STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

10. (RESERVED)

11. (RESERVED)

§1917e of the Act

12. Is required, as a condition of eligibility for Medicaid payment of long-term care services, to disclose at the time of application for or renewal of Medicaid eligibility, a description of any interest the individual or his spouse has in an annuity (or similar financial instrument as may be specified by the Secretary of Health and Human Services). By virtue of the provision of medical assistance, the state shall become a remainder beneficiary for all annuities purchased on or after February 8, 2006.

13. Is ineligible for Medicaid payment of nursing facility or other long-term care services if the individual's equity interest in his home exceeds $500,000. This dollar amount shall be increased beginning with 2011 from year to year based on the percentage increase in the Consumer Price Index for all Urban Consumers rounded to the nearest $1,000.

This provision shall not apply if the individual's spouse, or the individual's child who is under age 21 or who is disabled, as defined in Section 1614 of the Social Security Act, is lawfully residing in the individual's home.

The State has a process under which this limitation will be waived in the case of undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

Citation	Condition or Requirement
§1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans (12VAC30-20-210)

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 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 individuals who are related by blood, marriage, or adoption.

"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).

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

"Premium" means the fixed cost of participation in the group health plan, which 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 to cover the Medicaid eligible members under the employer-sponsored plan if DMAS determines it is cost effective to do so.

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

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

1. To enroll recipients who have an available employer group health plan that is likely to be cost effective;

2. To 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. To treat coverage under such employer group health plan as a third party liability consistent with §1906 of the Social Security Act.

C. Recipient eligibility. All family members who are eligible for coverage under the group health plan and who are eligible for Medicaid shall be eligible for consideration for HIPP, except those identified below. The agency will consider the recipients below for HIPP when extraordinary circumstances indicate the group health plan might be cost effective.

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

2. The recipient is currently enrolled in the employer sponsored health 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, or

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

D. Application required. A completed HIPP application must be submitted to DMAS to be evaluated for eligibility and 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.

E. 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 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 makes the cost effectiveness determination 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. Termination date of premium assistance subsidy Payment of premium assistance subsidy shall end on which ever of the following occurs the earliest:

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

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

c. The last day of the month in which adequate notice has been given (consistent with federal requirements) 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 plan is required in order for the recipient to obtain the group health 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. A person to whom DMAS is paying the group health 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 group health plan premium for the group health plan which DMAS determined to be cost effective.

F. Guidelines for determining cost effectiveness.

1. Existing family healthcare coverage is a factor in the determination of cost effectiveness. Cases that result in a determination that participation is not cost effective, based upon the existence of family healthcare coverage, shall be denied premium assistance and shall not undergo further review as described in subdivision 5 e of this subsection. The following healthcare plans are not cost effective:

a. If the family has or would have family healthcare coverage for the members who are not Medicaid eligible.
b. If the Medicaid recipient is eligible for or enrolled in Medicare.

2. 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 subdivision (5)(e) of this subsection. The annual deductible amount for a HDHP is defined by the Department of Treasury and is updated annually.

3. Group health plan information. 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 employee share of the group health plan premium. Coverage that is not comprehensive is not cost effective and shall be denied premium assistance subsidy.

4. Enrollment in a group health plan. The Medicaid eligible family member(s) must be covered under the employer group health plan to be enrolled in HIPP.

5. DMAS shall make the premium cost effectiveness determination based on the following methodology:

a. Recipient information. DMAS shall obtain demographic information on each recipient in each case, including, but not limited to, federal program designation, age, gender, and geographic region of the state.

b. 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.

c. 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.

d. 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.

e. Determination of premium cost effectiveness. DMAS shall determine that a group health plan is likely to be cost effective if (i) is less than (ii) below:

(i) The employee's responsibility for the group health plan premium

(ii) 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.

f. DMAS may reimburse up to the amount determined in subdivision 5 e (ii) of this subsection, if subdivision 5 e (i) is not less than subdivision 5 e (ii).

G. HIPP Program participation requirements. Participants must comply with 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 the employee share of the premium expense within specified time frame in accordance with DMAS established policy.

2. Changes that impact the cost effectiveness evaluation must be reported within 10 days.

3. Completion of annual HIPP redetermination.

H. HIPP Redetermination. DMAS shall redetermine the cost effectiveness of the group health plan periodically, at least every 12 months. DMAS shall also redetermine cost effectiveness when changes occur with the recipient average Medicaid cost and/or with the group health 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 premium assistance subsidy the group health plan continues to be cost effective.

I. Multiple group health plans. When a recipient is eligible for more than one group health plan, DMAS shall perform the cost effectiveness determination on the group health plan in which the recipient is enrolled. If the recipient is not enrolled in a group health plan, DMAS shall perform the cost effectiveness determination on each group health plan available to the recipient.

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 shall be given the opportunity to appeal adverse agency decisions consistent with agency regulations for client appeals (12VAC30-110).

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.