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MEDICAID BULLETIN

Last Updated: 07/26/2022

Final Exempt Action Pertaining to Medicaid Long-Term Services and Supports Screening Removal of Three-Day Allowance After Hospital Discharge

The purpose of this bulletin is to alert nursing facilities (NF) and screening entities for Medicaid-Long-Term Services and Supports (LTSS) Hospital Screeners to a regulatory change that is taking effect on February 1, 2020 that eliminates the additional three day, post-discharge screening period. The amendment to 12VAC30-60-306 requires hospitals that discharge individuals to Medicare-funded skilled nursing facilities or rehabilitation hospitals to complete and submit the LTSS Screening prior to an individual's admission to a NF to enable the NF to review a LTSS screening prior to admission, per 12VAC30-60-308.

Background

The Code of Virginia in § 32.1-330 requires 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. Per 12VAC30-60-308, prior to an individual's admission to a NF, the NF shall review the completed screening forms to ensure that applicable NF admission criteria have been met, documented, and submitted via e-PAS unless the individual meets any of the special circumstances outlined in 12VAC30-60-302 E.

For hospitals that are discharging Medicaid members to a NF, Virginia regulation (12VAC30-60-

306) had permitted hospitals up to three days after discharge to submit the required screening forms via the automated system. A regulatory change will remove the three-day allowance from 12VAC30-60-306 on February 1, 2020. In order to comply with the new regulatory requirement, hospitals must complete the required LTSS screening prior to an individual's discharge from the hospital.

Summary of Change to 12VAC30-60-306

The following sentence will be removed from the regulation, effective February 1, 2020:

"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."

Providers may find more information regarding the final exempt action, including changes to the regulation, on the Virginia Regulatory Town Hall at:

https://www.townhall.virginia.gov/l/ViewStage.cfm?StageID=8752. Questions and inquiries regarding this bulletin should be directed to: ScreeningAssistance@dmas.virginia.gov.

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Medicaid Expansion

New adult coverage began January 1, 2019. Providers will use the same web portal and enrollment verification processes in place today to verify Medicaid expansion coverage. In ARS, individuals eligible in the Medicaid expansion covered group will be shown as "MEDICAID EXP." If the individual is enrolled in managed care, the "MEDICAID EXP" segment will be shown as well as the managed care segment, "MED4" (Medallion 4.0), or "CCCP" (CCC Plus). Additional Medicaid expansion resources for providers can be found on the DMAS Medicaid Expansion webpage at: http://www.dmas.virginia.gov/#/medex.

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit:

Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627