Guidance for the July 1 Implementation of No UAI/No Payment

July 1, 2019

VHCA-VCAL has been in extensive communication with the Department of Medical Assistance Services (DMAS) on open issues related to the enforcement of the Medicaid Long Term-care Services and Supports (LTSS) Screening process and the linkage of the screening to payment of Medicaid custodial NF services. We have previously advised that after July 1, 2019 a new patient should not be admitted to a nursing facility (NF) without either 1) a completed screening for LTSS in hand, or 2) documentation supporting one of the special circumstance reasons for non-screening by the hospital screening team.

Documentation of Non-Screening

We had previously suggested that DMAS mandate the use of a standardized documentation tool for hospital staff to communicate the reason an individual is determined to be exempt from LTSS Screening process prior to admission to a nursing facility. After meeting with DMAS officials on June 25, it is now DMAS' intention to utilize such a standardized tool.

This form will serve as documentation from the hospital to the NF that would both be

- a trigger for your designated staff to conduct the PASRR Level 1 (per your organization's Policy and Procedure) prior to admission, and
- serve as the supporting evidence that an exemption was applicable at time of admission (should a subsequent need arise within six months of admission to utilize Medicaid-covered long term care).

The form will include the six "Population Exclusions and Special Circumstances" that exempt an individual from the screening and also addresses other situations where a non-Medicaid patient refuses the LTSS Screening or where a new admission was determined to not meet NF level of care criteria and, therefore, the hospital screening team did not complete the screening.

As a reminder, the six Population Exclusions and Special Circumstances for Medicaid-funded LTSS Screening are:

1. Private pay individual who will not become financially eligible for Medicaid within six months from admission to a Virginia nursing facility.
2. Individual who resides out-of-state and seeks direct admission to a Virginia nursing facility.
3. Individual who is an inpatient in an out-of-state hospital, in-state or out-of-state veteran's hospital, or in-state or out-of-state military hospital and seeks direct admission to a Virginia nursing facility.
4. Individual who is a patient or resident of a state owned/operated facility by Department of Behavioral Health and Developmental Services (DBHDS) and seeks direct admission to a Virginia NF.
5. A screening shall not be required for enrollment in Medicaid hospice services as set out in 12 VAC 30-50-270.
6. Wilson Workforce Rehabilitation Center (WWRC) staff shall perform screenings of the WWRC clients.

In addition to the six exclusions mentioned above, there are two other circumstances that could be reasons for the screening teams to not complete the screening for LTSS prior to admission to a nursing

facility. These two reasons will also be specified on the standardized notification tool from the hospital, on the revised DMAS-80, and in the new AE&D LTC Portal in some way similar to:

- A non-Medicaid individual shall have the right to refuse to participate in the screening process except for situations when a court has issued an order for a screening.
- LTSS Screening determined the individual is denied for nursing facility level of care and the individual is being admitted through Medicare, other insurance or payers (the DMAS definition of "Private Pay").

It is extremely important to note that a Medicaid-insured admission cannot be exempted under the first exemption reason above. DMAS has also stated that any Medicaid covered individual admitted to a NF/SNF (i.e., non-LTC approved, acute care Medicaid recipients being admitted to the SNF/NF) must have a screening or have been exempted.

DMAS has asserted that if such an individual refuses the screening he/she has forfeited the right to Medicaid coverage of subsequent LTC within six months of admission. (DMAS has acknowledged to VHCA-VCAL that **after** six months, the individual would be eligible for Medicaid coverage of LTC through the MDS and physician certification.). The nursing facility should be checking for any Medicaid eligibility prior to accepting a patient to verify that all Medicaid-covered individuals have been screened by the hospital screening team (or denied via the LTSS Screening for NF LOC) or fall in one of the other five exemption reasons. **Refusal of screening is not a viable option for a current Medicaid-covered individual; no Medicaid LTC reimbursement would be available within six months of admission.**

DMAS will not be able to implement the requirement for hospitals to use a standardized documentation tool on July 1 (the implementation date of this requirement remains to be determined). Per DMAS, until such time, a case note in the file indicating the exemption reason and the other two situations described above, along with the name and title of the hospital employee providing this information, will be sufficient documentation.

Until the hospital requirement is in effect, we are suggesting that facilities begin to use the VHCA-VCAL drafted *Interim Documentation of Non-Screening Determination* as an internal note. This form contains the DMAS-required information. Hospitals will eventually be required to provide this information directly to the SNF in a to-be-determined format.

When DMAS invokes the requirement for hospitals to use the agency's standardized documentation of the non-screening to the NF, use of this VHCA-VCAL provided form for self-reporting the non-screening will no longer be sufficient. NFs will need the DMAS-mandated hospital form at that point forward (date to be announced).

Refusal of Screening

DMAS has made it clear that someone entering a NF with Medicaid coverage must be screened. If the individual refuses the screening and are directly or subsequently admitted for LTC within six months, Medicaid coverage will not be provided.

However, in the event that a non-Medicaid individual refuses the screening and is admitted for skilled nursing services and subsequently qualifies for the need for Medicaid covered LTC, DMAS has indicated (and stated that written guidance is forthcoming) that the agency will allow for the MDS and physician certification of nursing facility level of care (NF LOC) to establish Medicaid NF LOC coverage even though the individual refused the screening prior to admission to the NF for skilled nursing care.

Selection of the reason on the ***Interim Documentation of Non-Screening Determination*** form (and subsequent use of a mandated hospital form once DMAS invokes the mandatory hospital form) would document this situation for Medicaid and thereby allow coverage once the MDS and physician certification indicate it (regardless of the six month timeline). If the hospital indicates the individual

refused the screening, the NF should verify whether or not the individual is enrolled in any Medicaid coverage prior to admission. If they are enrolled in non-LTC Medicaid coverage and were not screened or exempted, Medicaid coverage of LTC in the first six months would not be approved (i.e., Medicaid will not pay for it). If an individual is enrolled in the CCC Plus Waiver (the new name for the HCBS waivers; this is not the same as the CCC Plus managed care program) or is a PACE participant, he/she has already been approved for Medicaid coverage of LTC. The NF should receive a copy of the previous screening from the hospital screening team prior to admission.

Level of Care Not Met

In the event that the hospital begins the Medicaid LTSS Screening but determines that the NF level of care is not met, we have been informed that the hospital often ceases the screening and informs the NF that NF LOC criteria was not met for Medicaid covered LTC. The NF would then admit for the skilled care with no anticipated transition to Medicaid covered LTC. While this is not supposed to happen anymore, VHCA-VCAL is not convinced the hospitals are aware that they are technically required to continue the screening, including the PASRR Level 1 screening, and, if indicated, the hospital should ensure a referral to Ascend is made for a Level 2 evaluation prior to admission to the NF.

Recognizing that the completion of the full screening in these situations is often not happening, DMAS has agreed to allow the hospital to document that the screening was incomplete due to NF LOC not being met. This will allow the NF to conduct the PASRR Level 1 screening, and, if indicated, ensure a referral to Ascend is made for a Level 2 evaluation, prior to admission, and take the Medicare referral from the hospital anyway. Pending DMAS finalization of the mandated hospital form, the NF can use the ***Interim Documentation of Non-Screening Determination*** to complete the patient record.

DMAS has agreed to develop written guidance and amend the PASRR guidance issued in November 2018 to reflect this as a legitimate trigger for the NF to conduct the PASRR Level 1 screening, and, if indicated, ensure a referral to Ascend is made for a Level 2 evaluation, prior to admission. We will be discussing this with Virginia Department of Health Office of Licensure and Certification to verify surveyors understand this is a valid reason for NF policy and procedures on PASRR administration to be invoked.

If the individual's LOC subsequently changes to NF LOC within six months, the MDS and physician certification of nursing facility level of care would override the previous screening indicating NF LOC was not met. DMAS is investigating how the new AE&D LTC Portal will treat this situation when the NF enters new LTC coverage for an individual who had previously been screened, but the screening was denied due to NF LOC criteria not met. The form indicating that NF LOC was not met should provide the facility the reason the previous screening should be ignored. Obviously, the NF will need to maintain records of the MDS and physician certification to document the new LOC.

Additional Ongoing Screening Issues for Which VHCA-VCAL Is Seeking DMAS Guidance

1. **Access to Previous Screenings:** Neither the hospital screening teams nor the nursing facilities have access to screenings conducted previously (even the same hospital may not be able to access their previous screening). Only DMAS can access all the previous screenings. Given the requirement for the NF to review and verify the screening prior to admission, requesting the screening from DMAS will not always work with the timing of discharges and admissions. We are requesting that both hospitals and NFs be provided access to the system to review the actual screening on file with DMAS, with download/print capability.

2. **Removal of the Three Calendar Day Window Post-discharge for Submission of the Screening:** Current guidance states, "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 (3) calendar days post-discharge to submit the Screening. However, all relevant information should be collected prior to the individual's

discharge." This is no longer viable. NF cannot adhere to the rules imposed on them if the hospital screening teams are allowed to complete screenings after individuals are discharged.

3. **DMAS FAQs:** We anxiously await the FAQs and are happy to promote them once available and would like to review them prior to publication.

Questions

As always, you should feel free to email ***April Payne*** or ***Steve Ford*** with any additional questions or concerns regarding the screening process.

In addition, DMAS has established email addresses for provider questions and concerns. The agency will respond within 48 hours.

- Screening questions go to: ***screeningassistance@dmas.Virginia.gov***
- LTC Portal for FFS (NF entry) questions go to: ***AEandD@dmas.Virginia.gov***

Prior to submitting questions, we would encourage you to review the FAQs (once available) to see if your question has already been addressed adequately. To the extent you are not receiving timely or adequate responses, please let April or Steve know.