Nursing Home Pre-Admission Screening: A Review of State Programs

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From January through March of 1981, the Health Care Financing Administration (HCFA) surveyed the agencies of 49 States and the District of Columbia responsible for the administration of the Medicaid program. The purpose of the survey was to determine if the agencies had a nursing home pre-admission screening program for Medicaid patients. Twenty-eight States and the District of Columbia responded that there was a state-wide, pre-admission screening program for Medicaid patients prior to their entry into a nursing home, or that there was a program operating in a portion of the State. HCFA collected information on the scope of the programs, the agencies responsible for conducting pre-admission screening, the composition of the screening teams, and the characteristics of the client assessment instruments. Two States, Virginia and Massachusetts, provided information on program impact.

This article presents the findings of the survey and explores several aspects of the Medicaid program influencing the effectiveness of pre-admission screening. It begins with an overview of the policy issues which have influenced the development of pre-admission screening and defines the core components of these programs. We then discuss current Medicaid utilization control mechanisms required of States by statute and the problems associated with these review practices in preventing inappropriate or unnecessary institutionalization. The article then describes and analyzes current State pre-admission screening programs. Finally, we discuss further policy considerations surrounding the effectiveness of pre-admission screening programs in assuring Medicaid patients equitable access to appropriate long-term care services.

Background

Several factors help explain the growing interest among States in developing pre-admission screening programs for Medicaid patients at risk of nursing home placement. One factor is the remarkable growth in Medicaid nursing home costs over the past decade. Between 1969 and 1979, total expenditures on nursing home services rose 306 percent, while Medicaid nursing home expenditures increased 612 percent (HCFA, 1980).

Since 1973, nursing home care has been the fastest growing component of personal health expenditures, with Medicaid the largest single source of financing. Overall, Medicaid spent $8.79 billion on nursing home care in 1979, representing 87 percent of all public expenditures on nursing home care and almost half of the $17.8 billion total nursing home bill. At the State level, 47 States spent over a third of their Medicaid budgets for nursing home care; 23 of these States spent over 50 percent (HCFA, 1980). That rate of spending, coupled with the growth of the elderly population (especially those 75 and over), is increasing interest at both the Federal and State levels in mechanisms for controlling nursing home use and costs.

Another factor that has stimulated the development of pre-admission screening programs is the growing number of reports identifying inappropriate placements. Several studies have documented that many nursing home residents have been placed in a level of care higher than necessary. The Congressional Budget Office reviewed 14 studies of inappropriate placement (1977) and concluded that between 10 and 20 percent of patients in skilled nursing facilities (SNFs) and 20 to 40 percent of those in intermediate care facilities (ICFs) did not need the level of care provided by those facilities. Most of the inappropriately placed SNF patients required institutional care at the ICF level. However, a large proportion of the inappropriately placed ICF patients could have resided either in some form of sheltered housing or in their own homes if adequate community services were available.

The economic and social costs of inappropriate or unnecessary nursing home placements are becoming increasingly apparent to both Federal and State policymakers. First, several studies indicate that up to a certain level of disability, a significant proportion of inappropriately placed nursing home patients can be effectively treated at a lower cost in the community (Greenberg, 1974; U.S. Comptroller General, 1977). Second, in those parts of the country where there is a shortage of nursing home beds, light care patients who are inappropriately placed exacerbate the problems of placing public pay patients requiring heavy care who are backed up in hospitals (Scanlon, 1980; Gruenberg and Willemain, 1980). Finally, nursing homes are institutions, and unnecessary placements subject individuals capable of some independence to the inevitable discomforts and dependency of the regimentation and lack of privacy that characterize large institutions.

To address these problems, some States have instituted mandatory pre-admission screening programs for Medicaid patients prior to their entry into a nursing home. In the context of long-term care, pre-admission screening essentially assesses the need for institutional placement. These programs reflect the assumption that it is preferable and more practical to divert persons from entering nursing homes than it is to return nursing home residents to community settings. Beyond this core assumption, the purposes and intended effects of pre-admission screening programs vary widely. They include controlling costs, expanding community-based placements, and reducing the number of administratively necessary days for public pay patients backed up in hospitals awaiting nursing home placement.

Variations in the structure of pre-admission screening programs reflect these diverse goals. At a minimum, all pre-admission screening programs exhibit components of client intake, determination of eligibility, client assessment, and placement recommendation. Beyond these core components, pre-screening programs exhibit wide variation, and the following critical variables characterize their operation and effectiveness:

- geographic basis: state-wide or within catchment area
- population served: Medicaid, Medicare, private pay
- client origin: hospital discharge or from the community
- program scope: at a minimum, nothing beyond determination of appropriate placement; more broadly, referral or provision of care planning, case management, or formal services
- extent of denial authority: voluntary or mandatory where placement determination is either advisory or authorized to control payment
- composition of assessment team: single professional or team; physician, nurse, and/or social worker
- content of assessment: purely medical or inclusion of social, economic, or environmental factors
- the supply of nursing home beds and the availability of community-based services.

Efforts to describe and analyze State pre-admission screening programs must necessarily examine them in terms of these eight policy dimensions. Before presenting the survey results, however, we must place pre-admission screening in the context of the utilization control mechanisms statutorily required of States to monitor the appropriateness of placement and continued stay of Medicaid nursing home residents. It is largely the difficulties with these *post-admission* review procedures in returning residents to the community that has shifted the policy debate from deinstitutionalizing inappropriately placed nursing home residents to diverting these individuals from entering the institution in the first place.

Medicaid Utilization Control Programs Required by Statute

To avoid Medicaid payments for unnecessary institutional services, the Social Security Act establishes several assessment mechanisms to ensure that appropriate nursing home care is provided to Medicaid patients.[1] Medicaid law (Section 1903 (g)) specifies a utilization control (UC) program to ensure the necessity of admission, the need for continued stay in the facility, and the quality of care. Elements of a UC program include physician certification and recertification of the need for patient services, utilization review, and review of individual patient care plans. Medicaid UC further requires that participating facilities undergo State Inspection of Care. Most of these activities are post-admission reviews.

Physicians' Certification of Need

Section 1903 (g)(1)(A) of the Social Security Act requires that a physician certify the necessity for admission to either an SNF or an ICF at the time of admission or, if the patient has already been admitted, at the time he or she applies for Medicaid. A physician must recertify the necessity for continued institutional care at time intervals specified in regulation. Furthermore, each Medicaid nursing home resident must have a written plan of care established and periodically reviewed by a physician (Section 1903 (g)(1)(B)). Physician certification of need is the only utilization control activity under statute performed *prior* to admission for Medicaid eligibles who are entering a nursing home for the first time.

[1] The Social Security Act also mandates that minimum health and safety standards be met by providers and suppliers participating in the Medicare and Medicaid programs. These requirements are established in the Conditions of Participation. However, because State survey and certification activities focus more on the quality of the facility and its services than on patient care, they are not discussed in this article.

Utilization Review

Section 1903 (g)(1)(C) requires that a State must have a utilization review (UR) program which ensures that the necessity for both the admission and the continued stay of a Medicaid nursing home resident is reviewed in accordance with criteria established by medical personnel not directly responsible for the resident's care. Each long-term care facility must have an acceptable utilization review plan. The facility may, within general guidelines, develop its own review committee structure and procedures. Utilization review is carried out by physicians—either through a facility staff committee (which includes two or more physicians) or by a similar group outside the facility, such as one established by the local medical society or through the State.

The utilization review committee is responsible for admission review, continued stay review, and quality of care review. Admission review consists of verification that a physician certification of need is included in the patient's records and confirmation of the patient's need for nursing home care. This review is conducted on a post-admission basis. Continued stay review is conducted for each Medicare or Medicaid patient who has been in the facility for an extended period of time. These reviews are based on an evaluation of each patient's plan of care. Based on this evaluation, the committee determines whether the level of care (SNF or ICF) is appropriate to meet the patient's needs. Finally, based on review of plans of care or other mechanisms, the UR committee conducts quality of care studies.

State Inspection of Care

Section 1903 (g)(1)(D) requires the State to annually perform medical reviews of the care provided to every Medicaid resident in an SNF and independent professional reviews of the care provided to every Medicaid resident in an ICF. The periodic onsite Inspections of Care (IOC) of each facility are performed by teams composed of physicians and/or registered nurses and other appropriate health and social service personnel. The teams must assess the adequacy of the services available in the facility for meeting each patient's needs, the necessity and desirability of continued SNF or ICF care, and the feasibility of meeting the patient's health care needs through alternative institutional or community-based services.

The main function of State Inspection of Care is to review quality of care. Inspection of Care teams may examine physician certification and recertification of need, but they usually focus on the care plan, that is, whether the plan is appropriate to meet the patient's needs and whether it is carried out properly. Admission review and continued stay review are usually performed by other UC mechanisms, for example, UR committees.

Problems with Statutory Utilization Control Activities

The General Accounting Office (1979) criticized current programs to control nursing home use for being ineffective in regard to Medicaid patients. The GAO report cited the following problems with existing review requirements:

- Most of the reviews occur after admission when it is often difficult or impossible to discharge the resident to the community.
- State Inspection of Care reviews focus primarily on medical conditions and therefore do not provide information on other factors which are critical in determining placement.

Emphasis on Post-Admission Review

Outside of the physician's certification of need, all remaining Medicaid assessment and utilization review procedures required by statute are post-admission. The problems and costs involved in attempting to relocate an elderly nursing home resident who has been identified as being inappropriately admitted have been well documented. First, there is a problem with housing. Many elderly persons lose their homes around the time they enter a nursing home. The catastrophic expense of nursing home care makes it difficult to maintain housing in the community because financial resources that previously went to pay rent or a mortgage are quickly exhausted on costly nursing home bills. The costs of replacing such housing for deinstitutionalized nursing home residents could be significant.

Another problem is the regimentation and social deprivation that often characterizes large institutions such as nursing homes. The process of institutionalization creates dependency in the resident which reduces the will and capacity to live in the community. Thus, many elderly could not withstand the trauma of being transferred, particularly if the transfer were involuntary, to another environment.

The ineffectiveness of post-admission reviews in correcting inappropriate placements of long-stay residents was also demonstrated by the experiences of 10 PSRO demonstration projects that tested methods of assessing the appropriateness and quality of nursing home care provided to Medicaid and Medicare residents. A 1979 Rand Corporation evaluation of these projects found that extremely few nursing home residents were reclassified to a different level of care or discharged after they had been in the facility for six months or longer. According to the authors, the ideal time to make decisions about the appropriateness of nursing home care is prior to admission. They further suggest that post-admission reviews may be most cost-effective if they are focused on the first six months of a patient's stay, when he or she is still "dischargeable" (Kane and Kane, 1979).

Lack of Comprehensive Needs Assessment

Under Medicaid requirements for controlling utilization, the facility or the State must review the physician's certification of need to determine that the admission to the nursing home is appropriate. These post-admission reviews of physician placement decisions vary from State to State. Moreover, it is generally acknowledged that many Medicaid State agency programs for retrospective reviews of placement decisions are not well developed. Often they are paper reviews of medical records forms usually completed by nursing staff and signed by a physician.

Because of its primary focus on medical criteria, Medicaid Inspection of Care has been criticized as inadequate for identifying those applicants who meet the medical criteria for nursing home care but who have the potential to remain in the community. Research indicates that although some level of medical need is nearly universal among nursing home residents, it is not the major factor in requesting nursing home care. Much more important are the level of functional disability and the loss of informal support (such as the death of a spouse) (Brody, 1978; Butler and Newacheck, 1980; HCFA, 1981). These studies suggest that more appropriate placement decisions can be made by broadening the traditional medical examination to include a comprehensive assessment of the elderly individual's physical, social, mental, and environmental conditions.

The placement problem is further complicated by the variety of non-medical needs which nursing homes fulfill for residents, including: housing, supervision, homemaker, chore, and personal care. Many of these services can be provided in alternative settings. Thus, by overlooking the non-medical or social needs of the patient, Medicaid admission and IOC reviews do not consider non-institutional or non-medical alternatives that may be more appropriate and less costly.

The difficulties with Medicaid UC mechanisms in returning nursing home residents to the community have caused States to re-evaluate deinstitutionalization as the sole strategy to reduce inappropriate or unnecessary nursing home utilization. Several States have responded by supplementing existing UC mechanisms with pre-admission screening programs to avoid inappropriate institutionalization of Medicaid beneficiaries. The next section describes and analyzes State pre-admission screening activities.

Overview of State Programs

Geographic Basis

HCFA surveyed the agencies responsible for the administration of the Medicaid program in the 49 States and the District of Columbia in early 1981 to determine if they had a nursing home pre-admission screening program for Medicaid patients. HCFA staff with long-term care experience telephoned Medicaid staff from each State with responsibilities in the area of long-term care and discussed pre-admission assessment. Specifically, the following questions were asked:

- Are patient assessments (for example, pre-admission screening) required for entry into institutional long-term care? Yes or No?
- If so, are assessments required for Medicaid patients? Other patients?
- Who performs the assessment?
- Are assessments limited to medical criteria or do they include comprehensive (for example, social and environmental) factors as well?

In States which indicated that pre-admission assessments were required, there were discussions regarding the nature of the program, the availability of written information on the program, and the existence of data on the impact of the pre-admission screening programs. In addition to the information gathered in the telephone contact with States, many States submitted written information on their programs, including copies of their assessment forms. In view of the format used in this survey, we feel that the survey results are highly valid.

Twenty-eight States and the District of Columbia responded that they had a state-wide, pre-admission screening program for Medicaid patients prior to their entry into a nursing home, or that there was a program in a portion of the State.[2]

The three categories of State programs are State-wide, State-wide (PSRO), and Partial State. The inclusion of a State under the State-wide category indicates that, at the time of the survey, there was a program in operation in all parts of the State being carried out by the State and/or local agency staff. In the second category of program, designated as State-wide (PSRO), States were listed if a PSRO-operated program existed throughout the State. Under the category of Partial State, States were included where State and/or locally operated programs existed in only a portion of the State. This last category included States which were in the process of phasing in state-wide programs or were conducting demonstration programs in limited geographic areas. Table 1 lists the States which have pre-admission screening programs.

[2] For analytical purposes, the District of Columbia is considered a State in the remainder of this article.

TABLE 1

State Pre-Admission Screening Programs

State-wide	State-wide (PSRO)	Partial State
Maine	New Hampshire	Massachusetts
Rhode Island	District of Columbia	Georgia
New Jersey	Maryland	Minnesota
New York	Alabama	Kansas
Delaware	Kentucky	Montana
Virginia	Mississippi	Idaho
West Virginia	South Carolina	Oregon
Illinois	New Mexico	
Ohio	Iowa	
North Dakota	Colorado	
California		
Hawaii		

Table 1 indicates that there are 12 state-wide programs, 10 state-wide, PSRO-operated programs, and seven programs operating in portions of States.[3] Of the 12 state-wide programs, 10 screen applicants for nursing homes from both hospitals and the community while two screen community applicants only. Five of the seven partial State programs screen nursing home applicants from both hospitals and the community, while the other two screen only community applicants. A few States also include in their program Medicare and/or private pay nursing home applicants likely to convert to Medicaid.

Organizational Auspice

As Table 2 indicates, there are a number of different agencies responsible for operating pre-admission screening programs. Twelve States have State staff involved in pre-admission screening, and four States have programs operated by county agency staff. State/county teams operate programs in two States. These data indicate that States vary in placing responsibility for the operation of pre-admission screening programs, although there is a strong tendency for State staff involvement.

TABLE 2

Responsibility for Pre-Admission Screening

Responsible Agency	Number of States
State Agency Staff	12
County Agency Staff	4
State/County Team	2
State or County Agency Staff	1

Program Scope

The survey found that most programs are mandatory and that all require prior authorization. The programs are generally of two types: one model serves as a "gate-keeping mechanism" and solely prevents public pay admissions to the institution, usually by denying Medicare or Medicaid reimbursement for nursing home care when admission is deemed inappropriate. The second model may or may not have this denial authority, but, in addition, it plans care using community-based services whenever possible. Most State programs currently rely on the first model.

One example of the first model is the New York State program that uses an assessment instrument which is scored by the individual performing the assessment. If a certain score is attained, admission to a nursing home is approved. The assessor generally makes no effort to manage cases other than to provide a single referral to a service provider. Overall, the survey of the States indicated that state-wide programs at that time were largely intended to screen applicants out of nursing homes rather than to provide comprehensive services as an alternative to nursing home admission.

[3] The analyses that follow focus on the 19 States with non-PSRO programs, since the State staff contacted during the survey were not able to provide detailed information about PSRO-operated programs.

Five States presently use pre-admission screens with case management components in limited geographic areas or on a demonstration basis. A few of these States have indicated that they intend to expand this model state-wide. An example of this model is Georgia's Alternative Health Services (AHS) project, a HCFA-funded, long-term care demonstration which was initiated in 1976. The project offers alternative, long-term community services to Medicaid-eligible persons in a 17-county area who would otherwise be placed in institutions. The program, which is voluntary, provides a centralized single point of entry for all long-term care services. Following the intake phase, an AHS caseworker assesses the client. The caseworker then confers with other assessment team members (a registered nurse and a social worker) to assess the potential client's appropriateness for AHS services. If the client is judged appropriate for inclusion in the program, the team develops a care plan, and AHS manages the case. Based on its experience with the AHS demonstration, Georgia has amended its Medicaid State Plan and will phase in over a three-year period a mandatory pre-admission screening program for all Medicaid-eligible applicants to nursing homes.

Composition of Assessment Teams

In the 19 States which conduct their own Medicaid pre-admission screening programs, HCFA found a number of variations in the composition of screening teams. (See Table 3.) Most teams had two members (nine States), while four States had three members, and one State's team consisted of four people. In 13 States, a registered nurse either had sole responsibility for screening (three States) or was a member of a screening team (10 States). In 14 States, a social worker was a screening team member, while in one State the social worker had sole responsibility for screening. In six States, a physician was a member of a screening team, and in one State the physician had sole review responsibility.

Most screening teams consisted of a nurse and a social worker (five States). These two disciplines were part of a larger team in an additional five States. In four other States, a physician and a social worker composed the screening team.

Client Assessment Instruments

The instrument and scope of the needs assessment process range from being only medical to comprehensive in nature. The assessment may involve only a clinical judgment of the medical necessity of nursing home care. Alternatively, the process may include administration of a comprehensive assessment instrument to evaluate need for both institutional and non-institutional services based on any or all of the following items:

- an evaluation of the client's functional status (Activities of Daily Living, Instrumental Activities of Daily Living)
- a psychosocial evaluation, that is, emotional condition, mental functioning, social adjustment, and ability to communicate
- an evaluation of the individual's and family's preferences and lifestyles and the willingness of the family to provide informal care

- an evaluation of the individual's physical environment and living arrangements
- an assessment of financial resources.

States were asked whether their pre-admission screening is comprehensive or medical in nature. Eighteen States conducted comprehensive screenings, while 11 considered their programs to be mainly medical. In States with PSRO-operated programs, eight reported that their programs were medical, while two described the programs as comprehensive. Sixteen State-operated programs were described as comprehensive, while three were reported to be mainly medical.

TABLE 3
Composition of State Program Screening Teams

State	RN	Social Worker	Physician	Other
Maine	•			
Massachusetts	•	•		Placement Assistant
Rhode Island[1]		•	•	
New Jersey[2]	•	•		
New York[3]	•			
Delaware		•	•	
Virginia[2]	•	•	•	
West Virginia		•	•	
Georgia	•	•		Caseworker
Illinois		•		
Minnesota	•	•	•	
Ohio		•	•	
Kansas	•	•		
Montana	•	•		
North Dakota	•	•		
California	•			
Hawaii			•	
Idaho	•	•		Adult Services, Worker, Financial Eligibility Examiner
Oregon	•	•		

[1] ICF only
[2] Community patient reviews
[3] State level review

Specific State Case Studies: A Description and Reported Results from Virginia and Massachusetts

There are limited data available on the results of State pre-admission screening programs. One reason is that States have not developed systems for collecting data on results of these programs. Another factor is the recent implementation of many of these programs. There are a number of recently-initiated State programs, however, which are collecting data on program cost and impact. In the future, these programs will provide an opportunity for analyses of pre-admission screening programs.

There are two States, Virginia and Massachusetts, from which data are available on pre-admission screening program impact. These programs and their preliminary results are discussed in the following sections.

Virginia

Background and Program Description

On May 15, 1977, the Virginia Department of Health implemented a state-wide Nursing Home Pre-Admission Screening Program for persons in the community or in a State Department of Mental Health and Mental Retardation facility at the time of nursing home application. The program delays or avoids unwanted, unnecessary, and/or inappropriate nursing home placements by using interdisciplinary teams and community resources. It also identifies services required in the community to meet the needs of elderly and disabled persons.

The program screens individuals who are Medicaid-eligible or who are expected to become Medicaid-eligible within 90 days of nursing home admission. This coverage of individuals not currently on Medicaid is an innovative aspect of Virginia's program. The screening requirement is a part of the State's nursing home admission certification, and Medicaid payment is not made without the approval of a screening committee. Local health department screening committees are composed of a public health physician, a public health nurse, and a social worker who is employed by the local welfare department.

The State Health Department pays the local health departments $44 for each screening. An official of the State Health Department indicated that approximately 4.5 hours of staff time are required to complete an assessment (physician, nurse, social worker, clerical staff). The payment to the local health departments excludes the costs for the social workers.

The local screening committees have the following responsibilities:

- to evaluate the medical, nursing, and social needs of each individual referred for pre-admission screening
- to determine the services the individual needs
- to evaluate whether services are available in the community to meet the individual's needs.

To carry out those responsibilities, the social worker and public health nurse interview individuals referred for pre-admission screening and complete the Nursing Home Screening Certificate. The nurse evaluates nursing needs and obtains a medical history, and the social worker prepares a social evaluation of the individual. Then the full screening committee reviews the case to determine whether nursing home admission is appropriate or if the person can be cared for adequately in the community if necessary services are provided. The committee's decision is transmitted to the individual or referring agency and, if placement is approved, the nursing home is also informed.

The State Department of Health has also established a central office Pre-admission Screening Committee to screen prospective nursing home candidates from State Department of Mental Health and Mental Retardation facilities. This committee reviews and discusses medical, nursing, and social information on potential nursing home candidates which is supplied by the referring facility. When the committee reaches a decision, it notifies the referring facility.

Reported Program Results

The data in Table 4 indicate a relative stability in Virginia's pre-admission screening program over its initial three years of operation. The number of individuals screened from the community remained nearly constant, as did the placement recommendations. Overall results for May 15, 1977 to June 30, 1980 (excluding June 1 to June 30, 1978) indicate that of 6,259 individuals screened, 1,247, or 20 percent, were not recommended for nursing home placement.

TABLE 4

Community Patients

Time Period	Total Screened	Recommended: Nursing Home	Recommended: Non-Nursing Home
5/15/77–5/31/78	2062	1618 (78%)	444 (22%)
7/1/78–6/30/79	2132	1694 (79%)	438 (21%)
7/1/79–6/30/80	2065	1700 (83%)	365 (18%)
Total	6259	5012 (80%)	1247 (20%)

Source: "Nursing Home Pre-Admission Screening, May 15, 1977–May 31, 1978," Virginia Department of Health. "Nursing Home Pre-Admission Screening, July 1, 1978–June 30, 1979," Virginia Department of Health. Testimony of Charlotte Carnes, Virginia State Health Department, Before the Senate Finance Committee, Subcommittee on Health, August 27, 1980.

When we examine the data for individual health districts, it is apparent that recommendations against nursing home placement are much more prevalent in some areas than in others. For instance, in the period between July 1, 1978 and June 30, 1979, six health districts recommended against nursing home placement in more than 30 percent of the cases, while seven health districts made that recommendation in less than 10 percent of their cases. This is partly due to the lack of alternatives in some communities in Virginia. State staff indicated a belief that with the availability of a comprehensive community services package, the percentage of disapprovals for nursing home placement state-wide could be increased to 35 to 40 percent of the patients screened.

To gather information on nursing home placement, Virginia conducted a state-wide survey between December 1, 1978 and January 12, 1979 of 170 persons who were screened between April 1 and September 30, 1978. Of those 170 persons, 88 were not approved for nursing home care. Although the follow-up period was relatively soon after the individuals were screened, Table 5 indicates that a majority of the people diverted from nursing homes remained in the community. The survey also found that family members were providing care that enabled the individual to remain in the community in slightly over half of the 88 cases.

TABLE 5

Outcome of Individuals for Whom No Change was Recommended by the Screening Team

	Number	Percent
Living With Relatives	38	43
Living Alone	13	15
Living in Homes for Adults	12	14
Living in Nursing Homes	10	11
Deceased	5	6
In Room and Board Situations	3	5
Other	7	8

On August 27, 1980, a Virginia State Health Department official testified before the United States Senate Committee on Finance, Subcommittee on Health, that definitive data on cost savings were not available. However, in that testimony the State projected a potential "savings" of $698,320 per month from maintaining 1,247 individuals in the community with home health services rather than providing care in an intermediate care facility.

The Administration on Aging funded a study to evaluate the Virginia Pre-Admission Screening Program. The study was conducted by the Virginia Center on Aging to analyze the cost of community versus institutional care. The Center on Aging interviewed approximately 400 individuals between May and September 1980, with a follow-up interview six months later. The sample was composed of four equal groups: 1) persons screened and denied nursing home admission, 2) persons screened and approved for nursing home admission, 3) persons who entered nursing homes without being screened, and 4) persons from the community in need of services who have not yet applied for admission to a nursing home.

This study addresses a number of issues of considerable interest to Federal and State officials. A major emphasis was placed on acquiring cost data on all individuals in the sample to permit analysis of the cost implications of the pre-admission screening program. This effort included gathering data on private as well as public costs for each individual. Public program costs include Medicaid, Medicare, and Title XX, while private costs were traced through diaries maintained by community patients. In addition, the study examines the contributions family and friends made in permitting an individual at risk of institutionalization to remain in the community. The final study is available from the Virginia Center on Aging.

Virginia officials have been examining their program and are considering two significant modifications. The first would require hospitalized patients to be subject to pre-admission screening. This would result in *all* Medicaid patients, as well as other patients subject to the program, whether in the community or hospitalized, being subject to the program. No longer would the potential exist for an individual to go into the hospital and then directly to a nursing home without first being screened.

A second modification would require any individual with less than 13 months of funds available for nursing home care to be screened before admission to a nursing home. This modification would increase the number of individuals subject to the program by extending it to many more private pay patients.

Massachusetts

Background and Program Description

In 1978, the Massachusetts Departments of Public Welfare and Elder Affairs began implementing the Case Management Screening Program (CMSP) on a pilot basis. By early 1981, the program was operational in six sites, with an additional three sites scheduled for later in the year. When these nine sites are operational, approximately 35 percent of the State will be covered by the program.

The primary objective of the CMSP is to facilitate the appropriate placement of Medicaid recipients in the long-term care system. This objective is pursued in three principal ways:

- The program seeks to ensure that recipients who can be cared for in the community remain there. This is accomplished by helping these individuals receive community support services.
- The CMSP is designed to ensure that only needed institutional care is approved and reimbursed and that the institutional care which is approved is at the proper level.
- The program assists hospital discharge planners and other placement agents in expediting nursing home placement for recipients who cannot be cared for in the community. This function is designed to reduce the number of administratively necessary days. In addition, it monitors and discourages discrimination against Medicaid recipients by nursing homes.

A team consisting of a nurse and social worker performs the initial screening. In addition, a placement assistance specialist (nurse or social worker experienced in long-term care planning and placement) serves as a liaison among hospitals, nursing homes, and community agencies to facilitate the placement of patients. This team evaluates the data provided by the referral agent and, in approximately 15 percent of its cases, performs an on-site assessment.

Reported Program Results

Massachusetts has analyzed the data from one project site. The Cape Ann-North Shore Pilot project began operation on Cape Ann in August of 1978 and was expanded to serve parts of the North Shore in June of 1979. This project area has a target population of approximately 30,000 individuals over the age of 65.

Table 6 indicates that, after 18 months of operation, the Case Management Placement Review Team had reviewed 498 requests for approval of nursing home placement. Forty-two of the 498 placement requests (8.4 percent) reviewed on a pre-admission basis were denied nursing home placement. An additional 17 were approved for a different (nearly always lower) level of care. A total of 27 placement requests (5.4 percent) were approved for recipients who were later diverted to community services. Another 8 cases (1.6 percent) in the community were awaiting nursing home placement with the support of the Placement Review Team (PRT) and community agencies. Of the requests denied for nursing home care, 10 (23.8 percent) were for recipients judged by the PRT to be medically ineligible for nursing home care. The remaining 32 denials (76.2 percent) were found eligible for nursing home care but had acceptable community placement arranged.

TABLE 6

Results of Case Management Placement Review Screenings[1]

	Number	Percent
Approvals of Level Requested	406	81.5
Denial of One Level—Approval for Another	17	3.4
Denial of Nursing Home Placement	42	8.4
Diversions	27	5.4
Cases Awaiting Placement in the Community	8	1.6
Total Placement Requests	500	100.3

[1] A total of 500 outcomes were reported for the 498 placement requests. Therefore, outcomes are two more than placement requests and percentages total 100.3.

Source: "The Case Management Screening Project (Beverly, Massachusetts), Project Description and Report of Results, August 24, 1978–February 29, 1980)," Massachusetts Department of Public Welfare (Medicaid), Draft Document.

Table 7 indicates the number of placement requests approved and the reason approval was granted. The State reported that 119 (28.2 percent) of the 423 cases approved for nursing home admission could have been maintained in or returned to the community if adequate non-institutional services had been available.

TABLE 7

Reasons for Approval of Nursing Home Placement

Reason	Number of Cases Approved for Placement	Percent of Total Approvals
Community Placement Inappropriate	279	65.9
Appropriate for Community Placement but Services Lacking	119	28.2
a) Service Unavailable at Needed Times	(22)	(5.2)
b) Services Non-Existent	(97)	(23)
Community Placement Unacceptable to Family	18	4.3
Community Placement Unacceptable to Recipients	7	1.6
Total Approvals for Nursing Home Placement	423	100

The services most often missing were foster care and adult day care, both of which tend to offer complete service packages. The most common unmet need for services reflected in these 119 cases was the need for supervision and assistance at night and weekends. In only a small percentage of cases was community placement unacceptable to the family (4.3 percent) or to the individual (1.6 percent).

The Massachusetts report also indicated that of 82 patients who were returned to or maintained in the community, approximately two-thirds avoided institutionalization through the intervention of the PRT and other agencies. Seventy-four percent of these community placement cases had actively involved families, clearly indicating that the continuing support of these caretakers is essential to most viable community placements.

The costs of services per day spent in the community by all community placements was $9.92. Estimates of potential cost savings indicated that community placements cost all public payers $4.32 to $9.07 less per day of care than nursing home placements. Overall, the net savings resulting from the Cape Ann-North Shore project (three years of development and 18 concurrent months of operation) was $172,850.

Sources of Future Data on Pre-Admission Screening

While there is presently only limited information available on the impact of pre-admission screening programs, five States (including Georgia, which was discussed earlier) have recently initiated state-wide or pilot programs which include data collection and analysis. Since there is likely to be data available on their operations in the future, we provide a brief description of the other four programs.

Minnesota

In January 1981, Minnesota began implementing a pre-admission screening program modeled after the Virginia Nursing Home Pre-Admission Screening Program. This program, in operation in two counties as of March, 1981, is projected to be operational state-wide within one year. County welfare departments are the lead agencies and supply the screening teams' social workers. Local health departments provide the public health nurse and consulting physician to the team. The program also includes the Virginia feature, where not only are Medicaid patients from the community who apply for nursing home admission required to be screened, but also individuals who would be eligible for Medicaid within 90 days if they were admitted to a nursing home. This program should be an interesting contrast to Virginia, since Minnesota, unlike Virginia, has an extensive community-based service network.

Oregon

Oregon began implementing a pre-admission screening program in February 1980 in one geographic area of the State. By March 1981, areas of the State containing approximately 75 percent of its population were included in the program.

Pre-admission screening teams, which include a nurse, social worker, and adult service worker, operate out of regional offices of the State Department of Human Resources. Screenings are performed for Medicaid-eligible individuals who apply for nursing home admission from hospitals and the community. In addition, individuals from State mental retardation/developmental disabilities facilities are screened prior to nursing home placement.

Kansas

In January 1981, the Kansas Department of Social and Rehabilitation Services began implementing a pre-admission screening program on a pilot basis in four counties. The screening team is composed of a nurse from the county health department or Visiting Nurse Association and a social worker from the county Department of Social and Rehabilitation Services. The program, which is mandatory for Medicaid-eligible individuals who are applying for admission to an ICF, is presently operating under a one-year contract. The State will use the data on program costs collected during this period to determine whether to expand the program throughout the State.

Idaho

In December 1980, Idaho initiated an Elderly Screening Program on a pilot basis in two counties. The purpose of the program is to provide, prior to admission, an assessment of a person's social needs, medical needs, and functional abilities and to develop an individualized plan of care for in-home services, substitute home services, or care in the most appropriate and least restrictive setting.

The Elderly Screening Program Team is composed of staff from the Regional Office of the State Department of Health and Welfare. The staff includes a nurse, social worker, adult services worker, and adult financial eligibility examiner. Pre-admission screening is available to individuals eligible for or applying for Medicaid, persons who would be eligible for Medicaid within 90 days of admission to a nursing facility, and individuals receiving adult protective services under Title XX. Participation in the program is *voluntary*.

This program operated on a pilot basis until July 1, 1981. Idaho is analyzing statistical data on the program's operation and costs to decide whether to expand the program throughout the State.

Policy Considerations

Most States are not assessing the effectiveness of their pre-admission screening programs. As a result, there is considerable operational experience, but little data on costs, utilization, and client outcome. Nevertheless, there appears to be widespread agreement that such programs are desirable. Massachusetts and Virginia, which have analyzed costs, indicated that they had identified actual or potential savings. These programs also reported that a significant percentage of their clients were maintained in the community. These findings indicate that pre-admission screening programs merit more rigorous analysis to determine whether cost savings are indeed realized.

The need for comparative program analysis is especially important in light of the wide variation in structure and operations across State programs. For example, HCFA found little uniformity in the structure of pre-admission screening programs, in their delegation of organizational responsibility, in the minimal staffing skills necessary for the performance of responsibilities, in who monitors the placement determinations, or in how the information obtained from the various assessment instruments is converted into a placement decision and plan of care. Further information is needed to determine how variation in these areas influences the effectiveness of pre-admission screening programs.

Program analyses must further account for the numerous political factors affecting program operation and performance. The attitudes of the community—State and local officials, institutional and non-institutional service providers, long-term care professionals, and the public—toward the objectives of pre-admission screening programs play an important role in determining their effectiveness. Indeed, despite the widespread agreement on the desirability of pre-admission screening in principle, several implementation problems were noted. Among the most important were opposition by some hospitals which perceive pre-admission screening as a duplication of hospital discharge planners' activity or as diminishing the role and function of hospital staff and difficulties in defining the roles of State and local staff or securing agreement on common, state-wide forms to enhance standardized data collection.

Finally, evaluations of the efficacy of pre-admission screening programs must analyze their impact in terms of broader, systemic, long-term care policy issues. The most frequently-mentioned factors affecting program effectiveness were not specific program issues, but rather more basic, systemic policy problems. These include:

- the availability and cost of community-based services and the degree to which they prevent inappropriate nursing home placements
- the role of the family in providing informal care and how incentives to families can be provided which will permit individuals to remain in the community
- the approach which should be taken regarding the pre-admission screening of private pay patients.

Availability of Community-Based, Long-Term Care Services

States with data on their pre-admission screening programs have reported that the lack of appropriate community services, or their unavailability at night or on weekends, has significantly reduced their effectiveness in preventing nursing home placements. Community-based, long-term care services are directly related to the effectiveness of pre-admission screening because they provide non-institutional alternatives to nursing home placements. National survey data for 1977 show that less than 10 percent of the nursing home population is not dependent on others for assistance in the basic activities of daily living (NCHS, 1979). Moreover, the need for some level of medical care is nearly universal among nursing home residents. Therefore, it is likely that nearly all individuals seeking nursing home admission will need *some* level of medical and non-medical assistance. If the necessary services are not available in the community, the nursing home may indeed be appropriate to ensure that the patient's basic needs are met.

A related issue is the cost associated with expanding community-based services to the Medicare and Medicaid population who, without these services, would otherwise be placed in nursing homes. There is reason to believe that up to a certain level of disability, many of these individuals could remain in the community at a lower *per diem* cost to the government. The cost control problem is targeting non-institutional benefits solely to this "at risk" population without generating excess demand from beneficiaries not at risk but who could benefit from some additional non-institutional services. This issue needs further study.[4]

Where community-based services are available, another unresolved issue is the types and combination of community-based services that effectively delay or prevent unnecessary institutionalization. The extent to which alternative care settings and services can substitute for or complement institutionalization is not sufficiently defined or understood to target benefits solely to high risk clients. The relationship between risk factors and placement determination methods employed by pre-admission screening programs needs further investigation.

Family Involvement in the Provision of Community-Based Services

The limited data available from our review of State programs indicate that assistance from families was important in a significant proportion of cases where individuals were placed in the community instead of nursing homes. The factors which encourage such family support, as well as those which discourage that support in other instances, need to be identified, and policy options for enhancing family support should be developed. The relationship between informal support systems and pre-admission assessment of need for formal care also requires further investigation.

Private Pay Patients

There is evidence that a substantial number of current Medicaid nursing home residents initially entered nursing homes as private pay patients and were consequently not subject to Medicaid pre-admission review.[5] According to the 1979 GAO report, conversions represent 30 to 48 percent of all nursing home residents supported by Medicaid. Lewin and Associates (1981) re-examined the 1979 GAO study and found that as many as 30 percent of the private pay admissions became eligible for Medicaid within six months. Finally, information from Monroe County's Long-Term Care Program indicates that out of 929 Medicaid conversions of patients in nursing homes, 45 percent occurred within six months of entering the facility, 20 percent within the next six months, and 35 percent after one year of residence (Price, 1980). The private pay patients, therefore, represent an important population for pre-admission screening.

Whether private pay patients who later qualify for Medicaid because of depletion of resources actually "need" nursing home care at the time of admission is unknown. A GAO analysis (1979) of the 1976 Survey of Institutionalized Persons (SIP) indicated that non-Medicaid nursing home residents appeared in some cases to need less assistance in activities of daily living than Medicaid patients. However, more recent studies indicate that private pay patients in nursing homes are significantly (in a statistical sense) more disabled than the Medicaid population (Shaughnessy *et al*, 1980; Bishop, 1980; Liu and Mossey, 1980). Unfortunately, national data do not exist to compare *both* medical and functional status of private and public pay patients upon admission to the nursing home. Therefore, it is unclear whether pre-admission screening would effectively divert a significant number of private pay admissions.

There are a number of policy concerns relating to the inappropriate placement of private pay patients. Since private pay patients use their own resources to pay for nursing home care, there are legal questions concerning the ability or desirability of the Federal government requiring them to undergo pre-admission screening prior to entering a nursing home. Instead, with very few exceptions, present pre-admission screening programs are unable to influence the decisions of private pay patients who apply for admission to a nursing home.

An additional policy concern is that nursing homes presently determine who has priority in gaining admission. Since they can charge private pay patients at a higher rate than the Medicaid rate, nursing homes have an incentive to admit private pay patients instead of public pay patients. Since government expenditures account for more than 50 percent of the nursing home revenues, the question of whether government should require the industry to modify its policies in this area needs to be considered.

This issue is particularly important where the supply of available nursing home beds is tight. As the Monroe County demonstration revealed, a tight nursing home bed supply seriously affects the ability of case managers to place Medicaid patients in nursing homes, even after they have been determined appropriate for admission. Where the supply of nursing home beds for Medicaid patients is tight, there is the likelihood of a significant hospital backup of Medicaid patients awaiting nursing home placement. Under these circumstances, the ability of pre-admission screening programs to place Medicaid patients at the appropriate level of care is significantly reduced.

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[4] Several HCFA-sponsored demonstration projects have examined the policy implications of expanded community-based services under Medicaid, but none of them focus specifically on pre-admission screening programs. For a discussion of their findings, see Greenberg *et al*, 1980, and Stassen and Holohan, 1980.

[5] Many private pay patients are also eligible for the Medicaid SNF benefit and use their Medicare entitlement to enter the nursing home. How many of these patients later spend-down to Medicaid eligibility is unknown. However, a comprehensive pre-screening program would have to assess the entire spectrum of financial eligibility—Medicaid, Medicare, and private pay.

It seems clear from available information that it is better to determine the appropriateness of institutional placement prior to admission rather than afterward. It is also evident that some influence over the decisions of private pay patients seeking nursing home admission is required to maximize the effectiveness of pre-admission screening. What is not clear at this time is what approach is advisable in dealing with the issue of pre-admission screening for private pay patients.

A number of approaches have been suggested to deal with private pay patients. For example, States might:

- make pre-admission screening a condition for conversion to Medicaid from private pay status prior to entering a nursing home.
- impose vigorous screening and enforce assessment decisions at the point of application of private pay patients for conversion to Medicaid status while in the nursing home
- require that all Federally-eligible patients receive an assessment prior to hospital discharge if they are likely to require long-term care (either community-based or institutional)
- require an assessment of the need for institutionalization before admission to a nursing home for *all* patients
- develop incentives for private pay patients to voluntarily participate in pre-admission screening programs.

All of these approaches require further consideration in light of the concerns discussed earlier.

Summary

The existence of pre-admission screening programs in 29 States indicates that there are no *inherent* barriers to implementing these programs on a broad scale for public pay patients. The widespread agreement on the desirability of these programs and the growing incentives for States to reduce their institutional long-term care budgets as Federal funds are constrained suggest that these programs will increasingly characterize the long-term care delivery system in the 1980s.

While even more widespread operation of these programs seems likely in the future, three systemic issues consistently affect program effectiveness: the availability of community-based services, the role of the family in the provision of informal care, and whether pre-admission screening should include private pay patients. These issues raise the need for additional caution about the objectives of pre-admission screening programs. Many States view pre-admission screening programs primarily as a method to control escalating Medicaid costs caused by inappropriate use of nursing homes. Yet there is a paucity of data to support or refute this assumption. Amid the claims concerning the extent of inappropriate placement in nursing homes, it is important to note that there are no uniform criteria or definitions for this term. "Appropriate placement" implies that we are able to identify, that is, "target," either the persons who need the service or the services that are needed by the person. The state of the art in both kinds of targeting is very imprecise, or at least not uniform, both for nursing care and for community-based services. Instruments used to determine appropriate placement vary, and as Foley and Schneider found (1980), uniformity of placement criteria among the States is the exception rather than the rule. As a result, it may be possible to misinterpret the cost savings from pre-admission screening programs independent of important access and quality of care considerations.

Pre-admission screening works on the assumption that we can identify those persons who "need" nursing home care. Since this kind of need has not been precisely defined, nor have uniform criteria been developed for measuring it, there is great variability in who gains admission to nursing homes. That variability is compounded by the ability to substitute non-institutional services for nursing home care. Many persons at risk of institutional placement can be cared for in another setting. However, the primary factors which permit persons to remain outside nursing homes appear to be the availability of community-based services and family support. Unless all of these issues are addressed concurrently in Federal and State policy deliberations, the effectiveness of pre-admission screening programs in reducing costs and enhancing appropriate placement will be diminished.

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