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:** Rules

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

5. **Summary:** The proposed legislation requires the Secretary of Health and Human Resources to apply to the Centers for Medicare and Medicaid Services (CMS) for a §1115 waiver to establish a work requirement for all "able-bodied" adult Medicaid enrollees.

6. **Budget Amendment Necessary**: Yes

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

Expenditure Impact:

Fiscal Year	*Dollars*	*Positions*	*Fund*
2019	$10,521,431	5.5	General
2019	($79,328,590)	5.5	Non-general
2020	$25,876,749	5.5	General
2020	($340,807,699)	5.5	Non-general
2021	$30,444,075	5.5	General
2021	($364,691,141)	5.5	Non-general
2022	$31,002,761	5.5	General
2022	($378,821,010)	5.5	Non-general
2023	$31,002,761	5.5	General
2023	($378,821,010)	5.5	Non-general
2024	$31,002,761	5.5	General
2024	($378,821,010)	5.5	Non-general

8. **Fiscal Implications:** The proposed bill requires the Secretary of Health and Human Resources to apply to the Centers for Medicare and Medicaid Services (CMS) for a §1115 waiver to establish a work requirement for all "able-bodied" adult Medicaid enrollees. Under the bill, an individual could fulfill the work requirement by working at least 20 hours per week, demonstrating that he or she is actively seeking employment, or participating in an educational or training program. The following groups would be exempt from the requirement: (1) individuals age 18 or older who are still attending secondary school, (2) those who are the sole caregiver for a family member under the age of six, (3) those currently receiving temporary or permanent long-term disability benefits, and (4) individuals determined to be physically or mentally unable to work by a health care provider. The bill

requires 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.

Impact on Current Medicaid Recipients

DMAS reports that 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. In a letter to State Medicaid Directors dated January 11, 2018, CMS provided detailed guidance regarding waivers for work requirements. In that letter, CMS states, "Individuals enrolled in and compliant with a TANF or 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." Virginia SNAP requirements include exemptions for all caretaker adults with dependents 0 to 18, in line with Medicaid low-income families with children (LIFC) category eligibility requirements, pregnant women, elderly and disabled. Based on this information, DMAS assumes that the work requirement in the proposed legislation would not apply to any current Medicaid recipients.

Impact on Medicaid Expansion Population

The introduced budget includes a provision to expand Medicaid pursuant to 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). Assuming this Medicaid expansion is enacted, the proposed legislation's work requirement is expected to apply to the individuals who would begin receiving services under its provisions. The expansion population includes caretaker adults, with income above current LIFC adult limits and childless adults with income from zero percent up to 138 percent of poverty. Using exemptions required by CMS and experience with current Medicaid members, DMAS analyzed Virginia's potential expansion population with respect to dependents and employment status. Based on their findings, DMAS estimates that approximately 18 percent of the fully enrolled expansion population (approximately 50,000 individuals) would not meet the work requirements as outlined in the bill and be dis-enrolled from coverage. This enrollment reduction would decrease costs by $96.1 million total funds ($6.2 million state share) in FY 2019 and $401 million total funds ($34.0 million state share) in FY 2020.

The introduced budget (Section 3-5.15) covers the state share of expansion coverage costs with a provider assessment on hospitals. Instead of using general fund dollars, any newly eligible individual's cost of care would be entirely supported with special fund revenue generated by the assessment on hospitals. Therefore, since the state share of the cost reductions described above are covered by a provider assessment revenue, no savings would accrue to the general fund. DMAS estimates that the work requirements would result in a reduction in special fund revenue of $6.2 million in FY 2019 and $34.0 million in FY 2020, offsetting the savings of reduced coverage.

DMAS reports that the legislation will reduce enrollment under the ACA expansion, and there will be a corresponding reduction in offsetting savings from fewer members in current eligibility groups enrolling as ACA adults. With the work requirement, fewer women will enroll under the ACA provisions, and so more will eventually enroll as pregnant women

under current eligibility rules. In addition, fewer medically needy individuals will enroll as expansion low-income adults, reverting to enrolling as medically needy under current eligibility rules and higher federal match rate. This would result in an increase in expenditures of $10.4 million ($5.2 million general fund) in FY 2019 and $42.5 million ($21.3 million general fund) in FY 2020.

Administrative Costs

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.

Based on information from other states researching work requirements, DMAS estimates the cost of a system that uses available employment and exemption information, and manages the work requirement from a central location would be $3.5 million ($1.75 million general fund) for startup and implementation costs and $2.50 per person per month for ongoing costs. Assuming the current population was all exempt, the cost of such a system managing the expansion population would be $9.1 million ($4.5 million general fund) in FY 2019 and $7.7 million ($3.9 million general fund) in FY 2020.

To administer the work requirement in HB 338, DMAS estimates a need of 11 additional positions at a cost of $1,208,645 ($604,332 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. Staff would closely monitor contractors that perform evaluations and work requirement compliance activities. Because a work requirement would be so closely linked to the SNAP and TANF programs, the unit would ensure extensive coordination between DMAS and the Department of Social Services (DSS). In addition to new unit staff, DMAS estimates that five additional positions would be needed in the agency's appeals division due to the bill creating additional issues for dispute and litigation, which will likely lead to administrative and court appeals. Further, DMAS estimates that to make edits to the Medicaid Management Information System to account for the additional need to track dates of disability and whether recipients would be subject to the new requirement would cost $42,000 ($10,500 general fund).

In addition to estimates above, DMAS assumes there would be significate costs at DSS for staff and systems change. However, at this time, DSS has not provided this information as to the extent of those costs. It is assumed that this statement will be revised once data from DSS is provided.

9. **Specific Agency or Political Subdivisions Affected:**
   Department of Medical Assistance Services
   Department of Social Services

10. **Technical Amendment Necessary:** Line 28 add “and” after “benefits,”.

11. **Other Comments:** While the bill calls for the Secretary of Health and Human Resources to apply for the required waiver, DMAS is the proper entity to apply for such a waiver.