Virginia Regulatory Town Hall

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Fast Track Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) citation	12 VAC 30-20-210, 12 VAC 30-40-10, 12 VAC 30-130-750 and 790
Regulation title	General conditions of eligibility, State method on cost effectiveness of employer-based group health plans.
Action title	HIPP Program Modifications
Date this document prepared	

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 36 (2006) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary (no more than 2 short paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes.

The Department of Medical Assistance Services (DMAS) is proposing to amend regulations for the Health Insurance Premium Payment (HIPP) program to change the participation requirement from a mandatory requirement and a condition of Medicaid eligibility, to an optional program. In 1997 the federal statute governing HIPP, Sec. 1906 **[**42 U.S.C. 1396e**],** was amended to make the program optional. The mandatory requirement is inefficient, administratively time consuming and does not result in additional cost savings to the State. The regulations would also be amended to expand the eligibility requirement to allow family members who are not living in the same household but who have coverage under the group health plan to participate in HIPP.

Statement of final agency action

Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency taking the action, and (3) the title of the regulation.

I hereby approve the foregoing Regulatory Review Summary with the attached amended Virginia Administrative Code pages for 12VAC30-40-10, General conditions of eligibility; 12VAC30-20-210 State Method on cost effectiveness of employer based group health plans under Sec. 1902(a)(25) and 1906(a)(1) of the Act; 12VAC30-130-750, Time frames for determining cost effectiveness; 12VAC30-130-790, Information required of applicants and recipients, and adopt the action stated therein. I certify that this final regulatory action has completed all the requirements of the Code of Virginia § 2.2-4012.1, of the Administrative Process Act.

_____ _____

Date Patrick W. Finnerty, Director

Dept. of Medical Assistance Services

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the scope of the legal authority and the extent to which the authority is mandatory or discretionary.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

In 1990, in an effort to achieve Medicaid cost savings, Congress added Section 1906 to the Social Security Act, to provide for the *mandatory* enrollment of Medicaid eligibles in cost effective group health plans as a condition of Medicaid eligibility. States were required to pay premiums, deductibles, and coinsurance on behalf of Medicaid beneficiaries eligible for enrollment in employer-based group health plans when it is was determined cost-effective to do so. Thus the Health Insurance Premium Payment (HIPP) program was born. However, as a result of low enrollments and difficulties encountered by states with implementing the

requirements, Section 4741 of the Balanced Budget Act (BBA) of 1997 amended 1902(a)(25) and 1906(a)(1) of the Act making this provision optional, effective August 5, 1997.

The purpose of this regulatory change is to amend current Medicaid regulations to remove the requirement for enrollment in an employer-based group health plan, if such plan is available to the individual and is cost effective, as condition of Medicaid eligibility. The DMAS believes that the proposed amendment of current regulations contributes to preserving the health, safety, and welfare of the citizens of the Commonwealth.

Rationale for using fast track process

Please explain the rationale for using the fast track process in promulgating this regulation. Why do you expect this rulemaking to be noncontroversial?

Please note: If an objection to the use of the fast-track process is received within the 60-day public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, the agency shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

The fast track process is being utilized to promulgate this change in regulatory language as it is expected to be a non-controversial amendment to existing regulations. The result of the change would relieve the current administrative burden to obtain and process HIPP applications placed on Medicaid applicants, employers, DSS eligibility staff and HIPP unit staff that do not result in increased cost savings to the state. Additionally, the workload decrease for application processing would likely result in the program being more cost effective as a result of lower administrative costs. Reducing the administrative time required by this regulation would immediately increase the time available for HIPP and DSS eligibility staff to complete existing application processing requirements and reduce or eliminate the potential for increasing staff as a result of increased workloads.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (Provide more detail about these changes in the "Detail of changes" section.)

The sections of the Virginia Administrative Code regarding Medicaid policy that are affected by this action are 12VAC30-40-10, General conditions of eligibility and 12VAC30-20-210, State method on cost effectiveness of employer-based group health plans §1902(a)(25) and 1906(a)(1) of the Act, 12VAC30-130-750, Time frames for determining cost effectiveness, 12VAC30-130-780, Good cause failure to cooperate, and 12VAC30-130-790, Information required of applicants and recipients.

The current HIPP regulations require as a condition of Medicaid eligibility, that a Medicaid applicant or enrollee who has access to employer group health insurance must complete a HIPP application and enroll the Medicaid eligible household members in the employer's health insurance if it is determined to be cost effective. Cost effective means that it is likely to cost the state less to pay the employee's share of the health insurance premium and any cost sharing items for the Medicaid eligible household members, than it would cost otherwise under Medicaid.

All applicants or enrollees must complete a HIPP application when a member of the household is working 30 hours or more a week and has access to employer sponsored health insurance. In addition to the HIPP application form, an Employer Insurance Verification must be completed by the employer. The HIPP application forms are forwarded to DMAS HIPP unit staff to determine program eligibility, perform a cost effectiveness evaluation and enroll in the HIPP program if eligible.

The current mandatory requirement for HIPP is administratively burdensome, time consuming and inefficient for the Dept. of Social Services (DSS) eligibility staff, the DMAS HIPP unit staff, the Medicaid applicant/enrollee and employer. A significant amount of administrative time is expended to obtain and process HIPP applications as a result of this mandatory requirement. Seventy percent of these HIPP applications received by DMAS result in a denial, primarily because the Medicaid application does not coincide with the employer's health insurance open enrollment period. As a result DMAS loses much of the savings this program is projected to achieve. Changing the HIPP program to an optional program will result in a reduction of wasted administrative efforts on behalf of applicants, employers, DSS eligibility staff and DMAS HIPP unit staff. Individuals will still be able to apply for the HIPP program on a voluntary basis. As a voluntary program, the number of applications would decrease to only those cases where the Medicaid eligible child is enrolled in the employer health plan or is being added to the plan during the open enrollment period. Cost savings to the state will continue for those Medicaid applicants/enrollees who desire to participate requiring less administrative effort while reducing the efforts currently expended with requiring everyone to apply even if they are not able to currently enroll in the health plan.

With the change to make the HIPP program optional, recipient eligibility should be expanded to include any Medicaid eligible family member covered under the employer's health insurance regardless of whether they reside in the same household. Currently as a mandatory requirement, all household members residing in the same household who were eligible for coverage under the group health plan and eligible for Medicaid are eligible for consideration for HIPP. Medicaid enrollees who do not reside in the same household as the family member who had access to employer health insurance are not eligible to participate in HIPP. With the proposed change to expand recipient eligibility, if a family member moved out of the household, eligibility for HIPP participation could continue.

Nearly 20% of the current enrollees are disabled adults, who are eligible to continue health insurance coverage on their parent's health plan as a result of meeting certain disability criteria. Currently, if the disabled adult elects to move out of the household, they would no longer remain eligible for enrollment in the HIPP program. The premise of the HIPP program is to enroll

Medicaid eligible family members in an employer's group health plan when it is cost effective to do so. Whether a family member lives in the same household as the policy holder has no bearing on whether the employer health insurance plan is cost effective. Therefore this regulation makes a change to permit an adult disabled child who remains eligible under a parent's health insurance plan after they turn 18 to remain eligible for HIPP even if they move out of their parent's home into their own residence or a group home setting. Individuals would be able to continue medical care with existing providers who have in many cases provided care throughout the individual's lifetime. For children in situations where parents separate or divorce and leave the household, the child would be able to continue care under current medical providers. If the employer health insurance is dropped, the child would most likely be enrolled in a Medicaid Managed Care Organization with new medical provider. Medical continuity of care would be lost.

This regulation change has little impact on the HIPP program and would clarify current regulations regarding eligibility requirements and improve program operations. The change would provide greater stability and retention in employer's health insurance coverage. The regulation changes in 12VAC30-130-750, Time frames for determining cost effectiveness and 12VAC30-130-790, Information required of applicants and recipients is a clarification of existing policy.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.
If there are no disadvantages to the public or the Commonwealth, please indicate.

There are no disadvantages to the public or the Commonwealth in this regulation. The advantage is to applicants and employers who would no longer be required to complete an HIPP forms unnecessarily; eligibility and HIPP unit staff would not be burdened with obtaining and processing applications in which a majority were denied because the Medicaid eligible household member was not enrolled and/or could not enroll in the employer's health plan.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

There are no requirements in this proposal that are more restrictive than federal requirements.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

No localities are particularly affected by this change as implementation is statewide.

Regulatory flexibility analysis

Please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

There is no adverse impact on small business.

Economic impact

Please identify the anticipated economic impact of the proposed regulation.

There should be no budgetary or fiscal impact to the Medicaid Program. The changes would eliminate and/or administrative requirements that would provide staff with additional time to perform other requirements.

Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source / fund detail, and (b) a delineation of one-time versus on-going expenditures	No projected costs associated with this package.
Projected cost of the regulation on localities	No projected costs on localities associated with this package.
Description of the individuals, businesses or other entities likely to be affected by the regulation	The greatest impact of this regulation will be the savings of administrative time that can be re-directed by DMAS and DSS to providing eligibility decisions in a quicker and more efficient manner.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than	The major impact will be upon DSS and DMAS, two Virginia State agencies.

500 full-time employees or has gross annual sales of less than $6 million.	
All projected costs of the regulation for affected individuals, businesses, or other entities. Please be specific. Be sure to include the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses.	The impact of this change will be in administrative time savings, with no anticipated fiscal impact.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in §2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

DMAS determined after reviewing Medicaid Program regulations, that there were no alternatives that reduce the current administrative workload required to identify and enroll Medicaid eligible household members in employer group health insurance when it was determined cost effective.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

These changes would strengthen the authority or rights of parents in the education, nurturing, and supervision of their children; encourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not erode the marital commitment. It may increase disposable family income for low income families by allowing them to retain additional income that otherwise would have been expended for health insurance coverage for household members not eligible for coverage under Medicaid.

Detail of changes

Please detail all changes that are being proposed and the consequences of the proposed changes. Detail all new provisions and/or all changes to existing sections.

If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all changes between the pre-emergency regulation and the proposed regulation, and (2) only changes made since the publication of the emergency regulation.

Regulatory cite	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
12VAC30-40-10	N/A	Mandatory requirement for Medicaid applicants with available group health plan coverage to apply for HIPP program for cost-effectiveness determination. Where such enrollment is cost-effective, it is a condition of eligibility.	Makes application for HIPP optional instead of mandatory.
12VAC30-20-210	N/A	"Case" means all persons who are living in the same household who are eligible for coverage under the group health plan and who are eligible for Medicaid.	"Case" means all family members who are eligible for coverage under the group health plan and who are eligible for Medicaid.
12VAC30-20-210 1. Definitions	N/A	No current definition of "Family member."	Adds definition of "Family member" to include any individuals who are related by blood, marriage or adoption, regardless of whether they live in the home.
12VAC30-20-210 1. Definitions	N/A	Definition of "group health plan."	Expands "group health plan" to include self-employed persons who have access to group health insurance for themselves and their family members.
12VAC30-20-210 1. Definitions		No current definition of "Premium assistance."	Adds definition of "Premium assistance"
12VAC30-20-210 2. Program Purpose	N/A	A. To identify cases in which enrollment of a recipient in an available group health plan is likely to be cost effective;	A. To enroll recipients who have an available group health plan that is likely to be cost effective;
12VAC30-20-210 2. Program Purpose	NA	B. Requires recipients to enroll in available group health plan as a condition of Medicaid	Repeals this regulation because it's no longer required.

		eligibility	
12VAC30-20-210 2. Program Purpose	N/A	3. HIPP coverage open to all persons who are living in the same household.	Expands HIPP to all family members regardless of where they live.
12VAC30-20-210 4. Application Required.	N/A	4. Requires HIPP application to be filed, requires cooperation, and describes procedures for non-cooperation.	4. Simply requires that if intend to participate in HIPP, the application must be filed with DMAS.
12VAC30-20-210 4. Condition of Medicaid Eligibility	N/A	4. Mandatory requirements regarding HIPP application where group health plan is available and requirements for cooperation.	Removes these requirements
12VAC30-20-210 5.C. Evidence of Enrollment Required	NA	C. States that coverage may include non-Medicaid eligible family members.	C. Clarifies that DMAS will not cover cost-sharing (co-insurance and deductibles) for non-Medicaid eligible family members.
12VAC30-20-210 5. D. Evidence of Enrollment Required.	NA	D. Evidence of enrollment required to be sent to DSS.	D. Evidence of enrollment required to be sent to DMAS.
12VAC30-20-210 10. HIPP Program Phase-in.	NA	10. HIPP Program Phase-in across the Commonwealth.	Remove regulation as Phase-in reference no longer needed.
12VAC30-130-750. Time frames for determining cost effectiveness.	NA	DMAS shall determine cost effectiveness of the group health plan and shall provide notice to the recipient within 45 days from the date the completed Insurance Information Request Form is received from DSS.	Clarifies that DMAS shall determine HIPP eligibility within 45 days where the application contains all information necessary for the determination.
12VAC30-130-750. Time frames for determining cost effectiveness.		States that HIPP applications are held by DMAS for 30 days while recipient gathers an	Clarifies that once missing information is requested, DMAS shall dismiss the application after 30 days if the information is not

		missing information.	provided.
12VAC30-130-780. Good cause for failure to cooperate.	NA	Specifies what constitutes good cause for failure to cooperate with HIPP process.	Removes this section as no longer necessary.
12VAC30-130-790 Information required of applicants and recipients	NA	All applicants and recipients shall be required to provide all the information contained in the DMAS form Insurance Information Request Form.	All applicants and recipients shall be required to provide the information required on the prescribed DMAS HIPP applications forms and all requested information to determine eligibility and cost effectiveness.