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MEMORANDUM

TO: **Emily McClellan**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **Davis Creef**
Assistant Attorney General
Office of the Attorney General

DATE: **May 24, 2021**

SUBJECT: **2020 Long Term Services and Supports (LTSS) Screening Changes**

I have reviewed the attached emergency regulations regarding changes to the Long-Term Services and Supports (LTSS) screening procedures. You have asked the Office of the Attorney General to review and determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to amend the regulations and if the regulations comport with state and federal law.

The changes in these regulations reflect changes required to conform with newly amended provisions of the Code of Virginia. Further, pursuant to the General Assembly's direction, DMAS is required to promulgate these regulations to be effective within 280 days of enactment of the corresponding legislation. Based on my review, it is my view that the Director of DMAS, acting on behalf of the Board of Medical Assistance Services, under Virginia Code §§ 32.1-324 and 325, has the authority to amend these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act ("APA") and has not exceeded that authority. Based on the foregoing, it is my view that the amendments to these regulations are supported by emergency authority pursuant to Virginia Code § 2.2-4011(B).

Please note that Virginia Code § 2.2-4011(C) requires that all emergency regulations be limited to no more than 18 months in duration. If you have any questions or need additional information about these regulations, please contact me at (804)786-6522.

cc: Kim F. Piner, Esq.

Attachment

Emergency Text

highlight

Action: 2020 Long Term Services and Supports (LTSS) Screening Changes
Stage: Emergency 4/14/21 6:56 PM [latest]

12VAC30-60-301 Definitions
The following words and terms as used in 12VAC30-60-302 through 12VAC30-60-315 shall have the following meanings unless the context clearly indicates otherwise:

"Activities of daily living" or "ADLs" means personal care tasks such as bathing, dressing, toileting, transferring, and eating or feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

"Acute care hospital" or “Hospital” means an acute care hospital, a rehabilitation hospital, a rehabilitation unit in an acute care hospital, or a psychiatric unit in an acute care hospital.

"Adult" means a person age 18 years or older who may need Medicaid-funded long-term services and supports (LTSS) or who becomes functionally eligible to receive Medicaid-funded LTSS.

"Appeal" means the processes used to challenge actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110 and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20.

"At risk" means the need for the level of care provided in a hospital~~,~~ or nursing facility~~, or an intermediate care facility for individuals with intellectual disability (ICF/IID)~~ when there is reasonable indication that the individual is expected to need the services ~~in the near future (that is, 30 days or less)~~ within the next 30 days in the absence of home or community-based services.

"Child" means a person up to the age of 18 years who may need Medicaid-funded LTSS or who becomes functionally eligible to receive Medicaid-funded LTSS.

"Choice" means the individual is provided the option of either ~~home and community-based waiver services~~ the Commonwealth Coordinated Care Plus Waiver, the Program of All-Inclusive Care for the Elderly (PACE), if available and appropriate, or institutional services and supports~~, including the Program of All-Inclusive Care for the Elderly (PACE), if available and appropriate,~~ after the individual has been determined likely to need LTSS.

"Communication" means all forms of sharing information and includes oral speech and augmented or alternative communication used to express thoughts, needs, wants, and ideas, such as the use of a communication device, interpreter, gestures, and picture or symbol communication boards.

"Community-based team" or "CBT" means (i) a registered nurse or nurse practitioner; (ii) a social worker or other assessor designated by DMAS; and (iii) a physician. The CBT members are employees of, or contracted with, the Virginia Department of Health or the local department of social services. The authorization

or denial for Medicaid LTSS (DMAS-96 form) must be signed and attested to by the screener(s) and a physician.

"CSB" means a local community services board.

"DARS" means the Virginia Department for Aging and Rehabilitative Services.

"Day" means calendar day unless specified otherwise.

"DBHDS" means the Virginia Department of Behavioral Health and Developmental Services.

"DMAS" means the Department of Medical Assistance Services.

"DMAS designee" means the public or private entity with ~~an agreement~~ a contract with the Department of Medical Assistance Services to complete ~~preadmission~~ LTSS screenings pursuant to § 32.1-330 of the Code of Virginia when a community-based, hospital or nursing facility LTSS Screening team cannot complete LTSS Screenings within the required 30 days of the LTSS Screening request date.

"~~ePAS~~eMLS" means the DMAS ~~automated system or a DMAS-approved~~ electronic Medicaid Long Term Services and Supports (LTSS) Screening record system ~~for use~~ used by LTSS screening entities ~~contracted by DMAS~~ to ~~perform~~ record results from the LTSS screenings pursuant to § 32.1-330 of the Code of Virginia.

"Face-to-face" means an in-person meeting with the individual seeking Medicaid-funded LTSS.

"Feasible alternative" means a range of services that can be provided in the community via waiver or PACE, for less than the cost of comparable institutional care, in order to enable an individual to continue living in the community.

"Functional capacity" means the degree of independence that an individual has in performing ADLs, ~~ambulation, and instrumental ADLs~~ as measured on the UAI and as used as a basis for differentiating levels of long-term ~~care~~ services and supports.

"Functional eligibility" means the demonstrable degree to which an individual requires assistance with activities of daily living.

"Home and community-based services" means community-based waiver services or the Program of All-Inclusive Care for the Elderly (PACE).

"Home and community-based services provider" means a provider or agency enrolled with Virginia Medicaid to offer services to individuals eligible for ~~home and community-based waivers~~ the Commonwealth Coordinated Care (CCC) Plus waiver services or PACE.

"Home and community-based services waiver," "HCBS," or "waiver services" means the range of community services and supports, ~~including PACE,~~ approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to § 1915(c) of the Social Security Act to be offered to individuals as an alternative to institutionalization.

"Hospital team" means persons designated by the hospital who are responsible for conducting and submitting the LTSS screening documents for inpatients to ~~ePAS~~eMLS. The authorization or denial for Medicaid LTSS (DMAS-96 form) must be signed and attested to by the screener(s) and a physician.

"Inpatient" means an individual who has a physician's order for admission to an acute care hospital, rehabilitation hospital, or a rehabilitation unit in an acute care

hospital and shall not apply to outpatients, patients in observation beds, and patients of the hospital's emergency department.

"Local department of social services" or "LDSS" means the entity established under § 63.2-324 of the Code of Virginia by the governing city or county in the Commonwealth.

"Local health department" or "LHD" means the entity established under § 32.1-31 of the Code of Virginia.

"Long-term services and supports" or "LTSS" means a variety of services that help individuals with health or personal care needs and ADLs over a period of time that can be provided in the home, the community, or nursing facilities.

"Long-Term Services and Supports (LTSS) Screening" or “LTSS Screening” means the face to face process to (i) evaluate the functional, medical or nursing, and social support needs and at-risk status of individuals referred for certain long-term services requiring nursing facility level of care eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet the individual’s needs; and (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility, PACE plan services, or the Commonwealth Coordinated Care Plus waiver for those individuals who meet nursing facility level of care.

“Long-Term Services and Supports (LTSS) Screening Team” means the hospital screening team, community-based team (CBT), nursing facility LTSS team, or DMAS designee contracted to perform screenings pursuant to § 32.1-330 of the Code of Virginia.

"Managed care organization" or "MCO" means a health plan selected to participate in the Commonwealth's CCC Plus program and that is a party to a contract with DMAS.

"Medicaid" means the program set out in the 42 USC § 1396 et seq. and administered by the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Medical or nursing need" means (i) the individual's condition requires observation and assessment to ensure evaluation of needs due to an inability for self-observation or evaluation; (ii) the individual has complex medical conditions that may be unstable or have the potential for instability; or (iii) the individual requires at least one ongoing medical or nursing service.

"Medicare" means the Health Insurance for the Aged and Disabled program as administered by the Centers for Medicare and Medicaid Services pursuant to 42 USC 1395ggg.

"Minimum data set" or "MDS" means the ~~evaluation~~ assessment form used by nursing facilities, as federally required, for the purpose of documenting ongoing level of care required for all of an NF's residents.

"Nursing facility" or "NF" means any nursing home as defined in § 32.1-123 of the Code of Virginia.

"Nursing facility LTSS screening team" means nursing facility staff trained and certified in the use of the LTSS screening tools who are responsible for performing LTSS screenings for individuals who apply for or request LTSS while receiving skilled nursing services in a setting not covered by Medicaid and after discharge from a hospital. Nursing facility LTSS screening staff must include at least one registered nurse and a certifying physician. The authorization or denial for

Medicaid LTSS (DMAS-96 form) must be signed and attested to by the screener(s) and a physician.

"Ongoing" means continuous medical or nursing needs that shall not be temporary.

"Other assessor designated by DMAS" means an employee of the local department of social services holding the occupational title of family services specialist or an employee of a DMAS designee.

~~"Preadmission screening" or "screening" means the face-to-face process to (i) evaluate the functional, medical or nursing, and social support needs of individuals referred for screening for certain long-term care services requiring NF eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet the individual's needs; and (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility or home and community-based services for those individuals who meet nursing facility level of care.~~

"Private pay individual" means individuals who are not eligible for Medicaid or not expected to become eligible for Medicaid ~~within six months following admission~~ and have alternate payment sources for care.

"Program of All-Inclusive Care for the Elderly" or "PACE" means the community-based service pursuant to § 32.1-330.3 of the Code of Virginia.

"Provider" means an individual professional or an agency enrolled with Virginia Medicaid to offer services to eligible individuals.

"Referral for LTSS screening" means information obtained from an interested person or other third party having knowledge of an individual who may need Medicaid-funded LTSS and may include, for example, a physician, PACE provider, service provider, family member, or neighbor who is able to provide sufficient information to enable contact with the individual.

"Representative" means a person who is legally authorized to make decisions on behalf of the individual.

"Request date for LTSS screening" or "request date" means the date (i) that an individual, an emancipated child, the individual's representative, an adult protective services worker, child protective services worker, physician, or the managed care organization (MCO) (health plan) care coordinator contacts the LTSS screening entity in the jurisdiction where the individual resides asking for assistance with LTSS, or (ii) for hospital inpatients, that a physician orders case management consultation or a hospital's case management service determines the need for LTSS upon discharge from the hospital.

"Request for LTSS screening" means (i) communication from an individual, an emancipated child, individual's representative, adult protective services worker, child protective services worker, physician, managed care organization (MCO) care coordinator, or CSB support coordinator, expressing the need for LTSS or (ii) for hospital inpatients, a physician order for case management consultation or case management determination of the need for LTSS upon discharge from a hospital.

"Residence" means the location in which an individual is living, for example, an individual's private home, apartment, assisted living facility, nursing facility, jail or correctional facility.

"Screening entity" means the employer of the hospital screening team, community-based team, nursing facility LTSS screening team or DMAS designee contracted

to perform screenings pursuant to § 32.1-330 of the Code of Virginia.

"Significant change in condition" means a change in an individual's condition that is expected to last longer than 30 days and shall not include (i) short-term changes that resolve with or without intervention; (ii) a short-term illness or episodic event; or (iii) a well-established, predictive, cyclic pattern of clinical signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

"Submission" means the transmission of the LTSS screening findings via ~~ePAS~~eMLS the electronic portal for LTSS screenings.

"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional assessment instrument that is completed by the LTSS screening ~~entity~~ team that assesses an individual's physical health, mental health, and psycho/social and functional abilities to determine if the individual meets the nursing facility level of care.

"VDH" means the Virginia Department of Health.

12VAC30-60-302 Access to Medicaid-funded long-term services and supports.

A. Medicaid-funded long-term services and supports (LTSS) may be provided in either home and community-based or institutional-based settings. To receive LTSS, the individual's condition shall first be evaluated using the designated assessment instrument, the Uniform Assessment Instrument (UAI), and other DMAS-designated forms. ~~Screening~~ LTSS screening ~~entities~~ teams shall also use the DMAS-designated forms (~~DMAS-95,~~ DMAS-96~~,~~ and DMAS-97)~~, if~~ if selecting nursing facility placement, the DMAS-95 Level I (~~MI/IDD/RC~~MI/ID/RC)~~, as appropriate, the DMAS-108, and the DMAS-109. If~~ screening must be completed and if indicated by the DMAS-95 Level I results, the individual shall be referred to DBHDS for completion of the DMAS-95 Level II evaluation and determination ~~(for nursing facility placements only).~~ prior to admission to the nursing facility. For private duty nursing services under the Commonwealth Coordinated Care (CCC) Plus waiver, the DMAS-108 (adult), or the DMAS-109 (child), shall be used to document needs.

1. An individual's need for LTSS shall meet the established criteria (12VAC30-60-303) before any authorization for reimbursement by Medicaid or its designee is made for LTSS.

2. Appropriate home and community-based services shall be evaluated as an option for long-term services and supports prior to consideration of nursing facility placement.

B. The evaluation shall be the LTSS screening as designated in § 32.1-330 of the Code of Virginia, which, if eligible, shall preauthorize a continuum of LTSS covered by Medicaid. These LTSS screenings shall be conducted face to face.

1. Such LTSS screenings, using the UAI, shall be conducted by teams of representatives of (i) acute care hospitals for individuals (adults and children) who are inpatients; (ii) local departments of social services and local health departments, known herein as CBTs, for adults and children residing in the community and who are not inpatients; (iii) a DMAS designee for and children children residing in the community ~~who are not inpatients;~~ or are hospital inpatients and cannot be screened by the LTSS screening team within 30 days of the request date; and (iv) ~~a DMAS designee for adults residing in the community who are not inpatients and who cannot be screened by the CBT within 30 days of the request date~~ nursing facility LTSS screening teams for individuals who apply for or request LTSS while receiving skilled or rehabilitative nursing services in a

setting not covered by Medicaid and after discharge from an acute care hospital. ~~All of these entities~~ Hospitals, CBTs and DMAS designees shall be contracted with DMAS or authorized by DMAS to perform this activity and be reimbursed by DMAS.

2. All LTSS screenings shall be comprehensive, accurate, standardized, and reproducible evaluations of individual functional capacities, medical or nursing needs, and whether the individual is at risk for institutional placement within 30 days of the LTSS screening.

C. Individuals shall not be required to be financially eligible for receipt of Medicaid or have submitted an application for Medicaid in order to be screened for LTSS for admission to either a NF or home and community-based services.

D. Pursuant to § 32.1-330 of the Code of Virginia, ~~individuals shall be screened if they are financially eligible for Medicaid or are anticipated to become financially eligible for Medicaid reimbursement of their NF care within six months of NF admission or Medicaid reimbursement of home and community-based services and supports~~ every individual who applies for or requests Medicaid community or institutional long-term services and supports shall be screened prior to admission to such community or institutional LTSS to determine their need for long-term services and supports, including nursing facility services.

E. Special circumstances.

1. Private pay individuals ~~who will not become financially eligible for Medicaid within six months from admission~~ who seek admission to a Virginia nursing facility shall not be required to have a LTSS screening in order to be admitted to the NF.

2. Individuals who reside out of state and seek direct admission to a Virginia nursing facility shall not be required to have a LTSS screening. Individuals who need a LTSS screening for HCBS waiver or PACE programs and request the LTSS screening shall be screened by the CBT ~~or DMAS designee, as appropriate,~~ serving the locality in which the individual resides once the individual has relocated to the Commonwealth.

3. Individuals who are inpatients in an out-of-state hospital, in-state or out-of-state veteran's hospital, or in-state or out-of-state military hospital and seek direct admission to a Virginia NF shall not be required to have a LTSS screening. Individuals who need a LTSS screening for HCBS waiver or PACE programs and request the LTSS screening shall be referred, upon discharge from one of the identified facilities, to the CBT ~~or DMAS designee, as appropriate,~~ serving the locality in which the individual resides once the individual has relocated to the Commonwealth.

4. Individuals who are patients or residents of a state owned or operated facility ~~that is licensed~~ by DBHDS and seek direct admission to a Virginia NF shall not be required to have a LTSS screening. Individuals who need a LTSS screening for HCBS waiver or PACE and request the LTSS screening shall be referred, upon discharge from the facility, to the CBT ~~or DMAS designee, as appropriate~~, serving the locality in which the individual resides.

5. A LTSS screening shall not be required for enrollment in Medicaid hospice services as set out in 12VAC30-50-270 or home health services as set out in 12VAC30-50-160.

~~6. Wilson Workforce Rehabilitation Center (WWRC) staff shall perform screenings of the WWRC clients.~~

F. Failure to comply with DMAS requirements, including competency and training requirements applicable to staff, may result in retraction of Medicaid payments.

12VAC30-60-303 Screening criteria for Medicaid-funded long-term services and supports

A. Functional capacity alone shall not be deemed sufficient to demonstrate the need for nursing facility care admission or authorization for home and community-based services and supports. An individual shall be determined to meet the nursing facility level of care criteria when:

1. The individual has both limited functional capacity, medical or nursing needs, and is at risk of NF admission within 30 days according to the requirements of this section; or

2. The individual is rated dependent in some functional limitations, but does not meet the functional capacity requirements, and the individual requires the daily direct services or supervision of a licensed nurse that cannot be managed on an outpatient basis (e.g., clinic, physician visits, home health services).

B. In order to qualify for Medicaid-funded LTSS, the individual shall meet the following criteria:

1. The criteria for screening an individual's eligibility for Medicaid reimbursement of NF services shall consist of three components: (i) functional capacity (the degree of assistance an individual requires to complete ADLs); (ii) medical or nursing needs; and (iii) the individual is at risk of NF admission within 30 days of the LTSS screening date. The rating of functional dependency on the UAI shall be based on the individual's ability to function in a community environment and exclude all institutionally induced dependencies.

2. In order for Medicaid-funded community-based LTSS to be authorized, an individual shall not be required to be physically admitted to a NF. The criteria for screening an individual's eligibility for Medicaid reimbursement of community-based services shall consist of three components: (i) functional capacity; (ii) medical or nursing needs; and (iii) the individual's risk of NF placement within 30 days in the absence of community-based services.

C. Functional capacity.

1. When documented on a UAI that is completed in a manner consistent with the definitions of activities of daily living (ADLs) and directions provided by DMAS for the rating of those activities, individuals may be considered to meet the functional capacity requirements for nursing facility care when one of the following describes their functional capacity:

a. Rated dependent in two ~~to four~~ or more of the ADLs, and also rated semi-dependent or dependent in Behavior Pattern and Orientation, and semi-dependent or dependent in Joint Motion or dependent in Medication Administration.

b. Rated dependent in five to seven of the ADLs, and also rated dependent in Mobility.

c. Rated semi-dependent or dependent in two to seven of the ADLs, and also rated dependent in Mobility and Behavior Pattern and Orientation.

2. The rating of functional capacity on the LTSS screening instrument shall be based on the individual's ability to function in a community environment, not including any institutionally induced dependence. The following abbreviations shall mean: I = independent; d = semi-dependent; D = dependent; MH = mechanical help; HH = human help.

a. Bathing.

(1) Without help (I)

(2) MH only (d)

(3) HH only (D)

(4) MH and HH (D)

(5) Performed by Others (D)

(6) Is not Performed (D)

b. Dressing.

(1) Without help (I)

(2) MH only (d)

(3) HH only (D)

(4) MH and HH (D)

(5) Performed by Others (D)

(6) Is not Performed (D)

c. Toileting.

(1) Without help day or night (I)

(2) MH only (d)

(3) HH only (D)

(4) MH and HH (D)

(5) Performed by Others (D)

(6) Is not Performed (D)

d. Transferring.

(1) Without help (I)

(2) MH only (d)

(3) HH only (D)

(4) MH and HH (D)

(5) Performed by Others (D)

(6) Is not Performed (D)

e. Bowel function.

(1) Continent (I)

(2) Incontinent less than weekly (d)

(3) External/Indwelling Device/Ostomy -- ~~self care~~ self-care (d)

(4) Incontinent weekly or more (D)

(5) Ostomy -- not ~~self care~~ self-care (D)

f. Bladder function.

(1) Continent (I)

(2) Incontinent less than weekly (d)

(3) External device/Indwelling Catheter/Ostomy -- ~~self-care~~ self-care (d)

(4) Incontinent weekly or more (D)

(5) External device -- not ~~self-care~~ self-care (D)

(6) Indwelling catheter -- not ~~self-care~~ self-care (D)

(7) Ostomy -- not ~~self-care~~ self-care (D)

g. Eating/Feeding.

(1) Without help (I)

(2) MH only (d)

(3) HH only (D)

(4) MH and HH (D)

(5) Spoon fed (D)

(6) Syringe or tube fed (D)

(7) Fed by IV or clysis (D)

h. Behavior pattern and orientation.

~~(1) Appropriate or Wandering/Passive less than weekly Oriented (I)~~

~~(2) Appropriate or Wandering/Passive less than weekly Disoriented -- Some Spheres(I)~~

~~(3) Wandering/,Passive Weekly/or more Oriented (I)~~

~~(4) Appropriate or Wandering/Passive less than weekly Disoriented -- All Spheres Appropriate Disoriented some spheres some of the time (d)~~

~~(5) Wandering/Passive Weekly/Some or more Disoriented -All Spheres (d)~~

~~(6) Abusive/Aggressive/Disruptive less than weekly Oriented or Disoriented (d) (I)~~

~~(7) Abusive/Aggressive/Disruptive weekly or more Oriented (d)~~

~~(8) Abusive/Aggressive/Disruptive Disoriented -- All Spheres (D)~~

(1) Appropriate or Wandering/Passive less than weekly + Oriented (I)

(2) Appropriate or Wandering/Passive less than weekly + Disoriented -- Some Spheres (I)

(3) Wandering/Passive Weekly/or more + Oriented (I)

(4) Appropriate or Wandering/Passive less than weekly + Disoriented -- All Spheres (d)

(5) Wandering/Passive Weekly/Some or more + Disoriented -- All Spheres (d)

(6) Abusive/Aggressive/Disruptive less than weekly + Oriented or Disoriented (d)

(7) Abusive/Aggressive/Disruptive weekly or more + Oriented (d)

(8) Abusive/Aggressive/Disruptive + Disoriented -- All Spheres (D)

i. Mobility.

(1) Goes outside without help (I)

(2) Goes outside MH only (d)

(3) Goes outside HH only (D)

(4) Goes outside MH and HH (D)

(5) Confined -- moves about (D)

(6) Confined -- does not move about (D)

j. Medication administration.

(1) No medications (I)

(2) Self administered -- monitored less than weekly (I)

(3) By lay persons, Administered/Monitored (D)

(4) By Licensed/Professional nurse Administered/Monitored (D)

k. Joint motion.

(1) Within normal limits or instability corrected (I)

(2) Limited motion (d)

(3) Instability -- uncorrected or immobile (D)

D. Medical or nursing needs. An individual with medical or nursing needs is an individual whose health needs require medical or nursing supervision or care above the level that could be provided through assistance with ADLs, medication administration, and general supervision and is not primarily for the care and treatment of mental diseases. Medical or nursing supervision or care beyond this level is required when any one of the following describes the individual's need for medical or nursing supervision:

1. The individual's medical condition requires observation and assessment to ensure evaluation of the individual's need for modification of treatment or additional medical procedures to prevent destabilization, and the person has demonstrated an inability to ~~self-observe~~ self-observe or evaluate the need to contact skilled medical professionals;

2. Due to the complexity created by the individual's multiple, interrelated medical conditions, the potential for the individual's medical instability is high or medical instability exists; or

3. The individual requires at least one ongoing medical or nursing service. The following is a nonexclusive list of medical or nursing services that may, but need not necessarily, indicate a need for medical or nursing supervision or care:

a. Application of aseptic dressings;

b. Routine catheter care;

c. Respiratory therapy;

d. Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have recent history of weight loss or inadequate hydration that, if not supervised, would be expected to result in malnourishment or dehydration;

e. Therapeutic exercise and positioning;

f. Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder;

g. Use of physical (e.g., side rails, ~~poseys,~~ posey vests, geri-chairs, locked ~~wards~~ units) or chemical restraints (e.g. overuse of sedatives), or both;

h. Routine skin care to prevent pressure ulcers for individuals who are immobile or whose medical condition increases the risk of skin breakdown;

i. Care of small uncomplicated pressure ulcers and local skin rashes;

j. Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;

k. Chemotherapy;

l. Radiation;

m. Dialysis including observation of and care of the access port;

n. Suctioning;

o. Tracheostomy care;

p. Infusion therapy; or

q. Oxygen.

E. When screening a child, the screening entity who is conducting the screening for LTSS shall utilize the electronic Uniform Assessment Instrument (UAI) ~~interpretive guidance as referenced in DMAS' Medicaid Memo dated November 22, 2016, entitled "Reissuance of the Pre-Admission Screening (PAS) Provider Manual, Chapter IV,"~~ guidance provided in the Screening for Medicaid Long Term Services and Supports Manual, Chapter IV which can be accessed on the DMAS website at **https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/MedicaidMemostoProviders**.

12VAC30-60-304 Requests and referrals for LTSS screenings for adults and children living in the community and adults and children in hospitals, and Adults and Children Needing LTSS in Nursing Facilities

A. LTSS ~~Screenings~~ screenings for adults living in the community. ~~Screenings~~ LTSS screenings for adults who are residing in the community ~~but~~ and who are not hospital inpatients shall be completed and submitted by the CBT to ~~ePAS~~eMLS. If the individual, or any of the other persons permitted to make such requests, requests a LTSS screening, the CBT shall be required to perform the requested LTSS screening~~; otherwise, CBTs shall not be required to screen individuals who are not expected to become financially eligible for Medicaid-funded LTSS within six months of the screening~~ Every individual who applies for or request LTSS shall have the opportunity to choose the setting and provider of services, and have this choice documented.

1. Requests for LTSS screenings shall be accepted from either an individual, the individual's representative, an adult protective service worker, the individual's physician, or an MCO care coordinator having an interest in the individual. The CBT in the jurisdiction where the individual resides shall conduct such LTSS screening. For the LTSS screening to be scheduled by the CBT, the individual shall either agree to participate or, if refusing, shall be under order of a court of appropriate jurisdiction to have a LTSS screening. Medicaid payment for services cannot be considered without agreement of the individual, or the individual's representative, to participate in the LTSS screening.

a. The LDSS or LHD in receipt of the request for a LTSS screening shall contact the individual or his representative within seven days of the request date for screening to schedule a LTSS screening with the individual and any other persons whom the individual selects to attend the screening.

b. When the CBT has not scheduled a LTSS screening to occur within 21 days of the request date for screening, and the LTSS screening is not anticipated to be complete within 30 days of the request date for screening due to the screening entity's inability to conduct the LTSS screening, the LDSS and LHD shall, no later than seven days after the request date for screening, notify DARS and VDH staff designated for technical assistance.

2. Referrals for LTSS screenings may also be accepted by LDSS or LHD from an interested person having knowledge of an individual who may need LTSS. When the LDSS or LHD receives such a referral, the LDSS or LHD shall obtain sufficient information from the referral source to initiate contact with the individual or his representative to discuss the LTSS screening process. Within seven days of the referral date, the LDSS or LHD shall contact the individual or his representative to determine if the individual is interested in receiving LTSS and would participate in the LTSS screening. If the LDSS or LHD is unable to contact the individual or his representative, it shall document the attempt to contact the individual or his representative using the method adopted by the CBT.

a. After contact with the individual or his representative, or if the LDSS or LHD is unable to contact the individual or his representative, the LDSS or LHD shall advise the referring interested person that contact or attempt to contact has been made in response to the referral for an LTSS screening.

b. Information about the results of the contact shall only be shared by the LDSS or LHD with the interested person who made the referral when the LDSS or LHD has the individual's written consent or the written consent of his legal representative who has such authority on behalf of the individual.

B. ~~Screenings~~ LTSS screenings for children living in the community. ~~Screenings~~ LTSS screenings for children who are residing in the community ~~but~~ and who are not hospital inpatients shall be completed and submitted via ~~ePAS~~eMLS. If the individual or parent or guardian, or any of the other persons permitted to make such requests, requests a LTSS screening, the DMAS community screening designee shall perform the requested LTSS screening~~; otherwise, the DMAS designee shall not be required to screen individuals who are not expected to become financially eligible for Medicaid-funded LTSS within six months of the screening~~ Every individual who applies for or requests LTSS shall have the opportunity to choose the setting and provider of services, and have this choice documented.

1. A child who is residing in the community and is not an inpatient shall receive a LTSS screening from a DMAS community screening designee. The DMAS community screening designee may receive requests for LTSS screenings directly. Any requests for LTSS screenings for a child received by the CBT shall be forwarded directly to the DMAS designee. For the LTSS screening to be scheduled by the ~~CBT~~ DMAS community screening designee, the child shall either agree to participate or, if refusing, shall be under order of a court of appropriate jurisdiction to have a LTSS screening. Medicaid payment for services cannot be considered without agreement of the individual, or the individual's representative, to participate in the LTSS screening.

2. The request for LTSS screening of a child residing in the community shall be accepted from the parent, legal guardian, the entity having legal custody of that child, an emancipated child, a physician, ~~an~~ a MCO care coordinator, or a child protective service worker having an interest in the child.

3. Referrals for LTSS screenings may also be accepted from an interested person having knowledge of a child who may need LTSS. The process, timing, and limitations on the sharing of the results for referrals for LTSS screenings for

children shall be the same as that set out for adults in subdivision A 2 of this section.

C. ~~Screenings~~ LTSS screenings in hospitals for adults and children who are inpatients. ~~Screenings~~ LTSS screenings in hospitals shall be completed when an adult or child who is an inpatient is discharged directly to a NF, or may need LTSS in the community upon discharge or when the individual, MCO, or representative requests a LTSS screening. Medicaid payment for services cannot be considered without agreement of the individual, or the individual's representative, to participate in the LTSS screening. Every individual who applies for or requests LTSS shall have the opportunity to choose the setting and provider of services, and have this choice documented.

1. As a part of the discharge planning process, the hospital team shall ~~also~~ complete a face-to-face LTSS screening when:

a. The individual's physician, in collaboration with the individual or the individual's representative if there is one, makes a request of the hospital team. If the individual is a child, the LTSS screening shall be completed when the individual's physician, in collaboration with the child's parent, legal guardian, the entity having legal custody of the child, the emancipated child, adult protective services worker, child protective services worker, or MCO care coordinator makes a request of the hospital team; or

b. The individual, the individual's representative if there is one, parent, legal guardian, entity having legal custody, emancipated child, adult protective services worker, child protective services worker, or MCO care coordinator requests a consultation with hospital case management.

2. When there is a request, such individual shall receive a LTSS screening conducted by the hospital team regardless of if he is eligible for Medicaid or is anticipated to become eligible for Medicaid within six months after admission to a NF.

3. The hospital team shall exclude all institutionally-induced dependencies from the face-to-face LTSS screening documentation.

D. LTSS screenings for individuals needing LTSS after a skilled or rehabilitation nursing facility services admission. LTSS screenings for individuals who need LTSS after receiving skilled or rehabilitation nursing facility services that are not covered by the Commonwealth's program of medical assistance services after discharge from an acute care hospital shall be completed and submitted via eMLS by NF LTSS screening teams. Medicaid payment for services cannot be considered without agreement of the individual, or the individual's representative, to participate in the LTSS screening. Every individual who applies for or requests LTSS shall have the opportunity to choose the setting and provider of services, and have this choice documented.

1. Requests for LTSS screening shall be accepted from either an individual, the individual's representative, the individual's physician, the NF LTSS screening team, or a MCO care coordinator having an interest in the individual.

The NF LTSS screening team shall contact the individual or his representative prior to enrollment in LTSS to schedule a LTSS screening with the individual and any other persons whom the individual selects to attend the LTSS screening.

2. Nursing facility LTSS screening teams must include at least one registered nurse and physician, but may include a social worker or other members of the interdisciplinary team. The authorization or denial for Medicaid LTSS (DMAS-96

form) must be signed and attested to by the nursing facility LTSS screener(s) and a physician.

~~D~~E. ~~Screenings~~ LTSS screenings shall be submitted via ~~e-PAS~~eMLS within 30 days of the screening request.

12VAC30-60-305 LTSS Screenings in the community and hospitals and Nursing Facilities for Medicaid-funded long-term services and supports

A. Community LTSS screenings for adults.

1. Medical or nursing and functional eligibility for Medicaid-funded LTSS shall be determined by the CBT after completion of a LTSS screening of the individual's needs and available supports. The CBT shall consider all the supports available for that individual in the community (i.e., the immediate family, other relatives, other community resources), and other services in the continuum of LTSS. The LTSS screening shall be documented on the DMAS-designated forms identified in 12VAC30-60-306.

2. ~~Screenings~~ Upon receipt of a LTSS screening request, the CBT shall schedule an appointment to complete the requested LTSS screening. LTSS screenings shall be completed in the individual's residence unless the residence presents a safety risk for the individual or the CBT, or unless the individual or the representative requests that the LTSS screening be performed in an alternate location within the same jurisdiction. Community settings where LTSS screenings may occur include the individual's residence, other residences, residential facilities, or other settings with the exception of inpatients in acute care hospitals, rehabilitation units of acute care hospitals, and rehabilitation hospitals.

3. The individual shall be permitted to have another person present at the time of the screening. Other than situations when a court has issued an order for a LTSS screening, the individual shall also be afforded the right to refuse to participate. The CBT shall determine the appropriate degree of participation and assistance given by other persons to the individual during the LTSS screening and accommodate the individual's preferences to the extent feasible.

~~3~~4. The CBT shall:

a. Observe the individual's ability to perform appropriate ADLs according to 12VAC30-60-303 and consider the individual's communication or responses to questions or his representative's communication or responses;

b. Observe, assess, and report the individual's medical, nursing, and functional condition. This information shall be used to ensure accurate and comprehensive evaluation of the individual's need for modification of treatment or additional medical procedures to prevent destabilization even when the individual has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals;

c. Identify the medical or nursing needs, and functional needs of the individual; and

d. Consider services and settings that may be needed by the individual in order for the individual to safely perform ADLs.

~~4~~5. Upon completion of the LTSS screening and in consideration of the communication from the individual or his representative, if appropriate, and observations obtained during the LTSS screening, the CBT shall determine whether the individual meets the criteria set out in 12VAC30-60-303. If the individual meets the criteria for LTSS, the CBT shall inform the individual or his representative, if appropriate, of this determination in writing and provide choice of the ~~feasible alternatives~~ the setting and provider of LTSS, such as PACE or ~~home~~

~~and community-based~~ CCC Plus waiver services, as alternative options to placement in a NF.

~~5~~6. If waiver services or PACE, where available, are declined, the reason for declining shall be recorded on the DMAS-97, Individual Choice - Institutional Care or Waiver Services Form. The CBT shall have this document signed by either the individual or his representative, if appropriate. In addition to the electronic document, a paper copy of the DMAS-97 form with the individual's or his representative's signature shall be retained in the individual's record by the LTSS screening entity.

~~6~~7. If the individual meets criteria and selects home and community-based services, the CBT shall also document that the individual is at risk of NF placement in the absence of home and community-based services by finding that at least one of the following conditions exists:

a. The individual has been cared for in the home prior to the screening and evidence is available demonstrating a deterioration in the individual's health care condition, a significant change in condition, or a change in available supports. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

b. There has been no significant change in condition or available support but evidence is available that demonstrates the individual's functional, medical, or nursing needs are not being met. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

~~7~~8. If the individual selects NF placement, the CBT shall follow the Level I identification and Level II evaluation process as outlined in Part III (12VAC30-130-140 et seq.) of 12VAC30-130.

~~8~~9. If the CBT determines that the individual does not meet the criteria set out in 12VAC30-60-303, the CBT shall notify the individual or the individual's representative, as may be appropriate, in writing that LTSS are being denied for the individual. The denial notice shall include the individual's right to appeal consistent with DMAS client appeals regulations (12VAC30-110).

~~9~~10. For those LTSS screenings conducted in accordance with clause iv of 12VAC30-60-302 B 1, the ~~DMAS designee~~ CBT shall follow the process outlined in this subsection.

B. Community LTSS screenings for children.

1. Medical or nursing and functional eligibility for Medicaid-funded LTSS shall be determined by the DMAS community screening designee after completion of a LTSS screening of the child's needs and available supports. The DMAS community screening designee shall consider all the supports available for that child in the community (i.e., the immediate family, other community resources), and other services in the continuum of LTSS. The LTSS screening shall be documented on the designated DMAS forms identified in 12VAC30-60-306.

2. Upon receipt of a LTSS screening request, the DMAS community screening designee shall schedule an appointment to complete the requested LTSS screening. LTSS screenings shall be completed in the child's residence unless the residence presents a safety risk for the child or the DMAS community screening designee, or unless the child's representative request that the LTSS screening be performed in an alternate location within the same jurisdiction. Community settings where LTSS screenings may occur include the child's residence, other residences,

children's residential facilities, or other settings with the exception of acute care hospitals, rehabilitation units of inpatients in acute care hospitals, and rehabilitation hospitals.

3. The child shall be permitted to have another person present at the time of the LTSS screening. The DMAS community screening designee shall determine the appropriate degree of participation and assistance given by other persons to the child during the LTSS screening and accommodate the individual's preferences to the extent feasible.

~~3~~4. The DMAS community screening designee shall:

a. Determine the appropriate degree of participation and assistance given by other persons to the individual during the LTSS screening in recognition of the individual's preferences to the extent feasible;

b. Observe the child's ability to perform appropriate ADLs according to 12VAC30-60-303 and consider the parent's, legal guardian's, or emancipated child's communications or responses to questions;

c. Observe, assess, and report the child's medical or nursing and functional condition. This information shall be used to ensure accurate and comprehensive evaluation of the child's need for modification of treatment or additional medical procedures to prevent destabilization even when the child has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals;

d. Identify the medical or nursing and the functional needs of the child; and

e. Consider services and settings that may be needed by the child in order for the child to safely perform ADLs in the community.

~~4~~5. Upon completion of the LTSS screening and in consideration of the communication from the child or his representative, if appropriate, and observations obtained during the LTSS screening, the DMAS community screening designee shall determine whether the child meets the criteria set out in 12VAC30-60-303. If the child meets the criteria for Medicaid-funded LTSS, the DMAS community screening designee shall inform the child and his representative, if appropriate, of this determination in writing and provide choice of the ~~feasible alternatives~~ setting and provider of LTSS, such as PACE or ~~home and community-based~~ CCC Plus waiver services, as alternative options to ~~NF~~ placement in a NF.

~~5~~6. If waiver services are declined, the reason for declining shall be recorded on the DMAS-97, Individual Choice - Institutional Care or Waiver Services Form. The DMAS community screening designee shall have this document signed by either the emancipated child or his representative. In addition to the electronic document, a paper copy of the DMAS-97 form with the child's or his representative's signature shall be retained in the child's record by the LTSS screening entity.

~~6~~7. If the child meets criteria and selects home and community-based services, the DMAS community screening designee shall also document that the individual is at risk of NF placement in the absence of home and community-based services by finding that at least one of the following conditions exists:

a. The child has been cared for in the home prior to the LTSS screening and evidence is available demonstrating a deterioration in the child's health care condition, a significant change in condition, or a change in available supports. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

b. There has been no significant change in condition or available support but evidence is available that demonstrates the child's functional, medical, or nursing needs are not being met. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

~~7~~8. If the parent, legal guardian, entity having legal custody of the child, or emancipated child selects NF placement, the DMAS community screening designee shall follow the Level I identification and Level II evaluation process as set out in Part III (12VAC30-130-140 et seq.) of 12VAC30-130.

~~8~~9. If the DMAS community screening designee determines that the child does not meet the criteria to receive Medicaid-funded LTSS as set out in 12VAC30-60-303, the DMAS community screening designee shall notify the parent, legal guardian, entity having legal custody of the child, or the emancipated child and representative, as may be appropriate, in writing that Medicaid-funded LTSS are being denied for the child. The denial notice shall include the child's right to appeal consistent with DMAS client appeals regulations (12VAC30-110).

C. Screenings for adults and children in hospitals. For the purpose of this subsection, the term "individual" shall mean either an adult or a child.

1. Medical or nursing and functional eligibility for Medicaid-funded LTSS shall be determined by the hospital LTSS screening team after completion of a LTSS screening of the individual's medical or nursing and functional needs and available supports. The hospital LTSS screening team shall consider all the supports available for that individual in the community (i.e., the immediate family, other relatives, other community resources), and other services in the continuum of LTSS. The LTSS screening shall be documented on the DMAS-designated forms identified in 12VAC30-60-306 and entered into the eMLS system.

2. ~~Screenings~~ LTSS screenings shall be completed in the hospital prior to discharge.

3. The individual shall be permitted to have another person present at the time of the LTSS screening. Except when a court has issued an order for a LTSS screening, the individual shall also be afforded the right to refuse to participate. The hospital LTSS screening team shall determine the appropriate degree of participation and assistance given by other persons to the individual during the screening and accommodate the individual's preferences to the extent feasible.

~~3~~4. The hospital LTSS screening team shall:

a. Observe the individual's ability to perform appropriate ADLs according to 12VAC30-60-303, excluding all institutionally induced dependencies, and consider the individual's communication or responses to questions or his representative's communication or responses;

b. Observe, assess, and report the individual's medical or nursing and functional condition. This information shall be used to ensure accurate and comprehensive evaluation of the individual's need for modification of treatment or additional medical procedures to prevent destabilization even when the individual has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals;

c. Identify the medical, nursing, and functional needs of the individual; and

d. Consider services and settings that may be needed by the individual in order for the individual to safely perform ADLs.

~~4~~5. Upon completion of the LTSS screening and in consideration of the communication from the individual or his representative, if appropriate, and observations obtained during the LTSS screening, the hospital LTSS screening team shall determine whether the individual meets the criteria set out in 12VAC30-60-303. If the individual meets the criteria for Medicaid-funded LTSS, the hospital LTSS screening team shall inform the individual or his representative9, if appropriate, of this determination in writing and provide choice of the ~~feasible alternatives~~ setting and provider of LTSS, such as PACE or ~~home and community-based~~ CCC Plus waiver services, as alternative options to placement in a NF.

~~5~~6. If waiver services or PACE, where available, are declined, the reason for declining shall be recorded on the DMAS-97, Individual Choice - Institutional Care or Waiver Services Form. The hospital LTSS screening team shall have this document signed by either the individual or his representative, if appropriate. In addition to the electronic document, a paper copy of the DMAS-97 form with the individual's or his representative's signature shall be retained in the individual's record.

~~6~~7. If the individual meets criteria and selects home and community-based services, the hospital LTSS screening team shall also document that the individual is at risk of NF placement in the absence of home and community-based services by finding that at least one of the following conditions exists:

a. Prior to the inpatient admission, the individual was cared for in the home and evidence is available demonstrating a deterioration in the individual's health care condition, a significant change in condition, or a change in available supports. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

b. There has been no significant change in condition or available support but evidence is available that demonstrates the individual's functional, medical, or nursing needs are not being met. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

~~7~~8. If the individual selects NF placement, the hospital LTSS screening team shall follow the Level I identification and Level II evaluation process as outlined in Part III (12VAC30-130-140 et seq.) of 12VAC30-130.

~~8~~9. If the hospital LTSS screening team determines that the individual does not meet the criteria set out in 12VAC30-60-303, the hospital LTSS screening team shall notify the individual or the individual's representative, as may be appropriate, in writing that LTSS are being denied for the individual. The denial notice shall include the individual's right to appeal consistent with DMAS client appeals regulations (12VAC30-110).

D. LTSS screenings for individuals receiving skilled or rehabilitation nursing services in a setting not covered by Medicaid and after discharge from an acute care hospital.

1. Medical or nursing and functional eligibility for Medicaid-funded LTSS shall be determined by the NF LTSS screening team after completion of a LTSS screening of the individual's medical or nursing and functional needs and available supports. The NF LTSS screening team shall consider all the supports available for that individual in the community (i.e., the immediate family, other relatives, other community resources), and other services in the continuum of LTSS. The LTSS screening shall be documented on the DMAS-designated forms identified in 12VA30-60-306 and entered into the eMLS system.

2. LTSS screenings shall be completed prior to the enrollment or initiation of LTSS.

3. The individual shall be permitted to have another person present at the time of the LTSS screening. Except when a court has issued an order for a LTSS screening, the individual shall also be afforded the right to refuse to participate. The NF LTSS screening team shall determine the appropriate degree of participation and assistance given by other persons to the individual during the LTSS screening and accommodate the individual's preferences to the extent feasible.

4. The nursing facility LTSS screening team shall:

a. Observe the individual's ability to perform appropriate ADLs according to **12VAC30-60-303**, excluding all institutionally induced dependencies, and consider the individual's communication or responses to questions or his representative's communication or responses;

b. Observe, assess, and report the individual's medical or nursing and functional condition. This information shall be used to ensure accurate and comprehensive evaluation of the individual's need for modification of treatment or additional medical procedures to prevent destabilization even when the individual has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals;

c. Identify the medical, nursing, and functional needs of the individual; and

d. Consider services and settings that may be needed by the individual in order for the individual to safely perform ADLs.

5. Upon completion of the LTSS screening and in consideration of the communication from the individual or his representative, if appropriate, and observations obtained during the LTSS screening, the NF LTSS screening team shall determine whether the individual meets the criteria set out in **12VAC30-60-303**. If the individual meets the criteria for Medicaid-funded LTSS, the NF LTSS screening team shall inform the individual or his representative, if appropriate, of this determination in writing and provide choice of the setting and provider of LTSS, such as PACE or home and community-based waiver services, as alternative options to placement in a NF.

6. If waiver services or PACE, where available, are declined, the reason for declining shall be recorded on the DMAS-97, Individual Choice - Institutional Care or Waiver Services Form. The NF LTSS screening team shall have this document signed by either the individual or his representative, if appropriate. In addition to the electronic document, a paper copy of the DMAS-97 form with the individual's or his representative's signature shall be retained in the individual's record.

7. If the individual meets criteria and selects home and community-based services, the NF LTSS screening team shall also document that the individual is at risk of NF placement in the absence of home and community-based services by finding that at least one of the following conditions exists:

a. Prior to the admission to the acute care hospital, the individual was cared for in the home and evidence is available demonstrating a deterioration in the individual's health care condition, a significant change in condition, or a change in available supports. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

b. There has been no significant change in condition or available support but evidence is available that demonstrates the individual's functional, medical, or nursing needs are not being met. Examples of such evidence may include (i)

recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.

8. If the individual selects NF placement, the NF LTSS screening team shall follow the Level I identification and Level II evaluation process as outlined in Part III (**12VAC30-130-140** et seq.) of **12VAC30-130**.

9. If the NF LTSS screening team determines that the individual does not meet the criteria set out in **12VAC30-60-303**, the NF LTSS screening team shall notify the individual or the individual's representative, as may be appropriate, in writing that LTSS are being denied for the individual. The denial notice shall include the individual's right to appeal consistent with DMAS client appeals regulations (**12VAC30-110**).

12VAC30-60-306 Submission of LTSS screenings

A. The LTSS screening entity shall complete and submit the following forms to DMAS electronically via ~~ePAS~~eMLS:

1. DMAS-95 - ~~MI/IDD/RC~~MI/ID/RC (Supplemental ~~Assessment Process Form Level I~~Level I Screening for Mental Illness, Intellectual Disability, or Related Conditions form and follow up information), as appropriate;

2. DMAS-96 (Medicaid-Funded Long-Term ~~Care Service~~ Services and Supports Authorization Form);

3. DMAS-97 (Individual Choice - ~~Institutional Care or Waiver Services~~ Home and Community-Based or Institutional Care form), as applicable;

4. UAI (Uniform Assessment Instrument);

5. DMAS-108 (~~Tech Waiver~~ Private Duty Nursing Adult Referral form), as appropriate; and

6. DMAS-109 (~~Tech Waiver~~ Private Duty Nursing Pediatric Referral form), as appropriate.

B. For LTSS screenings performed in the community, the LTSS screening entity shall submit to DMAS via ~~ePAS~~eMLS each applicable screening form listed in subsection A of this section within 30 days of the individual's request date for screening.

C. For LTSS screenings performed in a hospital, the hospital team shall submit to DMAS via ~~ePAS~~eMLS each applicable screening form listed in subsection A of this section, which shall be completed prior to the individual's discharge to LTSS.

D. For LTSS screenings performed in a skilled or rehabilitation NF setting, the NF LTSS screening team shall submit to DMAS via eMLS each applicable screening form listed in subsection A of this section, which shall be completed prior to the individual's level of care change or enrollment in LTSS from skilled nursing or rehabilitation services.

12VAC30-60-308 Nursing facility admission for LTSS and level of care determination requirements

Prior to an individual's for LTSS admission, the NF shall review the completed LTSS screening forms to ensure that applicable NF admission criteria have been met, documented, and submitted via e-PAS unless the individual meets any of the special circumstances set out in 12VAC30-60-302 E. NFs shall not accept ~~paper~~ handwritten LTSS screening forms as proof that admission criteria have been met and documented.

The NF LTSS screening team shall be responsible for screening individuals admitted directly from a hospital for skilled nursing or rehabilitation not covered by

the Commonwealth's program of medical assistance and have a change in level of care requiring LTSS.

12VAC30-60-310 Competency training and testing requirements

By June 30, 2019, each person performing LTSS screenings on behalf of a screening entity shall complete required training and competency tests. A score of at least 80% on each module for each person who is required to give final approval on LTSS screenings on behalf of the screening entity shall constitute satisfactory competency test results. The most current competency test results shall be kept in the screening entity's personnel records for each person performing LTSS screenings for the screening entity. Such documentation results shall be provided to DMAS upon its request.

1. All persons who are required by the screening entity to give final approval of LTSS screenings shall complete the DMAS-approved training and pass the corresponding competency tests with a score of at least 80% for each module of the training prior to performing LTSS screenings. Each LTSS Screener who has passed the competency training will be provided a certification number which shall be entered into the eMLS upon final approval of the Medicaid LTSS screening.

2. Upon successful completion of the initial training, each person who is required to give final approval of LTSS screenings on behalf of the screening entity shall complete the shortened refresher course no less than every three years. A score of at least 80% on the refresher module shall be required for a person to continue to perform LTSS screenings or give final approval of LTSS screenings on behalf of the screening entity.

3. Failure to satisfy the training and competency tests requirements may result in the retraction of Medicaid payment.

12VAC30-60-313 Individuals determined to not meet criteria for Medicaid-funded long-term services and supports

Notwithstanding 12VAC30-60-302 E, an individual shall be determined not to meet the ~~medical or nursing~~ level of care ~~and functional criteria~~ for Medicaid-funded LTSS when there is no LTSS screening or MDS to document the individual meets the medical or nursing ~~and~~, functional or risk criteria or when one of the following specific care needs solely describes the individual's condition:

1. The individual requires minimal assistance with ADLs, including those individuals whose only need in all areas of functional capacity is for prompting to complete the activity;

2. The individual independently uses mechanical devices such as a wheelchair, walker, crutch, or cane;

3. The individual requires limited diets such as a mechanically altered, low-salt, low-residue, diabetic, reducing, or other restrictive diets;

4. The individual requires medications that can be independently self-administered or administered by the caregiver;

5. The individual requires protection to prevent him from obtaining alcohol or drugs or to address a social or environmental problem;

6. The individual requires minimal staff observation or assistance for confusion, memory impairment, or poor judgment; or

7. The individual's primary need is for behavioral management that can be provided in a community-based setting.

12VAC30-60-315 Periodic evaluations for individuals receiving Medicaid-funded long-term services and supports

A. Once an individual is enrolled in home and community-based services, the home and community-based services provider shall be responsible for conducting periodic evaluations to ensure that the individual meets, and continues to meet, the waiver program or PACE criteria, if appropriate. These periodic evaluations shall be conducted using the Level of Care Review tab in the Medicaid portal at (**https://www.virginiamedicaid.dmas.virginia.gov/wps/portal**). The home and community-based services provider shall promptly evaluate the individual after he experiences a significant change in his condition, as defined in 12VAC30-60-301.

B. Once an individual ~~is admitted to~~ has been screened for LTSS and is enrolled in LTSS in a NF, the NF shall be responsible for conducting periodic evaluations to ensure that the individual meets, and continues to meet, the NF criteria. For this purpose, the NF shall use the federally required Minimum Data Set (MDS) form (see **https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html**). ~~The post-admission evaluation shall be conducted~~ For individuals screened for LTSS by hospitals teams and CBT's and admitted directly into NF LTSS, the individual shall be evaluated using the MDS no later than 14 days after the date of NF admission. ~~and promptly after an~~ All individual's receiving NF LTSS and experiencing a significant change in his condition, as defined in 12VAC30-60-301, shall be evaluated using the MDS.

For individuals admitted to skilled or rehabilitation services in a NF, the NF shall be responsible for conducting periodic evaluations to ensure that the individual meets, and continues to meet criteria. For this purpose, the NF shall use the federally required MDS form (see **https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html**). The post enrollment evaluation shall be conducted no later than 14 days after the date of the NF admission and promptly after an individual's significant change in his condition, as defined in 12VAC30-60-301.

C. For individuals who are enrolled in an MCO that is responsible for providing LTSS, the MCO shall conduct periodic evaluations by qualified MCO staff to ensure the individual continues to meet criteria for LTSS. The MCO shall promptly evaluate the individual after he experiences a significant change in his condition, as defined in 12VAC30-60-301.

D. If an individual has been screened for LTSS and enrollment in LTSS has not occurred within one year of the completion date of the LTSS screening, a new LTSS screening shall be conducted to document the level of care and assure continued need for services.