VA - Submission Package - VA2023MS0002O - (VA-23-0007) - Administration

CMS-10434 OMB 0938-1188

Package Information

Package ID	VA2023MS0002O	**Submission Type**	Official
Program Name	N/A	**State**	VA
SPA ID	VA-23-0007	**Region**	Philadelphia, PA
Version Number	1	**Package Status**	Pending

Submission - Summary

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Package ID	VA2023MS0002O	**SPA ID**	VA-23-0007
Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name:	Virginia	**Medicaid Agency Name:**	Department of Medical Assistance Services

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

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Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID VA-23-0007

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Eligibility Determinations and Fair Hearings	11/1/2023	VA-18-0011
Organization and Administration	11/1/2023	VA-19-0016

Submission - Summary

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Executive Summary

Summary Description Including Goals and Objectives Changes are being made to reflect the implementation of a new state-based exchange (SBE). Functions previously handled by the Federally Facilitated Marketplace will move to Virginia's SBE.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2024	$0
Second	2025	$0

Federal Statute / Regulation Citation

45 CFR Part 155

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

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Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Submission - Medicaid State Plan

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The submission includes the following:

☐ Administration

☐ Organization

☐ Designation and Authority

☐ Intergovernmental Cooperation Act Waivers

☐ Eligibility Determinations and Fair Hearings

Reviewable Unit Name	Included in Another Submission Package	Source Type
Eligibility Determinations and Fair Hearings	(	APPROVED

☐ Organization and Administration

Reviewable Unit Name	Included in Another Submission Package	Source Type
Organization and Administration	(	APPROVED

☐ Single State Agency Assurances

☐ Eligibility

☐ Benefits and Payments

Submission - Public Comment

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Indicate whether public comment was solicited with respect to this submission.

- (•) Public notice was not federally required and comment was not solicited
- ( ) Public notice was not federally required, but comment was solicited
- ( ) Public notice was federally required and comment was solicited

Submission - Tribal Input

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Effective Date N/A
Superseded SPA ID N/A

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- (●) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- (●) Yes
- ( ) No

[ ] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

[ ] All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
	Will be added.

[ ] All Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

[ ] All Indian Tribes

Date of consultation:	Method of consultation:
	Will be added.

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
No items available		

Indicate the key issues raised (optional)

[ ] Access
[ ] Quality
[ ] Cost
[ ] Payment methodology
[ ] Eligibility

- **Summarize comments:**

- **Summarize response:**

☐ Benefits

☐ Service delivery

☐ Other issue

Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

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Superseded SPA ID	VA-18-0011		
	System-Derived		

A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:

- [x] a. The Medicaid agency
- [x] b. Delegated governmental agency
  - [x] i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - [x] ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - [ ] iii. Other

2. The entity or entities that conduct determinations of eligibility based on age (65 or older), or having blindness or a disability are:

- [ ] a. The Medicaid agency
- [x] b. Delegated governmental agency
  - [x] i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - [ ] ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - [ ] iii. The Social Security Administration determines Medicaid eligibility for:
    - [ ] (1) SSI beneficiaries
    - [ ] (2) Optional state supplement recipients
  - [ ] iv. Other

3. Assurances:

- [x] a. The Medicaid agency is responsible for all Medicaid eligibility determinations.
- [x] b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).
- [x] c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.
- [x] d. The delegated entity is capable of performing the delegated functions.

Eligibility Determinations and Fair Hearings

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	System-Derived		

B. Fair Hearings (including any delegations)

[x] The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.

[x] The Medicaid agency is responsible for all Medicaid fair hearings.

1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:

[x] a. Medicaid agency

[ ] d. Delegated governmental agency

3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):

[x] All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

Eligibility Determinations and Fair Hearings

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	System-Derived		

C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- ○ Yes
- ◉ No

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Organization and Administration

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	System-Derived		

A. Description of the Organization and Functions of the Single State Agency

1. The single state agency is:

- (•) a. A stand-alone agency, separate from every other state agency
- ( ) b. Also the Title IV-A (TANF) agency
- ( ) c. Also the state health department
- ( ) d. Other:

2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)

a. Eligibility Determinations

The Title IV-A Agency, the State Department of Social Services, maintains the Virginia Case Management System (VaCMS); the eligibility determination system implemented to evaluate and enroll eligible members directly into the MMIS.

A contractor vendor is responsible for operating the Medicaid call center, Cover Virginia, and for data entry of MAGI application information into the VaCMS system, the state's eligibility system. The Eligibility and Enrollment Services Division in the Department of Medical Assistance Services oversees the contracted vendor.

In addition, Virginia's State-Based Exchange will evaluate individuals to determine eligibility for Medicaid. Please see section B below.

b. Fair Hearings (including expedited fair hearings)

The Appeals Division within the State Medicaid agency provides a process by which clients and providers can appeal adverse decisions made by the Agency or its contractors. The Appeals Division has separate units that handle client appeals and provider appeals.

The FADS and Formal Appeals team oversees and manages the formal appeals process and reviews the formal appeals decisions issued by DMAS.

c. Health Care Delivery, including benefits and services, managed care (if applicable)

The Health Care Services Division focuses on the development, implementation, and administration of managed care, pharmacy, and quality assurance services provided to eligible Medicaid recipients.

The Integrated Care Division is responsible for ensuring individuals with complex care needs receive comprehensive care coordination, ensuring access to appropriate quality care that supports the highest possible level of health outcomes. The Division leads the development and implementation of necessary regulations, policies and procedures to promote the most effective and efficient care in the least restrictive environments.

The Division of Aging and Disability Services develops, implements and administers programs designed to improve the lives of the elderly and persons with disabilities. The Division analyzes, develops and promulgates long-term care regulations, policies and procedures, designs and conducts long-term care studies, provides policy and operational support for the long-term care programs of the Agency and develops new home-and-community-based waivers.

The Medical Support Unit is housed within the Office of the Chief Medical Officer and is a federally required critical component of the Medicaid Program. It ensures that medical consultation is available to Agency programs and to Agency administration, as well as to assure that peer review is available to enrolled providers.

d. Program and policy support including state plan, waivers, and demonstrations (if applicable)

The Policy, Regulation, and Member Engagement Division with the State Medicaid Agency provides program and policy support to include planning and innovation efforts in response to state and federal laws and other requirements, agency priorities, industry best practices and stakeholder inputs.

The Eligibility and Enrollment Services Division establishes and maintains the program rules related to financial and non-financial eligibility for the Virginia Medicaid and Family Access to Medical Insurance Security (FAMIS) programs in accordance with federal guidelines.

The Behavioral Health Division reviews the use of existing behavioral health services, reviews options for improving the quality of these services and access to care, and suggests policy and program improvements related to these services.

The Office of High Needs Supports reviews the use of services for individuals with developmental disabilities, reviews options for improving the quality of these services and access to care, and suggests policy and program improvements related to these services.

The Office of Community Living reviews the use of the CCC Plus Waiver as well as both consumer-directed and agency-directed services within the home and community based waivers. The Office reviews options for improving the quality of these services and access to care, and suggests policy and program improvements related to these services.

The Office of Quality and Population Health focuses on developing, analyzing, reporting, and improving quality measures and outcomes of health care provided to Medicaid members.

e. Administration, including budget, legal counsel

The Department of Medical Assistance Services (DMAS) is operated under the direct supervision of the Director of DMAS who is appointed by the Governor. The Director executes the Department's multi-billion dollar biennium budget, plans and implements medical services through a network of health providers, and represents DMAS with other governmental entities. The principal assistant is the Deputy Director who assists the Director in all aspects of Medicaid planning, development, evaluation and the daily operation of all program functions, in addition to supervising the Support Services Unit.

The Budget Division is responsible for developing and managing the Agency's budget, submitting the Agency's budget to the Department of Planning and Budget (the Agency responsible for managing the entire state government budget) and the federal Centers for Medicare and Medicaid Services.

The Federal Reporting Division is in charge of managing the federal reports that are sent to CMS for financial management.

The Internal Audit Division independently examines and evaluates the ongoing control processes of the Agency and provides counsel and recommendations for improvement whenever such opportunities are identified. The objective of the Division is to provide reasonable assurance to management, within economic limitations and subject to the availability of staff.

The Procurement and Contract Management Division directs the Agency procurement activities and directs the development of Requests for Proposals (RFP) and Invitations for Bids (IFB), contract preparation, solicitation evaluation processes, contractor selection and contract performance reporting.

f. Financial management, including processing of provider claims and other health care financing

The Fiscal Division provides accounting, reporting, and financial management services to the Agency. The accounting functions are in compliance with relevant laws, regulations, fiscal policies and procedures, and professional standards. The Division develops and operates financial systems with sufficient internal control to provide accurate, timely, and meaningful financial and operating information to all interested parties and to protect the Department against theft and other types of loss. The Division is responsible for financial reporting, disbursement, cash management, third party liability, purchasing and support operations, and financial system administration. The Controller performs general administrative functions; develops and maintains fiscal policies and procedures; develops and implements and uses major automated systems; and provides overall planning and guidance for the Division.

The Program Operations Division provides services for medical evaluation of services including an eligibility and enrollment component, payment processing, customer services, and provider training. The Payment Processing Unit within the Program Operations Division evaluates, processes, and adjudicates claims and payments for various providers in specific benefit programs.

The Provider Reimbursement Division (PRD) is responsible for determining the payments for participating providers in Virginia's Department of Medical Assistance Services, including calculating, reviewing, and updating Medicaid capitation and provider payment rates. In addition, PRD calculates and administers supplemental payments to hospitals, nursing care facilities and physicians. An important part of this work includes the settlement and auditing of institutional providers' cost reports and utilizing both regulatory and market information to determine appropriate and allowable payments.

The Office of Value Based Purchasing serves as an Agency expert in the development and implementation of value-based payment policy.

g. Systems administration, including MMIS, eligibility systems

The Information Management Division (IM) is responsible for the development, implementation, and maintenance of all computer software systems within the Agency as well as the procurement, maintenance, and operation of computer equipment. Much of the work is performed in tandem with Agency's fiscal agent. Under DMAS' direction, the fiscal agent designs, develops, and maintains the Agency's Medicaid Management Information System (MMIS).

The Title IV-A Agency, the State Department of Social Services, maintains the Virginia Case Management System (VaCMS); the eligibility determination system implemented to evaluate and enroll eligible members directly into the MMIS.

A contractor vendor is responsible for operating the Medicaid call center, Cover Virginia, and for data entry of MAGI application information into the VaCMS system, the state's eligibility system. The Eligibility and Enrollment Services Division in the Department of Medical Assistance Services oversees the contracted vendor.

The Office of Enterprise and Project Management is responsible for the implementation of agency information technology and program related projects.

In addition, Virginia's State-Based Exchange will evaluate individuals to determine eligibility for Medicaid. Please see section B below.

h. Other functions, e.g., TPL, utilization management (optional)

The Office of Data Analytics provide a structured analytics environment that assures data integrity, data consistency, well documented research, and repeatability.

The Program Integrity Division has responsibility for three units: Recipient Audit Unit, External Provider Audit and Policy Unit, and the Prior Authorization and Utilization Review (PAUR) Unit. The Recipient Audit Unit investigates referrals of fraudulent activity and abuse by Medicaid and FAMIS enrollees. The External Provider Audit and Policy unit oversees a wide variety of audit contracts in addition to providing policy analysis and expertise related to program integrity issues. The PAUR Unit conducts provider audits and also oversees a contractor that provides medical staff who review requests for service authorization and determine if the service is medically necessary under DMAS policy.

3. An organizational chart of the Medicaid agency has been uploaded:

Name	Date Created	
overall-org-structure 4-4-23	4/4/2023 12:19 PM EDT	

Organization and Administration

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B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency

Title	Description of the functions the delegated entity performs in carrying out its responsibilities:
Single state agency under Title IV-A (TANF)	The Title IV-A agency (State Department of Social Services or DSS) determines eligibility for Title XIX services, including eligibility under MAGI. Eligibility determinations are performed by staff supervised by the State DSS and administered by county and city departments of social services. The duties of the State DSS are as follows: certification by local social services agency superintendents/directors of current public assistance recipients and foster care children of the local social services department, acceptance of applications for medical assistance under Title XIX by the local department of social services of the city or county in which the applicant resides, or by State employees located in designated institutions. This includes determination of initial eligibility, certification of applicants found eligible, recertification on basis of periodic reviews of eligibility, and notification to the Department of Medical Assistance Services and to the applicant/recipient of the initial eligibility decision and any subsequent change in eligibility status. The State DSS is responsible for supervising the local departments of social services in the performance of the eligibility determination function. DMAS oversees the performance of these functions and retains all policy-making and decision-making authority as set forth in 42 CFR 431.10(e).
An Exchange that is a government agency	Virginia's State Based Exchange will conduct Medicaid eligibility determinations for groups of individuals whose income eligibility is determined based on Modified Adjusted Gross Income (MAGI) methodology and who apply through the SBE. The SBE will not be assigning an individual who is determined eligible for Medicaid whose income eligibility is determined using MAGI methodology to a specific eligibility group, determining cost-sharing (if applicable), or assigning a benefit package. These functions will be performed by the single state agency. The SBE also refers individuals to the single state agency for determination if potentially eligible for non-MAGI Medicaid (e.g., ABD or limited coverage) or if potentially eligible for MAGI coverage but the exchange was unable to make a full determination. The SBE will not be handling appeals.

Organization and Administration

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E. Coordination with Other Executive Agencies

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):.

(•) Yes
( ) No

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:
Department for Aging and Rehabilitative Services	The Department for Aging and Rehabilitative Services (DARS) coordinates and provides Medicaid services and advocates for resources and services to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families.
Department for the Blind and Vision Impaired	The Department for the Blind and Vision Impaired (DBVI) coordinates and provides services, to include Medicaid services, to assist citizens who are blind, deaf and blind, or vision impaired in achieving their maximum level of employment, education, and personal independence.
The Department of Health Professions	The Department of Health Professions (DHP) is responsible for the licensure and regulation of healthcare practitioners across 80 professions. Health regulatory boards issue permits and licenses to facilities, to include Medicaid facilities, such as pharmacies.
Department of Behavioral Health and Developmental Services	The Department of Behavioral Health and Developmental Services (DBHDS) licenses services that provide treatment, training, support and habilitation to individuals who have mental illness, developmental disabilities or substance abuse disorders, to individuals receiving services under the Medicaid DD Waiver, or to individuals receiving services in residential facilities for individuals with brain injuries.

Organization and Administration

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F. Additional information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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