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HOUSE BILL NO. 902

Offered January 8, 2020
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A BILL to amend and reenact §§ 32.1-330, 32.1-330.01, and 32.1-330.3 of the Code of Virginia, relating to long-term care services and supports; screenings.

Patron—Sickles

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-330, 32.1-330.01, and 32.1-330.3 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-330. Long-term care services and supports screening required.

A. ~~All individuals~~ *An individual* who ~~will be eligible~~ *applies* for community or institutional long-term care services *and supports* as defined in the state plan for medical assistance *services may choose to receive services in a community or institutional setting. Every individual who applies for community or institutional long-term care services and supports* shall *be afforded the opportunity to choose the setting and provider of long-term care services and supports from a list of approved providers.*

B. Every individual who applies for community or institutional long-term care services and supports shall be ~~evaluated~~ *screened prior to admission to such community or institutional long-term care services and supports* to determine ~~their~~ *his* need for *long-term care services and supports, including* nursing facility services as defined in ~~that~~ *the state* plan *for medical assistance services.* ~~The Department shall require 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. For community-based screening~~ *The type of long-term care services and supports screening performed shall not determine the long-term care services and supports settings or providers for which the individual is eligible.*

C. If an individual who applies for long-term care services and supports as defined in the state plan for medical assistance services is receiving services in a community setting at the time of such application, the *long-term care services and supports* screening *for long-term care services and supports required pursuant to subsection B shall be completed by (i) a long-term care services and supports screening* team ~~shall consist of~~ *that includes* a nurse~~,~~ *or* social worker or other assessor designated by the Department~~,~~ *who is an employee of the Department of Health or the local department of social services* and *a* physician who ~~are employees~~ *is an employee* of the Department of Health or the local department of social services or *(ii) if the individual is a client of the Wilson Workforce and Rehabilitation Center,* a team of licensed physicians, nurses, and social workers at the Wilson Workforce and Rehabilitation Center ~~(WWRC) for WWRC clients only. For institutional screening, the Department shall contract with acute care hospitals.~~

D. If an individual who applies for long-term care services and supports as defined in the state plan for medical assistance services is receiving services in an acute care hospital at the time of such application and will begin receiving long-term care services and supports as defined in the state plan for medical assistance services immediately upon discharge from such institutional setting, the long-term care services and supports screening for long-term care services and supports required pursuant to subsection B shall be completed by the acute care hospital in accordance with the requirements of a contract entered into by the acute care hospital and the Department for such purpose. The Department shall enter into contracts with acute care hospitals to conduct long-term care services and supports screenings pursuant to this subsection.

E. If an individual who applies for long-term care services and supports as defined in the state plan for medical assistance services is receiving skilled nursing services that are not covered by the Commonwealth's program of medical assistance services in an institutional setting following discharge from an acute care hospital, the Department shall accept the results of the Minimum Data Set assessment protocol described in the Federal Assessment schedule acquired by qualified staff of the skilled nursing institution in lieu of an evaluation required by subsection B if the results have been certified by a physician prior to the initiation of institutional long-term care services and supports under the state plan for medical assistance services.

~~The~~ *F. In any jurisdiction in which a long-term care services and supports screening team described in subsection C or D has failed or is unable to perform the long-term care services and supports*

screenings required by subsection C or D within 30 days of receipt of the individual's application for long-term care services and supports under the state plan, the Department shall ~~contract~~ *enter into contracts* with other public or private entities to conduct ~~required community-based and institutional~~ *such long-term care services and supports* screenings in addition to or in lieu of the *long-term care services and supports* screening teams described in ~~this section in jurisdictions in which the screening team has been unable to complete screenings of individuals within 30 days of such individuals' application~~ *subsections C and D.*

~~The Department shall report annually by August 1 to the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health regarding (i) the number of screenings for eligibility for community-based and institutional long-term care services conducted pursuant to this subsection and (ii) the number of cases in which the Department or the public or private entity with which the Department has entered into a contract to conduct such screenings fails to complete such screenings within 30 days.~~

~~B.~~ *G.* The Department shall require all individuals who ~~administer~~ *perform long-term care services and supports* screenings pursuant to ~~this section~~ *subsections C and D* to receive training on and be certified in the use of the uniform assessment instrument for screening individuals for eligibility for community or institutional long-term care services provided in accordance with the state plan for medical assistance *services* prior to conducting such *long-term care services and supports* screenings. ~~The Department shall publicly report by August 1, 2018, and each year thereafter on the outcomes of the performance standards.~~

H. The Department shall report annually by August 1 to the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health regarding (i) the number of long-term care services and supports screenings for eligibility for community and institutional long-term care services conducted pursuant to this section and (ii) the number of cases in which the Department or the public or private entity with which the Department has entered into a contract to conduct such long-term care services and supports screenings fails to complete such long-term care services and supports screenings within 30 days.

§ 32.1-330.01. Reports related to long-term care.

A. The Department shall (i) develop a program for the training and certification of individuals who perform ~~preadmission~~ *long-term care services and supports* screenings for community and institutional long-term care provided in accordance with the state plan for medical assistance *services pursuant to subsections C and D of § 32.1-330* and ensure that all screeners are trained on and certified in the use of the uniform assessment instrument for ~~preadmission~~ *long-term care services and supports* screening, (ii) develop guidelines for a standardized ~~preadmission~~ *long-term care services and supports* screening process for community and institutional long-term care provided in accordance with the state plan for medical assistance *services* and ensure that all *long-term care services and supports* screenings are performed in accordance with such guidelines, (iii) establish and monitor performance according to established standards, and (iv) strengthen oversight of the ~~preadmission~~ *long-term care services and supports* screening process for community and institutional long-term care to ensure that problems are identified and addressed promptly.

B. The Department shall require managed care organizations that provide managed long-term care services in the Commonwealth to develop the portion of the plan of care addressing the type and amount of long-term *care* services and supports for each recipient. For recipients of long-term care, the managed care organization shall participate in and collaborate with the existing interdisciplinary care team planning process already established pursuant to federal law and regulations in the development of the care plan.

C. The Department shall work with its actuary to (i) ensure that trends are consistent with Actuarial Standards of Practice, including consideration of negative historical trends in medical spending by managed care organizations to be carried forward when setting capitation rates paid to managed care organizations through the managed care program where appropriate, and (ii) annually rebase administrative expenses per member per month for projected enrollment changes and future program changes impacting administrative costs beginning in Fiscal Year 2019.

D. The Department shall include additional financial and utilization reporting requirements in contracts with managed care organizations and the Managed Care Technical Manual, including requirements for submission of (i) income statements that show medical services expenditures by service category, (ii) statements of revenues and expenses, (iii) information about related party transactions, and (iv) information about service utilization metrics, and shall monitor data submitted by managed care organizations to identify undesirable trends in spending and service utilization and work with managed care organizations to address such trends.

E. The Department shall (i) establish a compliance enforcement review process and apply consistent and uniform compliance standards in accordance with the Managed Care Technical Manual, managed care contracts, and federal standards; (ii) return all compliance feedback to managed care organizations

within the same reporting or auditing period in which such reports were generated; (iii) review the reasons for which the Commonwealth will mitigate or waive sanctions imposed on managed care organizations that fail to fulfill contract requirements and review and consider infractions due to unforeseen circumstances beyond the managed care organization's control, infractions occurring during the first year of the managed care organization's operation, infractions occurring for the first time, and infractions that are self-reported by the managed care organization; (iv) when applicable, include guidance in the Managed Care Technical Manual for managed care organizations that state the reasons for which sanctions may be mitigated or waived; (v) include information about the number of sanctions mitigated or waived and the reasons for such mitigation or waiver in its monthly compliance reports; and (vi) annually review the results of its contract compliance enforcement action process and include information about the process and results, including the percentage of points and fines mitigated or waived and the reasons for mitigating them for each managed care organization, in its annual report.

F. The Department shall (i) incrementally increase the amount of performance incentive awards granted to managed care organizations that meet certain performance goals to create a stronger incentive for managed care organizations to improve performance and (ii) retain at least one metric related to chronic conditions in the performance incentive award program.

G. The Department shall work collaboratively with managed care organizations and relevant stakeholders, where appropriate, to annually publish a uniform and agreed-upon managed care organization report card for the Department for the managed care program and shall make such information available to new enrollees as part of the enrollment process.

H. Upon the inclusion of behavioral health services in the managed care program and implementation of managed long-term care services and supports, the Department shall require all managed care organizations participating in the managed care program to provide to the Department information about (i) the managed care organization's policies and processes for identifying behavioral health providers who provide services deemed to be inappropriate to meet the behavioral health needs of the individual receiving services and (ii) the number of such providers that are disenrolled from the managed care provider's provider network.

I. The Department shall develop a process that allows managed care organizations providing services through the managed care program to determine utilization control measures for services provided but includes monitoring of the impact of utilization controls on utilization rates and spending to assess the effectiveness of each managed care organization's utilization control measures.

J. The Department shall include language in contracts for managed care long-term care services and supports requiring managed care organizations providing services through the managed care program to develop a plan that includes (i) a standardized process to determine the capacity of individuals receiving services to self-direct services received, (ii) criteria for determining when a person receiving services is no longer able to self-direct services received, and (iii) the roles and responsibilities of service facilitators, including requirements to regularly verify that appropriate services are provided.

K. Following inclusion of managed long-term care services and supports in the managed care program, the Department shall (i) review information about utilization and spending on long-term care services and supports provided by managed care organizations and work with managed care organizations to make necessary changes to managed care organizations' prior authorization and quality management review processes when undesirable trends are identified; (ii) include revenue and expense reports, information about related party transactions, and information about service utilization metrics in contracts for managed long-term care services and supports and the Managed Care Technical Manual and utilize data and information received from managed long-term care services and supports providers to monitor spending and utilization trends for managed long-term care services and supports and address problems related to spending and utilization of services through managed long-term care services and supports program contracts or the rate-setting process; (iii) include additional requirements for information about metrics related to behavioral health services in the managed long-term care services and supports contract and the Managed Care Technical Manual to facilitate identification of undesirable trends in service utilization and enable the Department to address problems identified with managed care organizations participating in the program; and (iv) include additional metrics related to the long-term care services and supports in the managed long-term care services and supports contract and the Managed Care Technical Manual to facilitate identification of differences between models of care, assessment of progress in and challenges related to keeping service recipients in community-based rather than institutional care, and cooperation with managed care organizations in resolving problems identified.

§ 32.1-330.3. Operation of a pre-PACE plan or PACE plan; oversight by Department of Medical Assistance Services.

A. As used in this section, unless the context requires a different meaning:

"PACE" means of or associated with long-term care health plans (i) authorized as programs of all-inclusive care for the elderly by Subtitle I (§ 4801 et seq.) of Chapter 6 of Title IV of the Balanced

Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 528 et seq., §§ 4801-4804, 1997, pursuant to Title XVIII and Title XIX of the United States Social Security Act (42 U.S.C. § 1395eee et seq.), and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care health plans.

"Pre-PACE" means of or associated with long-term care prepaid health plans (i) authorized by the U.S. Health Care Financing Administration pursuant to § 1903(m)(2)(B) of Title XIX of the United States Social Security Act (42 U.S.C. § 1396b et seq.) and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care prepaid health plans.

B. Operation of a pre-PACE plan or PACE plan that participates in the medical assistance services program shall be in accordance with a prepaid health plan contract or other PACE contract consistent with Chapter 6 of Title IV of the federal Balanced Budget Act of 1997 with the Department of Medical Assistance Services.

C. All contracts and subcontracts shall contain an agreement to hold harmless the Department of Medical Assistance Services and pre-PACE and PACE enrollees in the event that a pre-PACE or PACE provider cannot or will not pay for services performed by the subcontractor pursuant to the contract or subcontract.

D. During the pre-PACE or PACE period, the plan shall have a fiscally sound operation as demonstrated by total assets being greater than total unsubordinated liabilities, sufficient cash flow and adequate liquidity to meet obligations as they become due, and a plan for handling insolvency approved by the Department of Medical Assistance Services.

E. The pre-PACE or PACE plan must demonstrate that it has arrangements in place in the amount of, at least, the sum of the following to cover expenses in the event of insolvency:

1. One month's total capitation revenue to cover expenses the month prior to insolvency; and

2. One month's average payment of operating expenses to cover potential expenses the month after the date of insolvency has been declared or operations cease.

The required arrangements to cover expenses shall be in accordance with the PACE Protocol as published by On Lok, Inc. in cooperation with the U.S. Health Care Financing Administration, as of April 14, 1995, or any successor protocol that may be agreed upon between the U.S. Health Care Financing Administration and On Lok, Inc.

Appropriate arrangements to cover expenses shall include one or more of the following: reasonable and sufficient net worth, insolvency insurance, letters of credit, or parental guarantees.

F. Enrollment in a pre-PACE or PACE plan shall be restricted to those individuals who participate in programs authorized pursuant to Title XIX or Title XVIII of the United States Social Security Act, respectively.

G. Full disclosure shall be made to all individuals in the process of enrolling in the pre-PACE or PACE plan that services are not guaranteed beyond a 30-day period.

H. The Board of Medical Assistance Services shall establish a Transitional Advisory Group to determine license requirements, regulations, and ongoing oversight. The Advisory Group shall include representatives from each of the following organizations: Department of Medical Assistance Services, Department of Social Services, Department of Health, Bureau of Insurance, Board of Medicine, Board of Pharmacy, Department for Aging and Rehabilitative Services, and a pre-PACE or PACE provider.

I. The Department shall develop and implement a coordinated plan to provide choice and education about the PACE program. The plan shall ensure that:

1. Information about the availability and potential benefits of participating in the PACE program is provided to all eligible long-term services and supports clients as part of the ~~preadmission~~ *long-term care services and supports* screening process pursuant to § 32.1-330. The client's choice regarding participation in the PACE program shall be documented on the state ~~preadmission~~ *long-term care services and supports* screening authorization form. The Department shall provide initial and ongoing training of all ~~preadmission~~ *long-term care services and supports* screening teams on the PACE program.

2. The Department develops informational materials and correspondence, including the initial and annual enrollment letters, for use by the Department and its contractors to educate and notify potentially eligible clients about long-term services and supports. These informational materials shall include the following:

a. A description of the PACE program;

b. A statement that an eligible individual has the option to enroll in the PACE program or be automatically enrolled in a managed care organization; and

c. Contact information for PACE providers.

2. That the Department of Medical Assistance Services shall consider alternative assessment tools for community-based long-term care services and supports screenings completed on or after July

1, 2021. The Department of Medical Assistance Services shall report its findings and conclusions to the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by December 1, 2020.