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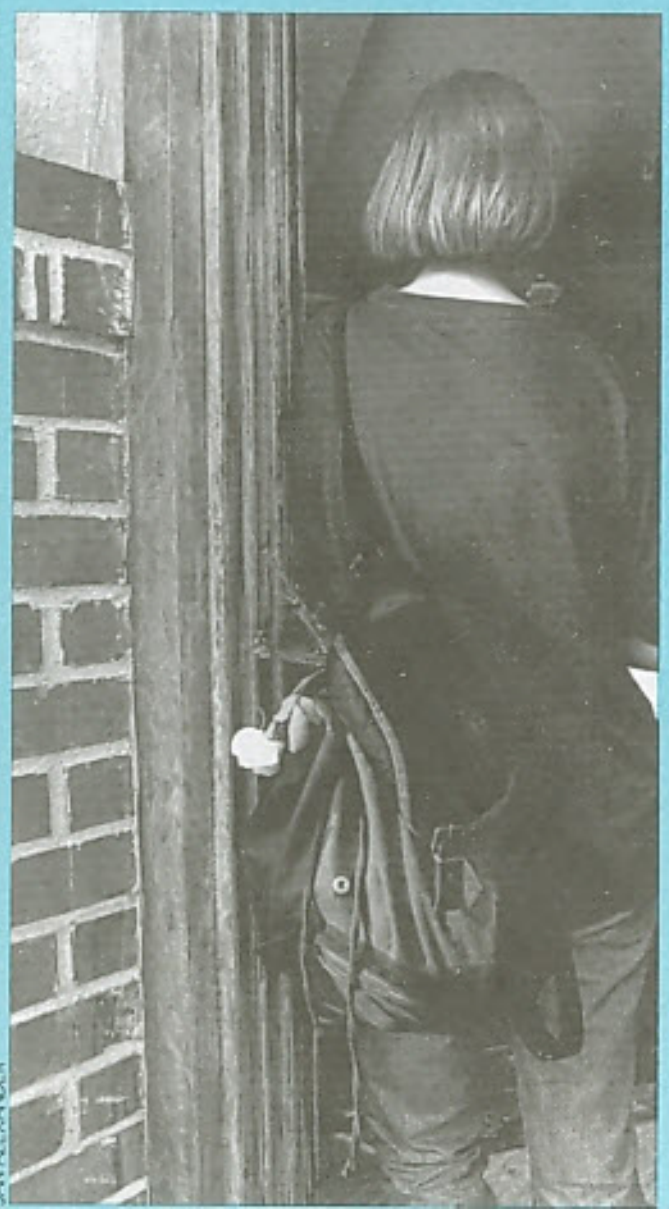

JAN ALEXANDER

Protecting Battered Women And Their Children

What Preadmission Screening and Annual Resident Review Means for Older People with Mental Illness

By Beth Pepper and Deborah P. Rubenstein

Beth Pepper, formerly the director of the Elders Project at the Bazelon Center for Mental Health Law, 1101 Fifteenth St. N.W., Suite 1212, Washington, DC 20005, is now a visiting assistant professor of law at the University of Maryland School of Law, 500 W. Baltimore St., Baltimore, MD 21201, (410) 706-3297. Deborah P. Rubenstein, formerly a consulting attorney for the Elders Project at the Bazelon Center, is now a social worker and an attorney in the District of Columbia. She may be reached through the Bazelon Center at (202) 467-5730. The authors acknowledge the contribution of Mead Summer, a law student, in assisting in the state-by-state survey.

I. Introduction

In 1987, Congress mandated a screening system for nursing home residents. /1/ The system, known as Preadmission Screening and Annual Resident Review (PASARR), has two goals: to prevent states from placing people with mental disabilities in nursing homes and to prod states into creating community-based services for these individuals. /2/

Congress is correct in articulating a national policy for getting people with disabilities out of nursing homes and into community-based settings with adequate supports and services. A screening system is an appropriate device for achieving this end. However, the screening system currently in place has many flaws. It must, therefore, be refined to meet more closely Congress' original objectives.

This article first describes the congressional policy and historical and social factors that led to the law's passage. Next, it lays out the statutory framework for implementing PASARR and then examines the gap between the letter and spirit of the law and its implementation by the states. Finally, it offers recommendations for legislative and regulatory changes.

The conclusions here are based substantially on a six-state survey of state mental health administrators and local advocates. /3/ The states surveyed are Florida, Indiana, Maryland, Michigan, New York, and Texas. They were selected on the basis of geographical diversity and population density. /4/

II. From Nursing Homes to Community-Based Settings

PASARR reflects Congress' vision of a system to identify people with mental disabilities in nursing homes who do not need to be there, and to compel states to meet their needs in supportive community-based settings. Congress was no longer "willing to tolerate continued inappropriate placement of mentally ill . . . individuals" in nursing homes. /5/

Congress' concern is justified by the very large numbers of nursing home residents with mental illness /6/ and is well supported by social science research showing that nursing homes are not appropriate settings for such persons. Life in nursing homes has many of the same harmful features as life in psychiatric hospitals. The institutional atmosphere of a nursing home can engender a downward spiral of dependence and learned helplessness. /7/ Despite new federal regulations aimed at improving nursing home care, /8/ staff use many of the same techniques employed by psychiatric hospitals, such as neuroleptic medication and physical restraints. /9/ Moreover, nursing home staff often lack training on working with individuals with mental illness. /10/

The belief that nursing homes are neither normal nor ideal settings for individuals with mental illness is a shift from the notion that nursing homes are the "institutions of choice" for people of all ages--a concept articulated during the deinstitutionalization of mental hospitals in the 1970s. Many elderly people with mental disabilities found themselves in nursing homes after years in the back wards of state psychiatric hospitals. /11/ At that time, their placement in nursing homes was viewed as "community placement" where they could be safe and supervised.

While research finds nursing home placement to have harmful effects, true community-based placement is often an appropriate alternative for older people with mental illness, whether chronic or late-onset, given adequate housing and supportive services. /12/ Yet most states have failed to integrate elders with mental illness into existing community-based systems and have done little to tailor services to the special needs of this population. /13/

Elders with mental illness suffer a "double jeopardy" of prejudice. In addition to being stigmatized by the widespread belief that individuals with mental illness should live apart from the community for their own protection, they are victims of ageist assumptions that older people cannot benefit from rehabilitation or live independently. In fact, many elderly people are capable of living independently with the aid of supportive services. /14/ Like people without disabilities, they may at times make a mistake or exhibit impaired judgement. And, like people without disabilities, they are entitled to take risks and make errors.

Elderly citizens with mental disabilities are further disenfranchised by the tendency of nursing homes to focus on custodial care rather than rehabilitation. As a result, residents are unlikely to rejoin their community. They are thus removed from the voting process, without an advocate to press their cause. Through PASARR, Congress sought to enfranchise them.

III. Overview of the PASARR Statute

PASARR requires states to screen all individuals with mental illness or mental retardation to determine whether they need nursing home care. The state must conduct both preadmission screens for applicants /15/ and annual resident reviews for individuals already living in nursing homes. /16/ This screening is a condition of participation in the federal-state Medicaid program and applies to all Medicaid-certified nursing facilities.

Congress mandated a two-tier screening process. First, the state must determine whether the person has a serious mental illness. This is called a Level I screen. The state must refer those so identified to a Level II screen to determine their need for nursing home care and specialized services. /17/

The state may conduct Level I screens itself through its mental health authority or may delegate the task to another entity, such as a hospital, nursing home, or central referral agency. /18/ The state may also delegate Level II screens, but the determination of need for nursing home care and for specialized services must be based on an evaluation conducted by a person or entity independent of the state mental health authority. /19/

PASARR determinations have important consequences. For example, if the state determines that an applicant does not need nursing home services, the applicant may not be admitted to a Medicaid-certified nursing home. Under the PASARR statute, the state has no further obligation to that individual. /20/

Need is defined in terms of health-related services above the level of room and board that can be provided only in an institutional setting. /21/ Applicants found to need nursing home services may be admitted. If they also need specialized services, the state must provide these services as well. /22/

Similarly, current residents found to need nursing home services may continue to reside in the nursing home; the state is also required to provide specialized services to these individuals. /23/

A resident who does not need nursing home services and who has lived in the nursing home for less than 30 months must be discharged. /24/ In consultation with the resident's family or legal representative and care givers, the state must prepare and orient the individual for discharge, arrange for a safe and orderly discharge, and, where needed, provide or arrange for specialized services. /25/

Individuals residing in a nursing home for at least 30 months who need specialized services but not nursing home services have the right to choose whether they will leave the facility or remain. The state must offer such a resident this choice, provide or arrange for specialized services wherever the resident chooses to be, inform the resident of the institutional and noninstitutional alternatives covered under the state Medicaid plan, and clarify the effect of the resident's decision on eligibility for Medicaid services, including the effect on readmission to the nursing home. /26/ Given this statutory framework, we now turn to its implementation.

IV. Implementation of PASARR: Failure to Fulfill Congress' Vision

Congress' original vision, as expressed in 1987, has been clouded by subsequent developments. In 1990, Congress passed certain statutory amendments, /27/ which, along with final regulations issued in 1992 by HCFA, the regulatory agency charged with enforcing the PASARR, /28/ have weakened Congress' original mandate that states provide community-based care. In this section, we describe these developments and identify the areas in which Congress, HCFA, and the states can, and should, begin to make changes to realize Congress' original vision.

A. Limitation on the Class of People Protected by Changes in the Definition of "Mental Illness"

In 1987, all individuals with mental illness were subject to the PASARR screen. Anyone with a mental illness, regardless of its nature or severity, was screened, /29/ and residents determined not to need nursing home care were then eligible for discharge to the community.

In the Omnibus Budget Reconciliation Act of 1990 (OBRA-90), /30/ Congress narrowed the class of people protected by PASARR. Under the 1990 amendment, PASARR applies only to those with a "serious mental illness." Moreover, Congress left the responsibility for actually defining "serious mental illness" to the Secretary of HHS, in consultation with the National Institute of Mental Health (NIMH). /31/ Congress also instructed the Secretary to refer to the definition of "serious mental illness" used by the Community Support Program (CSP) of NIMH. This program serves only individuals with chronic mental illness. Thus, Congress implied that only such individuals should be protected by PASARR. /32/

This change was misguided and, for several reasons, inconsistent with the original vision of PASARR. First, if Congress was indeed directing the Secretary to limit coverage to those with chronic mental illness, the change excludes from coverage many people who develop a mental illness late in life. Chronic mental illnesses usually develop in early or midadulthood, but many elders experience severe depression or another mental illness late in life for the first time. They are as much at risk of inappropriate nursing home placement as those with chronic mental illness and therefore have as much need for the protection of PASARR.

By using the term "serious mental illness," Congress excluded people whose mental illness is considered "minor," or not severe. While such exclusion may save states the cost of the PASARR screen, it also substantially increases the pool of elders at risk of inappropriate nursing home placement. For example, an elderly person with depression may experience impaired functioning. Yet, with relatively routine support services, this same individual may be able to function very successfully in the community. Unfortunately, many evaluators consider depression to be only a minor mental illness. As a result, an individual with depression would not be subject to the PASARR screen, and would be admitted to, or remain in, the nursing home, even though nursing care is not needed. The very situation Congress originally intended to prevent has been made possible by this amendment.

In its 1992 regulations, HCFA narrowed the definition even beyond the statutory amendment. /33/ Under the regulations, an individual must satisfy three criteria to be deemed as having a "serious mental illness." First, the person must have a major disorder. /34/ Second, the disorder must result in functional limitations in major life activities in the past three to six months. /35/ Third, the individual must have experienced partial or inpatient hospitalization at least once in the past two years. Or, in the past two years, there must have been a significant disruption to the person's normal living situation due to the mental disorder, which either required supportive services or residential treatment or resulted in intervention by housing or law enforcement officials. /36/

Of particular concern for advocates is the third component of the definition. Many people, including some who are homeless, may never be in contact with, or come to the attention of, mental health, social services, or law enforcement authorities. Others with a serious mental illness who function on their own or with the help of family and friends may never seek, or need, outside intervention. Yet these individuals, because they have functioned successfully in the past, have the greatest potential for living successfully in the community. Under the third component of the HCFA definition, however, they are exempt from any consideration of their ability to function in a less restrictive setting. Thus, excluded from PASARR is one of the groups most likely to benefit from it.

For precisely these reasons, some states, such as Michigan, have chosen not to apply the third component of the HCFA definition. /37/ Other states, such as Florida and Texas, have rejected other aspects of HCFA's narrow definition. /38/ Texas, for instance, has opted to require that a resident meet any two of the three criteria in order to qualify as having a serious mental illness. /39/

The effect of the amendment and regulations on the number of people to be screened is significant. For example, Texas officials estimate that the number of individuals eligible for a Level II screen will drop from 19,200 in 1992, to 4,800 in 1993. /40/

Advocates should urge both Congress and HCFA to reverse the harmful effects of the amendments and the regulations. Congress should reinstate the original definition of mental illness. And, HCFA should delete the third component of the definition. Finally, other states should follow the examples of Florida, Michigan, and Texas and apply a broad definition of mental illness. /41/

B. Further Harm Caused by Exempting Individuals with Dementia

In the original legislation, Congress exempted from PASARR coverage people with Alzheimer's disease and other forms of dementia. /42/ As a result of the exclusion, people with dementia do not pass through the PASARR screen and, therefore, are never assessed for community-based services or specialized services. Indeed, our survey shows that the exclusion prevents people with dementia from receiving critically needed services. For example, in Michigan, funds have been allocated to the community mental health centers to provide specialized services. But because individuals with dementia do not have a "serious mental illness" in terms of PASARR, they are not entitled to these services. /43/

Our survey also found that many people who do not have dementia but may otherwise have a serious mental illness are being labeled with dementia to avoid the PASARR screen. In Florida, for example, people with depression are often given a primary diagnosis of dementia to facilitate nursing home placement. /44/ The results of this misdiagnosis are particularly tragic because, with proper treatment for their depression, many of these individuals could live independently in the community.

HCFA, while acknowledging the potential for such abuse, has nonetheless opened the door even further to its occurrence. The final regulations allow physicians to give an individual a diagnosis of dementia without first conducting a neurological or neuropsychiatric examination. /45/ HCFA

appears to be responding to comments about the costs associated with such tests and the extended hospital stays that may be necessary in parts of the country where the technology is scarce. /46/ In light of the serious consequences of misdiagnosis of dementia, whether deliberate or inadvertent, HCFA's position places elders with mental illness at significant risk of inappropriate nursing home placement.

Congress should eliminate the dementia exclusion. It serves only to prevent people with this disability from receiving needed services and consideration for appropriate placements in the community. Until such time, however, HCFA should require that a dementia diagnosis be supported by test results, and it should periodically review the accuracy of dementia assessments.

C. HCFA's Abdication of Its Responsibility

As described above, once a person is referred to a Level II screen, the state mental health authority must determine whether the person requires nursing home services. /47/ This determination is critical, for if a resident does not need nursing home services, under most circumstances, the resident may not continue to reside in a nursing home and the state's mandate to provide appropriate community-based alternatives is triggered. Therefore, it is important for HCFA to articulate a clear standard for nursing home admission.

HCFA, unfortunately, has abdicated its responsibility in this instance. Instead of issuing clear guidance, HCFA stated that

-- Placement of an individual with [mental illness] in a [nursing facility] may be considered appropriate only when the individual's needs are such that he or she meets the minimum standards for admission. . . . /48/

In failing to set a meaningful guideline, HCFA has left this important issue to the discretion of state authorities.

To be consistent with the intent of PASARR, admission to a nursing home should be allowed in situations in which the individual has complex medical needs that can be met only in an institutionalized setting. Many elderly people find themselves in nursing homes simply because they can no longer eat or toilet independently, or because they wander from home and get lost. These impairments can be addressed through supervision and assistance with activities of daily living. Also, many medical needs can be addressed in a person's home or in a group home with the assistance of home health aides. /49/

A high threshold for admission to a nursing facility is supported by both the letter and spirit of the federal law. According to Congress, a nursing facility is

-- an institution . . . which is primarily engaged in providing to residents skilled nursing care . . . rehabilitation services . . . or on a regular basis health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities. /50/

By this language, Congress meant to make nursing homes places of last resort for individuals with mental disabilities. In particular, Congress intended nursing home placement to be selected only after less restrictive settings had been explored. Moreover, this phrase implies that if a person's needs can be met in the community--even though the services may not yet exist there--the person is no less inappropriate for nursing home placement, and the state must then develop the services in the community to meet the person's needs. HCFA should assume its responsibility and promulgate a standard consistent with these congressional objectives. /51/

D. States' Failure to Provide Community-Based Alternatives for Individuals Who Do Not Need Nursing Home Care

Our survey shows that few states are creating or expanding their community-based systems to serve people identified by the PASARR process as not being in need of nursing home care. There are two principal reasons for this failure. One is the states' reliance on their alternative disposition plans. Another is the lack of any clear mandate from HCFA directing states to create and expand community-based programs.

1. States' Reliance on Alternative Disposition Plans

Under the original 1987 legislation, Congress gave states until April 1, 1990, to make appropriate arrangements for residents who had to leave nursing homes. However, this deadline is extended to April 1, 1994, if a state enters with HCFA into an agreement, called an alternative disposition plan (ADP), specifying how the state will fulfill its obligations relating to the delivery of community-based services. /52/

Only one group of consumers is covered by the ADP: residents who are to be discharged because they are determined not to need nursing home services, but do need specialized services, regardless of how long they have been in the facility. /53/ Not covered in an ADP are residents who need neither nursing facility services nor specialized services, regardless of their length of stay. For this latter group, no extension of the April 1, 1990, deadline was granted.

HCFA required that the ADP include an estimate of the number of individuals inappropriately residing in nursing homes, a detailed description of the alternative placements, and the methods for furnishing and funding specialized services. The ADP had to be designed in consultation with advocates and local agencies. /54/

Some states viewed the ADP solely as a way to delay or circumvent their obligations to provide community-based alternatives for those covered by their plan. For example, a Rhode Island official stated that his state's ADP for individuals with mental illness was a "fiction" and an "insurance policy" against HCFA enforcement and lawsuits. /55/

Even if an ADP appears adequate as written, it is only as good as its implementation. In Indiana, for instance, no evidence exists that new money is being funneled into the creation of alternative

residential programs described in the state's ADP. Programs there remain small, and long waiting lists exist for alternative placements. /56/ In Texas, despite an apparently adequate ADP, actual outplacements have been greatly delayed by budget limitations. /57/

The April 1, 1994, deadline for fulfilling the terms of the ADP is quickly approaching. Advocates should be reviewing state plans and investigating the status of their states' compliance. If the plan is strong but implementation is slow, this is the time to prepare a lawsuit to enforce the ADP. /58/ Another strategy is to request that the regional HCFA office review ADP compliance and take appropriate enforcement action against a noncomplying state. For example, states could lose their Medicaid money if they are in breach of their ADP.

2. HCFA's Failure to Issue Rules Ensuring the Delivery of Community Care

The regulations do not go far enough in requiring states to meet their statutory obligations related to provision of community-based care.

As stated above, residents needing neither nursing home services nor specialized services are not covered by a state's ADP. Yet, Congress did not leave these individuals without any protection upon discharge from the nursing home. Indeed, as to these individuals, Congress stated that "the state must arrange for the[ir] safe and orderly discharge . . . and prepare and orient the resident[s] for discharge." /59/ Congress thus imposed an obligation on states to ensure that people leaving nursing homes are safely in noninstitutional settings with the supports that they need.

Despite this opportunity to put flesh onto these bare-bones obligations, HCFA has stated nothing. /60/ What should HCFA have said, and what can it say now?

HCFA should explain that the statutory phrase "prepare and orient" obligates a state to conduct adequate discharge planning. "Prepare" requires states to consult with individuals to learn about their preferences for housing, supports, or other rehabilitative services. These preferences should be reflected in the discharge plan. "Orient" obligates a state to help individuals make the necessary adjustments as they prepare themselves for their new home.

HCFA should also explain that the statutory phrase "safe and orderly discharge" obligates states to carry out the discharge plan, ensuring the resident's safety and security in the new setting with all necessary supports and services. In sum, the statutory phrase "prepare and orient . . . and ensure a safe and orderly discharge" is a mandate that states be involved in a continuing relationship with people leaving nursing homes. That relationship must include the monitoring and review of discharge planning and appropriate follow-up in the community.

HCFA's silence has led many states to abdicate their responsibilities to people leaving nursing homes. In Texas, for example, there have been cases in which alternative placement is not explained and cases in which the state has made no effort to check on the individual's status in the new setting. /61/

The obligations to "prepare and orient" and to ensure "safe and orderly discharge" also extend to those people covered by a state's ADP. /62/ HCFA, again, should make clear that the ADP does not relieve a state of these same obligations to people covered under it.

E. The Effect of HCFA's Definition of Specialized Services

Every state is obligated to provide specialized services to people with mental illness who do not need nursing home care. /63/ This requirement is a critical component of PASARR because it is meant to ensure that people with no need for nursing home care receive the rehabilitative services that they need to help them live in the community. /64/

Unfortunately, HCFA has defined specialized services so narrowly as to defeat the goal of community integration. Under HCFA's guidance, specialized services are concentrated on intensive mental health therapies to treat acute episodes of serious mental illness. /65/ This definition is no different from the standard for commitment since, in recent years, mental hospitals are used predominantly to treat acute episodes of mental illness.

Indeed, our survey shows that many states are equating the standard for specialized services with the standard for commitment. For example, in Texas, an individual must be a danger to himself or to others to qualify for specialized services. /66/

As a result of this narrow definition, a new phenomenon has emerged--"retransinstitutionalization." Many elderly people are its victims. These are older residents who had spent years or decades in psychiatric hospitals, only then to be transferred to nursing homes--transinstitutionalized. Now they are returning to the mental hospital ward. The narrow definition of specialized services both encourages and condones this practice. /67/

Consistent with Congress' intent, specialized services should be defined broadly. Rather than a narrow set of treatment therapies, they should consist of a broad array or package of rehabilitative services aimed at developing the skills necessary to live in the community. Michigan, for example, has interpreted specialized services as a broad spectrum of services, including community mental health services, assistance with activities of daily living, and vocational skills designed to help an individual reside independently in the community. /68/ Consequently, in many areas of Michigan, residents have been identified for community programs and are gradually being placed in them. /69/

F. HCFA's Creation of Loopholes in the Appeal Rights Process

Congress required states to set up an appeal procedure for individuals "adversely" affected by PASARR determinations. /70/ However, HCFA has defined "adverse" as a determination that "the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services." /71/ Thus, as the definition now reads, a determination that an individual does need nursing home care is not an issue that can be raised on appeal.

The definition of "adverse" has important implications. In Michigan, determination notices are given only to people whose outcomes are considered to be adverse. /72/ Hence, if the resulting determination is that the resident of a Michigan nursing home does need nursing facility care, the resident may never be informed of that determination. In Texas, litigation pending questions the procedure by which individuals are told of their determinations; cases have been reported in which nursing homes initiate appeals without consulting the individuals involved. /73/

How should "adverse determination" be defined? "Adverse" ought to encompass any decision the individual does not like. The decision that someone belongs in a nursing home may not seem adverse to HCFA or to the state mental health agency, but if the individual does not wish to be there, then it is adverse to that individual. Should not the interpretation of adverse rest with the individual?

Congress embraced the notion that persons should be free to interpret for themselves what is adverse. The House report accompanying the 1987 legislation states:

-- Individuals could be adversely affected not only by a determination that [they do] not need nursing facility services, but also by determinations that [they do] not need active treatment. /74/

This passage sets forth a bare minimum of what is appealable, but is not meant to be an exclusive list of appealable issues. Moreover, the spirit of the law--to find a setting that is both appropriate and satisfactory to meet the individual's needs--supports a comprehensive view of "adverse determination."

HCFA, therefore, should revise its definition of adverse determination to allow for appeals of determinations that nursing home care is appropriate.

V. Conclusion

PASARR as a system, given proper refinement, holds great promise. It is through PASARR that the gates to the community will swing, allowing people with mental disabilities to re-enter.

If Congress is to see its intent become operating law, it must provide a clear and unmistakable mandate for HCFA and the states. PASARR was to be this mandate. However, technical amendments and flaws in the initial legislation have led to weak implementation. These weaknesses must be addressed, whether in Congress, HCFA, or the courts, if PASARR is to accomplish all that Congress intended.

footnotes

/1/ Omnibus Budget Reconciliation Act of 1987 (OBRA-87), 42 U.S.C. Sec. 1396r(e)(7).

/2/ This system applies to nursing home residents and applicants, whether young or old, who have a mental illness, mental retardation, or a related condition. 42 U.S.C. Secs. 1396r(e)(7)(A), (7)(G). This article addresses only PASARR's effect on elders with mental illnesses.

/3/ This survey was conducted in the summer of 1993 by the Elders Project of the Bazelon Center for Mental Health Law and was made possible by a grant from the Administration on Aging.

/4/ We sent state officials and advocates a two-page questionnaire and then interviewed them by telephone about PASARR implementation in their states.

/5/ H.R. Rep. No. 391, 100th Cong., 1st Sess. 462 (1987).

/6/ The 1987 National Medical Expenditure Survey found that more than 68 percent of the nation's nursing home residents show one or more psychiatric symptoms. Most Nursing Home Residents Have Mental Disorders, 42 HOSP. & COMMUNITY PSYCHIATRY 330 (Mar. 1991) (citing PUB. HEALTH SERV., AGENCY FOR HEALTH CARE POLICY & RESEARCH, MENTAL HEALTH AND FUNCTIONAL STATUS OF RESIDENTS OF NURSING AND PERSONAL CARE HOMES, RESEARCH FINDINGS 7 (1990)).

/7/ Jonathan D. Lieff & Richard A. Brown, A Psychogeriatric Nursing Home Resocialization Program, 32 HOSP. & COMMUNITY PSYCHIATRY 862 (Dec. 1981).

/8/ 55 Fed. Reg. 48826 (1991) (to be codified at 42 C.F.R. part 483) (Medicare and Medicaid; Requirements for Long-Term Care Facilities and Nurse Aide Training and Competency Evaluation Programs).

/9/ Barry W. Rovner et al., The Prevalence and Management of Dementia and Other Psychiatric Disorders in Nursing Homes, 2 INTERNATIONAL PSYCHOGERIATRICS 13 (Spring 1990).

/10/ Marianne Smith et al., Psychiatric Nursing Consultation: A Different Choice for Nursing Homes, 28 J. PSYCHOSOCIAL NURSING 23 (Mar. 1990).

/11/ An estimated 40 to 60 percent of the people over 65 who were discharged, between 1963 and 1980, from state psychiatric hospitals in the U.S. were placed in nursing homes. Benjamin Liptzin, Major Medical Disorders/Problems in Nursing Homes: Implications for Research and Public Policy, in MENTAL ILLNESS IN NURSING HOMES: AGENDA FOR RESEARCH (Harper & Lebowitz eds., 1986) (article also issued by Nat'l Inst. of Mental Health, HHS Pub. No. ADM 86-1459).

/12/ Michael A. Bernstein & D. Rose, Psychosocial Programming for the Elderly Who Are Mentally Ill, 14 PSYCHOSOCIAL REHABILITATION J. 4 (Jan. 1991); Pearl Mosher-Ashley & M. Guild, When Older People with Chronic Mental Illness Move: From a State Institution to a Shared Apartment, AGING, 1991, at 22.

/13/ Suzanne Meeks et al., Mental Health Needs of the Chronically Mentally Ill Elderly, 5 PSYCHOL. & AGING. 163 (June 1990).

/14/ See Bernstein & Rose, supra, note 12.

/15/ 42 U.S.C. Sec. 1396r(e)(7)(A). Since January 1, 1989, nursing homes participating in Medicaid have been prohibited from admitting any individual with mental illness or mental retardation unless the individual is determined by the state to require the level of services provided by the nursing facility. 42 U.S.C. Sec. 1396r(b)(3)(F).

/16/ The first round of these annual reviews was to be completed by April 1, 1990. 42 U.S.C. Sec. 1396r(e)(7)(B).

/17/ 55 Fed. Reg. 56510 (1992) (to be codified at 42 C.F.R. Sec. 483.128(a)).

/18/ 55 Fed. Reg. 56508 (1992) (to be codified at 42 C.F.R. Sec. 483.106(e).

/19/ 57 Fed. Reg. 56508 (1992) (to be codified at 42 C.F.R. Sec. 483.106(e)(3)). The state may not delegate its PASARR evaluation or determination authority to a nursing facility or an entity directly or indirectly affiliated with a nursing facility. 57 Fed. Reg. 56508 (1992) (to be codified at 42 C.F.R. Sec. 483.106(e)).

/20/ State statutes may, however, mandate that the state provide community-based services to individuals with mental illness. E.g., Kostinos v. Boufford, 80 N.Y.2d 684, 610 N.E.2d 348 (N.Y. 1993) (mentally ill homeless have a right under state law to community services). In addition, at least two federal appellate courts have held that the Fourteenth Amendment to the U.S. Constitution provides a right to community services if the state's treating professionals recommend such services. Clark v. Cohen, 794 F.2d 79 (3d Cir. 1986) (Clearinghouse No. 41,122), cert. denied, 449 U.S. 839 (1986); Thomas v. Flaherty, 902 F.2d 250 (4th Cir. 1990).

/21/ See the definition of "nursing facility" at 42 U.S.C. Sec. 1396r(a).

/22/ 57 Fed. Reg. 56509, 56512 (1992) (to be codified at 42 C.F.R. Secs. 483.116(a), .116(b), .130(m)(1)).

/23/ 42 U.S.C. Secs. 1396r(b)(3)(F), r(e)(7)(C)(i)(IV), r(e)(7)(C)(ii)(III); 57 Fed. Reg. 56509, 56512 (1992) (to be codified at 42 C.F.R. Secs. 483.116(b)(2), .130(m)(3), .130(n)).

/24/ The 30-month period is measured from the date the determination is made. 42 U.S.C. Sec. 1396r(e)(7)(C)(ii)(I), r(e)(7)(C)(iii); 57 Fed. Reg. 56509, 56512 (1992) (to be codified at 42 C.F.R. Sec. 483.118(c)(2), .130(m)(5)).

/25/ 42 U.S.C. Sec. 1396r(e)(7)(C)(ii), (C)(iii); 57 Fed. Reg. 56509 (1992) (to be codified at 42 C.F.R. Sec. 483.118(b), .118(c)(2)).

/26/ 42 U.S.C. Sec. 1396r(e)(7)(C)(i); 57 Fed. Reg. 56509 (1992) (to be codified at 42 C.F.R. Sec. 483.118(c)(1)).

/27/ Omnibus Budget Reconciliation Act of 1990 (OBRA-90), Pub. L. No. 101-508, 104 Stat. 1388.

/28/ 57 Fed. Reg. 56450 (1993) (to be codified at 42 C.F.R. pts. 405, 431, 433, 483) (Medicare and Medicaid Programs; Preadmission Screening and Annual Resident Review).

/29/ The original definition covered all individuals with mental illness by including any mental disorder listed in the AM. PSYCHIATRIC ASSOC., DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed.). 42 U.S.C. Sec. 1396r(e)(7)(G)(i) (Supp. 1990).

/30/ OBRA-90, Pub. L. No. 101-508, 104 Stat. 1388.

/31/ Id. Sec. 4801(b)(7)(A), 42 U.S.C. Sec. 1396r(e)(7)(G)(i)).

/32/ 57 Fed. Reg. 56456 (1992) (Preamble, citing REP. OF THE HOUSE COMM. ON THE BUDGET TO ACCOMPANY H.R. 5835, H.R. REP. No. 881, 101st Cong., 2d Sess. 116 (1990)).

/33/ 57 Fed. Reg. 56456 (1992) (Preamble). HCFA's definition, included in the regulations as a final rule with a request for comments, is based on the narrow CSP definition. Although HCFA states that it will accept comments on the definition, it does not explain its plans, if any, to issue a revised definition in response to those comments.

/34/ The disorder must be diagnosable under the DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed.), see supra note 29, and it must be a mental disorder that may lead to a chronic disability. 57 Fed. Reg. 56507 (1992) (to be codified at 42 C.F.R. Sec. 483.102(b)(i)).

/35/ 57 Fed. Reg. 56507 (1992) (to be codified at 42 C.F.R. Sec. 483.102(b)(ii)).

/36/ 57 Fed. Reg. 56507 (1992) (to be codified at 42 C.F.R. Sec. 483.102(b)(iii)).

/37/ Conversation with David Verseput, Office of Specialized Nursing Homes/OBRA Program, Michigan Department of Mental Health (June 1993).

/38/ Conversation with James Noble, Senior Human Services Program Specialist, Florida Department of Mental Health (June 1993); conversation with Leslie Pearson, Program Administrator, PASARR Determination Office, Texas Department of Mental Health/Mental Retardation (June 1993).

/39/ Conversation with Pearson, supra note 38.

/40/ Id.

/41/ PASARR imposes a set of minimum standards on the states but does not preclude them from screening or providing specialized services to more individuals than required by law.

/42/ 42 U.S.C. Sec. 1396r(e)(7)(G)(i) (Supp. 1990). The legislative history is silent on the rationale. Congress may have been persuaded by the Alzheimer's lobby who perceived PASARR as a barrier to nursing home placement rather than an opportunity to encourage the creation of community-based services for people with dementia.

/43/ Conversation with Hollis Turnham, Long-Term Care Ombudsman, Citizens for Better Care, Detroit, Michigan (June 1993). Although the nursing home is required to provide mental health services below the level of specialized services to all residents, neither the state nor the nursing home is required to provide more intensive specialized services to individuals whose primary diagnosis is dementia. 42 U.S.C. Sec. 1396r(b)(4)(A)(vii).

/44/ Conversation with Noble, supra note 38.

/45/ See 57 Fed. Reg. 56507 (1992) (to be codified at 42 C.F.R. Sec. 483.102(b)(1)(B)). The proposed regulations solicited comments on whether primary diagnosis of dementia should be supported by "positive evidence from a thorough mental status exam focusing on cognitive functioning and performed in the context of a complete neurological or neuropsychiatric exam." 55 Fed. Reg. 10963 (1990) (Preamble).

/46/ 57 Fed. Reg. 56457 (1992) (Preamble).

/47/ 57 Fed. Reg. 56510 (1992) (to be codified at 42 C.F.R. Sec. 483.128(a)).

/48/ 57 Fed. Reg. 56510 (1992) (to be codified at 42 C.F.R. Sec. 483.126).

/49/ See, e.g., Potomac Group Home Inc. v. Montgomery County, 823 F. Supp. 1285 (D. Md. 1993) (Clearinghouse No. 49,082) (holding that two elderly women with dementia were entitled to remain in their group home where they received assistance with all activities of daily living and were visited by their physicians).

/50/ 42 U.S.C. Sec. 1396r(a).

/51/ HCFA has implicitly acknowledged what the standard for nursing home placement ought to be. HCFA requires that, in determining the need for nursing home care, the evaluator must assess whether "the individual's total needs are such that his or her needs can be met in an appropriate community setting." 57 Fed. Reg. 56512 (1992) (to be codified at 42 C.F.R. Sec. 483.132(a)(1)).

/52/ 42 U.S.C. Secs. 1396r(e)(7)(B)(i), (7)(C), (7)(E).

/53/ 42 U.S.C. Sec. 1396r(e)(7)(E). The preamble states that a person who requires specialized services but not nursing facility services may not be discharged unless the state makes an "appropriate" alternative noninstitutional placement available. It also states that creating the appropriate alternative is the state's obligation. 57 Fed. Reg. 56509 (1992) (to be codified at 42 C.F.R. Sec. 483.118(c)(2)).

/54/ HCFA Transmittal No. 88-8 (Sept. 1988); HCFA Transmittal No. 91-3 (June 1991).

/55/ Comment by Ron Tremper, Chief of Program Development, Rhode Island Department of Mental Health, Retardation, & Hospitals, at a PASARR workshop held in Providence, RI (June 24, 1993).

/56/ Conversation with Gary Richter, Indiana Protection and Advocacy Service (June 1993). "The ADP looks good on paper, but there's no new money going into housing. [Indiana is] real chintzy. We only provide housing that can be federally reimbursed." Id.

/57/ Conversations with Aaryce Hayes, Advocacy, Inc., Texas (June 1993); and Pearson, supra note 38.

/58/ The Elders Project of the Bazelon Center for Mental Health Law is available for consultation and assistance with litigation to enforce ADPs and other aspects of PASARR.

/59/ 42 U.S.C. Sec. 1396r(e)(7)(C)(iii).

/60/ The regulations merely repeat the statutory language. 57 Fed. Reg. 56509 (1992) (to be codified at 42 C.F.R. Sec. 483.118(b)(1)).

/61/ Conversation with Hayes, supra note 57.

/62/ 42 U.S.C. Sec. 1396r(e)(7)(C)(ii)(I).

/63/ 42 U.S.C. Secs. 1396r(e)(7)(C)(i)(IV) and (C)(ii)(III).

/64/ See REP. OF THE HOUSE COMM. ON THE BUDGET TO ACCOMPANY H.R. 3545, H.R. REP. No. 391, 100th Cong., 1st Sess. (1987).

/65/ 57 Fed. Reg. 56509 (to be codified at 42 C.F.R. Sec. 483.120(a)(1)). As with the definition of "serious mental illness," HCFA has invited comments on its definition of specialized services but has not indicated how it plans to respond to these comments.

/66/ Conversation with Hayes, supra note 57.

/67/ In Indiana, for example, 20 former nursing home residents in need of specialized services were placed, in 1992, in state-run mental hospitals. Conversation with Cindy Wagner, Director of PASARR--Determination Program, Indiana Department of Mental Health (June 1993).

/68/ Conversation with Verseput, supra note 37.

/69/ For example, in Wayne County, Michigan, under NSO Geriatric Screening and Outpatient Service of Detroit Michigan, a program directed by Dr. Robert Bernstein, 71 people with mental illness in need of specialized services (broadly defined to include a wide spectrum of services) have left the nursing home and are living in the community. Of these 71 people, 8 are in adult foster care homes, 34 are in homes for the aged, 26 are in independent living arrangements with various in-

home supports, and 3 are in group apartments. Approximately 90 more nursing home residents with mental illness have been identified for community care and are awaiting placement. State funds to support small group homes, specialized apartments, and enhanced in-home services for this group were expected for FY l993.

/70/ 42 U.S.C. Sec. 1396r(e)(7)(F). The regulations adopt the Medicaid fair hearing process to govern appeals of PASARR determinations. 57 Fed. Reg. 56505 (1992) (to be codified at 42 C.F.R. Sec. 431.200)).

/71/ 57 Fed. Reg. 56505 (1992) (to be codified at 42 C.F.R. Sec. 431.201).

/72/ Conversations with Verseput, supra note 37, and Turnham, supra note 43.

/73/ Plaintiffs' Second Amended Complaint for Declaratory and Injunctive Relief, Nancy D. et al. v. Jones et al., Case No. 92-CA 621 (W.D. Tex. filed Oct. 20, 1992).

/74/ H.R. REP. NO. 391, 100th Cong., 1st Sess. 462-63 (1987).