Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) citation	12 VAC 30-20-210
Regulation title	Administration of Medical Assistance Services: State method on cost effectiveness of employer-based group health plans – individual and family plans
Action title	HIPP Cost Effectiveness Methodology
Document preparation date	

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

Brief summary

Please provide a brief summary (no more than 2 short paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation. Also, please include a brief description of changes to the regulation from publication of the proposed regulation to the final regulation.

Chapter 781, Item 306 AAA of the 2009 Appropriation Act directed the Department of Medical Assistance Services (DMAS) to amend the State Plan for Medical Assistance to clarify that existing family healthcare coverage is a factor in the determination of eligibility under the Health Insurance Premium Payment program (HIPP). Cases which result in a determination that participation is denied based upon the existence of family health care coverage shall be denied premium assistance. This action is intended to satisfy that mandate.

Statement of final agency action

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

I hereby approve the foregoing Agency Background document with the attached amended State Plan: Administration of Medical Assistance Services: HIPP Cost Effectiveness Methodology (12 VAC 30-20-210) 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.

_____ _____

Date

Gregg A. Pane, M.D., MPA, Director

Dept. of Medical Assistance Services

Legal basis

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

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

Purpose

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

This regulatory action is intended to clarify that the HIPP eligibility evaluation includes whether family healthcare coverage exists at the time that HIPP participation is evaluated, regardless of whether the eligibility evaluation is at the time of initial application or during a re-evaluation. Upon implementation of this change, having existing family health care coverage will be considered in the HIPP eligibility determination. This change will require the amendment of regulations addressing HIPP eligibility, family healthcare coverage, and a clarification of the cost-effectiveness methodology. These changes are needed to ensure that HIPP payments made for the participants enrolled in the HIPP program are overall cost effective for the State.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. A more detailed discussion is required under the "All changes made in this regulatory action" section.

The Medicaid State Plan section affected by this regulatory action is State method on cost effectiveness of employer-based group health plans (12 VAC 30-20-210).

When the HIPP program was enacted in 1991 by the federal government it was envisioned as a means to reduce the cost of the Medicaid program by shifting the cost of medical expenses onto the employer health plan if one was available. The HIPP regulations require a cost effectiveness determination of the employer health plan for enrollment. Cost effectiveness is defined as meaning that it is likely to cost the state less to pay the employee's share of the health insurance premium and any cost sharing items for the Medicaid eligible household members, than it would cost otherwise under Medicaid. As a result of Medicaid eligibility rules, there are circumstances that allow a family member(s) to be evaluated for Medicaid without evaluating family income. Eligibility is based on the individual's income only. These Medicaid enrollees whose eligibility is not determined based on family household income are likely to be covered under a family health insurance policy which includes family members not enrolled in Medicaid. Under the current changes being made in this regulation, a family that would have family health coverage for three or more members not enrolled in Medicaid would not be eligible for the HIPP program. The family would have the family coverage regardless of whether there is or was a family member enrolled in Medicaid; therefore, the Commonwealth will no longer enroll Medicaid individuals in HIPP who would otherwise remain enrolled in the family health insurance if HIPP were not available.

High deductible health plans (HDHPs) are not cost effective for the HIPP program. In recent years as a result of increased insurance costs, many health care plans have adopted "high deductible" plans. An HDHP is defined in section 232(c)(2) of the Internal Revenue Code of 1986. The Department of Treasury updates the deductible amounts on an annual basis. These plans were nonexistent at the inception of the HIPP program; however, they have become more prevalent in recent years as health insurance premiums have increased. Medicaid would be paying all medical expenses until the deductible is met as well as the monthly premium. Because Medicaid eligibility only exists on a month to month basis, HDHPs are not cost effective for the HIPP program. Inclusion of this language provides clarity to the process that is currently followed today and is consistent with current federal regulations. The Child Health Insurance Program Reauthorization Action of 2009 included additional options for Premium Assistance Program under 1906A of the Social Security Action and specifically excludes HDHP coverage for consideration.

Program participation requirements have been defined to ensure participants initially found eligible continue to meet the cost effectiveness requirements. Additionally, program termination reasons have been included in the regulations. Current regulations provided reasons for terminating payments; however, nothing was defined regarding termination from the program.

Including termination reasons provides clear authority to terminate participation in the program when participation requirements are not met. These regulations respond to the General Assembly mandate clarifying several aspects of the HIPP cost effectiveness methodology, including promulgating several new definitions and addressing family healthcare issues with regard to HIPP.

Current regulations provided a clause for consideration for extraordinary circumstances of some recipients who are not eligible for HIPP. This language was removed because these eligibles are not cost effective for the HIPP program as they have limited eligibility, reside in a nursing home or are Medicare eligible. Revisions were made to clarify that premium assistance subsidies begin the month after a completed application is received rather than at the time the cost effectiveness determination is made. This change reflects the current methodology used.

Language was revised regarding the submission of documentation required for premium assistance subsidy reimbursement. The HIPP program became an optional program effective July 23, 2009; participation in HIPP is no longer a condition for Medicaid eligibility. Language regarding DSS receiving the required premium documentation has been removed from the regulation as the information is to be submitted directly to DMAS.

Please note: At the time of the emergency regulation promulgated as a precursor to this final regulation, 12 VAC 30-20-210 was also the subject of a fast-track regulatory action. Due to the difficulties of effecting changes in this section at the time another action is taking effect in the same regulatory subsection, DMAS elected to make the emergency changes both in 12 VAC 30-20-210 and in a new mirror image subsection, 12 VAC 30-20-211. The changes of the text in 12 VAC 30-20-210 made in the fast-track regulation are now final, and there is no further need to have two separate regulatory sections to address the current changes in 12 VAC 30-20-210. DMAS therefore inserted all the emergency changes from 12 VAC 30-20-211 into 12 VAC 20-30-210 in the previously published proposed regulation. This leaves 12 VAC 30-20-210 as the only regulatory subsection in this final regulatory stage.

Please also note: DMAS noted in the published emergency regulation background document that the Agency intended to address several other issues in this proposed and later final regulations that follow the prior emergency action. These changes were published in the proposed regulation and are included in this final regulation. These issues include, but are not limited to, requirements regarding consent forms in the HIPP program, termination from the program, and program eligibility and participation requirements.

Issues

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

The primary disadvantage of this regulatory action for the public is that the families that were enrolled in HIPP with family coverage have been canceled and new applications with existing family health insurance are being denied. The families were accustomed to receiving reimbursement for the cost of the health insurance plan and these funds have now been discontinued. However, these participants incurred the cost of the insurance prior to applying to the HIPP program. The intent of the HIPP program is to provide for premium assistance for an employer group health insurance plan when the Medicaid recipient otherwise would not be enrolled in the group health plan. The families impacted by this regulatory change are already enrolled in their employer group health plan and most likely will continue to be enrolled in their employer group health plan for the family members who are not enrolled in Medicaid regardless of whether they participated in HIPP or not. Although through this program there has been a cost savings for individual policy holders and their families, the purpose of the program is a cost savings measure for the Commonwealth. Removing these families from the HIPP program does not mean that an enrollee's Medicaid eligibility is lost. Recipients who remain otherwise eligible for Medicaid continue their Medicaid coverage.

The primary advantage to the Commonwealth is cost savings by ensuring that the HIPP program provides for premium assistance as appropriate by not enrolling participants who would otherwise be covered under private insurance. The HIPP program is intended to be an overall cost savings program for the Commonwealth. Medicaid enrollment has changed over the years with the inclusion of additional covered groups in which family income is not evaluated only the individual's income is taken into consideration, while the HIPP program regulations have not been revised to reflect these eligibility changes. The HIPP program was intended to provide premium assistance for Medicaid eligibles enrollment in their employer group health when they would otherwise not be enrolled without being in the HIPP program. The HIPP program was not intended to provide premium assistance for families who would have family coverage for the household members who are not enrolled in Medicaid. Participants being denied HIPP participation under this regulatory change are dissatisfied with this change; however, in most instances they were in HIPP when only one family member was enrolled in Medicaid. These current regulatory changes do not permit HIPP enrollment with family employer policies where three or more insured family members are non-Medicaid recipients.

Changes made since the proposed stage

Please describe all changes made to the text of the proposed regulation since the publication of the proposed stage. For the Registrar's office, please put an asterisk next to any substantive changes.

Section number	Requirement at proposed stage	What has changed	Rationale for change
12 VAC 30-20-210(D)(5)	Ineligibility for existing family coverage of 3 or more non-Medicaid eligible individuals	Added two exceptions to this ineligibility rule for families who would otherwise meet FAMIS eligibility but are not eligible due to enrollment in a group health plan	DMAS made these exceptions in light of the fact that there are families who would otherwise qualify for

		and for Medicaid family units where some family members are not Medicaid eligible due to age restrictions (age 19 and older), and made clarifying changes to language.	FAMIS but have group health coverage or Medicaid families who have some family members aged 19 or older.
12 VAC 30-20-210(E)(6)	Cost effectiveness evaluation	Added statement to clarify that otherwise qualifying individuals whose monthly premiums are higher than their average monthly Medicaid costs may elect to receive an amount equal to their average monthly Medicaid costs.	DMAS added this to maximize flexibility for those whose premiums are higher but still wish to participate in HIPP by accepting reimbursement that is less than their monthly premiums.
12 VAC 30-20-210(G)	Program participation requirements	Inserted references to 1a and 1b from paragraph I.	After the clarifying deletion of (I)(1) and (I)(2), these references now applied to (G)(1) and (G)(2).
12 VAC 30-20-210(I)	Program termination	Made clarifying changes to language and inserted a specific federal regulation citation in lieu of a general reference. Also, moved references to 1a and 1b to paragraph G.	These changes made the regulation more coherent and understandable.

In its economic analysis the Department of Planning and Budget (DPB) expressed concern that the new eligibility rule may exclude from the HIPP program families who would be eligible for HIPP except for some technicalities. DMAS is responding to DPB's concern in this final regulation. DMAS has revised the final HIPP regulations to create two exceptions for families with financial need who would be ineligible for the HIPP under the new rule. The first exception is for Medicaid families who have a family health plan with 3 or family members not enrolled in Medicaid but have family income below the family income limit for Medicaid eligibility. Some Medicaid families have children who aged out of Medicaid eligibility at age 19, but have continued Medicaid eligibility for their children under age 19. The dependents (Medicaid and non-Medicaid) are still covered under the family's insurance. With Health Care Reform, children can remain enrolled in a parent's health plan until age 26, so this change should address this issue.

The second exception is for families where at least 1 child is enrolled in Medicaid and the family would meet the income eligibility criteria for the Family Access to Medicaid Insurance Security (FAMIS) program, but because they have health insurance they are not eligible for FAMIS. In both types of these cases described here, where the family income is below the Medicaid or FAMIS income limits, the families will be considered for HIPP participation.

Public comment

Please summarize all comments received during the public comment period following the publication of the proposed stage, and provide the agency response. If no comment was received, please so indicate.

DMAS' proposed regulations were published in the 1/17/2011 (VR 27:10), *Virginia Register* for their public comment period from 1/17/2011, through 3/18/2011. No comments were received

All changes made in this regulatory action

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

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, rationale, and consequences
12 VAC 30-20-210 A		Definitions	Added definitions and modified existing definitions for Average Monthly Medicaid Cost, Average Monthly wraparound cost, Family member, Family health plan, high deductible health plan, and premium. Deleted definition for premium assistance definition and added definition for premium assistance subsidy.
12 VAC 30-20-210 B		Program Purpose	Added clarifying language
12 VAC 30-20-210 **D**	12 VAC 30-20-210 **C**	Application required	This subsection was moved from sub (D) to sub (C) to more logically reflect the application, eligibility determination, and cost-effectiveness determination process described in 12 VAC 30-20-210. Added clarifying language that the cost-effectiveness determination occurs only if the HIPP applicant is found otherwise eligible for the program.
12 VAC 30-20-210 D(5)	12 VAC 30-20-210 D(5)**[(a) and (b)]**	Ineligibility for existing family coverage of 3 or more non-Medicaid eligible individuals	Added two exceptions to this ineligibility rule for families who would otherwise meet FAMIS eligibility but are not eligible due to enrollment in a group health plan and for Medicaid family units where family members are not Medicaid eligible due to age restrictions (age 19 and older)

12 VAC 30-20-210 **C**	12 VAC 30-20-210 **D**	Recipient Eligibility	This subsection was moved from sub (C) to sub (D) to more logically reflect the application, eligibility determination, and cost-effectiveness determination process described in 12 VAC 30-20-210 Deleted extraordinary circumstances clause, modified language for retroactive Medicaid eligibility and clarified Medicare eligibility.
12 VAC 30-20-210 **E**.	12 VAC30-20-210 **F**	Payments	Added clarifying language. Moved 12VAC30-20-210E.2, Termination date of Premiums to 12VAC-20-210-I.3. Clarified language for Non-Medicaid family members to state no cost sharing will be made by DMAS. Adding language regarding documentation requirements.
12 VAC 30-20-210(E)(6)	Cost effectiveness evaluation	Added statement to clarify that otherwise qualifying individuals whose monthly premiums are higher than their average monthly Medicaid costs may elect to receive an amount equal to their average monthly Medicaid costs.	DMAS added this to maximize flexibility for those whose premiums are higher but still wish to participate in HIPP by accepting reimbursement that is less than their monthly premiums.
12 VAC 30-20-210 F and G	12 VAC30-20-210E	Guidelines for determining Cost Effectiveness and Determination of Cost Effectiveness.	These two subsections were collapsed into subsection E. DMAS added Cost Effectiveness Evaluation with clarifying language. Renumbered sections, added clarifying language for premium cost effectiveness methodology. Deleted cost effectiveness methodology that has not been utilized since 1999. 12VAC30-20-210G.3 changed to 12VAC30-20-210 H., HIPP Redetermination, clarified this is HIPP redetermination, not Medicaid eligibility redetermination.
12 VAC 30-20-210	12 VAC30-20-210G	Inserted references to 1a and 1b from paragraph I.	After the clarifying deletion of (I)(1) and (I)(2), these references now applied to (G)(1) and (G)(2).
12 VAC 30-20-210 H		Third party liability	Re-lettered to 210 J.

12 VAC30-20-210 I.		Appeal Rights	Re-lettered to 210 K
12 VAC30-20-210 J.		Provider Requirements	Re-lettered to 210 L

Changes subsequent to the Emergency Regulation:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, rationale, and consequences
12 VAC 30-20-210 A		Definitions	Added definition for Family health plan as a group health plan that covers three or more individuals and family health plans with 3 or more non-Medicaid eligible individuals are not eligible for HIPP participation.
12 VAC 30-20-210 **C**	12 VAC 30-20-210 **D**	Recipient Eligibility	This subsection was moved from sub (C) to sub (D) to more logically reflect the application, eligibility determination, and cost-effectiveness determination process described in 12 VAC 30-20-210
12 VAC 30-20-210 **D**	12 VAC 30-20-210 **C**	Application required	This subsection was moved from sub (D) to sub (C) to more logically reflect the application, eligibility determination, and cost-effectiveness determination process described in 12 VAC 30-20-210.
12 VAC 30-20-210 **E**	12 VAC 30-20-210 **D**	Cost effectiveness (E) and Recipient eligibility (D)	Moved subsections (E)(1)-(5) (Cost effectiveness evaluation) into subsection (D) (Recipient eligibility), as these components are eligibility factors and not cost-effectiveness factors. Added family healthcare coverage under eligibility exclusions Subsection E (6) is retained in the first paragraph of sub (E).
	12 VAC 30-20-210 G	Inserted references to 1a and 1b from paragraph I.	Added consent form requirements; After the clarifying deletion of (I)(1) and (I)(2), these references now applied to (G)(1) and (G)(2).
	12 VAC 30-20-210 I		Added Program Termination Language non-compliance language and moved Termination of Premiums (E.2) to this section

Regulatory flexibility analysis

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

There is no impact on small businesses.

Family impact

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

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; or encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment, but may decrease disposable family income for those families who will no longer have DMAS paying for their family health insurance policies.