SENATE BILL NO. __________ HOUSE BILL NO. __________

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

4 **Be it enacted by the General Assembly of Virginia:**

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

7 CHAPTER 17.

8 VIRGINIA HEALTH CARE INDEPENDENCE ACT.

9 **§ 32.1-370. Definitions.**

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

11 "Commission" means the Medicaid Innovation and Reform Commission.

12 "Department" means the Department of Medical Assistance Services.

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

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

16 **§ 32.1-371. Virginia Health Care Independence Taxpayer Recovery Fund.**

17 A. There is hereby created in the state treasury a special nonreverting fund to be known as the
18 Virginia Health Care Independence Taxpayer Recovery Fund, referred to in this section as "the Fund."
19 The Fund shall be established on the books of the Comptroller. All amounts of federal medical
20 assistance made available to the Commonwealth pursuant to 42 U.S.C. § 1396d(y) and any other funds
21 appropriated by or received from the federal government or granted by any federal agency, any funds as
22 may be appropriated by the General Assembly, and any gifts, grants, or donations from public or private
23 sources shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the
24 Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including

25 interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the
26 Fund. Moneys in the Fund shall be used solely for the purposes of improving access to health care
27 coverage for uninsured residents of the Commonwealth in accordance with the provisions of this
28 chapter. Expenditures and disbursements from the Fund shall be made by the State Treasurer on
29 warrants issued by the Comptroller upon written request signed by the Secretary.
30 B. The Secretary shall report annually no later than December 1 to the Governor, the Chairmen
31 of the Senate Finance and House Appropriations Committees, the Commission, and the Joint
32 Commission on Health Care on the status of the Fund, use of moneys contained in the Fund, and any
33 issues related to the Fund.
34 C. The Secretary shall regularly report to the Commission regarding the status of the Fund,
35 including the status of any grants for which the Fund has applied, any donations and appropriations
36 made to the Fund, and any disbursements from the Fund.
37 **§ 32.1-372. Virginia Health Care Independence Bridge Program.**
38 A. There is hereby established the Virginia Health Care Independence Bridge Program ("Bridge
39 Program") for the purpose of maximizing health care coverage of newly eligible adults by private
40 managed care organizations and health plans. The Bridge Program shall be designed and implemented in
41 a manner intended to (i) reduce the number of uninsured individuals in the Commonwealth; (ii) facilitate
42 the transition of eligible individuals from the Commonwealth's program of medical assistance services to
43 private insurance to support financial independence and improve economic opportunity; (iii) reduce the
44 cost to the Commonwealth of health care for indigent and uninsured individuals; (iv) improve access to
45 quality health care services, including integrated, coordinated mental health services; (v) promote
46 personal responsibility and accountability with regard to decisions related to health care spending and
47 outcomes; and (vi) reduce fraud, waste, and abuse in the delivery of medical assistance services and
48 health care in the Commonwealth.
49 B. The Secretary shall develop and, upon receipt of any waivers or federal approvals as may be
50 required, implement a plan for the Bridge Program, which shall include:

51 1. Provisions for the payment of health insurance premium payment assistance in accordance
52 with 42 U.S.C. § 1396e for newly eligible adults for whom it is determined that enrollment in a group
53 health plan, as defined in 26 U.S.C. § 5000(b)(1), is cost effective;
54 2. A process for enrolling every newly eligible adult who is not eligible for health insurance
55 premium payment assistance pursuant to subdivision 1 in an alternative benefit plan approved pursuant
56 to 42 U.S.C. § 1396u-7 provided by a managed care organization that has entered into a contract with the
57 Department for such purpose. The Secretary shall seek all necessary waivers and other federal approval
58 as may be necessary for implementation of such process as soon as is practicable. Health care coverage
59 provided by managed care organizations pursuant to this subdivision shall begin no later than January 1,
60 2015. The Department shall require managed care organizations providing health care coverage pursuant
61 this subdivision to include provisions for health risk assessments, wellness programs, care coordination,
62 and cost-sharing mechanisms that promote appropriate utilization of services and improved quality of
63 care;
64 3. Provisions for the payment of health insurance premium assistance for the purchase of health
65 care coverage through a federally facilitated health insurance exchange by newly eligible adults who are
66 not eligible for health insurance premium payment assistance pursuant to subdivision 1, including those
67 previously enrolled in health care plans provided by managed care organizations pursuant to subdivision
68 2, to be implemented no later than October 1, 2015. The Bridge Program plan shall provide for the
69 payment of health insurance premium assistance pursuant to this subdivision for newly eligible adults in
70 an amount sufficient to cover the cost of purchasing health care coverage at the silver level, as defined in
71 42 U.S.C. § 18022, through a qualified health plan and shall also include (i) requirements for qualified
72 health plans available to Bridge Program participants, which shall include (a) provisions for delivery of
73 health care to individuals determined to be medically frail; (b) requirements for cost-sharing for newly
74 eligible adults that are comparable to cost-sharing requirements applicable to individuals in the same
75 income range in the private insurance market that are structured to provide incentives and disincentives
76 for individual behavior that affects the cost of health care, to encourage appropriate use of health care

77 services; (c) provisions for selection of a primary medical provider or medical home; (d) provisions to
78 support access to and utilization of preventive services and wellness activities; (e) provisions governing
79 use of nonemergency transportation services, including maximum allowable limitations on use of
80 nonemergency transportation services; and (f) provisions for delivery of mental health services,
81 including provisions for coordination and integration of community-based and other mental health
82 services; (ii) requirements related to employment, work search, or job training for Bridge Program
83 participants; and (iii) program integrity requirements designed to reduce waste, fraud, and abuse,
84 including appropriate performance measures. In developing the Bridge Program, the Department shall
85 consider recommendations of the Commission and input from public and private stakeholders, including
86 health care practitioners, health care facilities, managed care organizations, and health insurance
87 providers. Health care coverage provided by qualified health plans pursuant to this subdivision shall
88 begin no later than January 1, 2016; and
89 4. Provisions for the payment of health insurance premium and cost-sharing assistance on behalf
90 of any individual who was previously enrolled in the Bridge Program and who has subsequently become
91 ineligible for the Bridge Program because his household income exceeds 133 percent of the federal
92 poverty level for a household of that size in an amount equal to the difference between the individual's
93 out-of-pocket expenses for premiums and cost-sharing for health care coverage pursuant to subdivision 2
94 or 3 and the individual's out-of-pocket expenses for health care coverage upon becoming ineligible for
95 health care coverage pursuant to subdivision 2 or 3, provided the individual's household income does not
96 exceed 150 percent of the federal poverty level for a household of that size. Payment of assistance
97 pursuant to this subdivision shall be subject to the availability of funds from demonstrated savings
98 attributable to implementation of the Bridge Program. The Bridge Program plan shall include eligibility
99 rules and requirements for health insurance premium and cost-sharing assistance pursuant to this
100 subdivision that are appropriate to effectively transition individuals to private insurance, promote
101 financial independence, and safeguard against abuse, which may include (i) a minimum threshold that
102 the difference in premium and cost-sharing amounts must exceed in order to qualify for assistance; (ii)

103 requirements related to individual responsibility for cost-sharing; (iii) a requirement that assistance made
104 available to individuals pursuant to this subdivision together with amounts required to be paid by the
105 individual be paid into a health savings account or similar account managed by the individual for the
106 purpose of paying premium and cost-sharing amounts; (iv) requirements for health plans to be made
107 available to Bridge Program participants; and (v) requirements related to the duration of enrollment.
108 C. Notwithstanding the provisions of subdivision B 3, a newly eligible adult who has a household
109 income that is less than 100 percent of the federal poverty level for a household of that size may
110 continue to be enrolled in a health care plan provided by a managed care organization in accordance with
111 subdivision B 2 if the Department determines that it is more cost effective to provide medical assistance
112 services through a health care plan provided by a managed care organization rather than a program of
113 premium assistance described in subdivision B 3.
114 D. As a condition of participation in the Bridge Program, a newly eligible adult shall be required
115 to acknowledge in writing that the Bridge Program is not an entitlement and is subject to cancellation
116 upon notice by the Department.
117 E. The Bridge Program shall expire and coverage shall be canceled within 120 days of the
118 earliest of (i) the effective date of any strategy to ensure access to quality health care services for newly
119 eligible adults established by the Virginia Health Care Independence Innovation Plan pursuant to § 32.1-
120 373, the General Assembly, or the Governor; (ii) any change in federal law or action of any federal
121 agency that results in the federal medical assistance percentage made available to the Commonwealth for
122 newly eligible adults that is less than the amount set forth in 42 U.S.C. § 1396d(y); (iii) any change in
123 any waiver or other federal approval required to implement the Bridge Program that conflicts with the
124 requirements of this section; or (iv) December 31, 2016.
125 F. The Department shall provide all individuals receiving health insurance premium payment
126 assistance pursuant to subdivision B 1 with notice of cancellation of coverage upon expiration of the
127 Bridge Program pursuant to subsection E. Every managed care organization or qualified health plan
128 providing health care coverage pursuant to subdivision B 2 or B 3, shall provide all individuals receiving

129 health care coverage with notice of cancellation of coverage upon expiration of the Bridge Program
130 pursuant to subsection E. Such notice shall be made in writing and shall provide the individual with
131 information regarding (i) alternative options for health care coverage available to the individual,
132 including health care coverage provided by the managed care organization or qualified health plan; (ii)
133 the process for enrollment in health care coverage through the federally facilitated health insurance
134 exchange; and (iii) other sources of health care coverage available in the Commonwealth, including
135 coverage provided through alternative strategies implemented in accordance with the Virginia Health
136 Care Independence Innovation Plan in accordance with § 32.1-373.

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

148 **§ 32.1-373. Virginia Health Care Independence Innovation Plan.**

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

154 B. The goals of the Innovation Plan shall include:

155 1. Ensuring the stabilization of growth in, and fiscal sustainability and predictability of, funding
156 for medical assistance programs using spending targets, block grants, or other funding mechanisms as
157 appropriate;
158 2. Ensuring the coordination of health care delivery for medical assistance program recipients,
159 including newly eligible adults, to address the entire spectrum of an individual's physical, behavioral,
160 and mental health needs by addressing, at a minimum, general population health, disease prevention,
161 health promotion, chronic disease management, and disability and long-term care services;
162 3. Ensuring the patient-centered orientation and coordination and integration of both clinical and
163 nonclinical care and supports, to provide individuals with the necessary tools to address determinants of
164 health and to empower individuals to be full participants in their own health. The health care delivery
165 model shall focus on addressing population health through primary and team-based care that
166 incorporates the attributes of a medical home or other advanced care planning model as appropriate;
167 4. Ensuring access to qualified health care providers;
168 5. Incorporating appropriate incentives that focus on quality outcomes and patient satisfaction, to
169 move from volume-based to value-based purchasing;
170 6. Providing for alignment of payment methods and quality measurement across health care
171 payers, to ensure a unified set of outcomes and to recognize, through reimbursement, all provider
172 participants in the integrated system of care; and
173 7. Promoting financial independence and economic opportunity for low-income individuals who
174 are eligible for medical assistance programs by transitioning such individual to private insurance;.
175 C. The Innovation Plan shall include strategies for:
176 1. Implementing reforms of existing medical assistance programs proposed by the Commission,
177 including implementation of care coordination programs for dual eligible, foster care, home care,
178 community-based care, and long-term care populations and redesign of intellectual disability and
179 developmental disability waivers;
180 2. Implementing a multipayer integrated care model methodology by aligning performance

181 measures, utilizing a shared savings or other accountable payment methodology, and integrating an
182 information technology platform to support the integrated care model. The strategy shall ensure
183 statewide adoption of integrated care for the medical assistance population; address the role of
184 coordinated care plans and expansion of coordinated care in the Commonwealth's program of medical
185 assistance as part of the integrated care model; and address the special circumstances of areas of the state
186 that are rural or underserved or that have higher rates of health disparities;
187 3. Ensuring access to quality health care services for newly eligible adults that incorporates
188 information collected from the Bridge Program. Such strategy may include a continuation of the Bridge
189 Program or similar program to provide health care coverage or a collaborative safety net provider
190 network to provide an integrated approach to health care delivery through care coordination that
191 supports primary care services and links patients with community resources necessary to empower
192 patients in addressing medical and social determinants of health;
193 4. Incorporating long-term care and behavioral health services for the medical assistance
194 population into the integrated care model, through integration of community health and community
195 prevention activities;
196 5. Addressing population health and health promotion, by investing in approaches to influence
197 modifiable determinants of health such as access to health care, healthy behaviors, socioeconomic
198 factors, and the physical environment that collectively impact the health of the community. The strategy
199 shall address the underlying, pervasive, and multifaceted socioeconomic impediments that medical
200 assistance recipients face in being full participants in their own health;
201 6. Implementing a statewide integrated care model to maximize access to health care in all areas
202 of the state. The strategy shall incorporate flexible integrated care model options and accountable
203 payment methodologies for participation by various types of providers, including individual providers,
204 safety net providers, and nonprofit and public providers that have long experience in caring for
205 vulnerable populations, into the integrated system;
206 7. Addressing the underlying socioeconomic impediments that low-income individuals and

207 medical assistance recipients face in being full participants in their own health and achieving financial
208 independence and economic opportunity; and
209 8. Including mechanisms for low-income individuals that are eligible for medical assistance
210 programs to achieve long-term financial independence and transition out of medical assistance programs
211 into employer-sponsored insurance and other available forms of health care coverage offered in the
212 private sector.
213 D. In developing the Innovation Plan, the Secretary shall consult the Commission, the Director of
214 the Department of Medical Assistance Services, and stakeholders representing public and private
215 entities, including organizations that represent low-income individuals, organizations that represent
216 health practitioners, organizations that represent health care facilities, organizations that represent
217 managed care organizations and health insurers, and such other individuals or organizations as the
218 Secretary determines are necessary to ensure that the process is comprehensive and provides ample
219 opportunity for the variety of stakeholders to participate.
220 E. The Secretary shall regularly report to the Commission on his progress in developing the
221 Innovation Plan and shall submit the Innovation Plan to the Commission no later than December 15,
222 2015. Such report shall include information about any changes to the state plan for medical assistance
223 services and any waivers that are proposed or that may be required, as well as any savings to the
224 Commonwealth associated with such proposals. If the Commission determines that federal medical
225 assistance funds for newly eligible adults as provided in 42 U.S.C. § 1396d(y) or other federal funds
226 combined with current and projected annual savings to the general fund and other nonfederal net savings
227 associated with the implementation and operation of the Innovation Plan are sufficient to cover the costs
228 to the Commonwealth of coverage for newly eligible adults, then the Commission shall approve
229 implementation of such coverage.
230 F. Upon approval by the Commission of any component of the Innovation Plan, the Secretary
231 shall submit an application for any necessary waivers, including, if applicable, a waiver for state
232 innovation pursuant to 42 U.S.C. § 18052, as soon as practicable following approval of any component

233 of the Innovation Plan required pursuant to subsection E.

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