Explanation of Differences in Amendments Between HB 29

(as Adopted by the House on February 22, 2018)

and HB 5001

Changed
Amendment

Item 306 #2h

Medicaid Transformation Requirements

Health and Human Resources

Department of Medical Assistance Services Language

Language:

Page 110, strike line 57.
Page 111, strike lines 1 through 8, and insert:
"4.a. No later than 45 days upon the passage of this act, the Department of Medical Assistance Services shall have the authority to (1) amend the State Plan for Medical Assistance under Title XIX of the Social Security Act, and any waivers thereof, to implement coverage for newly eligible individuals pursuant to 42 U.S.C. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act and (2) begin the process of implementing a § 1115 demonstration project to transform the Medicaid program for newly eligible individuals pursuant to the provisions of 4.a.(1) and eligible individuals enrolled in the existing Medicaid program. No later than 180 days from the passage of this act, DMAS shall submit the § 1115 demonstration application to CMS for approval. If the State Plan amendment is affirmatively approved by CMS prior to the submission of the waiver, Medicaid coverage for newly eligible individuals may be implemented. If the State Plan amendment becomes effective without affirmative action by CMS, coverage may begin upon submission of the completed § 1115 demonstration application, per CMS notification, but no later than January 1, 2019. If the demonstration waiver cannot be completed by 180 days, despite a good faith effort to complete the application, the department may request an extension from the Chairmen of the House Appropriations and Senate Finance Committee. The department shall provide updates on the progress of the State Plan amendments and waiver applications to the Chairmen of the House Appropriations and Senate Finance Committees, or their designees, upon request, and provide for participation in discussions with CMS staff. The department shall respond to all requests for information from CMS on the State Plan amendments and waiver applications in a timely manner.

b. At least 10 days prior to the submission of the application for the waiver of Title XIX of the Social Security Act, the department shall notify the Chairmen of the House Appropriations and Senate Finance Committees of such pending application and provide a copy of the application. If the department receives an official letter from either Chairman raising an objection about the waiver during the 10-day period, the department shall make all reasonable attempts to address the objection and modify the waiver(s). If the department receives no objection, then the application may be submitted. Any waiver specifically authorized elsewhere in this item is not subject to this provision. Waiver renewals are not subject to the provisions of this paragraph.

c. The Department of Medical Assistance Services shall include provisions to make

referrals to job training, education and job placement assistance for all unemployed, able-bodied adult enrollees as allowed under current federal law or regulations through the State Plan amendments, contracts, or other policy changes. DMAS shall also include provisions to foster personal responsibility and prepare newly eligible enrollees for participation in commercial health insurance plans to include use of private health plans, premium support for employer-sponsored insurance, health savings accounts, appropriate utilization of hospital emergency room services, healthy behavior incentives, and enhanced fraud prevention efforts, among others through the State Plan amendments, contracts, or other policy changes.

d. The demonstration project shall be designed to empower individuals to improve their health and well-being and gain employer sponsored coverage or other commercial health insurance coverage, while simultaneously ensuring the program's long-term fiscal sustainability. The demonstration project shall include the following elements in the design:

(i) two pathways for eligible individuals with incomes between 100 percent and 138 percent of the federal poverty level, including income disregards, to obtain health care coverage: premium assistance for the purchase of a health insurance plan, or premium assistance for the purchase of employer-sponsored health insurance coverage if cost effective. The premium assistance program shall assist participants in purchasing a comprehensive benefit package consistent with private market plans, compliant with all mandated essential health benefits, and inclusive of current Medicaid covered mental health and addiction recovery and treatment services. The premium assistance program shall include (1) the development of a deductible account for eligible individuals participating in the premium assistance programs, comprised of participant contributions and state funds to be used to fund the health insurance premiums and to ensure funds are available for the enrollee to cover the initial year of medical expenses for the deductible, with the ability to roll over the funds from the account into succeeding years if not fully used. The monthly premium amount for the enrollee shall be set on a sliding scale based on monthly income, not to exceed two percent of monthly income, nor be less than $1 per month; (2) provisions for coverage to begin on the first day of receipt of the premium payment or enrollment due to treatment of an acute illness; (3) provisions for instituting a grace period followed by a waiting period prior to re-enrollment if the premium is not paid by the participant or if the participant does not maintain continuous coverage; and (4) provisions to recover premiums payments owed to the Commonwealth through debt set-off collections;

(ii) provisions to enroll newly eligible individuals with incomes between 0 and 100 percent of the federal poverty level, including income disregards, in existing Medicaid managed care plans with existing Medicaid benefits or in employer-sponsored health insurance plans, if cost effective. Such newly eligible enrollees shall be subject to existing Medicaid cost sharing provisions;

(iii) cost-sharing for eligible enrollees with incomes between 100 percent and 138 percent of the federal poverty level, including income disregards, designed to promote healthy behaviors such as the avoidance of tobacco use, and to encourage personal responsibility and accountability related to the utilization of health care services such as the appropriate use of emergency room services. However, such individuals who also meet the exemptions listed in (iv) shall not be

subject to cost sharing requirements more stringent than existing Medicaid law or regulations. Enrollees who comply with provisions of the Medicaid program, including healthy behavior provisions, may receive a decrease in their monthly premiums and copayments, not to exceed 50 percent.

(iv) the establishment of the Training, Education, Employment and Opportunity Program (TEEOP) for every able-bodied, working-age adult enrolled in the Medicaid program to enable enrollees to increase their health and well-being through community engagement leading to self-sufficiency. The requirement for participation in the TEEOP program shall not apply to: (1) children under the age of 18 or individuals under the age of 19 who are participating in secondary education; (2) individuals age 55 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) individuals diagnosed with serious mental illness; (7) pregnant and postpartum women; (8) former foster children under the age of 26; and (9) individuals who are the primary caregiver for a dependent, including a dependent child or adult dependent with a disability.

The TEEOP shall include requirements for gradually escalating participation in training, education, employment and community engagement opportunities through the program as follows:
a. beginning three months after enrollment, at least 20 hours per month;
b. beginning six months after enrollment, at least 40 hours per month;
c. beginning nine months after enrollment, at least 60 hours per month; and
d. beginning 12 months after enrollment, at least 80 hours per month.

The TEEOP shall also include provisions for satisfaction of the requirement for participation in training, education, employment and community engagement opportunities through participation in job skills training; job search activities; education related to employment; general education, including participation in a program of preparation for the General Education Development (GED) certification examination or community college courses leading to industry certifications or a STEM-H related degree or credential; vocational education and training; subsidized or unsubsidized employment; community work experience; community service or public service; or caregiving services for a non-dependent relative or other person with a chronic, disabling health condition. The department may waive the requirement for participation in employment in areas of the Commonwealth with unemployment rates equal to or greater than 150 percent of the statewide average; however, requirements related to training, education and other community engagement opportunities shall not be waived in any area of the Commonwealth.

The TEEOP shall work with Virginia Workforce Centers or One-Stops to provide services to Medicaid enrollees. Such services shall include career services for program enrollees, services to link enrollees with industry certification and credentialing programs, including the New Economy Workforce Credential Grant Program, and individualized case management services.

The TEEOP shall, to the extent allowed under federal law, utilize federal and state funding available through the Temporary Assistance for Needy Families program, the Supplemental Nutrition Assistance Program, the Workforce Innovation and Opportunity Act, and other state and federal workforce development programs to support program enrollees.

Unless exempt, enrollees shall be ineligible to receive Medicaid benefits if, during any three months of the plan year, they fail to meet the TEEOP requirements and will not be permitted to re-enroll until the following plan year, unless the failure to comply or report compliance was the result of a catastrophic event or circumstances beyond the beneficiary's control.

(v) monitoring and oversight of the use of health care services to ensure appropriate utilization;

e. The State Plan amendment and the waiver program shall include (i) systems for determining eligibility for participation in the program, (ii) provisions for disenrollment if federal funding is reduced or terminated, and (iii) provisions for monitoring, evaluating, and assessing the effectiveness of the waiver program in improving the health and wellness of program participants and furthering the objectives of the Medicaid program.

f. The department shall have the authority to promulgate emergency regulations to implement these changes within 280 days or less from the enactment date of this act."

Explanation:

(This amendment adds language to provide authority for the Department of Medical Assistance Services to seek approval from the Centers for Medicare and Medicaid (CMS) to enhance Medicaid coverage to certain low income individuals pursuant to the federal Patient Protection and Affordable Care Act (ACA) within 45 days of the effectiveness of this act. Language requires DMAS to seek federal approval for a State Plan amendment, while simultaneously seeking approval for a Medicaid waiver to promote efficiency, accountability, personal responsibility, and competitive, value-based purchasing of health care to provide a model of health coverage for participants that is fiscally sustainable and cost effective. Language requires the Department of Medical Assistance Services to transform the Medicaid program for newly eligible individuals pursuant to the federal Patient Protection and Affordability Act (ACA) and the existing Medicaid program.

Language requires that DMAS submit the § 1115 demonstration application to CMS for approval no later than 180 days from the passage of this act. If the State Plan amendments are affirmatively approved by CMS prior to the submission of the waiver, Medicaid coverage for newly eligible individuals may be implemented; however, if the State Plan amendment becomes effective without affirmative action by CMS, coverage may begin upon submission of the completed § 1115 demonstration application, but no later than January 1, 2019. If the demonstration waiver cannot be completed by 180 days, despite a good faith effort to complete the application, the department may request an extension from the Chairmen of the House Appropriations and Senate Finance Committees. Language requires DMAS to provide updates on the progress of the State Plan amendments and waiver applications to the Chairmen of the House Appropriations and Senate Finance Committees upon request and provide for

participation in discussions with CMS staff. The department is required to respond to questions from the federal Centers for Medicare and Medicaid on the proposed state plan amendments and waiver application in a timely manner. Further, the agency is required to notify and submit a copy of the waiver application at least 10 days prior to federal submission to the Chairmen of the House Appropriations and Senate Finance Committees. If an objection to the waiver application is made by either Chairman, the department shall make all reasonable attempts to address the objection(s) and modify the waiver.

Language requires DMAS to include several provisions through the State Plan amendments, contracts or policy changes such as, referrals to job training, education and job placement assistance for all unemployed, able-bodied adult enrollees. In addition, DMAS is required to include provisions to foster personal responsibility and prepare enrollees for participation in commercial health insurance plans to include use of private health plans, premium support for employer-sponsored insurance, health savings accounts, appropriate utilization of hospital emergency room services, healthy behavior incentives, and enhanced fraud prevention efforts.

The demonstration waiver requires the development of a premium assistance program for individuals between 100% and 138% of the federal poverty level to obtain health insurance coverage through a private health insurance plan or through employer-sponsored coverage. It provides for a robust benefit package which includes mental health services and addiction recovery and treatment services. The premium assistance program would include the development of a deductible account for eligible individuals comprised of individual contributions and state funding, monthly individual contributions based on a sliding scale not to exceed two percent of monthly income, provisions for the date coverage begins, provisions for a grace period followed by a waiting period prior to enrollment if the premium is not paid or continuous coverage is not maintained, and provisions to recover premium payments owed through debt set-off collections. Individuals with incomes between 0 and 100% of the federal poverty level would be enrolled in Medicaid private managed care plans with existing Medicaid benefits, subject to existing Medicaid cost sharing requirements.

The waiver also requires cost sharing to encourage personal responsibility for individuals with incomes between 100% and 138% of the federal poverty level. However, individuals meeting one of nine exemptions to the Medicaid Training, Education, Employment, and Opportunity Program (TEEOP) would not be subject to cost sharing requirements more stringent than existing Medicaid law or regulations. Enrollees who comply with provisions of the Medicaid program, including healthy behaviors may receive a decrease in their monthly premiums and copayments, not to exceed 50 percent.

Language requires the waiver to include requirements that engage individuals enrolled in Medicaid in the TEEOP to enable them to increase their health and well-being through community engagement leading to self-sufficiency. Individuals meeting certain exemptions would not be subject to the TEEOP requirements; however, individuals who do not meet the TEEOP requirements three months out of the plan year would be disenrolled from the program and will not be permitted to re-enroll until the following plan year, unless the failure to comply or report compliance was the result of a catastrophic event or circumstances beyond the

beneficiary's control. Language is also added to require both the State Plan amendments and waiver application to include systems for determining eligibility for participation in the program, provisions for disenrollment if federal funding is reduced or terminated and an evaluation component for the project. Finally, language is added to authorize the agency to implement the provisions of the language prior to the completion of the regulatory process.)

New
Amendment

Item 4-14 #1h

Revenue Reserve Fund

Effective Date

Language

Language:

Page 292, line 9, strike "or June".
Page 292, line 10, strike "30, 2018,".
Page 292, line 11, after "D." insert "1.".
Page 292, line 11, after "remaining fifty percent" insert:
"from the fiscal year 2017 surplus revenues".
Page 292, after line 13, insert:
"2. The Comptroller shall reflect 100 percent of the amounts remaining from the fiscal year 2018 surplus revenues as a commitment on the preliminary balance sheet entitled Revenue Reserve to be held solely for the purposes of mitigating any loss of general fund revenues or transfers in future biennia pursuant to the provisions of House Bill 763, 2018 Session of the General Assembly, and any future appropriation acts."

Explanation:

(This amendment increases the percentage of excess fiscal year 2018 general fund revenues to be committed to the Revenue Reserve Fund established pursuant to House Bill 763, 2018 Session of the General Assembly, from 50 percent to 100 percent of the amounts remaining after other required commitments and assignments.)

Deleted
Amendment

Item 475 #1h

Central Appropriations

Central Appropriations Language

Language:

Page 190, after line 31, insert:
"BB.1. All classified employees of the Executive Branch, except those employee groups who are provided a targeted pay raise during fiscal year 2019 in this act, and other full-time employees of the Commonwealth, except elected officials and university faculty, who were employed on April 1, 2018 and remain employed until at least November 24, 2018, shall receive a one-time bonus payment equal to two percent of base pay on December 1, 2018, contingent upon additional general fund resources equaling or exceeding $32,800,000 from the combination of actual general fund revenue collections for fiscal year 2018 exceeding the official fiscal year 2018 revenue estimate contained in the first enactment of the 2016-18 appropriations act, as amended by the 2018 session of the General Assembly, and by any discretionary unspent general fund appropriations recommended by the Governor for reversion at the end of fiscal year 2018. In the event that the total of all funds provided for in this paragraph are insufficient to fully fund the general fund cost of the two percent one-time bonus payment, such bonus payment shall be prorated to a percent of base pay for the general fund payroll that equates to the amount of total general fund resources provided.

a. Employees in the Executive Department subject to the Virginia Personnel Act shall receive the bonus payment authorized in this paragraph only if they have attained an equivalent rating of at least "Meets Expectations" on their performance evaluation and have no active written notices under the Standards of conduct within the preceding twelve-month period.

2, For purposes of paying the general fund share of the December 1, 2018, one-time bonus, after meeting all Constitutionally-required deposits to the Revenue Stabilization Fund and any required deposits into the Water Quality Improvement Fund, the State Comptroller shall reserve $32,800,000 in the Restricted Fund Balance on the balance sheet for the general fund attributable to fiscal year 2018 general fund revenue collections in excess of the official revenue estimate and discretionary general fund balances recommended for reversion by the Governor, prior to designating amounts for the Committed Fund Balance.

3. The Director of the Department of Planning and Budget shall administratively increase nongeneral fund appropriations as required to implement the one-time bonus payment."

Explanation:

(This amendment provides for a one-time two percent bonus for state employees on December 1, 2018 contingent on year end June 30, 2018 discretionary general fund

balances and undesignated revenue surpluses.)