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HOUSE BILL NO. 2212

Offered January 15, 2015

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 and 32.1-371, relating to the Virginia Healthy Transitions Program.

Patrons—Hope and Rasoul

Referred to Committee on Health, Welfare and Institutions

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 and 32.1-371, as follows:

CHAPTER 17.

VIRGINIA HEALTHY TRANSITIONS PROGRAM.

§ 32.1-370. Definitions.

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

"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 Healthy Transitions Program.

A. There is hereby established the Virginia Healthy Transitions Program (Program) for the purpose of providing transitional health care coverage of newly eligible adults by private managed care organizations and health plans. The 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 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 Department shall require managed care organizations providing health care coverage pursuant to 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. Requirements for qualified health plans available to Program participants, which shall include (i) provisions for delivery of health care to individuals determined to be medically frail; (ii) 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; (iii) provisions for selection of a primary medical provider or medical home; (iv) provisions to support access to and utilization of preventive services and wellness activities; (v) provisions governing use of nonemergency transportation services, including maximum allowable limitations on use of nonemergency transportation services; and (vi) provisions for delivery of mental health services, including provisions for coordination and integration of community-based and other mental health services;

4. Requirements related to employment, work search, or job training for Program participants;

5. Program integrity requirements designed to reduce waste, fraud, and abuse, including appropriate performance measures; and

6. Eligibility rules and requirements for health insurance premium and cost-sharing assistance that

are appropriate to effectively transition individuals to private insurance, promote financial independence, and safeguard against abuse.

The Secretary shall seek all necessary waivers and other federal approval as may be necessary for implementation of such program as soon as is practicable. Health care coverage provided pursuant to this subdivision shall begin no later than July 1, 2015.

C. As a condition of participation in the Program, a newly eligible adult shall be required to acknowledge in writing that the Program is not an entitlement and is subject to cancellation upon notice by the Department.

D. The Program shall expire and coverage shall be canceled within 120 days of the earliest of (i) 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) or (ii) any change in any waiver or other federal approval required to implement the Program that conflicts with the requirements of this section.

E. The Department shall provide all Program participants, and managed care organizations and health plans shall provide their enrollees, with written notice of cancellation of coverage upon expiration of the Program pursuant to subsection D. 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.

F. The Secretary shall, no later than January 1, 2016, and annually thereafter, report to the Governor and the Chairmen of the Senate Committee on Finance and the House Committee on Appropriations (i) the number of individuals receiving assistance through the Program; (ii) current and projected annual savings to the general fund and other nonfederal net savings resulting from the Program; (iii) the effect of the 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 Program; (v) the effect of the Program on access to quality health care services in the Commonwealth; (vi) the effect of the 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.