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https://dmas.virginia.gov
MEDICAID MEMO

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Information Regarding DMAS Client Appeals (State Fair Hearing)

The purpose of this Medicaid Memo is to provide details regarding the State Fair Hearing process for client appeals. This Memo is meant to bring clarity to what members and the Agency/contractors can expect with regard to State Fair Hearings.

All Medicaid applicants and members who receive an adverse action, or who have not received a decision on a request in the required timeframe, have the right to appeal to DMAS for a State Fair Hearing. If the action being appealed is one that stems from a Medicaid Managed Care Organization ("MCO"), the member must exhaust the appeal process with the MCO prior to appealing to DMAS, except under certain circumstances outlined in 42 CFR § 438.402.

The federal requirements for the State Fair Hearing process are set forth at 42 CFR § 431.200 et seq. There are additional federal requirements at 42 CFR § 438.400 et seq. for appeals involving actions by MCOs. At the state level, the main client appeal regulations are found under 12 VAC 30-110-10 et seq., with Medallion managed care regulations addressing member appeals at 12 VAC 30-120-420.

Scope of the Appeal

42 CFR § 431.220 and 12 VAC 30-110-90 describe adverse actions that entitle a Medicaid applicant or member to an appeal. Effective with appeals filed on and after October 15, 2020, DMAS will conduct the State Fair Hearing as a de novo hearing, which is different from a de novo review of the underlying adverse decision. A de novo hearing is a hearing that starts over from the beginning by a new decision-maker – the Hearing Officer – examining all of the evidence and rendering an independent, new decision. During the DMAS State Fair Hearing, the appellant or an authorized representative is allowed to file evidence, provide witness testimony, and make arguments relevant to support their position. The Appellant is not limited to presenting evidence that was available to the Agency/contractor at the time the initial decision was made. Appellants are encouraged to submit the supporting information with their request for a State Fair Hearing so that it can be reviewed as soon as possible, but appellants can also submit documents prior to and at the hearing. At the hearing, the appellant or authorized representative can make arguments, call witnesses, and cross-examine witnesses called by the Agency/contractor who took the initial action.

In making the decision, all relevant information submitted, including testimony, will be considered by the Hearing Officer, whether or not it had been submitted prior to the State Fair Hearing request.

Prehearing Review

As part of the prehearing review conducted by the Hearing Officer in accordance with 12 VAC 30-110-190 and 12 VAC 30-110-210, the Hearing Officer will review the notice of action/adverse benefit determination ("Notice") issued by the Agency/contractor to the member to confirm (i) the

Notice was issued timely, and (ii) the content of the Notice complies with federal and state regulations. The review for each of these elements is set forth below.

- Timely Notice
  - Existing Eligibility/Current Services: When the Agency/contractor plans to terminate, suspend, or reduce an individual's existing eligibility or currently covered services, a Notice must be sent in advance, at least ten (10) days before the date of the proposed action. 42 CFR §§ 431.211; 438.404; 12 VAC 30-110-80. Exceptions to this requirement are set forth in 42 CFR §§ 431.213 – 214.
  - It is presumed the notice is received by the member 5 days after the date on the notice, unless the member shows he did not receive the notice within the 5-day period. 42 CFR 431.231(c)(2); 12 VAC 30-110-160.
    - This means a notice dated June 1, 2020 is presumed to be delivered on June 6, 2020. The notice will include a time limit for exercising any appeal rights (see "Required Content in Each Notice" below). In this example, the applicable time limit would begin to run on June 6, 2020, unless the member shows that he/she did not receive it within this 5-day period.
  - Long-Term Care Facilities: The notice of discharge from a long-term care facility must be sent at least 30 days before the discharge date. 42 CFR § 483.15(c)(4).
  - New applications for eligibility: The timeliness standards in 42 CFR § 435.912 apply. For example, the regulations provide 45 days to process a standard Medicaid application and 90 days for applications submitted on the basis of disability. 42 CFR § 435.912(c)(3). Some applications have shorter processing standards as set forth in the Medicaid Eligibility Manual, Chapter M01, M0130.100.
  - Standard service authorization requests: An MCO must provide Notice of its decision to the member within 14 calendar days of receiving the request. 42 CFR §§ 438.210(d)(1); 438.404(c)(3).
    - As described above, if the service authorization request is for continued authorization of existing services, any Notice that reduces or terminates the existing service must be issued in advance, at least ten (10) days before the date of the proposed reduction/termination.
  - Expedited service authorization requests: For cases in which a provider indicates, or the Agency/contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Agency/contractor must provide Notice of its decision as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service, or another expedited timeframe as set forth in the regulations. 42 CFR §§ 431.210(d)(2); 438.404(c)(6).

- Required Content in Each Notice
  - A statement of the specific action the Agency/contractor, skilled nursing facility, or nursing facility intends to take and the effective date of such action (42 CFR § 431.210);
  - A clear statement of the specific reasons supporting the intended action. This includes the factual basis and specific regulations and other authority that support the action, or the change in Federal or State law that requires the action (reference to a policy alone is not sufficient) (42 CFR § 431.210);
  - For Notices issued by MCOs – the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other

information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits (42 CFR § 438.404);
- An explanation of the individual's appeal rights and the procedures and time limits for exercising such rights. This includes the right to request an internal appeal or expedited internal appeal (for MCO Notices), the right to request a State Fair Hearing, and the right to request an expedited State Fair hearing. Additionally, the notice must include a statement that the member can file additional documents and arguments during the appeal process. (42 CFR§§ 431.220; 438.402; 12 VAC 30-110-90);
- The circumstances under which Medicaid benefits or services can be continued if a hearing is requested by the member, how to request continued benefits or services, and the circumstances under which the member may be required to repay the costs of these benefits and services (42 CFR §§ 431.230; 438.420; 12 VAC 30-110-100);
- The right of the member to represent himself/herself or be represented by legal counsel, a relative, a friend, or other spokesman (42 CFR § 431.206(b)(3); 12 VAC 30-110-50; 12 VAC 30-110-60); and
- The time frame in which the Agency/contractor must take final administrative action (42 CFR § 431.206).
  - In general, DMAS must take final administrative action within 90 days from a member's appeal. 42 CFR § 431.244(f). When a member receives services through an MCO, the 90 days begins when the member files the required internal appeal, and continues to run until the MCO renders its internal appeal decision. Once the MCO renders its internal appeal decision, the 90 day time period pauses until the member files a timely appeal with the DMAS Appeals Division for a State Fair Hearing. 42 CFR § 431.244(f)(1)(i).

Prehearing Decisions

Based on the Hearing Officer's prehearing review, if the Notice does not comply with the advance notice pre-termination/reduction/discharge timeframe requirement or fails to include one or more of the content requirements, the Hearing Officer will issue a decision that:

- Explains the deficiency in the Agency's/contractor's Notice;
- States that a hearing on the merits of the Agency's/contractor's action will not be convened;
- For Notices reducing or terminating existing coverage or services:
  - Finds in favor of the member by ordering the Agency/contractor to reinstate the existing level of coverage or services at issue for a period of at least 30 calendar days; and
  - Requires the Agency/contractor to issue a new compliant notice prior to the end of the 30 calendar day period by reviewing the same application or service authorization request. If the Agency/contractor requires additional information to process the application or service authorization request, they must ensure that the information is requested and obtained in order to timely issue the new compliant notice.
- For Notices concerning new applications for eligibility or requests for new services:
  - The Hearing Officer may issue a decision remanding the Notice to the entity that issued it and order that, within a reasonable period determined by the Hearing Officer, a new compliant Notice be issued to the member on the same eligibility application or service authorization request. If the Agency/contractor requires additional information to process the application or service authorization request, they must ensure that the

information is requested and obtained in order to timely issue the new compliant notice. Alternatively, the member will be given the option to waive the deficient notice and continue with the State Fair Hearing process.

Conducting the Hearing

The following is intended to clarify how the Hearing Officer will conduct the State Fair Hearing:

- The Hearing Officer shall explain during the opening remarks that the Hearing Officer is impartial and has not been involved in any prior part of the initial determination or internal appeal.
- The Hearing Officer shall consider all of the evidence presented and determine its relevance, regardless of whether the evidence was available to the original decision maker.
- The Hearing Officer shall determine the credibility and veracity of each witness.
- The Hearing Officer may leave the hearing record opened for a specified period of time in order to receive additional evidence or argument from the appellant. If the record indicates that evidence exists which was not presented by either party, with the appellant's permission, the hearing officer may attempt to secure such evidence. 12 VAC 30-110-360(B).
    - If the Hearing Officer receives additional evidence from a person other than the appellant or his representative, the hearing officer shall send a copy of such evidence to the appellant and his representative and give the appellant the opportunity to comment on such evidence in writing or to reconvene the hearing to respond to such evidence. 12 VAC 30-110-360(C).
- The Hearing Officer will make factual findings and shall not give deference to the Agency/contractor that made the decision that was appealed by the member.
- The Hearing Officer will take into consideration the previous level of services the member was receiving and any change in circumstances that would support an action to reduce, terminate, or otherwise limit the service. The existence of a previously approved service authorization indicates the requested services previously were deemed medically necessary. For a reduction or termination of those same services, due process to the Member requires an explanation as to what has changed, or how the previous service authorization approval was made in error. The Department is cognizant that a reduction or termination of services can be an indication that a member's condition has changed/improved or that, less often, the previous assessment of the member was somehow faulty. The Hearing Officer will look for an explanation of this in the record and any evidence/testimony provided at the hearing. The Hearing Officer's written decision will reference both parties' assertions on this issue and explain how the change in the member's condition/circumstances, or lack thereof, supports or does not support the termination/reduction of existing services.
- The Hearing Officer's decision issued after the hearing will explain why the Hearing Officer found one interpretation or argument to be more persuasive than the other and explain the facts and reasons for his/her decision, including citations to the evidence that was introduced at the hearing and the law or regulations relied upon.

For additional information and resources about the DMAS appeal process, please visit http://dmas.virginia.gov/#/appealsresources. The Appeals Division can also be contacted by email at Appeals@DMAS.Virginia.Gov, phone at (804) 371-8488, or fax at (804) 452-5454.

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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/
Appeals DMAS is launching an appeal portal in late May 2021. You can use this portal to file appeals and track the status of your appeals. Visit the website listed for appeal resources and to register for the portal.	https://www.dmas.virginia.gov/appeals/
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
Aetna Better Health of Virginia	www.aetnabetterhealth.com/Virginia 1-800-279-1878
Anthem HealthKeepers Plus	www.anthem.com/vamedicaid 1-800-901-0020

Magellan Complete Care of Virginia	www.MCCofVA.com 1-800-424-4518 (TTY 711) or 1-800-643-2273
Optima Family Care	1-800-881-2166 www.optimahealth.com/medicaid
United Healthcare	www.Uhccommunityplan.com/VA and www.myuhc.com/communityplan 1-844-752-9434, TTY 711
Virginia Premier	1-800-727-7536 (TTY: 711), www.virginiapremier.com