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MEDICAID BULLETIN

Last Updated: 06/03/2024

Changes to LTSS Screenings: Nursing Facilities and Acute Care Hospitals

The purpose of this bulletin is to notify providers and LTSS screening teams of new requirements for LTSS screening resulting from the 2024 General Assembly passing of House Bill 291 and Senate Bill 24.

Effective immediately, LTSS screenings are no longer required when a Medicaid member is discharged from an acute care hospital to a nursing facility to receive skilled services, including rehabilitation services. Previously, any individual who was enrolled in Medicaid or may become Medicaid eligible was required to have the LTSS screening conducted by a hospital screening team prior to admission to a nursing facility for skilled services. Hospital screening teams must continue to conduct LTSS screenings when a Medicaid member requests the screening or when the Member is discharged to a nursing facility for LTSS service or custodial care. They must also conduct screenings when the individual is discharged to the community and may need LTSS home and community-based services.

Nursing facility screening teams can conduct LTSS screenings when Medicaid members receiving skilled services are expected to need LTSS/custodial care after the skilled nursing stay.

The screening, including physician certification, must be completed within three business days of initiating LTSS/custodial care to receive Medicaid reimbursement from the initiation date. If the screening is not conducted within three business days, reimbursement for the services may not begin until after the screening has been completed.

Additionally, as an update to the Medicaid Bulletin “Post-Admission Long-Term Services and Supports Screenings by Skilled Nursing Facilities Effective July 1, 2023” on August 10, 2023, any individual who was previously not screened prior to admission to a nursing facility for LTSS/custodial care, may have a LTSS screening performed by the NF screening team. All other requirements, as outlined in the August 10, 2023, bulletin still apply and remain in effect.

When Medicaid members residing in the community are in imminent need of nursing facility placement and the community-based screening team cannot conduct the screening within 30 days of the screening request, the nursing facility may collaborate with the community-based team to determine which entity can conduct the screening most expeditiously. The nursing facility must document the agreement for the nursing facility to conduct the screening in their records. This documentation must be available for review upon DMAS's request. It should include the individual's name, Medicaid identification number, the name of the

community-based screener, and the nursing facility staff member, as well as details of the agreement.

When a nursing facility conducts an LTSS screening, the individual must be offered a choice between institutional or home and community-based services. This includes the Commonwealth Coordinated Care Plus (CCC Plus) Waiver and the Program of All-Inclusive Care for the Elderly (PACE). A choice must be offered to all individuals found to meet the nursing facility's level of care.

None of these changes impact the Pre-Admission Screening and Resident Review (PASRR) requirements, which are federally mandated. All individuals who seek admission to a nursing facility require the PASRR Level I screening to be completed prior to admission. If the individual is determined to have a serious mental illness (SMI) or intellectual disability during the PASRR Level I screening, the Level II screening must also be completed prior to the individual's admission to the nursing facility.

For questions, please email screeningassistance@dmas.virginia.gov

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.	https://vamedicaid.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
Provider Appeals DMAS launched an appeals portal in 2021. You can use this portal to file appeals and track the status of your appeals. Visit the website listed for appeal resources and to register for the portal.	https://www.dmas.virginia.gov/appeals/

Managed Care Programs

Cardinal Care Managed Care 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.

Cardinal Care Managed Care	https://www.dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/

PACE	Program of All-inclusive Care (virginia.gov)
Acentra Health Behavioral Health Services	https://vamedicaid.dmas.virginia.gov/sa
Provider Enrollment	In-State: 804-270-5105 Out of State Toll Free: 888-829-5373 Email: VAMedicaidProviderEnrollment@gainwelltechnologies.com
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
Aetna Better Health of Virginia	https://www.aetnabetterhealth.com/virginia/providers/index.html 1-800-279-1878
Anthem HealthKeepers Plus	http://www.anthem.com/ 1-800-901-0020
Molina Complete Care	1-800-424-4524 https://www.molinahealthcare.com/providers/va/medicaid/home.aspx
Sentara Community Plan	1-800-881-2166 https://www.sentarahealthplans.com/providers
United Healthcare	www.uhcprovider.com/ 1-844-284-0149
Dental Provider DentaQuest	1-888-912-3456