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Final 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	February 27, 2018

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

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of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed.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

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

The proposed stage action followed 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. The proposed stage action incorporated changes made in the emergency regulation as follows:

1. **Added 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. Periodic evaluations for individuals receiving Medicaid-funded long-term services and supports.

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

3. **Repealed 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.

In response to public comments received, DMAS recommends the following changes: (i) add definitions of long standing terminology (functional capacity and medical or nursing needs); (ii) modify the required training program to permit experienced screeners, who have successfully completed the initial training course, to take a shorter refresher course every 3 years; (iii) an additional six months to complete the required training has been added; (iv) the text of the special circumstances has been clarified; iv) the individual's physician has been added to those entities who can make requests and referrals for screenings; (vi) screenings are specified as being face-to-face; (vii) the statutory exception (i.e., an individual being financially eligible within six months of the screening) has been added to screenings conducted by CBTs (12 VAC 30-60-304) and hospitals; (viii) inpatients in hospitals can have APS/CPS workers request a screening; (ix) the term 'eligibility' has been qualified throughout regs with medical or nursing and functional descriptors as this was always the intent; (x) screeners will be able to complete the asterisked sections of on-line UAI form; (xi) the long

standing policy of the functional equivalency between UAI and MDS level of care determinations is clarified; and (xii) editorial corrections are made to improve clarity and readability.

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

Statement of final agency action

Please provide a statement of the final action taken by the agency including:1) the date the action was taken;2) the name of the agency taking the action; and 3) the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended State Plan pages entitled 2015 Long Term Services and Supports (LTSS) Screening Changes (12 VAC 30-60- 300 through 12 VAC 30-60-315) and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012, of the Administrative Process Act.

February 27, 2018	/Signature/
Date	Jennifer S. Lee, M.D., Director
	Dept. of Medical Assistance Services

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 and the 2017 Acts of Assembly, Chapter 836, 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 this 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 establishment of training requirements and competency assessment standards applicable to local agency screening staff.

This regulatory action is essential to protect the health and safety of individuals who may qualify for Medicaid and also require long term care services. This action defines terms and sets out time frames for action for clarity of interpretation and consistency of application by the various entities across the Commonwealth that perform these preadmission screenings.

This regulatory action does not affect the Commonwealth's citizens who are not eligible for Medicaid nor require long term care services.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both.

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 (12 VAC 30-60-300 et seq.) 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 included 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 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. 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 not changing. The federal requirement incumbant upon NFs to measure an individual's level of care via the Minimum Data Set (MDS) is not changing. The long standing Medicaid policy of recognizing the MDS as functionally equivalent to the UAI is 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 34,000 screenings per state year July 2016-June 2017. In State Fiscal Year 2017, 350 providers performed 34,400 screenings. Of the 350 providers, 120 were local DSS offices that do not get paid directly through fee for service claims; 132 were local Virginia

Department of Health clinics that are paid via fee for service claims and the rest were mainly hospitals that are also paid via fee for service claims.

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 in each locality;
- 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 revealed that when a screening is performed by a hospital, the resulting recommendation 88% of the time is that an individual has been directed to nursing facility (skilled NF or NF) services rather than receiving supports at home (community based services). DMAS recognizes that persons being discharged from inpatient hospital stays may have experienced an acute medical event, and therefore may need NF care, more so than individuals who have remained in their homes.

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 hospital/rehabilitation stay. 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 screening for Medicaid LTSS 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.

Medicare funding is not available for community-based long term care services which are only covered by Medicaid.

DMAS recognizes that staff resources are limited for community and hospital based screenings. Therefore, efficiency in the screening process has become more critical to managing the growing workload. The "paper-driven" screening process proved to be too cumbersome and time consuming. The forms used for the screening process are the Uniform Assessment Instrument (UAI), along with other DMAS forms, 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), DMAS 108 (Tech Waiver Adult Referral) and the DMAS 109 (Tech Waiver Pediatric Referral). The previous absence of an automated process to assist community and hospital screening 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. DMAS developed and implemented the Electronic PreAdmission Screening system (ePAS) and the proposed regulation included the mandatory use of this 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 screening teams when accepting requests for screenings, managing those requests within the established time period, and reporting the outcomes of the screenings once individuals received screenings.

RECOMMENDATIONS

The General Assembly directed DMAS to improve the 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 screenings for children and to perform screenings for those requests exceeding thirty days from the initial request; (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. In the absence of funding for th contractor mandate, DMAS is proceeding, to the degree feasible and with existing resources, to implement these requirements. 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 has been retained since these standards support the eligibility

process for the DMAS' home and community based waiver programs (currently named the CCC Plus Waiver (formerly the Elderly or Disabled with Consumer Direction (EDCD) waiver, the Technology Assisted waiver), the Alzheimer's Assisted Living waiver, the Program of All-Inclusive Care for the Elderly (PACE) Program and nursing facility care.

The prior proposed stage repealed the existing nursing facility criteria section (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 and the flow of the text.

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 and proposed stage additions included a Definitions (12VAC30-60-301) section and sections describing the requirement for the requests and referrals for screenings (12VAC30-60-304), community and hospital screenings for Medicaid-funded LTSS (12VAC30-60-305), submission of screenings to the ePAS system (12VAC30-306), NF admission and level of care determination requirements (12 VAC 30-60-308), individuals determined to not meet functional criteria (12 VAC 30-60-313), and periodic evaluations for individuals receiving Medicaid-funded LTSS (12 VAC 30-60-315). These additions remain in the final stage.

DMAS also recommended 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 contracted 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. The proposed stage provided for a delayed effective date of the onset of this requirement to permit local agency staff and hospital staff time to fulfill this requirement. This final stage advances that delayed effective date another six months in response to public comments.

The tracking system implemented by DMAS yields the following information for July-August 2017:

- Out of a total of 131 cities and counties, 102 (77.9%) completed 90% to 100% of screenings within 30 days; of this 102 localities, 95 (93.1%) of them performed 50 or fewer screenings;
- Only one locality (0.008) completed less than 50% of its screenings within 30 days;
- Seven localities (0.05%) completed more than 100 screenings; the range of screenings performed was a low of 2 to a high of 251; and
- Ten localities (0.08%) required 25 to 31 days to complete screenings; the remaining localities required 24 or fewer days to complete requested screenings.

In response to public comments received, DMAS recommends the following changes: (i) modify the required training program to permit experienced screeners, who have successfully completed the initial training course, to take a shorter refresher course every 3 years; (ii) the text of the special circumstances has been clarified; (iii) the individual's physician has been added to those entities who can make requests and referrals for screenings; (iv) screenings are specified as being face-to-face; (v) the statutory exception (i.e., an individual being financially eligible within six months of the screening) has been added to screenings conducted by CBTs (12 VAC 30-60-304) and hospitals; (vi) inpatients in hospitals can have APS/CPS workers request a screening; (vii) the term 'eligibility' has been qualified throughout regs with medical/nursing and functional descriptors as this was always the intent; (viii) screeners will be able to complete asterisked sections of UAI form; (ix) the long standing policy of the functional equivalency between UAI and MDS level of care determinations is clarified; and (x) editorial corrections are made to improve clarity and readability.

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 hospital staff 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 required a change to the Virginia Administrative Code. Also anecdotally, some community-based screenings were taking longer than 30 days to complete thereby creating a significant risk to individuals unable to access Medicaid LTSS.

The advantages of these changes are the improved timeliness and efficiency of the screening process with the use of the ePAS system. The consistent new definitions and specified process is expected to reduce local screening teams delays due to uncertainty and confusion.

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. Additionally, the number of required fields in the automated system has been

reduced to enhance efficiency. Even though not yet funded, the suggested regulations also provide for DMAS' use of a contractor or contractors and provide a framework for public or private entities to screen children.

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 once their members have agreed to participate with the screening. These strategies have been designed to ensure prompt services to citizens requesting Medicaid-funded LTSS, to protect their health, safety and welfare while ensuring, to the degree possible, that individuals receive appropriate and needed services in a patient centered system.

There are not any disadvantages that are anticipated.

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.

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, and does not increase or decrease disposable family income.

Changes made since the proposed stage

*Please list all changes that made to the text of the proposed regulation and the rationale for the changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. *Please put an asterisk next to any substantive changes.*

Section number	Requirement at proposed stage	What has changed	Rationale for change
12 VAC 30-60-301	Definitions.	Corrections made to definitions of: adult; at-risk; child; CSB; ePAS; home and community-based services waiver; hospital team; inpatient; long term services and supports; MCO; MDS; other assessor designated by DMAS; pread-mission screening; private pay individual; request date for screening; request for screening; residence; submission; UAI form. Definitions added for 'functional capacity', functional eligibility; and 'medical or nursing needs'; ongoing; provider. Definition of reimbursement; primary account holder; submission date are removed as unnecessary. All definition references to 'community-based' changed to 'home and community-based'.	To improve readability, accuracy, grammar, proper alphabetization, etc. recognition is given to the functional equiva-lency of the level of care information documented on the UAI and MDS forms. Long standing terms had never before been defined in regulation. OAG required the explanation of the long-standing term 'ongoing' (section 303 D).
60-302	Introduction	Corrections made to A, B, C, D and E.	To improve readability, accuracy, grammar, text consistency with other sections in these regulations, etc. Screening references are qualified with the face-to-face require-ment. Language in special circumstances is rewritten for clarity.
60-303	Screening criteria.	Corrections made to A, B, C, D and E.	To improve readability, accuracy, grammar,

			punctuation, text consistency with other sections in these regulations; etc. Dependency in joint motion specifically stated for correct interpretation of semi-dependency. Incorpor-ation by Reference to Medicaid Memo up-dated.
60-304	Requests for screening.	Corrections made to catch line; A, B, C. C 3 added.	To improve consistency between VAC sections, readability, accuracy, grammar, punctuation, and text consistency with other sections in these regulations, etc. Subsection A provides an exception for CBTs to not perform screenings. B(1) modified to more accurately reflect the handling of screenings for children. Physicians added to list of entities that may request screenings for children. C 3 is added for clarity and consistency across reg sections. Subsection D is added to ensure clarity about the 30 day submission date.
60-305	Screenings in community and hospitals.	Corrections made to A, B, C.	To improve consistency between VAC sections, readability, accuracy, grammar, and text consistency with other sections in these regulations, etc.
60-306	Submission of screenings	Corrections made to A, B and C.	To improve readability, accuracy, punctuation, and text consistency with other sections in these regulations, etc. Aster-isked sections of on-line UAI form will be required to be com-pleted.

60-308	NF admission and LOC determination requirements	Correction made.	For clarity and consistency with other text sections. Prior to new admissions, NFs are being prohibited from accepting paper UAI forms. This new requirement is to prevent screening entities from bypassing the ePAS which has been anecdotally noted.
60-310	Competency training and testing.	Corrections made.	For clarity and consistency with other text sections. Delayed deadline date is increased by six months to permit more time for compliance.
60-313	Individuals not meeting criteria	Corrections made.	For clarity and consistency with other text sections. Added requirement that an individual must have a screening or MDS document to be eligible for Medicaid-funded LTSS.
60-315	Ongoing evaluations	Corrections made.	For consistency with other text sections. Section establishes agency responsible for performing periodic evaluations of individuals of their eligibility for long term services and supports.

The Office of the Attorney General directed that a number of non-substantive editorial changes be made in the final regulation text.

Public comment

Please summarize all comments received during the public comment period following the publication of the proposed stage, and provide the agency response. If no comment was received, please so indicate.
Please distinguish between comments received on Town Hall versus those made in a public hearing or submitted directly to the agency or board.

DMAS' proposed regulations were published in the September 4, 2017 *Virginia Register* for their comment period from September 4, 2017, through November 3, 2017. Comments were received from representatives of Department of Rehabilitative Services (DARS), Virginia Hospital and Healthcare Association (VHHA), the Virginia Department of Health (VDH), Albemarle County Department of Social Services, the University of Virginia Health System, Moms in Motion/At Home Your Way via electronic mail and the Regulatory Town Hall.

In the context of public comments provided to DMAS about its proposed regulations regarding Consumer Directed Services Facilitation (TH 4046/7536) (comment period May 15, 2017 through July 14, 2017), an individual provided a comment about these LTSS changes. That comment is shown in this summary.

A summary of the comments received and agency responses follows:

DARS	Agency Summary of Comment	Agency Response to Comment
12 VAC 30-60-301	(i) 'Physician' is used in the definition of CBT but budget language used 'licensed health care professional'. Does this need clarification?	DMAS is relying on the inclusion of physician from the Code of Virginia § 32.1-330.
	(ii) 'Face-to-face' is defined but does not seem to be used elsewhere in these regulations.	Rather than removing the definition, DMAS has added this qualifying term before screenings in numerous sections as this has always been DMAS' intention.
	(iii) Why is assisted living facility listed in the definition of PAS when a different assessment is used for that type of care?	Assisted living facility (ALF) has been stricken out of the definition of PAS. However, it is appropriate for the ALF reference to remain in the definition of 'residence' as an individual who lives in an ALF may request a screening in order to move to either a NF or receive community-based services in order to leave the ALF.
	(iv) An MCO should be able to refer for a screening and not be listed as a	DMAS is leaving this language as is and will provide information and technical assistance to the MCO care coordinators to mitigate any potential communication issues to ensure that the client has the right to refuse to be screened.

	requester. If the MCO must remain a requester, then the MCO should be required to consult with the client prior to making a screening request. This affords the client the opportunity to refuse to be screened and avoids wasting the CBT's time.	
	(v) Add 'managed care organization' to definition of MCO.	Done.
	(vi) The term 'primary account holder' is defined but not used in the regulations.	This term has been stricken out.
	(vii) Including 'nursing facility' in the definition of 'residence' can have the unintended consequence of enabling hospital discharge teams to avoid performing screenings in the knowledge that CBTs are obligated to conduct screenings of individuals admitted to NFs without screenings.	DMAS recognizes this as a possibility. In 12 VAC 30-60-308, DMAS requires the NF to ensure criteria have been met and documented at the time of admission which is expected to preclude this. If the individual wants to transition from a NF to a community waiver or PACE services, the CBT will conduct the screening. DMAS will provide technical assistance to reduce confusion and misunderstanding.
	(viii) Need to clarify language of UAI definition	Recommendation has been addressed with the addition of asterisks in required fields to the on-line UAI form.

	to permit identifica-tion of mandatory and optional parts of the form.	
12 VAC 30-60-302 D	Language con-flicts with other reg sections. Text affords all screen-ing teams option to evaluate the individual's fin-ancial status prior to conducting a screening and not conduct screen-ings on individuals who may not be elig-ible for Medicaid in 6 months.	DMAS is relying on the authority of the Code of Virginia § 32.1-330 for this provision.
12 VAC 30-60-302 E	(i) Text in #2 is confusing. Does it mean that CBTs will not screen individuals who discharge to a NF from a veteran's hospital but will screen individuals discharged home and who may need waiver services? Why can't DMAS require DBHDS facility staff to conduct screen-ings for NF placement or waiver services? It seems risky to send a client home without a screen-ing and with just a referral	DMAS believes it has clarified this text. Individuals being discharged from a veteran's hospital to a NF will be evaluated via the MDS as required by federal law to establish their level of care needs. DBHDS already conducts discharge planning for residents leaving facilities and moving into communities for which DMAS already reimburses. For DMAS to also reimburse for screenings would be duplicative.

	to the CBT.	
	(ii) Word is misspelled.	Corrected.
12 VAC 30-60-303 A	(i) Is DMAS certain that ePAS will successfully process a screening that meets the criteria in 303 A 2?	DMAS has instituted a manual process to address this situation. Future modifications to the automated system may address this issue.
12 VAC 30-60-304 A, B, C,	(i) Can language be added to require the MCO to consult with the client or the client's representative prior to requesting a screening?	DMAS concurs with the need for consultation between the MCO and client and has modified the final regulations to require that the MCO care coordinator seek the client's concurrence before requesting a screening.
	(ii) Is it appropriate for these regulations to refer to a 'DMAS designee' to receive aging screening requests when no such designee exists at the present time?	Currently, VDH is the DMAS designee for child and aging screening requests.
	(iii) Reg text is not accurate. Some CBTs are con-ducting child screenings under the guidance of the DMAS designee (currently VDH). Other localities, the local health department is conducting these. Recommended a text change to require that child screening requests	Currently, VDH is the DMAS designee for child screening requests. The local health department is being authorized by VDH to conduct these screenings of children.

	be made to and accepted by the DMAS designee.	
	(iv) Text at C seems to conflict with C(1)(a) and C(1)(b).	The text does not conflict but represents multiple sources of requests for screenings. DMAS has modified this text for clarity.
	(v) Text seems to conflict with remainder of proposed text. Need to ensure consistency of text. Can't an APS worker or CPS worker request a screening for a hospitalized individual?	DMAS has added the clarification that APS and CPS workers may also request screenings for individuals who are hospitalized.
12 VAC 30-60-304	Text is awkward; alternative wording suggested. Text contradicts other text at 12 VAC 30-60-302 D.	Edits made for clarity.
12 VAC 30-60-305	Unclear use of the term 'eligibility'. Does it refer to functional or financial eligibility for Medicaid long term services and supports?	Nowhere in these regulations does DMAS address financial eligibility for medical assistance. DMAS' financial eligibility regulations are contained in Chapter 40 of the Virginia Administrative Code. All uses of the term 'eligibility' in Chapter 60 imply 'functional eligibility.' This has been clarified in text edits. Other edits are made for clarity and to improve readability.
12 VAC 30-60-306	Term UAI is defined so not necessary to spell out. The DMAS-95 form is only completed for NF placement and not waiver services so this needs clarifying.	Revised.
12 VAC 30-60-308	Consider adding that screenings	DMAS concurs with this recommendation and has modified the regulations accordingly.

	not processed by ePAS will not be accepted by providers. Screening entities are completing UAIs by hand outside of the ePAS system and submitting them as documentation of an approved screening.	
12 VAC 30-60-310	Is 12/31/2018 a realistic date for the completion of online screening training? Training requirements are onerous and burdensome especially for local departments of social services workers. Why is it necessary to repeat training every 3 years? Eight hours of training is excessive for workers who have a strong foundation in the screen-ing process. How will DMAS track compliance with online training? Is DMAS able to limit access to ePAS for workers who fail to comply with the training requirements?	DMAS has advanced the completion date to June 30, 2019 to afford screening entities more time to meet this standard. DMAS is also providing for an abbreviated training program every three years for persons who have already completed the initial program. DMAS has not yet determined how much time will be required to complete the initial training. DMAS is working on tracking compliance with the training requirements in the system. DMAS believes its regulations are clear on when the screening entity must complete a screening. The screening entity must ensure that it has trained staff to perform the screenings.

	Does this enable workers to get out of having to perform screen-ings because they don't have time to complete the train-ing?	
12 VAC 30-60-313	Does the term 'criteria' refer to functional or financial criteria?	The term refers to functional criteria. DMAS has clarified this issue.
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VHHA		
12 VAC 30-60-301	Definitions. ePAS seems to be the only approved e-lectronic record system for entities contracted by DMAS to perform screenings. VHHA recom-mends permitting other types of electronic filing mechanisms in-cluding Curaspan.	The ePAS definition already also includes a 'DMAS-approved electronic record system' without naming a specific product.
12 VAC 30-60-302	Individuals should be anticipated to become Medicaid eligible within six months; other-wise, all of a hospital's patients could request a screening and the hospital would be required to pro-vide one. This section should be modi-fied to demon-strate that it only	DMAS did not provide for this consideration since in the hospital setting, a patient's financial information is housed in the hospital's business office and not necessarily available to the physicians/nurses who are performing screenings at patients' bedsides. This is already provided for in the controlling statute § 32.1-330 of the COV. The term 'inpatient' is already defined in section 301 to clearly exclude emergency department patients, outpatients, and observation bed patients.

	pertains to in-patients and not outpatients, obser-vation patients, or emergency depart-ment patients. Subsection G on payment retrac-tions requires clar-ification.	Subsection G gives DMAS the latitude to retract payments should that be deemed appropriate in the future.
12 VAC 30-60-304	All sections con-cerning which in-dividuals should be provided a screening should relate to the individual who is anticipated to be-come eligible for Medicaid within six months after admission. The regulations need to be consistent throughout on this point.	This provision is provided for in 12 VAC 30-60-302 B.
12 VAC 30-60-306	Screening tools, other than ePAS, need to be pro-vided for in the regulations, in-cluding Curaspan.	Other types of screening tools are already permitted in the regulations: see 12 VAC 30-60-301, without a specific alternative product being named.
12 VAC 30-60-310	Section requires clarification re-garding which persons will be required to have training. Will physicians who may provide only a portion of the screening be re-quired to take the full training or	DMAS will clarify in the training section that screening entity staff who sign off on the screening, which includes the screener and physician, must receive the training. DMAS recognizes these concerns and has clarified the training section to require only a shortened refresher course every three years after the initial training. An on-line training program is being developed to facilitate screeners' completion of this requirement. DMAS determined that adding a recommended grace period was not appropriate because delays in completing training has the potential to adversely affect the health and

	only the person who signs the screening or the primary sub-mitter? There may be a need for a shortened training module covering general know-ledge for second-ary participants. Three years is too often for the full training require-ment. There should be a shorter refresher course available on-line that can be completed in 30 minutes which also has a grace period for com-pletion.	safety of individuals requiring long term services and supports.
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VDH		
General comments	(i) Modify the definition of the CBT to align with the Appropriation Act	DMAS is relying on the inclusion of physician from the Code of Virginia § 32.1-330.
	(ii) Reinforce that screenings must be conducted for any individual who requests one regardless of pay-er source	DMAS believes that these regulations make clear this requirement.
	(iii) Update the UAI as evidence-based practice changes occur	DMAS is giving this suggestion further consideration.
	(iv) Develop train-ing that is ap-plicable and ap-propriate for	DMAS is in the process of doing this.

	screening teams	
12 VAC 30-60-301	Definitions. Remove physician from CBT; term face-to-face is defined but not used in regulations; ePAS is not used for assisted living facilities so these screening regulations do not apply; MCOs should be able to refer for a screening and not be shown as a requester and individual should still be able to refuse to participate; definition of MCO is incomplete; 'primary account holder' is defined but not used in regulations; including nursing facility in the definition of 'residence' is a problem; recommend strengthening the requirement that anyone who requests a screening should get one regardless of payer source; UAI language limits DMAS ability to modify it – recommend using 'UAI or other	DMAS is relying on the inclusion of physician from the Code of Virginia § 32.1-330. DMAS has otherwise modified the regulations accordingly in response to public comments. An individual can be a resident of an assisted living facility (ALF) and request a screening but these LTSS screenings are not used for purposes of admission to ALFs. DMAS concurs that individuals should be able to refuse to participate in a screening and has provided for this in the revised regulations. Primary account holder definition has been stricken out. DMAS is committed to continuing the use of the UAI for these assessments.

	DMAS approved assessment tool'.	
12 VAC 30-60-302	Language in D conflicts with 12 VAC 30-60-304 C. This language gives all screening teams the option to evaluate an individual's financial status and deny screenings to individuals who may not be eligible for Medicaid in six months.	Subsections C and D provide for the treatment of individuals having different circumstances and how these individuals are to be handled by screening teams. DMAS is following the COV statutory language on this issue of screening teams evaluating individual's financial status.
	Language in E indicates that veteran/military hospital staff are not required to conduct screenings and that such individuals must be referred to the CBT upon discharge. Referring to the CBT may delay onset of services. Recom-mend that veteran/ military hospital staff and DBHDS should be per-mitted to conduct screenings for NF placement or waiver community services to avoid service gap.	DMAS believes it has clarified this text. Individuals being discharged from a veteran's hospital to a NF will be evaluated via the MDS as required by federal law to establish their level of care needs. DBHDS already conducts discharge planning for residents leaving facilities and moving into communities. DMAS already reimburses DBHDS facilities for this and to also reimburse for screenings would be duplicative.
12 VAC 30-60-303	Is DMAS certain that ePAS will process a screen-	DMAS has instituted a manual process to address this situation. Future modifications to the automated system may address this issue.

	ing that meets the criteria in A(2)?	
12 VAC 30-60-304	MCO should be required to consult with the individual or the individual's representative prior to making a screening request or permit MCOs to refer for screen-ings. Individuals should have the right to decline a screening. The DMAS des-ignee for screen-ings over 30 days has not been identified. Lang-uage in B should reflect that the request should be made directly to DMAS designee thereby reducing potential delays between the re-quest and the performance of the screening. Language in C, C1a, and C1b is not consistent. Add CPS and APS workers as per-mitted to request screenings for individuals who are in unsafe	DMAS' proposed regulations permitted MCO care coordinators to request screenings for individuals but also required the MCO care coordinator to discuss the matter with the client recognizing the client's right to refuse to be screened. DMAS concurs with this comment. Currently, the DMAS designee is VDH. DMAS prefers to retain the 'DMAS designee' language in its regulations in case this changes in the future. The proposed stage regulations required that the CBT contact the VDH/DARS technical assistance staff. The point about direct referrals reducing time delays is well taken but DMAS prefers to leave this requirement as it appeared in the proposed stage. DMAS has modified this text to remove the perceived inconsistency and has added APS/CPS workers as permissible sources of requests for screenings. Screening requirements for both CBTs and hospitals have been made consistent with the COV.

	situations. Consider adding that 'hospital screen-ing teams shall conduct screenings on the individual regard-less of payer source or if the individual has been determined to be financially eligible for Med-icaid.' This sec-tion contradicts 12 VAC 30-60-302 D.	
12 VAC 30-60-305	Use of the term 'eligibility' is un-clear as it could mean functional or financial elig-ibility for Med-icaid LTSS.	DMAS' financial eligibility regulations are contained in Chapter 40 of the Virginia Administrative Code. All uses of the term 'eligibility' in Chapter 60 are understood to imply 'functional eligibility.' This edit and others are made for clarity and to improve readability.
12 VAC 30-60-306	Why spell out 'Uniform Asses-sment Instrument' as it is defined and the DMAS-95 form is only completed for NF placement not for the use of waiver community services.	Change made.
12 VAC 30-60-308	Need to add that screening docu-ments completed in hard copy outside the ePAS system are not to be accepted by providers.	DMAS concurs and has changed 12 VAC 30-60-308 to prohibit NFs from accepting paper forms as proof that admission criteria have been met and appropriately documented. This also applies to community based providers.
12 VAC 30-60-310	Agree with the 80% pass rate for	DMAS appreciates this commenter's concurrence with its pass rate standard. DMAS has not yet

	a training standard but 8 hours of training could be burdensome for CBTs and hospital teams. Recommend shorter update every 3 years but not repetition of the initial training. DMAS should track compliance with online training.	determined how long this required training is expected to take. DMAS concurs with this comment and has made this change. DMAS concurs and is developing this ability.
12 VAC 30-60-313	Use of term 'criteria' is unclear as it could mean functional or financial criteria for Medicaid LTSS.	In this section, 'criteria' refers to functional. DMAS has made this clarification.
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UVA Transitional Care Hospital	Commenter reports knowing of patients not able to function outside of medical settings due to complex medical needs and mobility dependencies but who are alert and oriented with no behavior issues. Such patients are deter-mined to not meet criteria for either institutional or community based care. Commenter requested reevaluation of DMAS'	The effect of adopting these recommendations would be that DMAS would modify its long term services and supports criteria. It was not the intent nor purpose of this regulatory action to change the basic criteria which could have significant budgetary impacts.

	long term care guidelines to provide for patients who are alert/ oriented with no behavior issues but who are also dependent in 2-4 activities of daily living and mobility who require 24-hour medical management.	
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Albemarle County of Social Services	There is confusion about when local screening teams can/will enter a nursing facility to screen individuals who have not been screened and whose Medicare skilled nursing benefit is ending. Nursing facilities are confused about why local CBTs cannot screen individuals in the facility who are going to remain in the facility.	DMAS will continue to work with and educate NFs and CBTs on the appropriateness of screenings in a facility. The purpose of a screening is to determine that an individual meets the medical/nursing/functional levels of care to be eligible for Medicaid-funded long term supports and services. DMAS accepts the NFs use of the federally required MDS as appropriate documentation of the individual qualifying for Medicaid-funded NF services.
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University of Virginia Health System (UVAHS)	This organization commented that it uses a Curaspan electronic system to interface with DMAS' ePAS and that it is essential that these regulations permit such DMAS-approved systems	Other types of screening tools are already permitted in the regulations: see 12 VAC 30-60-301. DMAS' definition of an 'inpatient' already excludes emergency department patients, outpatients, and observation bed patients.

	for electronic screening and sub-mission. This commenter requested that hospital LTSS screenings will only be completed in the inpatient hospital setting, excluding the emergency depart-ment, outpatient clinics, etc. This commenter requested that the required LTSS training be limited to the organi-zation's staff who assume respon-sibility for sub-mitting UAIs.	DMAS requires that the screening entity require those staff who will be signing off on the screening documentation to undergo the required screening.
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Moms in Motion/At Home Your Way	As a services facilitator pro-vider, this commenter report-ed noticing a changing trend in the number of people with disabilities, espec-ially children with autism, who are being denied LTSS. These children seem to be meeting the functional, fin-ancial and medical nursing criteria. Since it is	DMAS appreciates this commenter's support of the training requirements. DMAS cannot address specific individuals being denied LTSS in this venue. Such individuals can be referred to www.screeningassistance@dmas.virginia.gov for further help. Because of DMAS' federal requirements (HIPAA) to protect specific information about Medicaid individuals, it may not be possible to release this information. In 2018, DMAS will be forwarding a report on performance standards to the General Assembly in response to the mandate. DMAS continues to work with its designee (currently VDH) to ensure the accurate and

	unclear where the discre-pancies lie, this commenter sup-ports the training requirements.	appropriate application of criteria to both adults and children. Currently, DMAS and VDH are collaborating to validate the children's screening criteria. DMAS continues to work with its designee (currently VDH) to ensure the accurate and appropriate application of criteria to both adults and children.
	This commenter encouraged DMAS to review LTSS denials to address trends and make the data available regarding the number of people who are referred for screening, request a screen-ing, are approved, denied, appeal and their ages.	DMAS is aware that different screening locations can vary in their interpretations of screening rules and guidance documents and continues to work with these entities to ensure uniformity and consistency to the degree possible. Such instances should be reported to www.sceeningassistance@dmas.virginia.gov for follow up by DMAS staff.
	This commenter encouraged train-ing for screeners that includes both adult and child screening as the criteria for elig-ibility and pro-cesses differ greatly.	DMAS understands the concern of this commenter and agrees. DMAS' proposed regulations already permit referrals from interested persons who have sufficient knowledge of an individual who may need long term services and supports.
	This organi-zation's review of the November 22nd provider manual update regarding child screenings showed that the 0-5 criteria considering the child and parent	DMAS continues to require that CBTs provide the complete list available at www.virginiamedicaid.dmas.virginia.gov/wps/portal.

	as a unit further limited eligibility when screeners interpret the criteria without consideration of other complex medical needs or equipment to complete the ADL task. It has been this organization's experience that various screening locations vary greatly in interpreting guidance documents resulting in variation in the number of people approved or denied LTSS. The inconsistency of interpretation presents a barrier to people with disabilities and their families. This organization reported screening denials given over the phone with an absence of a written denial and the accompanying appeal rights. This organization recommended appropriate designees for adult	

	referrals for screenings include an interested party having knowledge of an adult who may need LTSS. It would support the health and safety of aging adults who may be disabled and liv-ing in the community who may be unaware of available supports. This commenter also addressed the issue of local CBTs providing lists of appropriate providers for Medicaid-funded LTSS for those individuals meet-ing the NF level of care (12 VAC 30-60-301). The commenter's con-cern was that often the provided lists are not accurate and that they reflect the screen-ing entity's provider pre-ferences thereby limiting the in-dividual's choice of providers.	

All changes made in this regulatory action

Please list all changes that are being proposed and the consequences of the proposed changes. Describe new provisions and/or all changes to existing sections. Explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12 VAC 30-60-300		Nursing facility criteria.	Repealed and text moved to better placement.
	301		Definitions. Technical corrections made to improve accuracy and readability. Text changes made in response to public comment and to correct oversights.
	302		Introduction and special circumstances; access to Medicaid-funded long-term services and supports. Text changes made in response to public comment.
303		Preadmission screening criteria for long term care.	Modified for clarity and consistency with newly added sections. Use of UAI, application of same functional and medical/nursing criteria.
	304		Requests and referrals for screening for adults and children living in the community and adults and children in hospitals. Technical corrections made to improve accuracy and readability and text consistency across parallel subsections. Text changes made in response to public comment. Timelines for handling requests not changed from proposed stage.
	305		Screenings in the community and hospitals for Medicaid-funded long-term services and supports. Technical corrections made to improve accuracy and readability and text consistency across parallel subsections. Text changes made in response to public comment.
	306		Submission of screenings. Technical corrections made to improve accuracy and readability and text consistency across parallel subsections. Reference added to two forms needed for referral to

			technology assistance waiver. Text changes made in response to public comment.
307		Summary of pre-admission NF criteria.	Repealed and text moved to better place-ment.
	308		NF admission and level of care deter-mination requirements. Text changes made in response to public comment. NFs are herein prohibited from accepting paper UAI forms as a substitute for the ePAS.
	310		Competency training and testing require-ments. Technical corrections made to improve accuracy and readability and text consistency across parallel subsections. Text changes made in response to public comment.
312		Evaluation to determine eligibility for Medicaid payment of nursing facility or home and community-based care services.	Repealed and text moved to better place-ment.
	313		Individuals determined to not meet criteria for Medicaid-funded long-term services and supports. Technical corrections made to improve accuracy and readability and text consistency across parallel subsections. Text changes made in response to public comment. Special circumstances incor-porated by reference to permit exception to requirement for UAI or MDS for Medicaid coverage of long term service and support.
	315		Periodic evaluations for individuals receiving Medicaid-funded long-term services and supports. Technical corrections made to improve accuracy and readability and text consistency across parallel subsections.

Due to the organizational structure of these regulations, i.e., community screenings for adults, community screenings for children, and hospital screenings for inpatient adults and children, some regulatory requirements are repeated, as appropriate, in each section.

Changes made in this final stage regulatory action

12 VAC 30-60-301		Definitions.	Definitions added for clarity; term 'eligibility' qualifed with the addition of term 'functional'; 'assisted living facilities' removed from definition of long term care services because Medicaid does not cover assisted living facilities' services; 'face-to-face' added to preadmission screening definition for clarity; 'emancipated child' and 'physician' added to definition of request for screening for clarity; 'receipt of completed results' removed from definition of submission for accuracy.
-60-302			Form references corrected for accuracy. Screenings being performed face-to-face is specified thereby precluding use of electronic/video communications (as in instances of Tangiers Island); special circumstances re-worded for clarity.
-60-303			Editorial corrections made to clearly establish the 3 standards that must be met in order for Medicaid to reimburse for long term care services and supports (either institutional or community). Reference to guidance document updated.
-60-304			Text clarified that screening entities are allowed to determine if an individual is not likely to become Medicaid eligible within 180 days in order to decline a screening request. Adult/child protective services workers are added as being permitted to request screenings.
-60-305			Edits made for clarity, consistency with previous changes.
-60-306			Corrections made to form names/ numbers.
-60-308			NF prohibition from accepting hard copy versions of UAI is added to address an issue that had begun to occur in some localities after the onset of ePAS.
-60-310			Date for meeting the competency training/ testing advanced 6 months to afford localites more time to meet the require-ments. Shortened refresher course is added in response to public comments.
-60-313			Clarification given to situations that may disqualify individuals for Medicaid reimbursement of long term services and

			supports for consistency with earlier sections.
-60-315			Editorial corrections made for clarity in items that specify ongoing expectations of community, NF, and MCO providers once individuals have been admitted to their care.