COMMONWEALTH of VIRGINIA

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MEMORANDUM

TO: **Emily McClellan**
Regulatory Supervisor
Department of Medical Assistance Services

FROM: **Davis Creef**
Assistant Attorney General
Office of the Attorney General

DATE: **January 13, 2022**

SUBJECT: **Emergency Regulation – Client Appeals Update**

You have asked the Office of the Attorney General to review and determine if Department of Medical Assistance Services has the statutory authority to promulgate these regulations and if they comport with applicable state law. I have reviewed the attached emergency regulations posted to the Virginia Regulatory Town Hall that would update the Department's client appeal regulations, as mandated by the General Assembly in Item 317.GG (2) in the 2021 Appropriations Act.

Based on my review, it is this Office's view that the Director of the Department of Medical Assistance Services, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code § 32.1-324, has the authority to promulgate these regulations, subject to compliance with the provisions of Article 2 of the Virginia Administrative Process Act, and has not exceeded that authority. The proposed regulations will enable the Director the Department's client appeal regulations, consistent with the authority set forth in Virginia Code § 32.1-324 and the directives in Item 317.GG(2) of the 2021 Appropriation Act.

The authority for the emergency action is found in Virginia Code § 2.2-4011, which provides that Agencies may adopt emergency regulations when Virginia statutory law, the appropriation act, or federal law or regulation requires that the regulation be effective in 280 days or less from its enactment, as required by Item 317.GG(2) of the 2021 Appropriation Act.

Accordingly, with the prior approval of the Governor, these regulations will qualify for the "emergency" exemption from Article 2 requirements. Please be advised, however, that under Virginia Code §2.2-4011(A), the Department must state in writing the nature of and necessity for such emergency actions, and this appears to have been accomplished in the "Agency Background Document." In addition, the regulations shall be effective for no more than 18 months. If the Department intends to continue regulating the subject matter governed by this emergency regulation beyond 18 months, it will be necessary to replace these emergency regulations with regulations duly promulgated under Article 2 of the APA.

If you have any questions or need additional information about these regulations, please contact me at 786-6522.

cc: Kim F. Piner, Esq.

Attachment

Emergency Text

highlight

Action: Client Appeals Update
Stage: Emergency/NOIRA 1/13/22 9:46 AM [latest]

12VAC30-110-10 Definitions
Subpart I
General

Article 1
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.

"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 benefits or his eligibility for benefits and (ii) a nursing facility resident who seeks to challenge a transfer or discharge. Appellant also means an individual who seeks to challenge an adverse determination regarding services provided by a nursing facility.

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

"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.

"Department" means the Department of Medical Assistance Services.

"Division" means the department's Appeals Division.

"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.

"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.

12VAC30-110-185 Appeal Summary

A. The agency proposing the action about which the individual requested the state 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 ID number, or other identifying information;

3. The local office responsible for the appellant's case;

4. A summary of the facts surrounding, and the grounds supporting, the adverse action;

5. Citations to the statutes, regulations, and specific provisions of the Department's Medicaid 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 sent to the appellant and representative (if applicable) at least 5 days before the hearing date.

12VAC30-110-220 Evidentiary hearings

Article 3
Hearing

A. General. ~~A~~ 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 and policy 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 issue(s) 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 issue(s) on appeal.

C. Burden of Proof. The burden of proof shall be assigned to the party who is attempting to change the status quo. If an individual is seeking initial Medicaid eligibility, an increase in the Medicaid eligibility level, or the initial approval of a medical service, 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 to the satisfaction of the hearing officer 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 12 VAC 30-110-360. Failure to submit information with the appeal so that it can be moved forward will add delay to the appeal decision due date as per 42 CFR 431.244.

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 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 as per 12VAC30-110-220.

~~A.~~ 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 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 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 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 change the status quo as 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 change the status quo as 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.