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Emergency Regulation and Notice of Intended Regulatory Action (NOIRA) Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	_12_ VAC_30_-_300 et seq.
Regulation title(s)	Nursing Facility Criteria
Action title	2015 Preadmission Screening Changes
Date this document prepared	

This form is used when an agency wishes to promulgate an emergency regulation (to be effective for up to eighteen months), as well as publish a Notice of Intended Regulatory Action (NOIRA) to begin the process of promulgating a permanent replacement regulation. This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.

In 1984, the *Code of Virginia* was modified to add section 32.1-330 'Preadmission screening required'. The existing regulations (12 VAC 30-60-300 *et seq*.) for nursing facility criteria and preadmission screening (PAS or screenings) were first promulgated in 1994 and amended in 2002. The regulations include the criteria for receiving Medicaid-funded community-based and nursing facility long term services and supports (LTSS). This emergency regulation adds requirements for accepting, managing, and completing requests for community and hospital

electronic screenings for community-based and nursing facility services, and using the 'electronic Preadmission Screening' (ePAS) system. In order to make these additions and establish a new logical order for the existing regulations with the additions, the following actions are required:

1. **Add sections**:
   12VAC30-60-301. Definitions.
   12VAC30-60-302. Introduction; access to Medicaid-funded long-term services and supports.
   12VAC30-60-304. Requests for screenings for adults and children in the community and adults/children inpatients in hospitals.
   12VAC30-60-305. Screenings in the community and hospitals for Medicaid-funded long-term services and supports.
   12VAC30-60-306. Submission of screenings.
   12 VAC30-60-308. NF admission and level of care determination requirements.
   12VAC30-60-310. ePAS requirements and submission. (RESERVED)
   12VAC30-60-313. Individuals determined to not meet criteria for Medicaid-funded long term services and supports.
   12VAC30-60-315. Ongoing evaluations for individuals receiving Medicaid-funded long-term services and supports.

2. **Amend section**:
   12VAC30-60-303. Preadmission screening criteria for Medicaid-funded long-term services and supports.

3. **Repeal sections**:
   12VAC30-60-300. Nursing Facility Criteria. (Incorporated into 12VAC30-60 sections 302, 303, 304, 305, and 308.)
   12VAC30-60-307. Summary of preadmission nursing facility criteria. (Incorporated into 12 VAC 30-60 sections 303 and 313)
   12VAC30-60-312. Evaluation to determine eligibility for Medicaid payment of nursing facility or home and community-based. (Incorporated into 12 VAC 30-60-305.)

This action does not change any of the existing criteria that derive from the Uniform Assessment Instrument, which DMAS first adopted for the purpose of preadmission screening in 1984.

Emergency Authority

The APA (Code of Virginia § 2.2-4011) states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of subdivision A. 4. of § 2.2-4006. Please explain why this is an emergency situation as described above, and provide specific citations to the Code of Virginia or the Appropriation Act, if applicable.

Section 2.2-4011 (B) of the *Code of Virginia* states that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or

federal regulation requires that a regulation be effective in 280 days or less from its enactment, and the regulation is not exempt under the provisions of § 2.2-4006(A)(4). The 2016 *Acts of the Assembly*, Chapter XXX, Item 306 PPP directed the Department of Medical Assistance Services (DMAS or the Department) to contract out community based screenings for children, track and monitor all requests for screenings that have not been completed within 30 days of an individual's request, establish reimbursement and tracking mechanisms, and promulgate regulations to implement these provisions to be effective within 280 days of its enactment.

The Governor is hereby requested to approve this agency's adoption of the emergency regulations entitled 2015 Pre-admission Screening Changes (12 VAC 30-60-300 through 12VAC30-60-315) and also authorize the initiation of the promulgation process provided for in § 2.2-4007.

Legal basis

Other than the emergency authority described above, please identify the state and/or federal legal authority to promulgate this proposed regulation, including: 1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly chapter number(s), if applicable, and 2) the promulgating entity, i.e., agency, board, or person.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

The *Code of Virginia* §32.1-330 also states:

"All individuals who will be eligible for community or institutional long-term care services as defined in the state plan for medical assistance shall be evaluated to determine their need for nursing facility services as defined in that plan. The Department shall require preadmission screening of all individuals who, at the time of application for admission to a certified nursing facility as defined in §32.1-123, are eligible for medical assistance or will become eligible within six months following admission. For community-based screening, the screening team shall consist of a nurse, social worker or other assessor designated by the Department, and physician who are employees of the Department of Health or the local department of social services or a team of licensed physicians, nurses, and social workers at the Wilson Workforce and Rehabilitation Center (WWRC) for WWRC clients only. For institutional screening, the Department shall contract with acute care hospitals. The Department shall contract with other public or private entities to conduct required community-based and institutional screenings in addition to or in lieu of the screening teams described in this section in jurisdictions in which the screening team has been unable to complete screenings of individuals within 30 days of such individuals' application."

Purpose

Please describe the subject matter and intent of the planned regulatory action. Also include a brief explanation of the need for and the goals of the new or amended regulation.

In responding to the legislative mandate of the 2015 *Acts of the Assembly, Chapter XXX Item 306 PPP*, the purpose of the planned regulatory action is to define terms and establish regulatory requirements for i) accepting screening requests; ii) managing the screening process; iii) submitting findings from screenings completed by community and hospital PAS teams and contractors performing these activities; and iv) using the new electronic ePAS system. WILL COMPLETE THE APPROPRIATIONS ACT CITATION WHEN IT IS ASSIGNED A CHAPTER NUMBER.

Need

Please describe the specific reasons why the agency has determined that the proposed regulatory action is essential to protect the health, safety, or welfare of citizens. In addition, delineate any potential issues that may need to be addressed as the regulation is developed.

The *Code of Virginia* §32.1-330 requires that all individuals who will be eligible for community or institutional long-term services and supports (LTSS) as defined in the State Plan for Medical Assistance be evaluated to determine their need for Medicaid-funded nursing facility services. Also, the *Code* specifically requires the Department to utilize employees of local departments of social services (LDSS) and local health departments (LHDs) for community screenings and acute care hospitals for inpatient screenings, respectively. While this screening structure, established in the early 1980s, worked effectively for many years, the evolution of Virginia's Medicaid service delivery system has outgrown the original design. Significant challenges have developed that require a change to the Virginia Administrative Code. Some community based screenings have taken longer than 30 days to complete thereby creating a significant risk to individuals who have been unable to access Medicaid LTSS.

One potential issue may continue to be limited staff resources in community and hospital settings. These suggested regulations clarify requirements of community and hospital PAS teams and include requirements to use the new automated ePAS system to enhance work efficiency. These suggested emergency regulations also establish DMAS' use of a contractor or contractors and provide a framework for public or private entities to screen children and adults in communities where community PAS teams are unable to complete screenings within 30 days of the initial request date for a screening. These strategies have been designed to ensure prompt services to citizens requesting Medicaid-funded LTSS and to protect their health, safety and welfare.

Substance

Please describe any changes that are proposed. Please outline new substantive provisions, all substantive changes to existing sections, or both where appropriate. Set forth the specific reasons the agency has determined that the proposed regulatory action is essential to protect the healthy, safety, or welfare of Virginians.

The section of the State Plan for Medical Assistance that is affected by this action is Standards Established and Methods Used to Assure High Quality Care – Nursing Facility Criteria (12 VAC 30-60-300 et seq.)

CURRENT POLICY

The current screening policy contains the requirements for Medicaid-funded LTSS, including home and community-based services (HCBS) waivers, the Program of All-Inclusive Care for the Elderly (PACE), and nursing facility services. The policy also includes the three criteria for an individual's receipt of these services: (i) functional capacity (degree of assistance an individual needs to perform activities of daily living); (ii) medical or nursing needs; and, (iii) the individual's risk of nursing facility placement in the absence of home and community based services.

Section 303 lists the specific functional criteria that are used to evaluate the extent to which each individual can perform each of the activities of daily living (ADLs) (such as feeding, bathing, toileting, transferring, etc.) and what type of assistance the individual needs to perform each ADL safely. These functional criteria, reflected in the Uniform Assessment Instrument (UAI) form, are not changing in this regulatory action and the use of the UAI for this purpose remains the same. The changes that are being made to this section are editorial and technical in nature (such as substituting the acronym ADL for Activities of Daily Living and re-numbering the individual items under subsection B).

Specific instructions and reporting requirements are also provided for nursing facilities once an individual has chosen and is admitted into the facility. These are also not changing.

ISSUES

Since the inception of the PAS process in the early 1980s, the number of screenings performed in communities by LDSS/ LHD teams and in hospitals by hospital staff has grown to approximately 20,000 screenings per year. Over the past several years, from 2010 to 2013, the number of community based screenings for adults has increased while the number of hospital based screenings for adults has decreased; 10,710 to 13,116 (22% increase) for community screenings and 8,437 to 6,582 (28% decrease) for hospital screenings.

To date in 2015, 23,036 individuals have been screened (20,807 adults and 2,229 children); 6,464 individuals have been screened in acute hospitals (6,361 adults and 103 children); 16,572 individuals have been screening in the community (14,446 adults and 2,126 children).

Reports of long waits for community screenings and the corresponding delays of critical Medicaid-funded LTSS, subsequently resulted in passage of House Bill 702 (2014 Session). HB

702 required the Department to contract with public or private entities to perform screenings in jurisdictions where the community based PAS teams have been unable to complete screenings of individuals within 30 days of such individuals' requests for a screening. No appropriation accompanied this directive.

On April 15, 2014, the Virginia Department of Health (VDH) and the Department for Aging and Rehabilitative Services (DARS) conducted a point-in-time manual data collection initiative from each LDSS and LHD. DMAS coordinated the data analysis. The purposes of the data collection were: i) to determine the number of community based screenings taking longer than 30 days to complete; and, ii) to identify jurisdictions that were able to meet the 30 day timeframe and those unable to achieve the timeframe. DMAS' trend analysis indicated that:

- backlogs in community based screenings reported by LDSS and LHDs were not always congruent across the two agencies;
- some reports from localities on community based screening backlogs showed no corresponding increases in the number of screening requests over time; and,
- some localities having significant increases in the number of community based screening requests were able to meet the 30 day completion requirement as specified in HB 702 even with the increasing volume.

In addition to the data collection for the community based screenings, hospitals performing screenings for inpatients (adults and children) may not be completing needed screenings prior to patient discharges. During the hospital discharge process, an inpatient is screened for the most complex care required to meet the inpatient's needs post-discharge. DMAS' data reveals that when a screening is performed by a hospital, the resulting recommendation 88% of the time is that an individual utilize nursing facility (skilled NF or NF) services rather than receiving supports at home.

Medicare funds up to 100 days of skilled nursing facility (SNF) or rehabilitative care, resulting frequently in discharges of individuals who still have unmet care needs subsequent to their NF/rehabilitation stay. **Medicare** funding is not available for community-based long term care services that are covered by Medicaid. When the individual has been admitted, <u>without a prior screening</u>, to either a **Medicare**-funded skilled nursing facility or rehabilitation facility and, upon completion of the ordered rehabilitation or exhaustion of the 100 days of Medicare benefit, is then subsequently discharged to his home, the individual must immediately request a preadmission screening from a community team, thus delaying essential LTSS. Depending on (i) the individual's capabilities; (ii) his available community support system (if any), and (iii) the community screening team's backlog of pending screening requests, such individuals can experience endangerment of their health, safety, and welfare due to delays in needed LTSS.

For both community and hospital based screenings, staff resources are limited. Therefore, efficiency in the screening process is critical to managing the growing workload. The "paper-driven" screening process has proven to be too cumbersome and slow. The form used for the screening process is the Uniform Assessment Instrument (UAI), along with other DMAS forms used for the screening process including the DMAS 95 MI/MR/RC, DMAS 95 MI/MR/RC Supplement, DMAS 96 (Medicaid Funded LTC Service Authorization), the DMAS 97 (Individual Choice-Institutional Care or Waiver Services). The previous absence of an automated

process to assist community and hospital PAS teams to complete these forms accurately and quickly and to enable tracking of requests for and completions of screenings, has significantly barred efficient administration and prompt service delivery. The proposed regulation includes the use of an ePAS system to address this issue.

The current policy is silent regarding acceptance of requests for screenings, timeframes for completing or referring requests to a contractor, and tracking mechanisms for statewide consistency in the assurance of quality services and to ensure health, safety, and welfare for individuals requesting Medicaid-funded LTSS. Absent from the current policy are definitions and requirements to standardize and regulate community-based and hospital PAS teams when accepting requests for screenings, managing those requests within the established time period, and reporting the outcomes of the screenings once individuals receive screenings.

RECOMMENDATIONS

The *2016 Acts of the Assembly, Chapter XXX Item 306 PPP* directed DMAS to improve the preadmission screening process for individuals who will be eligible for long term services and supports. This mandate directed DMAS to (i) develop a contract with an entity for the purpose of conducting preadmission screenings for children; (ii) track and monitor all requests for screenings and report on those screenings that are not completed within 30 days of the initial request; (iii) report on the progress of meeting these new requirements, and; (iv) promulgate emergency regulations to implement these provisions.

The current policy related to the requirements for functional eligibility (12 VAC 30-60-303(B)) for Medicaid-funded LTSS are being retained since these standards support the eligibility process for the DMAS' home and community based waiver programs (the Elderly or Disabled with Consumer Direction (EDCD) waiver, the Technology Assisted waiver, the Alzheimer's Assisted Living waiver, the Program of All-Inclusive Care for the Elderly (PACE) Program and nursing facility care.

The suggested regulations repeal the existing nursing facility criteria (12VAC30-60-300) in order to move the criteria to a new location within new section 12VAC30-60-303. To be clear, the functional criteria, based on the Uniform Assessment Instrument (UAI) form, are not changing in this regulatory action and the use of the UAI for this purpose remains the same. This action simply moves the existing criteria to a new location in the regulatory chapter to assist the public and regulated entities to more easily understand the regulation.

The remaining current policy, as it appears in the current Virginia Administrative Code, is incomplete and fragmented. To remedy this, additions will include a Definitions (12VAC30-60-301) section and sections describing the requirement for the request for screenings (12VAC30-60-304), screenings for Medicaid-funded LTSS (12VAC30-60-305), submission of screenings (12VAC30-306), ePAS requirements and submissions (12VAC30-60-310), individuals determined to not meet criteria (12 VAC 30-60-313), and ongoing evaluations for individuals receiving Medicaid-funded LTSS (12 VAC 30-60-315).

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, and likely impact of proposed requirements
12 VAC 30-60-300		Sets out general requirements for nursing facility criteria and preadmission screening.	Section being repealed and existing provisions are being moved to new sections.
	12 VAC 30-60-301		New definition section is added to establish consistency in use of terminology.
	12 VAC 30-60-302		New introduction section and access to long term services and supports contains existing requirements from repealed sections.
12 VAC 30-60-303		Preadmission screening criteria for long-term care	Subsection B containing standards tied to the UAI form is not changing from old subsection B(1). New subsection D contains current standards for evaluating a child with the UAI. New subsection E reiterates the existing thresholds that must be met for an individual to qualify for Medicaid-funded LTSS.
	12 VAC 30-60-304		Sets out process for the handling of requests for preadmission screenings by community based teams for adults, the contractor for children, and hospitals for both adults and children inpatients.
	12 VAC 30-60-305		Sets out requirements for screenings: where they are to be conducted, what is to be done with the gathered information; who is to conduct the screenings; the screened individual who qualifies must be given his choice of either community or institutional services. The features that are unique to screening adults or children in the community and screenings of adults and children in hospitals are set out.
	12 VAC 30-60-306		Sets out requirements for screening entities to submit specific documentation in order to be reimbursed by Medicaid for having completed a preadmission screening.
12 VAC 30-60-307			Section being repealed and existing provisions are being moved to new sections.
	12 VAC 30-60-308		Sets out requirements for DMAS to review level of care reviews by NFs to ensure that residents meet NF criteria and that needed services are being provided.
	12 VAC 30-60-310		Establishes ePAS requirements. (RESERVED)
12 VAC 30-60-312			Evaluation section being repealed and contents are moved to other new sections.

	12 VAC 30-60-313		New section contains existing list of conditions that could occur but would not qualify an individual for LTSS. Text moved from old 12 VAC 30-60-307 B.
	12 VAC 30-60-315		New section provides for ongoing evaluations for individuals who have already qualified for LTSS.

Alternatives

Please describe all viable alternatives to the proposed regulatory action that have been or will be considered to meet the essential purpose of the action. Also describe the process by which the agency has considered or will consider other alternatives for achieving the need in the most cost-effective manner.

In collaboration with VDH and DARS, DMAS has provided technical assistance and training to community and hospital PAS teams and automated the PAS forms and the process by implementing the ePAS system to increase efficiencies and reduce delays. However, the absence of common definitions, clear timeframes and guidance for conducting screenings continue to hinder effective service delivery through Virginia's screening process. There are no other viable alternatives other than to promulgate these suggested emergency regulations.

Public participation

Please indicate whether the agency is seeking comments on the intended regulatory action, to include ideas to assist the agency in the development of the proposal and the costs and benefits of the alternatives stated in this notice or other alternatives. Also, indicate whether a public meeting is to be held to receive comments. Please also indicate whether a Regulatory Advisory Panel or a Negotiated Rulemaking Panel has been used in the development of the emergency regulation and whether it will also be used in the development of the permanent regulation.

The Department convened a work group (see attached list of participants) of public and private affected entity representatives to assist with formulating the needed new regulations and addressing challenges which have come to the fore in the past several years. The work group has met 10 times from April 2015 through September 2015. The group members are enumerated at the end of this document.

The Department is seeking comments on this regulatory action, including and not limited to: ideas to be considered in the development of this proposal, the costs and benefits of the alternatives stated in this background document or other alternatives, and the potential impacts of the regulation.

The Department is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include: projected reporting, recordkeeping, and other administrative costs; the probable effect of the regulation on affected small businesses;

and the description of less intrusive or costly alternatives for achieving the purpose of the regulation.

Anyone wishing to submit comments may do so via the Regulatory Town Hall website (**http://www.townhall.virginia.gov**), or by mail, email, or fax to Charlotte Arbogast, LTC Program Analyst, Division of Long Term Care Services, DMAS, 600 E. Broad St., Suite 1300, Richmond, VA 23219; Charlotte.Arbogast@dmas.virginia.gov ; (804) 225-2536; (804) 786-1680 (fax). Written comments must include the name and address of the commenter. In order to be considered, comments must be received by midnight on the last day of the public comment period.

A public hearing will not be held following the publication of the proposed stage of this regulatory action.

Family Impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; nor encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment, but may affect disposable family income depending upon which provider the recipient chooses for the item or service prescribed.

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