COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 1, 2026

MEMORANDUM

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

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

Michael Maul
Director, Department of Planning and Budget

FROM: Steve Ford
Director, Virginia Department of Medical Assistance Services

SUBJECT: Annual Alternative Health Coverage Report, 2026

This report is submitted in compliance with Item 295.II. of the 2026 Appropriation 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.

SF/wrf

Enclosure

Pc: The Honorable Marvin B. Figueroa, Secretary of Health and Human Resources

Annual Alternative Health Coverage Report, 2026

October 1, 2026

Report Mandate:

Item 295.II of the 2026 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.

Background: Federal and State Requirements

Federal regulations no longer require Medicaid applicants to take all necessary steps to obtain other benefits. The rules were changed in 2024 to simplify the eligibility and enrollment process and eliminate potential access barriers. (42 CFR 435.608 was repealed in June 2024.) Current federal rules (42 CFR 435.906) state that the agency must afford individuals the opportunity to apply for Medicaid without delay, and require the state to conduct outreach and coordinate where possible to increase the number of children with creditable health coverage (42 CFR 457.80 et seq.).

This Annual Alternative Health Coverage Report was first mandated in Virginia's 2024 Appropriation Act and has remained as standing budget language. The report was requested in response to concerns from providers that certain Medicaid members, specifically those with medical conditions that may qualify them for Medicare before age 65, were not aware of their potential eligibility.

Alternative Coverage Options

There are numerous alternative health coverage options for Medicaid members and other Virginians applying for Medicaid and CHIP, including employer sponsored coverage and Medicare. DMAS screens applicants and members renewing coverage each year to see if they have other health insurance. DMAS also notifies Medicaid members when they become eligible for Medicare.

Third Party Liability (TPL) Policy

Most Medicaid populations are permitted to have enrollment in other insurance programs. (Rules are different for CHIP programs like Virginia's Family Access to Medical Insurance Security [FAMIS]; FAMIS populations generally must be insured to qualify.) 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, the other insurer has the responsibility to pay for medical costs incurred by a Medicaid-enrolled individual: 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" or TPL. The Deficit Reduction Act of 2005 clarified that "third parties" means self-insured plans, pharmacy benefit managers, and "other parties that are, by statute, contract, or agreement legally responsible for a payment of a claim for a health care item or service."

DMAS receives daily updated TPL data from the Department of Social Services and Gainwell, a national contractor providing TPL services to state Medicaid agencies. In addition, DMAS receives a monthly file of TPL data from managed care organizations contracted by DMAS. This data is validated daily and monthly by the TPL unit at DMAS.

DMAS' TPL unit also handles inquiries from external stakeholders and makes corrections as needed. In addition, the system has functionality in place to check for TPL data and deny claims that violate the policy which requires Medicaid to be the payor of last resort.

Medicare Coverage

Individuals are generally eligible for the federally administered Medicare program when they turn 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 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 Department of Social Services 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, providing information around the Virginia requirement to enroll in the Medicare program, if eligible, 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

Beyond 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 outside of the Medicare program. While Virginia policy does require eligible individuals to enroll in Medicare, local DSS agencies have limited ability to know if someone meets the requirements. The information needed to verify Medicare enrollment may not be a factor of eligibility for Medicaid, and workers therefore cannot ask for that information. DMAS continues to use system edits and processing to identify members who are potentially eligible for other insurance and send out notifications or react with denials when appropriate. The Cover VA website captures information under the Learn section, which provides Medicare eligibility criteria, Medicare resources, and pathways to assistance.

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 approximately 1.7 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, and 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.