VIRGINIA ACTS OF ASSEMBLY -- 2006 SESSION

CHAPTER 655

An Act relating to medical assistance services; State Plan amendment or application for certain waiver.

[H 758]

Approved April 5, 2006

Be it enacted by the General Assembly of Virginia:

1. *§ 1. Medical assistance services; State Plan amendment or application for waiver.*

A. By July 1, 2006, the Department of Medical Assistance Services (DMAS) shall convene a Medicaid Revitalization Committee (the Committee) to prepare recommendations for any State Plan amendments or waiver authority, including but not limited to a research and demonstration project waiver pursuant to Section 1115 of Title XIX of the Social Security Act, as amended, necessary to reform and revitalize Virginia's Medicaid program. The Committee shall consist of no less than eight and no more than 15 members and shall include representatives from the affected state agencies and from stakeholder and advocacy groups and from providers that serve Medicaid enrollees.

Recommendations shall be developed that shall include fundamental elements to move toward emphasizing the state's role in purchasing healthcare services, leveraging the forces of the marketplace to customize services to meet the diverse needs of Virginia's Medicaid population, enhancing personal responsibility and empowering individuals who desire to manage their healthcare, bridging public and private coverage, maximizing access, and containing the growth of Medicaid expenditures in the Commonwealth.

By December 1, 2006, these recommendations developed by the Committee must be submitted by the Director of the Department of Medical Assistance Services to the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Education and Health and Finance and include estimates of the costs and cost savings for implementation of the waiver or amendments to the State Plan.

B. Prior to convening the Committee, the Director of the Department of Medical Assistance Services shall:

1. Prepare a concise and precise statement of the concept of fundamental elements listed in subsection A that is focused on bridging public and private coverage through client-centered planning, individual budgeting, and self-directed quality assurance and improvement. He shall distribute the statement to all interested parties.

2. Consult with the Centers for Medicare and Medicaid Services concerning the concepts and options of any waiver application.

C. To address these fundamental elements, the options that the Committee must consider in developing its recommendations shall include:

1. Voluntary enhanced benefits accounts (which may be named health opportunity accounts) for (i) individuals with chronic diseases or at risk of having or developing one or more chronic diseases; (ii) individuals for whom healthcare costs are or may become high; and (iii) individuals whose current or future health may be improved through a disease management program focused on identification of chronic illnesses, incentives for healthy behavior, and training in effective and appropriate self-care; or (iv) individuals wishing to exercise the option to purchase private health insurance through their employer as described in subdivision 4.

2. Disease management programs or other behavior modification activities, including behavioral health, a system of monetary incentives for Medicaid recipients to make healthy decisions and to engage in self-management of their healthcare, and the deposit of incentive funds in enhanced benefits accounts to be accessed by enrollees to purchase healthcare services or items that are not covered under Virginia Medicaid and will assist enrollees in being personally responsible for their own healthcare.

3. Risk-adjusted premiums for Medicaid recipients enrolled in Medicaid managed care organizations (MCOs), calculated to be actuarially comparable to currently covered services under the Virginia State Plan for Medical Assistance. The actuarially developed risk-adjusted premiums shall be designed to reduce adverse selection and provide incentives for cost containment through identification of chronic illness before the recipient becomes seriously ill because of lack of treatment.

4. Employer-sponsored insurance options, for recipients who have access to such insurance, that provides such individuals with enhanced benefits accounts having deposits of the actuarially prescribed amount referenced in subdivision 3 that may be used to purchase private health insurance through their employer, and requires these individuals to assume any costs of private health insurance that are not covered by the Medicaid premium.

5. A transitioning of all recipients remaining in the fee-for-service program to a disease management program, care coordination program, or enrollment in MCOs.

6. A requirement that all Medicaid MCOs take steps to phase in implementation of electronic funds transfer technology to add efficiencies to administrative procedures, reduce costs, and avoid mistakes and abuse.

7. The phased implementation of electronic benefits cards for enrollees to access voluntary enhanced benefits and services.

8. Criteria for determining eligibility for the various options being considered including enrollment in the waiver.

9. A process, amounts, and specific criteria for the award of incentive funds that can be earned by or awarded to enrollees.

10. A process for establishing voluntary enhanced benefits accounts into which the incentive funds may be deposited and from which enrollees may access the funds.

11. A determination of the services or items and insurance plans, where possible, for which the funds in the enhanced benefits accounts may be used by enrollees.

12. A mechanism by which (i) enrollees who lose Medicaid eligibility while enrolled in the voluntary program as identified in subdivision C 1 may retain access to the money in their enhanced benefits accounts but will only be eligible for the voluntary program for the purpose of depleting the funds in the enhanced benefits account and will not receive any other Medicaid services, and (ii) enrollees could access services in the event of a depletion of the voluntary program funding.

13. The contractor criteria (i) for the establishment and management of the voluntary enhanced benefits accounts; (ii) for the development of disease management plans, including training of enrollees; and (iii) for implementation of the electronic benefits funds transfer technology.

D. By May 15, 2007, the Department of Medical Assistance Services (DMAS) shall prepare, submit, and seek approval of any required State Plan amendments or waiver authority, including, but not limited to, a research and demonstration project waiver pursuant to Section 1115 of Title XIX of the Social Security Act, as amended, to reform Virginia's Medicaid program that shall include fundamental elements to move toward greater emphasis on the state's role in purchasing healthcare services, leveraging the forces of the marketplace to customize services to meet the needs of Virginia's various Medicaid populations, enhancing personal responsibility and empowering individuals to manage their healthcare, bridging public and private coverage, and containing the growth of Medicaid expenditures in the Commonwealth.

E. Neither this act nor any new or revised project that may be, but is not required to be, implemented pursuant to this act shall be construed as creating any legally enforceable right or entitlement to enrollment in an enhanced benefit account program, the Virginia Plan for Medical Assistance Services, or Title XIX of the Social Security Act, as amended, on the part of any person or to create any legally enforceable right or entitlement to participation in any program by any person.

2. That, upon the approval by the Centers for Medicare and Medicaid Services of any State Plan amendments or waiver authority pursuant to this act, expeditious implementation of the program modifications shall be deemed to be an emergency situation in accordance with § 2.2-4002 of the Administrative Process Act of the Code of Virginia; therefore, to meet this emergency situation, the Board of Medical Assistance Services or the Director, acting on the Board's behalf, shall promulgate emergency regulations to implement the waiver.

3. That, in order to avoid costs as much as possible during the regulatory process, the Board of Medical Assistance Services shall, when in compliance with the Administrative Process Act (§ 2.2-4000 et seq.) of the Code of Virginia, notify, distribute, and provide public access and opportunity for comment via electronic media, including but not limited to, posting documents to and receiving comments via the Department's website, by e-mail, and fax. The Board shall, however, continue to provide public notice and participation to those persons who do not have access to the Internet or other forms of electronic media.

4. That the provisions of this act shall not become effective unless an appropriation of general funds effectuating the purposes of this act is included in the general appropriations act passed by the 2006 Session of the General Assembly, which becomes law.