Frequently Asked Questions
Related to PASRR and Screening for LTSS
May 30, 2019

What are the Preadmission Screening and Resident Review (PASRR) requirements in CFR 42 §483.20(k)(1)-(3)?

This section of the Code of Federal Regulations addresses Mental Illness (MI), Intellectual Disability (ID), and/or Related Condition (RC) Determinations and Evaluations. Federal law requires that all individuals (regardless of payer source) who apply as a new admission to a Medicaid-certified nursing facility (NF) be evaluated for evidence of possible MI, ID, or RC. This evaluation and determination is conducted to ensure that individuals are placed appropriately, in the least restrictive setting possible and that individuals receive needed services, wherever they are living. The process involves two steps, known as Level 1 and Level 2 screening and evaluation. The use of a Level 1 and Level 2 screening and evaluation is known as the Preadmission Screening and Resident Review (PASRR) process. By federal law, an individual shall not be admitted to a NF unless a Level 1 screening has been completed, and, if it is determined that the individual has a condition of MI/ID or RC, then the individual shall not be admitted until the Level 2 evaluation and determination has been completed.

The Omnibus Budget Reconciliation Act (OBRA) of 1987, Part 2, Subtitle C of Title IV, added §1919 to the Social Security Act which prohibits Medicaid-certified NFs from admitting any new resident who may have MI, ID, or a RC unless that individual has been determined by the State Mental Health Authority (MHA) or State Intellectual Disability Agency (IDA) to require the level of services provided by a NF and/or the individual receives Specialized Services, if needed.

What was the purpose of the November 19, 2018 DMAS Medicaid Memorandum?

The federal requirement has not changed; an individual shall not be admitted to a Medicaid-certified NF unless a Level 1 screening has been completed, and, if it is determined that the individual has a Serious Mental Illness (SMI), Intellectual Disability (ID), and/or a Related Condition (RC), then the individual shall not be admitted until the Level 2 evaluation and determination has been completed.

The purpose of the Medicaid Memo was two part:

1. To provide clarification for who is responsible for screening Medicaid or Medicaid eligible individuals and to define who is able to complete the screenings for non-Medicaid eligible individuals:

   Screening teams will continue to conduct the Level 1 screening for those individuals who are Medicaid members or will become Medicaid eligible individuals within 180 calendar days of admission.

   NFs shall have policies and procedures in place to ensure Level 1 screenings are conducted for non-Medicaid eligible applicants prior to NF admission. These policies may include the use of NF staff who have medical knowledge of the individual and knowledge of the medical terminology in the Level 1 screenings, and, when needed, requests for Level 2 evaluations and determinations will be sent to the designated Level 2 contractor prior to admission to the NF.

2. To provide a temporary transition period for NF to complete the screenings for all current residents in a NF who do not have a Level 1 (and Level 2 if needed):

As described in the Medicaid Memo, from November 19, 2018 through July 1, 2019, NF staff who have medical knowledge of the resident and knowledge of the medical terminology in the Level 1 screening may temporarily complete these screenings for all residents in a NF who do not have a Level 1 screening. Any individual identified as needing a Level 2 evaluation and determination must be referred to the Level 2 evaluator, Ascend, A Maximus Company, as outlined in the memo.

After the temporary transition period, the screenings need to be completed according to 1.

After July 1, 2019 who can complete the PASRR Level 1 for a Medicaid resident if human error occurred and the resident was admitted without it?

Federal rules dictate that the PASRR Level 1 (and Level 2 if indicated) be completed prior to admission. Because this is a Medicaid resident admitted after July 1, 2019, the vast majority would have had a pre-admission screening requirement from the hospital or community (more likely hospital) and are outside the grace period referenced in the November 19, 2018 Medicaid Memo where qualified NF staff can complete it. **There is no remedy to this.** The facility needs to ensure that the full screening, for any individuals who require one, has been completed. It is important to note that the Level 2 is also federally required, if indicated, prior to admission. It takes the contractor several days to complete the Level 2. If the person was appropriately exempted from the screening process, the qualified staff at the NF can still conduct the Level 1 (and refer to the contractor for Level 2 if indicated).

What is the "penalty" for not completing the PASRR prior to admission?

It will not affect Medicaid reimbursement. However, this could be cited as a survey deficiency and would not be correctable. This could result in the assessment of a civil monetary penalty (CMP) on the facility.

Who is responsible for completing the Level 1, and referring to Ascend for a Level 2 if indicated for a new admission coming to a NF from an assisted living facility (ALF)?

An individual moving to a NF from an ALF who will be Medicaid eligible at the time of admission or within 180 days needs to have the Medicaid PAS and PASRR completed by a community screening team. If the individual will be private pay and has funds for more than the 180 days, a UAI is not required prior to admission and PASRR would need to be completed by the appropriate nursing facility staff member identified by your organization.

Does a resident moving from one NF to another NF need to have a PASRR Level 1, and Level 2 if indicated, prior to admission to the receiving NF?

In the case of an "interhome transfer", the transferring facility needs to provide the admitting facility a copy of both the resident assessment documentation and most recent PASRR. Your team should continue to be observant of whether the PASRR is not accurate based on the information that is received for the new admission. The admitting facility is still ultimately responsible for ensuring it is completed correctly and requesting the Level 2 evaluation is done.

Level 2 Evaluation Information
Ascend's webpage
Ascend's presentation on PASRR for VA

Screening for Long-Term Services and Supports (LTSS)

The Code of Virginia § 32.1-330 states that all individuals who will be eligible for community or institutional long-term care services as defined in the state plan for medical assistance shall be evaluated to determine their need for nursing facility (NF) services. The Screening for Long-Term Services and Supports (LTSS), formerly known as Pre-Admission Screening (PAS), is required of all individuals who, at the time of application for admission to a skilled nursing facility, skilled care facility… nursing or nursing care facility, or nursing home, are eligible for medical assistance or will become eligible within six months following admission. The Medicaid LTSS Screening is the first level of authorization for Medicaid reimbursement of NF care and home and community-based services (HCBS).

The Virginia Uniform Assessment Instrument (UAI) is the standardized multidimensional assessment instrument used in Virginia for assessing an individual's physical health, mental health, psycho/social and functional abilities, and medical or nursing needs. The UAI is one of several forms in the screening packet, which must be completed for individuals using the following LTSS:

- NF (to include skilled nursing facility, specialized care nursing facility, and longstay hospital)
- CCC Plus Waiver, which replaced the former Elderly or Disabled with Consumer Directed Services (EDCD) Waiver and Technology Assisted (Tech) Waiver covered services
- PACE

Who is exempted from PAS requirements?

1. Private pay individuals who will not become financially eligible for Medicaid within six months from admission to a Virginia nursing facility;
2. Individuals who refuse to have the screening conducted.
3. The screening was denied because it was determined the individual did not need / did not qualify for nursing facility level of care;
4. A screening has previously been completed.
5. Individuals who are out-of-state residents seeking direct admission to a Virginia nursing facility;
6. Individuals who are inpatients of an out-of-state hospital; in-state or out-of-state veterans hospital; or in-state or out-of-state military hospital and seek direct admission to a Virginia nursing facility;
7. Individuals who are patients or residents of a state owned/operated facility that is licensed by Department of Behavioral Health and Developmental Services (DBHDS) and seek direct admission to a Virginia nursing facility;
8. A screening shall not be required for enrollment in Medicaid hospice services as set out in 12 VAC 30-50-270; and
9. Wilson Workforce Rehabilitation Center (WWRC) staff shall perform screenings of the WWRC clients.

Of these exemption reasons, the first presents the most ambiguity for screening teams to consider. Prior to exempting an individual from PAS for that reason, we would recommend the patient or family be asked if the patient has resources in excess of the six-month cost of care in your facility. The six- month cost of care is estimated at your private pay per diem * 182.5 days. You would need to supply this information to your referral partners and update it to the extent your private pay rate changes. For any exemption, you should ask for and receive documentation from the screening team.

What are the general plans for providers with this pre-screening requirement?

The screening requirement for coverage (and payment) of long term care through Medicaid has been in place for some time. DMAS has signaled that it would begin enforcing the requirement when the managed care program was being planned. VHCA-VCAL worked to secure a delay in enforcement until the screening could be simplified and the hospitals could be trained on the simplified process. That training is ongoing currently.

Nursing facilities are going to have to stand firm that admissions cannot take place without the screening (UAI) showing the level of care required. The PASRR Level 1 (and 2 if indicated) is also required prior to admission (federal requirement). The hospital screening team is responsible for completing the UAI and the PASRR level 1 for those for whom a pre-admission screening (PAS) is required (there are some criteria on who requires a PAS; if the UAI is not required, there are provisions for adequate NF staff to do the Level 1 PASRR).

What if I have centers whose referral sources are stating they will not participate in the process?

VHCA-VCAL has met with DMAS to discuss this and other related issues. It is unlikely, and problematic relative to the administration of the PASRR, that DMAS will rescind this requirement, which means a facility will risk payment under Medicaid if the admission is accepted without the screening in place. This should be true across all Medicaid NFs and all Medicaid-covered LTC settings; the level of care must be determined and documented to warrant the NF level. VHCA-VCAL has prepared a sample letter for centers to share with their hospital referral partners about this issue.

If the individual is exempted from the screening, we have recommended that nursing facilities request documentation from the hospital screening teams indicating the reason for exemption from screening for LTSS prior to admission.

What happens if a resident is admitted and no UAI is done?

If the individual required a PAS, which includes the UAI (he/she was not exempted for the various reasons) the managed care organizations (MCO) (and FFS) would have authority to and would very likely deny payment. The MCOs are directed to deny payment, so if the NF is paid for these services , it would be in error and could also be found via post-audit. While you do not control the screening process, you control admissions; therefore, appeals may be difficult.

What can be done to "correct" a non-screening and start being paid?

Theoretically, if the required screening was subsequently done by the appropriate screening team, the level of care was determined as NF and entered into the DMAS system, it is possible that you would be reimbursed, but only from the entry date forward (as opposed to admission date). The practical reality is that getting the screening team to do this after the fact is going to be difficult (based on our discussions with folks) and there are no other entities authorized to do the screening after July 1, 2019. If the patient has been discharged and you admit without the screening complete, you risk not being paid for your services and compliance issues.

How are transfers between nursing facilities handled in regard to the PAS?

When a resident is transferred from one facility to another after 180 days of private pay, the discharging facility ("A") would provide the receiving facility ("B") a copy of the most recent MDS and the physician certification for NF LOC. The admitting NF would complete the appropriate admission assessment and notify the MCO of the admission by providing the aforementioned documentation. According to the Nursing facility provider manual:

> Individuals residing in a licensed Nursing Facility and desiring a transfer to another Nursing Facility in the Commonwealth of Virginia are not required to be screened by local or hospital screening teams. The Nursing Facility from which the individual is transferring must send a copy of all screening materials to the receiving Nursing Facility. The receiving Nursing Facility is then responsible for initiating the appropriate documentation for admission certification purposes.

Because the transfer does not require a generation of the UAI, and the level of care has already been established through the MDS, the UAI should not be required for payment. You should request the UAI from the transferring facility if the original admission date was after July 1, 2019. The resident would already be enrolled in Medicaid,

but when making notification to the MCO that the individual has transferred to a new facility, then all screening material needs to be on file with the receiving facility.

If the UAI is over a year old, i.e. it has expired, is a new UAI required for a NF to NF transfer?

Annual level of care reviews are required (regardless of transfer issue) but these are done through the MDS assessment process, not a new UAI. UAIs do not expire—they are for the initial admission. The MDS assessment and physician certification takes over after that to confirm level of care needed.

If a Medicaid resident goes out to the hospital and they do not have a current UAI (either grandfathered or expired), do they need one before coming back to the NF?

Again, UAIs don't expire. If a previous resident is returning, the level of care (UAI) does not need to be re-established, so the individual would remain grandfathered. Alternatively, if a Medicaid resident is discharged from the nursing facility for any other reason, a new UAI would be required prior to admission to a nursing facility after that time.

Can you please let me know if UAIs expire?

UAIs do not expire, but are really only relevant at admission. Subsequently the MDS drives the on-going level of care determination (see above).