that nursing facilities do not have mental health professionals on staff and the general staff does not have the skills required to provide adequate care for persons with intensive mental health needs. Also, many States believe that the many younger people who require specialized services may pose a risk to their elderly and frail residents. Some States mandate that these services be provided at inpatient psychiatric facilities; other States have authorized community mental health centers or other outpatient facilities to provide them in the form of day treatment. These individuals residing in nursing facilities at the time of treatment receive outpatient specialized mental health services provided by an agency contracted through the State.

Community-Based Alternatives

Studies of PASRR implementation suggest that increasingly States rely on community-based alternatives for providing specialized mental health services. The Bazelon Center study (1996) found that 25 percent of individuals receiving specialized treatment in 1993 were referred to psychiatric hospitals, compared with 51 percent in 1991. The number of individuals receiving services from nonpsychiatric inpatient placements

and nursing facilities increased during the same period. Alternative placements in community-based programs increased from 19 percent in 1991 to 22 percent in 1993, while the percentage of individuals remaining in nursing facilities and receiving specialized services from contracted agencies increased from 30 percent to 53 percent, respectively (Bazelon Center, 1996). There is one caveat to interpreting these data, however. Texas accounted for 76 percent of individuals receiving treatment from nursing facilities in 1993. Hence, the increase in referrals to community-based alternatives may be less substantial than the percentages suggest. However, Snowden and colleagues (1998) also found fewer referrals to inpatient psychiatric units in a study of PASRR implementation in Washington State, reporting that only 0.8 percent of Medicaid recipients were referred to inpatient psychiatric care in 1992 and 1993, while 74 percent of individuals were referred to non-nursing long-term care facilities during this same period.

According to the Bazelon Center study (1996), 36 percent of States (18) believe that PASRR had resulted in increased funding for community-based care; 39 percent (19) indicated no increased funding. Hence, reliance on community-based care varies across States and may relate to the State's own policies for increasing reliance on less restrictive settings for treatment. For example, although some States—such as Texas—are increasing reliance on alternative community-based options for specialized services, some State Mental Health Authorities still prefer referrals to more traditional inpatient facilities. For example, Maine's description of its OBRA program specifically designates psychiatric units of community hospitals as the best location for residents discharged from nursing facilities as a result of PASRR (Maine Department of Human Services, 1997). Oklahoma advises referring entities to place individuals in psychiatric units for specialized services since treatment is often short-term (Oklahoma DMHSAS, 1997).

Outcomes of PASRR Screening Process

An estimated 5.4 percent of all U.S. adults are considered to have a serious mental illness; further, it is estimated that a total of 9 percent of adults have mood disorders or SMI and experience functional impairment (U.S. Department of Health & Human Services, 1999).

No detailed studies address whether the PASRR program is achieving appropriate treatment for individuals with mental illness. However, a number of studies address the extent to which the PASRR screening process identifies people with serious mental illness.

Level I Screen

A recent Office of the Inspector General report (*PASRR Implementation and Oversight,* 2001) found States conducted Level I PASRR screens for only 47 percent of sampled residents with a serious mental illness. Of the screens completed, 16 percent were dated more than 2 months after admission to the facility. Compliance varied widely by State; the proportion of residents receiving Level I screens ranged from 11 to 100 percent.

In their review of PASRR, Borson and colleagues (1997) report that around 7 percent of individuals who received Level I screens

ultimately were referred for Level II screens. This figure is consistent with other studies. For example, in the Bazelon Center study (1996), the number of reviews conducted ranged from 14,314 per State in 1991 to 19,775 per State in 1993. Of the States reporting both the number of reviews conducted and the number referred for Level II screens, average referral rates were 6.2 percent in 1991 and 5.8 percent in 1993. Referral rates varied greatly among the States, with Washington State reporting the highest referral rate in both 1992 and 1993—63.4 percent and 92.1 percent, respectively (Bazelon Center, 1996).

The purpose of the Level I screen is to identify NF applicants and residents who are *suspected* of having SMI. The Level I often is administered by hospital discharge personnel and NF staff who are not mental health professionals, and thus, Federal regulations require the diagnosis of SMI not to be included in the Level I, but to be part of the actual PASRR evaluation, which is the Level II. By regulations, the Level I cannot require a person to meet the definition of mental illness in order to be triggered to have a Level II PASRR evaluation. The Office of the Inspector General report (2001), however, recounted finding States that did not comply with this requirement and only referred for a Level II persons who met all 3 parts of the PASRR definition of mental illness.

Snowden and colleagues (1998) found that of individuals identified by Level I screens, the majority (59.7 percent) were found to have schizophrenia or schizoaffective disorder; 20.1 percent of individuals exhibited major depression. Borson, Loebel, Kitchell, Domoto, & Hyde (1997) examined diagnosis by age and found that 26 percent of individuals receiving Level I screens were younger than 65. Of these individuals, 57 percent were diagnosed with psychosis and 23 percent with dementia or mental retardation with predominantly psychiatric or behavioral presentation. The major diagnoses were more evenly distributed for individuals over 65 years old: 21 percent were found to have psychosis and 26 percent to have dementia or mental retardation.

Level II Screen

The intent of PASRR screening is to ensure that NFs only admit individuals with serious mental illness who actually need NF services and to assure that States provide needed specialized mental health services to residents who need them. When the PASRR program was enacted, by April 1, 1990, States were required to conduct a Level II PASRR evaluation on each nursing facility resident who had mental illness or mental retardation and determine whether they required nursing facility services and specialized services. Except for certain long-term residents, any resident with SMI or MR who did not need NF services was required to be discharged. Forty-six States found significant numbers of residents with serious mental illness and mental retardation who were determined not to need NF services and who submitted requests to CMS (previously HCFA) for additional time to develop alternative programs in which to place them.

The Bazelon Center (1996) found that the average number of Level II screens conducted per State in 1991 and 1993 was 1,009 and 923, respectively. Most States reported identifying very few NF applicants with serious mental illness who were not appropriate for NF care. The percentage of individuals found to be inappropriate for NF care averaged 12 percent in 1991 and 9 percent in

1993. Interestingly, Illinois found 80 percent of applicants inappropriate for NF care in 1991 and 31 percent in 1993 (Bazelon Center, 1996), which may reflect the fact that Illinois initially had a high proportion of persons with SMI residing in nursing homes who subsequently transitioned from these facilities or were diverted out through the PASRR program. Other studies have confirmed Bazelon's findings of an average diversion rate (those found to be inappropriate for NF care) of less than 10 percent. For example, the SSWLHC study (1995) found an average diversion rate of 6 percent for the 20 States reporting data between 1992 and 1994. An even earlier survey of State Mental Health Authorities by the National Association of State Mental Health Program Directors reported a diversion rate of 9 percent of 32,171 screens in 1989, 5 percent of 76,471 screens in 1990, and 10 percent of 43,853 screens in 1991 (SSWLHC, 1995).

Eight percent of nursing facility applicants who received a Level II preadmission screen in 1991 were found to need specialized services, 8 percent in 1992, and 7 percent in 1993. Of the nursing facility residents who received an annual resident review, 5 percent were found to need specialized services in 1991, 4 percent in 1992, and 7 percent in 1993 (Bazelon Center, 1996). No information was available to compare the percentage of individuals identified as needing both specialized services and nursing facility care with the percentage of individuals referred to alternative placements for specialty services. Such information would be useful, as it would provide a perspective on how often nursing facilities are responsible for arranging mental health services for individuals with serious mental illness.

Treatment Issues

Several studies have documented the inadequacy of mental health treatment for nursing home residents with serious mental illness prior to enactment of PASRR (Borson et al., 1997; Burns et al., 1993; Emerson Lombardo, 1994), but no studies have been published concerning the adequacy of mental health services for this population *since* PASRR implementation. Using type of treatment recommended and nursing facility compliance with recommendations as proxies for adequacy of services, Snowden et al. (1998) found that among the Medicaid NF residents receiving PASRR screens between 1992 and 1993 in Washington State, mental health services other than medication therapy were limited. The majority (87 percent) of residents screened in the study were already receiving medication therapy. Of these, 59 percent received recommendations for new treatment. Therapy was the most common new treatment recommended (39.8 percent), although it was the least common treatment already being provided. This finding is confirmed by other studies that report widespread use of psychotropic medications in nursing homes (Abrams et al., 1992; Beers et al., 1988). Snowden et al. (1998) identified that consultation was another highly recommended new treatment (27 percent of individuals received recommendations for this service).

Information on whether nursing facilities are complying with Level II screening recommendations also indicates that PASRR has had only limited impact on the appropriateness of mental health services for individuals with SMI in nursing facilities. One of PASRR's intents was to ensure that such individuals received treatment other than medication for their illness (U.S. Congress,

1987). Phillips, Hawes, Morris, Mor, and Fries (1994) compared pre- and post-OBRA 1987 data from more than 250 nursing facilities in 10 States. Their results suggest that OBRA 1987 has positively affected treatment alternatives in NFs, as more nursing facilities were providing psychological therapy and behavior management programs in 1993 than before OBRA 1987. Although this study was unable to separate out the effect of PASRR from other components of OBRA 1987, such as the Resident Assessment Instrument (RAI) and OBRA 1990 that added a requirement for NFs to provide or arrange for mental health services, the findings indicate that nursing facilities are beginning to provide more appropriate mental health services for their residents. Such improvements appear to be limited, however, as Snowden et al. (1998) found that individuals were much less likely to comply with nonpharmaceutical services. Indeed, while 94 percent of residents complied with recommendations for medication therapy, only 30.5 percent followed recommendations for new nonpharmaceutical treatments. Only 52 percent of residents recommended for therapy and 7 percent recommended for consultation complied with orders for these two most commonly recommended nonpharmacological treatments. Overall, individuals were much less likely to comply with a recommendation for a new treatment (34.9 percent) than to continue an existing treatment (91.4 percent), and the majority of existing treatment was pharmaceutical. Snowden and colleagues hypothesized that it might be easier for nursing facilities to provide medication treatment since medication management does not require NF staff to have a particular knowledge of mental health issues. Hence, while the PASRR program may help identify individuals needing mental health services, the program appears to have limited impact on the nature of treatment received.

IX. Current Issues and Concerns

Because data specific to PASRR are limited, it is difficult to assess the nature of PASRR's impact on identifying individuals in need of mental health services. Organizations such as the American Psychiatric Association and the American Association for Geriatric Psychiatry expressed support for the program in their 1998 joint testimony to the Committee on Improving Quality in Long-Term Care. The same organizations, however, believe the program has made limited progress in providing the target population with necessary care (Colenda et al., 1999). Current concerns include the following:

Lack of Funding for PASRR Screens, Specialized Services or Alternative Treatment

Expenditures for PASRR determinations (an administrative expense) are eligible for 75 percent Federal financial participation. Level II determinations—the PASRR determination of whether an individual with SMI requires (1) nursing facility services and (2) specialized services—must be conducted by State Mental Health Authorities. However, the State share may come from any State agency. The only prohibition is that it may not come from another Federal funding source.

Funding PASRR screens and specialized treatment is a challenge for States. If individuals need specialized services to treat their mental illnesses, the State Medicaid Agency ultimately is responsible for providing or arranging for the provision of those services. Federal reimbursement is available for specialized services that are covered under the Medicaid State plan. Although the Federal Government will match State expenditures on meeting PASRR requirements, PASRR only evaluates individuals to determine the need for nursing facility services and specialized services. Finding and funding alternative placement is not a PASRR function.

Statutory Exemptions for Dementia

When OBRA 1987 was initially proposed, professional organizations such as the National Association of State Mental Health Program Directors were concerned that PASRR would force removal of residents with dementia from nursing facilities. To ensure that such individuals were not denied nursing facility care, they recommended that PASRR apply only to individuals with serious mental illness (Emerson Lombardo, et al., 1996). As a result, Congress amended

the law, constricting the definition of mental illness to SMI and does not include persons with dementia unless the person has a primary diagnosis of SMI. Because States are not required to conduct Level II screens on these populations, the statutory definition of mental illness inadvertently has failed to identify the need for specialized services for many individuals who have Alzheimer's disease or related disorders. Once individuals are diagnosed with dementia from a Level I identification screen, they are not required to go through a Level II PASRR screen unless it is suspected the person has a primary diagnosis of a serious mental illness. While nursing facilities are required to provide mental health services of lesser intensity than specialized services to residents who need them, the absence of a Level II evaluation reduces the possibility that they will receive any intensive treatment needed to address symptoms of the disease. Yet several studies have documented that individuals with dementia can benefit from mental health services (Bazelon Center, 1996; Emerson Lombardo, 1994; Emerson Lombardo et al., 1996; Streim, 1995).

Lack of Clear Definitions in the Legislation

The ambiguous language contained in the legislation regarding serious mental illness and specialized services has been a concern since the enactment of PASRR (Bazelon Center, 1996; Robinson, 1990). Although Federal minimum requirements for diagnosing serious mental illness exist, States are allowed to administer their own instruments to screen for suspected mental illness—instruments that might establish broader guidelines than Federal statute. Hence, an individual might be defined as having a serious mental illness in one State but not in another. The broad definition of "specialized services" leads to a similar situation—there is wide variation in the types of services that States provide to people with serious mental illness.

Barriers to Meeting PASRR Objectives

With few resources to monitor States and limited statutory penalties except closing a facility, denying payment, or imposing fines, CMS has had difficulty enforcing PASRR. Consequently, advocates and policymakers suspect that PASRR is not having the full intended results (Bazelon Center, 1996; Borson et al., 1997; Marek et al., 1996; Sherrell et al., 1998).

Because PASRR is a Medicaid program that is designed by each State within broad Federal guidelines, little consistency among States exists. Furthermore, because PASRR is unique in that it requires coordination between State agencies that are not accustomed to working together, there are communication problems and lack of consistency within States as well. Such inconsistency can pose problems, affecting everything from a State's ability to measure outcomes to a hospital's understanding of the process when it serves individuals from more than one State (Sherrell et al., 1998; SSWLHC, 1995). For example, Sherrell and colleagues (1998) found that Illinois relied on 27 different PASRR agencies, each contracting with its own independent consulting firm to conduct Level II screens. Inconsistencies among nursing facilities in Chicago, a product of disparate measurement instruments and the structures of final reports, hindered the researchers' ability to draw meaningful conclusions about PASRR's outcomes. In addition, Sherrell and colleagues assert that psychologists conducting Level II screens were

unfamiliar with the resources of the nursing facilities. Therefore, many of their recommendations for treatment were either inappropriate or not available in nursing facilities. For example, although the primary symptom identified in the Level II screens was social withdrawal, 64 percent of individuals screened were placed on psychotropic medications that were not helpful in managing withdrawal. Moreover, treatment recommendations did not vary by diagnosis, age, dementia, level of independence in daily activities, or symptoms (Sherrell et al., 1998).

Inefficient Utilization of the Expertise of Mental Health Professionals

The question of who provides mental health services to nursing home residents remains controversial in the current debate over PASRR. Emerson Lombardo and colleagues (1996) found that psychiatrists and other mental health professionals must dedicate their time to evaluation and medication management, leaving them unable to provide therapy and other more direct modes of treatment (Emerson Lombardo et al., 1996). In an unpublished study, Shea et al. (1995) found that only 29 percent of nursing home residents were receiving mental health services from a mental health professional (Emerson Lombardo et al., 1996). Some researchers say that the underlying problem limiting the use of psychiatrists and psychologists is low reimbursement rates under Medicare and Medicaid. Although there have been changes in Medicare reimbursement to encourage utilization of psychologists, Shea et al. (1995) found that fewer than 5 percent of residents in treatment were receiving services from psychologists (Emerson Lombardo et al., 1996). Furthermore, there is concern over the lack of knowledge about mental health issues among nursing facility staff. Unless staff members are trained in mental health issues, they will be unable to provide an environment conducive to improving each resident's mental health (Emerson Lombardo et al., 1996).

Administrative Burden and Cost

A study by Marek and colleagues (1996) reports that government officials and nursing facility staff are concerned by increased paperwork, administrative burden, and costs associated with OBRA 1987. Increased administrative costs are seen as effectively reducing the resources available for direct care. A study by SSWLHC (1995) indicates that the PASRR process is redundant of other nursing facility requirements to conduct assessments (e.g., RAI/MDS) of applicants after admission. Like PASRR, RAI/MDS collects information on psychiatric diagnosis. SSWLHC argues that this process alone is adequate in ensuring appropriate nursing facility placement, however, this view disregards the reality that the nursing facility resident assessment, under the minimum data (RAI/MDS) occurs *after* the admission when resident protections are in effect that provide the resident a 30-day notice and limit the reasons for which a facility can discharge or transfer a resident involuntarily. Regulations also provide the resident with the right to an appeal, which would extend an inappropriate nursing facility placement.

Prompted by concerns about high administrative burden and information redundancy, some organizations argue that PASRR should be repealed. However, it is not clear that the data collected in RAI/MDS, albeit completed after admission by nursing facility staff that often has no MH training, would be sufficient for determining the appropriate place-

ment needs for mentally ill individuals. In their joint testimony to the Committee on Improving Quality in Long-Term Care, the American Psychiatric Association and the American Association for Geriatric Psychiatry note that RAI screens may not be useful in indicating need for specialized services or developing quality monitors (Colenda et al., 1999). More research is needed to determine the extent to which other assessment instruments would be able to replace PASRR.

With regard to cost, SSWLHC (1995) reported that no cost/benefit analysis of PASRR has been performed. Studies that measure costs related to PASRR for particular areas document variation in the level of spending between States. For example, States responding to the Bazelon Center survey demonstrated an average of $2.10 million per State for individuals with SMI in 1991 and $2.13 million per State in 1993. Yet Texas exhibited spending levels of $12 million and $26 million alone for those 2 years, respectively (Bazelon Center, 1996). According to the SSWLHC (1995) survey of State Mental Health Authorities, program directors reported an average expenditure of $373 per Level II screen in 1989 and $336 per Level II screen in 1991. Neither study examined cost per individual in need of specialized services, although such information would be useful in determining whether the costs outweigh the benefits of the legislation.

Delays in Placement

Hospitals and NF staff report concerns over placement delays caused by the PASRR screening process (SSWLHC, 1995). According to PASRR regulations, individuals cannot be placed in nursing facilities until after the screens have been completed and must be made in writing within an annual average of 7 to 9 working days of referral. Placements can be initiated earlier by telephone or electronic authorization. However, the SSWLHC study documents that an individual requiring both Level I and Level II screens can be delayed for as long as 3 weeks for a final determination. The SSWLHC survey found that Level II screens delayed hospital discharge by between 0 and 24.5 days, with an average of 8.3 days. The high level of variation in these findings indicates that hospital discharge delays differ from one State to another and between one hospital and another. Because each State designs its own PASRR program, some are more or less efficient than others. Also, hospitals that begin discharge planning at the time of admission; conduct a Level I at admission if it appears nursing facility placement is likely; and schedule a Level II early, have significantly fewer discharge delays than hospitals that wait until the time of discharge to perform a Level I. Advocates of PASRR reform, however, argue that placement delay problems are primarily due to the unnecessary complexity of the PASRR process.

X. Conclusion

This document provides a context for understanding the various issues related to the implementation of PASRR. It will help establish and refine the research questions and study design used to evaluate PASRR and mental health services for persons in nursing facilities.

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XII. Appendix

Table 1. PASRR Program Requirements

Element	*Description*	*Title XIX*[1]	*CFR*[2]
Overall scope	As a condition of State Plan approval, States must operate a PASRR program; no Federal payment may be made for nursing facility (NF) services provided to individuals with mental illness (MI) and mental retardation (MR) not screened by a State PASRR program.	1919(e)(7)—PASRR was created in OBRA '87 and technical corrections provided in OBRA '90. In 1996, P.L. 104-315 removed the requirement that resident reviews be conducted annually.	42 CFR 483—Federal regulations have not been updated to reflect statutory changes in P.L. 104-315 (in 1996), which removed the requirement that resident reviews be conducted annually.
Applicability: NF	All Medicaid NFs must meet PASRR requirements.	1919(b)(3)(F)—Precludes NFs from admitting persons with MI/MR unless PASRR has determined they need NF services and whether specialized care is needed.	42 CFR 483.20(m)—Preadmission screening for individuals with MI/MR.
Applicability: Residents and applicants	All MI and MR residents and applicants must be screened regardless of payer.	1919(b)(3)(F)—Provides requirements relating to preadmission screening for individuals with MI/MR.	42 CFR 483.20(m)—Preadmission screening for individuals with MI/MR. 42 CFR 483.102(a)—Applicability and definitions.
Definition: MI	An individual must meet specific requirements related to diagnosis, level of impairment, and duration of illness to meet the definition of "serious mental illness" (SMI) as defined by OBRA 1992.	1919(e)(7)(G)—"An individual is considered to be 'mentally ill' if the individual has a serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness."	42 CFR 483.102(b)(1)—"An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements on diagnosis, level of impairment and duration of illness:" Diagnosis: 42 CFR 483.102(b)(1)(i)—"A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or any other mental disorder that may lead to a chronic disability diagnosable under the DSM-III-R other than dementia unless the primary diagnosis is a major mental disorder."

Note: State Medicaid Manual (SMM) PASRR sections 4250–4253 (published 1989) provided interim guidance, pending Federal regulations. Final Federal Regulations, published 1992, replaced the 1989 SMM issuance. CMS still plans to revise and update the SMM.

[1] Title XIX of the Social Security Act, Medicaid Program Statute.

[2] Code of Federal Regulations. 42 CFR, Parts 405, 431, 433, and 483. (DHHS, *Federal Register,* 1992)

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Definition: MI (continued)			Level of impairment: 42 CFR 483.102(b)(1)(ii)—"The disorder results in functional limitations in major life activities within the past 3 to 6 months that would be appropriate for the individual's developmental stage." Duration: 42 CFR 483.102(b)(1)(iii)—"The individual experienced at least one of the following: psychiatric treatment more intensive than outpatient care more than once in the past 2 years; or… significant disruption to the normal living situation requiring supportive services to return home or… intervention by housing or law enforcement officials."
CMS responsibilities	CMS reviews State plans and practice to ensure that they comply with Federal requirements. CMS develops minimum criteria to make PASRR determinations. CMS monitors State compliance with Federal PASRR requirements to discharge MI or MR short-term NF residents not needing NF services but needing specialized services.	1902(a)—Provides general provisions concerning Medicaid administration. 1919(f)(8)(A)—Instructs the Secretary to develop minimum criteria for PASRR determinations. 1919(f)(8)(B)—Requires monitoring compliance with Federal requirements regarding discharge and placement of MI or MR individuals who resided in NF less than 30 months, do not need NF care but need specialized services.	42 CFR 430.0 through 430.48
Medicaid agency responsibilities	PASRR is a required element of State Medicaid plans. State Medicaid agencies are responsible for administering and supervising State Medicaid plans. Thus, State Medicaid agencies bear overall responsibility for meeting PASRR obligations. However, the State Medicaid agency is not required to provide services directly and may delegate required activities unless specifically prohibited by statute.	1919(e)(7)—Provides State requirements for preadmission screening and resident review.	42 CFR 431.621—Requires written agreements with the SMHA and State Mental Retardation Authority detailing the operation of the PASRR program. The agreement must specify the respective responsibilities of the State Medicaid agency and the SMHA for (1) conducting joint planning; (2) ensuring access by the Medicaid agency to the SMHA's records; (3) recording, reporting, and exchanging medical and reporting, and exchanging medical and social information about individuals subject to PASRR; (4) ensuring that preadmission screenings and resident reviews are performed in a timely manner;

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Medicaid agency responsibilities (continued)	State Medicaid agencies must include a PASRR program in the State Medicaid plan that meets Federal requirements. They must have a written agreement with the SMHA detailing the operation of the PASRR program. They must ensure that specialized services are provided or arranged for MI or MR residents in NFs and for individuals needing such specialized services who resided in NFs but did not need NF services and were discharged or chose to leave because of PASRR.		(5) ensuring that if the SMHA delegates its determination responsibility, this delegation complies with regulations; (6) ensuring that PASRR determinations made by the SMHA are not countermanded by the Medicaid agency; (7) designating the independent person or entity that performs PASRR evaluations for individuals with MI; and (8) ensuring that all requirements of PASRR are met. 42 CFR 483.104—"As a condition of approval of [Medicaid] plan, the State must operate the State a preadmission screening and annual resident review program that meets the requirements of 481.100 through 483.138." 42 CFR 483.120(b)—"The State must provide or arrange for the provision of specialized services, in accordance with this subpart, to all NF residents with MI or MR whose needs are such that continuous supervision, treatment and training by qualified mental health or mental retardation personnel is necessary, as identified by the screening provided in 483.130 or 483.134 and 483.136."
NF responsibilities	NFs must not admit any new MI or MR resident who has not received a PASRR determination that the individual requires NF services and whether the individual needs specialized services for MI. NFs must promptly report to the SMHA any significant changes in the physical or mental condition of an NF resident. NFs must provide mental health services that are less intense than specialized services to all residents who need such services. NFs must transfer copies of most recent PASRR reports when MI or MR resident is	1919(b)(3)(F) —"A nursing home must not admit any new resident who is mentally ill unless the State mental health authority" has conducted a PASRR determination and was determined to need NF services. 1919(b)(3)(E)—"A nursing facility shall notify State mental health authority promptly after a significant change in the physical or mental condition of a resident who is mentally ill." 1919(b)(4)(vii)—NFs must provide "treatment and services required by mentally ill and	42 CFR 483.20(m)—Prohibits admission without PASRR determination that NF services are needed. 42 CFR 483.20(b)(2)—Requires a resident assessment within 14 days after a significant change in the resident's physical or mental condition (regardless of MI or MR). 42 CFR 483.120(c)—Requires NFs to provide mental health services of lesser intensity than specialized services. 42 CFR 483.106(b)(2)(ii)—"In cases of transfer of a resident with MI or MR from an NF to a hospital or to

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
NF responsibilities (continued)	transferred to a hospital or another NF. States may specify additional responsibilities such as Level I identification of whether residents and applicants are suspected of MI.	mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State."	another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent PASRR and resident assessment reports accompany the transferring resident."
SMHA responsibilities	SMHAs are required to fulfill their responsibilities detailed in a written agreement with the State Medicaid agency. SMHAs must determine whether MI individuals require NF services and whether the individuals need specialized services for MI. Regulations specify conditions under which SMHAs may delegate PASRR determination responsibilities. They may not delegate their Level II responsibilities to a NF or other entity related to a NF. Evaluations used in making Level II determinations must be performed by a person or entity other than the SMHA. A Level II review and determination must be conducted promptly after a NF notifies the SMHA of a change in a resident's physical or mental condition.	1919(b)(3)(F)—"A nursing home must not admit any new resident who is mentally ill unless the State mental health authority" has made a PASRR determination that NF services are needed." A State mental health authority… may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility)." 1919(e)(7)(B)—Resident reviews must be "based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority." 1919(e)(7)(B)(iii)—Prompt review is required upon significant change in resident's condition. N/A	42 CFR 483.106(d)—"The PASRR determination of N/A whether an individual requires NF services and whether specialized services are needed…must be made by the State mental health authority and be based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority." 42 CFR 483.106(d)—"(1)The State mental health… authority may delegate by subcontract or otherwise the evaluation and determination functions for which [it is] responsible to another entity only if—(i) The State mental health…authority retains ultimate control and responsibility for the performance of [its] statutory obligations; (ii) The two determinations as to the need for NF services and for specialized services are made, based on a consistent analysis of the data; and (iii) The entity to which the delegation is made is not an NF or an entity that has a direct or indirect affiliation or relationship with an NF. (2) The State mental retardation authority has responsibility for both the evaluation and determination functions for individuals with MR whereas the State mental health authority has responsibility only for the determination function. (3) The evaluation of individuals with MI cannot be delegated by the State mental health authority because it does not have responsibility for this function. The evaluation function must be performed by a person or entity other than the State mental health authority. In designating an independent person or entity to perform MI evaluations, the State must not use an

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
SMHA responsibilities (continued)	May develop advance group determinations by category.		NF or an entity that has a direct or indirect affiliation or relationship with an NF." 483-130 (b) (1) and C)
Level I identification of individuals with MI or MR	The State Medicaid PASRR program must identify all NF applicants and residents suspected of having MI or MR in order to conduct Level II evaluations and determinations.	The statute does not indicate how MI and MR individuals should be identified for PASRR.	42 CFR 483.128—"The State's PASRR program must identify all individuals who are suspected of having MI or MR…This identification function is termed Level I."
Level II preadmission screening	All applicants for new admission to an NF who are suspected of MI through a Level I screen must be referred for a Level II evaluation. A two-pronged determination must be made. The determinations are (1) whether the individual requires NF services and (2) whether the individual needs specialized services. Regulations specify that SMHAs may develop categories for advance group determinations based on minimum evaluation based on minimum evaluation criteria when data are current, accurate, and sufficient, or they may make more extensive individualized determinations.	1919(e)(7)(A)(i)	42 CFR 483.112—"For each NF applicant with MI or MR, the State mental health or mental retardation authority (as appropriate) must determine…if the individual requires the level of services provided by an NF… If the individual with mental illness or mental retardation is determined to require an NF level of care, the State mental health or mental retardation authority (as appropriate) must also determine… whether the individual requires specialized services." 42 CFR 483.128(e)—"The State's PASRR program must use at least the evaluative criteria of Sec. 483.130 (if one or both determinations can easily be made categorically as described in Sec. 483.130) or of Secs. 483.132 and 483.134 or Sec. 483.136 (or, in the case of individuals with both MI and MR, Secs. 483.132, 483.134 and 483.136 if a more extensive individualized evaluation is required)." 42 CFR 483.130—No determination that specialized services are needed can be made categorically. In addition, categorical determinations that specialized services are not needed are limited to provisional, emergency, and respite categories. "Determinations made by the State mental health or mental retardation authority as to whether NF level of services and specialized services are needed must be based on an

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Level II preadmission screening (continued)			evaluation of data concerning the individual… Determinations may be (1) Advanced Group determinations, in accordance with this section, by category that take into account that certain diagnoses, levels of severity of illness, or need for a particular service clearly indicate that admission to or residence in an NF is normally needed, or that the provision of specialized services is not normally needed; or 2) Individualized determinations (based on more extensive individualized evaluations.)"
Exemptions to preadmission screening requirements	Exempted hospital discharge—Individuals admitted directly from a hospital for acute inpatient care are exempted from preadmission screening if they require NF services for the condition for which they were hospitalized, and if their attending physician certifies before admission to the facility that the likely NF stay is less than 30 days. If such individuals are later found to require more than 30 days of NF care, the SMHA must conduct a review within 40 days of admission. Patients being readmitted to a NF or being transferred from another NF facility are not required to have a preadmission screening since they are not considered new admissions. However, they are subject to resident review requirements.	1919(e)(7)(A)(iii) "Exception For Certain Hospital Discharges.—The preadmission screening program under clause (i) shall not apply to the admission to a nursing facility of an individual —(I) who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (II) who requires nursing facility services for the condition for which the individual received care in the hospital, and (III) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services."	42 CFR 483.106(b)(2)—"(2) Exempted hospital discharge. (i) An exempted hospital discharge means an individual (A) Who is admitted to any NF directly from a hospital after receiving acute inpatient care at the hospital; (B) Who requires NF services for the condition for which he or she received care in the hospital; and (C) Whose attending physician has certified before admission to the facility that the individual is likely to require less than 30 days nursing facility services. (ii) If an individual who enters an NF as an exempted hospital discharge is later found to require more than 30 days of NF care, the State mental health or mental retardation authority must conduct an annual resident review within 40 calendar days of admission." 42 CFR 483.106(b)(3)—"Readmissions. An individual is a readmission if he or she was readmitted to a facility from a hospital to which he or she was transferred for the purpose of receiving care. Readmissions are subject to annual resident review rather than preadmission screening." 42 CFR 483.106(b)(4)—"Interfacility transfers. (i) An interfacility transfer occurs when an individual is transferred from one NF to another NF, with or without an intervening hospital stay. Interfacility

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Exemptions to preadmission screening requirements (continued)			transfers are subject to annual resident review rather than preadmission screening."
Level II resident review	All NF residents with MI must undergo evaluation and determinations of (1) whether NF services are required and (2) whether specialized services are needed NFs must promptly report changes in a resident's physical or mental condition to the SMHA, which must then promptly conduct a review and determinations. Congress repealed the Federal requirement for annual resident reviews in 1996, but did not.change the required elements of those reviews. No regulations or SMM transmittals from CMS have been issued to reflect the 1996 changes. CMS provided guidance to States through letters and memorandums from regional offices.	1919(e)(7)(B)—Requires resident reviews of MI and MR residents in nursing homes. 1919(b)(3)(E)—"A nursing facility shall notify the State mental health authority… promptly after a significant change in the physical or mental condition of a resident who is mentally ill." 1919(e)(7)(B)(iii)—Requires SMHA to conduct a resident review promptly after an NF notifies the authority of significant change in an MI or MR resident's physical or mental condition. The statute is silent on the frequency with which reviews must occur. But NFs are required to notify SMHAs of significant changes in the physical or mental functioning of MI or MR residents. And a review and determination must be conducted promptly by SMHAs after notification of a change in a president's physical or mental condition.	42 CFR 483.114—"For each resident of an NF who has mental illness, the State mental health authority must determine…whether, because of the resident's physical and mental condition, the resident requires (1) The level of services provided by (i) An NF; (ii) An inpatient psychiatric hospital for individuals under age 21…; or (iii) An institution for mental diseases providing medical assistance to individuals age 65 or older; and (2) Specialized services for mental illness."
Minimum evaluation criteria for the need for NF-level care	Regulations specify the evaluation criteria and minimum data requirements to evaluate the need for NF services and NF level of care.	1919(f)(8)(A)—Instructs the Secretary to develop minimum criteria for PASRR determinations.	42 CFR 483.132—The evaluator must determine (1) whether an individual's total needs can be met in an appropriate community setting; (2) whether the individual's total needs can only be met in an inpatient setting; (3) if inpatient care is needed and desired, whether the NF is an appropriate setting; (4) if inpatient care needed but the NF is inappropriate, whether an ICF/MR, IMD, or psychiatric hospital would be appropriate. Evaluators must prioritize the physical and mental needs of the

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Minimum evaluation criteria for the need for NF-level care (continued)			individual, taking into account the severity of each condition. The following data elements must be collected from the evaluation: physical status (diagnoses, date of onset, medical history, prognosis), mental status (diagnoses, date of onset, medical history, likelihood that the individual may be a danger to himself/herself or others), and functional status (activities of daily living). 42CFR 483.128(f)—The two determinations relating to the need for NF level of care and specialized services are interrelated and must be based upon a comprehensive analysis of all data. No personnel qualifications are specified.
Minimum criteria for screening of persons with MI to determine need for specialized services	Regulations specify the criteria, minimum data, and personnel requirements for evaluating the need for specialized services.	1919(f)(8)(A)—Instructs the Secretary to develop minimum criteria for PASRR determinations.	42 CFR 483.134—Evaluation of person's need for specialized services for MI must include the following data: comprehensive history and physical (including complete medical history, review of all body systems, and neurological evaluation of motor and sensory function, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes); comprehensive drug history, psychosocial evaluation, comprehensive psychiatric evaluation (including psychiatric history, intellectual and memory function and orientation, attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, degree of reality testing, and hallucinations); functional assessment of activities of daily living to determine level of support needed; functional assessments of self-monitoring of health and nutritional status; self-administration of medical treatment and medication compliance; and assessment of individual's ability to handle money, dress appropriately, and properly groom. Personnel requirements—If the history and physical examination are not performed by a physician, then

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Minimum criteria for screening of persons with MI to determine need for specialized services (continued)			a physician must review and concur with the examination. The State may designate the mental health professionals qualified to conduct the other parts of the evaluation. A qualified mental health professional, as designated by the State, must validate the diagnosis of MI and determine whether specialized services are needed.
Definition: Specialized services	Regulations define specialized services that must be provided to MI and MR residents of NFs when necessary.	1919(e)(7)(G)—"The term 'specialized' services has the meaning given such term by the Secretary in regulations."	42 CFR 483.120(a)(1)—Specialized services are those specified by the State, which, when combined with NF services, result in the continuous and aggressive implementation of an individualized plan of care that is (1) developed under and supervised by a physician in conjunction with an interdisciplinary team of qualified health professionals; (2) prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of severe MI that necessitates supervision by trained mental health personnel; and (3) is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the specialized level of services at the earliest possible time.
Requirement to provide or arrange for specialized services	Specialized services must be provided or arranged for all MI residents in NFs who are determined by the SMHA to need such specialized services. In addition, specialized services must be provided or arranged for all MI individuals needing such specialized services who resided in NFs but do not need NF services	1919(e)(7)(C)(i)(IV)—Long term NF residents not requiring NF services but requiring specialized services may choose to stay in the NF or be discharged to an alternative setting. "Regardless of the resident's choice, [the State must] provide for (or arrange for the provision of) such specialized services."	42 CFR 483.120(b)—"The State must provide or arrange for the provision of specialized services, in accordance with this subpart, to all NF residents with MI or MR whose needs are such that continuous supervision, treatment and training by qualified mental health or mental retardation personnel is necessary, as identified by the screening provided in 483.130 or 483.134 and 483.136."

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Requirement to provide or arrange for specialized services (continued)	and were discharged or chose to leave because of PASRR. The provision of specialized services is a required element of State Medicaid plans' PASRR program. State Medicaid agencies are responsible for administering and supervising State Medicaid plans. Thus, State Medicaid agencies bear overall responsibility for meeting PASRR obligations to provide or arrange for specialized services. However, the State Medicaid agency is not required to provide services directly and may delegate required activities unless specifically prohibited by statute.	1919(e)(7)(C)(ii)(III)—Other residents not requiring NF services but requiring specialized services must be discharged and the State must "provide for (or arrange for the provision of) such specialized services."	42 CFR 483.130(m)(1)—In the case of individuals with MI who require NF services, apply for admission to an NF and for whom NF placement is appropriate, "if specialized services are also needed, the State is responsible for providing or arranging for the provision of the specialized services." 42 CFR 483.130(m)(4)—In the case of long-term MI residents in NFs who do not require NF services but require specialized services and may choose to remain in the NF, "wherever the resident chooses to reside, the State must meet his or her specialized services needs." 42 CFR 483.130(m)(5)—Short-term MI residents in NFs who do not need NF services but require specialized services "must be discharged…to an appropriate setting where the State must provide specialized services." 42 CFR 483.130(n)—"If a determination is made to admit or allow to remain in a NF any individual who requires specialized services, the determination must be supported by assurances that the specialized services that are needed can and will be provided or arranged for by the State while the individual resides in the NF."
Timeliness of preadmission screenings	Preadmission screening determinations must be made within an annual average 7 to 9 working days after patients are identified as suspected of having an MI and referred to the SMHA. The Secretary may grant exceptions to this standard. There is no timeliness standard for identification and referral of NF applicants with suspected MI.	1919(b)(3)(F)—Requires PASRR determination before admission.	42 CFR 483.112(c)—"…a preadmission screening determination must be made in writing within an annual average of 7 to 9 working days of referral of the individual with MI or MR by whatever agent performs the Level I identification." 42 CFR 483.122(b)—"FFP for late reviews. When a preadmission screening has not been performed prior to admission or an annual review is not performed timely, in accordance with Sec. 483.114(c), but either is performed at a later

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Timeliness of preadmission screenings (continued)			date, FFP is available only for services furnished after the screening or review has been performed, subject to the provisions of paragraph (a) of this section."
Individualized determinations	Individualized determinations of the need for NF services and the need for specialized services must meet the minimum evaluation criteria specified in regulations (see above). Regulations specify content of evaluation reports for individualized determinations. All positive determinations of the need for specialized services must be made through individualized evaluations.	1919(f)(8)(A)—Instructs the Secretary to develop minimum criteria for PASRR determinations (see above)	42 CFR 483.130(b)(2)—"Determinations may be… individualized determinations based on more extensive individualized evaluations as required in Sec. 483.132, Sec. 483.134, or Sec. 483.136 (or, in the. case of an individual having both MR and MI, Secs. 483.134 and 483.136)." 42 CFR 483.128(i)—"For individualized PASRR determinations, findings must be issued in the form of a written evaluative report which (1) Identifies the name and professional title of person(s) who performed the evaluation(s) and the date on which each portion of the evaluation was administered; (2) Provides a summary of the medical and social history, including the positive traits or developmental strengths and weaknesses or developmental needs of the evaluated individual; (3) If NF services are recommended, identifies the specific services which are required to meet the evaluated individual's needs, including services required in paragraph (i)(5) of this section; (4) If specialized services are not recommended, identifies any specific mental retardation or mental health services which are of a lesser intensity than specialized services that are required to meet the evaluated individual's needs; (5) If specialized services are recommended, identifies the specific mental retardation or mental health services required to meet the evaluated individual's needs; and (6) Includes the bases for the report's conclusions." 42 CFR 483.130(g)—"The State mental health and mental retardation authorities must not make

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Individualized determinations (continued)			categorical determinations that specialized services are needed. Such a determination must be based on a more extensive individualized evaluation under Sec. 483.134 or Sec. 483.136 to determine the exact nature of the specialized services that are needed."
Categorical determinations	SMHAs may establish categories to make advance group determinations that NF services are needed. Categories must be approved by CMS and included in the State plan. Time limits may be established for NF service need. Time limits are required for provisional and respite care admissions. Residents who will exceed time limits must have a resident review. SMHAs may also make categorical determinations on whether specialized treatment is not needed only in the provisional, emergency, and respite categories and when a person has both MR and dementia. When specialized services are needed, individualized evaluations are required. Categorical determinations of NF need do not eliminate the requirement for the SMHA to determine the individual's need for specialized services. Regulations specify content of evaluation reports for categorical determinations.	1919(f)(8)(A)—Instructs the Secretary to develop minimum criteria for PASRR determinations (see above).	42 CFR 483.130(b)(1)—"Determinations may be (1) Advance group determinations, in accordance with this section, by category that take into account that certain diagnoses, levels of severity of illness, or need for a particular service clearly indicate that admission to or residence in an NF is normally needed, or that the provision of specialized services is not normally needed." 42 CFR 483.130(c)—"Advance group determinations by category developed by the State mental health or mental retardation authorities may be made applicable to individuals by the NF or other evaluator following Level I review only if existing data on the individual appear to be current and accurate and are sufficient to allow the evaluator readily to determine that the individual fits into the category established by the State authorities (see Sec. 483.132(c)). Sources of existing data on the individual that could form the basis for applying a categorical determination by the State authorities would be hospital records, physician's evaluations, election of hospice status, records of community mental health centers or community mental retardation or developmental disability providers." 42 CFR 483.130(e)—"The State may specify time limits for categorical determinations that NF services are needed and in the case of paragraphs (d)(4), (5) and (6) of this section, must specify a time limit which is appropriate for provisional admissions pending further assessment for emergency

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Categorical determinations (continued)			situations and respite care. If an individual is later determined to need a longer stay than the State's limit allows, the individual must be subjected to an annual resident review before continuation of the stay may be permitted and payment made for days of NF care beyond the State's time limit." 42 CFR 483.128(j)—"For categorical PASRR determinations, findings must be issued in the form of an abbreviated written evaluative report which (1) Identifies the name and professional title of the person applying the categorical determination and the data on which the application was made; (2) Explains the categorical determination(s) that has (have) been made and, if only one of the two required determinations can be made categorically, describes the nature of any further screening which is required; (3) Identifies, to the extent possible, based on the available data, NF services, including any mental health or specialized psychiatric rehabilitative services, that may be needed; and (4) Includes the bases for the report's conclusions."
Placement options	Regulations specify 6 possible options for individuals with MI or MR, as determined under PASRR.	1919(e)(7)(C)	42 CFR 483.130(m)—The options for placement are as follows: "(1) Can be admitted to an NF. Any applicant for admission to an NF who has MI or MR and who requires the level of services provided by an NF, regardless of whether specialized services are also needed, may be admitted to an NF, if the placement is appropriate, as determined in Sec. 483.126. If specialized services are also needed, the State is responsible for providing or arranging for the provision of the specialized services. (2) Cannot be admitted to an NF. Any applicant for admission to an NF who has MI or MR and who

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Placement options (continued)			does not require the level of services provided by a NF, regardless of whether specialized services are also needed, is inappropriate for NF placement and must not be admitted. (3) Can be considered appropriate for continued placement in an NF. Any NF resident with MI or MR who requires the level of services provided by an NF, regardless of the length of his or her stay or the need for specialized services, can continue to reside in the NF, if the placement is appropriate, as determined in Sec. 483.126. (4) May choose to remain in the NF even though the placement would otherwise be inappropriate. Any NF resident with MI or MR who does not require the level of services provided by an NF but does require specialized services and who has continuously resided in an NF for at least 30 consecutive months before the date of determination may choose to continue to reside in the facility or to receive covered services in an alternative appropriate institutional or noninstitutional setting. Wherever the resident chooses to reside, the State must meet his or her specialized services needs. The notice must provide information concerning how, when, and by whom the various placement options available to the resident will be fully explained to the resident. (5) Cannot be considered appropriate for continued placement in an NF and must be discharged (short-term residents). Any NF resident with MI or MR who does not require the level of services provided by an NF but does require specialized services and who has resided

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Placement Options (continued)			in an NF for less than 30 consecutive months must be discharged in accordance with Sec. 483.12(a) to an appropriate setting where the State must provide specialized services. The determination notice must provide information on how, when, and by whom the resident will be advised of discharge arrangements and of his/her appeal rights under both PASRR and discharge provisions. (6) Cannot be considered appropriate for continued placement in an NF and must be discharged (short or long-term residents). Any NF resident with MI or MR who does not require the level of services provided by an NF and does not require specialized services regardless of his or her length of stay, must be discharged in accordance with Sec. 483.12(a). The determination notice must provide information on how, when, and by whom the resident will be advised of discharge arrangements and of his or her appeal rights under both PASRR and discharge provisions."
Adaptation to culture, language, ethnic origin	Evaluations and notices must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated.	1919(c)	42 CFR 128(b)
Participation by individual and family	Evaluations must involve the individual, his or her legal representatives, and the individual's family if family members are available and their participation is agreed to by the individual.	1919(c)	42 CFR 483.128(c)
Record retention	The State PASRR system must maintain records of evaluations and determinations, regardless of whether they are performed categorically or individually.	1919(e)(7)(C)(iv)	42 CFR 483.130(o)

Table 1. PASRR Program Requirements (continued)

Element	*Description*	*Title XIX*	*CFR*
Tracking system	The State PASRR system must establish and maintain a tracking system for all individuals with MI or MR in NFs to ensure that appeals and future reviews are performed.	1919(e)(7)(F)	42 CFR 483.130(p)
Appeals	Each State must provide a system of appeals for individuals adversely affected by any PASRR preadmission screening or resident review determination.	1919(e)(7)(F)	42 CFR 483.204
FFP for PASRR activities	States receive 75% FFP under administrative costs for PASRR activities. To prevent duplicative payment, FFP is not available for specialized services furnished to NF residents as NF services.	1903(a)(20)(C) — Provides 75% FFP for PASRR activities.	42 CFR 433.15(b)(9) — Provides 75% FFP for PASRR activities. 42 CFR 483.124 — "FFP is not available for specialized services furnished to NF residents as NF services."
Enforcement	CMS may deny FFP if the State Medicaid plan fails to meet federal requirements or the or the State does not comply in practice with Federal requirements.	1902(a), 1904	42 CFR 430.35

Notes: NF = nursing facility; MI = serious mental illness; MR = mental retardation; FFP = Federal financial participation, ICF = intermediate care facility; IMD = institution for mental disease; PASRR = preadmission screening and resident review; OBRA = Omnibus Budget Reconciliation Act; SMM = State Medicaid Manual; CMS = Centers for Medicare and Medicaid Services; SMHA = State Mental Health Authority; N/A = not applicable

Table 2. Criteria for Serious Mental Illness (SMI) (of 31 States Responding)[1]

State	*Federal Minimum Standard under PASRR Statute and Regulations*	*Broader Definitions than Federal Minimum Standard*
AL		
AK		◆
AR	◆	
AZ	◆	
CA	◆	
CO		◆
CT		◆
FL		◆
GA	◆	
HI	◆	
IL	◆	
IN		◆
KS	◆	
LA	◆	
MA		
MD	◆	
MI		◆
MN	◆	
MO		
MS	◆	
ND	◆	
NH	◆	
NM	◆	
OH	◆	
OK	◆	
RI		◆
TN		◆
TX	◆	
UT	◆	
VA	◆	
VT	◆	
WA	◆	
WI		◆
WY	◆	
TOTAL	22	9

[1] This table includes Mississippi, raising the total number of States to 34 although only 33 States responded. Presumably, Mississippi represents an error in transcription.

Data Source: Bazelon Center, 1996.

Table 3. Level I Screen: Responsibility for Conducting Review (of 31 States Responding)

State	*State Agency*	*Mix of State Agency/ Private Providers*	*Private Agency*	*Treating Physician*	*Nursing Facility*	*Nursing Facilities and Hospital*	*Individual Private Health Care Providers*
AL							◆
AK	◆						
AR							◆
AZ		◆					
CA		◆					
CO		◆					
CT		◆					
FL	◆						
GA			◆				
HI				◆			
IL		◆					
IN		◆					
KS			◆				
LA				◆			
MA			◆				
MD							
MI							◆
MN		◆					
MO		◆					
ND			◆				
NH		◆					
NM					◆		
OH		◆					
OK		◆					
RI							
TN							◆
TX		◆					
UT					◆		
VA		◆					
VT		◆					
WA							◆
WI						◆	
WY						◆	
TOTAL	2	14	4	2	2	2	5

Data Source: Bazelon Center, 1996.

Table 4. Criteria for Identifying Individuals Who Do Not Meet the PASRR Definition of Mental Illness Because of Dementia to Whom PASRR Does Not Apply (of 28 States Responding)

State	*DSM-IIIR Diagnostic Criteria*	*Internal Policy Documents*	*Unspecified Criteria*
AL			
AK			
AR			
AZ		◆	
CA			
CO			
CT			
FL			
GA			
HI			◆
IL			
IN			
KS	◆		
LA			◆
MA			◆
MD	◆		
MI			
MN			
MO			
ND			
NH		◆	
NM		◆	
OH			
OK			
RI			
TN			
TX		◆	
UT			
VA			
VT		◆	
WA			◆
WI	◆		
WY			
TOTAL	19[1]	5	4

[1] The Bazelon Center study reported a total of 19 States that use DSM-IIIR diagnostic criteria, but included the names of only 3 States.

Data Source: Bazelon Center, 1996.

Table 5. Criteria for Determining Need for Nursing Facility Care (of 26 States Responding)

State	*State's Own Nursing Facility Admission Criteria*	*Definition of Need in Federal Regulations*	*Criteria Equivalent to Federal Regulations*
AL	◆		
AK	◆		
AR	◆		
AZ	◆		
CA	◆		
CO	◆		
CT	◆		
FL		◆	
GA	◆		
HI			
IL		◆	
IN			
KS			
LA		◆	
MA			
MD		◆	
MI		◆	
MN			
MO			◆
ND	◆		
NH	◆		
NM	◆		
OH		◆	
OK			
RI	◆		
TN	◆		
TX	◆		
UT	◆		
VA	◆		
VT			◆
WA			
WI		◆	
WY	◆		
TOTAL	17	7	2

Data Source: Bazelon Center, 1996.

Table 6. States' Criteria for Determining the Need for Specialized Services (of 33 States Responding)

State	*24-Hour Inpatient Psychiatric Care*[1]	*Broad Spectrum of Rehabilitative Services Aimed at Developing Skills Necessary to Live in the Community*
AL	◆	
AK	◆	
AR	◆	
AZ	◆	
CA	◆	
CO		◆
CT	◆	
FL	◆	
GA	◆	
HI	◆	
IL	◆	
IN	◆	
KS	◆	
LA	◆	
MA	◆	
MD	◆	
MI		◆
MN		◆
MO	◆	
ND	◆	
NH	◆	
NM	◆	
OH	◆	
OK	◆	
RI	◆	
TN	◆	
TX	◆	
UT	◆	
VA	◆	
VT	◆	
WA	◆	
WI	◆	
WY	◆	
TOTAL	30	3

[1] The Bazelon Center report includes the names of only 3 States that define the need for specialized services as extending beyond 24-hour inpatient care. The remaining 30 States that responded use 24-hour inpatient care as their criteria. The 30 States checked presumably represent these remaining 30 States; we assume that the Bazelon Center did not receive a response from Mississippi.

Data Source: Bazelon Center, 1996.

Table 7. Level II Screen: Responsibility for Conducting Review (of 33 States Responding)[1]

State	*Private Entity*	*Independent State Agency*	*Independent Psychiatric Contractor*	*Community Mental Health Agencies or Organizations*	*Mix of Health Professionals and Agency Staff*
AL	◆				
AK		◆			
AR	◆				
AZ		◆			
CA	◆				
CO				◆	
CT					◆
FL	◆				
GA	◆				
HI	◆				
IL				◆	
IN				◆	
KS	◆				
LA	◆				
MA	◆				
MD	◆				
MI	◆			◆	
MN[2]					
MO					
ND	◆				
NH		◆			
NM		◆	◆		
OH				◆	
OK	◆				
RI					◆
TN	◆				
TX		◆			
UT	◆				
VA				◆	
VT	◆				
WA				◆	
WI	◆				
WY				◆	
TOTAL	17	5	1	8	2

[1] The Bazelon Center study indicates that 33 States responded to the survey. This table shows responses from only 32 States (31 in the table and one in the footnote). The study does not list a response for Missouri.

[2] Minnesota uses a combination of mental health professionals, including community mental health and independent mental health providers and promotes client involvement in the choice of assessor whenever possible.

Data Source: Bazelon Center, 1996.

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