



Virginia Department of Medical Assistance Services


Unwinding the COVID-19 Public Health Emergency: Medicaid Redetermination Plan



Commonwealth of Virginia
Department of Medical Assistance Services

Table of Contents

Executive Summary.....	2
Background	2
Returning to Normal Operations – The End of Continuous Coverage Requirements	4
Federal Requirements and Guidance	4
Communications & Community Outreach and Engagement Plan.....	4
Phase I: Member Contact Information	4
Phase II: Redetermination Process	5
Phase III: Resources and Referral.....	5
Partnerships with Managed Care Organizations (MCOs)	6
Fee-for-Service Members	7
Communication Channels	7
Websites.....	7
Mailings and Back-to-School Event.....	7
Text Messaging	7
Email.....	8
Collateral	8
Social Media, Television, Radio, and Media.....	8
Town Halls, Public Meetings, and Stakeholder Updates	8
Overview of Eligibility and Enrollment.....	9
System Readiness & Technological Enhancements	10
Cover Virginia Call Center, Central Processing Unit, and Redetermination Unit.....	11
Steps to Promote Continuity of Coverage	12
Leveraging Other Public Assistance Programs.....	12
Referrals and Partnerships with the Exchange	12
High-Risk Populations	12
Providers	12
Appeals.....	13
Flexibilities	14
Conclusion.....	14



Unwinding the COVID-19 Public Health Emergency: Virginia's Medicaid Redetermination Plan



Executive Summary

As a result of the COVID-19 Public Health Emergency (PHE) declaration, Congress passed the Families First Coronavirus Relief Act (FFCRA) which directed states to maintain Medicaid health coverage for individuals enrolled on or after March 18, 2020, through the end of the PHE – regardless of changes in their circumstances. In January 2022, the Secretary of Health and Human Resources formed a taskforce to prepare for the eventual unwinding of the continuous coverage requirements. On December 29, 2022, the 2023 Consolidated Appropriation Act decoupled the continuous coverage requirements from the PHE mandate and provided a date certain for states to begin the redetermination process for all individuals enrolled in the Medicaid program. Beginning in March 2023, the Department of Medical Assistance Services (DMAS) and the Department of Social Services (DSS) began performing Medicaid eligibility redeterminations for 2.2 million members and transitioning back to normal enrollment operations and procedures.

Shortly after the PHE declaration, Virginia developed a plan to resume normal operations once the continuous coverage requirements ended with the following goals in mind: (a) keeping eligible members enrolled, (b) transitioning ineligible members to other health insurance, if needed, (c) minimizing member burden, (d) achieving a sustainable schedule of redeterminations in future years, and (e) meeting the timeline set forth by the Centers for Medicare and Medicaid Services (CMS). CMS highlighted Virginia as a highly prepared state and referred the agency to share preparations with other states. To prepare for the transition of returning to normal Medicaid operations, Virginia acted early to make system improvements, ensure clear, concise, and timely communications and outreach to members and stakeholders, and strengthen the workforce at local DSS agencies.

This report focuses on the Commonwealth's plan for ending federal COVID-19 continuous coverage Medicaid policies and flexibilities. The report will discuss how DMAS and DSS will initiate eligibility redeterminations for the entire Medicaid population and revert to pre-pandemic operations.

Background

The Medicaid program is the state/federal partnership that provides health coverage to low-income families and individuals. In Virginia, DMAS is the designated single-state agency for administering the Medicaid program. DSS provides oversight of the program to the 120 local city and county offices that perform the eligibility determinations and ongoing case maintenance. DMAS oversees the performance of these functions and retains all policy-making and decision-making authority of the program.

On January 31, 2020, the U.S. Department of Health and Human Services declared a federal PHE in response to the COVID-19 pandemic. To support states and promote stability of Medicaid coverage during the pandemic, the FFCRA provided a 6.2% enhancement to the Medicaid federal matching rate, tied to certain conditions that states had to meet. The primary condition tied to the enhanced match rate was the requirement for states to maintain Medicaid health coverage for individuals enrolled on or after March 18, 2020, regardless of changes in

Unwinding the COVID-19 Public Health Emergency: Virginia's Medicaid Redetermination Plan





their circumstances, through the end of the PHE. As a result, the Virginia Medicaid program did not take any adverse actions which would reduce or close coverage from March 18, 2020, through March 31, 2023.

The 2023 Consolidated Appropriations Act, passed by Congress on December 23, 2022, and signed by President Biden on December 29, 2022, included the decoupling of the continuous coverage requirement from the PHE and provided a date certain of March 31, 2023, to end those requirements. As a result, in March 2023, Virginia returned to normal operations, beginning to redetermine eligibility for all Medicaid members for the first time since the start of the COVID-19 pandemic.

The passage of the 2023 Consolidated Appropriations Act signaled the end of the COVID-19 era federal requirements related to eligibility processes, such as continuous Medicaid coverage, and outlined a step-down reduction in the enhanced federal medical assistance percentage (FMAP). Beginning on April 1, 2023, the enhanced FMAP was reduced from 6.2% to 5.0%, further reduced to 2.5% for the quarter beginning July 1, 2023, and finally reduced to 1.5% for the quarter beginning October 1, 2023. Effective January 1, 2024, the state will no longer receive an enhanced federal match. Since the start of the federal match enhancement, the Commonwealth has received nearly \$2.5 billion in additional federal funding to support efforts required by the federal government.

During the pandemic Medicaid enrollment increased from 1.5 million to almost 2.2 million members as of March 2023. Enrollment grew the most among non-elderly, non-disabled adults, and the least among children and aged, blind, and disabled eligibility groups. Over the course of the next year, Virginia estimates approximately 14 percent of the state's total Medicaid enrollees may lose coverage. Nationally, the expected loss of Medicaid coverage is 20 percent. Historically, the Commonwealth has experienced churn, which is the process of a member losing coverage and re-gaining coverage within one to six months of coverage loss. It is expected that approximately four percent of Medicaid members will experience churn as the state begins to conduct redeterminations over the next year.

OBJECTIVES

-  Ensure continuity of coverage for individuals who remain eligible for the Medicaid program while assisting individuals who are no longer eligible for the program to transition to other health coverage.
-  Prioritize exceptional customer service through communication and education to Medicaid members and strong community and stakeholder collaboration.
-  Increase operational efficiencies and leverage technology to supplement existing workforce.
-  Implement strategies to closely monitor appropriate use of all Medicaid funding while maintaining compliance with all state and federal laws and guidance.

Returning to Normal Operations – The End of Continuous Coverage Requirements

The 2023 Consolidated Appropriations Act provided parameters for the resumption of normal operations and a statutory end-date of March 31, 2023, for the continuous coverage requirement. The federal government permitted states 9 to 14 months to reevaluate the eligibility status of all Medicaid enrollees and either renew coverage for another year, or transition individuals out of the Medicaid program if no longer eligible. Virginia initiated the first month of redeterminations in March 2023, with coverage closures beginning April 30, 2023.

In the pre-unwinding phases, DMAS and DSS placed a strong emphasis on compliance, system readiness, and increased efficiencies. Communicating the changes clearly to Medicaid members and stakeholders was a critical component to readiness. During the redetermination period, the agencies will execute a robust plan to successfully evaluate the status of 2.2 million Medicaid members and ensure equal access to the appeals process. For individuals unable to maintain Medicaid coverage, Virginia will work with federal, state, and community partners to connect people with resources and options for other health coverage.

Federal Requirements and Guidance

CMS guidance required states to complete a full redetermination by requesting new eligibility information. Federal guidance further indicated any redeterminations that resulted in a closure could not occur prior to the month after the continuous coverage requirement ended. This meant closures could not occur prior to April 30, 2023.


To meet federal compliance and continue receiving enhanced FMAP for the remainder of calendar year 2023, states are not permitted to initiate redeterminations for more than one-ninth of the total population per month.

Communications & Community Outreach and Engagement Plan

In preparation for the end of the continuous coverage requirements, Virginia Medicaid developed a three-phase plan for communications and community engagement with a strong focus on clear and concise messaging to members, community partners, providers, and stakeholders. The plan ensures members receive appropriate, accurate information and education regarding the resumption of normal operations, and how the redetermination period will impact Medicaid enrollment. Outreach and communications staff developed educational materials and resources for recipients to prepare for these changes and provide information on additional resources available for any member who may transition out of the program.

Phase I: Member Contact Information

Phase I of the Communications and Community Outreach and Engagement Plan began in March 2022. The goal of Phase I was to encourage Medicaid members to update their contact information. Due to the continuous coverage requirements, many members enrolled in the Virginia Medicaid program did not receive any communications for several years. Not having this contact with members increased the likelihood that the state did not have up-to-date address information for the individual. Virginia, like many states, participated in strategies targeted to obtain updated member contact information. These procedures will continue throughout the redetermination period, with some being made permanent. Strategies implemented by the state include:



Unwinding the COVID-19 Public Health Emergency: Virginia's Medicaid Redetermination Plan



- 1902(e)(14) waiver authority to accept updated address information from the six managed care plans contracted with DMAS. DMAS, in collaboration with the managed care plans, developed a data exchange which allows the managed care plans to accept updated contact information from individuals, which is transmitted to the state agency to allow staff to update the member's record.
- 1902(e)(14) waiver authority to utilize the National Change of Address (NCOA) file. This waiver authority allows the state to update the member's address based on the NCOA file without additional verification requirements from the individual.
- Social media, mailing, radio, television, and email campaigns encouraging individuals to update their contact information and avoid unnecessary coverage loss once the redetermination period begins. Individuals were encouraged to update their contact information by phone, email, or online using the self-service portal, CommonHelp.
- To ensure accurate enrollment in Virginia's program, the state has continually evaluated members with active Medicaid coverage who have out-of-state addresses.

With the goals of churn mitigation and continuity of coverage, these strategies have been successful in updating contact information and correcting enrollments for tens of thousands of Medicaid members.

Phase II: Redetermination Process

Phase II of Virginia's communications, outreach and engagement plan began in March 2023. The goal of Phase II is to educate members, staff and stakeholders on the redetermination process and provide available resources. In addition, the agency worked to ensure consistent messaging across all platforms, agencies, health plans and stakeholders. Phase II outreach will continue through the end of the unwinding period.

Key messaging for Phase II included information advising members and stakeholders that health care coverage would not be reduced or terminated without a full redetermination and allowing members to submit updated information. Messaging to members and stakeholders on the redetermination process and timeline ensures the Commonwealth will be able to manage the influx of calls and questions and allows availability of staff to provide a high level of customer service to callers. Phase II messaging also includes communications advising members to look for official mail, email or texts on next steps and the importance of meeting deadlines once contact is made.

Phase III: Resources and Referral

Phase III of the communications, outreach and engagement plan began in April 2023. The goal of Phase III is to refer members who completed their redetermination, but were found ineligible, to the Federally Facilitated Marketplace (health exchange), provide other resources such as how to file an appeal if they believe a mistake was made in the redetermination of their benefits and information about purchasing other health care coverage. Individuals who fail to complete their redetermination will be contacted with messaging encouraging them to turn in needed information to avoid coverage loss, or if ineligible, to receive a referral to the Federally Facilitated Marketplace for other coverage options.

Unwinding the COVID-19 Public Health Emergency: Virginia's Medicaid Redetermination Plan



Partnerships with Managed Care Organizations (MCOs)

Early in the planning process, DMAS acknowledged the need for assistance from outside partners to ensure an outreach and communications plan would reach all members. DMAS has strong relationships with the six contracted managed care organizations (MCOs): Aetna, Anthem, Molina, Optima, United Healthcare, and Virginia Premier. Prior to CMS providing guidance, DMAS proactively reached out to the health plans to determine the best coordination strategy for sharing information to managed care members, who make up 91% of Virginia's Medicaid population. The MCOs reviewed and provided feedback on the outreach toolkits developed for all three phases and maintained an ongoing dialogue with DMAS as the agency introduced new guidance.

DMAS implemented an enhanced reporting requirement for MCOs to provide DMAS with member contact information updates (addresses, phone numbers, email addresses) on a weekly basis. DMAS staff reviewed the information and updated the contact information or provided the information to the local DSS, depending on the type of case. This reporting has been a major factor in updating addresses in advance of sending redetermination forms and will continue through the unwinding period.

Outreach from MCOs to members will occur in two major areas during unwinding, Phase II, and Phase III:

- After the automated ex parte (no touch passive renewal) process completes each month, MCOs receive a file identifying members who were not able to be automatically renewed for another year and who will be required to complete a paper form. The MCOs are performing outreach to those members, encouraging the completion of the renewal, and offering resources and assistance to complete the form.

Unwinding the COVID-19 Public Health Emergency: Virginia's Medicaid Redetermination Plan

- A second data file was developed to allow health plans to receive monthly closure information which identifies individuals who completed the redetermination process but are no longer eligible for Medicaid and those who are losing coverage due to failure to complete the redetermination process. This data file provides the necessary information for the MCOs to perform the Phase III outreach activities.
- The MCOs and DMAS exchange contact information to allow this outreach and communication to occur within as many modalities (postal service, phone, text, email) as available to the household and will use outreach attempts to validate and increase the diversity of modalities if possible.

Fee-for-Service Members

While most of the Virginia's Medicaid population is enrolled in managed care, approximately 9% of members are in fee-for-service Medicaid, excluding these individuals from the outreach efforts of the MCOs. To ensure equitable messaging and education to all members, DMAS is utilizing an existing contract to enable text messaging, phone call, and emails to fee-for-service members. All outreach modalities will be used to mirror the outreach strategy put into place for managed care enrollees.

Communication Channels

Websites

DMAS has three public-facing websites: dmas.virginia.gov, coverva.dmas.virginia.gov, and the agency's Spanish language site, cubrevirginia.dmas.virginia.gov. Since the beginning of the PHE, DMAS has regularly updated all three websites with COVID-19 specific pages to inform members and stakeholders of changes, resources, and actions the agency was taking during the pandemic. Prominent information was displayed for all phases of the agency's outreach and communication efforts, including links to order resources for stakeholders, downloadable templates, social media graphics, fact sheets, frequently asked questions, fliers, and animated videos. Member-facing material was translated and made available in seven languages to include English and the top five non-English spoken languages in Virginia, accounting for over 99% of the state's Medicaid population.

Mailings and Back-to-School Event

DMAS mailed letters to over 1.1 million households with information about the continuous coverage requirements, the importance of keeping contact information up to date, and information about next steps when redeterminations resumed.


DMAS's back-to-school outreach campaign is the agency's largest campaign each year. During the 2022 campaign, DMAS, in collaboration with the Department of Education, send fliers to over one million households with students.

Text Messaging

DMAS sent Phase I and II outreach information via text message to all households who subscribe through the agency's Granicus platform to receive updates about the program.



Unwinding the COVID-19 Public Health Emergency: Virginia's Medicaid Redetermination Plan



Email

Members and providers have regularly received email blasts throughout the Phase I campaign and will continue to receive electronic messages throughout the redetermination period via the agency's web platform, and through the agency's formal memorandum process for providers. Providers can view these memos on the Medicaid Enterprise System (MES) provider portal and receive communications advising them of the availability of this information. The DMAS agency director also emailed providers advising of the start date for redeterminations and the importance of the provider's role in these efforts.

Collateral


In addition to the creation of outreach materials and toolkits for all stakeholder types, DMAS worked to distribute member fliers and posters throughout the Commonwealth to stakeholders and other community partners. DMAS mailed printed materials to all 120 local DSS agencies and 40 Community Service Board Offices throughout the state, with requests to display the information prominently in lobbies and other areas visited by members. DMAS provided written guidance for legislators on assisting constituents through the transition to normal operations.

Social Media, Television, Radio, and Media


DMAS participated in multiple paid media campaigns including search ads, programmatic and display ads, video ads, radio ads (in English and Spanish), and television spots. Additionally, DMAS conducted rolling information sessions directed at the Latino community on Radio Poder, a Spanish radio station in the Metro Richmond area. The agency was strategic in selecting diverse regions with high populations of Medicaid recipients to ensure large audiences received the messaging. The agency's campaign resulted in over 8.6 million impressions, over 117,000 website visits, and more than 6,000 calls to the Cover Virginia Call Center. Throughout the PHE, the agency has partnered with the press on both a state and national level, responding to media inquiries to ensure the most up-to-date information is available to the public. DMAS developed social media content and copy for provider and stakeholder use throughout the outreach and communication campaign. The agency had a social media campaign with Phase I messaging for the year leading up to the redetermination period. The agency has continued the social media campaign adding Phase II messaging, which will continue throughout the transition to normal operations.

Town Halls, Public Meetings, and Stakeholder Updates

To enable platforms for specific provider and advocate types to ask questions, voice concerns, and make recommendations, DMAS scheduled a series of targeted Town Halls and Listening Sessions leading up to the beginning of the redetermination period. These meetings included sessions for providers, older adults, advocates and community leaders, home health associations, housing organizations (including shelters), and a general forum for all stakeholders and members. DMAS recorded and posted the sessions on the agency's website. Virtual and in-person meetings were held and are planned to continue through the redetermination period for community advocates, health plans, providers, and other stakeholders.



Unwinding the COVID-19 Public Health Emergency: Virginia's Medicaid Redetermination Plan



DMAS and DSS staff serve on multiple taskforces and committees where regular updates were given throughout the PHE. The updates and meetings will continue throughout the redetermination work to include public-facing meetings, such as each agency's quarterly Board of Medical Assistance Services (BMAS), Children's Health Insurance Program Advisory Committee (CHIPAC), and Member Advisory Committee (MAC) meetings.

In January 2022 the Secretary of Health and Human Services formed a Medicaid Unwinding Taskforce bringing together staff from the Governor's Office, Department of Planning and Budget, the Office of the Attorney General, and eventually, Senate and House Appropriations staff. DMAS and DSS leadership have reported out to this group at least monthly since the inception of the taskforce and will continue to do so through the end of the unwinding period.

Beginning in late 2022, DMAS assembled a bi-weekly meeting consisting of representatives from a wide range of organizations to include other agencies, providers, advocates, community leaders and others who serve as ambassadors, to assist DMAS and DSS in relaying information within their communities and areas of expertise, bring concerns and questions to DMAS, and help with solutioning to ensure a smooth transition.

On March 8, 2023, DMAS hosted a "Medicaid: Return to Normal Enrollment Summit" attended by over three hundred stakeholders to include legislators, agency heads, MCOs, local departments of social services, providers and provider associations, and community partners.

Additional communication with stakeholders was provided through regular meetings, emails, phone calls, social media connections, and through articles in the monthly *Partner Points* newsletter, which is distributed to 30,000 organizations.


Overview of Eligibility and Enrollment

DMAS administers the Medicaid program in Virginia and has contractual oversight of the Commonwealth's state-wide call center application processing operation, Cover Virginia. DSS oversees the eligibility determination and enrollment activities of the 120 local county and city offices which serve as the "front door" for the Medicaid program.

The local DSS agencies and Cover Virginia determine eligibility for the following groups within the program:

- Children up to age 21
- Parents and caretaker relatives of minor children
- Adults between the ages of 19 to 64
- Pregnant individuals
- Aged, blind, or disabled individuals

Virginia has an integrated self-service portal, CommonHelp, which allows individuals to apply for, renew and report changes to Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for



Unwinding the COVID-19 Public Health Emergency: Virginia's Medicaid Redetermination Plan



Needy Families (TANF), energy assistance, and childcare through a single site that is available 24 hours a day. The portal also includes a streamlined application for MAGI covered groups that is separated from other benefit programs. Individuals may also file an application by mail, fax, in person at their local DSS, or by calling Cover Virginia.

There are two separate systems in Virginia used to manage Medicaid eligibility and enrollment: the Virginia Case Management System (VaCMS) and the Medicaid Enterprise System (MES). VaCMS is maintained by DSS and serves as the state integrated benefit program system. Eligibility for Medicaid is determined within VaCMS. DMAS maintains MES, which serves as the enrollment system for all individuals enrolled in the Medicaid program. MES connect providers and the program's six MCOs to the data and enrollment information needed for members.

Individuals are required to meet financial and non-financial requirements to qualify for assistance in the Medicaid program. These requirements vary depending on the coverage group for which the individual is assessed. If an individual is found ineligible for Medicaid due to financial or non-financial reasons, either at initial application or redetermination, DSS makes an automatic referral to the Federally Facilitated Marketplace where the individual may be assessed for other affordable health coverage.

Conducting the redetermination of 2.2 million Medicaid members will not be an entirely manual process. In accordance with federal requirements, if the state can obtain needed information using electronic data sources, Virginia processes applications and redeterminations without requesting additional verifications from the applicant or member. Should additional verifications be required, the agency will send a request for information to the individual. In Virginia, over half of all redeterminations are completed through an automated process that does not require intervention from staff or the member. This process, called "ex-parte," continued to run during the PHE, which allowed redeterminations for some individuals who continued to meet all requirements for the program to be completed.

System Readiness & Technological Enhancements

DMAS and DSS prioritized technology, system readiness, and automating processes to enable the success of resuming normal operations, while easing the workload for agency staff and reducing the burden to Medicaid members. Virginia implemented system enhancements to assist with the projected increase in workflow. These modifications were established with the intent of providing local DSS agency staff operational stability, while maintaining safeguards to ensure access to health care for the most vulnerable members.

System enhancements implemented in preparation for the end of the continuous coverage requirements include:

- Changes to route certain types of cases to Cover Virginia to allow vendor assistance during the redetermination period.



Unwinding the COVID-19 Public Health Emergency: Virginia's Medicaid Redetermination Plan



- Increased automation for individuals in certain coverage groups to include those transitioning to former foster care coverage and members enrolled in Family Access to Medical Insurance Security (FAMIS) who have reached the end of their 12-month postpartum period.
- Increased automation to act when an individual has not returned needed paperwork or verifications.
- Alignment of eligibility determination and enrollment systems.
- Increasing reasonable compatibility which increases the number of cases authorized using existing data sources.
- Ability to identify multiple contact modalities to text, call, and email individuals to meet federal returned mail requirements.
- Automation to close individuals on date of death when report is received from the Virginia Department of Health indicating a death certificate has been issued.
- The development of dashboards to enhance monitoring and oversight of the return to normal work and provide transparency to the public. The dashboards created include information on outreach work, redetermination, and a dashboard specific to legislators. These dashboards will be updated regularly to track monthly outcomes. The Legislative Dashboard, which reflects updated districts can be accessed on the DMAS website's [Legislative Office Resources Page](#). The Redetermination Dashboard is available on the DMAS website [here](#).

Cover Virginia Call Center, Central Processing Unit, and Redetermination Unit

Since the pandemic began, local DSS agencies have seen increases in their workload across all benefit programs. Those increases, combined with serious workforce recruitment and retention challenges, have resulted in the inability for the local agencies to manage the unprecedented volume of work resulting from the continuous coverage requirements. To address the shortfall of resources, DMAS temporarily expanded its existing Cover Virginia contract to implement a Redetermination Call Center and Redetermination Unit during the period of transition back to normal operations. The new operation went live on April 3, 2023, and will cease on March 31, 2024, after which point, normal operations will resume with all redeterminations being assigned to local DSS agencies.

Currently, the Cover Virginia operations includes a state-wide, centralized Medicaid Call Center, Central Processing Unit (CPU) and Cover Virginia Incarcerated Unit (CVIU). Under the existing base contract, the vendor will continue to accept telephonic redeterminations and answer general questions about the PHE and the end of the continuous coverage requirements. Under the temporary contract modification, the vendor will also process a portion of the Medicaid redeterminations and manage any appeals associated with those redeterminations. Additionally, the call center's Interactive Voice Response (IVR) has been enhanced with an assister unit line, which gives access to application assisters and navigators collaborating with members and households to assist with filing the filing of applications, redeterminations, and obtaining needed case status information.

The Cover Virginia vendor has developed a comprehensive contingency plan to monitor work through the unwinding period. Contingency planning includes the personnel, system updates, training required to mitigate project specific tasks, and resources external to the Virginia project that can be utilized. Examples of contingency plans include high volume Interactive Voice Response (IVR) messaging, flex staff to meet high-volume call types, engaging all levels of personnel to assist with the redetermination processes, escalation support, and implementing disaster recovery processes, if necessary.

Steps to Promote Continuity of Coverage

Leveraging Other Public Assistance Programs

Virginia is an integrated eligibility state, which means the local DSS offices can leverage information received during the processing of other benefit programs, such as SNAP and TANF, to support information needed when determining ongoing eligibility in the Medicaid program. Because the recertification period for other benefit programs may occur more frequently, current information may be available for individuals who receive multiple benefits. This would allow an individual's Medicaid to be renewed for an additional 12-month period without having to contact the member for additional information.

Referrals and Partnerships with the Exchange

Certain changes in circumstances will result in individuals no longer meeting the requirements for eligibility in the Medicaid program. These changes may include an increase in income or a change in their household composition. Individuals who are no longer eligible for Medicaid will automatically receive a referral to the Federally Facilitated Marketplace (FFM) and beginning in the fall of 2023, a referral to the new Virginia State Based Exchange, the Virginia Insurance Marketplace.

DMAS has partnered with the FFM and the Virginia Insurance Marketplace with outreach about the end of the continuous coverage requirements and alternatives, such as low-cost policies, which may be available. Additionally, DMAS worked with the program's six managed care organizations to develop outreach strategies and assistance to individuals to help them transition to other health coverage.

High-Risk Populations

Prior to and during the transition to normal operations, DMAS is working closely with MCOs, providers, associations, and other stakeholders to ensure high-risk populations are closely monitored and provided an additional layer of support.

Providers

Strong partnerships with the Medicaid provider community are key in preparing for the return to normal operations. To equip providers and staff who are on the front lines and in contact with Medicaid members daily, DMAS provided education and outreach material through provider-specific toolkits. An overwhelming request received from providers was to allow staff access to view a member's redetermination date through the

Unwinding the COVID-19 Public Health Emergency: Virginia's Medicaid Redetermination Plan

Automated Response System (ARS), the state's provider portal. The DMAS Information Management team was able to work quickly to list member redetermination dates within the provider portal by March 31, 2023. Communication was sent to providers, along with instructions on accessing the portal and how to use the redetermination date and calendar to assist patients with completing the process timely.

Appeals

The DMAS Appeals Division anticipates a substantial increase in fair hearing requests during the redetermination period. In preparation for the increased volume of member appeals, DMAS supplemented the existing division staff with six temporary positions. Prior to the announcement of the end of the continuous coverage period, the Appeals Division began revamping its internal procedures: evaluating its systems to ensure efficient case processing, cross-training team members to ensure an agile workforce capable of responding to changes in volume, and developing an outreach strategy to ensure that all stakeholders understand the appeals process. Additionally, the division worked closely with DSS and local DSS agencies to provide refresher trainings about the appeals process, answer questions, and provide resources. Although DMAS anticipates high volume during the unwinding of the continuous coverage requirements, the Appeals Division will strive to issue each appeal decision within the required timeframe.

For appeals to be processed efficiently, DMAS encourages appellants to follow these suggestions:

- (1) Use the Appeals Information Management System ("AIMS") portal to file the appeal. DMAS will continue to accept appeals through all other methods but AIMS allows the appellant to input all the relevant information, submit documents, and track the status of the appeal. Information about AIMS and the appeal process is available at <https://dmas.virginia.gov/appeals/>.
- (2) Include a copy of the notice of action with the appeal request.
- (3) On the appeal request, specifically state what is being appealed. Explain what was wrong with the action being appealed.
- (4) When submitting the appeal request, include all documents the hearing officer should consider. Including documents up front will help DMAS make a faster decision, although documents may be submitted throughout the appeal process.
- (5) If appealing on behalf of someone else, please be sure to include proof of authorization with the appeal request. A form is available at <https://dmas.virginia.gov/appeals/>
- (6) If filing an appeal more than 30 days after the date on the notice of action, please be sure to include an explanation for filing a late appeal. A form is available at <https://dmas.virginia.gov/appeals/>
- (7) Monitor the mail (or email if that is the preferred communication method) during the appeal for important letters from DMAS.
- (8) If a hearing is scheduled:
 - a. Review the letter with the scheduled hearing date and time to make sure the contact information is accurate. If it is incorrect, update the DMAS Appeals Division immediately.
 - b. Review the appeal summary completed by the responsible agency.
 - c. Be ready to participate at the scheduled date and time.

Flexibilities

The Virginia Medicaid agency implemented a variety of policies in 2020 in response to the needs of our members and providers as they confronted the COVID-19 pandemic.

During the PHE, DMAS moved to make several flexibilities permanent in Virginia, such as:

- Permitting telehealth for many practice areas.
- Allowing electronic signatures for visits conducted through telehealth.
- Flexibilities related to medications for addiction and recovery treatment services.
- Eliminating copayments for all Medicaid and FAMIS members.
- Allowing a 90-day supply for many prescription drugs.

Those flexibilities which the Commonwealth was unable to make permanent were tied to the federal PHE, which ended on May 11, 2023. Several of the flexibilities ended at midnight on May 11, 2023, with the remainder of the flexibilities expiring six months after the end of the PHE on November 11, 2023.

A full listing of the remaining flexibilities, along with information about when those flexibilities will end, can be found on the DMAS [COVID-19 webpage](#) under [Provider Flexibilities](#)¹.

Conclusion

Throughout the pandemic, the Medicaid program in Virginia has been a vital means of ensuring access to health care for low-income seniors, families, adults, and children. Not only was Medicaid critical in the coverage of testing and vaccines, but it also allowed people to get many types of medical and behavioral health services through accessible means, including telehealth. The end of the Medicaid continuous coverage requirements brings unprecedented challenges in Virginia and nationally. The shift back to pre-pandemic operational procedures represents the largest health coverage transition since the Affordable Care Act.

While most of those enrolled will continue to be eligible for the program, the reality is that some individuals and families will no longer be eligible for Medicaid. DMAS will continue to provide education and resources to support people who are no longer eligible for Medicaid in connecting them to other sources of insurance and to ensuring individuals who are eligible for coverage, remain enrolled. The Virginia Medicaid program exists to serve our communities and neighbors. DMAS remains committed to working hard to ensure processes that put our members first while honoring the critical role health insurance plays in the lives of individuals and families across the Commonwealth.

¹ Linked version is as of 04.03.2023 – visit the COVID 19 webpage and navigate to Provider Flexibilities for the most recent version.