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**State Name:** Virginia

**State Plan Amendment (SPA) #:** 10-17

This file contains the following documents in the order listed:

- 1) Approval Letters
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
150 S. Independence Mall West  
Suite 216, The Public Ledger Building  
Philadelphia, Pennsylvania 19106-3499



**Region III/Division of Medicaid and Children's Health Operations**

SWIFT #122020104052

JAN 1 2011

Gregg A. Pane, M.D.  
Director  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

Dear Dr. Pane:

We have reviewed State Plan Amendment (SPA) 10-17, in which you propose to provide health insurance premium assistance to children under age 19. This SPA is acceptable. Therefore, we are approving SPA 10-17 with an effective date of October 1, 2010. Enclosed are the approved SPA pages and signed CMS-179 form.

If you have further questions about this SPA, please contact William G. Cahill at (215) 861-4173.

Sincerely,

/s/

Ted Gallagher  
Associate Regional Administrator

Enclosures

cc: Roy Trudel, CO

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER <input type="text" value="1"/> <input type="text" value="0"/> - <input type="text" value="1"/> <input type="text" value="7"/> <input type="text" value=""/>	2. STATE <input style="width: 100%;" type="text" value="Virginia"/>
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
5. TYPE OF PLAN MATERIAL (Check One) <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		4. PROPOSED EFFECTIVE DATE <input style="width: 100%;" type="text" value="October 1, 2010"/>	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION <input style="width: 100%;" type="text" value="42 CFR Part 433, Subpart D"/>	7. FEDERAL BUDGET IMPACT a. FFY <input type="text" value="2011"/> \$ <input style="width: 100%;" type="text" value="585,107.00"/> b. FFY <input type="text" value="2012"/> \$ <input style="width: 100%;" type="text" value="574,361.00"/>		
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT <input style="width: 100%; height: 80px;" type="text" value="Preprint Page 29d and Attach. 4.22-C, Pages 0.1 - 0.4 of 9"/>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <input style="width: 100%; height: 80px;" type="text" value="Same pages"/>		
10. SUBJECT OF AMENDMENT <input style="width: 100%;" type="text" value="Premium Assistance Option Under CHIPRA - HIPP For Kids Program"/>			
11. GOVERNOR'S REVIEW (Check One) <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <sup>2011</sup> <input checked="" type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL /S/		16. RETURN TO <input style="width: 100%; height: 100px;" type="text" value="Dept. of Medical Assistance Services&lt;br/&gt;600 East Broad Street, #1300&lt;br/&gt;Richmond VA 23219&lt;br/&gt;&lt;br/&gt;Attn: Regulatory Coordinator"/>	
13. TYPED NAME <input style="width: 100%;" type="text" value="Gregg A. Pane, MD, MPA"/>		16. RETURN TO (continued)	
14. TITLE <input style="width: 100%;" type="text" value="Director"/>			
15. DATE SUBMITTED <input style="width: 100%;" type="text" value="October 25, 2010"/>			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED October 25, 2010	18. DATE APPROVED January 21, 2011		
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL October 1, 2010	20. SIGNATURE OF REGIONAL OFFICIAL /S/		
21. TYPED NAME Ted Gallagher	22. TITLE Associate Regional Administrator		
23. REMARKS			

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of VIRGINIA

<u>Citation</u>	<u>Condition or Requirement</u>
1906 of the Act	<p>(c) <u>Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations</u></p> <p>The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.</p> <p>When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in §4.22(h).</p>
1906(A) of the Act	<p>(c)-1 <u>Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations</u></p> <p>Pursuant to §1906(A) 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, without regard to limitations specified in section 1916 or section 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 which are not included in the employer-sponsored coverage. For qualified employer-sponsored coverage, the employer must contribute at least 40 percent of the premium cost.</p> <p>When coverage for eligible family members under age 19 is not possible unless an ineligible family member enrolls, the Medicaid agency pays premiums for enrollment of the ineligible family member and, at the option of the parent or legal guardian, other family members that are eligible for coverage under the employer-sponsored plan. The agency also pays deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan for the ineligible family member. Attachment 4.22-C of this plan provides a detailed description of this program.</p>
1902(a)(10(F) of the Act	<p>(d) <input type="checkbox"/> The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.</p>

TN No. 10-17  
 Supersedes  
 TN No. 93-02

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) FOR KIDS PROGRAM

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**12 VAC 30-20-205. Health Insurance Premium Payment (HIPP) for Kids**

A. Definitions. The following words and terms when used in these regulations 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 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 individuals who are related by blood, marriage, or adoption.

"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.

"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, their designated agent, or the Department of Social Services.

"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 amount that DMAS will pay of the employee's cost of participating in the Qualified Employer-Sponsored Coverage to cover the Medicaid eligible member(s) under age 19.

"Qualified Employer-Sponsored Coverage" 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 section 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 percent; 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 section 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

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

1. To enroll members who are eligible for coverage under a Qualified Employer-Sponsored Coverage plan;
2. To 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 non-eligible parent for items and services covered under the Qualified Employer Sponsored Coverage that are also covered services under the State Plan for Medical Assistance (the Plan). There is no cost sharing for parents for services not covered by the Qualified Employer Sponsored Coverage.
3. To treat coverage under such employer group health plan as a third party liability consistent with § 1902(a)(25) of the Social Security Act.

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C. Member eligibility. DMAS shall obtain specific information on Qualified Employer-Sponsored Coverage 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 co-payments 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. All Medicaid eligible family members under the age of 19 who are eligible for coverage under the Qualified Employer-Sponsored Coverage, 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 Coverage and is only retroactively eligible for Medicaid.

D. 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 Coverage.

E. Qualified Employer-Sponsored Coverage 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 section 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 percent; 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 section 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).
4. Exceptions: The term "Qualified Employer-Sponsored Coverage" does not include coverage consisting of:
- a. Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986) or
  - b. A high deductible health plan (as defined in section 223(c)(2) of such Code), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).
  - c. For self-employed individuals, Qualified Employer-Sponsored Coverage 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 in items 1-3 of section (E) above. Family for this purpose includes family by "blood, marriage or adoption."

F. Payments. When DMAS determines that a Qualified Employer-Sponsored Coverage 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 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 which Qualified Employer-Sponsored 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. Payments for deductibles, coinsurances and other cost-sharing obligations

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State of VIRGINIA

**HEALTH INSURANCE PREMIUM PAYMENT (HIPP) FOR KIDS PROGRAM**

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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, without regard to limitations specified in section 1916 or section 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 which are not included in the Qualified Employer-Sponsored Coverage.

b. Ineligible Family Members. When coverage for Medicaid eligible family members under age 19 is not possible unless an ineligible parent enrolls, the Medicaid agency pays premiums only for enrollment of the ineligible parent and, at the parent's option, other family members who are eligible for coverage under the Qualified Employer-Sponsored Coverage. In addition, the agency provides cost sharing for the child's ineligible parent for items and services covered under the Qualified Employer Sponsored Coverage that are also covered services under the State Plan for Medical Assistance (the Plan). There is no cost sharing for ineligible parents for items and services not covered by the Qualified Employer Sponsored Coverage.

3. Documentation required for premium assistance subsidy reimbursement. A person to whom DMAS is paying a Qualified Employer-Sponsored Coverage 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, as well as payment of coinsurances, co-payments and deductibles for services received.

G. 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 premium expense within specified time frame in accordance with DMAS established policy.
2. Changes in the Qualified Employer-Sponsored Coverage 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. HIPP for Kids Redetermination. DMAS shall redetermine the eligibility of the Qualified Employer-Sponsored Coverage periodically, at least every 12 months. DMAS shall also redetermine eligibility when changes occur with the group health plan information that was used in determining HIPP for Kids eligibility.

I. 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).

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, or,
  - b. Failure to provide information required for re-evaluation of the Qualified Employer-Sponsored Coverage (non-compliance); or,
  - c. Loss of Medicaid eligibility for all household members; or,
  - d. Medicaid household member no longer covered by the Qualified Employer-Sponsored Coverage; or,

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## HEALTH INSURANCE PREMIUM PAYMENT (HIPP) FOR KIDS PROGRAM

- e. Medicaid eligible child turns age 19; or,  
 f. Employer-sponsored health plan no longer meets Qualified Employer- Sponsored Coverage requirements.
2. Termination date of premiums. 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 member loses eligibility for coverage in the group health plan; or
  - c. The last day of the month in which the child turns age 19; or
  - d. 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 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) that HIPP for Kids participation requirements have not been met.
- J. Third party liability. When members are enrolled in Qualified Employer-Sponsored Coverage 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. Appeal rights. Members 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 member or the Medicaid program amounts that would result in aggregate payments greater than the Medicaid rate as required by 42 CFR 447.20.

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