NASMHPD
National Association of State Mental Health Program Directors
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May 14, 2020

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
314G-01 Humphrey Bldg.
200 Independence Avenue
Washington, D.C. 20201

Re: Proposed Regulation: Medicaid Program; Preadmission Screening and Resident Review (CMS-2418-P) – NASMHPD Response

Dear Administrator Verma:

The National Association of State Mental Health Program Directors (NASMHPD)— the member organization representing the state executives responsible for public mental health service delivery systems in all 50 states, 5 territories, and the District of Columbia, thanks you for the opportunity to comment on the proposed revisions to the Medicaid regulations governing Preadmission Screening and Resident Review (PASRR) (CMS-2418-P).

NASMHPD welcomes CMS's initiative to update and clarify the PASRR regulations, and we are generally in support of what is proposed. We also express our appreciation for the willingness of CMS to extend the deadline for comments to May 20 given the pressing exigencies inherent in responding to the COVID19 pandemic.

However, we have concerns about proposed appeals of Level 1 (L1) identifications, proposed mandated provider clinical qualifications for conducting evaluations and determinations, and complications that would arise from removing State Mental Health Agency (SMHA) personnel from Level 2 (L2) evaluations and determinations, particularly in states where the SMHA and the State Intellectual Disabilities Agency are the same agency.

First, we cannot support the proposed mandate within the right to appeal an adverse outcome under 42 CFR 431.204 that states provide a formal appeal mechanism for the L1 identification of an individual with a possible mental illness or intellectual disability. The right to a formal appeal of an L1 identification is not a formal right that states currently afford under PASRR procedures. First, appeals within the PASRR structure are generally handled by the State Medicaid Agency, not the State Mental Health Agency handling the initial identification. About two-thirds of State Mental Health Agencies surveyed by NASMHPD said they do not currently have a formal appeals procedure in place for Level I Determinations. Secondly, the L1 review is a screening level review, and thus does not yield any "final determination." When an individual screens in as potentially a person with behavioral health and DD conditions, a deeper review is conducted. Thus, as with all screenings, the questions are broad and basic and set off flags for more information. Thus, an appeal of a screening would not be feasible. Instead, an individual can always be re-screened if requested by the individual or a representative of the individual.

LI determinations are made based entirely on the information submitted at the point in time of the individual admittee's LI screen. States have informal procedures in place for updating the initial identification where supplemental information is provided or the original information provided is incorrect. A new LI identification can be undertaken at any time, including the same day a prior LI identification is completed. An LI identification can be repeated with whatever additional information is presented at the point of the identification where there is disagreement with the identification. In at least one state, the Level I identification is re-assigned to ensure an objective re-screening.

Given the number of LI identifications undertaken across any state, implementing a mandated formal appeals procedure would impose unreasonable costs and significant administrative burden and could result in a less than appropriate or cost-effective assignment of services to persons not needing those services simply to avoid the threat of a formal appeal. Of the states

surveyed by NASMHPD, about 18 percent said it would take 3 to 6 months to implement a formal LI appeals procedure, 35 percent predicted a formal appeals procedure would take 6 to 12 months to implement, and 30 percent predicted it could take 12 months or more to implement formal L1 appeals procedures. Of those surveyed, 23.5 percent said implementing such a procedure would require a state legislative change, 59 percent said it would take a state regulatory change, and 41 percent said it would require a change in state appropriations. Again, all of this is based on the premise that the L1 can yield a denial (which it is actually a screening procedure for further evaluation).

Given the wide existence of informal procedures for revising L1 identifications among the states and the significant administrative burden and costs inherent in implementing formal appeals for L1 identifications, combined with the potential adverse consequences to the effective utilization of state resources, and the significant time it would take to implement formal appeals procedures, we ask that this mandate be eliminated from the final regulations adopted.

Additionally, NASMHPD has concern regarding Item 5. Basic Rules and Responsibilities (§483.106), specifically the proposed clarifications to the role of the State Mental Health Authority (SMHA). The proposal calls for clarifying language that "indicates that the SMHA's determination for people with mental illness must be based on a physical and mental evaluation performed by a person or entity that is 'independent from' the SMHA; however, the State Intellectual Disabilities Agency (SIDA) is empowered and enabled to complete the evaluation of IDD. While we acknowledge that this change is dictated by the underlying statute, in states in which the SMHA and the SIDA are one in the same, the current ambiguity has allowed best practice to emerge whereby the evaluation teams are managed by the same governmental entity promoting coordination, partnership, and resource access for those with concomitant mental illness and intellectual/developmental disabilities. The proposed clarity may actually radically impact current state designs and contracts and, if adopted, may require states to terminate contracts, re-procure new vendors, and redesign workflows for individuals applying for or currently in Nursing Facilities. If this is implemented, states will require a period of time to manage this structural re-design (at least 6 months). This is a particular concern right now as states manage the emergency response to COVID-19.

Finally, we are concerned that the proposal at §483.128(b) that would require the state to specify what mental health practitioners or intellectual disability or developmental disability practitioners are qualified to make or confirm the clinical diagnoses specified within the PASRR regulations would be problematic and costly due to professional workforce shortages across the nation, but particularly in rural, inner city, and frontier locations. For some states, this would require a significant adjustment to the workforce and necessitate associated increased costs. Many individuals applying for nursing facilities have already received multiple diagnoses from many healthcare systems and professionals. This data is generally available for review, and the evaluating team is required to be multi-disciplinary, with a physician who can assist team members where there may be need for diagnostic discernment. The mandate that only highly qualified practitioners be permitted to diagnose individuals for particular conditions seems like an unnecessary, inefficient, and impractical use of those practitioners. The universe of practitioners available for this purpose needs to be broadened, not narrowed. As an alternative, we suggest making training on PASRR procedures available at a federal level to achieve the goals of ensuring proper application of the PASRR regulations.

Thank you for taking these concerns into consideration in adopting the final PASRR regulations. If you have any questions regarding this correspondence, please feel free to contact me at 703-682-5181 or by email or NASMHPD's Senior Director of Policy and Communications, Stuart Yael Gordon, at 703-682-7552 or by email.

Sincerely,

Brian Hepburn, M.D.
Executive Director
National Association of State Mental Health Program Directors (NASMHPD)

cc: Ann Blackfield, Health Insurance Specialist, Division of Long-Term Services and Supports, Center for Medicare