REGULATORY REVIEW CHECKLIST

To accompany Preliminary Determination Package

Agency Department of Medical Assistance Services

Regulation title Family Planning Waiver

Purpose of the regulation To provide family planning services to non-Medicaid eligible women who were Medicaid eligible while pregnant

Summary of items attached:

☒ **Item 1:** An explanation of the specific reason for the proposed regulation.

☒ **Item 2:** A statement identifying the source of the agency legal authority to promulgate the contemplated regulations and a statement as to whether the contemplated regulation is mandated by state law or federal law or regulation, and, if mandated in whole or in part, a succinct statement of the source (including legal citation) and scope of the mandate. **(Be sure to attach a copy of all cited legal provisions).**

☒ **Item 3:** A statement setting forth the reasoning by which the agency has concluded that the contemplated regulation is essential to protect the health, safety or welfare of citizens or for the efficient and economical performance of an important governmental function.

☐ **Item 4:** A statement describing the process by which the agency has considered, or will consider, less burdensome and less intrusive alternatives for achieving the essential purpose, the alternatives considered or to be considered (to the extent known), and the reasoning by which the agency has rejected any of the alternatives considered.

/s/ Dennis G. Smith	11/3/99	11/9/99 VPS
Signature of Agency Head	Date	Date forwarded to DPB & Secretary

PRELIMINARY JUSTIFICATION FOR REGULATORY ACTION
UNDER EXECUTIVE ORDER TWENTYFIVE (98)

I. IDENTIFICATION INFORMATION

Regulation Name: Family Planning Waiver

Issue Name: Family Planning Services

VAC Numbers: 12 VAC 30-120

Registrar's Filing Deadline: _____

II. LEGAL AUTHORITY

Agency Legal Authority: Code of Virginia §§32.1-324 and 32.1-325; 42 U.S.C. §1396.

Director Approval of Action: /s/ Dennis G. Smith Nov. 3. 1999
Dennis G. Smith Date

III. JUSTIFICATION

1. Statement of Reason for Regulation

To provide family planning services (only) up to 24-months post-delivery for women who were Medicaid eligible for their prenatal care and deliveries. Presently, DMAS is permitted by federal law to extend Medicaid eligibility (for all covered services) for only 60 days to these women.

2. Federal/State Mandate and Scope

The legal authority of the Agency to administer the Medicaid Program is as stated above (II.).

Medicaid law provides a number of options for states wishing to use innovative methods for delivering or paying for Medicaid services. Since the earliest years of the Medicaid program, states have arranged for the enrollment of Medicaid recipients under contracts with health

maintenance organizations or comparable organizations. The Omnibus Budget Reconciliation Act of 1981 (OBRA '81) established two new options, freedom-of-choice (§ 1915(b) and home and community based services (§ 1915(c)), waiver programs. Under these provisions, the Secretary of Health and Human Services, through the Health Care Financing Administration (HCFA), may waive certain statutory requirements in order to allow states to develop cost-effective alternative methods of service delivery or reimbursement. The purpose of these waiver programs was to give states greater flexibility in managing their Medicaid programs.

In the case of the § 1915(b) waivers, the greater flexibility was intended to offset the temporary reduction in Federal Medicaid funding imposed by OBRA '81. The § 1915 (c) option was intended to correct a perceived "institutional bias" in Medicaid services for the chronically ill by providing states an alternative of offering a broad range of home and community-based care to persons at risk of institutionalization.

Finally, states have periodically been granted waivers of Medicaid requirements in order to conduct demonstration projects. Several statutes give the Secretary a broad authority to waive statutory requirements for Medicaid and other programs in order to conduct demonstration projects. For Medicaid purposes, the most important of these in recent years has been § 1115(a) of the *Social Security Act*, which allows the waiver of any provision of Medicaid law for demonstrations "likely to assist in promoting the objectives" of the program. A state may be exempted from compliance with the usual requirements and may receive Federal financial participation for expenditures not ordinarily eligible for Federal matching funds.

Demonstration waivers differ from the other waiver programs described above in several important ways. They are granted for research purposes, to test a program improvement or investigate an issue of interest. Projects must usually include a formal research or experimental methodology and provide for an independent evaluation. Most projects run for a limited period, no more than 3 or 4 years, and are usually not renewable. Finally, the number and subject matter of the demonstrations are generally at the discretion of the Secretary. A state does not qualify for a demonstration waiver, as it does for the 1915(b) or 1915(c) waivers, simply by meeting certain established conditions. HCFA has approved such demonstration waivers (to cover solely family planning services for poor (but non-Medicaid eligible) women) in a few other states: Maryland, Arkansas, Florida, Oregon, South Carolina, New Mexico.

The 1999 General Assembly directed DMAS, in Chapter 1024 (HB 2717), to obtain from HCFA approval of a waiver to cover family planning services for a longer postpartum period of time than is now required by federal law. This service is to be directed to women who were Medicaid-eligible for prenatal care and delivery. Current policy provides that once these women deliver their babies and pass the federally mandated 60-day period of eligibility, barring their meeting any other qualified group's standards, they lose their Medicaid eligibility. Services for family planning-only will begin at 60 days postpartum and continue for a period of twenty-two months if the women continue to meet the financial eligibility requirements for pregnant women under Medicaid.

This legislation requires that the agency request a waiver from HCFA to extend Medicaid eligibility for purposes of providing only family planning services. The services will become effective within three months of federal approval of the waiver should it be granted. Should HCFA approval not

be granted, DMAS expects to seek the administration's direction on the continued implementation of this service or the termination of the rule making process.

DMAS estimates family planning expenditures for this targeted population to be $942,464 for FY 2000 and $3,756,098 for FY 2001. Medicaid family planning services are reimbursed by HCFA at 90% federal funds. These cost estimates assume this rate of federal matching and are adjusted for population turnover and onset of federal funding.

DMAS has estimated that administrative costs would approximate $195,000 for waiver preparation and computer system modifications. Administrative costs are also eligible for the 90% federal matching rate. A confounding factor in implementing this additional service will be the significant but necessary computer system modifications when the DMAS fiscal agent's resources are dedicated to Y2K compliance issues.

3. Essential Nature of Regulation

This regulation is essential for the protection of the health of these affected women because it creates a new health care service previously unavailable by establishing the limits and requirements of this new family planning service. For purposes of this waiver, family planning services will be defined as only those services that delay or prevent pregnancy, other than abortions. Abortions are specifically excluded from coverage by the referenced legislation. Services and drugs that promote or result in pregnancy will not be covered.

This new waiver service will affect local departments of social services because they will have to annually review these women's income and resources to determine if they continue to meet the Medicaid limitations.

4. Agency Consideration of Alternatives

Due to the legislative mandate, the agency has no discretion in whether or not to implement this special service or in the service design due to the highly prescriptive nature of the legislation. The Agency will consider any alternatives identified through the public comment process. The only exception would be HCFA's refusal to approve the waiver request.

5. Family Impact Assessment (Code of Virginia §2.1-7.2)

Under current policy, these poor women lose their Medicaid eligibility after 60 days postpartum (assuming they do not meet any other eligibility category's requirements). Consequently, they also lose their access to publicly funded health care (including family planning) services. These poor women will have access to publicly funded family planning services for an additional 22 months upon HCFA approval of the demonstration waiver and the completion of the Administrative Process Act.