COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 1, 2024

MEMORANDUM

TO: The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Louise L. Lucas
Chair, Senate Finance and Appropriations Committee

Michael Maul
Director, Department of Planning and Budget

FROM: Cheryl J. Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on hospital readmissions, July 2020-December 2023

This report is submitted in compliance with item 292 FF. of the *2024 Appropriations Act*, which states:

> *The Department of Medical Assistance Services shall improve efforts to determine if individuals applying for and enrolled in the Medicaid and CHIP programs are eligible for alternative health care coverage. The department shall report on its efforts, as well as potential strategies to enhance coverage identifications, to the Chairmen of the House*

Appropriations and Senate Appropriations and Finance Committees and the Director, Department of Planning and Budget by October 1 of each year."

Should you have any questions or need additional information, please feel free to contact me at (804) 664-2660.

CJR/wrf

Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

Annual Alternative Health Coverage Report

October 2024

Report Mandate:

Item 292 FF. of the 2024 Appropriation Act states: The Department of Medical Assistance Services shall improve efforts to determine if individuals applying for and enrolled in the Medicaid and CHIP programs are eligible for alternative health care coverage. The department shall report on its efforts, as well as potential strategies to enhance coverage identifications, to the Chairmen of the House Appropriations and Senate Appropriations and Finance Committees and the Director, Department of Planning and Budget by October 1 of each year.

Available Health Options

Some individuals eligible for Medicaid may be eligible for other health care coverage options, including employer sponsored coverage and Medicare. DMAS screens new applicants and members renewing Medicaid and Family Access to Medical Insurance Security (FAMIS) coverage each year to see if they have other health insurance. DMAS also notifies Medicaid members when they turn 65 and become eligible for Medicare.

DMAS uses these proactive measures to encourage members to take advantage of alternative coverage options because federal rules prohibit the conditioning of Medicaid eligibility on the use of other coverage. Rule 42 CFR 435.608, which required applicants to take all necessary steps to obtain other benefits, was removed in June 2024. Additionally, Medicaid eligibility policy 42 CFR 435.906 states that the agency must afford an individual wishing to do so the opportunity to apply for Medicaid without delay. The intent of this rule is to simplify the eligibility and enrollment process and eliminate access barriers.

Third Party Liability (TPL) Policy

Most Medicaid populations are permitted to have enrollment in other insurance programs. In cases where individuals are enrolled in other insurance coverage, federal law mandates the Medicaid program is the payor of last resort. In these cases, that entity is required to pay all or part of the cost of the claim prior to Medicaid making any payment. This is known as Third Party Liability (TPL).

DMAS receives daily updated TPL data from the Virginia Department of Social Services (VDSS) and Gainwell, a national TPL contractor providing TPL services to state Medicaid agencies. In addition, DMAS receives a monthly file of TPL data from Managed Care Organizations (MCOs) contracted by DMAS. This data is validated daily and monthly by the TPL unit at DMAS. This TPL unit also handles inquiries from external stakeholders and makes corrections as needed. In addition, the system has claims edits in place that checks for TPL data and reacts appropriately to deny the claim if a TPL is found, and Medicaid was not billed as secondary.

Medicare Coverage

Individuals are generally eligible for the federally administered Medicare program when they turn age 65 if they are citizens or permanent residents and meet certain requirements. Some individuals qualify for Medicare earlier if they receive a disability determination from the SSA, have End-Stage Renal Disease (requiring regular dialysis or a transplant), or have been diagnosed with Lou Gehrig's (also known as ALS) disease. Disabled individuals under 65 years of age are required to receive Social Security Disability payments for 24 months prior to meeting eligibility for Medicare. Other rules also apply, such as meeting citizenship requirements or being a lawfully admitted citizen who has lived in the United States for at least five years.

During the Medicaid application and annual redetermination process, eligibility for the Medicare program is checked by the Local Departments of Social Services (LDSS) where the individual resides through a data exchange with the Social Security Administration. Additionally, DMAS receives a monthly Medicare Modernization Act (MMA) file that is a key data source for identifying individuals with Medicare. DMAS monitors newly eligible individuals aged 65 or older and those who are approaching age 65 and performs outreach to those individuals through providing information around their potential eligibility in the Medicare program, as well as resources for assistance with the Medicare application process. DMAS currently sends an average of 400 letters each month to Medicaid enrolled individuals.

The process to identify the Medicare eligible recipients is performed for all active enrollments in the Medicaid programs. When a change is reported or discovered within reliable data sources, the worker must evaluate the member for all other types of coverage prior to reduction or closure of their current coverage, including if an individual gains Medicare.

Summary and Recommendations

DMAS recommends a strengthened outreach approach in state fiscal year (SFY) 2025 to include updating resources available on the agency's Cover VA website to include a page dedicated to Medicare resources and pathways to assistance. Expected completion of the updated website is in the first quarter of SFY2025. Outside of assisting individuals with transitioning to other health coverage after the loss of Medicaid eligibility, current policies prevent the agency from requiring enrollment in other health insurance.

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage. The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives an approximate dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.