

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: District of Columbia

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans  District of Columbia's Health Insurance Premium Payment Program

Introduction:

This section sets for the methods and standards established for the District of Columbia Medicaid Program. This Program shall provide mandatory enrollment of Medicaid eligibles in cost effective group health plans as a condition of Medicaid eligibility.

Legal Basis:

The related Federal Statute is the Social Security Act, Section 1906 was added by Section 4402(a)(2) of the Omnibus Budget Reconciliation Act of 1990

The legislation requires states to identify Medicaid cases in which payment of employer-related group health insurance would be cost effective.

Definitions:

"HIPPP" means the Health Insurance Premium Payment Program administered by the District of Columbia's Medicaid Program consistent with section 1906 of the Act.

"CHCF" means the Commission on Health Care Finance consistent with the code of the District of Columbia.

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"Recipient" means a person who has been determined to be Medicaid eligible by the Commission on Social Services and who has been added to the Medicaid recipient eligibility file.

"Group Health Insurance" means any plan of, or contributed by an employer (including a self-insured plan), to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees.

"Premium" means that portion of the cost for the group health plan which is the responsibility of the policy holder.

"Cost Effective" and "Cost Effectiveness" mean the reduction in Medicaid expenditures, which are likely to be greater than the additional expenditures for premiums and cost sharing obligations under an insurance plan.

"Health Insurance" means the protection which provides payment of benefits for covered sickness or injury.

Program Purpose:

The purpose of the HIPPP Program shall be:

- A. To identify cases in which enrollment of a recipient in a group health plan is likely to be cost effective;
- B. To require that recipients in those cases enroll in the group health plan as a condition of continued Medicaid eligibility;

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C.	To provide for payment of the premiums and other cost sharing obligations for items and services otherwise covered under the State Plan;
D.	To treat coverage under such group health plan as a third party payer liability consistent with 1906 of the Act.

Recipient Eligibility:

All Medicaid eligible recipients shall be eligible for HIPP except those as may be identified by the criteria listed below:

- A. While the individual is in the spend down process, he/she will not be eligible for the Health Insurance Premium Program. Once the individual has spent down, he/she would be eligible for Medicaid and also eligible to participate in the Health Insurance Premium Program.
- B. The recipient has a deduction from patient pay responsibility to cover the insurance premium.

Condition of Eligibility:

The Medicaid recipient, or a person acting on the recipient's behalf, shall cooperate in providing information necessary. All Medicaid eligible recipients shall be eligible for HIPP. Persons who are eligible to enroll

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in a group health insurance plan which the Department has determined cost effective, and who are otherwise eligible for Medicaid, shall apply for enrollment in the plan as a condition of Medicaid eligibility.

Cooperation Required:

A Medicaid recipient's enrollment in a group health plan does not change the individual's eligibility for benefits. If Medicaid services covered under the state plan are not part of the services covered in the group health plan, the recipient may obtain those services at participating Medicaid providers.

Non-Cooperation of Parent or Spouse:

When a parent fails to provide information necessary to determine availability and cost effectiveness of group health insurance, fails to enroll in a group health insurance plan that has been determined to be cost effective, or disenrolls from a group health insurance plan the Department has determined to be cost effective, Medicaid benefits of the parent shall be terminated.

Application Required:

If the recipient is not already enrolled in a group health plan at the time the cost effectiveness determination is made, the recipient may not be able to enroll in the group health plan until a later date (such as open enrollment period). The recipient shall provide the District of Columbia Medicaid Program a completed application for enrollment as proof of cooperation.

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The recipient shall, as a condition of continued Medicaid eligibility, enroll in the group health plan at the earliest date in which enrollment is possible, unless failure to cooperate has been established or unless the recipient is unable to enroll on his own behalf.

Non-Compliance:

If a recipient does not enroll in the group health plan which the District of Columbia Medicaid Program has determined to be cost effective or refuses to provide a completed application for enrollment in the group health plan, the recipient shall lose eligibility for Medicaid. Medicaid eligibility shall end after appropriate written notice is given to the recipient as required by 42 CFR 431.211.

This ineligibility shall remain effective until the earliest date that the recipient could next enroll in the group health plan.

Multiple Group Health Plans:

When more than one group health plan is available to the recipient, the recipient shall, as a condition of continued Medicaid eligibility, enroll in the group health plan of his or her choice.

Time Frames for Determining Cost Effectiveness:

The Medicaid Program shall determine cost effectiveness of the insurance plan and notify the recipient of the decision regarding payment of premiums as specified at 42 CFR 435.911.

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Notices:

An adequate notice shall be provided to the household under the following circumstances:

- A. To inform the household of the initial decision on cost effectiveness and premium payment.
- B. To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the policy.
- C. The policy is no longer available to the family (i.e., the employer drops insurance coverage or the policy is terminated by the insurance company.)
- D. A timely and adequate notice shall be provided to the household informing them of a decision to discontinue payments of the health insurance premium because the Department has determined the policy is no longer cost effective.

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Disenrollment:

If a recipient disenrolls from a group health plan which the Department has determined to be cost effective or the most cost effective in the case of multiple plans, the recipient shall lose eligibility for Medicaid. The Medicaid eligibility shall end after appropriate written notice is given to the recipient as required in 42 CFR 431.211. This ineligibility shall remain effective until the earliest date that the recipient could re-enroll in the group health plan.

Payments:

CHCF shall provide for the payment of premiums and other cost effective sharing obligations for items and services otherwise covered under the Plan, except for the nominal cost sharing amounts permitted under Section 1916.

- A. Effective date of premium: Payment of premiums shall become effective on the first day of the month in which CHCF makes the cost effectiveness determination or the first day of the month in which the group health plan coverage becomes effective, whichever is later. Payment of premiums shall be made to the employer in accordance with the Code.
- B. Termination date of premiums: The District will not be responsible for the premium when Medicaid eligibility is lost. Medicaid eligibility will govern and control items:
1. The month in which Medicaid eligibility ends;
  2. The month in which eligibility for group coverage ends; or

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3. The month in which it is determined that payment of premiums is no longer cost effective, whichever comes later.
- C. Non-Medicaid eligible family members: Payment of premiums for Non-Medicaid eligible family members shall 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 payment shall be treated as payments for Medicaid benefits for the eligible individual.
- D. Non-Medicaid providers: CHCF shall encourage all providers to become Medicaid participating providers. If Non-Medicaid providers refuse to bill Medicaid for services rendered to recipients, CHCF shall elect to resolve these problems by:
1. Deem providers to be Medicaid participating providers through the submission of bills for services to the state agency.

Guidelines for Determining Cost Effectiveness:

CHCF shall determine the cost effectiveness of a group health plan subsequent to the determination of eligibility for Medicaid.

- A. Enrollment limitation: CHCF shall take into account that a recipient may only be eligible to enroll in the group health plan at limited times and only if other non-Medicaid family members are also enrolled in the plan simultaneously.



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Step 2:	<p><u>Average Estimated Medicaid Expenditures:</u></p> <p>Using the Medicaid Management Information System (MMIS), the District of Columbia shall estimate the average annual Medicaid expenditures for the recipient. The expenditures will be based on the expenditures for persons like the recipient. The expenditures shall be adjusted accordingly for inflation and scheduled provider reimbursement rate increases.</p>
Step 3:	<p><u>Medicaid Expenditures by the Group Health Plan:</u></p> <p>The District of Columbia shall compare the services covered by the group health plan to the Medicaid expenditures for those services and estimate the total annual Medicaid expenditures which would be covered by the group health plan for the recipient.</p>
Step 4:	<p><u>Group Health Plan Cost Allowance for Included Services:</u></p> <p>The District of Columbia shall use the allowance factor that is supplied and updated by HCFA periodically. The factor shall be multiplied by the Medicaid expenditures (amount from Step 3) covered by the group health plan to produce the estimated covered expense as recognized by the employer plan.</p>
Step 5:	<p><u>Covered Expense Amount:</u></p> <p>The District of Columbia shall multiply an average group health plan payment rate by the group health plan allowance (amount from Step 4) to produce an estimated covered expense amount. The average group health plan payments rate shall be based on a state specific rate, national rate, or group health plan specific rate.</p>



