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HOUSE BILL NO. 2304

Offered January 12, 2017

A BILL to amend and reenact § 32.1-330 of the Code of Virginia, relating to Department of Medical Assistance Services; requirements related to long-term care.

Patron—Orrock

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-330 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-330. Preadmission screening required.

A. All individuals who will be eligible for community or institutional long-term care services as defined in the state plan for medical assistance shall be evaluated to determine their need for nursing facility services as defined in that plan. 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 screening team shall consist of a nurse, social worker or other assessor designated by the Department, and physician who are employees of the Department of Health or the local department of social services or 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. The Department shall contract with other public or private entities to conduct required community-based and institutional screenings in addition to or in lieu of the 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.

B. The Department shall require all individuals who administer screenings pursuant to this section 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 prior to conducting such screenings.

2. That the Department of Medical Assistance Services shall (i) develop a program for the training and certification of individuals who perform preadmission screenings for community and institutional long-term care provided in accordance with the state plan for medical assistance and ensure that all screeners are trained on and certified in the use of the uniform assessment instrument for preadmission screening, (ii) develop guidelines for a standardized preadmission screening process for community and institutional long-term care provided in accordance with the state plan for medical assistance and ensure that all screenings are performed in accordance with such guidelines, and (iii) strengthen oversight of the preadmission screening process for community and institutional long-term care to ensure that problems are identified and addressed promptly.

3. That the Department of Medical Assistance Services shall implement a blended rate with established targets for the percentage of recipients of long-term care services served in community and institutional settings in contracts for managed long-term care services and supports to incentivize managed care organizations to rebalance enrollment away from institutional care and toward home-based and community-based care.

4. That the Department of Medical Assistance Services 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 services and supports for each recipient.

5. That the Department of Medical Assistance Services shall work with its actuary to (i) identify potential inefficiencies in the Medallion program that lead to increased spending by managed care organizations, determine the portion of those inefficiencies that managed care organizations can reasonably reduce each year, and adjust capitation rates paid to managed care organizations through the Medallion program to ensure the Department is not paying for inefficient care, with implementation of the adjustment phased in over time to allow managed care organizations to attain necessary reductions in spending; (ii) monitor spending for medical services paid by managed care organizations to related parties through the Medallion program and adjust historical medical spending when necessary to ensure that capitation rates do not include spending above market value for services provided; (iii) adjust capitation rates paid to managed care organizations through the Medallion program to account for expected savings from initiatives required by the Commonwealth; (iv) allow 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 Medallion program in cases in which the Department and its actuary project future trends based primarily on historical trends; and (v) annually rebase administrative expenses per member per month for projected enrollment changes beginning in Fiscal Year 2019.

6. That the Department of Medical Assistance Services shall include additional financial and utilization reporting requirements in Medallion contracts with managed care organizations and the Managed Care Technical Manual, including requirements for submission of (i) detailed income statements that show expense by rate cell and detailed service category, (ii) balance sheets, (iii) information about related party transactions, and (iv) information about service utilization metrics, and 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.

7. That the Department of Medical Assistance Services shall (i) review the reasons for which the Commonwealth will mitigate or waive sanctions imposed on managed care organizations that fail to fulfill contract requirements and consider limiting the basis for mitigating or waiving sanctions to include only cases involving an infraction 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; (ii) amend contracts with managed care organizations to specifically state the reasons for which sanctions may be mitigated or waived; (iii) include information about the number of sanctions mitigated or waived and the reasons for such mitigation or waiver in its monthly compliance reports; and (iv) annually review the results of its contract compliance enforcement action process and include information about the process and results, including the parentage of points and fines mitigated or waived and the reasons for mitigating them for each managed care organization, in its annual report.

8. That the Department of Medical Assistance Services 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.

9. That the Department of Medical Assistance Services shall annually publish a managed care organization report card for each managed care organization providing services through the Medallion program and shall share such information with new enrollees as part of the enrollment process.

10. That the Department of Medical Assistance Services shall regularly analyze spending by managed care organizations on chronic conditions and service utilization by recipients of managed care services with chronic conditions to evaluate managed care organizations' performance and shall use such information to develop incentives for improvement that are targeted to the areas identified as in need of improvement with regard to spending and service outcomes.

11. That upon the inclusion of behavioral health services in the Medallion program and implementation of managed long-term care services and supports, the Department of Medical Assistance Services shall require all managed care organizations participating in the Medallion 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.

12. That the Department of Medical Assistance Services shall develop a process that allows managed care organizations providing services through the Medallion 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.

13. That the Department of Medical Assistance Services shall include language in contracts for managed care long-term care services and supports requiring managed care organizations providing services through the Medallion 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.

14. That following inclusion of managed long-term care services and supports in the Medallion program, the Department of Medical Assistance Services 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 financial and utilization requirements, including a requirement for income statements that show expenses by rate cell and detailed service category, balance sheets, information about related party transactions, and information about service utilization metrics, in contracts for managed long-term care services and supports and the 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 Technical Manual to facilitate identification of undesirable trends in service utilization and assessment of the effectiveness of utilization controls 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 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.