NASDDDS
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May 20, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-2418-P
PO Box 8016
Baltimore MD 21244-8016

Dear Administrator Verma,

The National Association of State Directors of Developmental Disabilities Services (NASDDDS) appreciates the opportunity to comment on the proposed rule "Medicaid Program: Preadmission Screening and Resident Review" (CMS-2418-P). NASDDDS represents the nation's agencies in 50 states and the District of Columbia providing services to children and adults with intellectual and developmental disabilities and their families (the State Intellectual Disability Authorities). The NASDDDS mission is to assist member state agencies in building person-centered systems of services and supports for people with intellectual and developmental disabilities and their families.

NASDDDS applauds CMS's effort to modernize the requirements for Preadmission Screening and Resident Review (PASRR). NASDDDS members view PASRR as an important tool for meeting our obligations under *Olmstead* and support any endeavor to enhance the program's utility in this regard. Further, we agree with CMS's assessment that "portions of the current PASRR regulations are unclear, illogical, duplicative, or out of touch with current long-term care practices," and appreciate the importance of updating and streamlining the rule. We offer comments on specific elements of the Notice of Proposed Rule Making (NPRM) with both of these important goals in mind.

§483.106 (Basic Rules and Responsibilities)

NASDDDS acknowledges the underlying statute that prohibits the state Mental Health Authority (SMHA) from performing or delegating responsibility for evaluations for people with mental illness (MI). However, many NASDDDS members designated as the state Intellectual Disability Authority (SIDA) operate as a single agency in tandem with the SMHA or under an umbrella organization with the responsibility for both SIDA and SMHA activities. The NPRM intends to

clarify at §483.106 that the SMHA cannot have a contractual relationship with the entity performing the evaluation for people with MI. NASDDDS notes this provision creates an undue hardship for states where these tandem or umbrella operations exist and PASRR evaluations are performed under a single contract. Should CMS enact the NPRM as written, states would have to engage in costly re-procurement of contracts and workflow redesigns, time-intensive legislative approval processes and, acquisition of additional human resources to manage a separate vendor. NASDDDS recommends regulatory language that recognizes these circumstances in some states and provides for such allowances while complying with the underlying statute.

§483.112 (Preadmission Screening of Applicants for Admission to NFs)

CMS proposes to revise the existing expectation at §483.112 that Level II determinations must be made in writing within an annual average of 7-9 working days from the day the Level I referral was made to an annual average of 9 calendar days from date of receipt of the Level I referral. While we agree with CMS's rationale that setting a standard that is both an average and a range is unnecessary, and support the simplification to a single average, we are concerned about the change from working days to calendar days. SIDAs report that they are challenged to process a Level II determination and get a diagnosis within the current required 9 working days. Not all PASSR programs operate 7 days a week, and most do not have mail service on Sundays, which further complicates this new deadline. We request either retaining the use of a "working days" standard or allowing a number of calendar days significantly greater than 9 between receipt of a Level I referral and completion of a Level II determination.

NASDDDS supports all aspects of the NPRM that reinforce the Congressional purpose of PASRR and the legal requirements of the ADA and *Olmstead*. However, NASDDDS has concerns the proposal for 'provisional admissions' at §483.112 falls short of these tenets. Any provisional admission, even with the completion of a Level I screening and specified time limits depending on the circumstance, misses the opportunity to use PASRR as a tool for diversion and informed choice, as well as risks an individual not receiving a full PASRR evaluation to determine critical specialized services to support a short-term stay and prompt transfer to community-based services. Should CMS choose to maintain provisional admissions in the final rule, NASDDDS recommends minimally that CMS require states to: 1) use the state plan amendment process to formalize provisional admissions via public comment; 2) inform provisional admission applicants of community-based options as part of the Level I screening process; and 3) compel specialized services for anyone admitted under provisional status where HCBS-like services are in place at the time of the Level I screening.

NASDDDS recommends that CMS emphasize in all appropriate parts of the regulation the need for transition planning to begin immediately upon admission and throughout the NF stay.

§483.114 (Review of NF Residents)

CMS proposes at §483.114(c)(1) that referrals to the PASRR program for Resident Review would have to be made within 72 hours of when the resident experiences one of the triggering circumstances, including an apparent significant change in an individual's mental or physical condition, or evidence of a previously-unidentified MI or ID. The 72-hour requirement is a

significant change that would create a considerable burden. In particular, this timeframe would not allow an evaluator to have sufficient information to determine whether the 'significant change' is the result of a temporary condition (such as an infection), and therefore whether the altered behavior may resolve. While NASDDDS shares the view that prompt referral is important (and required by statute), the requirement for a 72-hour timeframe will likely lead to a significant number of referrals for individuals who do not require resident review, placing an unnecessary burden on state PASSR programs and causing unnecessary confusion for residents experiencing a temporary change in condition.

§483.120 (Specialized Services and NF Services)

CMS proposes to replace the current definition of "specialized services" for people with ID, in which such services are described as equivalent to active treatment offered in ICF/IIDs, with a new set of criteria. We applaud CMS's intention to clarify that specialized services are not restricted to institutional-type services. Further, we support the new criteria, with special emphasis on:
(1) the focus on person-centered design that "promotes self-determination and independence";
(2) The requirement that an intellectual disability or developmental disability professional develop the services;
(3) The requirement that specialized services be "designed to support any goals the individual may have of transition to the most integrated setting appropriate."

We particularly appreciate CMS's focus on "solidifying the commitment to using specialized services as a tool for assisting individuals' transition to the community." To ensure that specialized services are well designed to maximize the goal of "allow[ing] people to live in the optimal setting for that individual, as reflected by the individual's needs and preferences," we recommend that the final rule clarify that the state must define this service package through a state plan amendment, in order to provide ample opportunity for input from a broad range of stakeholders.

Additionally, NASDDDS encourages CMS to be clear about several points related to specialized services. First, the new requirement for a periodic review of specialized services consistent with the person-centered planning process is a positive addition. NASDDDS members recommend clarity about the frequency and monitoring responsibility for such a review. Second, NASDDDS suggests a broader collection of information listed at §483.128(e) to be used for nursing facility (NF) level of services and specialized services to include information on communication needs, community placement evaluations and preferences, and informed choice of alternative placement options. Third, while the state specifies allowable specialized services in the state plan and Level II evaluators recommend specialized services for individuals, the NPRM gives responsibility for determining the specialized services that are ultimately provided to the NF care planning team which may not possess adequate qualifications to determine the habilitative needs of a person with an I/DD. NASDDDS encourages CMS to incorporate requirements for NF treatment teams to have the qualifications necessary to develop treatment plans and specialized services, including familiarity with the state's community-based services system, to appropriately support an individual during a NF stay, promote self-determination and transition to integrated community services. This could be accomplished through a community-based case manager or service coordinator as part of a treatment team.

§483.128 (Level II PASRR Evaluation Criteria)

NASDDDS agrees with the provision of an abbreviated evaluation report in certain circumstances. The provision at §483.128(j) is to be retitled “Evaluation report: Terminated evaluations.” NASDDDS does suggest less obtrusive language by replacing the word ‘terminated’ with wording such as ‘halted’. Due to the highly sensitive nature of some circumstances for an abbreviated evaluation (e.g., comatose or terminal illness), NASDDDS recommends language that is appropriately considerate of the context for abbreviated evaluations.

§483.130 (Criteria for Nursing Facility Placement)

At 483.130(c) CMS proposes new criteria for NF placement. According to the new criteria, an individual who meets the state's criteria for NF admission and whose total needs do not exceed the services which can be delivered in the NF can be admitted to a NF only when “placement in a home and community-based program cannot be achieved because:

(i) The individual's total needs pursuant to § 483.128(e) exceed or cannot currently be accommodated by the state's home and community-based programs; or

(ii) The individual does not want community placement.

We support the idea that individuals with ID should be served in the most integrated setting appropriate to their needs. We believe this criterion would be strengthened in the regulatory language if the following language:

“(3) Placement in a home and community-based program cannot be achieved because:

(i) The individual's total needs pursuant to § 483.128(e) exceed or cannot currently be accommodated by the state's home and community-based programs; or

(ii) The individual does not want community placement.”

were struck and replaced with:

“(3) All possible placements in a more integrated setting have been fully explored and exhausted through a process that includes fully informed choice.”

We further recommend that throughout the proposed rule, wherever CMS refers to the concept of choice, or the preferences of the individual, related to the setting where the individual may receive long term services and supports, that CMS clarify that this means fully informed choice that includes the opportunity to experience other options besides NF placement. CMS should define informed choice in the definition section of the regulation.

§483.204 (Provision of a Hearing and Appeal System)

The NPRM appears to mandate a formal appeals process for Level I identifications at §483.204. The Level I review is a screening level review, and thus does not yield any “final determination,” or adverse action to be appealed. As with all screenings, the questions are broad and basic and

set off flags for more information, and an appeal of a screening would not be feasible. Since an individual can always be re-screened if requested by the individual or a representative of the individual, this requirement appears to create an unnecessary logistical and cost burden not only for SIDAs and NFs, but individuals being admitted, whose admission processes will halt during an appeals process that could reasonably be expected to take three months or more.

Finally, NASDDDS encourages CMS to include permissive language that supports states incentivizing greater compliance with PASRR regulations and improved quality outcomes for individuals with PASRR conditions through the use of alternative payment models to NFs. This ultimately supports states that have an eye toward maximizing PASRR's potential as a diversionary tool and a strategy for community reintegration.

Conclusion

The PASRR program is a key tool for ensuring that individuals with ID receive the services they need to live in the most integrated setting possible. NASDDDS appreciates this long-overdue update of the PASSR regulations, which we hope will facilitate a stronger and more effective program.

Sincerely,

Mary P. Sowers
Executive Director
NASDDDS