STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

Medi-Cal Payments for Individual and Group Health Plan Coverage

The Department of Health Care Services (DHCS or Department) submits this SPA to address updates to our administration of the Health Insurance Premium Payment (HIPP) program. The HIPP program is a voluntary program available to full-scope Medi-Cal members, and authorized under Sections 1906 and 1905(a) of the Social Security Act. Medi-Cal members who qualify to participate in the HIPP program are eligible to receive payment for the cost of the Medi-Cal member's other health coverage premium and cost-sharing obligations. The purpose of the HIPP program is to provide newly enrolled Medi-Cal members with the option to maintain their other health coverage for a limited time as they transition onto Medi-Cal coverage. The HIPP program does not affect a Medi-Cal member's eligibility or access to services under Medi-Cal. HIPP members disenrolled from the HIPP program who remain eligible for Medi-Cal will be eligible to receive medical care through the Medi-Cal delivery system.

The effective date for this SPA is July 1, 2021.

Eligibility for HIPP

Medi-Cal members may participate in the HIPP program if they meet all of the following criteria:

1. The Medi-Cal member has an existing policy.
    a. An "existing policy" is an other health insurance policy that a Medi-Cal member is covered under when they first become enrolled in Medi-Cal, and is continuously maintained, including policies under which a Medi-Cal member is a dependent.
    b. "Other health insurance" or "other health coverage" means comprehensive third party health coverage provided by a private employer, Consolidated Omnibus Budget Reconciliation Act COBRA continuation coverage, or an individual health care marketplace.
2. The Medi-Cal member has a medical condition covered under the Medi-Cal member's existing policy and the Medi-Cal member has received treatment for the medical condition within 90 days of application to the HIPP program.

3. The Medi-Cal member has full scope Medi-Cal coverage.
4. The Medi-Cal member has applied for Medicare benefits.
5. The Medi-Cal member's other health coverage is cost-effective to Medi-Cal. Cost-effectiveness is determined by comparing the sum of the Medi-Cal member's individual or group other health insurance medical premium, cost-sharing obligations, administrative cost, and the total Medi-Cal utilization costs, to the anticipated cost to Medi-Cal for the treatment of the condition and any associated diagnoses included in a statement completed by the Medi-Cal member's physician.
    a. "Premium" means:
        i. If a HIPP member is the only person covered under his or her other health coverage, the monthly amount to insure the policyholder, or
        ii. If a HIPP member is insured under a policy that covers additional people, the cost reasonably attributed to the HIPP member's portion of the monthly amount, except in cases where a HIPP member cannot enroll in a group health plan without the concurrent enrollment of family members ineligible for Medi-Cal.
    b. "Cost-sharing obligations" means the sum of the HIPP member's in-network costs for deductible(s), co-payment(s), and co-insurance for medical care billed by other health coverage to the policyholder.
    c. "Administrative cost" means the cost for the Department to administer the HIPP program on behalf of a HIPP member. This cost is calculated as 125% of the maximum Staff Services Analyst (SSA) Range C pay, divided by the number of current HIPP members. This calculation is made on the first day of every state fiscal year and is applicable until the following fiscal year.
    d. The "Medi-Cal utilization cost" means the sum of costs billed to Medi-Cal for services not covered by the Medi-Cal member's other health insurance and available through Medi-Cal, and costs for services billed to Medi-Cal that are covered by the Medi-Cal member's individual or group other health insurance, including cost sharing, minus adjustments for post payment recoveries.

Medi-Cal members shall not participate in the HIPP program if any of the following apply:

1. The Medi-Cal member is enrolled in Medicare.
2. The Medi-Cal member is enrolled in a Medi-Cal managed care plan.
3. The Medi-Cal member does not have full-scope Medi-Cal coverage.
4. A court has ordered a non-custodial parent to provide medical insurance to the Medi-Cal member.

5. The Medi-Cal member, or a policyholder under which the Medi-Cal member is insured as a dependent, is fully reimbursed for their premiums and/or cost-sharing obligations by a third party.

The HIPP program will not pay other health premiums and cost-sharing for Medi-Cal members for any month in which they have not met their monthly spend-down obligation.

Prospective Payment for Services Provided by the Other Health Insurance

The Department will pay the HIPP member prospectively for the member's premiums and cost-sharing obligations when the HIPP member submits a bill, invoice or other documentation demonstrating the member's liability to the Department no less than thirty (30) calendar days before payment is due. The Department may, at its discretion, pay the member's premiums and cost-sharing obligations if the member submits a bill or invoice less than thirty (30) calendar days before payment is due.

Payment for Family Members Ineligible for Medi-Cal or the HIPP program

The Department shall pay the medical premiums for family members ineligible for Medi-Cal, or family members eligible for Medi-Cal but ineligible for HIPP, if:

1. A HIPP member is enrolled in a group health plan which requires the concurrent enrollment of family members ineligible for Medi-Cal, or family members eligible for Medi-Cal but ineligible for HIPP; and
2. The cost of the entire family premium, in addition to the HIPP member's cost sharing obligations and administrative cost, is projected to be less than the anticipated amount that Medi-Cal would pay for the Medi-Cal member's medical services; and
3. The family policy cannot be reasonably apportioned between the individual family members.

DHCS shall not pay cost-sharing obligations for non-HIPP members.

Redetermination Reviews

HIPP members are subject to an annual redetermination of their program eligibility. The Department may, at its discretion, complete a redetermination review of program eligibility for a HIPP member when any of the following occurs:

1. A change in the HIPP member's Medi-Cal eligibility;
2. A change in medical services covered by the HIPP member's other health insurance; or
3. A change in medical premium rates and/or cost-sharing obligations for the HIPP member's other health insurance. This occurs when a HIPP member's other health insurer changes the member's premium and/or cost sharing obligations to an amount different from the amounts approved by the Department during the HIPP member's most recent eligibility determination or redetermination.

HIPP members must notify the HIPP program within thirty (30) days of any changes in their other health insurance benefits, insurance premiums, co-payment or co-insurance obligations, personal contact information, marital status, or any other changes that may affect their HIPP program eligibility.

Disenrollment from the HIPP program

The Department may disenroll a member from the HIPP program if any of the following occurs:

1. The HIPP member does not submit documents requested by the Department to complete a redetermination of their program eligibility within 90 days after the Department issues an initial notice of redetermination.
2. The HIPP member becomes enrolled in Medicare.
3. The HIPP member is enrolled in a Medi-Cal managed care plan, or has the option to enroll in a Medi-Cal managed care plan.
4. The HIPP member does not have full-scope Medi-Cal coverage.
5. A court has ordered a non-custodial parent to provide medical insurance to the HIPP member.
6. The HIPP member, or a policyholder under which the HIPP member is insured as a dependent, is fully paid for their premiums and/or cost-sharing obligations by a third party.