COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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August 17, 2020

MEMORANDUM

TO: The Honorable Ralph S. Northam
Governor of Virginia

Delegate Mark D. Sickles
Chairman, House Committee on Health, Welfare and Institutions

Senator L. Louise Lucas
Chairman, Senate Committee on Education and Health

FROM: Karen Kimsey KK
Director, Virginia Department of Medical Assistance Services

SUBJECT: Annual Report: Timeliness of Medicaid Long-Term Services and Supports Screenings – CY2019

This report is submitted in compliance with the Virginia Acts of the Assembly – Section 32.1-330 I., 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.

KK/

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 - CY2019

A Report to the Virginia General Assembly

August 1, 2020

Report Mandate:

Section 32.1-330 I 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's 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 for more than 1.6 million Virginians. Members have access to primary and specialty health services, inpatient care, behavioral health as well as 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 more than 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 I 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 LTSS Screenings occur in a timely manner, DMAS has completed the following:

- Provided ongoing technical assistance and training to support community and hospital screeners;
- Provided monthly WebEx training for LTSS screeners to ask questions, discuss identified problems in the screening process, and receive technical assistance; and
- Revised the Screening for Medicaid-Funded Long-Term Services and Supports Manual, which is a resource that provides essential screening information.

DMAS has also initiated the process of procuring Inter-rater Reliability (IRR) services for Medicaid Long Term Services and Supports (LTSS) Functional Eligibility Screenings via a Request for Proposal (RFP).

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 2019, 51,531 Screenings for Medicaid LTSS were conducted. Hospitals conducted 70.1% of those screenings (36,137) and community-based teams conducted 29.9% (15,394). Ninety-two percent of LTSS Screenings conducted in the community were completed within the 30 day time frame with a statewide average of LTSS Screenings being conducted within 18 days of a request. Figure #1 displays the total number of community-based LTSS screenings completed during CY2019. Data from CY2018 is also included for comparative purposes. The green line represents LTSS screenings completed within the required time frame of 30 days and the yellow line represents LTSS screenings completed 31 days or more.

Figure #1

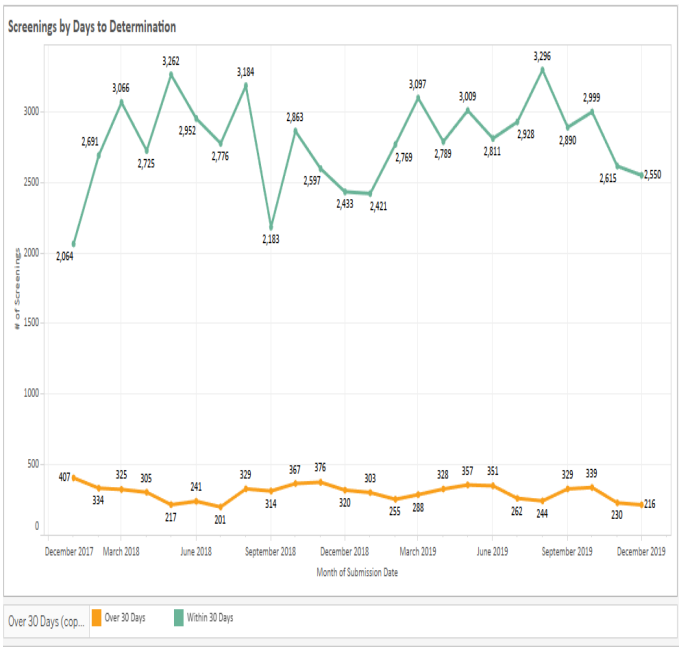
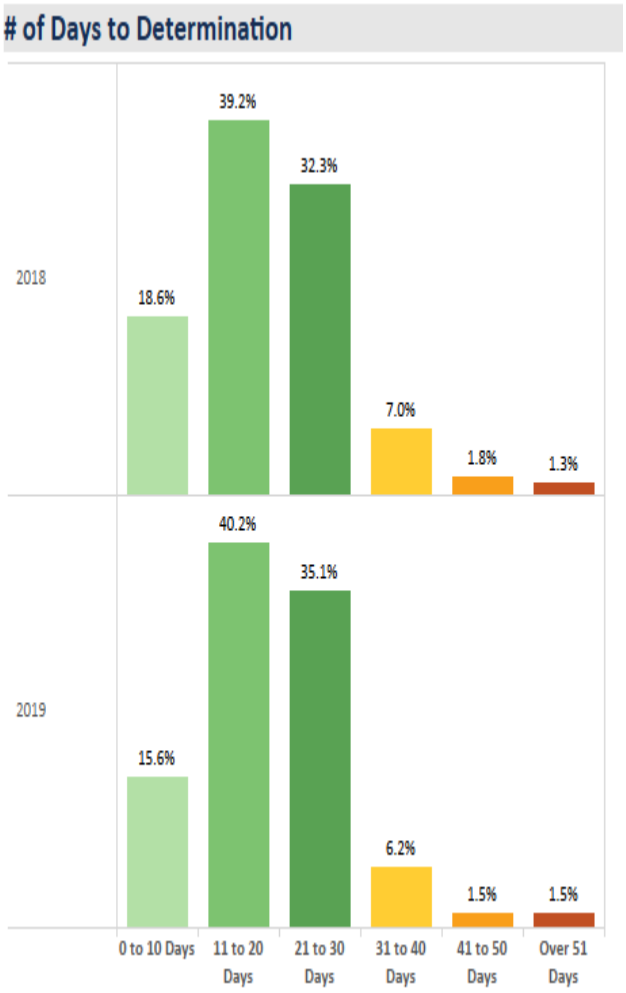


Figure #2 below reflects the total number of days in which LTSS screenings were completed by all localities during both CY 2018 and CY2019.

For LTSS screenings completed in CY2019:

- 15.6% were completed within 10 days or less;
- 40.2% were completed within 11 to 20 days; and
- 35.1% were completed within 21 to 30 days.
- 6.2% were completed within 31 to 40 days;
- 1.5% were completed within 41 to 50 days; and
- 1.5% were completed in over 51 days.



The comparative review of data from CY2019 and CY2018 indicates that a total of 8 percent of LTSS screenings were not completed within the required 30 day time frame in CY2019 compared to a total of 10 percent of LTSS screenings in CY2018.

The primary reason LTSS Screenings were not completed within the 30-day time frame in CY2019 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, 92% of all LTSS screenings in the community are conducted within 30 days of a request. DMAS continues to review LTSS Screening results and make necessary adjustments with technical assistance and outreach provided to LTSS Screeners in both the community and in hospitals. This outreach is specific in addressing issues identified through data review and questions from LTSS Screeners. Finally, DMAS continues its participation in the public engagement process by conducting regular meetings with affected stakeholders.