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https://dmas.virginia.gov
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 memorandum is to provide an overview of Virginia's plan to utilize Civil Monetary Penalty Funds to help improve the quality of life for individuals residing in Nursing Facilities within the Commonwealth. This Memorandum outlines the timeline and process for projects applying for CMP funds, requirements, exclusions, and frequently asked questions.

The Civil Monetary Penalties (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 are 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 base funding to provide 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 shall have discretion to release funding for this category. Nursing facilities shall NOT rely on this as their sole source for planning for or implementing 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 will 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 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. DMAS anticipates funding 2-3 projects per year, with some projects spanning multiple years, not to exceed three years.

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 involves the submission of a Request for Funding Cover Sheet and a formal Project Application. It is strongly encouraged that you use the Application Guideline and information at the website above when completing a Project Application.

The timeline for submitting new applications for projects beginning September 1, 2018 will be Monday, April 2, 2018 to Friday, April 27, 2018.

Applications received prior to April 2, 2018 will need to be resubmitted utilizing the process outline.

Applications received before Monday, April 2, 2018 or after 2:00 pm on Friday, April 27, 2018 shall not be considered in this funding round.

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

CMP Timeline

CMP Milestone	**Due Date**
Medicaid Memo	Released February 2018
Cover Sheet	**Accepted March 1, 2018 – March 30, 2018 (*no later than 2:00 p.m., E.T.)***
Application	**Accepted April 2, 2018 - April 27, 2018 (*no later than 2:00 p.m., E.T.)***
DMAS Review	Reviewed April 30, 2018 – May 31, 2018
CMS Review	Reviewed June 1, 2018 – July 15, 2018
Contracting	Completed July 15, 2018 – September 1, 2018
Project Start Date	September 1, 2018

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 may also be found here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/CMP-FAQs.pdf

Q1: What are CMP funds?

A: CMP means "civil monetary penalty." It is a financial penalty 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 LTC Facilities (42 CFR 488.430). The requirements for participation with Medicare and Medicaid for (LTC) facilities can be found at 42 CFR 483.

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 3 years);
- Temporary manager salaries; and
- 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; and
- 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, and 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 organizations
- Provider Associations
- Universities

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/Content_pgs/ltc-cmp.aspx

Q6: Who should I contact with additional questions?

Ms. Gabrielle Stevens

CMP Program Analyst

CMPFunds@dmas.virginia.gov
(804) 786-2153

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status,

service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Most Medicaid individuals are enrolled in one of the Department's managed care programs: Medallion 3.0, 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/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0:

  http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx

- Medallion 4.0:

  http:/www.dmas.virginia.gov/Content_pgs/medallion_4-home.aspx

- Commonwealth Coordinated Care Plus (CCC Plus):

  http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx

- Program of All-Inclusive Care for the Elderly (PACE):

  http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA.pdf

COMMONWEALTH COORDINATED CARE PLUS

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long-term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to

access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx and the form can be accessed from there by clicking on, "Click here to download a Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

PROVIDERS: NEW MEDICARE CARDS ARE COMING

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1st.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

MEMBERS: NEW MEDICARE CARDS ARE COMING

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that's unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link:

https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html