



**COMMONWEALTH of VIRGINIA**  
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**MEMORANDUM**

**TO:** EMILY MCCLELLAN  
Regulatory Supervisor  
Department of Medical Assistance Services

**FROM:** JENNIFER L. GOBBLE *JLG*  
Assistant Attorney General

**DATE:** March 29, 2019

**SUBJECT:** Emergency Regulations – Medicaid Expansion-Related Changes  
(Expansion Group; FMAP; HIPP; Determination State; SNAP)

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I have reviewed the attached emergency regulations that would make changes necessary to implement Medicaid expansion in accordance with the directive in the 2018 *Acts of Assembly*, Chapter 2, Item 303.SS.4(a), to “amend the State Plan for Medical Assistance under Title XIX of the Social Security Act, . . . 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.” The emergency regulations combine in one regulatory package several of the Medicaid expansion-related state plan amendments required by the Centers for Medicare and Medicaid Services (CMS). The expansion-related state plan amendments that are the subject of this regulatory action are described in the agency background document and have been approved by CMS.

Based on my review, it is this Office’s view that the Director of the Department of Medical Assistance Services, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code § 32.1-324, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Virginia Administrative Process Act (VAPA), and has not exceeded that authority.

The authority for this emergency action is found in Virginia Code § 2.2-4011(B), which provides that agencies may adopt emergency regulations in situations in which Virginia statutory law or the appropriation act or federal law or federal regulation requires that a regulation be effective in 280 days or less from its enactment and the

regulation is not exempt under the provisions of subdivision A.4 of Virginia Code § 2.2-4006.

Pursuant to Virginia Code § 2.2-4012, the attached emergency regulations shall become effective upon approval by the Governor and filing with the Registrar of Regulations. In addition, the emergency regulations shall be effective for no more than 18 months. If the Department intends to continue regulating the subject matter governed by these emergency regulations beyond 18 months, it will be necessary to replace these emergency regulations with regulations promulgated in accordance with Article 2 of the VAPA. A Notice of Intended Regulatory Action relating to the proposed replacement regulations must be filed with the Registrar within 60 days of the effective date of the emergency regulations. The proposed replacement regulations must be filed with the Registrar within 180 days after the effective date of the emergency regulations. Va. Code § 2.2-4011(C).

If you have any questions or need any additional information, please feel free to contact me at 786-4905.

cc: Kim F. Piner  
Senior Assistant Attorney General

## Emergency Text

Action:

Expansion-Related Changes - Expansion Group, FMAP, HIPP, ...

Stage: Emergency/NOIRA

3/27/19 2:37 PM [latest]

Part I

Single State Agency Organization

### **12VAC30-10-10. Designation and authority.**

A. The Department of Medical Assistance Services is the single state agency designated to administer or supervise the administration of the Medicaid program under Title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this subsection.)

12VAC30-20-10 is a certification signed by the State Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program.

B. The entire plan under Title XIX is administered or supervised by the state agency named in subsection A of this section.

C. No waivers of the single state agency requirements have ever been granted.

~~D. Determinations of eligibility for Medicaid under this plan are made by the agency or agencies specified in 12VAC30-30-10. There is a written agreement between the agency named in subsection A of this section and other agencies making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.~~

#### D. Eligibility determinations (including any delegations).

1. The entities that conduct determinations of eligibility for families, adults, and individuals under 21 are DMAS, the single state agency under Title IV-A (TANF), and the Exchange which is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act (the Exchange).

2. The entities that conduct determinations of eligibility based on age, blindness, and disability are DMAS and the single state agency under Title IV-A (TANF).

3. DMAS makes the following assurances with regard to eligibility determinations:

a. DMAS is responsible for all Medicaid eligibility determinations.

b. There is a written agreement between DMAS, the Exchange, and the single state agency under Title IV-A. The Exchange and the single state agency under Title IV-A have been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

c. DMAS does not delegate authority to make eligibility determinations to entities other than government entities which maintain personnel standards on a merit basis.

d. The delegated entity is capable of performing the delegated functions. —

E. All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under Title XI of the Act.

F. All other requirements of 42 CFR 431.10 are met.

### **12VAC30-10-20. Organization for administration.**

A. 12VAC30-20-20 contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

B. Within the state agency, the Department of Medical Assistance Services has been designated as the medical assistance unit. 12VAC30-20-30 contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

C. 12VAC30-20-40 contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

D. Eligibility determinations are made by ~~state or local staff of an agency other than the agency named in 12VAC30-10-10 A~~ entities identified in 30-10-10 D.

## Part II

### Coverage and Eligibility

#### **12VAC30-10-60. Application; determination of eligibility and furnishing Medicaid.**

A. The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility and furnishing Medicaid.

B. 1. Except as provided in subdivisions 2 and 3 of this subsection, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in 12VAC30-40-10.

2. For individuals who are eligible for Medicaid cost sharing expenses as qualified Medicare beneficiaries under § 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. 12VAC30-40-10 specifies the requirements for determination of eligibility for this group.

3. Pregnant women are not entitled to ambulatory prenatal care under the plan during a presumptive eligibility in accordance with § 1920 of the Act. 12VAC30-40-10 specifies the requirements for determination of eligibility of this group.

C. The Medicaid agency elects to enter into a risk contract with an HMO that is qualified under Title XIII of the Public Health Service Act or is provisionally qualified as an HMO pursuant to § 1903(m)(3) of the Social Security Act (42 USC § 1396(m)).

The Medicaid agency elects to enter into a risk contract with an HMO that is not federally qualified, but meets the requirements of 42 CFR 434.20(c) and is defined in 12VAC30-20-60.

D. The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income, pregnant women, infants, and children under age 19, described in § 1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the Title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA the Centers for Medicare and Medicaid Services (CMS) instructions.

E. The state elects the option to use income determined by the following means-tested public benefits program to support Medicaid eligibility determinations: Supplemental Nutrition Assistance Program (SNAP).

1. In electing this option, the state assures that it:

a. Verifies citizenship and non-citizen status consistent with Medicaid statutory and regulatory requirements in Section 1137 of the Social Security Act, 42 CFR 435.406, and 435.407.

b. Complies with Medicaid reporting requirements with respect to participants enrolled through this strategy.

c. Provides applicants with program information required under 42 CFR 435.905, such as information about available services and the rights and responsibilities of applicants and beneficiaries.

d. Has procedures to ensure that eligible individuals are enrolled in the appropriate Medicaid eligibility group.

e. Has procedures to ensure that eligible American Indians or Alaska Natives enrolled through this strategy are exempt from cost sharing/and or premiums, consistent with section 1916 A(b)(3) of the Social Security Act.

f. Has post-enrollment procedures to ensure assignment of rights to third party benefits and to secure cooperation in establishing medical support as appropriate, per 42 CFR 435.610.

2. The state will use gross income determined by SNAP to support Medicaid eligibility determinations for all modified adjusted gross income (MAGI) based Medicaid eligibility groups at initial application. In applying this option, all of the following conditions are met:

a. All members of the SNAP household are eligible for SNAP, other than for

SNAP transitional benefits.

b. No one in the SNAP household has any type of income that is excluded in determining gross income for purposes of eligibility for SNAP, but would be included in MAGI-based income.

c. No one in the SNAP household is part of a tax household that includes an individual who lives outside the home.

d. The SNAP household consists of individuals who live alone, parents living with their children, or married couples (with or without children), with the result that they will also be considered a household under Medicaid rules and either:

(1) There are no other members present who would not be considered to be part of the household used for purposes of determining MAGI- based Medicaid eligibility; or

(2) Other members are present in the household, but the total household income is below the applicable Medicaid standard for a household of one.

e. Households with self-employment income are excluded from this option. The state uses a methodology for treating self-employment income that differs from the standard SNAP methodology. The treatment of income from self-employment is found at M0440.100.B.3 of the Virginia Medical Assistance Eligibility Manual located at <http://www.dmas.virginia.gov/#/assistance>.

f. None of the household's income is excluded from gross income as payment of child support for children living outside of the household. (Virginia does not exclude payment of child support for children from gross income when determining eligibility for SNAP.)

g. The state obtains all information necessary for a Medicaid eligibility determination that is not contained in the case record for SNAP. If available, electronic data sources are consulted before paper documentation is requested.

### 3. Collection of Information to Determine Eligibility

a. The state collects information to ensure that no one in the SNAP household is part of a tax household that includes an individual who lives outside the home:

(1) Information is available through electronic data sources. Information is collected on the application or renewal form for the means-tested program.

(2) The state agency provides a form to the individual to complete and return.

b. The state identifies individuals who have income which is counted in determining household income using MAGI-based methodologies but is not included in SNAP gross income by providing a form for the individual to complete and return. This includes, but may not be limited to income received through an AmeriCorps Education Award income from a minor dependent child above the applicable tax filing threshold.

c. The state obtains a signature whether physical, electronic, or telephonic authorizing a determination of Medicaid eligibility as required under 42 CFR 435.907(f). The state allows the authorization form to be completed on paper, by telephone, and electronically.

### **12VAC30-10-410. Hearings for applicants and recipients.**

A. The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR 431, Subpart

E. The Medicaid agency is responsible for all Medicaid fair hearings.

No termination of coverage under § 1925 shall be effective earlier than 10 days after the date of mailing of the notice required by § 1925(b)(3)(B).

B. The entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are DMAS and the Health and Human Services appeals entity, the Exchange.

C. The state assures the following with respect to delegations of authority to conduct fair hearings regarding eligibility based on MAGI:

1. There is a written agreement between DMAS and the Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

2. When authority is delegated to the Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their hearing conducted instead by DMAS.

3. DMAS does not delegate authority to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

4. The delegated entity is capable of performing the delegated function.

D. All fair hearings not related to an eligibility determination based on MAGI are conducted at DMAS.

#### **12VAC30-20-205. Health Insurance Premium Payment (HIPP) for Kids.**

A. Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise:

"Case" means all family members who are eligible for coverage under the group health plan ~~qualified employer-sponsored insurance plan~~ and who are eligible for Medicaid.

"Code" means the Code of Virginia.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"DSS" means the Department of Social Services consistent with Chapter 1 (§ 63.2-100 et seq.) of Title 63.2 of the Code of Virginia.

"Family member" means an individual in the household, who is not a parent, who are related by blood, marriage, or adoption, or legal custody.

"Group health plan" means a plan which meets § 5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to Title XXII of the Public Health Service Act, § 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974. Section 5000(b)(1) of the Internal Revenue Code provides that a group health plan is a plan, including a self-insured plan, of, or contributed to by, an employer (including a self-insured person) or employee association to provide health care (directly or otherwise) to the employees, former employees, or the families of such employees or former employees, or the employer.

"High deductible health plan" means a plan as defined in § 223(c)(2) of the Internal Revenue Code of 1986, without regard to whether the plan is purchased in conjunction with a health savings account (as defined under § 223(d) of the Internal Revenue Code of 1986).

"HIPP" means the Health Insurance Premium Payment Program administered by DMAS consistent with § 1906 of the Act.

"HIPP for Kids" means the Health Insurance Premium Payment Program administered by DMAS consistent with § 1906A of the Act.

"Member" means a person who is eligible for Medicaid as determined by DMAS, or a DMAS designated agent, or including the Department of Social Services.

"Network Provider" means a provider who is enrolled with one of DMAS contracted managed care organizations (MCO) as a provider, and meets the requirement for an expedited enrollment as a fee-for-service (FFS) Medicaid provider for payment and billing purposes.

"Parent" means the biological or adoptive parent or parents, or the biological or adoptive parent and the stepparent, living in the home with the Medicaid-eligible child. The health insurance policyholder shall be a parent as defined herein.

"Payee" means the insured employee who is the policy holder of the qualified employer-sponsored insurance plan who is paid the HIPP or HIPP for Kids premium and cost sharing reimbursement.

"Premium" means the fixed cost of participation in the group health plan qualified employer-sponsored insurance plan, which cost may be shared by the employer and employee or paid in full by either party.

"Premium assistance subsidy" means the amount that DMAS will pay of the employee's cost of participating in the qualified employer-sponsored ~~coverage~~ insurance plan to cover the Medicaid eligible member or members under age 19 if DMAS determines it is cost effective to do so.

"Qualified employer-sponsored coverage insurance" as defined in section 2105(c)(10)(B) of the Social Security Act means a group health plan or health insurance coverage offered through an employer:

1. That qualifies as creditable coverage as a group health plan under § 2701(c)(1) of the Public Health Service Act;
2. For which the employer contribution toward any premium for such coverage is at least 40%; and
3. That is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of paragraph (3)(A)(ii) of § 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

"State Plan" means the State Plan for Medical Assistance for the Commonwealth of Virginia.

B. Program purpose. The purpose of the HIPP for Kids program shall be to:

1. Enroll members who are eligible for coverage under a qualified employer-sponsored ~~coverage~~ insurance plan.
2. Provide premium assistance subsidy for payment of the employee share of the premiums and other cost-sharing obligations for the Medicaid-eligible child under age 19. In addition, to provide cost sharing for the child's ~~noneligible~~ parent who is not Medicaid-eligible for items and services covered under the qualified employer-sponsored ~~coverage~~ insurance that are also covered services under the State Plan. There is no cost sharing for parents for services not covered by the qualified employer-sponsored ~~coverage~~ insurance.
3. Treat coverage under such ~~employer-group health plan~~ qualified employer-sponsored insurance plan as a third party liability consistent with § ~~1902(a)(25)~~ 1906 of the Social Security Act.

C. Cost Effectiveness Methodology

1. DMAS shall evaluate the member to determine the appropriate managed care organization (MCO) capitation rate to be used. The capitation rate will be determined based on aid category, nursing facility/waiver eligibility, age, gender, and region.

2. DMAS shall adjust the capitation rate to exclude Medicaid services that are not available through commercial group health insurance policies. This requires that the capitation rate be adjusted to exclude services including, but not limited to, nursing facility and long term services and supports provided in the Commonwealth Coordinated Care (CCC) Plus program as well as community mental health services and non-emergency transportation services available in CCC Plus and Medallion.

3. DMAS shall adjust the reduced capitation rate from paragraph 2 to reflect the higher prices employer plans pay. The Virginia price factor shall be based on the national factor of 1.3 that is published by the Centers for Medicare and Medicaid Services (CMS).

4. The qualified employer-sponsored insurance plan cost for the member shall be increased to reflect the amount of coinsurance and other member cost sharing typically imposed on HIPP members and paid by DMAS. Such amount shall be determined by averaging the aggregate amount of such expenditures by DMAS in the most recently completed fiscal year by the number of HIPP members covered during the fiscal year.

5. The qualified employer-sponsored insurance plan cost determined in subdivision C 4 shall be increased to reflect DMAS's administrative expenses directly related to the HIPP program. This additional cost is determined based on the average total monthly compensation paid to each HIPP analyst employed by DMAS divided by the anticipated caseload.

6. The cost effectiveness shall be affirmed if the adjusted capitation rate from subdivision C 3 equals or exceeds the adjusted qualified employer-sponsored insurance plan cost from subdivision C 5.

C. D. Member eligibility. DMAS shall obtain specific information on qualified employer-sponsored coverageinsurance available to the members in the case including, but not limited to, the effective date of coverage, the services covered by the plan, the deductibles and copayments required by the plan, and the amount of the premium paid by the employer and employee. Coverage that is not comprehensive shall be denied premium assistance. A qualified employer-sponsored insurance plan must provide the following services in order to be considered comprehensive:

1. Physician services;
2. In and out patient hospitalization;
3. Outpatient labs, shots, and x-rays;
4. Prescription drugs

All Medicaid-eligible family members under the age of 19 who are eligible for coverage under the qualified employer-sponsored coverageinsurance shall be eligible for consideration for HIPP for Kids except the following:

1. The member is Medicaid-eligible due to "spenddown"; or
2. The member is currently enrolled in the qualified employer-sponsored coverageinsurance and is only retroactively eligible for Medicaid.

D. E. Application required. A completed HIPP for Kids application must be submitted to DMAS to be evaluated for program eligibility. The HIPP for Kids application consists of the forms prescribed by DMAS and any necessary information as required by the program to evaluate eligibility and determine if the plan meets the criteria for qualified employer-sponsored coverageinsurance.

E. F. Exceptions. The term "qualified employer-sponsored coverageinsurance" does not include coverage consisting of:

1. Benefits provided under a health flexible spending arrangement (as defined in § 106(c)(2) of the Internal Revenue Code of 1986) or
2. A high deductible health plan (as defined in § 223(c)(2) of the Internal Revenue Code of 1986), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under § 223(d) of the Internal Revenue Code of 1986).
3. For self-employed individuals, qualified employer-sponsored coverageinsurance obtained through self-employment activities shall not meet the program requirements unless the self-employment activities are the family's primary source of income and the insurance meets the requirements of the definition of qualified employer-sponsored coverage in subsection A of this section. Family for this purpose includes family by blood, marriage, or adoption.

F. G. Payments. When DMAS determines that a qualified employer-sponsored coverageinsurance plan is eligible and other eligibility requirements have been met, DMAS shall provide for the payment of premium assistance subsidy and other cost-sharing obligations for items and services otherwise covered under the State Plan, except for the nominal cost-sharing amounts permitted under § 1916 of the Social Security Act.



1. Effective date of premium assistance subsidy. Payment of premium assistance subsidies and other cost-sharing obligations shall become effective on the first day of the month in which DMAS receives a complete HIPP application or the first day of the month in following an approved application for which qualified employer-sponsored coverage insurance becomes effective, whichever is later. Payments shall be made to either the employer, the insurance company, or the individual who is carrying the group health plan qualified employer-sponsored insurance plan coverage.

2. Payments for deductibles, coinsurances, and other cost-sharing obligations.

a. Medicaid eligible children under age 19 pursuant to § 1906A of the Act. The Medicaid agency pays all premiums, deductibles, coinsurance, and other cost-sharing obligations for items and services covered under the State Plan, as specified in the qualified employer-sponsored coverage insurance, without regard to limitations specified in § 1916 or § 1916A of the Act, for eligible individuals under age 19 who have access to and elect to enroll in such coverage. The eligible individual is entitled to services covered by the State Plan that are not included in the qualified employer-sponsored coverage insurance.

b. In order to receive reimbursement, the individual shall submit to DMAS an Explanation of Benefits (EOB) or similar documentation from the insurance company or doctor's office showing: the date of service (DOS); that the expense is the responsibility of the member or parent; that the expense was paid prior to the submission of the request; and sufficient identification codes for the DOS to enable DMAS to determine if the service is reimbursable before applying the remaining cost sharing criteria.

c. Reimbursement for cost sharing shall be processed on a quarterly basis.

b.d. Ineligible family members. When coverage for Medicaid-eligible family members under age 19 is not possible unless an ineligible a parent who is not Medicaid-eligible enrolls in qualified employer-sponsored health insurance, the Medicaid agency pays premiums only for enrollment of the ineligible parent who is not Medicaid-eligible and, at the parent's option, other family members who are eligible for coverage under the qualified employer-sponsored coverage insurance. In addition, the agency provides cost sharing for the child's ineligible parent that is not Medicaid-eligible for items and services covered under the qualified employer-sponsored coverage insurance that are also covered services under the State Plan. There is no cost-sharing for ineligible parents who are not Medicaid-eligible for items and services not covered by the qualified employer-sponsored coverage insurance.

3. Documentation required for premium assistance subsidy reimbursement. A person payee to whom DMAS is paying a qualified employer-sponsored coverage insurance premium assistance subsidy shall, as a condition of receiving such payment, provide documentation as prescribed by DMAS of the payment of the employer group health plan qualified employer-sponsored insurance plan premium, as well as payment of coinsurances, copayments, and deductibles for services received.

#### H. Cost-Sharing Wrap.

1. Premium Assistance enrollment will be voluntary. Individuals enrolled in the state's Health Insurance Premium Payment (HIPP) program are afforded the same member protections provided to all other Medicaid enrollees. Cost sharing shall only be charged to Medicaid members as permitted under Section 1916 and 1916A of the Social Security Act. Cost sharing shall not exceed 5% of household income.

2. The state will provide a cost sharing wrap to any cost sharing amounts of a Medicaid covered service that exceeds the cost sharing limits described in the state plan, regardless of whether individuals enrolled in a HIPP program receive care from a Medicaid participating provider or a non-participating provider.

3. To effectuate the cost sharing wrap, the state will encourage non-participating providers to enroll by conducting targeted outreach to inform non-participating Medicaid providers on how to enroll in Medicaid for the purposes of receiving payment from the state for cost sharing amounts that exceed the Medicaid permissible limits.

4. The state will inform members regarding options available when the member obtains care from a non-participating provider, including, as applicable, reimbursement for out of pocket cost sharing costs from this provider.

5. In order to receive reimbursement, the individual shall submit to DMAS an EOB or similar documentation from the insurance company or doctor's office showing: DOS; that the expense is the responsibility of the

member or parent; that the expense was paid prior to the submission of the request; and sufficient identification codes for the DOS to enable DMAS to determine if the service is reimbursable before applying the remaining cost sharing criteria

6. Reimbursement for cost sharing shall be processed on a quarterly basis.

~~G. I.~~ Program participation requirements. Participants must comply with program requirements as prescribed by DMAS for continued enrollment in HIPP for Kids. Failure to comply with the following may result in termination from the program:

1. Submission of documentation of any changes to the qualified employer-sponsored insurance plan, to include any changes to the employee share of the premium expense, specified time frame in accordance with DMAS established policy within 10 days of receipt of notice of the change.

2. ~~Report~~Any household changes, to include income and individuals in household, into the qualified employer-sponsored coverage insurance must be reported within 10 days of the family's receipt of notice of the change.

3. Completion of annual redetermination.

4. Completion of consent forms. Participants may be required to complete a consent form to release information necessary for HIPP for Kids participation and program requirements as required by DMAS.

~~H. J.~~ HIPP for Kids redetermination. DMAS shall redetermine the eligibility of the qualified employer-sponsored ~~coverage insurance~~ periodically, at least every 12 months. DMAS shall also redetermine eligibility when changes occur with the ~~group health plan~~qualified employer-sponsored insurance plan information that was used in determining HIPP for Kids eligibility.

~~I. K.~~ Program termination. Participation in the HIPP for Kids program may be terminated for failure to comply or meet program requirements. Termination will be effective the last day of the month in which advance notice has been given (consistent with federal regulations), requirements at 42 CFR 431.211).

1. Participation may be terminated for failure to meet program requirements including, but not limited to, the following:

a. Failure to submit documentation of payment of premiums;

b. Failure to provide information required for reevaluation of the qualified employer-sponsored ~~coverage insurance; (noncompliance);~~

c. Loss of Medicaid eligibility for all household members;

d. Medicaid household member no longer covered by the qualified employer-sponsored ~~coverage insurance;~~

e. Medicaid-eligible child turns age 19; or

f. Employer-sponsored health plan no longer meets qualified employer-sponsored ~~coverage insurance~~ requirements.

2. Termination date of premiums. Payment of premium assistance subsidy shall end on whichever of the following occurs the earliest:

a. On the last day of the month in which eligibility for Medicaid ends;

b. The last day of the month in which the member loses eligibility for coverage in the ~~group health plan~~qualified employer-sponsored insurance plan;

c. The last day of the month in which the child turns age 19;

d. The last day of the month in which adequate notice has been given (consistent with federal ~~requirements~~) requirements at 42 CFR 431.211) that DMAS has determined that the ~~group health plan~~qualified employer-sponsored insurance plan no longer meets program eligibility criteria; or

d. The last day of the month in which adequate notice has been given (consistent with federal ~~requirements~~) requirements at 42 CFR 431.211) that HIPP for Kids participation requirements have not been met.

J. ~~L.~~ Third-party liability. When members are enrolled in qualified employer-sponsored coverage ~~insurance~~ health plans, these plans shall become the first sources of health care benefits, up to the limits of such plans, prior to the availability of payment under Title XIX.

K. ~~M.~~ Appeal rights. ~~Members~~ Applicants and members shall be given the opportunity to appeal adverse agency decisions consistent with agency regulations for client appeals (12VAC30-110). ~~(12VAC30-110-10 through 12VAC30-110-370).~~

L. ~~N.~~ Provider requirements. Providers shall be required to accept the greater of the group health plan's ~~qualified employer-sponsored insurance plan~~ s reimbursement rate or the Medicaid rate as payment in full and shall be prohibited from charging the member or the Medicaid program amounts that would result in aggregate payments greater than the Medicaid rate as required by 42 CFR 447.20.

O. Provider Participation/Enrollment. The state will enroll network providers as full Medicaid providers or enroll as FFS Medicaid providers solely for the purpose of receiving cost sharing, similar to processes related to enrolling Medicare-participating providers that serve dually-eligible members. If the state enrolls providers for the sole purpose of being reimbursed for cost sharing, the provider would make the decision to enroll knowing that the provider network would be the same as for other enrollees of the qualified employer-sponsored insurance plan. In either scenario, the member would never pay more than the permissible Medicaid copayment.

**12VAC30-20-210. State method on cost effectiveness of employer-based group health qualified employer-sponsored insurance plans.**

A. Definitions. The following words and terms when used in these regulations shall have the following meanings unless the context clearly indicates otherwise:

~~"Average monthly Medicaid cost" means average monthly medical expenditures based upon age, gender, Medicaid enrollment covered group, and geographic region of the state.~~

~~"Average monthly wraparound cost" means the average monthly aggregate costs for services not covered by private health insurance but covered under the State Plan for Medical Assistance, also includes copayments, coinsurance, and deductibles.~~

~~"Case" means all family members who are eligible for coverage under the qualified employer-sponsored insurance plan group health plan and who are eligible for Medicaid.~~

~~"Code" means the Code of Virginia.~~

~~"Cost effective" and "cost effectiveness" mean the reduction in Title XIX expenditures, which are likely to be greater than the additional expenditures for premiums and cost-sharing items required under § 1906 of the Social Security Act (the Act), with respect to such enrollment.~~

~~"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.~~

~~"DSS" means the Department of Social Services consistent with Chapter 1 (§ 63.2-100 et seq.) of Title 63.2 of the Code of Virginia.~~

~~"Family member" means an individual in the household, who is not a parent, who are is related by blood, marriage, adoption, or legal custody.~~

~~"Family health plan" and "family care coverage" means a group health plan that covers three or more individuals. Family health plans that cover three or more non-Medicaid eligible individuals are not eligible for the HIPP premium assistance subsidy.~~

~~"Group health plan" means a plan which meets § 5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to Title XXII of the Public Health Service Act, § 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974. Section 5000(b)(1) of the Internal Revenue Code provides that a group health plan is a plan, including a self-insured~~

plan, of, or contributed to by, an employer (including a self-insured person) or employee association to provide health care (directly or otherwise) to the employees, former employees, or the families of such employees or former employees, or the employer.

"High deductible health plan" means a plan as defined in § 223(c)(2) of Internal Revenue Code of 1986, without regard to whether the plan is purchased in conjunction with a health savings account (as defined under § 223(d) of ~~such Code~~ the Internal Revenue Code of 1986).

"HIPP" means the Health Insurance Premium Payment Program administered by DMAS consistent with § 1906 of the Act.

"Member" means a person who is eligible for Medicaid as determined by DMAS or a DMAS designated agent, including the Department of Social Services.

"Network Provider" means a provider who is enrolled with one of DMAS contracted managed care organizations (MCO) as a provider, and meets the requirement for an expedited enrollment as a fee-for-service (FFS) Medicaid provider for payment and billing purposes.

"Parent" means the biological or adoptive parent or parents, or the biological or adoptive parent and the stepparent, living in the home with the Medicaid-eligible child. The health insurance policyholder shall be a parent as defined herein.

"Payee" means the insured employee who is the policy holder of the qualified employer-sponsored insurance plan who is paid the HIPP or HIPP for Kids premium and cost sharing reimbursement.

"Premium" means the fixed cost of participation in the group health plan; such cost may be shared by the employer and employee or paid in full by either party.

"Premium assistance subsidy" means the portion that DMAS will pay of the employee's cost of participating in ~~an employer's health plan~~ qualified employer-sponsored insurance plan to cover the Medicaid eligible members under the employer-sponsored plan if DMAS determines it is cost effective to do so.

"Qualified employer-sponsored insurance" as defined under section 2105(c)(10)(B) of the Social Security Act means a group health plan or health insurance coverage offered through an employer:

1. That qualifies as creditable coverage as a group health plan under § 2701(c)(1) of the Public Health Service Act;
2. For which the employer contribution toward any premium for such coverage is at least 40%; and
3. That is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of paragraph (3)(A)(ii) of § 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

~~"Recipient" means a person who is eligible for Medicaid as determined by the Department of Social Services.~~

"State Plan" means the State Plan for Medical Assistance for the Commonwealth of Virginia.

B. Program purpose. The purpose of the HIPP Program shall be to:

1. Enroll ~~recipients~~ members who have an ~~available group health plan~~ qualified employer-sponsored insurance plan that is likely to be cost effective;
2. Provide premium assistance subsidy for payment of the employee share of the premiums and other cost-sharing obligations for items and services otherwise covered under the State Plan for Medical Assistance (the Plan); and
3. Treat coverage under such ~~employer group health plan~~ qualified employer-sponsored insurance plan as a third party liability consistent with § 1906 of the Social Security Act.

C. Cost Effectiveness Methodology

1. DMAS shall evaluate the individual to determine the appropriate managed care organization (MCO) capitation rate to be used. The capitation rate will be determined based on aid category, nursing facility/waiver eligibility, age, gender, and region.

2. DMAS shall adjust the capitation rate to exclude Medicaid services that are not available through commercial group health insurance policies. This requires that the capitation rate be adjusted to exclude services including, but not limited to, nursing facility and long term services and supports provided in the Commonwealth Coordinated Care (CCC) Plus program as well as community mental health services and non-emergency transportation services available in CCC Plus and Medallion.

3. DMAS shall adjust the reduced capitation rate from paragraph 2 to reflect the higher prices employer plans pay. The Virginia price factor shall be based on the national factor of 1.3 that is published by the Centers for Medicare and Medicaid Services (CMS).

4. The qualified employer-sponsored insurance cost for the individual shall be increased to reflect the amount of coinsurance and other member cost sharing typically imposed on HIPP members and paid by DMAS. Such amount shall be determined by averaging the aggregate amount of such expenditures by DMAS in the most recently completed fiscal year by the number of HIPP members covered during the fiscal year.

5. The qualified employer-sponsored insurance plan cost determined in subdivision C 4 shall be increased to reflect DMAS's administrative expenses directly related to the HIPP program. This additional cost is determined based on the average total monthly compensation paid to each HIPP analyst employed by DMAS divided by the anticipated caseload.

6. The cost effectiveness shall be affirmed if the adjusted capitation rate from subdivision C 3 equals or exceeds the adjusted qualified employer-sponsored insurance plan cost from subdivision C 5.

C. Application required. A completed HIPP application must be submitted to DMAS to be evaluated for HIPP program eligibility; if HIPP program eligibility is established, DMAS shall then evaluate the group health plan for cost effectiveness. The HIPP application consists of the forms prescribed by DMAS and any necessary information as required by the program to evaluate eligibility and perform a cost-effectiveness evaluation.

D. Recipient/Member eligibility. DMAS shall obtain specific information on all group health plans available to the recipients in the case including, but not limited to, the effective date of coverage, the services covered by the plan, the deductibles and copayments required by the plan, the exclusions to the plan, and the amount of the premium. Coverage that is not comprehensive shall be denied premium assistance. A qualified employer-sponsored insurance plan must provide the following services in order to be considered comprehensive:

1. Physician services;

2. In and out patient hospitalization;

3. Outpatient labs, shots, and x-rays;

4. Prescription drugs

Cases that result in a determination that the applicant is not eligible for the HIPP program shall be denied premium assistance and shall not undergo further review as described in subsection E of this section. All family members persons who are eligible for coverage under the group health plan qualified employer-sponsored insurance plan and who are eligible for Medicaid shall be eligible for consideration for HIPP, except those who meet any one or more of the factors identified in subdivisions 1 through 7 5 of this subsection.

1. The recipient is Medicaid eligible due to "spend-down".

2. The recipient is currently enrolled in the qualified employer-sponsored health insurance plan and is only retroactively eligible for Medicaid.

3. The recipient is in a nursing home or has a deduction from patient pay responsibility to cover the insurance premium.

4. Currently, Medicare beneficiaries who are enrolled in a MCO do not qualify for participation in the HIPP Program. If a Medicaid beneficiary is enrolled in an MCO, the beneficiary must wait until they are disenrolled

from the MCO to become eligible for HIPP. HIPP applications are not approved until the managed care eligibility has ended at the end of the month.

4. 5. The recipient is eligible for Medicare Part B, but is not enrolled in Part B.

5. The recipient's family has, or would have, family healthcare coverage for three or more members who are not Medicaid eligible. Exceptions to the family health care coverage exclusion are as follows:

a. The family meets Family Access to Medical Insurance Security (FAMIS) eligibility criteria but due to existing group health insurance cannot enroll in FAMIS for the non-Medicaid family members enrolled in the health care plan; or

b. Medicaid eligibility is based upon family income (Medicaid family unit) and the family members enrolled in the health care plan are not Medicaid eligible due to Medicaid age restrictions (aged 19 or older).

6. Medicare eligibility. Medicaid recipients eligible for, or enrolled in, Medicare Part A and/or Part B who are also covered by an employer group health plan are not eligible for HIPP.

7. High Deductible Health Plans (HDHPs) are defined in § 223(c)(2) of the Internal Revenue Code of 1986. HDHPs are not cost effective for the HIPP program and shall be denied premium assistance and shall not undergo further review as described in subsection E of this section. The annual deductible amount for a HDHP is defined by the Department of Treasury and is updated annually.

E. Application required. A completed HIPP application must be submitted to DMAS to be evaluated for HIPP program eligibility; if HIPP program eligibility is established, DMAS shall then evaluate the group health plan for cost effectiveness. The HIPP application consists of the forms prescribed by DMAS and any necessary information as required by the program to evaluate eligibility and perform a cost-effectiveness evaluation.

1. Effective date of premium assistance subsidy. Payment of premium assistance subsidy shall become effective on the first day of the month following the month in which DMAS approves the application and makes the cost effectiveness determination. Payment shall be made to either the employer, the insurance company or to the individual who is carrying the group health plan coverage.

2. Termination date of premium assistance subsidy. Payment of premium assistance subsidy shall end on whichever of the following occurs the earliest:

a. On the last day of the month in which eligibility for Medicaid ends;

b. The last day of the month in which the recipient loses eligibility for coverage in the qualified employer-sponsored insurance plan; or

c. The last day of the month in which adequate notice has been given (consistent with federal requirements at 42 CFR 431.211) that DMAS has redetermined that the group health plan is no longer cost effective.

3. Non-Medicaid eligible family members. Payment of premium assistance subsidy for non-Medicaid eligible family members may be made when their enrollment in the group health qualified employer-sponsored insurance plan is required in order for the recipient to obtain the group health qualified employer-sponsored insurance plan coverage. Such payments shall be treated as payments for Medicaid benefits for the recipient. No payments for deductibles, coinsurances, and other cost-sharing obligations for non-Medicaid eligible family members shall be made by DMAS.

4. Evidence of enrollment required. The payee to whom DMAS is paying the group health qualified employer-sponsored insurance plan premium assistance subsidy shall, as a condition of receiving such payment, provide to DSS or DMAS, upon request, written evidence of the payment of the employee's share of the plan premium for the qualified employer-sponsored insurance plan which DMAS determined to be cost effective.

E. Cost-effectiveness evaluation. If the Medicaid eligible(s) is enrolled in the health plan and is not excluded from HIPP program participation under the criteria described in subsection D of this section, DMAS shall conduct the premium cost-effectiveness evaluation based upon the following methodology:

1. Recipient information. DMAS shall obtain demographic information on each recipient in each case including, but not limited to, Medicaid enrollment covered group, age, gender, and geographic region of residence in the state.

2. DMAS shall compute the average monthly Medicaid cost for each Medicaid enrollee on the group health insurance plan and compare the total cost to the employee's responsibility for the health insurance cost.

3. Wraparound cost. DMAS shall total the average monthly wraparound cost for each Medicaid enrollee on the HIPP case and subtract the amount from the average monthly Medicaid cost for the cost-effectiveness evaluation.

4. Administrative cost. DMAS shall total the administrative costs of the HIPP program and estimate an average administrative cost. DMAS shall subtract the administrative cost from the average monthly Medicaid cost for the cost-effectiveness evaluation.

5. Determination of premium cost effectiveness. DMAS shall determine that a group health plan is likely to be cost effective if subdivision a is less than subdivision b below:

a. The employee's responsibility for the group health plan premium.

b. The total of the average monthly Medicaid costs less the wraparound costs for each Medicaid enrollee covered by the group health plan and the administrative cost.

6. For individuals who otherwise meet all HIPP eligibility criteria in subdivision 5 of this subsection, such individuals may elect to have DMAS reimburse them up to the amount determined in subdivision 5 b of this subsection, if subdivision 5 a of this subsection is not less than subdivision 5 b of this subsection.

F. Payments. When DMAS determines that a group health plan is likely to be cost effective based on the DMAS established methodology, DMAS shall provide for the payment of premium assistance subsidy and other cost-sharing obligations for items and services otherwise covered under the Plan, except for the nominal cost sharing amounts permitted under § 1916.

1. Effective date of premium assistance subsidy. Payment of premium assistance subsidy shall become effective on the first day of the month following the month in which DMAS receives a complete HIPP application or the first day of the month in which the group health plan coverage becomes effective, whichever is later. Payments shall be made to either the employer, the insurance company or to the individual who is carrying the group health plan coverage.

2. No payments for deductibles, coinsurances, and other cost-sharing obligations for non-Medicaid eligible family members shall be made by DMAS.

3. Documentation required for premium assistance subsidy reimbursement. A person to whom DMAS is paying an employer group health plan premium assistance subsidy shall, as a condition of receiving such payment, provide documentation as prescribed by DMAS of the payment of the employer group health plan premium for the group health plan that DMAS determined to be cost effective.

#### F. Cost-sharing Wrap.

1. Premium Assistance enrollment will be voluntary. Individuals enrolled in the state's Health Insurance Premium Payment (HIPP) program are afforded the same member protections provided to all other Medicaid enrollees. Cost sharing shall only be charged to Medicaid members as permitted under Section 1916 and 1916A of the Social Security Act. Cost sharing shall not exceed 5% of household income.

2. The state will provide a cost sharing wrap to any cost sharing amounts of a Medicaid covered service that exceeds the cost sharing limits described in the State Plan, regardless of whether individuals enrolled in a HIPP program receive care from a Medicaid participating provider or a non-participating provider.

3. To effectuate the cost sharing wrap, the state will encourage non-participating providers to enroll by conducting targeted outreach to inform non-participating Medicaid providers on how to enroll in Medicaid for the purposes of receiving payment from the state for cost sharing amounts that exceed the Medicaid permissible limits.

4. The state will inform members regarding options available when the member obtains care from a non-participating provider, including, as applicable, reimbursement for out of pocket cost sharing costs from this provider.

5. In order to receive reimbursement, the individual shall submit to DMAS an EOB or similar documentation from the insurance company or doctor's office showing: DOS; that the expense is the responsibility of the member or parent; that the expense was paid prior to the submission of the request; and sufficient identification codes for the DOS to enable DMAS to determine if the service is reimbursable before applying the remaining cost sharing criteria

6. Reimbursement for cost sharing shall be processed on a quarterly basis.

G. HIPP Program participation requirements. Participants must comply with the following program requirements as prescribed by DMAS for continued enrollment in HIPP. Failure to comply shall result in termination from the program.

1. Submission of documentation of any changes to the qualified employer-sponsored insurance plan, to include any changes to the employee share of the premium expense, within 10 days of receipt of notice of the change, specified time frame in accordance with DMAS established policy.

2. ChangesAny household changes, to include income and individuals in household, that impact the cost-effectiveness evaluation must be reported within 10 days of the change.

3. Completion of annual redetermination.

4. Completion of consent forms. Participants may be required to complete a consent form to release information necessary for HIPP participation and program requirements as required by DMAS.

~~5. Participants terminated for noncompliance under subdivision 1 or 2 of this subsection shall be barred from reapplying to the HIPP program for three months from the date of cancellation.~~

H. HIPP redetermination. DMAS shall redetermine the cost effectiveness of the group healthqualified employer-sponsored insurance plan periodically, and at least every 12 months. DMAS shall also redetermine cost effectiveness when changes occur with the recipient's average Medicaid cost and/or with the group healthqualified employer-sponsored insurance plan information that was used in determining the cost effectiveness. When only part of the household loses Medicaid eligibility, DMAS shall redetermine the cost effectiveness to ascertain whether payment of the premium assistance subsidy of the group health qualified employer-sponsored insurance plan continues to be cost effective.

~~I. Program termination. Participation in the HIPP program shall be terminated for failure to comply with or meet program requirements. Termination will be effective the last day of the month in which advance notice has been given (consistent with 42 CFR 431.211).~~

~~1. In addition to the reasons listed in subsection G of this section, participation shall be terminated for:~~

~~a. Loss of Medicaid eligibility for all household members;~~

~~b. Medicaid household member no longer covered by employer health plan; or~~

~~c. Employer group health plan is determined to be not cost effective.~~

~~2. Termination date of premiums. Payment of premium assistance subsidy shall end on whichever of the following occurs the earliest:~~

~~a. On the last day of the month in which eligibility for Medicaid ends;~~

~~b. The last day of the month in which the recipient loses eligibility for coverage in the group health plan;~~

~~c. The last day of the month in which adequate notice has been given (consistent with federal requirements) that DMAS has determined that the group health plan is no longer cost effective; or~~

~~d. The last day of the month in which adequate notice has been given (consistent with federal requirements) that HIPP participation requirements have not been met.~~

I. Multiple group health plans. When a member is eligible for more than one group health plan, DMAS shall perform the cost effectiveness determination on the group health plan in which the member is enrolled. If the



member is not enrolled in a group health plan, DMAS shall perform the cost effectiveness determination on each group health plan available to the member.

J. Third party liability. When recipients are enrolled in group health plans, these plans shall become the first sources of health care benefits, up to the limits of such plans, prior to the availability of Title XIX benefits.

K. Appeal rights. ~~Recipients~~ Applicants and members shall be given the opportunity to appeal adverse agency decisions consistent with agency regulations for client appeals (12VAC30-110). ~~(12VAC30-110-10 through 12VAC30-110-370).~~

L. Provider requirements. Providers shall be required to accept the greater of the group health plan's reimbursement rate or the Medicaid rate as payment in full and shall be prohibited from charging the recipient or Medicaid amounts that would result in aggregate payments greater than the Medicaid rate as required by 42 CFR 447.20.

M. Provider Participation/Enrollment. The state will enroll network providers as full Medicaid providers or enroll as FFS Medicaid providers solely for the purpose of receiving cost sharing, similar to processes related to enrolling Medicare-participating providers that serve dually-eligible members. If the state enrolls providers for the sole purpose of being reimbursed for cost sharing, the payee would make the decision to enroll knowing that the provider network would be the same as for other enrollees of the qualified employer-sponsored insurance. In either scenario, the member would never pay more than the permissible Medicaid copayment.

**12VAC30-30-10. Mandatory coverage: categorically needy and other required special groups.**

The Title IV-A agency or the Department of Medical Assistance Services Central Processing Unit determines eligibility for Title XIX services. The following groups shall be eligible for medical assistance as specified:

1. Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state in 12VAC30-40-100 consistent with 42 CFR 435.110 and §§ 1902(a)(10)(A)(i)(I) and 1931(b) of the Social Security Act. Individuals qualifying under this eligibility group shall meet the following criteria:

a. Parents, other caretaker relatives (defined at 42 CFR 435.4) including pregnant women, or dependent children (defined at 42 CFR 435.4) younger than the age of 18 years. This group includes individuals who are parents or other caretaker relatives of children who are 18 years of age provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training and are expected to complete such school or training before their 19th birthday.

b. Spouses of parents and other caretaker relatives shall include other relatives of the child based on blood (including those of half-blood), adoption, or marriage. Other relatives of a specified degree of the dependent child shall include any blood relative (including those of half-blood) and including (i) first cousins; (ii) nephews or nieces; (iii) persons of preceding generations as denoted by prefixes of grand, great, or great-great; (iv) stepbrother; (v) stepsister; (vi) a relative by adoption following entry of the interlocutory or final order, whichever is first; (vii) the same relatives by adoption as listed in this subdivision 1 b; and (viii) spouses of any persons named in this subdivision 1 b even after the marriage is terminated by death or divorce.

MAGI-based income methodologies in 12VAC30-40-100 shall be used in calculating household income.

2. Women who are pregnant or postpartum with household income at or below a standard established by the Commonwealth in 12VAC30-40-100, consistent with 42CFR 435.116 and §§ 1902(a)(10)(A)(i)(III) and (IV), 1902(a)(10)(A)(ii)(I) and (IX), and 1931(b) of the Act. Individuals qualifying under this eligibility group shall be pregnant or postpartum as defined in 42 CFR 435.4.

a. A woman who, while pregnant, was eligible for, applied for, and received Medicaid under the approved state plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period, beginning on the last day of her pregnancy, and for any remaining days in the month in which the 60th day falls.

b. A pregnant woman who would otherwise lose eligibility because of an increase in income of the family in which she is a member during the pregnancy or the postpartum period that extends through the end of the month in which the 60-day period, beginning on the last day of pregnancy, ends.

MAGI-based income methodologies in 12VAC30-40-100 shall be used in calculating household income.

3. Infants and children younger than the age of 19 years with household income at or below standards based on this age group, consistent with 42 CFR 435.118 and §§ 1902(a)(10)(A)(i)(III), (IV) and (VIII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) of the Act. Children qualifying under this eligibility group shall meet the following criteria:

- a. They are younger than the age of 19 years; and
- b. They have a household income at or below the standard established by the Commonwealth.

MAGI-based income methodologies in 12VAC30-40-100 shall be used in calculating household income.

4. The Adult Group as described at 42 CFR 435.119.

4. 5. Former foster care children younger than the age of 26 years who are not otherwise mandatorily eligible in another Medicaid classification, who were on Medicaid and in foster care when they turned age 18 years, or who aged out of foster care. Individuals qualifying under this eligibility group shall meet the following criteria:

- a. They shall be younger than the age of 26 years;
- b. They shall not be otherwise eligible for and enrolled for mandatory coverage under the state plan; and
- c. They were in foster care under the responsibility of the state of Virginia or a federally recognized tribe and were enrolled in Virginia Medicaid under the state plan when they turned age 18 years or at the time of aging out of the foster care program.

5. 6. Families terminated from coverage under § 1931 of the Act solely because of earnings or hours of employment shall be entitled to up to 12 months of extended benefits in accordance with § 1925 of the Act.

6. 7. A child born to a woman who is eligible for and receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year from birth, as long as he remains a resident of the Commonwealth. A redetermination of eligibility must be completed on behalf of the deemed child at age one year and annually thereafter so long as he remains eligible.

7. 8. Aged, blind, and disabled individuals receiving cash assistance.

a. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under § 1619(a) of the Act or who meet the eligibility requirements for SSI status under § 1619(b)(1) of the Act and who met the state's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under § 1619(a) or met the requirements under § 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the § 1619(a) eligibility standard or the requirements of § 1619(b) of the Act.)

b. These persons include the aged, the blind, and the disabled.

c. Protected SSI children (pursuant to § 1902(a)(10)(A)(i)(II) of the Act) (P.L. 105-33 § 4913). Children who meet the pre-welfare reform definition of childhood disability who lost their SSI coverage solely as a result of the change in the definition of childhood disability, and who also meet the more restrictive requirements for Medicaid than the SSI requirements.

d. The more restrictive categorical eligibility criteria are described in 12VAC30-30-40.

Financial criteria are described in 12VAC30-40-10.

8. 9. Qualified severely impaired blind and disabled individuals under age 65 years who:

a. For the month preceding the first month of eligibility under the requirements of § 1905(q)(2) of the Act, received SSI, a state supplementary payment (SSP) under § 1616 of the Act or under § 212 of P.L. 93-66 or benefits under § 1619(a) of the Act and were eligible for Medicaid; or

b. For the month of June 1987, were considered to be receiving SSI under § 1619(b) of the Act and were eligible for Medicaid. These individuals must:

(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;

(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;

(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under § 1611(b) of the Act;

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself a reasonable equivalent of the Medicaid, SSI (including any federally administered SSP), or public funded attendant care services that would be available if he did have such earnings.

The state applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under § 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under § 1619(b)(1) of the Act and who met the state's more restrictive requirements in the month before the month they qualified for SSI under § 1619(a) or met the requirements of § 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under § 1619(a) of the Act or meet the SSI requirements under § 1619(b)(1) of the Act.

9. 10. Except in states that apply more restrictive requirements for Medicaid than under SSI, blind or disabled individuals who:

a. Are at least 18 years of age; and

b. Lose SSI eligibility because they become entitled to Old Age, Survivor, and Disability Insurance (OASDI) child's benefits under § 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.

The state does not apply more restrictive income eligibility requirements than those under SSI.

40. 11. Except in states that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional state supplements (if the agency provides Medicaid under § 435.230 of the Act), because of requirements that do not apply under Title XIX of the Act.

41. 12. Individuals receiving mandatory state supplements.

42. 13. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as a spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the state's approved plan for Old Age Assistance, Aid to the Blind, Aid to the Permanently and Totally Disabled, or Aid to the Aged, Blind, and Disabled and the spouse continues to meet the December 1973 requirements for have his needs included in computing the cash payment. In December 1973, Medicaid coverage of the essential spouse was limited to the aged, the blind, and the disabled.

43. 14. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of Title XIX medical institutions or residents of Title XIX intermediate care facilities, if, for each consecutive month after December 1973, they:

a. Continue to meet the December 1973 Medicaid State Plan eligibility requirements;

b. Remain institutionalized; and

c. Continue to need institutional care.

44. ~~15.~~ Blind and disabled individuals who:

- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;
- b. Were eligible for Medicaid in December 1973 as blind or disabled; and
- c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

45. ~~16.~~ Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under P.L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. This includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this state's August 1972 plan), and persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this state's August 1972 plan).

46. ~~17.~~ Individuals who:

- a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and
- b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under § 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

The state applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

47. ~~18.~~ Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by § 134 of P.L. 98-21 and who are deemed, for purposes of Title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under § 1634(b) of the Act.

The state does not apply more restrictive income eligibility standards than those under SSI.

48. ~~19.~~ Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least 10 years before the divorce became effective, who have attained the age of 50, who are receiving Title II payments, and who because of the receipt of Title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive Title II payments, who would be eligible for SSI or SSP if the amount of the Title II benefit were not counted as income, and who are not entitled to Medicare Part A.

The state applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

49. ~~20.~~ Qualified Medicare beneficiaries:

- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under § 1818 of the Act);
- b. Whose income does not exceed 100% of the federal level; and
- c. Whose resources do not exceed twice the maximum standard under SSI or, effective January 1, 2010, the resource limit set for the Medicare Part D Low Income Subsidy Program.

Medical assistance for this group is limited to Medicare cost sharing as defined in item 3.2 of this plan.

20. ~~21.~~ Qualified disabled and working individuals:

- a. Who are entitled to hospital insurance benefits under Medicare Part A under § 1818A of the Act;
- b. Whose income does not exceed 200% of the federal poverty level;
- c. Whose resources do not exceed twice the maximum standard under SSI; and

d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

Medical assistance for this group is limited to Medicare Part A premiums under §§ 1818 and 1818A of the Act.

21- 22. Specified low-income Medicare beneficiaries:

a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under § 1818A of the Act);

b. Whose income for calendar years 1993 and 1994 exceeds the income level in subdivision 25 b of this section, but is less than 110% of the federal poverty level, and whose income for calendar years beginning 1995 is less than 120% of the federal poverty level; and

c. Whose resources do not exceed twice the maximum standard under SSI or, effective January 1, 2010, the resource limit set for the Medicare Part D Low Income Subsidy Program.

Medical assistance for this group is limited to Medicare Part B premiums under § 1839 of the Act.

22- 23. a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of § 1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.

b. The state applies more restrictive eligibility standards than those under SSI. Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of § 1611(e)(3)(A) and who continue to meet the more restrictive requirements for Medicaid eligibility under the state plan, are eligible for Medicaid as categorically needy.

#### **12VAC30-40-348. Adult Group Individual Income-Based Determinations.**

A. Methodology for Identification of Applicable Federal Medical Assistance Percentages (FMAP) rates. DMAS will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

B. Adult group individual income-based determinations. For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the Modified Adjusted Gross Income (MAGI) Conversion Plan (Part 2) approved by CMS on February 11, 2014. In general, and subject to any adjustments described in this section, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available.

C. Population-based adjustments to the newly eligible population based on resource test, enrollment cap, or special circumstances.

1. The state does not apply a resource proxy adjustment.

2. The state does not apply an enrollment cap.

3. The state does not apply a special circumstance adjustment.

4. The state does not apply any additional adjustment to the adult group FMAP methodology.

D. Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan or a section 1902(e)(14)(A) waiver.

E. Applicability of special FMAP rates.

1. The state does not meet the definition of an expansion state in 42 CFR 433.204(b).

2. The state does not qualify for a temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

F. The state attests to the following:

1. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

2. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.