APPENDIX F

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INTRODUCTION

Federal regulations (42CFR § 441.302), under which waiver services are made available, mandate that individuals receiving Medicaid waiver services through the Commonwealth Coordinated Care Plus Waiver (CCC Plus) be reviewed each year using the Series 99 form on the Medicaid LOC web portal, to assure that those enrolled continue to meet level-of-care (LOC) criteria. All individuals receiving waiver services must annually meet the functional criteria and have a medical/nursing need. Financial eligibility criteria determined by the local departments of social services must also be met annually.

For the purposes of this appendix, the term "provider" is used to describe Fee-for-Service (FFS) providers as well as Health Plans.

PURPOSE OF LEVEL OF CARE ELIGIBILITY REDETERMINATION REVIEW (ANNUAL LOC)

The purpose of an Annual LOC review is to validate that Medicaid individuals enrolled in a waiver continue to meet criteria for (LTSS) and DMAS criteria for reimbursement.

Annual LOC does not guarantee payment for waiver services. Payment is contingent upon the individual's continued Medicaid financial eligibility, provider's continued Medicaid participation, and ongoing waiver eligibility.

WEB PORTAL SUBMISSION

The Virginia Medicaid Web portal allows providers easy access and extends business capabilities to Virginia Medicaid providers by offering user-friendly tools and resources. The web portal is available 24-hours per day, seven days per week, with the exception of routine maintenance, which will be posted in advance. Providers may access a complete list of secure interactive features such as Provider Services and Resources, which includes the LOC review tab along with the provider manuals, links, trainings, Automated Response System (ARS) and Search for Providers.

Submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission of Annual LOC reviews via the DMAS Web Portal. Access to the Virginia Medicaid Web Portal can

be found at www.virginiamedicaid.dmas.virginia.gov. The web portal has additional information related to the Annual LOC process for programs identified in this Appendix.

Updates or changes to the Annual LOC process for the specific services outlined in this Appendix will be posted in the form of a Medicaid Memo to the DMAS web portal. Changes identified in the Medicaid Memo will be incorporated within the provider manual.

Providers must verify member eligibility prior to web portal submission. The Virginia Medicaid Web Portal replaced the paper submission process for all Annual LOC reviews in 2014. DMAS does not accept or process Annual LOC reviews submitted by fax, mail, or e-mail.

REGISTRATIONS

Provider Registration

To utilize the web portal submission process for Annual LOC, a FFS provider will need to complete two registrations: (1) Registering as a provider on the web portal, and; if a Fee for Service provider (2) Registering as a secure email user. A Health Plan will need to complete only the registering as a provider on the web portal.

For detailed instructions, please see the Provider Registration Users Guide available on the web portal at:
https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Webregistration

Providers should access and read the Web Portal Annual LOC Users Guide prior to completing the DMAS-99 series form.

FFS Provider Secure E-mail Registration

Upon receipt of the first secure email, instructions will be provided for registration.
The secure e-mail registration involves creating a login and password as instructed in the registration information. There is no cost to the provider for registering with the secure e-mail provider.

COMMUNICATION INFORMATION

DMAS has established the LOCreview@dmas.virginia.gov e-mail address and has instructed providers to provide a non-personalized, dedicated e-mail address specifically for Annual LOC communications.

When providers submit an e-mail to LOCreview@dmas.virginia.gov the "Form ID Number" (from the Series 99 / LOC form completed on the portal); must be included, which provides identification specific to the Medicaid member's LOC. This identifier is located in the top on the printed copy of the submitted review.

GUIDELINES FOR ANNUAL LOC

The Annual LOC process is required by Federal mandate (42CFR § 441.302 (c) (2)) and regulated by the Centers for Medicare and Medicaid Services (CMS). Federal regulation requirements state:

> "Periodic re-evaluations, at least annually, to determine if the beneficiary continues to need the level of care provided and would, but for the provision of waiver services, otherwise be institutionalized."

CMS/DMAS guidelines include:

1. A 365-day review cycle defined as:
    a. Initial enrollment in a waiver year is 365 days from the individual's waiver enrollment date.
    b. All other years, the annual review must be within 365 days of the last face-to-face LOC.

2. An Annual LOC review may be completed up to 60 days in advance of the scheduled 365-day Annual LOC due date. The intent of this 60-day period allows the provider to coordinate other face-to-face contacts in a single session. The Annual LOC process does not change/replace the provider's required routine supervisory assessment visits that are to be documented as defined in the DMAS CCC Plus Waiver Manual for FFS individuals or the health risk assessment for individuals enrolled in a health plan. A provider may complete multiple reports during the same visit.

3. Completion of the annual face-to face-review within the advance 60-day window changes the subsequent 365-day cycle.

4. Any assessment completed after the 365th day will be treated as out of compliance-and this will not change the next LOC review period date.

5. Electronic submission, via the portal, of the Annual LOC review must occur within two (2) business days after the completion of the face-to-face visit with the individual.

6. The following is a listing of timeframes for both agency-directed and consumer directed waiver services documentation, *this list is not all inclusive, for additional information refer to Chapter IV.*

   Agency Directed
   - RN supervisory visits required at a minimum, every 90 days
   - RN reassessment and evaluation of POC must be performed every 90 days
   - A follow up visit is *recommended* within 30 calendar days of the initial visit for assurance POC is sufficient
   - Supervisory visit at least every 30 days for individuals with cognitive impairment
   - Care Coordinator annual PDN visit

   Consumer Directed
   - SF face-to-face visits every 90 days
   - Two (2) in-home visits by the SF within 60 days (once every 30 days) of the initial comprehensive visit is r*ecommended*
   - SF to perform reassessment visits every 6 months for personal care or if respite is sole service, every 6 months or upon usage of 240 respite hours

   Health Plan Directed
   - Health Plan Risk Assessment
   - Any other visits as defined by the Health Plan

7. The DMAS-99 series form also includes the DMAS 108 and DMAS 109, which are used exclusively for the CCC Plus Waiver Private Duty Nursing (PDN) services LOC submission.

8. The provider is responsible for printing the Annual LOC (DMAS- 99 series) form and retaining it in the individual's file for audit purposes. The submitted form may be printed from the top right hand corner of the submission page via the print link. DMAS does not have the capability to print replacement copies of submitted LOC reviews.

9. The Annual LOC must be performed by a registered nurse (RN), a service facilitator (SF), or Care Coordinator, using the most current information available.

10. Submission requires the name of the RN, SF, or Care Coordinator who completed the LOC review. Although, any employee of the provider may enter the data, the name entered in the signature box must meet the RN, SF or Care Coordinator requirement. The RN, SF, or Care Coordinator acknowledges, if another staff enters his or her name, that it is considered to be RN or SF or Care Coordinator's official signature and she or he is attesting the information entered is accurate for that assessment.

ANNUAL LOC COMPLETION PROCESS

The LOC process consists of four (4) steps to assure the individual's participation in their own care as well as determining a consensus that the annual LOC criteria is met.

Review of Documentation
The initial step in the Annual LOC process is a review of various documents related to the individual's care needs and overall well-being that will assist in the determination of service needs and that criterion is met.

Face-to-Face Assessment
The second step in the Annual LOC process is a face-to-face assessment to be completed by the individual's Health Plan Care Coordinator or FFS RN or SF. The assessment is completed with input from the individual and/or their legal representative to determine the functional and medical needs of the individual.

Consensus
This is the agreement by all parties that the individual meets criteria for the waiver. If the consensus is the individual meets criteria, the LOC is submitted and services continue. If the consensus is that the individual does not meet the criteria, it provides the opportunity to review new service options and the LOC be submitted to begin the discharge process.

Submission of Assessment
Upon completion of a review, the provider must complete and submit the LOC review data in the Web portal within two (2) days of the assessment completion date. Upon submission of a LOC in the portal, the review undergoes a two-step review process: automated review and higher level review

LOC REVIEW PROCESS

Automated Review of Submitted LOC

A series of edits are performed by the system once the provider selects "submit." If any required information was not provided, the system will prompt the provider to enter that information and "submit" again. Once successful submission has occurred, a confirmation will appear on the screen. This confirmation will automatically assign a unique "Form ID Number" that captures all of the information entered. The submitted form must be printed via the print link in the top right corner. This printed copy of the confirmation must be retained in the individual's record.

Once the submission of the LOC has been validated by passing all of the initial submission edits, an automated determination of "met" or "not met-pended for higher level review" will be made. Notification of the determination will be sent to either the Health Plan or the FFS provider, via e-mail.

Pended for Higher Level of Review

Automated reviews that are determined as not meeting are automatically sent for higher-level review. If the higher level of review findings differs from the automated review findings, the provider will be contacted to obtain additional information. If the higher level review decision results in a disenrollment from the waiver, written notice will be sent to the individual and will include the individual's right to appeal in accordance with 42 CFR §200 *et seq.* and 12 VAC 30-110 *et seq.*

TYPES OF LOC REVIEWS

There are different circumstances in which an individual is listed as discharged or in which a disenrollment via the Annual LOC system would occur:

Criteria Not Met Based on Annual or Non-Annual LOC Review

An "annual" review is defined as the 365-day LOC review. The LOC team will process providers' submissions. Any individuals who do not meet the LOC criteria will undergo a second review. Upon the second review, those individuals who do not meet criteria will receive a notice of discharge from the waiver that includes appeal rights. Copies of this notice will be sent to the appropriate provider (health plan or fee for service).

A "non-annual" review is defined as any review submitted before the annual review resulting from a concern that the individual no longer meets the functional or medical/ nursing need criteria.

These submissions will all undergo a second review. When the second review differs with the submitted review, the provider will be contacted to obtain additional information. Once agreement occurs the individual will either continue services or the LOC team will send notice of discharge to the individual and the appropriate provider. The notice will include appeal rights. Information on appeal rights can be found in Chapter II.

Process for Disruption of Service Health Plans

The specific health plan care coordinator submits to the Care Management Unit the MCO Waiver Change Notice form via CCCPlus@dmas.virginia.gov. The Care Management Unit will review the documentation submitted and provide guidance if a discharge is appropriate.

The plan will also submit a 225 to the local DSS seeking a redetermination Medicaid financial eligibility. If financial eligibility is not met, the Local DSS will notify the individual. If eligibility is met and the individual meets the functional and medical nursing need criteria, services continue.

FFS Providers

The provider submits a 225 to the local DSS seeking a redetermination of Medicaid financial eligibility. If financial eligibility is not met, the Local DSS will notify the individual. If eligibility is met and the individual meets the functional and medical nursing need criteria services continue.

If eligibility is not met, the FFS provider will submit to the LOC team the LTC Enrollment/Disenrollment form via LOCreview@dmas.virginia.gov. The LOC team will appropriately process offering appropriate notices and appeal rights to the individual.

Death of the Enrolled Individual

The provider for either the FFS or Health Plan individual must complete the Series 99 form through the discharge date, print a copy, sign and date, and file the form in the individual's record. No notification is sent when the reason for waiver disenrollment is death.

In summary, the waiver disenrollment date is defined by the reason for the disenrollment:

- An individual is discharged or discontinued from services – the date of discharge or discontinuation should be the last date services were rendered.
- An individual refuses services – list the date of refusal
- Death – list the date of death

Regardless of the reason, the date of disenrollment must be entered as a LOC discharge on the 99 series form in the Medicaid web portal.

All final determination letters, as well as correspondence between various entities, are to be maintained in the individual's file and are subject to review during post payment and Quality Management Reviews (QMR's).

NOTIFICATIONS FOR UPCOMING LOC REVIEW DATES

Additional notifications specific to alerting the provider of upcoming LOC reviews include:

The Annual LOC Listing
This list identifies the individuals who are due for an Annual LOC review and is typically sent in January. It enables providers to schedule their Annual LOC reviews.

The Monthly Listing
This list provides the provider with the required Annual LOC's that will be due soon. (Typically within the next 60 days)

The Failure to Submit Notification Process
Federal regulations (42CFR § 441.302), pertaining to waiver services mandate that every individual receive:

> "Periodic re-evaluations, at least annually, to determine if the beneficiary continues to need the level of care provided and would, but for the provision of waiver services, otherwise be institutionalized."

When a provider has fails to submit timely a "failure to submit" is determined and DMAS will initiate two (2) follow-up requests. These requests will be in the form of an e-mail sent to the non-personalized e-mail address provided by the provider.

Each of the above notifications will contain the following: The names and Medicaid numbers of all waiver individual reviews required for submission, and the status and due date of each LOC. The status will indicate the annual due date for the LOC, and notify the provider if the review is out of compliance, or delinquent. The due date is the latest date the review will be accepted and considered a timely submission.

REMEDIATION PROCESS

DMAS has established a remediation process to inform providers of failure to submit an Annual LOC review within the 365-day requirement. This process consists of three (3) steps:

Out of Compliance Notices

- Any provider that does not submit the Annual LOC's within the required time frame will be notified via e-mail that they are out of compliance.
- The provider has five (5) business days to submit the needed Annual LOC review.

Delinquent Notice

- Any Annual LOC's that are determined out of compliance and have not been submitted timely will be notified via e-mail that they delinquent.
- The provider has three (3) business days to submit the needed annual LOC review.

Registration of Non-Compliance and Delinquent Notices

- A monthly report will be sent to the DMAS CCC Plus Quality Management Team and the Care Management Unit which may recommend financial penalties.
- The individual enrolled in the waiver is provided notification that their provider has placed their continuation in the waiver at risk. Information regarding how to continue waiver services are provided.

If there are any questions about this process, please call the DMAS Helpline at (800) 552-8627.

TECHNICAL ASSISTANCE

DMAS offers training and technical assistance at the following sites:

Web Registration FAQ:
Select "Level of Care Review Instrument (LOCERI)"
https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/FAQ

Web Registration Quick Reference:
https://www.virginiamedicaid.dmas.virginia.gov/ECMPdfWeb/ECMServlet/Documentationreference/WebregistrationR/uac_quickstart

Web Registration User Guide:
https://www.virginiamedicaid.dmas.virginia.gov/ECMPdfWeb/ECMServlet/Documentationguides/WebregistrationG/uac_general

Web Registration Tutorial:
https://www.virginiamedicaid.dmas.virginia.gov/onlinehelp/cbt/RegCBT.htm

Provider Account Holder Change Form:
https://www.virginiamedicaid.dmas.virginia.gov/ECMPdfWeb/ECMServlet?memospdf=PAH.pdf

Power points on Virginia Learning Center:
http://www.dmas.virginia.gov/Content_pgs/ltc-home.aspx.
Appendix F for Annual LOC assessment information and guidance in assessing functional and/or medical needs

Medicaid Manuals (Waivers, NF's, and Screening Information):
LTSS screening manual for determination of Activities of Daily Living (ADL) functioning levels
https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual