Budget Amendments Introduced – House & Senate- GA2018
As Of 022818 - House & Senate Budget Priority Reports
vaACCSES Sponsored

Explanation/Language	Patron(s)	FY19 7/1/18 – 6/30/19	FY18 7/1/19 – 6/30/20	Senate Report	House Report	Conference Report
DARS						
LTESS						
Provides $500k from the General Fund in FY19 and $1M GF in FY20 for Long-Term Employment Support Services (LTESS). Amendment provides funding to address the program's projected shortage of available funding to meet the needs of an additional 1,730 individuals placed in supported employment services in FY17. (1,730 = 4,037 placed in Competive Employment x 43% in SE in FY17)	Hanger (329#1s) Favola (329 #3s) Vogel (329 #2s) Sickles (329#2h) (Boyskco/Carr) Hope (329#8h) Pogge (329#3h)	$500k GF	$ 1.0M GF	+ $250k each year **(329 #1s)**	-0-	
Combine EES & LTESS Employment Programs (VA-APSE)	McClellan (329#8s) (Deeds/Dunnavant) Ingram (329#1h)	Language	Language	-0-	-0-	
Workgroup for LTESS & EES (Companion for SB560/Hanger & HB916/Landes) Creates Workgroup of Stakeholders to evaluate combining EES & LTESS funding into one program. Report to SFin/HAppro by Nov 1, 2018.	Hanger (329#9s) Landes (329#9h)	Language	Language	**Language (329 #2s)**	**Language (329#1h)**	
Study of Transportation Needs of Disabled Individuals (HJ 109)	Gooditis (335#1h)	$50k GF	-0-	-0-	-0-	
Vocational Rehabilitation						
Increases funds for VR services - Students This amendment provides $1.0 million from the general fund in fiscal year 2019 for the vocational rehabilitation services program to help reduce the waiting list for services. Language is added to adjust the state matching funds and federal grant amounts based in this increased funding. The added general fund may be matched with federal vocational rehabilitation funds if there are balances available to be reallocated to states. These funds will help support expanded services required under the re-authorization of the federal Workforce Innovation and Opportunity Act to provide services for students with disabilities in grades 9 through 12. As of November 1, 2017, all persons determined eligible for services by the Department for Aging and Rehabilitative Services	Marsden (329#10s) Black/Deeds/Edwards/Hanger /Lewis/Locke/Mason/McClellan/ McPike/Peake/Peterson/Spruill/ Sturtevant/Wexton) Heretick (Pogge/Orrock) (329 #4h)	$1.0M GF	-0-	-0-	-0-	

are being placed on a waiting list due to limited resources.)						
Brain Injury Services						
Increases funds for Brain Injury Services	Howell (329#4s) Sickles (329#5h)	$2M GF	$2M GF	-0-	-0-	
Increases funds for Brain Injury Case Management Services "Amendment provides funds for specialized community-based case management services to people with moderate to severe brain injuries across the Commonwealth, including those in unserved and underserved areas. According to BI Assn of VA, there are nearly 800 individuals with moderate to severe brain injuryies in the Southern, Piedmont, Northwest, Middle Peninsula, and Northern Nect who lack access to state funded core safety new services. These funds would be used to develop specialized brain injury case management funds in those areas, and provide additional funds to existing programs to address waitlists."	Edwards (329#5s)	$4.375M GF	$4.375M GR	+ $500k **(329 #3s)**	-0-	
CILS						
Expand Centers for Independent Living to Unserved Areas	Hanger (329#6s) Landes (329#6h)	$287,651 GF	$287,651 GF	-0-	-0-	
Independent Living Transition Services from Nursing Homes through CILS	Hager (329#7s) Landes (329#7h)	$334,737 GF	$334,737 GF	-0-	-0-	
DBHDS						
Staff Competencies – Supported Employment						
House Language - "R. The DBHDS and DMAS shall modify competency requirements for supported employment providers in the developmental disability Medicaid Waiver programs to allow providers that are DARS vendors that hold a national three-year accreditation from CARF be deemed qualified to meet any staff competency requirements." DBHDS staff competency requirements. DARS supported employment providers are encouraged to continually incorporate best practice staff competencies into their administrative and human resource policies and procedures	Sickles (310#1h) (Filler-Corn)	Language	Language	-0-	**Language** **(310 #2h)**	
DMAS						
Waiver Slots						

Add Reserve Waiver Slots Provides $1.3 million from the general fund and a like amount of federal matching funds each year to fund 35 reserve waiver slots in the first year and another 15 waiver slots in the second year. The introduced budget created 25 the first year and 25 in the second year. These additional slots provide for a total of 60 reserve slots in the first year and 40 in the second year. Reserve waiver slots are used to allow individuals to move between the Medicaid developmental disability waivers when a recipient's circumstances change necessitating a change in services that requires a transfer to another waiver.)	Howell (303#3s) Torian (303#1h) Guzman (303#2h)	$2,624,300 GF/NGF	$2,624,300 GF/NGF	-0- **Gov Budget includes +25 each year**	-0- **Gov Budget includes +25 each year**	
Add Waiver Slots to Eliminate Priority1 Wait List e. The Department of Medical Assistance Services (DMAS) shall amend the BI waiver to add 305 new slots effective July 1, 2018. The department shall seek federal approval for necessary changes to the BI waiver to add the additional slots." (Provides $37.7 million from the general fund and a like amount of federal Medicaid matching funds for an additional 2,296 Medicaid waiver slots to eliminate the priority one wait-list. The governor's budget included 755 Community Living (CL) and Family and Individual Support (FIS) slots in accordance with the DOJ Settlement Agreement, which does reduce the wait-list. This funding eliminates the wait-list by adding 144 CL slots, 1847 FIS slots and 305 Building Independence slots in FY 2019. The priority one wait-list includes individuals currently in need of waiver services.)	Howell (303#9s) Barker (303#12s) (Howell/McPike/Weston) Torian (303 #1h) Guzman (303 #2h)	$75,445,640 GF/NGF	$75,445,640 GF/NGF	-0- No New Slots Above Gov **825 Slots Included in Gov Intro Budget (Biennium Total)** 70 - Training Center Slots (35 each year) 75 – FIS Slots (25-FY19/50-FY20) 680 – CL Slots (325-FY19/355-FY20) (Priority 1 slots linked to passage of SB915/ Dunnavant - Demo for Managed Care – **Failed in House Appro.)**	-0- No New Slots Above Gov **825 Slots Included in Gov Intro Budget (Biennium Total)** 70 - Training Center Slots (35 each year) 75 – FIS Slots (25-FY19/50-FY20) 680 – CL Slots (325-FY19/355-FY20)	
Waiver Rates						
In-Home Support Services DMAS shall adjust the direct support wage assumption from 50% of the federal FY14 BLS included in DD Waiver Program to 90% of the FY18 BLS for NoVa and to 75% of the FY18 BLS for the Rest of State for In-Home Support Services. DMAS shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactmet date of this Act.	Howell (303 #17s) Sickles (303#5h) (J.Bell/Boysko/Bulova/ Carter/Delaney/Guzman/Hope/ Keam/Levine/Plum/Rasoul /Reid/Roem/Sullivan/Watts	$250k GF $250k NGF DBHDS Est = $10.4M GF/NGF	$250k GF $250k NGF DBHDS Est = $10.4M GF/NGF	-0-	-0-	
Waiver Group Supported Employment	Hanger (303 #24s)	$175k GF	$175k GF	-0-	-0-	

Provides funding to adjust the direct support staff wage assumption from 50%ile of the Federal Bureau of Labor Statistics (BLS) to 75%ile of the BLS included in the DD Waiver rate methodology for Rest of State (ROS) and to 90%ile of the BLS for Northern Virginia (NoVa). The Group Supported Employment rate was reduced during the DD Waiver redesign and is based on size of group vs needs of individual. Jeopardizes employment for individuals with significant disabilities that need full-time supervision in the community. A more realistic wage will assist in the recruitment and retention of competent professional staff to provide quality community-based employment.	Sickles (303#3h) (J.Bell/Boysko/Bulova/Carter Delaney/Guzman/Keam/Levine Plum/Rasoul/Reid/Roem/ Sullivan/Watts) Hope (303 #4h)	$175k NGF DBHDS est = $1.7M GF/NGF	$175k NGF DBHDS est = $1.7M GF/NGF			
Waiver Rates – NoVa Provides funding to adjust the direct support staff wage assumption from 50%ile of the Federal Bureau of Labor Statistics (BLS) to 75%ile of the BLS included in the DD Waiver rate methodology for Northern Virginia (NoVa). A "living wage" assumption will assist in the recruitment and retention of competent professional staff to provide quality community-based waiver services. The current staff wage assumption used for DD Waiver provider rates is currently based on 50%ile of the FY14 BLS. *NOTE: Working with Finance & Appro for +2.75% statewide for all waiver & restore +15% for NoVa. Similar to PC/PA ask.*	Favola (Barker/Ebbin/Marsden/ McPike/Peterson/Surovell/ Howell/Wexton) Hope (303 #6h)	$1.8M GF $1.8M NGF DBHDS Est = $18.7M GF/NGF	$1.8M GF $1.8M NGF DBHDS Est = $18.7M GF/NGF	-0-	-0-	
Rates for Agency-Based Personal Care Services The amendment provides $5.8 million each year from the general fund and a like amount of federal matching funds each year for a 2.75 percent increase in agency-directed personal care, companion and respite services in the Medicaid developmental disability waivers to be effective July 1, 2018.	Hanger (303#23s) Landes (303#19h)	$11,661,824 GF/NGF	$11,661,824 GF/NGF	-0-	**$9.8M (GF/NGF) + 1% in FY2020 (070119)** Agency & CD	
Inflation for Nonprofit Residential Psychiatric Treatment Facilities This amendment eliminates the prohibition in the budget on providing inflation to residential psychiatric treatment facilities that are operated by a nonprofit organization. State regulations authorize inflation for these providers but budget language prevents such inflation adjustments from being made. Restoring inflation to nonprofit providers results in an increase in Medicaid expenditures by $1.2 million from the general fund and a like amount of federal matching funds each year.	Peace (303#27h)	$2.4M GF/NGF	$2.4 GF/NGF	-0-	-0-	

Increase Rates for Psychiatric Professional Services Page 278, after line 4, insert "The Department of Medical Assistance Services shall review the rates paid to residential psychiatric treatment facilities and determine if those rates are appropriate for those facilities and whether or not they are comparable to other states. As part of this review the department shall assess whether an annual inflation adjustment is appropriate for these types of facilities. The department shall report its findings to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2018."	Hanger (303#19s) Peace (303#29h)	$1.342M GF/NGF	$1.342M GF/NGF	-0- **+ Language to Review Rates** (See language to left)	-0-	
Raise Outpatient rates to 100% of Medicare (VNPP) "PPP. The Department of Medical Assistance Services shall increase rates for psychiatric professional services to 100 percent of Medicare rates effective July 1, 2018. The rate paid to psychologists shall be 90 percent of physician rates and the rate for licensed clinical social workers shall be 67.5 percent of physician rates."	Hanger (303#19s) Peace (303#29h)	$671k GF/NGF	$705k GF/NGF	-0-	-0-	
Consumer-Directed Services						
Paid Sick Leave for CD Providers PPP. The Department of Medical Assistance Services shall have the authority to provide five days of sick leave each year for consumer-directed home- and community-based Medicaid providers who work an average of 20 or more hours per week, effective July 1, 2018. The department shall have the authority to implement this change prior to the completion of the regulatory process." This amendment provides $1.5 million from the general fund and $1.5 million from federal Medicaid matching funds to provide five paid days of sick leave per year to providers of consumer-directed Medicaid home-and-community-based services who work an average of 20 or more hours per week.)	Howell (303#1s) Favola (303#5s) Simon (303#26h)	$2,975,532 GF/NGF	$2,975,532 GF/NGF	-0-	-0-	
Overtime for Consumer-Directed Attendants (Start FY19) This amendment adds $9.6 million the first year from the general fund and a like amount of federal Medicaid matching funds to authorize the Department of Medical Assistance Services to pay overtime compensation to consumer directed attendants in the Medicaid waivers beginning in	Tran (303#25h)	$19,218,446 GF/NGF	-0-	-0-	-0-	

fiscal year 2019. The introduced budget provided funding and authority to pay overtime beginning in fiscal year 2020. Language is modified change the start date of the payments.						
Training Requirements for CD Attendants Page 278, after line 4, insert: "PPP. Effective July 1, 2018, the Department of Medical Assistance Services shall explore and utilize private sector technology-based platforms and service delivery options to allow qualified, licensed providers to deliver the Consumer-Directed Agency with Choice model in the Commonwealth of Virginia. The department shall work with stakeholders to develop and implement this model of care and shall submit a status report to the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2018. The department shall have the authority to amend the necessary waiver(s) and the State Plan under Title XIX of the Social Security Act to make the necessary changes. Such changes shall include the services covered, provider qualifications, medical necessity criteria, and reimbursement methodologies and rates. 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."				**Language (303 #13s)**	**($1M) Eliminates Training Requirement** **(303 #6h)**	
Eliminate Overtime for CD Attendants Eliminates the authorization and funding contained in the introduced budget for DMAS to pay overtime compensation to consumer directed attendants in the Medicaid waivers. Agency-directed care is not paid additional funding for overtime cost so this amendment maintains parity and ensures a level playing field in the marketplace. In addition, the U.S. Department of Labor significantly limits the ability to designate individuals as independent contractors, which may lead to DMAS being determined to be the employer of record for consumer directed attendants. If that occurs, paying overtime could result in the Commonwealth being responsible to provide health insurance and workers compensation for these workers.	Hanger (303#26s) Landes (303#23h)	-0-	($19,218,446) GF/NGF	**($9,609,223) (GF)** **Eliminates OT for CD PA in Gov's Introduced Budget**	**($9,609,223) (GF)** **Eliminates OT for CD PA in Gov's Introduced Budget**	
Eliminate Rate Increase for CD Personal Care Services This amendment eliminates funding and language contained in the introduced budget for the proposed 2.0 percent rate increase for consumer-directed personal care, respite, and companion	Hanger (303#27s) Landes (303#18h)	($9,546,392) GF/NGF	($10,110,204) GF/NGF	**($9,546,392) GF/NGF FY 2020**	**($10,110,204) GF/NGF FY2020**	

services.				**(303 #12s)**	**(303 #3h)**	
Medicaid Audits						
Waiver Audit Recovery – Hold Harmless Budget Report Language: "*PPP. For the period beginning September 1, 2016 until 180 days after publication and distribution of the DD Waiver provider manual by DMAS, retraction of payment from DD waiver providers following an audit by DMAS or one of its contractors is only permitted when the audit points identified are supported by the Code of Virginia, regulations, DMAS general provider manuals, or DMAS Medicaid Memos in effect during the date of services being audited.*"	McPike (Dunnavent/Howell/Surovell) (303#8s) Sickles (Filler-Corn) (303#7h) Pogge (303#8h)	Language	Language	**Language (303 #4s)** (See language at left)	**Language (303 #4h)** (See language at left)	
Modification of Appeals Process Medicaid Informal Appeals Decisions "The Department of Medical Assistance Services and the provider may jointly agree to extend the 180 day period for up to an additional period of days to facilitate settlement discussions. Page 264, line 9, after "request" strike "," and insert: "or, in the case of a joint agreement to extend the period, within that extended period,". (Implements a recommendation of the Department of Medical Assistance Services' appeals workgroup created in the 2017 Appropriation Act. The amendment allows an extension to the 180 day requirement for informal appeals decisions in order to facilitate early settlement discussions between the agency and providers.)	Sturtevant (303#15s) Stolle (303#32h)	Language	Language	**Language (303 #8s)**	**Language (303 #13h)**	
Private Duty Nursing/Skill Nursing Medical Necessity Review						
Page 278, after line 4, insert: "PPP.1. The Department of Medical Assistance Services shall work with stakeholders to review and adjust medical necessity criteria for Medicaid-funded nursing services including private duty nursing, **skilled nursing**, and home health. The department shall adjust the medical necessity criteria to reflect advances in medical treatment, new technologies, and use of integrated care models including behavioral supports. The department shall have the authority to amend the necessary waiver(s) and the State Plan under Titles XIX and XXI of the Social Security Act to				**Language (303 #7s)**	**Language (303 #12h)**	

include changes to the medical necessity criteria. The adjustments to these services shall meet the needs of members and maintain budget neutrality by not requiring any additional expenditure of general fund beyond the current projected appropriation for such nursing services. 2. The department shall have authority to implement these changes effective no later than October 1, 2018. The department shall also have authority to promulgate any emergency regulations required to implement these necessary changes within 280 days or less from the enactment date of this Act. The department shall submit a report and estimates of any projected cost savings to the Chairmen of the Senate Finance Committee and House Appropriations Committee 30 days prior to implementation of such changes. 3. The department shall work with stakeholders to review changes to services covered, provider qualifications, rates and rate methodologies for private duty nursing services and make recommendations to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2018." **Explanation (**This amendment authorizes the the Department of Medical Assistance Services (DMAS) to review and adjust the medical necessity criteria for private duty nursing services as a part of Medicaid home and community-based services (HCBS) waivers and the Medicaid Early, Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. The medical necessity criteria for private duty nursing services for individuals in HCBS waivers and those who use the EPSDT benefit has not been evaluated for many years. This review is necessary to ensure that DMAS is applying updated medical necessity criteria that reflects the advances in medical treatment, new technologies, and use of integrated care models that allow medically complex individuals to live longer, healthier lives in their homes and communities. It will also ensure this service is being utilized in a clinically appropriate and cost effective manner for all Medicaid and FAMIS members and that lower costs services such as skilled nursing, home health nursing, personal care, and behavioral supports are utilized when clinically appropriate.)						
Electronic Visit Verification						

Modification to EVV Requirement Page 277, line 21, strike "Elderly and Disabled with". Page 277, line 22, strike "Direction (EDCD)" and insert "CCC Plus Waiver". Page 277, after line 30, insert: "3. Nothing stated above shall apply to respite services provided by a DBHDS licensed provider in a DBHDS licensed program site such as a group home, sponsored residential home, supervised living, supported living or similar facility/location licensed to provide respite." Page 277, line 31, strike "3" and insert "4". **Explanation** (This amendment modifies budget language included in the introduced budget that directs the Department of Medical Assistance Services to implement electronic visit verification (EVV) as mandated in the federal 21st Century Cures Act. The federal law only required EVV for personal care services whereas the budget also requires it for companion and respite services. EVV is not intended to be used to verify service provided at a location other than the individual's home. This budget language clarifies implementation of EVV does not apply to a provider who does periodic service within their regular program setting (respite provided in a group home, a sponsored residential home, or the Reach Program.)	Howell (303#10s) Hope (303#22h)	Language	Language	**Language (303 #5s)** (See Language on Left)	**Language (303 #10h)** (See Language on Left)	
Payment Incentive for Implementation of EVV Systems PPP.1. The Department of Medical Assistance Services is authorized to require consumer directed aides providing personal care and respite care in the Medicaid Commonwealth Coordinated Care (CCC) Plus Waiver **and Developmental Disability waiver programs to utilize an Electronic Visit Verification (EVV) system.** The department is authorized to contract with a vendor to provide access to an EVV system for use by consumer-directed aides. 2. The department shall require, for personal care and respite care agencies, EVV systems comply with state and federal requirements by identifying: (i) the type of services identified in the care plan to be performed; (ii) the individual receiving the services; (iii) the date and time the service begins and ends; (iv) the location where services were delivered; (v) the individual providing services; (vi) daily back up for all data; (vii) protection of data securely and reliably; (viii) a demonstrated	Hanger (303#22s) Landes (303#21h)	$10,601,658 GF/NGF	$10,601,658 GF/NGF	-0-	-0-	

disaster recovery mechanism; (ix) that the system does not permit the modification of dates and times except for late entry documentation by a licensed health care professional; and (x) utilization of a unique identification system eliminating the requirement for hand written signatures. These provisions shall not apply to respite services provided by a DBHDS licensed provider in a DBHDS licensed program site such as a group home, sponsored residential home, supervised living, supported living or any similar facility/location licensed to provide respite. 3. The Department of Medical Assistance Services shall increase rate for agency personal care and respite care services by 2.5 percent beginning July 1, 2018. The rate increase shall be effective for agencies upon implementation of a functioning EVV system. 4. The department shall have the authority to implement these changes effective July 1, 2018, and prior to completion of any regulatory process to effect such changes."						
Priority Needs Assess – (Senate - Medicaid Expansion)						
PPP.1. Subject to appropriation by the General Assembly, it is the intent that the following high priority items in the Health and Human Resources Secretariat be considered for future implementation: (i) That the Department of Medical Assistance Services (Department) shall amend the Medicaid demonstration project (Project Number 11-W-00297/3) to (i) increase the income eligibility from 100 to 138 percent of the federal poverty level; (ii) expand program eligibility to individuals with a diagnosis of mental illness, substance use disorder, or a life-threatening or complex chronic medical condition; (iii) include in the benefit package inpatient hospital and emergency room services; and (iv) include the demonstration project in the Commonwealth Coordinated Care Plus managed care program. Such demonstration program shall be known as the Priority Needs Access Program. The total number of individuals enrolled in the Priority Needs Access Program as a result of the increase in income eligibility pursuant to clause (i) or the expansion of program eligibility pursuant to clause (ii) shall not exceed 20,000 individuals. (ii) The Department of Medical Assistance Services shall amend the Community Living waiver to add 144 new waiver slots. (iii) The Department of Medical Assistance Services shall amend the Family and				**Language (303 #15s)** **(Like SB815/ Dunnavant)**		

Individual Support waiver to add 1,847 new waiver slots. (iv) The Department of Medical Assistance Services shall amend the Building Independence waiver to add 305 new waiver slots. (v) The Department of Medical Assistance Services shall ensure that children in the Medicaid and FAMIS programs are screened for adverse childhood experiences. 2. The language in paragraph PPP.1. does not provide an appropriation to meet the requirements of the second enactment clause of Senate Bill 915." **Explanation -** This amendment provides that it is the General Assembly's intent, subject to future appropriation, to increase coverage to currently unserved populations in need of behavioral health treatment, fund waiver slots for individuals on waiting lists for Medicaid waiver services, and other safety net programs reflected in Senate Bill 915. The bill creates the Priority Needs Access Program which modifies the existing Medicaid GAP waiver to: (i) include individuals with income up to 138 percent of the federal poverty level; (ii) add inpatient and emergency room hospital benefits; (iii) add qualifying diagnoses of mental illness, substance use disorder, or life-threatening or complex medical conditions; and (iv) moves the waiver population into Medicaid managed care. In addition, it provides for 2,296 Medicaid waiver slots to eliminate the Priority One waiting list for disabled individuals in need of services. Lastly, it includes language to ensure that children in Medicaid and FAMIS are being screened for adverse childhood experiences. These items are all subject to appropriation and will not take effect until an appropriation is provided for these purposes.						
Medicaid - Other						
Adult Dental Benefit in Medicaid "PPP. The Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to include a comprehensive dental benefit for the adult population effective July 1, 2018. The department shall have the authority to promulgate regulations to implement these changes within 280 days or less from the enactment date of this act." (Provides $15.0 million general fund the first year and $18.4 million general fund the second year along with a like amount of federal Medicaid matching funds to provide an adult dental benefit in the Medicaid program. The current Medicaid program only	Barker (303#7s) Sickles (303#31h)	$29.9M GF/NGF	$29.9M GF/NGF	-0-	-0-	

provides a comprehensive dental benefit to children and pregnant women and limits all other adults to emergency care only.)						
Medicaid Supportive Housing Transfer	Dunnavant (303#32s)	$3.4M GF/NGF	$3.4M GF/NGF	-0-	-0-	
Public-Private Partnership for CVTC Page 288, after line 25, insert: "R. The Department of Behavioral Health and Developmental Services shall accept a proposal, in accordance with Chapter 22.1 of Title 56, Code of Virginia, from a private hospital to provide the necessary level of care for the residents at the Central Virginia Training Center, which could include either intermediate care or a nursing facility level of care. The department shall provide to the private hospital all relevant information, including financial information, capital assets of the training center, operational details, and information regarding the current medical and long-term care needs of the residents, in accordance with federal law, and any other information the private hospital requests to properly develop a proposal. The proposal submitted may include the leasing of state property and buildings on the site of the current training center with a primary focus on the newer facilities, and other buildings as necessary, or may include other facility options offsite from the current training center. If the proposal is financially feasible for the private hospital and meets the requirements of Chapter 22.1 of Title 56, Code of Virginia, the Secretary of Health and Human Resources shall, after reviewing the proposal, direct the department to approve the project. If the project is approved, the department shall notify the Chairmen of the House Appropriations and Senate Finance Committees within 15 days of such approval with details regarding the project, and any operational, financial and legal impacts associated with it."				**Language (310 #1s)**		
Site Assessment Work At CVTC Page 285, line 42, strike "$96,598,446" and insert "$96,848,446". Page 288, after line 25, insert: "R. Out of this appropriation, $250,000 the first year from special funds is designated to conduct the next phase of Environmental Site Assessment (ESA) at the Central Virginia Training Center to assess the presence of contaminants in the soil					**$250k GF (310 #1h)**	

and ground water from the high and medium priority findings presented in the Site Specific Environmental Conditions Assessment that was performed by EEE Consulting, Inc, in July 2017. The Department of Behavioral Health and Developmental Services shall be responsible for conducting and reporting results of the assessment by December 1, 2018, to the Governor and General Assembly. The department may request assistance from the Department of General Services in procuring the services for this assessment."						
Consumer-Directed Agency with Choice Model PPP. Effective July 1, 2018, the Department of Medical Assistance Services shall explore and utilize private sector technology-based platforms and service delivery options to allow qualified, licensed providers to deliver the Consumer-Directed Agency with Choice model in the Commonwealth of Virginia. The department shall work with stakeholders to develop and implement this model of care, and shall submit a status report to the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2018. The department shall have the authority to amend the necessary waiver(s) and the State Plan under Title XIX of the Social Security Act to make the necessary changes. Such changes shall include the services covered, provider qualifications, medical necessity criteria, and reimbursement methodologies and rates. 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."	Reeves (303#28s) Miyares (303#24h)	Language	Language	**Language (303 #13s)**	**Language (303 #11h)**	
Personal Needs Allowance Wexton Amendment provides $13.8 million from the general fund and a like amount of federal Medicaid matching funds for an increase in the personal needs allowance from $40 to $100, pursuant to SB892, for Medicaid individuals in long-term care facilities. The personal needs allowance is how much personal income a Medicaid recipient is allowed to retain each month. Simon amendment provides $13.8 million each year from the general fund and a like amount of federal Medicaid matching funds each year for an increase in the personal needs allowance from $40 to $150, pursuant to House Bill 1056, for	Wexton (303#29s) (SB893) Simon (303#16h) (HB1056)	$27,666,720 GF/NGF $25,731,522 GF/NGF	$27,666,720 GF/NGF $25,731,522 GF/NGF	-0-	-0-	

Medicaid individuals in long-term care facilities.						
Early Intervention Case Mgmt. Rates						
PPP. The Department of Medical Assistance Services shall increase the case management rate for early intervention services to $242.73 per month effective July 1, 2018." (rPovides $3.1 million GF and a like amount of Medicaid matching funds to increase the early intervention case management the rate of $132 per month to $242.73 per month to cover the cost of services. The last increase occurred in fiscal year 2013.)	Howell (303#11s) Ingram (303#30h)	$6,145,514 GF/NGF	$6,145,514 GF/NGF	-0-	-0-	
DSS						
Expand Community Employment & Training Grants "2. Out of the amounts provided in paragraph 1, $2,000,000 the first year and $2,000,000 the second year from the Temporary Assistance to Needy Families (TANF) block grant the shall be provided for a second round of grant recipients in the Employment for TANF Participants Program who did not receive awards dated June 22, 2017."	Hanger (346#5s) Sickles (346#1h) (Boysko/Carr)	$2M (TANF Funding)	$2M (TANF Funding)	**+ $2M ea yr (346 #2s)**	**+ $3M ea yr (346 #1h)**	
Increase Auxillary Rate **Senate Budget Report**: "b. Effective July 1, 2019, the Department of Social Services, in collaboration with the Department for Aging and Rehabilitative Services, is authorized to base approved licensed assisted living facility rates for individual facilities on an occupancy rate of 85 percent of licensed capacity, not to exceed a maximum rate of $1,296 per month, which rate is also applied to approved adult foster care homes, unless modified as indicated below. The department may add a 15 percent differential to the maximum amount for licensed assisted living facilities and adult foster care homes in Planning District Eight." (This amendment provides $1.0 million the second year from the general fund to raise the auxiliary grant monthly rate for adult foster care, assisted living facilities and supportive housing by $25 per month the second year of the biennium. The auxiliary grant is funded by state and local funds at a match rate of 80 percent from the state general fund and 20 percent from local funds. The introduced budget provided an increase in the auxiliary grant rate of $35 per month increase beginning July 1, 2018. This budget amendment was recommended by the Joint Commission on	Carrico (342#1s) Dance (342#2s) (Dunnavant) Tyler (343#1h) (Aird, McQuinn, Torian)	$2.28M GF	$4.56M GF	**+ 1M in FY2020** **(343 #1s)**	-0-	

Health Care.)						
Extend TANF Transitional Services This amendment provides $50,000 from the general fund and $303,187 from the federal Temporary Assistance for Needy Families (TANF) block grant each year to extend transitional services for 12 months up to 24 months for individuals who participate in the Virginia Initiative for Employment Not Welfare (VIEW) program and who are enrolled in an accredited post-secondary program for an industry recognized license or certificate program, associates degree or other college certification program. Transition services would terminate upon completion of the program.	Favola (346#2s)	$353,187	$353,187	-0-	-0-	

Medicaid Expansion – House Medicaid Transformation

Page 269, strike line 50 through 57. Page 270, strike line 1 and insert: "4.a.No later than 45 days upon the passage of House Bill 29, 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 House Bill 29, 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. 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		**Language (303 #1h)**	

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.

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 House Bill 29."

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. 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.) .			