

Medicaid Member Advisory Committee Meeting
Department of Medical Assistance Services
Via WebEx Videoconferencing

April 11, 2022 Minutes
 Approved by Unanimous Vote

Committee Members	DMAS Staff
Summer Sage	Karen Kimsey, Director
Ghadah Aljamali	Sarah Hatton, Deputy of Administration
Karin Anderson	Ivory Banks, Chief of Staff
Olatunji Fakunmoju	Emily McClellan, Division Director, Policy, Regulation and Member Engagement
Geoffrey Short	Brian McCormick, Division Director for Constituent, Legislative and Intergovernmental Affairs
Michelle Meadows	John Stanwix, Appeals Director
Elvira Prince	Estelle Kendall, Member & Provider Solutions Manager
Sabrina Redd	Bryan Talbert, Contract Administrator
	Lynne Vest, Member and Provider Relations Specialist
	Mariam Siddiqui, Senior Advisor
	Jessica Anecchini, Senior Advisor
	Rich Rosendahl, Chief Health Economist
	Michael Puglisi, Eligibility Cases Manager
	Mavora Donoghue, Medical and Provider Cases Manager
	Aneida Winston, Quality Assurance Manager
	Dalia Tejada Halter, Outreach and Member Engagement Specialist (PowerPoint administrator)
	Natalie Pennywell, Outreach and Community Engagement Manager (meeting organizer and facilitator)
	Walter Burton (meeting organizer)
	Kristin Lough (prepared minutes)

Welcome and Call To Order

Natalie Pennywell called to order the meeting of the Medicaid Member Advisory Committee (MAC or Committee) at 10:03 a.m. on Monday, April 11, 2022, via WebEx online meeting platform. Ms. Pennywell explained that the meeting had a full agenda and emphasized that Committee members would have time to ask questions and share feedback during the meeting. She then introduced the DMAS Deputy of Administration, Sarah Hatton.

Welcome

Welcome – Sarah Hatton, DMAS Deputy of Administration

Deputy of Administration Hatton greeted the Committee and thanked the Committee for their participation in the virtual MAC meeting. She explained that Director Kimsey would be late for the meeting but the Director would join the meeting in progress. Deputy Hatton indicated that the day's agenda would be quite full. Deputy Hatton thanked the members for joining and working with the MAC. Deputy Hatton turned the meeting back over to Ms. Pennywell.

Member Introduction

Ms. Pennywell listed member names to confirm attendance.

Review and Vote to Approve Minutes from Meeting on December 13, 2021

Each of the MAC members was provided a copy of the December 13, 2021, meeting draft minutes, and the draft minutes were posted on the Committee's webpage on DMAS' website, and on the Virginia Town Hall website.

MAC member Michelle Meadows made a motion to accept the draft minutes from the December 13, 2021, meeting. MAC member Summer Sage seconded the motion to accept the minutes. Ms. Pennywell offered the Committee the opportunity to provide objections or changes to the minutes. The Committee then voted to approve the minutes with a unanimous vote. Ms. Pennywell introduced the Managed Care presentation and Contract Administrator Bryan Talbert.

Presentation – The Role of Managed Care Organizations in Virginia Medicaid

Estelle Kendall, Member & Provider Solutions Manager – Healthcare Services

Bryan Talbert, Contract Administrator – Healthcare Services

Lynne Vest, Member and Provider Relations Specialist – Integrated Care

Mr. Talbert expressed gratitude for the opportunity to present to the MAC. Managed Care is a delivery system used to manage cost, benefit utilization and quality of care in Medicaid. DMAS contracts with six Managed Care Organizations (MCOs), and each of which receives a monthly rate per member for providing care, called a capitation fee. Managed care ensures a high-quality provider network, enhanced benefits, and comprehensive healthcare coverage focused on prevention. MCOs can also provide help with food, housing, cell phones, vision plans and community resources, while working with physical, health, and educational systems, as well as community, mental health, and family needs. Approximately 96% of DMAS members receive care through MCOs. Medallion 4.0 covers 1.5M members like infants, children, pregnant members, caretaker adults and newly eligible adults. Commonwealth Coordinated Care (CCC+) covers older adults, disabled children, disabled adults, and medically complex newly eligible adults. Aetna, Optima Health, Anthem, United Healthcare, Molina Healthcare (acquired Magellan in 2021), and Virginia Premier are MCOs in the Commonwealth, and the six regions are tidewater, central, northern, western, Roanoke/Alleghany, southwest. Members can change their assigned change health plans at designated times or with good cause, and DMAS assigns members to an MCO according to a determination system. Once assigned, members have 90 days to request an MCO change. Members can choose a health plan via phone, website, or mobile app.

Ms. Vest explained that each member is assigned a Care Coordinator to help members to get to the right time at the right place. Care Coordinators help answer questions and resolve network barrier issues, including transportation and provider coordination, even when providers are out of network. DMAS monitors the contracts with each organization to ensure compliance with the agreements, including issues like appeals and compliance actions. DMAS offered new dental coverage for adults, effective July 1, 2021, through DentaQuest.

Ms. Vest asked MAC members who work with CCC+ members if they have received outreach from Care Coordinators, and, if so, whether they received the assistance needed. Ms. Sage indicated that she had had a great relationship with her CCC+ Care Coordinator and offered to share her and other families' experiences. Ms. Sage shared that while respectful, the Care Coordinators struggle to have information, resources, and new services for recipients, which has been a concern for both Care Coordinators and families. Ms. Sage also stated that Care Coordinators set up Integrated Care calls with the Care Coordinator, members, and people like educators, Primary Care Physicians (PCPs), groups like Moms in Motion, and similar groups. However, she noted, rarely does anyone participate in these important calls. Ms. Sage indicated that doctors do not always participate in the calls because they cannot bill Medicaid for those calls. She asked if DMAS was gathering data about the impact of the calls and the effect of not being able to organize all parties in the calls. Is DMAS gathering any kind of data on the impact of these calls and the lack of an ability to get everybody in the room simultaneously? Is DMAS gathering data about how that affects care coordination across all of these different partners? Ms. Sage asked if the lack of coordination undermines the DMAS goal of integrated care.

Ms. Vest answered she has experience participating in the interdisciplinary care team (ICT) meetings. She stated that sometimes Care Coordinators could organize information from PCPs or organizations who

cannot participate in the calls and relay the information back to the call. DMAS will research more about the data from the calls, success, and struggles from the billing and scheduling limitations. After the meeting, Ms. Vest followed up with, “I was able to confirm that we do not collect any data on Interdisciplinary Care Team Meetings. Again, I'm happy to follow up to assist and facilitate anything needed for her ICT meetings with the MCO and providers.” In the same email, Ms. Vest requested more information about Ms. Sage’s question regarding quality and data.

Ms. Meadows asked if Care Coordinators were only available by phone. Ms. Vest answered that they could be seen face-to-face, and all CCC+ waiver members must be seen face-to-face, but non CCC+ members can also request face-to-face meetings. Ms. Meadows indicated that it has been challenging to get on the phone due to personal scheduling complications and that email or other communication styles would be beneficial for reaching the Care Coordinator. Ms. Vest answered that email is also acceptable, but that mode of communication best suited for the member is the communication that should be followed. Still, parties must communicate health information via secure email to comply with HIPAA regulations. Ms. Pennywell thanked the presenters and introduced Director Kimsey.

Director Kimsey shared her gratitude for the members of the Committee and the opportunity to participate in the meeting today. Ms. Pennywell introduced Deputy Hatton.

Presentation – Public Health Emergency Updates

Sarah Hatton – Deputy of Administration

Natalie Pennywell – Outreach and Community Engagement Manager

Miriam Siddiqui – Senior Advisor

Deputy Hatton indicated that federal funding increased due to COVID, under the Federal Public Health Emergency (PHE), but that states had to maintain enrollment of individuals in Medicaid until the PHE ends in order to receive that additional 6.2% match. Exceptions to that mandatory enrollment included if someone passed away, moved from the state, or asked DMAS to close their coverage. One in four Virginians has Medicaid, which is 500,000 more people than were enrolled before the PHE. The PHE renews every 90 days, it is currently scheduled to end April 16, 2022, but DMAS expects the federal government to renew the PHE one more time. DMAS expects to begin renewals in July 2022, when the federal government indicates the PHE should end based on projections. DMAS is preparing for the end of PHE and working with DSS and local agencies.

DMAS has not completed paper renewals since PHE began, but has completed automatic renewals, which have confirmed coverage for individuals who would otherwise retain coverage. At the end of the PHE, DMAS and the Department of Social Services (DSS) will need to redetermine eligibility for all 2 million Medicaid members in Virginia. When the PHE ends, DMAS expects to review eligibility for most Medicaid recipients for 12-months. DMAS expects about 20% of individuals will lose coverage. Before

the emergency, 25% of the Virginia Medicaid population would lose coverage for administrative reasons, like failure to complete renewals, and they would reapply soon after losing coverage. DMAS is working with MCOs to reach all members to ensure DMAS has appropriate contact information to complete renewals. Some individuals will be ineligible due to excess income from new employment, etc., and DMAS will refer those individuals to the Health Insurance Marketplace to seek coverage. DMAS and DSS expect to renew more than 100,000 members per month after PHE. DMAS and DSS want to complete renewals efficiently and accurately, so they intend to spread the renewal analysis over 12-months as allowed by the federal government. Local agencies will also be reaching out for contact information and verification of necessary eligibility standards from members. DMAS and DSS have created systems updates that will improve automation, the “no-touch process,” and access to information electronically to reduce verification requests as appropriate. DMAS and DSS will also augment staff to local agencies, as needed, through the “Adjunct Task Force,” where backlogs exist. If a person’s coverage ends due to failure to complete a renewal, that member has 90 days after the termination to complete a renewal, and, if approved, receive Medicaid coverage with no gap once re-approved.

Deputy Hatton reminded members that the current PHE expires on April 16, 2022, but DMAS expects the federal government to extend the PHE another 90 days, causing it to end on July 15, 2022. From the date it ends, DMAS will have 12 months from the PHE end to complete all necessary renewals. DMAS asks members not to renew early, as they would have to renew again during the appropriate month of the 12-month reevaluation window.

Questions raised by Committee Members included:

Ms. Prince asked about the income limits for Medicaid at this point. Deputy Hatton stated that income limits depend on the covered group, family size, and others.

Ms. Meadows asked if there were guidelines for a single individual with no children. Deputy Hatton indicated that there were screening tools on the Cover Virginia Website to help individuals. Jessica Anecchini reflected in the chat feature of WebEx, “See: <https://coverva.org/en/our-programs> for general income limits!”

Ms. Redd asked if members should proactively complete a renewal form or wait until they receive a paper renewal. Deputy Hatton indicated that DMAS encourages members to communicate appropriate contact information to DMAS, local agencies, and MCOs now, but encourages members not to complete a renewal yet, because it would not be valid as a post-PHE renewal. The federal government will not allow DMAS to use old data, so members would be required to submit a second renewal packet during the appropriate month of unwinding.

Ms. Pennywell discussed outreach information that DMAS has sent and will be sending to members. DMAS sent a member letter asking members to update contact information and how to update that information, which is available in seven languages. MCOs and non-MCO members have toolkits, and

both toolkits are available on the Cover Virginia website. The toolkits include stakeholder documents, member documents, messaging templates, and customizable templates for outreach and that this is an ongoing effort of engagement. Ms. Pennywell noted that DMAS is looking for feedback from Medicaid members as well as they continue to develop the current and future toolkits and resources.

Presentation – Understanding the Role & Process of Appeals

John Stanwix, Director – Appeals

Michael Puglisi, Eligibility Cases Manager – Appeals

Mavora Donoghue, Medical and Provider Cases Manager – Appeals

Aneida Winston, Quality Assurance Manager – Appeals

Mr. Stanwix introduced the Appeals Division and introduced Michael Puglisi.

Mr. Puglisi summarized that the purpose of appeals is to provide due process to the applicants, members and providers, written notice of an adverse action, and the opportunity to review documents, present testimony, and have an attorney or representative at review, as determined in a United States Supreme Court case *Goldberg v. Kelly*. The reviewers, Hearing Officers, are impartial and separate from the eligibility workers who made the initial decisions. The Hearing Officer issues a written decision based on the facts and appropriate law. Client appeals hear eligibility issues like denials, termination, reduction of services, and medical issues regarding certain medical services. Eligibility issues include failure to evaluate an application, failure to provide verifications, failure to review, income and resource issues, and Recipient Audit Unit recovery. Medical issues include appeals related to the provision of medical services, like preadmission screening, personal care hours, and nursing home appeals.

DMAS conducts hearings under a process called *de novo* (*new*). The purpose is to provide Medicaid members the opportunity to challenge eligibility and medical services determinations that are not in their favor. DMAS strives to ensure that members' due process rights are protected and they have a fair opportunity to be heard. In a *de novo* review, a Hearing Officer must issue a new eligibility decision back to the application or Agency's denial or termination. Appellants may submit additional documentation at any time during the appeals process. The DSS workers must review any new documentation and evaluate it to determine if the new documentation would change the outcome. If it would, the DSS worker must reevaluate the case and issue a new Notice of Action. The Hearing Officer must review the information that the Agency did not have at the time of its determination, if any exists. The Hearing Officer will evaluate if that new decision from the DSS resolves the case, and if it does not, the DSS worker must issue an appeal summary with all appropriate documentation and proceed to the hearing. The Hearing Officer will issue a decision encompassing the entirety of that appeal process.

Ms. Donoghue outlined the process of filing an appeal and the appeal process. Generally, a timely appeal must be filed within 30 days of receipt of notification. The Virginia Administrative Code assumes that notification is received within five days of mailing. There are four exceptions to that rule – 1) the appellant

was unable to appeal due to a medical issue, 2) the appellant did not receive the notice, 3) the appellant sent the appeal to the wrong agency, like the Department of Social Services, and 4) unusual or unavoidable circumstances. Appeals are deemed received on the postmark date of the letter or actual receipt if delivered other than by mail. DMAS has 90 days to issue a decision on the appeal request.

MCO appeals are appeals of specific medical coverage denied by the MCO, and include a two-step filing process. Members must appeal first through the MCO appeal process, and then appeal to DMAS if dissatisfied with the outcome through the MCO.

Standard Appeals: The Appeals Division has 90 days to render a decision once a client appeal request is received (exception for the appellant delay)

MCO Appeals: The Appeals Division has 90 days minus the time MCO took to decide the internal appeal (exception for the appellant delay)

Expedited Appeals: When a doctor certifies that operating under the standard time frame (90 days) could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function

- 7 days for eligibility related matters
- 3 days for benefit or services related matters

A Hearing Officer must conduct a fair and impartial hearing. All Hearing Officers are lawyers, are familiar with the due process requirements, and must maintain order within the hearing. Each party must be allowed to present facts they find relevant to the case, but the Hearing Officer must focus on the issue at appeal. The Hearing Officer gathers evidence to use based on evaluating the documents and policy before the hearing.

Medicaid hearings are informal, which allows hearings to flow. The Hearing Officer will introduce the participants, explain the process, and define the issue on appeal as needed. The Hearing Officer then asks the Agency questions about the action, reason, and authority for the Agency's action, and asks the Agency to discuss the new information provided by the Appellant under the de novo process. The Appellant may then present testimony and evidence they believe will advance their case. Closing remarks/statements may be made by the parties. After all questioning, the Hearing Officer will issue a closing statement outlining the process after the hearing, including when to expect the written decision.

After the hearing, the Hearing Officer will issue a final decision, which the appellant may appeal to Circuit Court. The local Agency does not have appeal rights from the Hearing Officer's decision. The outcomes are sustained where the Hearing Officer agrees with the Agency; reverse, where the Hearing Officer disagrees with the Agency; or remand, where the Hearing Officer sends the case to the Agency for further review. A remand will be accompanied by specific instructions for the Agency and a timeframe to complete the instructions. The decision may be a combination of sustain, reverse, and/or remand.

Ms. Winston outlined the Appeals Information Management System (AIMS), a portal that streamlines the appeals process and communication with parties. Members, providers, and agency workers can all access each associated case through the AIMS portal, upload documents, and review case status through AIMS. The AIMS Portal Training Website <https://vamedicaid.dmas.virginia.gov/training/appeals> includes training documents, videos, practice simulations, and frequently asked questions for the portal. The DMAS Appeals Webpage outlines an overview of client and provider Medicaid appeals, information for applicants and members for client appeals, appeals overview, and appeals forms in English and Spanish. The webpage includes a link to AIMS. Ms. Winston included contact information for the Appeals Division and commonly used acronyms in the presentation.

Ms. Winston asked three questions of the MAC members: 1) What mode of communication works best for you? 2) If you need to file an appeal, what resources would you use to learn more about the appeals process? 3) How user-friendly are our online resources?

Questions and responses presented by Committee Members included:

Ms. Redd asked about notices of appeal rights, and stated that some notices included dmas-info@dmas.virginia.gov, which is an inactive email address. When she contacted the Appeals division, they advised her in the past that the email should not be on the Notice of Action (NOA), but that DMAS cannot force the author to remove that email address from the NOA. HIPP denials indicate, “not approved due to medical necessity,” but no more specific denial reason. Will *de novo* and due process requirements drive updates and additional, detailed information on HIPP notices? Will appellants receive the appeal summary? Mr. Stanwix stated that the referenced email address is being phased out. Mr. Stanwix asked Ms. Redd to provide copies of those NOAs to him to ensure the Agencies uphold the appellants’ fundamental rights.

In response to Ms. Winston’s questions, Ms. Meadows answered that she preferred written communications, and that she would use the DMAS website or search engine to learn how to file an appeal and about the appeals process. “User friendliness for the appeals process has greatly improved over the last ten years. It is still tedious but is much easier to use than it used to be.” Mr. Short indicated he preferred visual communications.

Ms. Meadows has a list of questions about the appeals process, and asked whom she should send the questions after the meeting. Mr. Stanwix answered that Ms. Meadows could send them directly to him, and that he would respond.

Ms. Pennywell thanked the members for assisting DMAS in evaluating and improving the process. Ms. Pennywell asked members to provide any questions and information the members would like to hear about in future meetings. Ms. Pennywell then opened the meeting to public comment.

Public Comment

No public comment was made at the meeting. Ms. Pennywell asked that members communicate questions and suggestions to MAC@dmas.virginia.gov after the meeting if they had any after the meeting.

Adjournment

In closing, Director Kimsey thanked members for participating and her team for presenting and helping answer questions at the meeting. Ms. Pennywell thanked the Committee for joining and adjourned the meeting at 11:48 a.m.