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State Name: Virginia

State Plan Amendment (SPA) #: 16-006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT #092020164039

November 21, 2016

Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Jones:

The Centers for Medicare & Medicaid Services (CMS) has reviewed Virginia's State Plan Amendment (SPA) 16-006, Pre-Admission Screening Changes. This SPA adds requirements for accepting, managing, and completing requests for community and hospital electronic screenings to meet level of care for community-based and nursing facilities, and using the electronic Preadmission Screening (ePAS) system. This SPA also repeals the existing nursing facility criteria in order to move the criteria to a new location.

This SPA is acceptable. Therefore, we are approving SPA 16-006 with an effective date of September 1, 2016. Enclosed is the approved SPA pages and signed CMS-179 form.

If you have further questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 16 — 006

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: September 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 440

7. FEDERAL BUDGET IMPACT
a. FFY 2016 $ -0-
b. FFY 2017 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-C, Supplement 1, revised pages 1-9
Attachment 3.1-C, Supplement 1 new pages 9.1-9.11

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same pages

10. SUBJECT OF AMENDMENT: Pre-Admission Screening Changes

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted] /S/

13. TYPED NAME: Cynthia B. Jones

14. TITLE: Director

15. DATE SUBMITTED: 8/19/16

16. RETURN TO
Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 15, 2016

18. DATE APPROVED: November 21, 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: September 1, 2016

20. SIGNATURE OF REGIONAL OFFICIAL: Francis McCullough /s/

21. TYPED NAME: Francis McCullough

22. TITLE: Associate Regional Administrator

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

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NURSING FACILITY CRITERIA

PART I

12 VAC 30-60-300 **REPEALED.**

A. Definitions. (12 VAC 30-60-301)

The following words and terms as used in this part shall have the following meanings unless the context clearly indicates otherwise:

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

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

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

"At risk" means the need for the level of care provided in a hospital, nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) when there is reasonable indication that the individual is expected to need the services in the near future (that is, one month or less) in the absence of home or community-based services.

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

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

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

"Community-based screening" means the face-to-face process conducted pursuant to *Code of Virginia* §32.1-330 to determine whether an individual meets the criteria for Medicaid-funded LTSS and which shall be conducted in the individual's place of residence or, at the request of the individual, an alternate location within the same jurisdiction.

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

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

"Community-based team" or "CBT" means a nurse, social worker or other assessors designated by the Department and a physician who are employees of, or contracted with, the Virginia Department of Health or the local department of social services.

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

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

"Day" means calendar day unless specified otherwise.

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

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

"Electronic Pre-Admission Screening" or "ePAS" means the DMAS' automated system for use by all entities contracted by DMAS to perform pre-admission screenings pursuant to § 32.1-330 of the *Code of Virginia.*

"Face-to-face" means an in-person meeting with the individual seeking Medicaid-funded LTSS that may also occur through technological means that permit visualization and real-time communication with the individual if circumstances prohibit in-person access to the individual.

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

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

"Hospital team" means persons designated by the hospital who are responsible for conducting and submitting the PAS for inpatients to DMAS' automated system.

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

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"Institutional screening" means the face-to-face process conducted pursuant to *Code of Virginia* §32.1-330 for individuals who are inpatients in hospitals to determine whether an individual meets the criteria for Medicaid-funded LTSS.

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

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

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

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

"Medicaid" means the program set out in the 42 U.S.C. § 1396 and administered by the Department of Medical Assistance Services consistent with §32.1-323 et seq. of the *Code of Virginia.*

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

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

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

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

"Program of All-Inclusive Care for the Elderly" or "PACE" means the community-based service pursuant to §32.1-325 of the *Code of Virginia.*

"Referral for screening" means information obtained from an interested person or other third party having knowledge of an individual who may need Medicaid-funded LTSS and may include, for

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example, a physician, PACE provider, service provider, family member, or neighbor who is able to provide sufficient information to enable contact with the individual.

"Reimbursement" means the evaluation of the submitted claims for completeness, accuracy, and service resulting in the payment by DMAS for the services represented on the claims.

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

"Request date for screening" or "request date" means the date that an individual or the individual's representative contacts the screening entity in the jurisdiction where the individual resides asking for assistance with LTSS or, for hospital inpatients, a physician orders case management consultation or case management determines the need for LTSS upon discharge from a hospital.

"Request for screening" means communication from an individual, individual's representative, Adult Protective Services (APS), or Child Protective Services (CPS) expressing the need for LTSS, or for hospital inpatients, a physician order for case management consultation or case management determination of the need for LTSS upon discharge from a hospital.

"Residence" means, an individual's private home, apartment, assisted living facility, nursing facility or jail/correctional facility, for example, if the individual to be screened is seeking Medicaid-funded LTSS and does not request an alternative screening location as allowed in 12 VAC 30-60-303(A).

"Screening entity" means the hospital screening team, community-based team (CBT) or DMAS' designee contracted to perform pre-admission screenings pursuant to § 32.1-330 of the Code of Virginia.

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

"Submission" means the transmission of the screening findings and receipt of successfully processed results using DMAS' automated system.

"Submission date" means the date that the screening entity transmits to DMAS the screening findings using DMAS' automated system.

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

"VDH" means the Virginia Department of Health.

"VDSS" means the Virginia Department of Social Services.

B. Introduction; access to Medicaid-funded long-term services and supports. (12VAC30-60-302)

1. Medicaid-funded long-term services and supports (LTSS) may be provided in either community- or institutional-based settings. To receive LTSS, the individual's condition shall first be evaluated using the designated assessment instrument, the Uniform Assessment Instrument (UAI) and other designated forms. Screening entities shall use the DMAS-designated forms (UAI, DMAS-95, DMAS-96, DMAS-95 Level I (MI/IDD/RC) and if appropriate, DMAS-95 Level II (for nursing facility placements only), and the DMAS-97) to perform pre-admission screenings for LTSS.

a. An individual's need for LTSS shall meet the established criteria (Attachment 3.1-C, Supplement 1, pages 6 through 9.1; 12 VAC 30-60-303) before any authorization for reimbursement by Medicaid is made for LTSS.

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

2. The evaluation shall be the pre-admission screening (PAS) or screening process, as designated in the *Code of Virginia* § 32.1-330, which shall preauthorize a continuum of LTSS covered by Medicaid.

a. Such screenings, using the UAI, shall be conducted by teams of representatives of either: (i) hospitals for individuals (adults and children) who are inpatients; (ii) local departments of social services and local health departments, known herein as CBTs, for individuals (adults) residing in the community and who are not inpatients; or (iii) DMAS' designee for individuals (children) residing in the community who are not inpatients. All of these entities shall be contracted with DMAS to perform this activity and be reimbursed by DMAS.

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

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3. The authorization for Medicaid-funded LTSS shall be rescinded by either the community-based services provider, the NF, or by DMAS when the individual is determined to no longer meet the criteria for Medicaid-funded LTSS. The individual shall have the right to appeal such rescission decision. The individual shall be responsible for all expenditures made after the date of the rescission decision in the event that the rescission is upheld on appeal.

4. Individuals shall not be required to be financially eligible for receipt of Medicaid or have submitted an application for Medicaid in order to be screened for LTSS.

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

12 VAC 30-60-303 PRE-ADMISSION SCREENING CRITERIA FOR MEDICAID-FUNDED LONG-TERM SERVICES AND SUPPORTS

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

1. The individual has both limited functional capacity and medical or nursing needs according to the requirements of this section, or

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

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

1. In order for Medicaid-funded nursing facility services to be authorized, the screening entity shall document that the individual has both functional and medical or nursing needs. The criteria for screening an individual's eligibility for Medicaid reimbursement of NF services shall consist of two components: (i) functional capacity (the degree of assistance an individual requires to complete ADLs) and (ii) medical or nursing needs. The rating of functional dependency on the UAI shall be based on the individual's ability to function in a community environment and exclude all institutionally-induced dependencies.

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

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C. Functional capacity.

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

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

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

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

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

(1) Bathing
(a) Without help (I)
(b) MH only (d)
(c) HH only (D)
(d) MH and HH (D)
(e) Performed by Others (D)

(2) Dressing
(a) Without help (I)
(b) MH only (d)
(c) HH only (D)
(d) MH and HH (D)
(e) Performed by Others (D)
(f) Is not Performed (D)

(3) Toileting
(a) Without help day or night(I)
(b) MH only (d)
(c) HH only (D)
(d) MH and HH (D)
(e) Performed by Others (D)

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(4) Transferring
(a) Without help (I)
(b) MH only (d)
(c) HH only (D)
(d) MH and HH (D)
(e) Performed by Others (D)
(f) Is not Performed (D)

(5) Bowel Function
(a) Continent (I)
(b) Incontinent less than weekly (d)
(c) External/Indwelling Device/Ostomy - self care (d)
(d) Incontinent weekly or more (D)
(e) Ostomy - not self care (D)

(6) Bladder Function
(a) Continent (I)
(b) Incontinent less than weekly (d)
(c) External device/Indwelling Catheter/Ostomy - self care (d)
(d) Incontinent weekly or more (D)
(e) External device - not self care (D)
(f) Indwelling catheter - not self care (D)
(g) Ostomy - not self care (D)

(7) Eating/Feeding
(a) Without help (I)
(b) MH only (d)
(c) HH only (D)
(d) MH and HH (D)
(e) Spoon fed (D)
(f) Syringe or tube fed (D)
(g) Fed by IV or clysis (D)

(8) Behavior Pattern and Orientation
(a) Appropriate or Wandering/Passive less than weekly + Oriented (I)
(b) Appropriate or Wandering/Passive less than weekly + Disoriented - Some Spheres (I)
(c) Wandering/Passive Weekly/or more + Oriented (I)
(d) Appropriate or Wandering/Passive less than weekly + Disoriented - All Spheres (d)
(e) Wandering/Passive Weekly/Some or more + Disoriented - All Spheres (d)
(f) Abusive/Aggressive/Disruptive less than weekly + Oriented or Disoriented (d)
(g) Abusive/Aggressive Disruptive weekly or more + Oriented (d)
(h) Abusive/Aggressive Disruptive + Disoriented - All Spheres (D)

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(9) Mobility
- (a) Goes outside without help (I)
- (b) Goes outside MH only (d)
- (c) Goes outside HH only (D)
- (d) Goes outside MH and HH (D)
- (e) Confined - moves about (D)
- (f) Confined - does not move about (D)

(10) Medication Administration
- (a) No medications (I)
- (b) Self administered - monitored less than weekly (I)
- (c) By lay persons, Administered/Monitored (D)
- (d) By Licensed /Professional nurse Administered/Monitored (D)

(11) Joint Motion
- (a) Within normal limits (I)
- (b) Limited motion (d)
- (c) Instability - uncorrected or Immobile (I)

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

(1) the individual's medical condition requires observation and assessment to assure evaluation of the person's need for modification of treatment or additional medical procedures to prevent destabilization **and** the person has demonstrated an inability to self observe or evaluate the need to contact skilled medical professionals;

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

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

- (a) Application of aseptic dressings;
- (b) Routine catheter care;
- (c) Respiratory therapy
- (d) Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have recent history of weight loss or inadequate hydration which, if not supervised would be expected to result in malnourishment or dehydration;

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(e) Therapeutic exercise and positioning;
(f) Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder;
(g) Use of physical (e.g. side rails, poseys, locked wards) or chemical restraints, or both;
(h) Routine skin care to prevent pressure ulcers for individuals who are immobile;
(i) Care of small uncomplicated pressure ulcers, and local skin rashes;
(j) Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;
(k) Chemotherapy;
(l) Radiation;
(m) Dialysis;
(n) Suctioning;
(o) Tracheostomy care;
(p) Infusion Therapy;
(q) Oxygen.

E. When screening a child, the screening entity conducting pre-admission screenings for LTSS shall utilize the electronic UAI Pediatric Guidance for children as contained in DMAS' Medicaid Memo (dated October 3, 2012), entitled, "Development of Special Criteria for the Purposes of Pre-Admission Screening," on the DMAS website at https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vsId=%7bC4FB1791-9693-409C-937D-5F78139D87B6%7d&impersonate=true&objectType=document&id=%7b1EA71A81-EDBF-4FCB-8138-6AFABEF34B15%7d&objectStoreName=VAPRODOS1

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

A. Screenings for adults living in the community. Screenings for adults who are residing in the community but who are not inpatients in acute care hospitals shall be completed and submitted to DMAS' automated system within 30 days of the request date for screening.

1. Requests for screenings shall be accepted from either an individual, the individual's representative, or an Adult Protective Services (APS) worker having an interest in the individual. The community-based team (CBT) in the jurisdiction where the individual resides shall conduct such screening. For the screening to be scheduled by the CBT, the individual shall either agree to participate or if refusing, shall be under order of a court of appropriate jurisdiction to have a screening.

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

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b. When the CBT has not scheduled a screening to occur within 21 days of the request date for screening and the screening is not anticipated to be complete within 30 days of the request date for screening due to the screening entity's inability to conduct the screening, the LDSS and LHD shall, no later than seven days of the request date for screening, notify the DARS and VDH staff designated for technical assistance. After contact with the LDSS and LHD, if DARS and VDH confirm that the screening entity is unable to complete the screening within 30 days of the request date for screening, the designated VDH staff shall refer the the CBT and screening request to DMAS designee for scheduling of a screening and submission of documentation.

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

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

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

B. Screenings for children living in the community. Screenings for children who are residing in the community shall be completed and submitted to DMAS' automated system within 30 days of the request date for screening.

1. A child who is residing in the community and is not an inpatient in an acute care hospital, rehabilitation unit of an acute care hospital, or a rehabilitation hospital, and who may need LTSS, shall receive a screening from DMAS' designee. Local CBTs shall forward requests for such screenings directly to DMAS' designee.

2. The request for screening of a child residing in the community shall initiate from either the parent, the entity having legal custody of that child, an emancipated child or from a Child Protective Services Worker having an interest in the child.

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3. Upon receipt of such a request, the DMAS designee shall schedule an appointment to complete the screening. Community settings where screenings may occur include the child's residence, other residences, children's residential facilities, or other settings with the exception of acute care hospitals, rehabilitation units of acute care hospitals and rehabilitation hospitals.

4. Referrals for screenings may also be accepted from an interested person having knowledge of a child who may need LTSS. The same process and timing and limitations on the sharing of the results shall apply to such referrals for screenings for children as set out for adults.

C. Screening in hospitals for adults and children who are inpatients. Screening in hospitals shall be completed when an adult or child who is an inpatient may need LTSS upon discharge.

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

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

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

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

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

A. Community screenings for adults.

1. Functional eligibility for Medicaid-funded long-term services and supports (LTSS) shall be determined by the community-based team (CBT) after completion of a screening of the individual's needs and available supports. The CBT shall document a screening of all the supports available for that individual in the community (i.e., the immediate family, other relatives, other community resources and other services in the continuum of LTSS).

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2. Screenings shall be completed in the individual's residence unless the residence presents a safety risk for the individual or the CBT, or unless the individual or the representative requests that the screening be performed in an alternate location within the same jurisdiction. The individual shall be permitted to have another person or persons present at the time of the screening. The CBT shall determine the appropriate degree of participation and assistance given by other persons to the individual during the screening and accommodate the individual's preferences to the extent feasible.

3. The CBT shall:

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

b. Observe and assess the individual's medical condition to ensure accurate evaluation of the individual's need for modification of treatment or additional medical procedures to prevent destabilization even when the individual has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals; and

c. Identify the medical or nursing needs, or both, of the individual.

4. The CBT shall consider services and settings that may be needed by the individual in order for the individual to safely perform ADLs.

5. Upon completion of the screening and in consideration of the communication from the individual, his representative, if appropriate, and observations obtained during the screening, the CBT shall determine whether the individual meets the criteria set out in Attachment 3.1-C, Supplement 1, pages 6 through 9.1 (12 VAC 30-60-303). If the individual meets the criteria for LTSS, the CBT shall inform and provide choice to the individual, and his representative, if appropriate, of the feasible alternatives available through waiver services, PACE where appropriate and available, or placement in a NF. If waiver services or PACE, where available, are declined, the reason for the declination shall be recorded on the DMAS-97, Individual Choice, Institutional Care or Waiver Services form. The CBT shall have this document signed by either the individual or his representative, if appropriate. In addition to the electronic document, a paper copy of the DMAS-97 form with the individual's or his representative's signature shall be retained in the individual's record by the screening entity.

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

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

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

7. If the individual selects NF placement, the CBT shall complete a Level I screening, on the DMAS-95 Level I form, for mental illness, intellectual disability or related condition or conditions as required by § 1919(e)(7) of the *Act*. When the Level I screening indicates that the individual may have mental illness, intellectual disability or related condition or conditions, the CBT shall refer the individual to DBHDS for a Level II screening.

a. DBHDS shall perform the Level II screening, documenting it on the DMAS-95 Level II form.

b. DBHDS shall determine if the individual may benefit from additional specialized services upon NF placement. DBHDS shall provide the outcome of its Level II screening to the CBT for NF placements only.

c. The CBT shall provide the outcome of the Level II screening to the NF that admits the individual and agrees to provide the required specialized services indicated by the Level II outcome. The individual shall be permitted to exercise choice among Medicaid-funded LTSS programs throughout the process.

8. If the CBT determines that the individual does not meet the criteria set out in Attachment 3.1-C, Supplement 1, pages 6 through 9.1 (12 VAC 30-60-303), then the CBT shall notify in writing the individual and family/caregiver, as may be appropriate, that LTSS are being denied for the individual. The denial notice shall include the individual's right to appeal consistent with DMAS client appeals regulations 12 VAC 30-110-10 et seq.

B. Community screenings for children.

1. Functional eligibility for Medicaid-funded LTSS shall be determined by the DMAS designee. The DMAS designee shall document a complete assessment of the child's needs and available supports. The assessment shall be documented on the designated DMAS forms identified in 12 VAC 30-60-306. If the child meets criteria defined in 12 VAC 30-60-303, the DMAS designee shall provide the parent or entity having legal custody of the child, or the emancipated child the choice of waiver services or nursing facility placement.

2. The DMAS designee shall determine the appropriate degree of participation and assistance given by other persons to the individual during the screening in recognition of the individual's preferences to the extent feasible.

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3. The DMAS designee shall:

a. Observe the child's ability to perform ADLs according to 12 VAC 30-60-303 in addition to considering the parent's, legal guardian's, or emancipated child's communications or responses to questions;

b. Observe and assess the child's medical condition to assure accurate evaluation of the child's need for modification of treatment or additional medical procedures to prevent destabilization even when the child has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals, and;

c. Identify the medical or nursing, or both, needs of the child.

4. The DMAS designee shall consider services and settings that may be needed by the child in order for the child to safely perform ADLs.

5. Upon completion of the screening and in consideration of the communication from the individual, his representative, if appropriate, and observations obtained during the screening, the DMAS designee shall determine whether the individual meets the criteria set out in Attachment 3.1-C, Supplement 1, pages 6 through 9.1 (12 VAC 30-60-303). If the individual meets the criteria for LTSS, the DMAS designee shall inform and provide choice to the individual, and his representative, if appropriate, of the feasible alternatives available through waiver services or placement in a NF. If waiver services are declined, the reason for declining shall be recorded on the DMAS-97, Individual Choice, Institutional Care or Waiver Services form. The DMAS designee shall have this document signed by either the individual or his representative, if appropriate. In addition to the electronic document, a paper copy of the DMAS-97 form with the individual's or his representative's signature shall be retained in the individual's record by the screening entity.

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

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

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

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7. If the parent, entity having legal custody of the child, or emancipated child selects NF placement, the DMAS designee shall complete a Level I screening, on the DMAS-95 Level I form, for mental illness, intellectual disability or related condition or conditions as required by § 1919(e)(7) of the *Act*. When the Level I screening indicates that the child may have mental illness, intellectual disability or related condition or conditions, the DMAS designee shall refer the child to DBHDS for a Level II screening.

a. DBHDS shall perform the Level II screening, documenting it on the DMAS-95 Level II form.

b. DBHDS shall determine if the child may benefit from additional specialized services upon NF placement. DBHDS shall provide the outcome of its Level II screening to the DMAS designee.

c. The DMAS designee shall provide the outcome of the Level II screening to the NF that admits the child and agrees to provide the required specialized services indicated by the Level II outcome. The child, parent, entity having legal custody or emancipated child shall be permitted to exercise choice among Medicaid-funded LTSS programs throughout the process.

8. If the DMAS designee determines that the child does not meet the criteria to receive LTSS as set out in Attachment 3.1-C, Supplement 1, pages 6 through 9.1 (12 VAC 30-60-303), then the DMAS designee shall in writing notify the parent, entity having legal custody of the child, or the emancipated child and family/caregiver, as may be appropriate, that LTSS are being denied for the child. The denial notice shall include the child's right to appeal consistent with DMAS client appeals regulations 12 VAC 30-110-10 et seq.

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

1. Eligibility for Medicaid-funded LTSS for individuals who are inpatients shall be determined by the hospital screening team, which shall document a complete assessment of the individual's needs and available supports.

2. Screenings shall be completed in the hospital prior to discharge. The individual shall be permitted to have another person or persons present at the time of the screening. The hospital screening team shall determine the appropriate degree of participation and assistance given by other persons to the individual during the screening.

3. The hospital screening team shall:

a. Observe the individual's ability to perform ADLs according to 12 VAC 30-60-303, excluding all institutionally induced dependencies, in addition to considering the individual's, individual's representative if appropriate, communications or responses to questions;

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b. Observe and assess the individual's medical condition to ensure accurate evaluation of the individual's need for modification of treatment or additional medical procedures or services to prevent destabilization even when an individual has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals; and

c. Identify the medical or nursing needs, or both, of the individual.

4. In developing the individual's discharge plans, the hospital screening team shall consider services and settings that may be needed by the individual in order for him to safely perform ADLs.

5. Upon completion of the screening and in consideration of the communication from the individual, his representative, if appropriate, and observations obtained during the screening, the hospital screening team shall determine whether the individual meets the criteria set out in Attachment 3.1-C, Supplement 1, pages 6 through 9.1 (12 VAC 30-60-303). If the individual meets the criteria for LTSS, the hospital screening team shall inform and provide choice to the individual, and his representative, if appropriate, of the feasible alternatives available through waiver services, PACE where appropriate and available, or placement in a NF. If waiver services or PACE, where available, are declined, the reason for declining shall be recorded on the DMAS-97, Individual Choice, Institutional Care or Waiver Services form. The hospital screening team shall have this document signed by either the individual or his representative, if appropriate. In addition to the electronic document, a paper copy of the DMAS-97 form with the individual's or his representative's signature shall be retained in the individual's record by the hospital screening team.

6. If the individual, or his representative, if appropriate, selects NF placement, the hospital screening team shall complete a Level I screening, on the DMAS-95 Level I form, for mental illness, intellectual disability or related condition as required by § 1919(e)(7) of the *Act*. When the Level I screening indicates the presence of either mental illness, intellectual disability or related condition or conditions, then the hospital screening team shall refer the individual to DBHDS for a Level II screening, prior to discharge, to determine if the individual may benefit from additional specialized services upon NF admission.

a. DBHDS shall perform the Level II screening, documenting it on the DMAS-95 Level II form.

b. DBHDS shall determine if the individual may benefit from additional specialized services upon NF placement. DBHDS shall provide the outcome of its Level II screening on the DMAS-95 Level I (MI/MR/RC) and if appropriate, the DMAS-95 Level II form for NF placements only.

c. The hospital screening team shall provide the outcome of the Level II screening to the NF that admits the individual and agrees to provide the required specialized services indicated by the Level II outcome. The individual, or his representative as appropriate, shall be permitted to exercise choice among Medicaid-funded LTSS programs throughout the process.

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7. If the hospital screening team determines that the individual does not meet the criteria for LTSS set out in 12 VAC 30-60-303, then the hospital screening team shall notify in writing the individual and family/caregiver, as may be appropriate, that LTSS are being denied for the individual. The denial notice shall include the individual's right to appeal consistent with DMAS client appeals regulations 12 VAC 30-110-10 et seq.

Submission of screenings. (12VAC30-60-306)

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

1. DMAS 95 - MI/MR/ID/RC (revised 12/08) (Supplemental Assessment Process Form Level I);

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

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

4. DMAS – 95 MI/MR Supplement II (revised 03/03); and

5. UAI (Uniform Assessment Instrument).

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

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

12 VAC 30-60-307 **(REPEALED)**

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

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

B. The Department of Medical Assistance Services shall conduct reviews of Minimum Data Set individuals' data submitted by NFs.

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12VAC30-60-310. ePAS requirements and submission. [Reserved.]

12 VAC 30-60-312 **(REPEALED)**

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

An individual shall be determined to not meet criteria for Medicaid-funded LTSS when one of the following specific care needs solely describes the individual's condition:

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

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

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

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

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

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

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

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

A. Once an individual is admitted to community-based services, the CBS provider shall be responsible for conducting ongoing evaluations to ensure that the individual meets, and continues to meet, the waiver program or PACE criteria. These ongoing evaluations shall be conducted using the Level of Care form (DMAS 99 LOC).

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B. Once an individual is admitted to a NF, the NF shall be responsible for conducting ongoing evaluations to ensure that the individual meets, and continues to meet, the NF criteria. For this purpose, the NF shall use the federally-required Minimum Data Set (MDS) form. The post-admission evaluation shall be conducted no later than 14 days after the date of NF admission and promptly after an individual's significant change in circumstances.

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