



MENTAL RETARDATION BULLETIN

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF PUBLIC WELFARE

DATE OF ISSUE

December 30, 1993

EFFECTIVE DATE

February 1, 1994

NUMBER

00-93-30

SUBJECT

OBRA PROCEDURES FOR INDIVIDUALS WITH MENTAL
RETARDATION

E

A handwritten signature in black ink, appearing to read "Nancy R. Thaler".

Nancy R. Thaler

Deputy Secretary for Mental Retardation

SCOPE:

Area Agency on Aging Directors
County Mental Health and Mental Retardation Administrators
Base Service Unit Directors
Intermediate Care Facility for the Mentally Retarded (ICF/MR) Directors
County Mental Retardation Fiscal Directors
County Mental Retardation Coordinators
Nursing Facility Administrators

PURPOSE:

The purpose of this bulletin is to clarify County Mental Health/Mental Retardation (MH/MR) Program and Department responsibilities related to individuals with mental retardation who are applicants or residents of nursing facilities, in accordance with Federal requirements under the Omnibus Budget Reconciliation Act (OBRA) of 1987.

BACKGROUND:

Federal regulations issued on November 30, 1992 (42 CFR Parts 405, 431, 433 and 483) set forth State requirements for Preadmission Screening and Annual Resident Review (PASARR) of individuals with mental retardation who are applicants or residents of nursing facilities certified for Medicaid funding. The regulations include criteria for determination of need for nursing facility services and specialized services together with procedures for ensuring individual freedom of choice and appeal rights.

Federal regulations place ultimate control and responsibility with the Pennsylvania Office of Mental Retardation to evaluate and determine the need for services for individuals with mental retardation. This responsibility is delegated to the Regional Program Manager of the Office of Mental Retardation. This bulletin explains how the Office of Mental Retardation will carry out these responsibilities, along with the roles of the County MH/MR Programs and other Department of Public Welfare Offices, or their agents.

REFER COMMENTS AND QUESTIONS TO:

Appropriate Regional Mental Retardation Program Manager

This bulletin is organized into five parts and five attachments which are as follows:

- Part I: Identifying Persons With Mental Retardation (page 3)
- Part II: Determination on Need for Nursing Facility Services (page 6)
- Part III: Determination on Need for Specialized Services (page 8)
- Part IV: Evaluation Report and Determination Notices (page 11)
- Part V: Responsibilities of County MH/MR Programs (page 14)

- Attachment A: PASARR Appeal Procedures
- Attachment B: Freedom of Choice Procedures
- Attachment C: Definition of Terms
- Attachment D: Criteria for Nursing Facility Services

PART I. IDENTIFYING PERSONS WITH MENTAL RETARDATION

A. Criteria

For purposes of OBRA, an individual is considered to have mental retardation only when all of the following three requirements are satisfied:

1. A licensed psychologist, certified school psychologist, or psychiatrist certifies that the person has significantly subaverage intellectual functioning which is documented by either:

a) performance which is more than two standard deviations below the mean of a standardized general intelligence test, or

b) performance which is slightly above two standard deviations below the mean of a standardized general intelligence test during a period when the person manifests serious impairments of adaptive behavior.

2. A qualified mental retardation professional certifies that the person has impairments in adaptive behavior based on the results of a standardized assessment of adaptive functioning which show that the person has either:

a) significant limitations in meeting the standards of maturation, learning, personal independence, and/or social responsibility of his or her age and cultural group, or

b) substantial functional limitation in three or more of the following areas of major life activity:

1. self-care

2. receptive and expressive language

3. learning

4. mobility

5. self-direction

6. capacity for independent living

7. economic self-sufficiency

3. There is documentation to substantiate that the person has had these conditions manifest between the person's birth and 22nd birthday.

The results of both the standardized general intelligence test and the standardized assessment of adaptive functioning shall consist of:

a) the clinical data and an overall score,

b) a statement by the certifying practitioner that the results are considered valid and consistent with the person's degree of functional restriction, and

c) a statement by the certifying practitioner as to whether the results indicate that the person has mental retardation.

The requirement for a standardized general intelligence test may be waived for a person who is unable to communicate and follow directions to the extent that the use of standardized measures is precluded. In such cases, the requirement for the standardized intelligence test shall be satisfied by a licensed psychologist's (or psychiatrist's) written statement that the person's inability to communicate and follow directions precludes the use of standardized measures. The statement should include the opinion of the certifying practitioner that the person has mental retardation.

The requirement for a standardized general intelligence test and an assessment of adaptive functioning may also be waived for a person who has documentation obtained from the individual's family, County MH/MR Program, human service agency, school, or other agency which verifies that the individual received mental retardation services in the past, or would have received such services if they had been made available.

The following documentation of mental retardation will not be accepted for purposes of PASARR without further corroboration of mental retardation that conforms with the requirements of this section:

1. A medical evaluation for use by the Department, which is currently the MA-51.
2. Certification of mental retardation by a professional employed or affiliated with a nursing facility which is involved in the individual's transfer, placement or discharge, and
3. Certification of mental retardation by an agency or individual whose function or relationship with the individual constitutes a conflict of interest, as determined by the Office of Mental Retardation.
4. Evaluation material which does not substantiate that the onset of the individual's impairment occurred prior to the age of 22.

B. Procedures

The Level I or identification (ID) Phase of PASARR includes a screening to identify persons who may have mental retardation. This ID screening is conducted by the nursing facility, the applicant or someone who is knowledgeable about the applicant, or the hospital where the person is receiving medical care. The ID screen is then verified by:

- the Options Site for individuals who are considered for admission into a nursing facility as part of the preadmission screening process.
- the Utilization Management Review (UMR) Team for individuals who are residing in a nursing facility as part of the Annual Resident Review (ARR) process.

The Options Site or UMR Team will notify the individual, the family, or legal representative about the results of the screening when the individual is suspected of having mental retardation. Family notification during this and other phases of PASARR is contingent on the agreement of the individual to involve his/her family members.

Evaluation to corroborate mental retardation is conducted during the PASARR Level II or Evaluation Phase. During the Evaluation Phase, the Options Site or UMR Team consults with the responsible County MH/MR Program and establishes whether the individual has mental retardation in accordance with the criteria established in this bulletin.

Corroboration of mental retardation has to be established only once for an individual. If the Options Site or UMR Team cannot corroborate mental retardation during the Evaluation Phase, but has reason to believe that the individual has mental retardation, the evaluator is responsible to ensure that any necessary assessments are conducted for this purpose. Assessments are to be arranged by the Options Site or UMR team after consultation with the responsible County MH/MR Program. The purpose of this consultation is to determine if the individual is known to the county system, and if assessments that document mental retardation are available.

Assessments may be completed by the County MH/MR Program, or a consultant of the Options Site or UMR Team. Selection of Options Site Consultants who provide pre-admission assessments that establish an individual's mental retardation should have the involvement of responsible County MH/MR Programs, beginning with contracts established in fiscal year 1994-95.

Reasonable efforts are expected by all parties in the evaluation process to establish the age of disability onset. If reasonable efforts are made and disability onset prior to the age of 22 cannot be established, the individual should not be placed in the mental retardation target population.

The Options Site or UMR Team recommendation to the Office of Mental Retardation about nursing facility or specialized services must include documentation of mental retardation when nursing facility services are determined to be needed. A recommendation without corroboration of mental retardation will be returned to the evaluator for additional information. If the Office of Mental Retardation does not concur that this person has mental retardation, the person's name should be removed from the OBRA target population.

For purposes of OBRA, the responsible County MH/MR Program is the County MH/MR Program which was or would have been responsible for providing services to the individual immediately prior to the individual's admission into the nursing facility. For example, a gentleman who lived in Pennsylvania County A is admitted to a nursing facility in a neighboring County. The County MH/MR Program for County A is the responsible County Program, since it provided community mental retardation services for the individual prior to being admitted to the nursing facility. Agreements between County MH/MR Programs are encouraged to facilitate the provision of appropriate case management and other services when individuals reside in nursing facilities which are too far for the responsible County to effectively serve. The Regional Office of Mental Retardation should be contacted if there are delays in deciding which is the responsible County MH/MR Program.

PART II. DETERMINATION OF NEED FOR NURSING FACILITY SERVICES

A. Criteria

An individual with mental retardation as determined in Part I. A. of this bulletin will be determined to need nursing facility services when the individual meets the standards for admission to a nursing facility. In order to meet these standards for admission and be determined to require the level of services provided by a nursing facility, the individual must be determined to have age-related health problems and/or medical needs which cannot be treated in the home and community.

The only exception to the preceding criteria is for individuals requiring specialized services who have resided in a nursing facility for at least 30 consecutive months prior to the date of the individual's initial determination to not need nursing facility service. These individuals may choose to remain in the facility, or may choose to move to an alternative residential setting.

B. Responsibilities

The Regional Office of Mental Retardation is responsible for determining the need for nursing facility services for individuals with mental retardation.

The determination will be based on an evaluation of the individual's total needs, including health and age-related needs, by Options Site or UMR Team in consultation with the responsible County MH/MR Program, individual, family, and providers of service.

Except for data required as part of an advance group determination explained below, the elements of the evaluation will consist of minimum data requirements and an evaluation report, as explained in Parts III and IV of this bulletin. Recommendations which do not contain documentation in accordance with minimum data requirements will be returned to the evaluator without determination.

C. Types of Determinations

Determinations of need for nursing facility services may be made on an advance group or individual basis. Advance group determinations take into account that certain age or health-related conditions clearly indicate that nursing facility services are needed, or that specialized services are not needed. Individual determinations take into account each individual's conditions.

An advance group determination may be made applicable by the nursing facility or other evaluator following the ID if the existing data about the individual appear to be current and accurate and are sufficient to allow the evaluator to readily determine that the individual fits into the advance group category.

Sources of existing data that can form the basis of applying the advance group determination include hospital records, physician evaluation, election of hospice status, and records of mental retardation providers or the responsible County MH/MR Program.

Individuals who have an advance group determination applied after the ID review are exempt from further pre-admission screening procedures, as long as their nursing facility stay corresponds with the limits established by the Department. Extension of nursing facility stays beyond established limits are subject to pre-admission screening or other reviews required by the Department.

1. Advance Group Determinations on Need for Nursing Facility Services

Advance group determinations on need for nursing facility services for individuals requesting admission to or residing in a nursing facility can be made under the following circumstances:

a) Individual is an Exempted Hospital Discharge

Although identified as an individual with mental retardation, an applicant/resident may be directly admitted for nursing facility services from an acute care hospital for a period up to 30 days without further evaluation if such admission is based on a written medically prescribed period of recovery for the conditions requiring hospitalization.

b) Individual Requires Respite Care

Although identified as an individual with mental retardation, an applicant/resident may be admitted to a nursing facility for respite care for a period up to 14 days without further evaluation if he or she is certified by a referring or attending physician to require 24 hour nursing facility services and supervision.

c) Individual is in a Coma or Functions on a Brain Stem Level

Although identified as an individual with mental retardation, an applicant/resident may receive nursing facility services without further evaluation if certified by the referring or attending physician to be in a coma or functioning on a brain stem level.

2. Advance Group Determinations on Specialized Services

An advance group determination that specialized services are not needed may be made when the individual has a primary diagnosis of dementia which exists in combination with mental retardation.

3. Individual Determinations

An individual determination on need for nursing facility and specialized services is made for each individual whose condition does not warrant an advance group determination. The individual determination is based on a comprehensive evaluation of the individual's medical and mental status, and a functional assessment, as specified in Section III of this bulletin.

To facilitate appropriate nursing facility utilization, individual determinations for nursing facility services may be made for a period of 180 days or less when the circumstances warranting admission are expected to be time limited. An example of a time limited circumstance is the need for an extended period for recuperation from an accident or illness. An admission of this nature to the nursing facility will require a comprehensive evaluation of the individual's medical and mental status, and a functional assessment. Continued stay in the nursing facility will be based on a resident review conducted by the UMR Team by the end of the authorized period.

D. Release of Information

The County MH/MR Program and its designee(s) are authorized to release information requested by Options and UMR Teams pertaining to an individual's application to a nursing facility, continued stay in a nursing facility, and other purposes of this bulletin.

Persons who are involved in the direct administration of the Medicaid Program do not need special release of information forms to allow them access to individual files and other pertinent information in order for them to carry out their assigned duties. Therefore, staff from the Office of Medical Assistance Programs, Division of Long Term Care Client Services, or their agent, the Pennsylvania Department of Aging's Option Program, are to have full access and cooperation when requesting information on individuals who are in, or who have applied for nursing facility services.

PART III. DETERMINATION OF NEED FOR SPECIALIZED SERVICES.

A. Specialized Services Criteria

For the purposes of this bulletin, the term specialized services means services, which combined with services provided by the nursing facility or other service providers, results in treatment which includes aggressive, consistent implementation of a program of specialized and generic training, treatment and related services that are directed toward:

1. The acquisition of the behaviors and skills necessary for the individual to function with as much self-determination, and independence as possible, and
2. The prevention or deceleration of regression or loss of current optimal functional status.

Specialized services may be provided in or outside the nursing facility and can only be provided by qualified mental retardation personnel. A service or combination of services of less intensity than services meeting the definition of specialized services are the responsibility of the nursing facility, and should be provided as a nursing facility service.

An example of a "nursing facility" service would be occupational therapy to help individuals use a knife and fork at meal times. An example of a specialized service would be a regularly attended structured day support program outside the facility where the individual receives occupational therapy in conjunction with other services provided by qualified mental retardation personnel.

Additional information related to specialized services and nursing facility services is provided by Interpretive Guidelines issued by the Office of Medical Assistance Programs. (See Attachment D.) Updates to these guidelines and other information on the interfacing of specialized and nursing facility services will continue to be forwarded to County MH/MR Programs by the Office of Mental Retardation.

B. Procedures

1. Responsibilities

The determination of need for specialized services is made by the Office of Mental Retardation based on a comprehensive evaluation of the individual's medical and mental status, and a functional assessment.

The comprehensive evaluation is completed by the Options Site or UMR Team in consultation with the responsible County MH/MR Program designee, the individual, and the individual's family or legal guardian. The Options Site or UMR Team is responsible for gathering all pertinent information and forwarding it to the responsible County MH/MR Program, which in turn, forwards the information, together with its concurrence/non-concurrence and comments to the Regional Office of Mental Retardation. The Regional Office of Mental Retardation will then determine need for specialized services as part of the individual's determination notice, as included in Part IV.

Specialized services are then authorized by the responsible County MH/MR Program for individuals with mental retardation who are residents of a nursing facility when the individual's needs are such that continuous supervision, treatment, and training by qualified mental retardation personnel are necessary.

2. Data Requirements

The evaluation of the individual's medical and mental status, and a functional assessment require collection of the following minimum data:

- 1) The individual's age and health-related problems
- 2) The level of impact these age and health related problems have on the individual's independent functioning
- 3) All current medication used by the individual and the current response of the individual to any prescribed hypnotic, antipsychotic, mood stabilizer, antidepressants, antianxiety-sedative, or anti-Parkinson medications
- 4) Self-monitoring of health status
- 5) Self-administration and scheduling of medical treatment
- 6) Self-monitoring of nutritional status
- 7) Self-help development such as toileting, dressing, grooming and eating
- 8) Sensori-motor development, such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination, and extent to which prosthetic or other supportive devices can improve the individual's functional capacity
- 9) Speech and language (communication) development, such as expressive and receptive language, and extent to which nonoral amplification or other communication systems can improve the individual's functional capacity
- 10) Social development, such as interpersonal skills, recreation-leisure skills, and relationships
- 11) Academic/education development, including functional learning skills
- 12) Independent living development such as meal preparation, budgeting and personal finances, survival skills, mobility skills, laundry, housekeeping, shopping, bedmaking, care of clothing, and orientation skills

13) Vocational development, including present vocational skills

14) Affective development such as interests and skills involved with expressing emotions, making judgments, and making independent decisions, and

15) The presence of identifiable challenging behaviors.

Adaptation to Culture, Language, Ethnic Origin, and Communication

All evaluations are to be adapted to the individual's cultural background, language, ethnic origin, and means for communication, such as signing.

If an Options Site or UMR Team is unable to evaluate an individual's needs in a manner which adapts to these circumstances and conditions, the evaluator will arrange for the appropriate persons who are competent in these matters to assist in the evaluation process.

Data Interpretation

Based on the minimum data, the Regional Office of Mental Retardation will make a qualitative judgment on the extent to which the person's status reflects the characteristics commonly associated with the need for specialized services. These characteristics include the inability to:

- take care of personal care needs
- understand simple commands
- communicate basic needs and wants
- be employed at a productive wage without systematic long-term supervision or support
- learn new skills without aggressive and consistent training
- apply skills learned in a training situation to other environments or settings without aggressive and consistent training
- demonstrate behavior appropriate to the time, situation, or place without direct supervision
- make decisions requiring informed consent without extreme difficulty
- demonstrate behavior which does not severely jeopardize health and safety
- attain skills or specialized training without the constant availability of trained mental retardation personnel

PART IV. EVALUATION REPORT AND DETERMINATION NOTICES.

A. Summary

Findings and recommendations related to establishing mental retardation, need for nursing facility services, and need for specialized services are combined in a written evaluation report.

A preliminary evaluation report is developed by the Options Site or UMR Team in consultation with the individual, the individual's family and the responsible County MH/MR Program. This preliminary report should contain all findings and recommendations related to the individual's mental retardation, need for nursing facility services, and need for specialized services.

The preliminary report is forwarded by the Options Site or UMR Team to the responsible County MH/MR Program for concurrence/non-concurrence. The County MH/MR Program will review and concur/non-concur on the preliminary report or offer comments on the report in a timely manner. The Regional Office of Mental Retardation will be copied on the transmittal letter from the preliminary report sent to the responsible County MH/MR Program by the Options Site or UMR team. The County MH/MR Program is responsible for forwarding the preliminary report, together with the County's concurrence/non-concurrence and/or comments to the Regional Office of Mental Retardation.

Based on the data compiled in the preliminary evaluation report, the Regional Office of Mental Retardation will: 1) ensure that all necessary information is available to finalize the report, 2) validate that the individual has mental retardation, and 3) determine whether nursing facility and/or specialized services are needed. Notice of determinations, together with the final evaluation report, will be distributed to the appropriate individuals and agencies by the Regional Office of Mental Retardation.

In the preliminary evaluation report, the Options Site, and UMR Team will make a recommendation on each individual's need for nursing facility services and specialized services. The Regional Office of Mental Retardation will then issue a determination based on this preliminary evaluation report.

The Preadmission Screening process only requires a determination for both nursing facility services and specialized services when nursing facility services are determined to be needed. If nursing facility services are determined not to be needed during the Preadmission Screening process, the Office of Mental Retardation will not determine need for specialized services.

B. Evaluation Report

The preliminary and final evaluation report for individuals with mental retardation will contain:

1. Information corroborating the individual's mental retardation in accordance with the criteria and procedures indicated in Part I of this bulletin.

2. Evaluation findings and recommendations related to the individual's need for nursing facility services in accordance with the criteria and procedures indicated in Part II of this bulletin.

3. Evaluation findings and recommendations related to the individual's need for specialized services in accordance with criteria and procedures indicated in Part III of this bulletin.

4. A summary which:

a. identifies the name and professional title of the person(s) who performed the evaluations(s), and the date when each portion of the evaluation was administered

b. summarizes the individual's medical and social history, including the positive traits and developmental strengths, weaknesses, or needs of the individual

c. identifies the specific nursing and specialized services which are required for the individual

d. identifies the name and mailing address of the individual's family and/or legal representatives who are entitled to receive copies of the determination notice, and

e. identifies adaptations to cultural background, language, ethnic origin, and means of communication which should be followed as part of the notification process.

C. Individualized Determination Notice and Evaluation Report Issuance

The Office of Mental Retardation will issue its individualized determination notice, together with the final evaluation report, to the:

1. Evaluated individual and his/her legal representative
2. Admitting or retaining nursing facility (if known)
3. Individual's physician (if known)
4. Discharging hospital (if applicable)
5. Responsible County MH/MR Program
6. Office of Medical Assistance Program or designee
7. Referring Options Site for individuals undergoing a preadmission screening, and
8. County Assistance Office.

The determination will include notice of:

1. Whether a nursing facility level of services is needed
2. Whether specialized services are needed
3. The options available to the individual consistent with these determinations, including the option of home and community services, where appropriate.
4. The right of the individual to appeal certain determinations, and
5. Other information related to the individual's choice to receive services, and services provided by the County MH/MR Program and advocacy agencies.

Procedures related to the rights of the individual to appeal determinations and exercise individual freedom of choice are contained in Attachments A and B of this bulletin.

The County MH/MR Program will ensure that the final evaluation report is interpreted to the individual and where applicable to the individual's legal representative. This interpretation of the evaluation report should be done within 30 working days after the County's receipt of the evaluation report.

If technical assistance is needed in interpreting the report, the County MH/MR Program may request assistance from the Regional Office of Mental Retardation or the appropriate Options Site or UMR Team.

Timeliness

According to Federal regulations, preadmission screening determinations by the Office of Mental Retardation should be made in writing within an annual average of seven to nine working days of referral of the individual to the Office of Mental Retardation by whatever agent performs the ID screening. Although additional time may be necessary to procure appropriate data and interpretation of findings for individuals in this target population, all parties are encouraged to fulfill their PASARR responsibilities as expeditiously as possible in order to avoid Federal financial penalties.

The Office of Mental Retardation may convey determinations verbally to nursing facilities and the individual and confirm them in writing.

Annual review of nursing facility residents with mental retardation should be conducted not less often than annually, which means during every fourth quarter after the previous preadmission screen or annual resident review.

PART V. RESPONSIBILITIES OF COUNTY MH/MR PROGRAMS

County MH/MR Programs retain certain responsibilities for individuals with mental retardation requesting admittance to or residing in nursing facilities.

A. PASARR Activities

PASARR responsibilities of the County MH/MR Program consist of:

1. Providing technical assistance and support to Options Site and UMR Teams in corroborating whether an individual has mental retardation.
2. Providing technical assistance and support to Options Site and UMR Teams in evaluating the individual's need for nursing facility services and specialized services.
3. Providing written concurrence/non-concurrence and/or comments on the preliminary evaluation report submitted by the Options Site or UMR Team.
4. Interpreting the findings of the evaluation report to the individual, or his/her representative within 30 working days of issuance of the determination notice by the Regional Office of Mental Retardation. For the purposes of this bulletin, 30 working days are based on a five day work week.
5. Offering the right to choose alternative home and community based services to individuals residing in a nursing facility for at least 30 continuous months prior to the date of determination.

B. Additional OBRA Related Activities

County MH/MR Programs are responsible for the following additional non-PASARR, OBRA related activities for individuals with mental retardation residing in or discharged from nursing facilities:

1. Providing or arranging for specialized services for individuals residing in nursing facilities.
2. Providing or arranging for home and community services for individuals discharged from nursing facilities.
3. Developing an individual plan for specialized services or home and community services within 30 working days of issuance of the Office of Mental Retardation's determination. The Regional Office of Mental Retardation should be contacted if an extension to this 30 day time frame is required.

C. Budgeting/Funding

The County MH/MR Program is responsible for budgeting for the cost of both PASARR and other OBRA related activities and services through the needs-based budgeting process and through the annual rebudget process.

Funding for the cost of OBRA related activities is to be available through the County's Community Mental Retardation allocation including, but not limited to:

1. The Medicaid 2176 Waiver for home and community services.
2. Targeted Service Management for: a) the transition of individuals leaving the nursing facility during the last 30 days of the individual's nursing facility placement, and b) locating, coordinating and monitoring home and community services in accordance with the approved State Plan Amendment.

Additional funding guidelines for PASARR and OBRA will be issued to the County MH/MR Programs, as necessary, Mental Retardation.