COMMONWEALTH of VIRGINIA

Office of the Attorney General

202 North 9th Street
Richmond, Virginia 23219
804-786-2071
FAX 804-786-1991
Virginia Relay Services
800-828-1120

Mark R. Herring
Attorney General

TO: **EMILY MCCLELLAN**
Regulatory Supervisor
Virginia Department of Medical Assistance Services

FROM: **MICHELLE A. L'HOMMEDIEU**
Assistant Attorney General

DATE: **April 25, 2017**

SUBJECT: **Proposed Regulations – 2015 Long Term Services and Supports Screening Changes (4342/7694)**

I am in receipt of the attached regulations to add, amend, and repeal portions of the current regulations regarding long term services and supports screenings ("pre-admission screenings"). You have asked the Office of the Attorney General to review these regulations determine if the Department of Medical Assistance Services ("DMAS") has the legal authority to promulgate these regulations, and if they comport with state and federal law.

The enactment of amendments to the pre-admission screenings regulations was first implemented through emergency regulations that became effective September 1, 2016. The proposed regulations will allow these changes to remain in place after the expiration of the current emergency regulations.

I have reviewed these proposed regulations. Based on that review, it is this Office's view that the Director, acting on behalf of the Board of Medical Assistance Services under Virginia Code §§ 32.1-324 and 325, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Administrative Process Act ("APA"), and has not exceeded that authority.

These regulations will amend the State Plan, making approval from the Centers for Medicare and Medicaid necessary. It is my understanding DMAS has obtained this approval. If

you have any questions or need additional information about these regulations, please contact me at 786-6005.

cc: Kim F. Piner, Esq.
Attachment

Project 4355 - Proposed

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

2015 Long Term Services and Supports Screening Changes

12VAC30-60-300. ~~Nursing facility criteria.~~ (Repealed.)

~~A. Medicaid-funded long-term care services may be provided in either a nursing facility or community-based care setting. The criteria for assessing an individual's eligibility for Medicaid payment of nursing facility care consist of two components: (i) functional capacity (the degree of assistance an individual requires to complete activities of daily living) and (ii) medical or nursing needs. The criteria for assessing an individual's eligibility for Medicaid payment of community-based care consist of three components: (i) functional capacity (the degree of assistance an individual requires to complete activities of daily living), (ii) medical or nursing needs and (iii) the individual's risk of nursing facility placement in the absence of community-based waiver services. In order to qualify for either Medicaid-funded nursing facility care or Medicaid-funded community-based care, the individual must meet the same criteria.~~

~~B. The preadmission screening process preauthorizes a continuum of long-term care services available to an individual under the Virginia Medical Assistance Program. Nursing Facilities' Preadmission Screenings to authorize Medicaid-funded long-term care are performed by teams composed by agencies contracting with the Department of Medical Assistance Services (DMAS). The authorization for Medicaid-funded long-term care must be rescinded by the nursing facility or community-based care provider or by DMAS at any point that the individual is determined to no longer meet the criteria for Medicaid-funded long-term care. Medicaid-funded long-term care services are covered by the program for individuals whose needs meet the criteria established by program regulations. Authorization of appropriate non-institutional services shall be evaluated before nursing facility placement is considered.~~

~~C. Prior to an individual's admission, the nursing facility must review the completed pre-admission screening forms to ensure that appropriate nursing facility admission criteria have been documented. The nursing facility is also responsible for documenting, upon admission and on an ongoing basis, that the individual meets and continues to meet nursing facility criteria. For this purpose, the nursing facility will use the Minimum Data Set (MDS) The post admission assessment must be conducted no later than 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. If at any time during the course of the resident's stay, it is determined that the resident does not meet nursing facility criteria as defined in the State Plan for Medical Assistance, the nursing facility must initiate discharge of such resident. Nursing facilities must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity and medical and nursing needs.~~

~~The Department of Medical Assistance Services shall conduct surveys of the assessments completed by nursing facilities to determine that services provided to the residents meet nursing facility criteria and that needed services are provided.~~

~~D. The community-based provider is responsible for documenting upon admission and on an ongoing basis that the individual meets the criteria for Medicaid-funded long-term care.~~

~~E. The criteria for nursing facility care under the Virginia Medical Assistance Program are contained herein. An individual's need for care must meet these criteria before any authorization for payment by Medicaid will be made for either institutional or non-institutional long-term care services. The Nursing Home Pre-Admission Screening team is responsible for documenting on the state-designated assessment instrument that the individual meets the criteria for nursing facility or community-based waiver services and for authorizing admission to Medicaid-funded long-term care. The rating of functional dependencies on the assessment instrument must be~~

~~based on the individual's ability to function in a community environment, not including any institutionally induced dependence.~~

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

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/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

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

"Appeal" means the processes used to challenge actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110-10 et seq. and 12VAC30-20-500 et seq.

"At risk" means the need for the level of care provided in a hospital, 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, one month or less) 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 eligible to receive Medicaid-funded LTSS.

"Choice" means the individual is provided the option of either home and community-based waiver services 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/symbol communication boards.

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

"Community-based services provider" or "CBS provider" means a provider or agency enrolled with Virginia Medicaid to offer services to individuals eligible for home and community-based waivers services or PACE.

"Community-based team" or "CBT" means (i) a licensed health care professional, who is a registered nurse, nurse practitioner (ii) a social worker or other assessors 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.

"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" or "the department" means the Department of Medical Assistance Services.

"DMAS designee" means the public or private entity with an agreement with the Department of Medical Assistance Services to complete preadmission screenings pursuant to § 32.1-330 of the Code of Virginia.

"Electronic preadmission screening" or "ePAS" means the DMAS automated system or a DMAS-approved electronic record system for use by all entities contracted by DMAS to perform 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.

"Home and community-based services waiver" or "waiver services" means the range of community services and supports 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 screening document for inpatients to ePAS.

"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 outpatient, patients in observation beds, and patients of the hospital's emergency department.

"Licensed health care professional" or "LHCP" means a registered nurse, nurse practitioner, or physician currently employed or contracted by the Virginia Department of Health and licensed by the relevant health regulatory board of the Department of Health Professions who is practicing within the scope of his license.

"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, assisted living facilities, or nursing facilities.

"MCO" or "participating plan" 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 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.

"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.

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

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

"Preadmission screening," "PAS," or "screening" means the process to (i) evaluate the functional, 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.

"Primary account holder" means the person who performs the initial web registrations for the screening entity and establishes the security needed for accessing ePAS.

"Private pay individual" means individuals who are not eligible for Medicaid or not expected to become eligible for Medicaid for 180 days following admission.

"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.

"Referral for 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.

"Reimbursement" means the determination that a submitted claim is completed accurately and completely and the service is covered resulting in the payment by DMAS for the services represented on the claims.

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

"Request date for screening" or "request date" means the date (i) that an individual, the individual's representative, an Adult Protective Services (APS) worker, Child Protective Services (CPS) worker, or the managed care organization (MCO) care coordinator contacts the 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 screening" means (i) communication from an individual, individual's representative, Adult Protective Services (APS) worker, Child Protective Services (CPS) worker,

or managed care organization (MCO) care 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, for example, an individual's private home, apartment, assisted living facility, nursing facility, or jail/correctional facility if the individual to be screened is seeking Medicaid-funded LTSS and does not request an alternative screening location as allowed in 12VAC30-60-305 A.

"Screening entity" means the hospital screening team, community-based team (CBT), 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 screening findings and receipt of successfully processed results using ePAS.

"Submission date" means the date that the screening entity transmits to DMAS the screening findings using ePAS.

"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional assessment instrument that is completed by the screening entity 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.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-60-302. Introduction; 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 designated forms. Screening entities shall use the DMAS-designated forms (UAI, DMAS-95, DMAS-96, DMAS-97) and, if selecting nursing facility placement, the DMAS-95 Level I (MI/IDD/RC). If indicated by the DMAS-95 Level I results, the individual shall be referred to DBHDS for completion of the DMAS-95 Level II (for nursing facility placements only).

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

2. Appropriate community-based services shall be evaluated prior to consideration of nursing facility placement.

B. The evaluation shall be the screening as designated in § 32.1-330 of the Code of Virginia, which shall preauthorize a continuum of LTSS covered by Medicaid.

1. Such screenings, using the UAI, shall be conducted by teams of representatives of (i) 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 residing in the community and who are not inpatients; or (iii) a DMAS designee for children residing in the community who are not inpatients; 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. All of these entities shall be contracted with DMAS to perform this activity and be reimbursed by DMAS.

2. All screenings shall be comprehensive, accurate, standardized, and reproducible evaluations of individual functional capacities, medical or nursing needs, and risk for institutional placement.

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.

D. Pursuant to § 32.1-330 of the Code of Virginia, individuals shall be screened if they are eligible for Medicaid or are anticipated to become eligible for Medicaid reimbursement of their NF care within six months of NF placement.

E. Special circumstances.

1. Out-of-state hospitals shall not be required to perform a screening for residents of the Commonwealth who are inpatients. If a screening is needed and is requested by either the individual or the individual's representative, individuals shall be screened upon discharge from the out-of-state hospital by the CBT serving the locality in which the individual resides. Screenings shall not be required for individuals who transfer into a nursing facility in the Commonwealth from an out-of-state nursing facility.

2. Veterans' and military hospitals located in the Commonwealth that have inpatients who are residents of the Commonwealth shall not be required to perform screenings and may refer, upon discharge, the individual who requests a screening to the CBT serving the locality in which the individual resides. Screenings shall not be required for individuals who transfer to a nursing facilty in the Commonwealth from a veteran's or military hospital.

3. State facilities that are licensed by DBHDS shall not be required to perform screenings of individuals who are receiving their services. Individuals shall be referred, upon discharge from such state facilities, to the CBT serving the locality in which the individual lives if the facility anticipates an individual may need a screening.

4. Hospitals shall not be required to initiate screenings for inpatients who are determined by the hospital team to be private pay individuals unless there is a request for a screening as outlined in 12 VAC 30-60-304(C).

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

6. A screening shall not be required for enrollment in Medicaid hospice services as set out in 12 VAC 30-60-130 and home health services as set out in 12 VAC 30-50-160.

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

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-60-303. ~~Preadmission screening~~ Screening criteria for Medicaid-funded long-term ~~care~~ services and supports.

A. Functional dependency alone ~~is~~ shall not be deemed sufficient to demonstrate the need for nursing facility care or placement or authorization for community-based ~~care~~ services. An individual shall be determined to meet the nursing facility criteria when:

1. The individual has both limited functional capacity and medical or nursing needs 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. ~~An individual shall only be considered to meet the nursing facility criteria when both the functional capacity of the individual and his medical or nursing needs meet the following requirements. Even when an individual meets nursing facility criteria, placement in a noninstitutional setting shall be evaluated before actual nursing facility placement is considered~~ In order to qualify for Medicaid-funded LTSS, the individual shall meet the following criteria:

1. For Medicaid-funded nursing facility services to be authorized, the screening entity shall document that the individual has both functional and medical or nursing needs. The criteria for screening an individual's eligibility for Medicaid reimbursement of NF services shall consist of two components: (i) functional capacity (the degree of assistance an individual requires to complete ADLs) and (ii) medical or nursing needs. 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 services 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 needs (the degree of assistance an individual requires in order to complete ADLs), (ii) medical or nursing needs, and (iii) the individual's risk of NF placement within 30 days in the absence of community-based services.

~~1.~~ C. Functional capacity.

~~a.~~ 1. When documented on ~~a completed state-designated preadmission screening assessment instrument~~ 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:

~~(1)~~ a. Rated dependent in two to four of the ~~Activities of Daily Living~~ ADLs, and also rated semi-dependent or dependent in Behavior Pattern and Orientation, and semi-dependent in Joint Motion or dependent in Medication Administration.

~~(2)~~ b. Rated dependent in five to seven of the ~~Activities of Daily Living~~ ADLs, and also rated dependent in Mobility.

~~(3)~~ c. Rated semi-dependent in two to seven of the ~~Activities of Daily Living~~ ADLs, and also rated dependent in Mobility and Behavior Pattern and Orientation.

~~b.~~ 2. The rating of functional dependencies on the ~~preadmission~~ screening ~~assessment~~ instrument ~~must~~ 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.

~~(1)~~ a. Bathing.

~~(a)~~ (1) Without help (I)

~~(b)~~ (2) MH only (d)

~~(c)~~ (3) HH only (D)

~~(d)~~ (4) MH and HH (D)

~~(e)~~ (5) Performed by Others (D)

~~(2)~~ b. Dressing.

~~(a)~~ (1) Without help (I)

~~(b)~~ (2) MH only (d)

~~(c)~~ (3) HH only (D)

~~(d)~~ (4) MH and HH (D)

~~(e)~~ (5) Performed by Others (D)

~~(f)~~ (6) Is not Performed (D)

~~(3)~~ c. Toileting.

~~(a)~~ (1) Without help day or night (I)

~~(b)~~ (2) MH only (d)

~~(c)~~ (3) HH only (D)

~~(d)~~ (4) MH and HH (D)

~~(e)~~ (5) Performed by Others (D)

~~(4)~~ d. Transferring.

~~(a)~~ (1) Without help (I)

~~(b)~~ (2) MH only (d)

~~(c)~~ (3) HH only (D)

~~(d)~~ (4) MH and HH (D)

~~(e)~~ (5) Performed by Others (D)

~~(f)~~ (6) Is not Performed (D)

~~(5)~~ e. Bowel ~~Function~~ function.

~~(a)~~ (1) Continent (I)

~~(b)~~ (2) Incontinent less than weekly (d)

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

~~(d)~~ (4) Incontinent weekly or more (D)

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

~~(6)~~ f. Bladder ~~Function~~ function.

~~(a)~~ (1) Continent (I)

~~(b)~~ (2) Incontinent less than weekly (d)

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

~~(d)~~ (4) Incontinent weekly or more (D)

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

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

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

~~(7)~~ g. Eating/Feeding.

~~(a)~~ (1) Without help (I)

~~(b)~~ (2) MH only (d)

~~(c)~~ (3) HH only (D)

~~(d)~~ (4) MH and HH (D)

~~(e)~~ (5) Spoon fed (D)

~~(f)~~ (6) Syringe or tube fed (D)

~~(g)~~ (7) Fed by IV or clysis (D)

~~(8)~~ h. Behavior ~~Pattern~~ pattern and ~~Orientation~~ orientation.

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

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

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

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

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

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

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

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

~~(9)~~ i. Mobility.

~~(a)~~ (1) Goes outside without help (I)

~~(b)~~ (2) Goes outside MH only (d)

~~(c)~~ (3) Goes outside HH only (D)

~~(d)~~ (4) Goes outside MH and HH (D)

~~(e)~~ (5) Confined -- moves about (D)

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

~~(10)~~ j. Medication ~~Administration~~ administration.

~~(a)~~ (1) No medications (I)

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

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

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

~~(11)~~ k. Joint ~~Motion~~ motion.

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

~~(b)~~ (2) Limited motion (d)

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

~~c.~~ 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 ~~Activities of Daily Living~~ ADLs, ~~Medication Administration~~ 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)~~ 1. The individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization, and the person has demonstrated an inability to self observe or evaluate the need to contact skilled medical professionals;

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

~~(3)~~ 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)~~ a. Application of aseptic dressings;

~~(b)~~ b. Routine catheter care;

~~(c)~~ c. Respiratory therapy;

~~(d)~~ 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)~~ e. Therapeutic exercise and positioning;

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

~~(g)~~ g. Use of physical (e.g., side rails, poseys, locked wards) ~~and/or~~ or chemical restraints, or both;

~~(h)~~ h. Routine skin care to prevent pressure ulcers for individuals who are immobile;

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

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

~~(k)~~ k. Chemotherapy;

~~(l)~~ l. Radiation;

~~(m)~~ m. Dialysis;

~~(n)~~ n. Suctioning;

~~(o)~~ o. Tracheostomy care;

~~(p)~~ p. Infusion therapy; or

~~(q)~~ q. Oxygen.

~~d. Even when an individual meets nursing facility criteria, provision of services in a noninstitutional setting shall be considered before nursing facility placement is sought.~~

~~C.~~ E. When ~~assessing an individual 21 years of age or younger~~ screening a child, the ~~teams who are~~ screening entity who is conducting ~~preadmission screenings~~ screening for ~~long-term care services~~ LTSS shall utilize the electronic Uniform Assessment Instrument (UAI) interpretive guidance as ~~contained~~ referenced in DMAS' Medicaid Memo dated ~~October 3, 2012, entitled "Development of Special Criteria for the Purposes of Pre-Admission Screening,"~~ November 22, 2016, entitled "Reissuance of the Pre-Admission Screening (PAS) Provider Manual, Chapter IV", which can be accessed on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-60-304. Requests for screening for adults and children living in the community and adults and children in hospitals.

A. Screenings for adults living in the community. Screenings for adults who are residing in the community but who are not inpatients shall be completed and submitted (submission date) by the CBT to ePAS within 30 days of the request date for screening.

1. Requests for screenings shall be accepted from either an individual, the individual's representative, an Adult Protective Service worker, or an MCO care coordinator having an interest in the individual. The CBT in the jurisdiction where the individual resides shall conduct such screening. For the 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 screening.

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

b. When the CBT has not scheduled a screening to occur within 21 days of the request date for screening, and the 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 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. After contact with the LDSS and LHD, if DARS and VDH confirm that the screening entity is unable to complete the screening within 30 days of the request date for screening, the designated VDH staff shall refer the CBT and screening request to the DMAS designee for scheduling of a screening and submission of documentation.

2. Referrals for 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 PAS 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 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 screening.

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

B. Screenings for children living in the community. Screenings for children who are residing in the community but who are not inpatients shall be completed and submitted (submission date) to ePAS within 30 days of the request date for screening.

1. A child who is residing in the community and is not an inpatient shall receive a screening from a DMAS designee. The CBT shall forward requests for such screenings directly to the DMAS designee.

2. The request for screening of a child residing in the community shall initiate from the parent, the entity having legal custody of that child, an emancipated child, an MCO care coordinator, or from a Child Protective Service worker having an interest in the child.

3. Referrals for 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 screenings for children shall be the same as that set out for adults in subsection (A)(2) of this section.

C. Screenings in hospitals for adults and children who are inpatients. Screening in hospitals shall be completed when an adult or child who is an inpatient may need LTSS upon discharge or when the inpatient, or representative, requests a screening.

1. As a part of the discharge planning process, the hospital team shall complete a screening when:

a. The individual's physician, in collaboration with the individual, the individual's representative, if there is one, parent, entity having legal custody, or emancipated child makes a request of the hospital team; or

b. The individual, the individual's representative, if there is one, parent, entity having legal custody, or emancipated child requests a consultation with hospital case management.

2. Such individual shall receive a screening conducted by the hospital team regardless of the primary payer source (e.g., Medicare, health maintenance organization) and whether or not they are eligible for Medicaid or are anticpiated to become eligible for Medicaid within six months after admission to a NF.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

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

A. Community screenings for adults.

1. Eligibility for Medicaid-funded LTSS shall be determined by the CBT after completion of a screening of the individual's needs and available supports. The CBT shall document a screening of 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 screening shall be documented on the designated DMAS forms identified in 12VAC30-60-306.

2. 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 screening be performed in an alternate location within the same jurisdiction. The individual shall be permitted to have another person or persons present at the time of the screening. Other than situations when a court has issued an order for a 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 screening and accommodate the individual's preferences to the extent feasible.

3. The CBT shall:

a. Observe the individual's ability to perform 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 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, or both, 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. Upon completion of the screening and in consideration of the communication from the individual, his representative, if appropriate, and observations obtained during the 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 and provide choice to the individual and his representative, if appropriate, of the feasible alternatives to placement in a NF.

5. If waiver services or PACE, where available, are declined, the reason for the declination 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 screening entity.

6. If the individual meets criteria and selects community-based services, the CBT shall also document that the individual is at risk of NF placement in the absence of 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 preventing previous services and supports from meeting the individual's needs. 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. If the individual selects NF placement, the CBT shall follow the Level I identification and Level II evaluation process as outlined in 12 VAC 30-130-140 et seq.

8. If the CBT determines that the individual does not meet the criteria set out in 12VAC30-60-303, the CBT shall notify in writing the individual and the individual's representative, as may be appropriate, 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. For those screenings conducted in accordance with 12 VAC 30-60-302 (B)(iv), the DMAS designee shall follow the process outlined in this subsection.

B. Community screenings for children.

1. Eligibility for Medicaid-funded LTSS shall be determined by the DMAS designee after completion of a screening of the child's needs and available supports.. The DMAS designee shall document a screening of 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 screening shall be documented on the designated DMAS forms identified in 12VAC30-60-306.

2. Upon receipt of a screening request, the DMAS designee shall schedule an appointment to complete the requested screening. Community settings where 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 acute care hospitals, and rehabilitation hospitals.

3. The DMAS designee shall:

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

b. Observe the child's ability to perform 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 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 needs, or both, 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. Upon completion of the screening and in consideration of the communication from the child, his representative, if appropriate, and observations obtained during the screening, the DMAS designee shall determine whether the child meets the criteria set out in 12VAC30-60-303. If the child meets the criteria for LTSS, the DMAS designee shall inform and provide choice to the child and his representative, if appropriate, of the feasible alternatives to NF placement.

5. 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 designee shall have this document signed by either the child or his representative, if appropriate. 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 screening entity.

7. If the child meets criteria and selects community-based services, the DMAS designee shall also document that the individual is at risk of NF placement in the absence of 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 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 preventing previous services and supports from meeting the child's needs. 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.

8. If the parent, entity having legal custody of the child, or emancipated child selects NF placement, the DMAS designee shall follow the Level I identification and Level II evaluation process as set out in 12 VAC 30-130-140 et seq.

9. If the DMAS designee determines that the child does not meet the criteria to receive LTSS as set out in 12VAC30-60-303, the DMAS designee shall notify in writing the parent, entity having legal custody of the child, or the emancipated child and representative, as may be appropriate, that LTSS are being denied for the child. The denial notice shall include the child's right to appeal consistent with DMAS client appeals regulations (12VAC30-110-10 et seq.).

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. Eligibility for Medicaid-funded LTSS shall be determined by the hospital screening team after completion of a screening of the individual's needs and available supports. The hospital screening team shall document a screening of 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).

2. Screenings shall be completed in the hospital prior to discharge. The individual shall be permitted to have another person or persons present at the time of the screening. Other than situations when a court has issued an order for a screening, the individual shall also be afforded the right to refuse to participate. The hospital 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. The hospital screening team shall:

a. Observe the individual's ability to perform 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 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, or both, 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. Upon completion of the screening and in consideration of the communication from the individual, his representative, if appropriate, and observations obtained during the screening, the hospital screening team shall determine whether the individual meets the criteria set out in 12VAC30-60-303. If the individual meets the criteria for LTSS, the hospital screening team shall inform and provide choice to the individual and his representative, if appropriate, of the feasible alternatives to placement in a NF.

5. If waiver services or PACE, where available, are declined, the reason for the declination shall be recorded on the DMAS-97, Individual Choice, Institutional Care, or Waiver Services form. The hospital 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. If the individual meets criteria and selects community-based services, the hospital screening team shall also document that the individual is at risk of NF placement in the

absence of 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 preventing previous services and supports from meeting the individual's needs. 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. If the individual selects NF placement, the hospital screening team shall follow the Level I identification and Level II evaluation process as outlined in 12 VAC 30-130-140 et seq.

8. If the hospital screening team determines that the individual does not meet the criteria set out in 12VAC30-60-303, the hospital screening team shall notify in writing the individual and the individual's representative, as may be appropriate, 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 (12VAC30-110-10 et seq).

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12VAC30-60-306. Submission of screenings.

A. The screening entity shall complete and submit the following forms to DMAS electronically on ePAS:

1. DMAS 95 - MI/IDD/RC (Supplemental Assessment Process Form Level I);

2. DMAS - 96 (Medicaid-Funded Long-Term Care Service Authorization Form), as appropriate;

3. DMAS - 97 (Individual Choice – Institutional Care or Waiver Services); and,

4. UAI (Uniform Assessment Instrument).

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

C. For screenings performed in a hospital, the hospital team shall submit to DMAS on ePAS each screening form listed in subsection A of this section, which shall be completed prior to the individual's discharge. For individuals who will be admitted to a Medicare-funded skilled NF or to a Medicare-funded rehabilitation hospital (or rehabilitation unit) directly upon discharge from the hospital, the hospital screener shall have up to an additional three days post-discharge to submit the screening forms via ePAS.

12VAC30-60-307. ~~Summary of pre-admission nursing facility criteria.~~ (Repealed.)

~~A. An individual shall be determined to meet the nursing facility criteria when:~~

~~1. The individual has both limited functional capacity and requires medical or nursing management according to the requirements of 12VAC30-60-303, 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. An individual shall not be determined to meet nursing facility criteria when one of the following specific care needs solely describes his or her condition:~~

~~1. An individual who requires minimal assistance with activities of daily living, including those persons whose only need in all areas of functional capacity is for prompting to complete the activity;~~

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

~~3. An individual who requires limited diets such as a mechanically altered, low salt, low residue, diabetic, reducing, and other restrictive diets;~~

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

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

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

~~7. An individual whose primary need is for behavioral management which can be provided in a community-based setting;~~

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

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

Prior to an individual's admission, the NF shall review the completed screening forms to ensure that applicable NF admission criteria have been met and documented.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

12VAC30-60-310. Competency training and testing requirements.

By no later than December 31, 2018, each person performing screenings on behalf of a screening entity shall complete required training and competency assessments. A score of at least 80% on each module shall constitute satisfactory competency assessment results. The most current competency assessment results shall be kept in the screening entity's personnel records for each person performing screenings for the screening entity. Such documentation results shall be provided to DMAS upon its request.

1. All persons performing screenings shall complete the DMAS-approved training and pass the corresponding competency assessment with a score of at least 80% for each module of the training prior to performing screenings. This training shall be repeated no less than every three years resulting in a score of at least 80% on each module.

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

12VAC30-60-312. ~~Evaluation to determine eligibility for Medicaid payment of nursing facility or home and community-based care services.~~ (Repealed.)

~~A. The screening team shall not authorize Medicaid-funded nursing facility services for any individual who does not meet nursing facility criteria. Once the nursing home preadmission screening team has determined whether or not an individual meets the nursing facility criteria, the screening team must determine the most appropriate and cost-effective means of meeting the needs of the individual. The screening team must document a complete assessment of all the resources available for that individual in the community (i.e., the immediate family, other relatives, other community resources and other services in the continuum of long-term care which are less intensive than nursing facility level-of-care services). The screening team shall be responsible for preauthorizing Medicaid-funded long-term care according to the needs of each individual and the support required to meet those needs. The screening team shall authorize Medicaid-funded nursing facility care for an individual who meets the nursing facility criteria only when services in the community are either not a feasible alternative or the individual or the individual's representative rejects the screening team's plan for community services. The screening team must document that the option of community-based alternatives has been explained, the reason community-based services were not chosen, and have this document signed by the client or client's primary caregivers.~~

~~B. The screening team shall authorize community-based waiver services only for an individual who meets the nursing facility criteria and is at risk of nursing home placement without~~

~~waiver services. Waiver services are offered to such an individual as an alternative to avoid nursing facility admission pursuant to 42 CFR 441.302 (c)(1).~~

~~C. Federal regulations which govern Medicaid-funded home and community-based services require that services only be offered to individuals who would otherwise require institutional placement in the absence of home- and community-based services. The determination that an individual would otherwise require placement in a nursing facility is based upon a finding that the individual's current condition and available support are insufficient to enable the individual to remain in the home and thus the individual is at risk of institutionalization if community-based care is not authorized. The determination of the individual's risk of nursing facility placement shall be documented either on the state-designated pre-admission screening assessment or in a separate attachment for every individual authorized to receive community-based waiver services. To authorize community-based waiver services, the screening team must document that the individual is at risk of nursing facility placement by finding that one of the following conditions is met:~~

~~1. Application for the individual to a nursing facility has been made and accepted;~~

~~2. The individual has been cared for in the home prior to the assessment and evidence is available demonstrating a deterioration in the individual's health care condition or a change in available support preventing former care arrangements from meeting the individual's need. Examples of such evidence may be, but shall not necessarily be limited to:~~

~~a. Recent hospitalizations;~~

~~b. Attending physician documentation; or~~

~~c. Reported findings from medical or social service agencies.~~

~~3. There has been no change in condition or available support but evidence is available that demonstrates the individual's functional, medical and nursing needs are not being met. Examples of such evidence may be, but shall not necessarily be limited to:~~

~~a. Recent hospitalizations;~~

~~b. Attending physician documentation; or~~

~~c. Reported findings from medical or social service agencies.~~

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

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

An individual shall be determined not to meet criteria for Medicaid-funded LTSS 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.

THE TEXT OF THIS REGULATION IS IN DRAFT FORM AND SHOULD NOT BE RELIED UPON FOR LEGAL INTERPRETATION.

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

A. Once an individual is admitted to community-based services, the CBS provider shall be responsible for conducting ongoing evaluations to ensure that the individual meets, and continues to meet, the waiver program or PACE criteria, if appropriate. These ongoing evaluations shall be conducted using the Level of Care Review tab in the Medicaid portal. (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal).

B. Once an individual is admitted to a NF, the NF shall be responsible for conducting ongoing 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 no later than 14 days after the date of NF admission and promptly after an individual's significant change in condition.

C.For individuals wo are enrolled in a MCO that is responsible for providing LTSS, the MCO shall conduct ongoing evaluations by qualified MCO staff to ensure the individual continues to meet criteria for LTSS.

FORMS (12VAC30-60)

Certificate of Medical Necessity -- Durable Medical Equipment and Supplies, DMAS 352 (rev. 8/95).

Request for Hospice Benefits, DMAS 420 (rev. 1/99).

Screening for Mental Illness, ~~Mental Retardation/~~ Individuals with Intellectual Disability, or Related Conditions, DMAS-95/IDD/RC (rev. 12/2015)

Medicaid Funded Long-Term Services and Supports Authorization Form, DMAS-96 (rev. 12/2015)

Individual Choice - Institutional Care or Waiver Services Form, DMAS-97 (rev. 8/2012)

Virginia Uniform Assessment Instrument

Virginia Uniform Assessment Instrument, DMAS-98 (eff. 2/2016), including:

UAI-A; UAI-B; Eligibility Communication Document; Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions; MI/MR Supplemental: Level II; Medicaid Funded Long-Term Care Service Authorization Form; Individual Choice - Institutional Care or Waiver Services Form; and Attachment to Public Pay Short Form Assessment

Community-Based Care Level of Care Review Instrument, DMAS-99LOC (undated)