

**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. Cost Effectiveness Methodology

1. DMAS shall evaluate the individual to determine the appropriate 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 qualified employer-sponsored insurance policies. This requires that the capitation rate be adjusted to exclude nursing facility and long term services and supports provided in the 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.
4. The qualified employer-sponsored insurance plan 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 paragraph 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 paragraph 3 equals or exceeds the adjusted health plan cost from paragraph 5.

D. 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.

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 Coverage.

F. 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;

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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.”

G. 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 the first day of the month following an approved application for which Qualified Employer-Sponsored Coverage becomes effective. 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
  - 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.

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- 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.

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 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.

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 premium expense within specified time frame in accordance with DMAS established policy.

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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.

J. 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.

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).

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,
- 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
- e. 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.

L. 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.

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

N. 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.

Provider Participation/Enrollment. The state will enroll network providers as full Medicaid providers or enroll as Medicaid providers solely for the purpose of receiving cost sharing, similar to processes related to enrolling Medicare-participating providers that serve dually-eligible beneficiaries. If the state enrolls providers for the sole purpose of being reimbursed for cost sharing, the beneficiary would make the decision to enroll knowing that the provider network would be the same as for other enrollees of the private plan. In either scenario, the beneficiary would never pay more than the permissible Medicaid copayment. The State will conduct outreach activities to the provider community. The outreach activities include: Posting Provider Enrollment FAQs and information on the provider portal. In addition, training information regarding how to reach the Provider Enrollment Services Call Center for support; as well as blast emails to the current or potential provider population about the benefits of HIPP and how it affects the providers business. Other states will be engaged to determine the best practices for Provider Outreach. Lastly, providing same day Provider Enrollment for those that are not currently enrolled into Medicaid. All State and Federal Provider Enrollment Regulations and Procedures will remain as normal.

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<u>Citation</u>	<u>Condition or Requirement</u>
§1906 of the Act Health Plans (12 VAC 30-20-120)	State Method on Cost Effectiveness of Employer-Based Group
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 the Code of Virginia, Chapter 10, Title 32.1, §§32.1-323 et seq.
	"DSS" means the Department of Social Services consistent with the Code of Virginia, Chapter 1, Title 63.1, §63.1-1.1 et seq.
	“Family health plan” and “family care coverage” means a group health plan that covers three or more individuals.
	“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 any 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 employer's 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 such Code).

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"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 if 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 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 group health plan as a third party liability consistent with §1906 of the Act.

C. Cost Effectiveness Methodology

1. DMAS shall evaluate the individual to determine the appropriate 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 nursing facility and long term services and supports provided in the 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.
4. The group health plan 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 group health plan cost determined in paragraph 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 paragraph 3 equals or exceeds the adjusted health plan cost from paragraph 5.

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D. Recipient Eligibility. All persons 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. Currently, Medicaid beneficiaries who are enrolled in a Medicaid Managed Care Organization (MCO) do NOT qualify for participation in the HIPP program. If a Medicaid beneficiary is enrolled in a MCO, the beneficiary must wait until the MCO is terminated to become eligible for HIPP. HIPP applications are not approved until the managed care eligibility has ended at the end of the month.
5. The recipient is eligible for Medicare Part B, but is not enrolled in Part B.

E. 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 preform 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 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. One the last day of the month in which eligibility for Medicaid end;
  - 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 payment 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 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.

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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 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.

F. 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.

G. 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.

H. 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.

I. 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 the availability of Title XIX benefits.

J. Appeal rights. Recipients shall be given the opportunity appeal adverse agency decisions consistent with agency regulations for client appeals (12 VAC 30-110).

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K. 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.

L. Provider Participation/Enrollment. The state will enroll network providers as full Medicaid providers or enroll as Medicaid providers solely for the purpose of receiving cost sharing, similar to processes related to enrolling Medicare-participating providers that serve dually-eligible beneficiaries. If the state enrolls providers for the sole purpose of being reimbursed for cost sharing, the beneficiary would make the decision to enroll knowing that the provider network would be the same as for other enrollees of the private plan. In either scenario, the beneficiary would never pay more than the permissible Medicaid copayment. The State will conduct outreach activities to the provider community. The outreach activities include: Posting Provider Enrollment FAQs and information on the provider portal. In addition, training information regarding how to reach the Provider Enrollment Services Call Center for support; as well as blast emails to the current or potential provider population about the benefits of HIPP and how it affects the providers business. Other states will be engaged to determine the best practices for Provider Outreach. Lastly, providing same day Provider Enrollment for those that are not currently enrolled into Medicaid. All State and Federal Provider Enrollment Regulations and Procedures will remain as normal.

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