Department of Planning and Budget
2018 Fiscal Impact Statement

1. **Bill Number:** HB 338

House of Origin	☐	Introduced	☒	Substitute	☐	Engrossed
Second House	☐	In Committee	☐	Substitute	☐	Enrolled

2. **Patron:** Miyares

3. **Committee:** Appropriations

4. **Title:** Medicaid; Work Requirement

5. **Summary:** The proposed legislation requires the Department of Medical Assistance Services to apply to the Centers for Medicare and Medicaid Services (CMS) for a §1115 waiver to implement a program to improve the health and well-being of Medicaid participants. This program is expected to incentivize community engagement and employment among able-bodied, working-age adults with the goal of empowering program participants and providing them with the necessary tools to seek and obtain employment and transition to self-sufficiency.

   The bill also specifies that the following groups are exempt from participation: 1) children under the age of 18 or individuals under the age of 19 who are participating in secondary education; 2) individuals age 65 years and older; 3) individuals who qualify for medical assistance services due to blindness or disability, including individuals who receive services pursuant to a § 1915 waiver; 4) individuals residing in institutions; 5) individuals determined to be medically frail; 6) pregnant and postpartum women; 7) former foster children under the age of 26; and 8) individuals who are the primary caregiver for a dependent, including a dependent child or adult dependent with a disability.

   The program's participation requirements are as follows:
   - Beginning three months after enrollment, at least 5 hours per week;
   - Beginning six months after enrollment, at least 10 hours per week;
   - Beginning nine months after enrollment, at least 15 hours per week; and
   - Beginning 12 months after enrollment, at least 20 hours per week.

   The bill requires the Department Medical Assistance Services (DMAS) to report on the status of the waiver application to the Governor and the General Assembly by December 1, 2018.

6. **Budget Amendment Necessary**: Yes

7. **Fiscal Impact Estimates:** See Item 8.

8. **Fiscal Implications:** The proposed legislation establishes a work and community engagement requirement for Medicaid coverage. The bill outlines the overall purpose,

excludes specific populations and sets the participation expectations. However, the bill does not include any indications as to how vigorous efforts should be with regard to verification, case management, and supportive services (i.e. job training, child care etc.). Therefore, the following fiscal implications illustrates two potential implementation alternatives. The first is a "high touch" option that is based on the current Temporary Assistance for Needy Families (TANF) Virginia Initiative for Employment not Welfare (VIEW) program which offers comprehensive case management, employment assistance, and monitoring services by staff in local department of social services (LDSS). It is followed by a "low touch" option that assumes a nominal amount of time by local staff to provide minimal case management and to certify attestations by the work participants of program compliance. Each scenario will cover three chief areas with fiscal implications: the impact on Medicaid coverage; the information systems and administrative costs; and the cost of case management and services. The following table offers a summary of both options:

Funding Option Summary

High Touch Program Option				Low Touch Program Option			
	FY 2018	FY 2019	FY 2020		FY 2018	FY 2019	FY 2020
Medicaid Coverage	-	(72,781,486)	(217,900,956)	Medicaid Coverage	-	(32,735,931)	(98,009,872)
Systems and Administration	3,300,000	3,068,600	1,326,600	Systems and Administration	3,300,000	3,068,600	1,326,600
Case Management and Services	-	195,756,585	216,852,469	Case Management and Services	-	6,749,305	7,421,415
Fund Splits							
General	825,000	51,097,259	63,788,382	General	825,000	3,763,146	7,605,722
Federal	2,475,000	49,826,802	(76,545,732)	Federal	2,475,000	(25,243,072)	(88,512,905)
Special	-	(5,222,632)	(20,576,670)	Special	-	(2,384,439)	(9,395,647)
Local	-	30,342,270	33,612,133	Local	-	946,339	1,040,973

Overall Facts and Assumptions:

- Current Medicaid enrollment includes 223,817 full benefit aged, blind and disabled individuals, 60,210 limited benefit Medicare beneficiaries, 114,868 low income caretaker adults, 15,411 pregnant women, 125,599 limited-benefit Plan First beneficiaries, and 13,776 limited-benefit GAP members for those with serious mental illness.

- Local departments are reimbursed by the state based on the actual cost of delivering required services. These costs are then allocated to the appropriate source of funding (i.e. general, federal, etc). There is no way to determine how the increased costs associated with this bill will be distributed across local departments of social services. However, it is necessary to acknowledge the impact of any additional responsibilities being placed on local departments and workers. This statement uses historical workload data to estimate the fiscal implications at the state level. This statewide estimate of increased costs would be allocated to localities based on actual annual experience.

- Along with the requirements outlined in HB 338, both alternatives below are based on guidance received in a recent letter to State Medicaid Directors dated January 11, 2018. The CMS provided detailed guidance regarding waivers for work requirements. In that letter, CMS states, individuals enrolled in and compliant with a TANF or Supplemental Nutrition Assistance Program (SNAP) work requirement, as well as individuals exempt from a TANF or SNAP work requirement, must automatically be considered to be complying with the Medicaid work requirements. Therefore, pursuant to this requirement, those individuals who are already compliant with the SNAP and/or TANF

work programs or who are exempt from those work requirements will automatically be considered to be complying with the Medicaid work requirement. Therefore, the following analysis looks only at those individuals who do not receive SNAP or TANF.

- Based on conversations with the Commonwealth of Kentucky, it is assumed that Virginia's efforts associated with validating work and community engagement-related activities will be eligible for enhanced federal matching dollars (75 percent) as they are a condition on Medicaid eligibility.

- The introduced budget includes a provision to expand Medicaid pursuant to the Affordable Care Act (ACA), 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). This statement assumes this provision to expand Medicaid is enacted and the proposed legislation's work requirement will apply to the newly eligible individuals. The expansion population includes caretaker adults, with income above current Low Income Families with Children (LIFC) adult limits and childless adults with income from zero percent up to 138 percent of poverty.

- The introduced budget (Section 3-5.15) covers the state share of expansion coverage costs with a provider assessment on hospitals instead of general fund dollars. Therefore, any newly eligible individual's cost of care would be entirely supported with special fund revenue generated by these assessments. As such, any reductions to the state share of expansion costs would equate to a reduction in the provider assessment rate and no general fund savings would accrue.

"High Touch" Community Engagement and Work Requirement Program

VIEW is a work program with full case management and support services for enrollees. Case management services are provided by the LDSS workers, who thoroughly assess the knowledge, skills, and abilities of the clients and evaluate any barriers to employment. Staff work with the clients to develop both long and short range plans in order to steer the clients to appropriate jobs assignments. There is continued case management by the local employees in order to help clients maintain employment.

Calculation Assumptions:

- A small portion of current Medicaid recipients who are a part of two parent family cases are subject to the work requirement. The count of individuals in this category is 32,710 according to Department of Social Services (DSS) data. Of that total, 20,259 already receive SNAP and are therefore exempt. Of the remaining 12,451 (32,710 – 20,259), only the primary dependent caregiver will be exempt, leaving 50 percent or 6,226 (12,451 x 0.50) subject to the work requirement.

- DMAS estimates the full Medicaid expansion population to be 305,973. However, DSS data shows that 115,166 will be exempt from the work program due to current participation in the SNAP program; DMAS estimates another 40,000 will be exempt because they are the primary caregiver to a child (32,400) or have an illness that precludes them from participating (7,600). Therefore, 150,807 (305,973 – 115,166 –

40,000) is the total expanded population obligated to participate in a Medicaid work requirement.

- VIEW program data shows that 22 percent of individuals do not continue with the program after referral, so in this analysis only 78 percent of individuals will continue with the Medicaid work program 117,629 (150,807 x 0.78).

- In FY 2017, local staffing and administration expenditures totaled $587,851,572. Utilizing a point in time random moment sampling system to determine the focus of effort for local staff, VIEW administrative related tasks account for $21,562,323 (or approximately 3.67 percent) of this total.

- The total number of individuals who participated in the VIEW program is estimated at 15,633, and the average cost per VIEW case for local staffing is $1,379 ($21,562,323 / 15,633). This population includes all participants, including those who meet the work requirement and require very little case management and those who require extensive case management by the local workers.

- Under the Medicaid work requirement program, the local staffing costs will be funded with 75 percent federal Medicaid funding and a 25 percent state match, split 9.5 percent general fund and 15.5 percent local funds.

Medicaid Coverage

Summary Table

	FY 2019	Fund	FY 2020	Fund
Current Population	(1,808,381)	General	(4,822,350)	General
	-	Special	-	Special
	(1,808,381)	Federal	(4,822,350)	Federal
Expansion Population	-	General	-	General
	(5,222,632)	Special	(20,576,670)	Special
	(75,125,559)	Federal	(221,501,803)	Federal
ACA Savings Reduction	5,490,699	General	16,640,036	General
	-	Special	-	Special
	5,692,768	Federal	17,182,181	Federal

Current Population

Based on the assumptions above, it is estimated that 6,226 individuals eligible for the current Medicaid program would be subject to the work requirements because they are in a household with more than one adult and only one can be considered primary for the purposes of an exemption. When the VIEW participation rate is applied the number drops to 4,856, which represents a loss of coverage for 1,370 individuals. DMAS estimates the resulting

savings in Medicaid to be $3.6 million ($1.8 million state share) in FY 2019 and $9.6 million ($4.8 million state share) in FY 2020.

Expansion Population
Based on the above assumptions, it is estimated that 150,807 recipients of Medicaid under expansion would eventually be subject to a work requirement annually. When the VIEW participation rate is applied the number drops to 117,629, which represents a loss of coverage for 33,178 individuals. DMAS estimates that this enrollment reduction would decrease costs by $80.3 million total funds ($5.2 million state share) in FY 2019 and $242.1 million total funds ($20.6 million state share) in FY 2020. As stated above, the state share of these savings will result in a reduction in special fund revenue due to the provider assessment. No general fund savings is expected.

ACA Savings Reduction
Because some individuals receiving coverage under the ACA would have otherwise received services based on eventual eligibility under an aid category with a higher state match requirement, expansion would result in significant savings. DMAS reports that the legislation would reduce enrollment under the ACA expansion by about ten percent, or roughly 33,000 persons. Some of these persons will experience a life event that will trigger coverage under another DMAS aid category that has a lower federal match rate than the expansion category, resulting in additional cost. Such aid categories include Breast and Cervical Cancer, Temporary Detention Orders, and Pregnant Women. DMAS applied a ten percent reduction to ACA savings in each of those categories. In addition, because the number of individuals covered under expansion would be reduced, DMAS estimates indigent care payments would increase relative to expansion with a work requirement. The result of these assumptions is an increase in expenditures of $11.2 million ($5.5 million general fund) in FY 2019 and $33.8 million ($16.6 million general fund) in FY 2020.

Information Systems and Administration

Summary Table

	FY 2018	Fund	FY 2019	Fund	FY 2020	Fund
VaCMS	825,000	General	425,000	General	-	General
	2,475,000	Federal	1,275,000	Federal	-	Federal
MMIS	-	General	10,500	General	-	General
	-	Federal	31,500	Federal	-	Federal
DMAS Administration	-	General	663,300	General	663,300	General
	-	Federal	663,300	Federal	663,300	Federal

Under a §1115 waiver for a work requirement, states are required to complete an annual robust independent evaluation to track and evaluate health and community engagement outcomes both for those who remain enrolled in Medicaid, and those who are subject to the requirement but lose eligibility. Based on experience with other CMS-required independent

evaluations and the additional need to provide outcomes for recipients that are no longer in the Medicaid programs, DMAS estimates that the independent evaluation will cost $300,000 ($150,000 general fund) annually for a contractor to gather data, evaluate eventual outcomes, and prepare findings for CMS review.

To administer the work requirement in HB 338, DMAS estimates a need of nine additional positions at a cost of $1,026,600 ($513,300 general fund) in both FY 2019 and FY 2020. DMAS estimates that six additional positions would be necessary to administer and oversee the new requirement. Unit staff would be responsible for the extensive data gathering and reporting required of the §1115 waiver by CMS. Because a work requirement would be so closely linked to the SNAP and TANF programs, the unit would ensure extensive coordination between DMAS and DSS. In addition, DMAS estimates that three additional positions would be needed in the agency's appeals division to address an expected increase in the number of administrative and court appeals. This is based on CMS guidance that due process is guaranteed for any impacted individuals. Further, DMAS maintains that modifications to the Medicaid Management Information System (MMIS), to account for new data tracking requirements, will be necessary. The estimated cost of these changes is $42,000 ($10,500 general fund).

It is assumed that DSS will leverage the existing Virginia Case Management System (VaCMS) to meet requirements included in this bill. Modifications to VaCMS will be necessary with one-time costs estimated at $5,000,000 for requirements, design, testing and support, training material development, implementation, and online help. CMS will provide 75 percent of the funding for these systems modifications, at a cost of $3,750,000 (0.75 x $5,000,000) federal funds and $1,250,000 (0.25 x $5,000,000) general fund. The adjustments to VaCMS must be complete prior to program implementation in October 2018. It is estimated that 66 percent or $3,300,000 of the funding will be needed in FY 2018 and the remaining 34 percent or $1,700,000 in FY 2019.

Case Management and Services

Summary Table

	FY 2019	Fund	FY 2020	Fund
Local Staffing for Current Population	477,120	General	636,197	General
	3,766,739	Federal	5,022,608	Federal
	778,459	Local	1,038,005	Local
Local Staffing for Expansion Population	13,868,975	General	15,255,925	General
	109,491,910	Federal	120,441,515	Federal
	22,628,328	Local	24,891,247	Local
Support Services for Participants	31,970,046	General	35,415,274	General
	5,839,525	Federal	6,468,817	Federal
	6,935,483	Local	7,682,881	Local

As stated in the assumptions, 6,226 of current Medicaid recipients would not be exempt from the work requirement, and it is assumed that 22 percent of them would not participate in the program. At $1,379 per case for the case management services, the local staffing cost for this population is $6,696,810 (6,226 x $1,379 x .78) on an annual basis. These expenses are broken down $5,022,608 federal funds, $636,200 general fund, and $1,038,006 local match. It is expected that this program will be operational beginning October 1, 2018; as such, only costs for nine months of the year are included in FY 2019 at a total cost of $5,022,608.

As stated in the assumptions 117,629 Virginians who receive Medicaid under expansion will enroll in the work program. A graduated enrollment of 90 percent in FY 2019, 99 percent in FY 2020, and a full population by FY 2022 is expected. The case management services costs, at $1,379 per case, total $162,210,391 (117,629 x $1,379) for Medicaid expansion recipients fully implemented in the third year.

The local staffing costs for a robust work requirement program, with both the current Medicaid residents and those who fall under the expanded population are totaled below.

Support Services for Participants

As part of the current VIEW program, clients receive services or funding for services like bus tickets, gas cards, job training, job safety equipment, and uniforms. In FY 2017, total VIEW support services costs were $11,723,179. There are also LDSS costs related to the local worker time necessary to assist clients with support services. In FY 2017, that staff time equated to approximately 0.42 percent of local effort and cost $2,466,869 (0.0042 x $587,851,572) for total VIEW services expenditures of $14,190,048 ($11,723,179 + $2,466,869) or $908 per case ($14,190,048 / 15,633). Kaiser Family Foundation statistics show that 45 percent of uninsured, non-elderly adults in Virginia are in a non-working family; therefore, 55 percent of this population is assumed to be working and those individuals will not need support services.

Employment support services for 2,185 (6,226 x .78 x 0.45) current Medicaid recipients and 52,933 (117,629 x 0.45) Medicaid expansion recipients would cost $50,047,485 (908 x [2,185 + 52,933]). Providing support services for a work requirement program is not a federal condition for Medicaid eligibility; for that reason, it is expected that Medicaid would not provide funding for these costs. With no certain federal funding source, it is estimated that general fund (84.5 percent) and local match (15.5 percent) will be necessary to fund the services expenses. However, the local staff time associated with these activities will receive 75 percent reimbursement from Medicaid.

"Low Touch" Community Engagement and Work Requirement

One alternative to a robust work requirement program that helps improve the employment status of participants is to simply notify participants of their work requirement and track their compliance with the work requirement, offering no services. DSS estimated the costs related to an approximate amount of time required by local staff to provide minimal case management, which includes certifying attestations by the work participants of program compliance. In this work program model, LDSS staff would interact or receive

communications from participants quarterly to verify their attestations of compliance with the program. These case management functions include activities like reviewing earning statements for employment verification, evaluating income for eligibility, and inputting data into the case management system.

Calculation Assumptions:

- A small portion of current Medicaid recipients who are a part of two parent family cases are subject to the work requirement. The count of individuals in this category is 32,710 according to DSS data. Of that total, 20,259 already receive SNAP and are therefore exempt. Of the remaining 12,451 (32,710 – 20,259), only the primary dependent caregiver will be exempt, leaving 50 percent or 6,226 (12,451 x 0.50) subject to the work requirement.

- DMAS estimates the full Medicaid expansion population to be 305,973. However, DSS data shows that 115,166 will be exempt from the work program due to current participation in the SNAP program; DMAS estimates another 40,000 will be exempt because they are the primary caregiver to a child (32,400) or have an illness that precludes them from participating (7,600). Therefore, 150,807 (305,973 – 115,166 – 40,000) is the total expanded population obligated to participate in a Medicaid work requirement.

- Ninety percent or 135,726 (150,807 x 0.90) of individuals will continue with the program after referral, as the client will only need to communicate his/her current eligibility status with the caseworker quarterly, putting a minimal burden on the client.

- Of the 6,226 current Medicaid recipients subject to the work requirement, 90 percent or 5,603 (6,226 x 0.90) will continue with the program.

- It will take an average of 15 minutes per participant to provide minimal case management services as defined in this work program each quarter for a total of 60 minutes annually.

- The cost of employing a local eligibility worker (salary, benefits, and nonpersonal expenses) is $71,592. Assuming 1,500 annual productive hours per full-time employee, the hourly cost to perform this additional workload is $48 ($71,592 / 1,500 hours).

- Under the Medicaid work requirement program, the local staffing costs will be funded with 75 percent federal Medicaid funding and a 25 percent state match, split 9.5 percent general fund and 15.5 percent local funds.

Medicaid Coverage

Summary Table

	FY 2019	Fund	FY 2020	Fund
Current Population	(821,991)	General	(2,191,977)	General
	-	Special	-	Special
	(821,991)	Federal	(2,191,977)	Federal
Expansion Population	-	General	-	General
	(2,384,439)	Special	(9,395,647)	Special
	(34,299,244)	Federal	(101,141,380)	Federal
ACA Savings Reduction	2,745,350	General	8,320,018	General
	-	Special	-	Special
	2,846,384	Federal	8,591,091	Federal

Current Population

Based on the assumptions above, it is estimated that 6,226 individuals eligible for the current Medicaid program would be subject to the work requirements because they are in a household with more than one adult and only one can be considered primary for the purposes of an exemption. When "low touch" participation rate is applied the number drops to 5,603, which represents a loss of coverage for 623 individuals. DMAS estimates the resulting savings in Medicaid to be $1.6 million ($0.8 million state share) in FY 2019 and $4.4 million ($2.2 million state share) in FY 2020.

Expansion Population

Based on the above assumptions, it is estimated that 150,807 recipients of Medicaid under expansion would eventually be subject to a work requirement annually. When a "low touch" participation assumption is applied the number drops to 135,726, which represents a loss of coverage for 15,081 individuals. DMAS estimates that this enrollment reduction would decrease costs by $36.7 million total funds ($2.4 million state share) in FY 2019 and $110.5 million total funds ($9.4 million state share) in FY 2020. As stated above, the state share of these savings will result in a reduction in special fund revenue due to the provider assessment. No general fund savings is expected.

ACA Savings Reduction

Because some individuals receiving coverage under the ACA would have otherwise received services based on eventual eligibility under an aid category with a higher state match requirement, expansion would result in significant savings. DMAS reports that the legislation would reduce enrollment under the ACA expansion by about five percent, or roughly 15,000 persons. Some of these persons will experience a life event that will trigger coverage under another DMAS aid category that has a lower federal match rate than the expansion category, resulting in additional cost. Such aid categories include Breast and Cervical Cancer, Temporary Detention Orders, and Pregnant Women. DMAS applied a five percent reduction to ACA savings in each of those categories. In addition, because the

number of individuals covered under expansion would be reduced, DMAS estimates indigent care payments would increase relative to expansion with a work requirement. The result of these assumptions is an increase in expenditures of $5.6 million ($2.8 million general fund) in FY 2019 and $16.9 million ($8.3 million general fund) in FY 2020.

Information Systems and Administration

Summary Table

	FY 2018	Fund	FY 2019	Fund	FY 2020	Fund
VaCMS	825,000	General	425,000	General	-	General
	2,475,000	Federal	1,275,000	Federal	-	Federal
MMIS	-	General	10,500	General	-	General
	-	Federal	31,500	Federal	-	Federal
DMAS administration	-	General	663,300	General	663,300	General
	-	Federal	663,300	Federal	663,300	Federal

Under a §1115 waiver for a work requirement, states are required to complete an annual robust independent evaluation to track and evaluate health and community engagement outcomes both for those who remain enrolled in Medicaid, and those who are subject to the requirement but lose eligibility. Based on experience with other CMS-required independent evaluations and the additional need to provide outcomes for recipients that are no longer in the Medicaid programs, DMAS estimates that the independent evaluation will cost $300,000 ($150,000 GF) annually for a contractor to gather data, evaluate eventual outcomes, and prepare findings for CMS review.

To administer the work requirement in HB 338, DMAS estimates a need of nine additional positions at a cost of $1,026,600 ($513,300 general fund) in both FY 2019 and FY 2020. DMAS estimates that six additional positions would be necessary to administer and oversee the new requirement. Unit staff would be responsible for the extensive data gathering and reporting required of the §1115 waiver by CMS. Because a work requirement would be so closely linked to the SNAP and TANF programs, the unit would ensure extensive coordination between DMAS and DSS. In addition, DMAS estimates that three additional positions would be needed in the agency's appeals division to address an expected increase in the number of administrative and court appeals. This is based on CMS guidance that due process is guaranteed for any impacted individuals. Further, DMAS maintains that modifications to the Medicaid Management Information System (MMIS), to account for new data tracking requirements, will be necessary. The estimated cost of these changes is $42,000 ($10,500 general fund).

It is assumed that DSS will leverage the existing Virginia Case Management System (VaCMS) to meet requirements included in this bill. Modifications to VaCMS will be necessary with one-time costs estimated at $5,000,000 for requirements, design, testing and support, training material development, implementation, and online help. CMS will provide 75 percent of the funding for these systems modifications, at a cost of $3,750,000 (0.75 x

$5,000,000) federal funds and $1,250,000 (.25 x $5,000,000) general fund. The adjustments to VaCMS must be complete prior to program implementation in October 2018. It is estimated that 66 percent or $3,300,000 of the funding will be needed in FY 2018 and the remaining 34 percent or $1,700,000 in FY 2019.

Case Management and Services

Summary Table

	FY 2019	Fund	FY 2020	Fund
Local Staffing for Current Population	22,995	General	25,294	General
	181,537	Federal	199,691	Federal
	37,518	Local	41,269	Local
Local Staffing for Expansion Population	557,020	General	612,721	General
	4,397,522	Federal	4,837,275	Federal
	908,821	Local	999,703	Local
Printing and Postage	160,973	General	176,365	General
	482,919	Federal	529,096	Federal

The total count of recipients needing minimal case management services is 141,329 (5,603 + 135,726) when fully implemented. As stated above, it is estimated that an hour of staff time will be needed for each participant annually. With a total population of 141,329, the additional hours of work resulting from this bill is also 141,329 at a cost of $6,783,811 when fully implemented. The amounts reflected in the table above assumes a graduated enrollment through FY 2021. Additional funding for the printing and mailing of notices to the participants is estimated at $712,300 annually when fully implemented.

9. Specific Agency or Political Subdivisions Affected:
Department of Medical Assistance Services
Department of Social Services
Local departments of social services

10. Technical Amendment Necessary: No

11. Other Comments: None