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SENATE BILL NO. 659

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Education and Health on February 9, 2012)

(Patron Prior to Substitute—Senator Martin)

A BILL to amend the Code of Virginia by adding in Chapter 10 of Title 32.1 an article numbered 5, consisting of sections numbered 32.1-331.18 through 32.1-331.22, relating to coordinated long-term care.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 10 of Title 32.1 an article numbered 5, consisting of sections numbered 32.1-331.18 through 32.1-331.22, as follows:

Article 5.

Coordinated Long-Term Care.

§ 32.1-331.18. Director to develop long-term care program.

A. The Director shall develop and implement a statewide fully integrated managed care long-term care program that is risk-based and integrates Medicaid-reimbursed primary, acute, and long-term care services, building in strong consumer protections and aligning incentives to ensure that the right care is delivered in the right place at the right time. The long-term care program shall expand access to and utilization of cost-effective home and community-based alternatives to institutional care for Medicaid-eligible individuals. Such program may include expansion of Programs of All-Inclusive Care for the Elderly (PACE) sites in additional areas of the state.

B. The Director shall ensure that comprehensive, person-centered care coordination across all Medicaid primary, acute, and long-term care services is a central component of the integrated long-term care system. This long-term care program shall require a comprehensive assessment of an individual's needs and the development of a care plan with active participation of the member and family or other caregivers that addresses the identified needs and builds on and does not supplant family and other care-giving supports. The managed care entities responsible for the program and care coordination shall cost-effectively implement the care plan; assure coordination and monitoring of all Medicaid primary, acute, behavioral health, and long-term care services to assist individuals and family or other caregivers in providing and securing necessary care; and assure the availability of a qualified workforce, including backup workers when necessary, to timely provide necessary services.

C. The Director shall design and implement the integrated long-term care program in a manner that affords access to the appropriate level of cost-effective home and community-based services for the greatest number of Medicaid-eligible elderly and physically disabled individuals who would otherwise need placement in nursing facilities or other institutional settings.

§ 32.1-331.19. Level of care criteria.

The Director shall maintain and modify, as appropriate, the existing level of care criteria for new nursing facility admissions that ensure the most intensive level of long-term care services is provided to persons with the highest level of need. The long-term care program shall have the objective of delivering home and community-based services to individuals representing the greatest number of Medicaid-eligible elderly and individuals with disabilities as possible who would otherwise need nursing facility or other institutional placement.

§ 32.1-331.20. Institutional transition initiative.

Within the long-term care program, The Director shall develop and implement an institutional transition initiative for individuals residing in nursing facilities and other institutions that enables individuals to transition readily to private homes or other community placements when service in those home and community settings is more cost-effective and is chosen by the individual and their family. In addition, the Director shall specify in agreements with the managed care entities responsible for coordination of Medicaid primary, acute, behavioral health, and long-term care services requirements related to the timing and availability of institution-to-community transitions.

§ 32.1-331.21. Nursing Facility Reimbursement Methodology under an Integrated Care Model.

A. The managed care entity shall develop and implement a reimbursement methodology for nursing facility services, based on an individualized assessment of need, as an alternative to the current cost-based nursing facility reimbursement system. Such methodology may include the development of enhanced rates for specified chronic care services that may encourage the establishment of chronic care units that specialize in the care of persons with specified chronic care conditions such as persons who are ventilator-dependent.

§ 32.1-331.22. Implementation.

A. The Director shall seek appropriate authority from the Centers for Medicare and Medicaid

Services (CMS) and upon receiving such authority shall implement a fully integrated managed care long-term care program that is risk-based and integrates Medicare-and-Medicaid-reimbursed primary, acute, behavioral health, and long-term care services for individuals who are dually eligible for Medicare and Medicaid services. This program shall be developed beginning in regions determined by the Director and shall expand until the program is available statewide.

B. The Director shall implement a fully integrated managed care long-term care program that is risk-based and integrates Medicaid-reimbursed primary, acute, behavioral health, and long-term care services for Elderly or Disabled with Consumer Direction (EDCD) waiver participants. This program shall be developed beginning in regions determined by the Director and shall expand until the program is available statewide.

C. The Director shall implement this fully integrated managed care long-term care program on a regional basis with the minimum of two and a maximum of three participating Medicaid Managed Care Organizations per region.

D. The Director shall design and implement the program on a mandatory basis with minimal exclusions of covered populations in order to incorporate as many Medicaid-eligible seniors and individuals with disabilities as possible who would otherwise need nursing facility placement. This promotes greater provider participation and allows for continuity of care during the transition from fee for services (FFS) to coordinated care.

E. Upon receiving CMS authority and funding approvals, the Director shall design and implement the program on a mandatory basis and to include all categories of full benefit dual eligibles, including those who meet level of care criteria for a nursing facility or long-stay hospitals or who are living in nursing facilities or long-stay hospitals. For those individuals who require nursing facility or long-stay hospital placement from any setting, whether an acute setting, a behavioral health setting or a home and community-based setting, the responsible managed care entity will be responsible for the entire institutional stay and continue to manage care for institutionalized members. This will be reflected in the program design of the managed care entities' rate and benefits structures.

F. The Director shall design and implement the integrated long-term care program as a model to promote efficiencies, improve quality, and maximize program cost savings. The program will be implemented within existing budget parameters and program enhancements funded by the cost savings derived from the elimination of the access barriers and administrative inefficiencies in the current FFS long-term care program as well as the acute care cost savings derived from the implementation of care coordination within the integrated care program.

G. The Department of Medical Assistance Services shall report its progress to design and implement a statewide fully integrated managed care long-term care program to the Chairmen of the House Appropriations and Senate Finance Committees and the Department of Planning and Budget by November 1 of each year until 2017.