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SENATE BILL NO. 659

Offered January 20, 2012

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 32.1-331.25, relating to coordinated long-term care.

Patron—Martin

Referred to Committee on Education and Health

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 32.1-331.25, as follows:

Article 5.

Coordinated Long-Term Care.

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

A. The Director shall develop and implement a statewide fully integrated risk-based long-term care system that 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 system shall expand access to and utilization of cost-effective home and community-based alternatives to institutional care for Medicaid-eligible individuals. Such system 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 system 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 entity responsible for care coordination shall cost-effectively implement the care plan; assure coordination and monitoring of all Medicaid primary, acute, 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 system 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 possible.

§ 32.1-331.19. Single entry point for services.

The Director shall ensure that there is a single entry point into the long-term care system that is responsible for ensuring that persons seeking care and their families have access to readily available, easy-to-understand information about long-term care options. Functions performed by the single entry point may include counseling and assistance in evaluating long-term care options, screening and intake for long-term care programs, facilitated enrollment for Medicaid financial eligibility, and assistance with evaluation of level of care in order to facilitate determination of medical eligibility for Medicaid long-term care services.

§ 32.1-331.20. Determination of eligibility.

The Director shall implement policies and processes that expedite the determination of Medicaid categorical and financial eligibility and medical eligibility for home and community-based programs and services.

§ 32.1-331.21. Level of care criteria.

A. The Director shall develop 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.

B. Nursing facility residents who meet continued stay criteria and who remain financially eligible for Medicaid shall continue to be eligible to receive nursing facility services, or cost-effective home and community-based waiver services, and shall not be required to meet new nursing facility level-of-care criteria.

C. Current enrollees in the statewide home and community-based services waiver program for persons who are elderly and adults with physical disabilities who meet continued stay criteria and remain financially eligible for Medicaid shall continue to be eligible to receive cost-effective home and community-based waiver services and shall not be required to meet new nursing facility level-of-care

criteria except for admission to a nursing facility.

D. The Director shall develop and seek approval of a waiver application or amendment thereto that allows persons who meet a lesser level of care, but are at risk of institutional care, to qualify for a more moderate package of Medicaid-reimbursed home and community-based waiver services up to a specified enrollment cap.

§ 32.1-331.22. Nursing facility transition initiative.

The Director shall develop and implement a nursing facility transition initiative. In addition, the Director shall specify in agreements with contractors responsible for coordination of Medicaid primary, acute, and long-term care services requirements related to nursing facility-to-community transitions.

§ 32.1-331.23. Expansion of residential alternatives to care.

The Director shall develop and implement a plan to expand cost-effective community-based residential alternatives to institutional care for persons who are elderly and adults with physical disabilities, which may include, but are not limited to, the development of multiple levels of assisted-care living facility services, adult family care homes, adult foster care homes, companion care models, and other cost-effective residential alternatives to nursing facility care.

The Director and the Commissioner of Health and the Commissioner of Social Services shall work to develop or modify licensure requirements for such facilities to support a nursing facility substitute framework for members who want to age in place in residences that offer increasing levels of cost-effective home and community-based care as an alternative to institutionalization as members' needs change.

§ 32.1-331.24. Acuity-based reimbursement methodology.

A. The Director shall develop and implement an acuity-based 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.

§ 32.1-331.25. Consumer-directed care.

The Director shall, upon approval of a waiver amendment granting authority from the federal government, develop and make available consumer-directed options for persons receiving home and community-based long-term care services under the long-term care program, which may include the ability to select, direct, or employ persons delivering unskilled hands-on or support services such as personal care services, personal care assistants, homemaker services, in-home respite, the ability to direct and supervise a paid personal aide in the performance of a health care task, and the ability to manage, utilizing the services of a fiscal intermediary, an individual home and community-based services budget allowance based on functional assessment and the availability of family and other caregivers who can help provide needed support.