COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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MEMORANDUM

August 23, 2019

TO: The Honorable Ralph S. Northam
Governor of Virginia

Delegate Robert D. Orrock, Sr.
Chairman, House Committee on Health, Welfare and Institutions

Senator Stephen D. Newman
Chairman, Senate Committee on Education and Health

FROM: Jennifer S. Lee, M.D.
Director, Virginia Department of Medical Assistance Services

SUBJECT: Annual Report: Timeliness of Medicaid Long-Term Services and Supports Screenings – CY2018

This report is submitted in compliance with the Virginia Acts of the Assembly – Section 32.1-330 A., of the Code of Virginia, which states:

> *The Department shall report annually by August 1 to the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health regarding (i) the number of screenings for eligibility for community-based and institutional long-term care services conducted pursuant to this subsection and (ii) the number of cases in which the Department or the public or private entity with which the Department has entered into a contract to conduct such screenings fails to complete such screenings within 30 days.*

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

JSL/kb

Enclosure

Pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

Annual Report: Timeliness of Medicaid Long-Term Services and Supports Screenings - CY2018

A Report to the Virginia General Assembly

August 1, 2019

Report Mandate:

Section 32.1-330 A of the Code of Virginia states: 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 services as defined in that plan. The Department shall require a preadmission screening of all individuals who, at the time of application for admission to a certified nursing facility as defined in § 32.1-123, are eligible for medical assistance or will become eligible within six months following admission. For community-based screening, the screening team shall consist of a nurse, social worker or other assessor designated by the Department, and physician who are employees of the Department of Health or the local department of social services or a team of licensed physicians, nurses, and social workers at the Wilson Workforce and Rehabilitation Center (WWRC) for WWRC clients only. For institutional screening, the Department shall contract with acute care hospitals. The Department shall contract with other public or private entities to conduct required community-based and institutional screenings in addition to or in lieu of the screening teams described in this section in jurisdictions in which the screening team has been unable to complete screenings of individuals within 30 days of such individuals' application.

The Department shall report annually by August 1 to the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health regarding (i) the number of screenings for eligibility for community-based and institutional long-term care services conducted pursuant to this subsection and (ii) the number of cases in which the Department or the public or private entity with which the Department has entered into a contract to conduct such screenings fails to complete such screenings within 30 days.

Executive Summary

On July 1, 2016, the Department of Medical Assistance Services (DMAS) implemented the use of an automated system that enables Virginia's Medicaid Long-Term Services and Supports Screeners to enter Screening results into an on-line electronic portal. Mandatory use of the electronic screening system enables DMAS to track the number of Screenings conducted and monitor the length of time it takes between the receipt of a request for a Screening and completion of a Screening. Due to a variety of interventions and improved communications, Virginia's community screening compliance has greatly improved in conducting Screenings within 30 days of a request.

About DMAS and Medicaid

DMAS' mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs. Through the Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus managed care programs, more than 1 million Virginians access primary and specialty health services, inpatient care, behavioral health, and addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to close to 400,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

Background

The Code of Virginia §32.1-330 requires that all individuals who will become eligible for community or institutional long-term services and supports (LTSS), as defined in the State Plan for Medical Assistance Services, shall be evaluated to determine if those individuals meet the level of care required for services in a nursing facility. All applicants for Medicaid LTSS must meet functional criteria (meaning they need assistance with activities of daily living such as bathing, eating, dressing, toileting, transferring, etc.), have a medical or nursing need, and be at risk for institutionalization within 30 days. The *Code* authorizes the Department of Medical Assistance Services (DMAS) to require a screening of all individuals who may need LTSS and who are or will become financially eligible for Medicaid within six months of admission into a nursing facility.

In order to assure that Screenings occur in a timely manner, DMAS has completed the following:

- Implemented the Electronic Preadmission Screening (ePAS) System to automate the screening and claims processes and enable tracking to support the goal of completing community screenings within 30 days of the request for screening;
- Promulgated final regulations 12VAC30-60-300 through 12VAC30-60-315 on August 22, 2018, which added requirements for accepting, managing, and completing requests for screenings using the ePAS system;
- Provided ongoing technical assistance and training to support community and hospital screeners;
- Established a dedicated mailbox for screeners to ask questions and submit concerns;
- Developed an on-line modular training which all current authorized screeners must complete with an 80% passing score by July 1, 2019;
- Updated Screening forms with current terminology; and
- Revised the Screening for Medicaid-Funded Long-Term Services and Supports Manual, which is a resource that provides essential screening information.

Outcomes

Beginning July 2016, DMAS began, through the mandatory use of an electronic screening record system, to maintain monthly records on the numbers of LTSS Screenings completed in the Commonwealth and the completion times for Screenings conducted by local communities.

For calendar year 2018, 37,422 Screenings for Medicaid LTSS were conducted. Hospitals conducted 59% of those screenings (22,001) and community-based teams conducted 41% (15,421). Ninety percent of Screenings conducted in the community were completed within the 30 day time frame with a statewide average of Screenings being conducted within 18 days of a request.

The primary reason Screenings were not completed within the 30-day time frame was due to lack of available staffing at the local level. Temporary staffing shortages in some communities resulted in delays.

Summary

DMAS has made significant progress toward improving the Screening process for individuals seeking Medicaid long-term services and supports. From the implementation date of the ePAS system, 90% of all screenings in the community are conducted within 30 days of a request. DMAS continues to review Screening results and make necessary adjustments with technical assistance and outreach provided to Screeners in both the community and in hospitals. This outreach is specific in addressing issues identified through data review and questions from Screeners. Finally, DMAS continues its participation in the public engagement process by conducting regular meetings with affected stakeholders.