COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: **MEREDITH LEE**
Policy, Regulations, and Manuals Supervisor
Virginia Department of Medical Assistance Services

FROM: **MORGAN GREER**
Assistant Attorney General

DATE: **March 15, 2024**

SUBJECT: **Fast Track Regulations – Client Appeals Update (Project 6871)**

I have reviewed the attached fast-track regulations regarding updates to the client appeals process. You asked the Office of the Attorney General to review and determine if DMAS has the legal authority to amend the regulations and if the regulations comports with state and federal law.

Based on my review, it is my view that the Director, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code §§ 32.1-324 and 325, has the authority to amend these regulations subject to compliance with the provisions of Article 2 of the Administrative Process Act and has not exceeded that authority. The proposed regulations are consistent with the directives in Item 317.GG.2 of the 2021 Appropriations Act and Item 308.W.2 of the 2022 Appropriations Act.

Pursuant to Va. Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either house of the General Assembly or of the Joint Commission on Administrative Rules, DMAS shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process set out in this article with the initial publication of the Fast-Track regulations serving as the Notice of Intended Regulatory Action.

If you have any questions or need additional information about this action, please contact me at 804.786.6522.

cc: Kim F. Piner, Esquire

Attachment

Project 6871 - Other Action

Department of Medical Assistance Services

Client Appeals Update

12VAC30-110-10. Definitions.

The following words and terms, when used in these regulations, shall have the following meanings unless the context clearly indicates otherwise:

"Action" means a denial of, termination of, suspension of, or reduction in covered benefits or services; a denial of or termination, suspension, or reduction in Medicaid eligibility; or an increase in beneficiary liability, including a determination that a beneficiary must incur a greater amount of medical expenses in order to establish income eligibility in accordance with 42 CFR 435.121(e)(4) or 42 CFR 435.831 or is subject to an increase in premiums or cost-sharing charges under Subpart A of 42 CFR Part 447. It also means (i) determinations by a skilled nursing facility or nursing facility to transfer ~~or~~, discharge, or fail to readmit a resident and (ii) an adverse determination made by a state with regard to the preadmission screening and resident review requirements of § 1919(e)(7) of the Social Security Act. It also means the failure to take an application for benefits or to act with reasonable promptness on an application for benefits, on a reported change in circumstances, or on a request for a particular medical service.

"Adverse determination" means a determination made in accordance with § 1919(b)(3)(F) or 1919(e)(7)(B) of the Social Security Act that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.

"Agency" means:

1. An agency or contractor that, on the department's behalf, makes determinations regarding benefits or applications for benefits provided by the department; or

2. The department itself.

"Appellant" means (i) an applicant for or recipient of medical assistance benefits from the department who seeks to challenge an action regarding ~~his~~ their benefits or ~~his~~ their eligibility for benefits and (ii) a nursing facility resident who seeks to challenge a transfer, ~~or~~ discharge, or failure to readmit. Appellant also means an individual who seeks to challenge an adverse determination regarding services provided by a nursing facility.

"Burden of proof" means the duty placed upon a party to prove or disprove a disputed fact.

"Date of action" means the intended date on which a termination, suspension, reduction, transfer, or discharge becomes effective. It also means the date of the determination made by a state with regard to the preadmission screening and annual resident review requirements of § 1919(e)(7) of the Social Security Act.

"Day" means calendar day unless otherwise specified or required by law.

"De novo" means that, where a hearing is required, the department's hearing officer will consider all relevant evidence submitted during the appeal in order to make a determination on the issues on appeal, even if the evidence was not previously received by the agency.

"Department" means the Department of Medical Assistance Services.

"Division" means the department's Appeals Division.

"Fail to readmit" means when a nursing facility refuses to readmit a resident who meets the criteria for a bed hold under 42 CFR 438.15.

"Final decision" means a written determination by a hearing officer that is binding on the department, unless modified on appeal or review.

"Hearing" means the de novo evidentiary hearing described in this chapter, conducted by a hearing officer employed by the department.

"Preponderance of the evidence" means that the party with the burden of proof has demonstrated to the hearing officer that their position on the issue in the appeal is more likely valid than not.

"Representative" means an attorney or agent who has been authorized to represent an appellant pursuant to these regulations.

"Send" means to deliver by mail or in electronic format consistent with 42 CFR 431.201 and 42 CFR 435.918.

"State fair hearing" means the entire appeal process for applicants and beneficiaries as set forth in 42 CFR Subpart E.

12VAC30-110-185. Appeal summary.

A. The agency proposing the action about which the individual requested the state fair hearing shall complete an appeal summary, which shall include:

1. The appellant's name and case name, if different;

2. The appellant's case number, Medicaid identification number, or other identifying information;

3. The agency or contractor responsible for the appellant's case;

4. A summary of the facts surrounding and the grounds supporting the action, the failure to take an application for benefits or to act with reasonable promptness on an application for benefits, a reported change in circumstances, or a request for a particular medical service. The summary of facts must include:

a. A list of the documents reviewed or relied upon, including those reviewed as part of the appeal.

b. A narrative explanation describing the agency or contractor's position on the action when considering all documentation submitted until the appeal summary is filed. When the action under appeal is for a reduction of termination of existing coverage, the narrative should include an explanation as to what has changed, or how the previous approval was made in error.

5. Citations to the statutes, regulations, and specific provisions of the Virginia Medical Assistance Eligibility manual or other policy that support the agency's action; and

6. The adverse benefit determination or the decision notice and any other documents relating to the appeal upon which the agency relied in making its decision.

B. The summary shall be filed with the DMAS Appeals Division with a complete copy sent to the appellant and the appellant's authorized representative, if applicable, at least five business days before the hearing date.

12VAC30-110-220. Evidentiary hearings.

~~A~~ A. General. The hearing officer shall review all agency determinations ~~which~~ that are properly appealed; conduct informal, fact-gathering hearings; evaluate evidence presented; and issue a written final decision ~~sustaining, reversing, or remanding each case to the agency for further proceedings~~ that is based on the evidence, policy, laws, and regulations relevant to the appeal.

B. De novo hearing. All hearings shall be considered "de novo," meaning that the department's hearing officer will consider all relevant evidence submitted during the appeal in order to make a determination on the issues on appeal, even if the evidence was not previously received by the agency. The hearing officer shall consider testimony and evidence that explains, supports, or is probative to the issues on appeal. In the *de novo* hearing, no deference is given to the agency or contractor who took the action.

C. Burden of proof. The burden of proof shall be assigned to the party who is attempting to make a change. If an individual is seeking initial Medicaid eligibility, the initial approval of Medicaid covered services, or eligibility for a higher level of coverage than has already been approved, the individual has the burden of proof. Conversely, when an already-eligible individual is facing a proposed termination or reduction in Medicaid eligibility or medical services, the burden of proof shall be assigned to the entity that has proposed the change to an individual's coverage. To prevail in the appeal, the party with the assigned burden of proof shall establish its position by a preponderance of the evidence.

D. Submission of evidence. The appellant's appeal request should include all documents the appellant would like considered during the appeal. The appellant can also submit additional documents leading up to and during the appeal hearing. The hearing officer has the discretion to reschedule or delay a hearing in order to allow the hearing officer and agency time to review documents submitted close to or at the scheduled hearing. Post-hearing supplementation of the record is addressed in 12VAC30-110-360. If the appeal request does not identify the action being appealed with reasonable specificity, include documentation to validate authorization for representation (if elected), or the Department requests good cause for late filing of the appeal, then delay will be added to the appeal decision due date per 42 CFR 431.244.

E. Previously approved coverage. In an appeal involving a proposed termination or reduction of previously approved coverage, the existence of the prior approval shall create a presumption that the approval was proper when it was previously made if it was consecutive to the current request. The strength of this presumption is directly related to the number and duration of previous approvals. For the entity that has proposed the termination or reduction to satisfy its burden of proof, it must demonstrate that the individual's circumstances have changed, or that the previous approval was made in error.

12VAC30-110-370. Final decision and transmission of the hearing record.

A. After conducting the hearing, reviewing the record, and deciding questions of law, the hearing officer shall issue a written final decision ~~which either sustains or reverses the agency action or remands the case to the agency for further action consistent with his written instructions~~ based upon the evidence and testimony presented. The hearing officer's final decision shall be considered as the agency's final administrative action pursuant to 42 CFR~~,~~ 431.244(f). The final decision shall include:

1. A description of the procedural development of the case;

2. Findings of fact that identify supporting evidence;

3. Conclusions of law that identify supporting regulations and law;

4. Conclusions and reasoning;

5. The specific action to be taken by the agency to implement the decision;

6. The deadline date by which further action must be taken; and

7. A cover letter stating that the hearing officer's decision is final, and stating that the final decision may be appealed directly to circuit court as provided in 12VAC30-110-40.

B. The hearing record shall be forwarded to the appellant and ~~his~~ the appellant's authorized representative with the final decision.

12VAC30-120-670. State fair hearing process and final decision.

A. All state fair hearings shall be conducted de novo per 12VAC30-110-220. As such, no deference will be given to the entity who made the adverse action being appealed.

B. All state fair hearings must be scheduled at a reasonable time, date, and place, and the appellant and the appellant's authorized representative shall be notified in writing prior to the hearing.

1. The state fair hearing location will be determined by the Appeals Division.

2. A state fair hearing ~~shall~~ may be rescheduled at the appellant's request no more than twice unless compelling reasons exist, which shall be determined by the department hearing officer.

3. Rescheduling the state fair hearing at the appellant's request will result in automatic waiver of the 90-day deadline for resolution of the appeal. The delay date for the decision will be calculated as set forth in 12VAC30-120-650 H and I.

~~B.~~ C. The state fair hearing shall be conducted by a department hearing officer. The hearing officer shall review the complete record for all MCO decisions that are properly appealed; conduct informal, fact-gathering state fair hearings; evaluate evidence presented; research the issues; and render a written final decision.

~~C.~~ D. Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeal record shall be made accessible to the appellant and the appellant's authorized representative at a convenient place and time before the date of the state fair hearing, as well as during the state fair hearing. The appellant and the appellant's authorized representative may examine the content of the appellant's case file and all documents and records the department will rely on at the state fair hearing except those records excluded by law.

~~D.~~ E. Appellants who require the attendance of witnesses or the production of records, memoranda, papers, and other documents at the state fair hearing may request in writing the issuance of a subpoena. The request must be received by the department at least 10 ~~working~~ business days before the scheduled state fair hearing. Such request shall (i) include the witness's or respondent's name, home and work addresses, and county or city of work and residence; and (ii) identify the sheriff's office that will serve the subpoena.

~~E.~~ F. The hearing officer shall conduct the state fair hearing; decide on questions of evidence, procedure, and law; question witnesses; and assure that the state fair hearing remains relevant to the issue being appealed. The hearing officer shall control the conduct of the state fair hearing and decide who may participate in or observe the state fair hearing.

~~F.~~ G. State fair hearings shall be conducted in an informal, ~~nonadversarial~~ impartial manner. The appellant ~~or~~ and the appellant's authorized representative shall have the right to bring witnesses, establish all pertinent facts and circumstances, present an argument without undue interference, and question or refute the testimony or evidence, including the opportunity to confront and cross-examine agency representatives.

~~G.~~ H. The rules of evidence shall not strictly apply. All relevant, nonrepetitive evidence may be admitted, but the probative weight of the evidence will be evaluated by the hearing officer.

~~H.~~ I. The hearing officer may leave the state fair hearing record open for a specified period of time after the state fair hearing in order to receive additional evidence or argument from the appellant ~~or~~ and the appellant's authorized representative.

1. At the appellant's option, the hearing officer may order an independent medical assessment when the appeal involves medical issues, such as a diagnosis, an examining physician's report, or a medical review team's decision, and the hearing officer determines that it is necessary to have an assessment by someone other than the person or team who made the original decision (e.g., to obtain more detailed medical findings about the impairments, to obtain technical or specialized medical information, or to resolve conflicts or differences in medical findings or assessments in the existing evidence). A medical assessment ordered pursuant to this chapter shall be at the department's expense, shall not extend any of the timeframes specified in this chapter, shall not disrupt the continuation of benefits, and shall become part of the record.

2. The hearing officer may receive evidence that was not presented by either party if the record indicates that such evidence exists, and the appellant or the appellant's authorized representative requests to submit it or requests that the hearing officer secure it.

3. If the hearing officer receives additional evidence from an entity other than the appellant or the appellant's authorized representative, the hearing officer shall send a copy of such evidence to the appellant and the appellant's authorized representative and give the appellant or the appellant's authorized representative the opportunity to comment on such evidence in writing or to have the state fair hearing reconvened to respond to such evidence.

4. Any additional evidence received will become a part of the state fair hearing record, but the hearing officer must determine whether or not it will be used in making the final decision.

~~I.~~ J. After conducting the state fair hearing, reviewing the record, and deciding questions of law, the hearing officer shall issue a written final decision ~~that sustains or reverses, in whole or in part, the MCO's adverse benefit determination or remands the case to the MCO for further evaluation consistent with the hearing officer's written instructions. Some decisions may be a combination of these dispositions~~. The hearing officer's final decision shall be considered as the department's final administrative action pursuant to 42 CFR 431.244(f). The final decision shall include:

1. Identification of the issue;

2. Relevant facts, to include a description of the procedural development of the case;

3. Conclusions of law, regulations, and policy that relate to the issue;

4. Discussions, analysis of the accuracy of the MCO's appeal decision, conclusions, and hearing officer's decision;

5. Further action, if any, to be taken by the MCOs to implement the hearing officer's decision;

6. The deadline date by which further action must be taken; and

7. A cover letter informing the appellant and the appellant's authorized representative of the hearing officer's decision. The letter must indicate that the hearing officer's decision is final, and that the final decision may be appealed directly to circuit court.

~~J.~~ K. A copy of the state fair hearing record shall be forwarded to the appellant and the appellant's authorized representative with the final decision.

~~K.~~ L. An appellant who disagrees with the hearing officer's final decision described in this section may seek judicial review pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and Rules of the Supreme Court of Virginia, Part Two A. Written instructions for requesting judicial review must be provided to the appellant or the appellant's authorized representative with the hearing officer's decision, and upon request by the appellant or authorized representative.

12VAC30-141-40. Appeal of adverse actions or adverse benefit determinations.

A. Upon written request, all FAMIS applicants and enrollees shall have the right to a state fair hearing of an adverse action made by the local department of social services, CPU, or DMAS and to an internal appeal of an adverse benefit determination made by an MCO.

B. During the appeal of a suspension or termination of enrollment or a reduction, suspension, or termination of services, the enrollee shall have the right to continuation of coverage if the enrollee requests an internal appeal with the MCO or an appeal to DMAS prior to the effective date of the suspension or termination of enrollment or suspension, reduction, or termination of services.

C. An appeal of an adverse action made by the local department of social services, CPU, or DMAS shall be heard and decided by an agent of DMAS who has not been directly involved in the adverse action under appeal.

D. An internal appeal of an adverse benefit determination made by the MCO must be conducted by a person or agent of the MCO who has not been directly involved in the adverse benefit determination under appeal.

E. Pursuant to 42 CFR 438.402(c)(1)(B), after exhausting the MCO's internal appeals process, there shall be opportunity for the enrollee to request an external medical review by an independent external quality review organization. "External quality review organization" means the independent contractor assigned by DMAS to handle quality reviews and to conduct final review of MCHIP adverse actions for FAMIS. The review is optional and shall not be required before proceeding to a state fair hearing. The review shall not extend any of the timeframes for issuing a decision and shall not disrupt any continuation of coverage granted to the enrollee.

F. There will be no opportunity for appeal of an adverse action to the extent that such adverse action is based on a determination by the director that funding for FAMIS has been terminated or exhausted. There will be no opportunity for appeal if the sole basis for the decision is a provision in the State Plan or in a state or federal law requiring an automatic change in eligibility or enrollment or is a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

G. The burden of proof shall be ~~upon the applicant or enrollee to show that an adverse action or adverse benefit determination is incorrect~~ assigned to the party who is attempting to make a change per 12VAC30-110-220 C.

H. At no time shall local department of social services, MCO, CPU, or DMAS failure to meet the timeframes set in this chapter or set in MCO or DMAS written appeal procedures constitute a basis for granting the applicant or enrollee the relief sought.

I. Adverse actions related to health benefits covered through the FAMIS Select program shall be resolved between the insurance company or employer's plan and the FAMIS Select enrollee and are not subject to further appeal by DMAS or its contractors.

12VAC30-141-700. Appeal of adverse actions or adverse benefit determinations.

A. Upon request, all FAMIS MOMS program applicants and enrollees shall have the right to a state fair hearing of an adverse action made by the local department of social services, CPU, or DMAS, or an internal appeal of an adverse benefit determination made by the MCO.

B. During the appeal of a suspension or termination of enrollment or a reduction, suspension, or termination of services, the enrollee shall have the right to continuation of coverage if the enrollee requests an internal appeal with the MCO or an appeal to DMAS prior to the effective date of the suspension or termination of enrollment or suspension, reduction, or termination of services.

C. An appeal of an adverse action made by the local department of social services, CPU, or DMAS shall be heard and decided by an agent of DMAS who has not been directly involved in the adverse action under appeal.

D. An internal appeal of an adverse benefit determination made by the MCO must be conducted by a person or agent of the MCO who has not been directly involved in the adverse benefit determination under appeal.

E. Pursuant to 42 CFR 438.402(c)(1)(B), after exhausting the MCO's internal appeals process, there shall be opportunity for the enrollee to request an external medical review by an independent external quality review organization. "External quality review organization" means the

independent contractor assigned by DMAS to handle quality reviews and to conduct final review of MCHIP adverse actions for FAMIS MOMS. The review is optional and shall not be required before proceeding to a state fair hearing. The review shall not extend any of the timeframes for issuing a decision and shall not disrupt any continuation of coverage granted to the enrollee.

F. There will be no opportunity for appeal of an adverse action to the extent that such adverse action is based on a determination by the director that funding for FAMIS MOMS has been terminated or exhausted. There will be no opportunity for appeal if the sole basis for the decision is a provision in the State Plan or in a state or federal law requiring an automatic change in eligibility or enrollment or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

G. The burden of proof shall be ~~upon the applicant or enrollee to show that an adverse action or adverse benefit determination is incorrect~~ assigned to the party who is attempting to make a change per 12VAC30-110-220 C.

H. At no time shall MCO, LDSS, CPU, or DMAS failure to meet the timeframes set in this chapter or set in MCO or DMAS written appeal procedure constitute a basis for granting the applicant or enrollee the relief sought.