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Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation(s)	12 VAC 30-300
Regulation title(s)	Nursing Facility Criteria
Action title	2015 Long Term Services and Supports (LTSS) Screening Changes
Date this document prepared	November 4, 2016

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 (preferably no more than 2 or 3 paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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 proposed stage action follows an emergency regulation that added 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. This proposed stage action incorporates the changes made in the emergency regulation:

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 living in the community and adults and children 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. Competency training and testing requirements.
   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.

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.

ADLs = activities of daily living
DARS = Department for Aging and Rehabilitative Services
DMAS = Department of Medical Assistance Services
EDCD = Elderly and Disabled with Consumer Direction
ePAS = electronic preadmission screening
LHD = local health department
LTSS = long term services and supports

MCO = managed care organization
NF = nursing facility
PACE = Program of All-Inclusive Care to the Elderly
PAS = preadmission screening
SNF = skilled nursing facility
UAI = uniform assessment instrument
VDH = Virginia Department of Health

Legal basis

Please identify the (1) the agency (includes any type of promulgating entity) and (2) the state and/or federal legal authority for the proposed regulatory action, including the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable. Your citation should include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

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 2016 *Acts of the Assembly*, Chapter 780, 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.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Describe the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

In responding to the legislative mandate of the General Assembly, the purpose of the planned regulatory action is to define terms and establish regulatory requirements for i) accepting screening requests; ii) management of the screening process; iii) submission of findings from screenings completed to the agency's electronic ePAS system by community and hospital PAS teams and contractors performing these activities; and iv) the establishement of training requirements and competency assessment standards applicable to local agency screening staff.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of changes" section below.

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 screening policy that was in place before the emergency regulation took effect contained 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 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 were also provided for nursing facilities once an individual had chosen and was 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. In State Fiscal Year 2016, 350 providers performed 22,901 screenings. Of the 350 providers, 120 were local DSS offices that do not get paid directly through fee for service claims; 117 were local Virginia Department of Health clinics and the rest were mainly hospitals. Payments for screenings through fee for service claims were $2,282,345 total funds, of which 75%, or $1,711,759, were Federal Funds. CMS uses a 90% federal matching rate for such screenings.

Anecdotal 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, without a prior screening, 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 pending screening requests, such individuals may 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.

Before the emergency regulation went into effect, the policy was 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. Also absent from that policy were 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 General Assembly 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. JLARC reported on the Commonwealth's long term services and supports screening at http://jlarc.virginia.gov/pdfs/reports/Rpt489.pdf

The prior policy related to the requirements for functional eligibility (12 VAC 30-60-303(B)) for Medicaid-funded LTSS is 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.

This proposed stage regulation repeals 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 improve the readability of the regulation.

The remaining policy that was in effect prior to the emergency regulations, as it appeared in the current Virginia Administrative Code, was incomplete and fragmented as the result of having been created and modified over a number of years. To remedy this, the emergency regulation additions included 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 to the ePAS system (12VAC30-306), 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). These additions remain in this proposed stage regulation.

DMAS is also recommending that a training program (in 12VAC30-60-310) be developed to be applicable to all screening entities and their staff who will be performing screenings. The training program will provide testing that staff must pass at a standard of 80% in order for the staff to be authorized to conduct screenings. DMAS will be contracting this element via the state proposal process and the system will be available online to avoid travel time and expenses. A training program was a specific recommendation of JLARC in its report about pre-admission screening. These proposed stage regulations provide for a delayed effective date of the onset of this requirement to permit local agency staff and hospital staff time to fulfill this requirement.

Issues

Please identify the issues associated with the proposed regulatory action, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please indicate.

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 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 proposed 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.

With the onset of required managed care for the majority of Medicaid members, DMAS is also adding that MCO care coordinators will have the authority to request screenings for their members.

These strategies have been designed to ensure prompt services to citizens requesting Medicaid-funded LTSS and to protect their health, safety and welfare.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

There are no requirements that exceed applicable federal requirements.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

No locality is particularly affected by this regulation as the changes apply statewide.

Public participation

Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.

In addition to any other comments, the agency is seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, the agency/board is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments for the public comment file may do so by mail, email or fax to Charlotte Arbogast, Long-Term Care Policy Analyst, DMAS, 600 Broad Street, Richmond, VA 23219, phone: 804-225-2536, fax: 804-786-1680, or email: Charlotte.Arbogast@dmas.virginia.gov. Comments may also be submitted through the Public Forum feature of the Virginia Regulatory Town Hall web site at: http://www.townhall.virginia.gov. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

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

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.

Projected cost to the state to implement and enforce the proposed regulation, including: **a) fund source / fund detail; and** **b) a delineation of one-time versus on-going expenditures**	In SFY 2016, DMAS paid $2.3 M in claims for screenings of which 75% (or $1.7 M) was federal funds. Such expenditures will be ongoing as long as screenings for admission to long term services and supports are required.
Projected cost of the new regulations or changes to existing regulations on localities.	There are no costs to localities as a result of these changes.
Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.	Inpatient hospitals; local departments of social services and local health departments; nursing facilities;
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	From May 2015 – August 2016, providers performed 35,866 screenings: 131 community based teams and 108 hospitals. There are no small businesses that perform preadmission screenings.
All projected costs of the new regulations or changes to existing regulations for affected individuals, businesses, or other entities. Please be specific and include all costs including: **a) the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; and** **b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.**	This is an ongoing expenditure for DMAS as screenings have been required since 1984. The local CBTs and hospitals are already performing these screenings. These regulations clarify the process and establish exceptions that have not to date been formally stated.
Beneficial impact the regulation is designed to produce.	The regulation is designed to clarify process 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.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

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 regulations.

Regulatory flexibility analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

No other alternatives will meet the General Assembly mandate.

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 decrease disposable family income depending upon which provider the recipient chooses for the item or service prescribed.

Public comment

Please summarize all comments received during the public comment period following the publication of the NOIRA, and provide the agency response.

DMAS submitted its Notice of Intended Regulatory Action to the Registrar of Regulations on June 21, 2016, for publication in the Virginia Register of Regulations on July 11, 2016. The comment period ended on August 10, 2016. Comments were received from representatives of the Virginia Hospital and Healthcare Association (VHHA) and the Virginia Health Care Association-Virginia Center for Assisted Living (VHCA-VCAL). The comments are summarized as follows with the agency's responses.

Commenter	Comment	Agency Response
VHHA	1. Regulations should be carefully drafted to ensure that hospitals and community-based agencies are not unnecessarily performing screenings when the individual is not eligible for Medicaid or will not become eligible within six months.	DMAS concurs. The proposed regulations should further clarify instances in which screenings are required.
	2. Hospitals are continually receiving requests for preadmission screenings for individuals who are not inpatients but are outpatients, observation patients, and are emergency department patients.	DMAS concurs. The proposed regulations clarify the term "inpatients".
VHCA-VCAL	1. This comment seeks clarification to the new text at 12 VAC 30-60-315 providing for community-based and nursing facility service providers ongoing determinations that individuals meet functional needs for Medicaid long term services and supports. Managed care organizations that render long term services and supports lack parameters to guide	DMAS concurs and has modified these proposed stage regulations to address this issue.

	these evaluations. 2. As DMAS moves to managed long term services and supports, a high percentage of individuals qualified for these services will also be enrolled in managed care organizations (MCOs). There is no delineation of dual responsibility and hierarchy of the determination of ongoing need. Where there is disagreement between the provider and the MCO, it is not clear which assessment would prevail.	DMAS concurs and has modified these proposed stage regulations to address this issue.

Detail of changes

*Please list all changes that are being proposed and the consequences of the proposed changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action. If the proposed regulation is intended to replace an emergency regulation, please list separately: (1) all differences between the **pre**-emergency regulation and this proposed regulation; and 2) only changes made since the publication of the emergency regulation.*

For changes to existing regulation(s), use this chart:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, intent, rationale, 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 consistent use of terms.
	12 VAC 30-60-302		New introduction section and access to long term services and supports contains existing requirements from repealed sections such as old section 300; COV 32.1-330 is borrowed from; sec. 302 F is

			new.
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). Subsection labeled new D contains current standards for evaluating a child with the UAI. Sub-section labeled new 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 new 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 new 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 new 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 subsection 303 A and sec. 313.
	12 VAC 30-60-308		Sets out existing 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. Moved from 300 C.
	12 VAC 30-60-310		Establishes new local screening staff competency training and assessment requirements. Establishes 80% as the minimum score considered as satisfactory. Delayed effective date of 12/31/2018 provided to permit time for local screening staff to meet this standard.
12 VAC 30-60-312			Evaluation section being repealed and contents are moved to new section 302.
	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-		New section provides for ongoing

	60-315		evaluations for individuals who have already qualified for LTSS. Moved from sec 300 C & D.

MEMBERS OF THE PRE-ADMISSION SCREENING WORK GROUP

Pamela Cole, Family Services Supervisor/Adult Services, Norfolk Department of Human Services Pamela.Cole@Norfolk.gov

Alison Holmes, MSSA, CCM, Director of Case Management, Southside Regional Medical Center; 804-765-5990 Alison_Holmes@chs.net

Brittany Hall, Southside Regional Medical Center Brittany_Hall2@chs.net

Brenda B. Burrus, RN, MSEd, Nurse Manager Senior, New River Health District
Phone - 540-585-3356 (NEW) Brenda.Burrus@VDH.virginia.gov
Paige McCleary, Program Manager, Department for Aging and Rehabilitative Services (DARS)
804-662-7605 Paige.McCleary@DARS.virginia.gov
Lisa Park, Health Care Reimbursement Manager, Virginia Department of Health (VDH),
804-864-7018 Lisa.Park@vdh.virginia.gov
William (Bill) Edmunds, Director of Process & Evaluation Oversight, VDH, 804-864-7942
William.Edmunds@VDH.Virginia.gov

Steve Lanman, St. Mary's Hospital; 804-371-4190 Steve.Lanman@BSHSI.org

Linda Godsey Stanley, Henrico DSS, 804-501-4013 sta04@henrico.us

Brent Rawlings, Virginia Hospital and Healthcare Association, VHHA, 804- 965-1228
Brawlings@VHHA.com

Ruth Wolford, RN, Registered Nurse Manager I, New River Health District (540) 585-3355
Ruth.Wolford@vdh.virginia.gov

DMAS staff:
Terry Smith, Long-Term Care Division Director, DMAS
Terry.Smith@DMAS.virginia.gov
Helen Leonard, Administrative Manager, DMAS, 804-786-2153
Helen.Leonard@DMAS.virginia.gov
Charlotte Arbogast, Program Specialist, LTC, DMAS, 804-786-7933
Charlotte.Arbogast@DMAS.virginia.gov
Emily McClellan, Manager, Div. of Policy and Research, DMAS, 804-371-4300
Emily.McClellan@dmas.virginia.gov
Vicki Simmons, Regulatory Coordinator, DMAS, 804-371-6043
Victoria.Simmons@dmas.virginia.gov