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HOUSE BILL NO. 5008

Offered September 8, 2014

A BILL to amend the Code of Virginia by adding in Title 32.1 a chapter numbered 17, consisting of sections numbered 32.1-370 through 32.1-373, relating to the Virginia Health Care Independence Act.

Patrons—Rust and Davis

Referred to Committee on Rules

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 32.1 a chapter numbered 17, consisting of sections numbered 32.1-370 through 32.1-373, as follows:

CHAPTER 17.

VIRGINIA HEALTH CARE INDEPENDENCE ACT.

§ 32.1-370. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Commission" means the Medicaid Innovation and Reform Commission.

"Department" means the Department of Medical Assistance Services.

"Newly eligible adult" means a person described in 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) who is eligible for medical assistance.

"Secretary" means the Secretary of Health and Human Resources.

§ 32.1-371. Virginia Health Care Independence Taxpayer Recovery Fund.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Health Care Independence Taxpayer Recovery Fund, referred to in this section as "the Fund." The Fund shall be established on the books of the Comptroller. All amounts of federal medical assistance made available to the Commonwealth pursuant to 42 U.S.C. § 1396d(y) and any other funds appropriated by or received from the federal government or granted by any federal agency, any funds as may be appropriated by the General Assembly, and any gifts, grants, or donations from public or private sources shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purposes of improving access to health care coverage for uninsured residents of the Commonwealth in accordance with the provisions of this chapter. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Secretary.

B. The Secretary shall report annually no later than December 1 to the Governor, the Chairmen of the Senate Finance and House Appropriations Committees, the Commission, and the Joint Commission on Health Care on the status of the Fund, use of moneys contained in the Fund, and any issues related to the Fund.

C. The Secretary shall regularly report to the Commission regarding the status of the Fund, including the status of any grants for which the Fund has applied, any donations and appropriations made to the Fund, and any disbursements from the Fund.

§ 32.1-372. Virginia Health Care Independence Bridge Program.

A. There is hereby established the Virginia Health Care Independence Bridge Program ("Bridge Program") for the purpose of maximizing health care coverage of newly eligible adults by private managed care organizations and health plans. The Bridge Program shall be designed and implemented in a manner intended to (i) reduce the number of uninsured individuals in the Commonwealth; (ii) facilitate the transition of eligible individuals from the Commonwealth's program of medical assistance services to private insurance to support financial independence and improve economic opportunity; (iii) reduce the cost to the Commonwealth of health care for indigent and uninsured individuals; (iv) improve access to quality health care services, including integrated, coordinated mental health services; (v) promote personal responsibility and accountability with regard to decisions related to health care spending and outcomes; and (vi) reduce fraud, waste, and abuse in the delivery of medical assistance services and health care in the Commonwealth.

B. The Secretary shall develop and, upon receipt of any waivers or federal approvals as may be required, implement a plan for the Bridge Program, which shall include:

1. Provisions for the payment of health insurance premium payment assistance in accordance with 42 U.S.C. § 1396e for newly eligible adults for whom it is determined that enrollment in a group health

plan, as defined in 26 U.S.C. § 5000(b)(1), is cost effective;

2. A process for enrolling every newly eligible adult who is not eligible for health insurance premium payment assistance pursuant to subdivision 1 in an alternative benefit plan approved pursuant to 42 U.S.C. § 1396u-7 provided by a managed care organization that has entered into a contract with the Department for such purpose. The Secretary shall seek all necessary waivers and other federal approval as may be necessary for implementation of such process as soon as is practicable. Health care coverage provided by managed care organizations pursuant to this subdivision shall begin no later than January 1, 2015. The Department shall require managed care organizations providing health care coverage pursuant this subdivision to include provisions for health risk assessments, wellness programs, care coordination, and cost-sharing mechanisms that promote appropriate utilization of services and improved quality of care;

3. Provisions for the payment of health insurance premium assistance for the purchase of health care coverage through a federally facilitated health insurance exchange by newly eligible adults who are not eligible for health insurance premium payment assistance pursuant to subdivision 1, including those previously enrolled in health care plans provided by managed care organizations pursuant to subdivision 2, to be implemented no later than October 1, 2015. The Bridge Program plan shall provide for the payment of health insurance premium assistance pursuant to this subdivision for newly eligible adults in an amount sufficient to cover the cost of purchasing health care coverage at the silver level, as defined in 42 U.S.C. § 18022, through a qualified health plan and shall also include (i) requirements for qualified health plans available to Bridge Program participants, which shall include (a) provisions for delivery of health care to individuals determined to be medically frail; (b) requirements for cost-sharing for newly eligible adults that are comparable to cost-sharing requirements applicable to individuals in the same income range in the private insurance market that are structured to provide incentives and disincentives for individual behavior that affects the cost of health care, to encourage appropriate use of health care services; (c) provisions for selection of a primary medical provider or medical home; (d) provisions to support access to and utilization of preventive services and wellness activities; (e) provisions governing use of nonemergency transportation services, including maximum allowable limitations on use of nonemergency transportation services; and (f) provisions for delivery of mental health services, including provisions for coordination and integration of community-based and other mental health services; (ii) requirements related to employment, work search, or job training for Bridge Program participants; and (iii) program integrity requirements designed to reduce waste, fraud, and abuse, including appropriate performance measures. In developing the Bridge Program, the Department shall consider recommendations of the Commission and input from public and private stakeholders, including health care practitioners, health care facilities, managed care organizations, and health insurance providers. Health care coverage provided by qualified health plans pursuant to this subdivision shall begin no later than January 1, 2016; and

4. Provisions for the payment of health insurance premium and cost-sharing assistance on behalf of any individual who was previously enrolled in the Bridge Program and who has subsequently become ineligible for the Bridge Program because his household income exceeds 133 percent of the federal poverty level for a household of that size in an amount equal to the difference between the individual's out-of-pocket expenses for premiums and cost-sharing for health care coverage pursuant to subdivision 2 or 3 and the individual's out-of-pocket expenses for health care coverage upon becoming ineligible for health care coverage pursuant to subdivision 2 or 3, provided the individual's household income does not exceed 150 percent of the federal poverty level for a household of that size. Payment of assistance pursuant to this subdivision shall be subject to the availability of funds from demonstrated savings attributable to implementation of the Bridge Program. The Bridge Program plan shall include eligibility rules and requirements for health insurance premium and cost-sharing assistance pursuant to this subdivision that are appropriate to effectively transition individuals to private insurance, promote financial independence, and safeguard against abuse, which may include (i) a minimum threshold that the difference in premium and cost-sharing amounts must exceed in order to qualify for assistance; (ii) requirements related to individual responsibility for cost-sharing; (iii) a requirement that assistance made available to individuals pursuant to this subdivision together with amounts required to be paid by the individual be paid into a health savings account or similar account managed by the individual for the purpose of paying premium and cost-sharing amounts; (iv) requirements for health plans to be made available to Bridge Program participants; and (v) requirements related to the duration of enrollment.

C. Notwithstanding the provisions of subdivision B 3, a newly eligible adult who has a household income that is less than 100 percent of the federal poverty level for a household of that size may continue to be enrolled in a health care plan provided by a managed care organization in accordance with subdivision B 2 if the Department determines that it is more cost effective to provide medical assistance services through a health care plan provided by a managed care organization rather than a program of premium assistance described in subdivision B 3.

D. As a condition of participation in the Bridge Program, a newly eligible adult shall be required to

acknowledge in writing that the Bridge Program is not an entitlement and is subject to cancellation upon notice by the Department.

E. The Bridge Program shall expire and coverage shall be canceled within 120 days of the earliest of (i) the effective date of any strategy to ensure access to quality health care services for newly eligible adults established by the Virginia Health Care Independence Innovation Plan pursuant to § 32.1-373, the General Assembly, or the Governor; (ii) any change in federal law or action of any federal agency that results in the federal medical assistance percentage made available to the Commonwealth for newly eligible adults that is less than the amount set forth in 42 U.S.C. § 1396d(y); (iii) any change in any waiver or other federal approval required to implement the Bridge Program that conflicts with the requirements of this section; or (iv) December 31, 2016.

F. The Department shall provide all individuals receiving health insurance premium payment assistance pursuant to subdivision B 1 with notice of cancellation of coverage upon expiration of the Bridge Program pursuant to subsection E. Every managed care organization or qualified health plan providing health care coverage pursuant to subdivision B 2 or B 3, shall provide all individuals receiving health care coverage with notice of cancellation of coverage upon expiration of the Bridge Program pursuant to subsection E. Such notice shall be made in writing and shall provide the individual with information regarding (i) alternative options for health care coverage available to the individual, including health care coverage provided by the managed care organization or qualified health plan; (ii) the process for enrollment in health care coverage through the federally facilitated health insurance exchange; and (iii) other sources of health care coverage available in the Commonwealth, including coverage provided through alternative strategies implemented in accordance with the Virginia Health Care Independence Innovation Plan in accordance with § 32.1-373.

G. The Secretary shall, no later than January 1, 2016, and annually thereafter, report to the Commission (i) the number of individuals receiving assistance through the Bridge Program; (ii) current and projected annual savings to the general fund and other nonfederal net savings resulting from the Bridge Program; (iii) the effect of the Bridge Program on the number of uninsured individuals in the Commonwealth; (iv) changes in the cost to the Commonwealth of health care for indigent and uninsured individuals resulting from the Bridge Program; (v) the effect of the Bridge Program on access to quality health care services in the Commonwealth; (vi) the effect of the Bridge Program on availability of, access to, and coordination of mental health services in the Commonwealth, including community-based mental health services; (vii) the effect of promoting personal responsibility and accountability with regard to decisions related to health care spending and outcomes; and (viii) the effect of waste, fraud, and abuse prevention activities.

§ 32.1-373. Virginia Health Care Independence Innovation Plan.

A. The Secretary shall prepare a Virginia Health Care Innovation Plan (Innovation Plan) to promote innovation in the delivery of health care in the Commonwealth to ensure the long-term fiscal sustainability of health care programs funded in whole or in part by the Commonwealth and to improve patient outcomes and satisfaction while improving efficiency in the delivery of health care and reducing the cost of health care to the Commonwealth.

B. The goals of the Innovation Plan shall include:

1. Ensuring the stabilization of growth in, and fiscal sustainability and predictability of, funding for medical assistance programs using spending targets, block grants, or other funding mechanisms as appropriate;

2. Ensuring the coordination of health care delivery for medical assistance program recipients, including newly eligible adults, to address the entire spectrum of an individual's physical, behavioral, and mental health needs by addressing, at a minimum, general population health, disease prevention, health promotion, chronic disease management, and disability and long-term care services;

3. Ensuring the patient-centered orientation and coordination and integration of both clinical and nonclinical care and supports, to provide individuals with the necessary tools to address determinants of health and to empower individuals to be full participants in their own health. The health care delivery model shall focus on addressing population health through primary and team-based care that incorporates the attributes of a medical home or other advanced care planning model as appropriate;

4. Ensuring access to qualified health care providers;

5. Incorporating appropriate incentives that focus on quality outcomes and patient satisfaction, to move from volume-based to value-based purchasing;

6. Providing for alignment of payment methods and quality measurement across health care payers, to ensure a unified set of outcomes and to recognize, through reimbursement, all provider participants in the integrated system of care; and

7. Promoting financial independence and economic opportunity for low-income individuals who are eligible for medical assistance programs by transitioning such individual to private insurance;.

C. The Innovation Plan shall include strategies for:

1. Implementing reforms of existing medical assistance programs proposed by the Commission, including implementation of care coordination programs for dual eligible, foster care, home care, community-based care, and long-term care populations and redesign of intellectual disability and developmental disability waivers;

2. Implementing a multipayer integrated care model methodology by aligning performance measures, utilizing a shared savings or other accountable payment methodology, and integrating an information technology platform to support the integrated care model. The strategy shall ensure statewide adoption of integrated care for the medical assistance population; address the role of coordinated care plans and expansion of coordinated care in the Commonwealth's program of medical assistance as part of the integrated care model; and address the special circumstances of areas of the state that are rural or underserved or that have higher rates of health disparities;

3. Ensuring access to quality health care services for newly eligible adults that incorporates information collected from the Bridge Program. Such strategy may include a continuation of the Bridge Program or similar program to provide health care coverage or a collaborative safety net provider network to provide an integrated approach to health care delivery through care coordination that supports primary care services and links patients with community resources necessary to empower patients in addressing medical and social determinants of health;

4. Incorporating long-term care and behavioral health services for the medical assistance population into the integrated care model, through integration of community health and community prevention activities;

5. Addressing population health and health promotion, by investing in approaches to influence modifiable determinants of health such as access to health care, healthy behaviors, socioeconomic factors, and the physical environment that collectively impact the health of the community. The strategy shall address the underlying, pervasive, and multifaceted socioeconomic impediments that medical assistance recipients face in being full participants in their own health;

6. Implementing a statewide integrated care model to maximize access to health care in all areas of the state. The strategy shall incorporate flexible integrated care model options and accountable payment methodologies for participation by various types of providers, including individual providers, safety net providers, and nonprofit and public providers that have long experience in caring for vulnerable populations, into the integrated system;

7. Addressing the underlying socioeconomic impediments that low-income individuals and medical assistance recipients face in being full participants in their own health and achieving financial independence and economic opportunity; and

8. Including mechanisms for low-income individuals that are eligible for medical assistance programs to achieve long-term financial independence and transition out of medical assistance programs into employer-sponsored insurance and other available forms of health care coverage offered in the private sector.

D. In developing the Innovation Plan, the Secretary shall consult the Commission, the Director of the Department of Medical Assistance Services, and stakeholders representing public and private entities, including organizations that represent low-income individuals, organizations that represent health practitioners, organizations that represent health care facilities, organizations that represent managed care organizations and health insurers, and such other individuals or organizations as the Secretary determines are necessary to ensure that the process is comprehensive and provides ample opportunity for the variety of stakeholders to participate.

E. The Secretary shall regularly report to the Commission on his progress in developing the Innovation Plan and shall submit the Innovation Plan to the Commission no later than December 15, 2015. Such report shall include information about any changes to the state plan for medical assistance services and any waivers that are proposed or that may be required, as well as any savings to the Commonwealth associated with such proposals. If the Commission determines that federal medical assistance funds for newly eligible adults as provided in 42 U.S.C. § 1396d(y) or other federal funds combined with current and projected annual savings to the general fund and other nonfederal net savings associated with the implementation and operation of the Innovation Plan are sufficient to cover the costs to the Commonwealth of coverage for newly eligible adults, then the Commission shall approve implementation of such coverage.

F. Upon approval by the Commission of any component of the Innovation Plan, the Secretary shall submit an application for any necessary waivers, including, if applicable, a waiver for state innovation pursuant to 42 U.S.C. § 18052, as soon as practicable following approval of any component of the Innovation Plan required pursuant to subsection E.