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HOUSE BILL NO. 2304

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Health, Welfare and Institutions on February 2, 2017)

(Patron Prior to Substitute—Delegate Orrock)

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.

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 separate rate cells for recipients of long-term care services in community and institutional settings and a transition rate cell. Further, the Department shall work to implement a blended rate in Fiscal Year 2020 for managed long-term care services and supports to incentivize managed care organizations to ensure clinically appropriate rebalancing of enrollment away from institutional care and toward home-based and community-based care. The blended rate and targets described herein shall include institutional long-term care recipients with a RUGs weight of 0.7 or below. The Department shall implement capitation rates for institutional long-term care recipients with a RUGs weight above 0.7 based on that population's characteristics only and not subject to transition targets.

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. 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.

5. That the Department of Medical Assistance Services 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 Medallion 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.

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) income statements that show medical services expenditures by service category, (ii) statements of revenues 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.

7. That the Department of Medical Assistance Services 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 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 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 Department for the Medallion program and shall make such information available to new enrollees as part of the enrollment process.

10. 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.

11. 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.

12. 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.

13. 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 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.