Meeting of the Medicaid Appeals Workgroup
600 East Broad Street, 7A&B
Richmond, Virginia

July 11, 2017
Minutes

Present:	**DMAS Staff:**
Workgroup Members:	Cindi Jones, Director
Steve Rosenthal, Esq.	Suzanne Gore, Deputy Director for Administration
Matt Cobb, Esq.	Brian McCormick, Policy Division Director
Jeffery Palmore, Esq.	Sam Metallo, Appeals Division Director
Brent Rawlings, Esq.	John Stanwix, Formal Appeals Supervisor
Jennifer Fidura	Susan Puglisi, Senior Policy Advisor
Brian Wilmoth	
Matt Russel	
Tamara Blow, Ed.D, R.N.	
Kim Piner, Esq. (OAG)	
Jennifer Gobble, Esq. (OAG)	
Jill Costen, Esq.(OAG)	
William Clay Garrett, Esq. (OAG)	
Shreen Mahmoud, Formal Appeals Representative (DMAS)	
Vanea Preston, External Provider Audit Manager (DMAS)	
Louis Elie, Program Integrity Division Director (DMAS)	

Speakers:
Brian McCormick
Cindi Jones
Jeffrey Palmore
Louis Elie
Sam Metallo

CALL TO ORDER

Suzanne Gore called the meeting to order at 1:30 pm. Brian McCormick, the Department of Medical Assistance Services (DMAS) Policy Director, thanked all present for attending and gave a brief description of the purpose of the workgroup. He then informed all present that there was a designated sign-up sheet for members of the public who wished to speak during the public comment period. Mr. McCormick then asked the members of the Workgroup to introduce themselves. Introductions continued around the room. Brian McCormick then introduced DMAS Director Cynthia B. Jones.

DIRECTOR'S WELCOME AND OPENING REMARKS

Cynthia Jones welcomed the workgroup members and thanked them for their participation. She provided a brief overview of the current climate of Medicaid, specifically the movement to

managed care organizations and stressed that it is DMAS's mission to ensure the integrity of Medicaid providers. She further noted that audits are necessary, but they should be fair and expeditious.

BACKGROUND: REASONS FOR THE WORKGROUP

Jeffrey Palmore on behalf of the Virginia Bar Association (VBA) spoke about the background behind the workgroup. He stated that the Health Law Section of the VBA identified an issue with the audit/appeal process: a long and costly audit and appeal process for providers and large retractions of payments for issues that the VBA and their clients believed were non-material breaches of the DMAS provider participation agreement. He noted the issues identified in the audits in question are the types of issues that could and should be quickly resolved. Mr. Palmore noted that there was language within the 2016-2018 Budget, which would allow settlements at the informal appeal level without the approval of the Office of the Attorney General if the amount was less than $250,000, but the Governor vetoed that language.

DMAS AUDIT METHODOLOGY AND FINDINGS

The meeting continued with Mr. Louis Elie, DMAS's Program Integrity Director, providing a presentation of DMAS's audit methodology. Mr. Elie provided a brief overview of the audit process itself and stressed that DMAS is mandated to conduct audits. He explained that subject matter experts of each provider type assist in the development of the audit process. Mr. Wilmoth asked whether DMAS has identified underpayments. Mr. Elie stated DMAS does not currently do so due to a lack of resources. A provider representative from the audience stated that providers are their own best advocates in these circumstances and would identify underpayments themselves. Workgroup members noted it would be helpful if DMAS could present the gross and net amount of overpayments. DMAS staff stated they would gather that information for the workgroup.

APPEALS PROCESS

DMAS Appeals Division Director Samuel Metallo provided a presentation of the appeals process. Mr. Metallo noted that the Appeals Division must remain neutral, which is the reason why he would not be serving on the workgroup, but that he will be happy to assist in facilitating the workgroup as appropriate. He also noted that the number of provider appeals has been declining over time and that there would be serious policy considerations should a material breach standard be adopted. Mr. Metallo asked the workgroup to consider whether applying a subjective standard to the process, such as "substantial performance" or "material breach" will lead to inconsistent and arbitrary results. He offered the example that one Hearing Officer's opinion of what is "material" may be very different from another Hearing Officer's opinion on the same facts and with a different provider, leading to inconsistent and unfair resulting Final Agency Decisions. At this point, the discussion turned away from a substantial compliance standard and towards the informal appeals process. Members of the workgroup had specific questions about the authority of the informal appeals agent. Members of the workgroup also requested that DMAS provide a breakdown of the 30 recommended decisions the Director accepted in her Final Agency Decisions within 2016, specifically the number of those decisions that were in favor of the provider and the number in favor of DMAS.

DISCUSSION

Mr. McCormick noted that the workgroup's questions had carried into the allotted time for the workgroup discussion and stated that these questions would be considered the beginning of discussion. Members asked Mr. Metallo what would prevent an informal appeals agent from being involved in facilitating a settlement at the informal appeal level. Mr. Metallo responded that the informal appeals agent could enter a resolved appeal decision based on the agreement of the parties but that the informal appeals agent could not be a mediator to the settlement negotiations because that would interfere with the role of being a neutral decision-maker. The workgroup requested that DMAS present the role, authority and limitation of the informal appeals agent at the next workgroup meeting. Mr. Cobb replied that the goal of the informal appeal process should be to avoid protracted litigation for what are very technical audit findings. Mr. Russel interjected that other providers had told him that once an auditor made a finding, they would not remove the finding unless it was a glaring error, meaning the informal appeals process usually does not yield any changes in the audit findings. Ms. Fidura stated that it is her experience that there is typically no change to an overpayment once the auditor has made the initial finding. Members of the workgroup asked if DMAS has statistics on how many informal appeals upheld the DMAS overpayment finding. Suzanne Gore noted that staff would research that information to the extent it is available prior to the next workgroup meeting.

Mr. Russel expressed an opinion that instead of focusing the conversation on the appeal process, it would be better to see what changes the workgroup could make to the audit process. He described a recent audit that his company had been involved with where a majority of the overpayment was reversed during appeal, although he claimed that the information had only been reorganized from how it was submitted during the audit. Mr. Russel expressed frustration that he and his company had to go through the expense of the appeals process.

Ms. Blow stated that many providers feel like audits are just an avenue for DMAS to have money returned to the Commonwealth. She stated that the errors identified do not usually involve questions of the health and safety of the treatment of the Medicaid recipients reviewed. She provided an example of an audit where DMAS retracted payment because the aide who provided services wrote that a patient had a "good week" in the comments field of the DMAS form.

Workgroup members noted a desire to have audits focus more on retracting payment for quality of care issues. Workgroup members stated that there is no flexibility with DMAS requirements and that the amount retracted does not always fit the severity of the audit finding. Ms. Fidura gave an example of incomplete information in a quarterly review. She stated that even if many months' worth of services are properly documented, if there is anything missing within the quarterly review, then DMAS will retract for the entire quarter of services. She requested the workgroup consider if retractions are fiscally appropriate for the audit finding. Ms. Fidura asked if the workgroup could consider other methods besides full retractions to deal with technical data omissions that do not affect the health and safety of patients.

Ms. Gore asked Mr. Elie to explain how auditors assign error codes. Mr. Elie explained that subject matter experts identify important requirements for each provider type. When asked if providers are involved in the discussion of what to audit, Mr. Elie stated that DMAS made

changes to the audit process based on input from provider subject matter experts for behavioral health providers. He also noted that appeal trends are reviewed to determine if audits on specific requirements should continue or not. The workgroup expressed desire for all provider types to have similar input in the audit process. Mr. Elie also explained that because DMAS funding is partially derived from federal payments, DMAS must return the federal portion of any retraction of payment identified by an audit to the federal government.

The workgroup stated that they understand that DMAS must return the federal portion within a year of issuing the overpayment letter, but questioned if there was a way to delay when the year period starts. Mr. Metallo noted that under current regulations, the timeframe to appeal begins when the overpayment letter is issued. The workgroup explored a possibility of having another phase of the process between when the preliminary findings letter is issued and the final overpayment letter is issued. One idea was to have a more thorough discussion during that period, wherein DMAS and the provider could evaluate whether retraction was warranted. Under the proposal, if the provider still disagreed, the case would then move to a formal appeal. A suggestion was made that the new phase could be similar to an arbitration proceeding, with the individual facilitating the discussion being someone not employed by DMAS.

Mr. McCormick noted that a portion of the agenda had been reserved for public comment and that one individual had signed up to make a comment. Bruce Green from the Pediatric Connection thanked DMAS for conducting the workgroup and said that it was his hope that commonsense could be used during the audit process to avoid retractions for nonmaterial issues.

Ms. Piner stated that she wanted to raise a legal consideration for the workgroup: since DMAS is required to have a State Plan approved by the federal government, there is a question of whether the federal government would allow a substantial compliance standard to be applied to federal requirements.

The meeting concluded by planning for the next meeting by reviewing the workgroup's requests for more data and highlighting the main discussion points.

The workgroup requested the following information to be presented at the next workgroup meeting:

- The authority and limitations of the informal appeals agent;
- How many informal appeals upheld the DMAS overpayment finding within the past year;
- The effect that the Culpepper and 1st Stop cases have on the number of provider appeals;
- Comparison of gross overpayment amounts vs. net overpayment amounts; and
- A breakdown of the 30 recommended decisions the Director accepted in her Final Agency Decisions within 2016, specifically the number of those decisions that were in favor of the provider and the number in favor of DMAS.

The workgroup identified the following discussion points as areas of focus for the next meeting:

- Restructuring Informal Appeals Process
    - Timing
    - Authority of informal appeal agent
    - Effect on cost, fraud, waste and abuse

- How items are selected for audit
    - Greater inclusion of provider subject matter experts in the process
    - Scope of the audit
- The amount/fiscal impact of the retraction to the provider