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MEDICAID MEMO

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Overview of the Use of Civil Monetary Penalty (CMP) Funds

CIVIL MONETARY PENALTY FUND OVERVIEW

The purpose of this bulletin is to remind providers of Virginia's use of Civil Monetary Penalty (CMP) funds in accordance with the overview and details contained in the DMAS Medicaid memo dated December 28, 2018. As stated in that memo, CMP funds help improve the quality of life for individuals residing in Nursing Facilities within the Commonwealth. This bulletin outlines this year's timeline and process for projects applying for CMP funds, and reminds potential applicants of requirements, exclusions, and frequently asked questions.

The CMP fund is a collection of monetary penalties the U.S. Centers for Medicare & Medicaid Services (CMS) may impose against skilled nursing facilities (SNFs), nursing facilities (NFs), and dually-certified SNF/NF for either the number of days or for each instance a facility is not in substantial compliance with one or more Medicare and Medicaid participation requirements for Long Term Care Facilities (LTC) (42 CFR 488.430). The requirements for participation with Medicare and Medicaid for (LTC) facilities may be found at 42 CFR 483.

In Virginia, CMP funds continue to be used for projects that directly benefit individuals residing in a nursing facility in the Commonwealth and must be reviewed by DMAS and approved by CMS. The goal of the CMP funds is to help protect and improve the quality of care for individuals residing in nursing facilities. Utilizing CMP funds provides the unique opportunity to improve the lives of many individuals across the Commonwealth. DMAS has been given the responsibility for administering these funds, and providing direct oversight in accepting proposals.

USE OF FUNDS

Virginia will maintain a core amount of civil money penalty funds in reserve for emergencies, such as relocation of residents pursuant to an involuntary termination from Medicare or Medicaid. In addition, this fund provides assistance, support, and protection for individuals in the event that a nursing facility in Virginia:

1. Closes voluntarily;
2. Closes involuntarily;
3. Loses Medicare or Medicaid certification and individuals require relocation; or
4. Experiences an emergency or natural disaster, including when individuals must be evacuated or transferred to alternative locations.

Such funding is not guaranteed in every instance. DMAS has the discretion to release funding for this category. Nursing facilities should NOT rely on this as their sole source for planning for or implementing solutions to the above listed scenarios. In some cases, funds may be used to cover the cost of transferring individuals from their current nursing facility to an approved alternate temporary site when a nursing facility experiences an emergency or evacuation. Providers must

demonstrate how and why the Long-Term Care Mutual Aid Plan (LTC-MAP), or other comparable agreements, and other avenues for resources will not suffice as funding to support the needs of the individuals within their facility.

SPECIAL PROJECTS

The Virginia General Assembly continues to appropriate a reasonable amount of CMP funds for DMAS and CMS-approved projects that protect or improve the quality of life and care of individuals in nursing facilities. Through an annual proposal submission and review process, DMAS will continue to ensure that CMP guidelines and policies are followed. Upon review by the Commonwealth that the proposal is complete, DMAS will forward projects for review and final approval to CMS. If approved by CMS, DMAS will oversee project progress by way of reviewing obligatory quarterly and final program and financial reports.

Information concerning awarded projects, including dollar amounts, recipients, project results, and other relevant information, can be found using this link:

http://www.dmas.virginia.gov/#/longtermprograms

APPLICATION PROCESS

The application process as in past years involves the submission of a Request for Funding Cover Sheet and a formal Project Application. It is strongly encouraged that you use the Application Guidelines and information at the website above when completing a Project Application.

The timeline for submitting Cover Sheets for the 2020 CMP Cycle will be February 3, 2020 to February 28, 2020.

The timeline for submitting Project Applications for projects beginning July 1, 2020 will be March 21, 2020 to March 31, 2020.

The full details on the proposal submission and review process, including how to submit proposals, requirements of proposals, are available at:

http://www.dmas.virginia.gov/#/longtermprograms

If you would like confirmation if your organization is eligible to apply for CMP funds, please contact the Virginia CMP Program Analyst Team (CMPFunds@dmas.virginia.gov).

CMP Timeline

CMP Milestone	**Due Date**
Medicaid Bulletin	Released January 2020
Cover Sheet	**Accepted February 3, 2020 – February 28, 2020 (*no later than 2:00 p.m., E.T.)***
Application	**Accepted March 2, 2020 – March 31, 2020 (*no later than 2:00 p.m., E.T.)***

DMAS Review	Reviewed April 1, 2020 – April 30, 2020
CMS Review	Reviewed May 1, 2020 – June 2020
Contracting	Completed June 2020
Project Start Date	July 1, 2020

FREQUENTLY ASKED QUESTIONS

Below you will find a list of frequently asked questions compiled by the Center for Medicare and Medicaid Services (CMS). These questions are available using the following link:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/CMP-FAQs.pdf

Q1: What are CMP funds?

A: CMP stands for civil money penalty. It is a monetary penalty the Centers for Medicare& Medicaid Services (CMS) may impose against skilled nursing facilities (SNFs), nursing facilities (NFs), and dually-certified SNF/NF for either the number of days or for each instance a facility is not in substantial compliance with one or more Medicare and Medicaid participation requirements for Long Term Care Facilities (Code of Federal Regulations (CFR) 42 Part488.430). The requirements for participation with Medicare and Medicaid for Long Term Care (LTC) facilities can be found at 42 CFR Part 483 subpart B.

Q2: Are there prohibited uses of CMP Funds?

A: CMP funds may not be used for uses prohibited by law, regulation, or CMS policy. These include and are not limited to:

- Projects disapproved by CMS
- Survey and certification operations or State expenses
- Capital expenses of a facility
- Nursing facility services or supplies that are the responsibility of nursing facilities (*such as laundry, linen, food, heat, staffing costs, etc.)*
- Funding projects, items or services that are not directly related to improving the quality of life and care of individuals who are residents of nursing facilities
- Projects for which a conflict of interest or the appearance of a conflict of interest exists
- Long-term projects (*greater than three (3) years*)
- Temporary manager salaries
- Nurse aide training
- Supplementary funding of federally required services (*e.g., Quality*

Improvement Organization-Quality Improvement Network Initiatives).

Q3: Who may apply for the use of CMP Funds?

A: Funds may be granted to any entity for proper use of CMS-approved projects to protect or improve the quality of life for individuals in nursing facilities provided that the responsible receiving entity is:

- Qualified and capable of carrying out the intended project or use
- Not in any conflict of interest relationship with the entity or entities that will benefit from the intended project or use
- Not paid by a State or federal source to perform the same function as the CMP project or use. CMP funds **may not be used** to enlarge or enhance an existing appropriation or statutory purpose.

Examples of eligible organizations include, but are not limited to:

- Consumer advocacy organizations
- Individual or family councils
- Professional or state nursing facility associations
- Certified LTC facilities (SNF, NF, SNF/NF)
- Private Contractors
- Universities
- Licensed and Medicaid-certified Nursing Facilities
- Healthcare systems
- State agencies
- For-profit or non-profit organization
- Provider associations

Q4: How long can a project be?

A: Projects cannot exceed three years, but there is no minimum requirement for project length.

Q5: Where can additional application information be found?

A: Additional information, application and guidelines may be found here:

http://www.dmas.virginia.gov/#/longtermprograms

Q6: Who should I contact with additional questions?

Virginia CMP Program Analyst Team

CMPFunds@dmas.virginia.gov
(804) 225-4218

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Medicaid Expansion

Medicaid coverage for the new expansion adult group began January 1, 2019. Providers may use the Virginia Medicaid Web Portal and the Medicall audio response systems, as shown in the table below, to verify Medicaid eligibility and managed care enrollment, including for the new adult group. In the Virginia Medicaid Web Portal, individuals eligible in the Medicaid expansion covered group are shown as "MEDICAID EXP." If the individual is enrolled in managed care, the "MEDICAID EXP" segment will be shown as well as the "MED4" (Medallion 4.0) or "CCCP" (CCC Plus) managed care enrollment segment. Eligibility and managed care enrollment information is also available through the DMAS Medicall eligibility verification system. Additional Medicaid expansion resources for providers are available on the DMAS Medicaid Expansion webpage at: http://www.dmas.virginia.gov/#/medex.

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-for-service members.	https://dmas.kepro.com/

Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627