Department of Planning and Budget
2006 Fiscal Impact Statement

1. **Bill Number** HB 758

   House of Origin ☐ Introduced ☐ Substitute ☐ Engrossed

   Second House ☐ In Committee ☐ Substitute ☒ Enrolled

2. **Patron** Hamilton

3. **Committee** Passed Both Houses

4. **Title** Medicaid reform: waiver application

5. **Summary/Purpose:** The bill requires the Department of Medical Assistance Services (DMAS), by July 1, 2006, to convene a Medicaid Revitalization Committee to prepare recommendations to reform and revitalize Virginia's Medicaid program through either state plan amendments or waiver authority, including but not limited to a research and demonstration Section 1115 waiver of Title XIX of the Social Security Act. The reforms are to be focused on bridging public and private coverage, client-centered planning, individual budgeting, and self-directed quality assurance and improvement. The language mandates that the Committee include between 8 and 15 members, including representatives from affected state agencies, stakeholders, advocacy groups and providers who serve Medicaid enrollees.

   The committee must develop recommendations and submit them to the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Education and Health and Finance by December 1, 2006.

   The legislation states that the potential reform options the committee must consider include:
   1) Offering voluntary enhanced benefits accounts (health savings accounts) for those with chronic diseases.
   2) Implementing disease state management (DSM) programs with monetary incentives for individuals to make healthy decisions.
   3) Including risk-adjusted premiums for Medicaid managed care organization (MCO) enrollees which provide incentives for the identification of chronic illness before the recipient becomes seriously ill.
   4) Offering employer-sponsored insurance options including an enhanced benefit account option.
   5) Transitioning all Medicaid recipients into either MCOs, a DSM program, or care coordination program.
   6) Requiring all MCOs to phase in electronic funds transfer technology.
   7) The phased in implementation of electronic benefits cards for waiver enrollees to access voluntary enhanced benefits and services.
   8) A provision for incentive funds that can be earned and awarded to enrollees.

The legislation also states that by May 15, 2007, DMAS shall prepare and submit any necessary waivers to the federal Centers for Medicare and Medicaid Services. While the legislation does mandate the date for the submission of a waiver it does not mandate any specific initiatives be included in any new waiver.

6. **Fiscal Impact Estimates are**: Not Available. SEE ITEM 8.

7. **Budget amendment necessary:** No.

8. **Fiscal implications:** This legislation requires DMAS to convene a committee to consider and prepare recommendations to reform the current Medicaid program. The legislation requires that DMAS submit the recommendations from the committee to the General Assembly by December 1, 2006 and that if a waiver is needed to implement any of the proposed reforms that the waiver be submitted by May 15, 2007.

   The only initiative actually mandated by this legislation is the formation of the Medicaid Revitalization Committee, the issues that must be addressed by the Committee, and the submission of its recommendations by December 1, 2006. The formation of this committee and the preparation of this report will have a minimal fiscal impact on DMAS' administrative budget, which can be absorbed within the agency's existing appropriation.

   The initiatives that are included in this legislation for the Committee's consideration represent extensive modifications and reforms to the current Medicaid program and may require a Section 1115 waiver for implementation. Under the conditions of the waiver a state must demonstrate to the federal government that total program expenditures for the Medicaid program under the waiver are no more than they would have been in the absence of the waiver. The waiver must be budget neutral or not cost the federal government more funds than otherwise would have under the existing program.

   While it is difficult to ascertain which of these reforms could be accomplished in the near future and what the long-term financial impact of such reforms would be, it is certain that there would be some immediate and direct start-up costs incurred by DMAS in trying to implement these initiatives. The amount of start up-costs is dependent on which of these initiatives are included in the final proposal. The start up costs that would be incurred likely would include computer systems modifications, increased actuarial services and some additional staffing/consultant work necessary to implement these reforms.

   If all of the initiatives mentioned in the legislation are included in a proposed waiver a preliminary estimated start up cost for the waiver is:

   - $498,000 total funds ($124,500 GF) for modifications to the Medicaid Management Information System (MMIS) in FY 2008.

- $375,000 total funds ($187,500 GF) in the 2006-2008 biennium for additional actuarial services. DMAS currently contracts with a private actuarial firm for the development of the MCO rates. The provisions included in this legislation would require substantially more work both in setting the MCO rates and in completing the budget neutrality calculation for the Section 1115 waiver.
- $400,000 total funds ($200,000 GF) in the 2006-2008 biennium to hire consultants to assist with the development of the waiver and the implementation and coordination of health savings accounts and other provisions.

The information below discusses the potential impact of the initiatives included for consideration in the legislation:

1) Enhanced benefits accounts for those with chronic diseases: Enhanced benefits accounts or health savings accounts (HSAs) are intended to allow recipients to take a more active role in managing their health care and provide them with a greater range of choices; however, these programs would require additional MMIS capabilities and would require systems modifications.

2) Disease management programs with monetary incentives for individuals to make healthy decisions: DMAS recently implemented an expanded disease management program for its fee-for-service recipients under a waiver program that focuses on individuals with diabetes, asthma, coronary artery disease and congestive heart failure. In addition, each of the managed care organizations which contract with DMAS to provide services through the MEDALLION II program provide disease management services for various conditions. The legislation does not mandate which conditions would have to be included in the program, so it is not clear if DMAS would have to expand the current program to include additional disease states. The legislation also requires the committee to consider deposits of "incentive funds" into the enhanced benefit accounts for individuals participating in the DSM program. This would be a modification to the current program.

3) Risk-adjusted premiums for Medicaid MCO enrollees which provide incentives for the identification of chronic illness before the recipient becomes seriously ill: Risk-adjusted premiums are intended to reduce adverse selection and provide incentives for cost containment. As of January 2006, 54 percent of Virginia's Medicaid population is enrolled in a Managed Care Organization. The state pays MCOs a risk-adjusted capitated fee for each Medicaid enrollee and the MCOs are financially at risk for providing all medically necessary services to each enrollee regardless of their cost. This provides an incentive for the MCOs to be outcome focused. Recipients have choice to the extent that, in any given area of the state, they can choose between at least two MCOs or between an MCO and the fee-for-service program if only one MCO operates in that area. MCOs compete for recipients by offering better services and in some cases by offering additional optional services. This provision would result in additional actuarial costs and would require systems modifications to implement any new rate structure. The extent that this proposal would impact rates paid to MCOs is not known.

4) Employer-sponsored insurance (ESI) options: In Virginia both Medicaid and FAMIS currently offer ESI components. Medicaid ESI (Health Insurance Premium Payment or HIPP) is mandatory if the recipient has employer coverage and it is determined to be cost-effective for the state. Under the current HIPP program, as required by federal law, Medicaid covers the wrap-around services not covered by the private insurer. If a waiver modifies the current HIPP program by including other types of benefits, the current HIPP application in the MMIS would have to be modified.

5) Transitioning all Medicaid recipients into MCOs, DSM or care coordination programs: The current populations that are not in an MCO or care coordination program are primarily individuals in long term care (either an institution or a community based care waiver), and individuals with other types of insurance (either Medicare or private insurance) where Medicaid is the secondary payer. If it is decided to include these individuals in an MCO, the only fiscal impact is the increased actuarial costs.

6) Requiring all MCOs to implement electronic funds transfer technology: If all of the Medicaid MCOs are required to implement this technology it may have a fiscal impact on the MCOs. This may result in higher rates to be paid to MCOs, however the impact is not known.

7) Implementing electronic benefits cards: DMAS already produces cards with a magnetic stripe. These cards can be used to determine enrollee benefits but would have to be modified if enhanced benefit accounts are incorporated into the program. Any modifications would have a fiscal impact due to system changes that would be required.

8) A provision for incentive funds that can be earned and awarded to enrollees: The impact of this proposal on the program is heavily dependent on the scope of the proposal. If this initiative is included in the waiver it may require systems changes and DMAS may incur other administrative costs depending on the specifics of the proposal.

9. **Specific agency or political subdivisions affected:** Department of Medical Assistance Services.

10. **Technical amendment necessary:** No.

11. **Other comments:** None.

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cc: Secretary of Health and Human Resources