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Fast-Track Regulation
Agency Background Document

Agency name	DEPT. OF MEDICAL ASSISTANCE SERVICES
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 30-10-10; 12 VAC 30-10-20; 12 VAC 30-10-410; 12 VAC 30-20-205; 12 VAC 30-20-210; 12 VAC 30-30-10; 12 VAC 30-40-348
VAC Chapter title(s)	Designation and authority Organization for administration Hearings for applicants and recipients Health Insurance Premium Payment (HIPP) for Kids State method on cost effectiveness of employer-based group health plans Mandatory coverage: categorically needy and other required special groups Adult Group Individual Income-Based Determinations
Action title	Expansion-Related Changes: Expansion Group; FMAP; HIPP; Determination State
Date this document prepared	10/9/2019

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code.*

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

This regulatory action incorporates changes made to the Virginia State Plan in order to implement Medicaid Expansion. The topics included in this regulation action are: 1) including

the adult eligibility group as a group eligible for Medicaid coverage; 2) updating the Health Insurance Premium Payment (HIPP) program and HIPP for Kids program; 3) making expansion-related changes to the federal medical assistance percentage; and 4) updating the federal medical assistance percentage for expenditures associated with new enrollees.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

CMS = Centers for Medicare and Medicaid Services
DMAS = Department of Medical Assistance Services
FMAP = Federal Medical Assistance Percentage
HIPP = Health Insurance Premium Payment

Statement of Final Agency Action

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 entitled "Expansion-Related Changes: Expansion Group; FMAP; HIPP; Determination State; SNAP" 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, of the Administrative Process Act.

October 9, 2019
Date

/signature/
Karen Kimsey, Director
Dept. of Medical Assistance Services

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

As required by Virginia Code § 2.2-4012.1, also explain why this rulemaking is expected to be noncontroversial and therefore appropriate for the fast-track process.

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

The regulations are intended to replace emergency regulations that combine several of the Medicaid expansion-related state plan amendments required by CMS into one regulatory package. The expansion-related state plan amendments that are the subject of this regulatory action have been approved by CMS. The regulations are part of the overall implementation process for Medicaid expansion in accordance with ongoing directives in the 2018 Acts of Assembly, Chapter 2, Item 303.SS.4(a)(1), the 2019 Acts of Assembly, Chapter 854, Item 303.SS.4(a)(1), the 2020 Acts of Assembly, Chapter 1289, Item 313.QQ.3(a)(1), and the 2021 Special Session 1 Acts of Assembly, Item 313.QQ.3(a)(1) to "amend the State Plan for Medical Assistance under Title XIX of the Social Security Act, and any waivers thereof, to implement coverage for newly eligible individuals pursuant to 42 U.S.C. § 1396d(y)(1)[2010] of the Patient Protection and Affordable Care Act."

This regulatory package is expected to be non-controversial because it describes changes that were approved by CMS and that went into effect on January 1, 2019. As of August 23, 2019, over 312,000 individuals had enrolled in Medicaid expansion, and no formal or informal complaints or comments had been received about these changes from any Medicaid member, Medicaid provider, or member of the public.

In addition, a NOIRA comment period that occurred from August 5, 2019 through September 4, 2019 produced one public comment requesting that additional changes be made to the HIPP program in the future.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

The Code of Virginia § 32.1 325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance and to promulgate regulations. The Code of Virginia § 32.1-324, grants the Director of the Department of Medical Assistance Services the authority of the Board when it is not in session.

The 2018 Appropriation Act, Item 303.SS 4a, and 2019 Appropriation Act, Item 303.SS 4a directed the agency to " amend the State Plan for Medical Assistance … to implement coverage for newly eligible individuals…" These amendments were required to implement Medicaid expansion.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it's intended to solve.

This regulation is essential to protect the health, safety, and welfare of citizens in that it implements the General Assembly mandate to expand Medicaid coverage to new populations.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

This regulatory action seeks to combine several of the expansion-related state plan amendments that were required by the Centers for Medicare and Medicaid Services (CMS) into one regulatory package.

The changes related to the expansion of Medicaid to the adult group are contained in 12 VAC 30-30-10. These changes amend mandatory eligibility categories to include adults with incomes below 138% of the federal poverty level.

The changes related to the HIPP and HIPP for Kids programs are in 12 VAC 30-20-205 and 210. The changes related to the HIPP program in 12 VAC 30-20-210 include: 1) adding text related to the cost-effectiveness methodology; 2) clarifying recipient eligibility criteria; application criteria; effective dates; termination dates; and rules for non-Medicaid eligible family members; and 3) adding text relating to the cost-sharing wrap and provider participation and enrollment. The changes to the HIPP for Kids program in 12 VAC 30-20-2015 include adding text related to: 1) the cost-effectiveness methodology, 2) the cost-sharing wrap; and 3) provider participation/enrollment. These changes update both the HIPP and the HIPP for Kids programs to meet CMS requirements.

The changes related to the federal medical assistance percentage are in a new section, 12 VAC 30-40-348. This section describes the methodology used by DMAS to determine the increased FMAP rates associated with new enrollees in the expansion population.

The changes related to the change from an Assessment State to a Determination State are in 12 VAC 30-10-10, 12 VAC 30-10-20, and 12 VAC 30-10-410. These changes delegate DMAS authority to make eligibility determinations to the federally facilitated marketplace. (Under an assessment state, these eligibility determinations came to DMAS for verification; that will no longer be the case.) In addition, the changes delegate eligibility hearings that arise out of marketplace determinations to the federal Health and Human Services appeals entity.

The emergency regulation included changes related to the expedited enrollment of SNAP recipients on a one-time basis for purposes of increasing enrollment in Medicaid expansion. This one-time enrollment has already occurred, and will not occur again in the future without additional approval from CMS. Therefore, the text relating to the use of SNAP income was not copied from the emergency regulation into this Fast Track action.

Issues

Identify the issues associated with the regulatory change, 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, include a specific statement to that effect.

The primary advantage of this regulatory action is that additional individuals will have access to comprehensive health insurance, which should help improve health measures and outcomes across the Commonwealth. There are no disadvantages to the agency or the public.

Requirements More Restrictive than Federal

Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and 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 specific statement to that effect.

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

Agencies, Localities, and Other Entities Particularly Affected

Identify any other state agencies, localities, or other entities particularly affected by the regulatory change. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

Other State Agencies Particularly Affected: None.

Localities Particularly Affected: None.

Other Entities Particularly Affected: None.

Economic Impact

Pursuant to § 2.2-4007.04 of the Code of Virginia, identify all specific economic impacts (costs and/or benefits), anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is change versus the status quo.

Impact on State Agencies

For your agency: projected costs, savings, fees or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources	Costs of expanding Medicaid to the adult group: General funds: FY 2019: $66,660,234 FY 2020: $214,714,775 Non-general funds: FY 2019: $885,628,823 FY 2020: $2,106,526,036 These costs have been appropriated by the General Assembly.
For other state agencies: projected costs, savings, fees or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.	None
For all agencies: Benefits the regulatory change is designed to produce.	This regulatory package includes Medicaid expansion text from the State Plan into the Virginia Administrative code for consistency between federal and state authorities.

Impact on Localities

Projected costs, savings, fees or revenues resulting from the regulatory change.	None
Benefits the regulatory change is designed to produce.	This regulatory package includes Medicaid expansion text from the State Plan into the Virginia Administrative code for consistency between federal and state authorities.

Impact on Other Entities

Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.	Individuals enrolled in Medicaid expansion.
Agency's best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	Approximately 400,000 individuals are expected to enroll through Medicaid expansion.
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees;	None

d) purchases of equipment or services; and e) time required to comply with the requirements.	
Benefits the regulatory change is designed to produce.	This regulatory package includes Medicaid expansion text from the State Plan into the Virginia Administrative code for consistency between federal and state authorities.

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. 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 regulatory change.

No alternatives will meet the requirements of the legislative mandate. These changes have already been approved by CMS and added to the Virginia state plan. This regulatory action seeks to replicate these changes in the Virginia Administrative Code.

Regulatory Flexibility Analysis

Pursuant to § 2.2-4007.1B of the Code of Virginia, 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) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing 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 regulatory change.

No alternatives will meet the requirements of the legislative mandate. This regulatory does not impose compliance or reporting requirements or performance standards for small businesses.

Public Comment

Please summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency response. Ensure to include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency or board. If no comment was received, enter a specific statement to that effect.

Commenter	Comment	Agency response
Health Management Systems	HMS supports DMAS efforts to modernize the HIPP program and suggests a number of additional changes: 1. The regulations allow for voluntary participation in the HIPP	The changes proposed by HMS go beyond those that are included in the current regulatory package, but can be considered as possible future changes.

	program and HMS seeks clarification whether the Department will soon require HIPP for individuals in Medicaid expansion, where cost effective. 2. HMS strongly recommends establishing HIPP as a mandatory program for all eligible Medicaid members (and family coverage) so long as it is cost effective. 3. HMS recommends new methodology rules to allow eligible individuals to maintain Medicaid coverage through Medicaid managed care organizations under adjusted capitation rates. 4. DMAS should automate processes. 5. DMAS should incentivize and/or compel members and employers to respond to Medicaid outreach about HIPP. 6. DMAS should consider program changes to improve engagement with HIPP members, maximize response rates, further leverage technology to move away from manual processes, and directly deposit premium payments to employers.	

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below.

As required by § 2.2-4011 of the Code of Virginia, if an objection to the use of the fast-track process is received within the 30-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: 1) file notice of the objections with the Registrar of Regulations for publication in the Virginia Register and 2) proceed with the normal promulgation process with the initial publication of the fast-track regulation serving as the Notice of Intended Regulatory Action.

If you are objecting to the use of the fast-track process as the means of promulgating this regulation, please clearly indicate your objection in your comment. Please also indicate the nature of, and reason for, your objection to using this process.

DMAS is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal and any alternative approaches, (ii) the potential impacts of the regulation, and (iii) the agency's regulatory flexibility analysis stated in this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail, email or fax to Emily McClellan, 600 E. Broad Street,

Richmond, VA 23219, 804-371-4300, or emily.mcclellan@dmas.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

Changes made in the emergency regulation:

Current section number	New section number, if applicable	Current requirement	Change, intent, rationale, and likely impact of new requirements
12 VAC 30-10-10			Delegates authority for MAGI eligibility decisions to the federally facilitated marketplace.
12 VAC 30-10-20			Updates the reference to 30-10-10 D to allow delegation of MAGI eligibility determinations to the federally facilitated marketplace.
12 VAC 30-10-410			Delegates authority
12 VAC 30-20-205			Updates to HIPP for Kids program.
12 VAC 30-20-210			Updates to HIPP program.
12 VAC 30-30-10			Expands Medicaid to the Adult Group.
	12 VAC 30-40-348		A new section is established describing the methodology for increased FMAP rates.

Changes made between the emergency regulation and the fast track:

Current section number	New section number, if applicable	Current requirement	Change, intent, rationale, and likely impact of new requirements
12 VAC 30-10-60			Text in the emergency regulation allowed for a one-time expedited enrollment process for SNAP recipients. This change cannot be made permanent without additional approval from CMS. Therefore, this text was removed from the Fast Track.