COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

December 1, 2017

MEMORANDUM

TO: The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones
Director, Virginia Department of Medical Assistance Services

SUBJECT: Medicaid Appeals Workgroup Report

Item 306 WW of the 2017 Appropriation Act states the Department of Medical Assistance Services shall convene a workgroup with representatives from the provider community, and the legal community, and the Office of Attorney General to develop a plan to avoid or adjust retractions for non-material breaches of the Provider Participation Agreement when the provider has substantially complied with the Provider Participation Agreement. The plan shall include an assessment of any administrative financial impact that implementation of such plan would have on the department and an analysis of any implications for the department's efforts to combat fraud, waste, and abuse. The workgroup shall report on the status of this plan to the Chairmen of the House Appropriations and Senate Finance Committees no later than December 1, 2017.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Medicaid Appeals Workgroup Report

A Report to the Virginia General Assembly

December 1, 2017

Report Mandate:

Item 306 WW of the 2017 Appropriations Act states the Department of Medical Assistance Services shall convene a workgroup with representatives from the provider community, and the legal community, and the Office of Attorney General to develop a plan to avoid or adjust retractions for non-material breaches of the Provider Participation Agreement when the provider has substantially complied with the Provider Participation Agreement. The plan shall include an assessment of any administrative financial impact that implementation of such plan would have on the department and an analysis of any implications for the department's efforts to combat fraud, waste, and abuse. The workgroup shall report on the status of this plan to the Chairmen of the House Appropriations and Senate Finance Committees no later than December 1, 2017.

Background

The Department of Medical Assistance Services (DMAS) convened a workgroup consisting of representatives of the provider community, legal community and Office of the Attorney General. *(The list of participants is set forth in Appendix A).* DMAS held three open public meetings to explore and discuss DMAS' audit methodology and findings, and the appeals process. The meetings were convened to address the General Assembly's mandate "to develop a plan to avoid or adjust retractions for non-material breaches of the Provider Participation Agreement," while taking into consideration the need to ensure that DMAS maintains compliance with requirements of the Centers for Medicare and Medicaid Services (CMS).

DMAS arranged three meetings of the workgroup. The meetings were held on July 11 (*Minutes included as Appendix B*), September 27 (*Minutes included as Appendix C*) and October 31 (*Minutes included as Appendix D*). The workgroup discussed several topics but was unable to reach a consensus on the issue of utilizing a material breach or substantial compliance standard. However, the workgroup did agree to adopt the plan of action contained herein and continue to revisit the topic of a material breach or substantial compliance standard.

Plan of Action

The following plan of action was approved by the workgroup and will be implemented by DMAS. The purpose of the plan is to address providers' concerns raised throughout the workgroup meetings without causing a serious risk of the loss of substantial federal matching funds.

About DMAS and Medicaid

DMAS' mission is to ensure Virginia's Medicaid enrollees receive high quality and cost effective health care.

Medicaid plays a critical role in the lives of over a million Virginians, providing health care for those most in need. Medicaid enrollees include children, pregnant women, parents and care takers, older adults and individuals with disabilities. Virginians must meet income thresholds and other eligibility criteria before qualifying to receive Medicaid benefits.

Medicaid covers primary health care services, inpatient and outpatient services that support individuals in need of behavioral health support including addiction and recovery treatment. Medicaid also covers long term supports and services, making it possible for thousands of Virginians to remain in their homes or to access residential and nursing home care.

Quick Medicaid facts:

- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

Virginia Medicaid and Children's Health Insurance Program (CHIP) is administered by the Department of Medical Assistance Services (DMAS) and is jointly funded by Virginia and the federal government under the Title XIX and Title XXI of the Social Security Act. Virginia generally receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

Issue: Inability to settle cases that do not merit the time and cost of a formal administrative hearing.
Plan: The DMAS attorney for formal administrative hearings shall be available and authorized to discuss and seek approval of settlements at the Informal Appeal level. A settlement at this stage of the process could be for some or all of the findings subject to the retraction. If DMAS and the provider agree to a partial settlement, any non-settled issues can continue through the informal appeal process. DMAS will publish a Medicaid Memo detailing the process (*see Appendix E*) and will make reference to the Memo in the final overpayment letters sent to providers. The Memo will be posted on DMAS' Website.

The workgroup proposes DMAS seek emergency regulatory authority to amend 12VAC30-20-540 of the Virginia Administrative Code to allow additional time for issuance of the informal appeal decision beyond 180 days to allow sufficient time for settlement if the provider waives the deadline.

Issue: Provider audits are too lengthy causing hardship in record retrieval.
Plan: DMAS has shortened the review period on all audits to from 15 months to 12 months.

Issue: Provider education regarding the audit process
Plan: DMAS will share areas of audit emphasis with provider groups prior to beginning that year's audits and clarify how auditors plan to evaluate compliance with the requirements set forth in regulations and the provider manuals. DMAS will ensure that audit points of focus are based upon requirements specified in regulation and/or Agency guidance documents, including citations to such requirements that are being relied upon by the auditor. Provider groups will be given the opportunity to provide feedback to DMAS regarding proposed audit points of focus. DMAS hopes that these efforts will give providers a more complete understanding of the audit process and the expectations of DMAS auditors with respect to these reviews.

Issue: Provider participation in audit process.
Plan: Auditors will conduct a detailed exit conference prior to leaving the facility in the case of an onsite audit and via phone prior to sending the preliminary findings in the case of a desk audit. At the close of the audit review DMAS will send the preliminary findings to the provider. The provider will then have 30 calendar days from receipt of the preliminary findings to request a re-review and provide additional documentation to the Agency. After 30 days DMAS follows up with the final findings and the next steps in the process. DMAS is dedicated to reviewing and strengthening this process. DMAS welcomes provider input on methods to improve the process.

Issue: Provider education regarding audit findings.
Plan: At the conclusion of each year's audits, DMAS will compile a list of common issues identified in those audits and share those with provider groups. DMAS will also identify a list of common issues that were originally identified in the audits as being an issue but were later overturned in the reconciliation, informal appeal, and/or formal appeal. This information will be used to ensure that the Provider Manuals provide the appropriate direction and explanation. DMAS will also evaluate whether revisions to applicable Provider manuals are necessary or appropriate to clarify standards applied to services.

Issue: DMAS documentation requirements are unclear to members in the Provider community.
Plan: In accordance with § 32.1-324.4 of the Code of Virginia, DMAS posts its Provider manuals on its website for public comment for 30 days prior to making any amendments to the manuals. This became effective on July 1, 2017. DMAS will evaluate its current manual provisions to ensure that documentation requirements for each service type are clearly identified and described in a manner designed to allow objective interpretation of the standards by DMAS providers, and auditors. DMAS encourages providers to comment on any areas of the manuals which require clarification.

Issue: The workgroup has not come to a consensus on the issue of a material breach or substantial compliance standard.
Plan: Due to the fact that the members of the workgroup began with different viewpoints regarding the focus of the group, the feasibility and impact of requiring a material breach standard and the limited time the workgroup had prior to submission of this Report, further work and an ongoing relationship will be necessary to fully address all of the concerns of the providers on the workgroup. DMAS is committed to continue discussion with providers to address these concerns. DMAS will continue to engage with stakeholders on at least an annual basis to revisit the topic of a substantial compliance or material breach standard and monitor the plan of action.

Appendix A.

Workgroup Members:

Steve Rosenthal, Esq. (Troutman Sanders)
Matt Cobb, Esq. (Williams Mullen)
Jeffery Palmore, Esq. (Reed Smith)
Brent Rawlings, Esq. (Virginia Hospital and Healthcare Association)
Jennifer Fidura (Virginia Network of Private Providers)
Brian Wilmoth (UVA Health Systems)
Matt Russel (ABC Healthcare)
Tamara Blow, Ed.D, R.N.(Virginia Association of Personal Care Providers)
Kim Piner, Esq. (OAG)
Jennifer Gobble, Esq. (OAG)
Jill Costen (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)

Appendix B.

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

July 11, 2017
Minutes

Present:
Workgroup Members:
Steve Rosenthal, Esq.
Matt Cobb, Esq.
Jeffery Palmore, Esq.
Brent Rawlings, Esq.
Jennifer Fidura
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)

DMAS Staff:
Cindi Jones, Director
Suzanne Gore, Deputy Director for Administration
Brian McCormick, Policy Division Director
Sam Metallo, Appeals Division Director
John Stanwix, Formal Appeals Supervisor
Susan Puglisi, Senior Policy Advisor

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

Appendix C.

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

September 27, 2017
Minutes

Present:
Workgroup Members:
Steve Rosenthal, Esq.
Matt Cobb, Esq.
Jeffery Palmore, Esq.
Brent Rawlings, Esq.
Brian Wilmoth
Jennifer Fidura
Matt Russel
Tamara Blow, Ed.D, R.N.
Kim Piner, Esq. (OAG)
Jennifer Gobble, Esq. (OAG)
Jill Costen, (OAG)
William Clay Garrett, Esq. (OAG)
Shreen Mahmoud, Formal Appeals Representative (DMAS)
Louis Elie, Program Integrity Division Director (DMAS)

DMAS Staff:
Suzanne Gore, Deputy Director for Administration
Brian McCormick, Policy Division Director
Sam Metallo, Appeals Division Director
John Stanwix, Formal Appeals Supervisor
Susan Puglisi, Senior Policy Advisor
Josh Lief, Provider and Medical Cases Manager

Speakers:
Brian McCormick
John Stanwix

CALL TO ORDER

Brian McCormick the Department of Medical Assistance Services (DMAS) Policy Director called the meeting to order. Mr. McCormick mentioned that members of the Workgroup have requested a third meeting but requested that discussion of another meeting be deferred to the end of the current meeting. 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 noted that DMAS held a discussion with the Centers for Medicare and Medicaid Services (CMS) to discuss the potential impact of DMAS moving to a material breach/substantial compliance standard. Mr. McCormick explained that DMAS presented CMS with three scenarios from appeal cases that were representative of the issues discussed by the Workgroup during the first meeting. For each of the circumstances presented CMS indicated that the entire federal match amount would have to be returned. CMS plainly noted that federal law overrides state law, that CMS would not recognize a substantial compliance standard and therefore DMAS would be financially liable for all federal dollars associated with cases where such a standard was utilized.

Steve Rosenthal asked for clarification by posing the following question: If an overpayment started at $100,000 and was reduced to $75,000 during the appeal, would DMAS owe the federal share on the larger or lower amount. DMAS responded that would be the lower amount provided the reduction was not based on a substantial compliance standard. He then asked whether the results of the call meant that DMAS was currently

liable for past case decisions that were based on a substantial compliance standard. Ms. Mahmoud responded that she did not believe that there were any such case decisions, with which Mr. Rosenthal disagreed. He said he would research his cases and advise the Workgroup. Matt Cobb asked whether DMAS has discretion to interpret its own provider manuals. Mr. McCormick responded yes and stated that the Workgroup would have an opportunity to discuss that topic and other topics during the portion of the agenda reserved for the Workgroup discussion.

Susan Puglisi then presented the draft meeting minutes from the first Medicaid Appeals Workgroup meeting. She noted that there had been no objection or edits to the draft minutes when they were circulated to the Workgroup at the end of July. Jennifer Fidura moved that the minutes be accepted and that motion was seconded by Brian Wilmoth. The minutes were unanimously accepted.

Mr. John Stanwix then provided the Workgroup with the data elements requested by the group at the last meeting and reviewed the authority of the Informal Appeals Agent. DMAS posted discussion topics on the Virginia Regulatory Town Hall due to the cancellation of the last Workgroup meeting, Ms. Puglisi reviewed the public comment DMAS received in response to that posting. The comment expressed concerns that DMAS may eliminate certain tools for providers. Ms. Puglisi assured the Workgroup and members of the public that DMAS does not envision any changes to DMAS' provider helpline or provider email portal.

WORKGROUP DISCUSSION

The meeting was then opened for Workgroup discussion. Mr. Cobb stated that the *Culpeper* Court of Appeals case cited to a provision within a DMAS policy manual that stated providers must maintain "adequate" documentation. Mr. Cobb asserted that there is some room for interpretation of what constitutes adequate documentation and stressed that in cases where there is no dispute that the services have been rendered that documentation errors should be treated as a minor infraction. Mr. Russel also noted that DMAS is transitioning to a managed care model and asked how audits will occur with managed care organizations (MCOs); specifically, whether the audit would use the MCO's policy manual or DMAS'. Mr. Louis Elie replied that some joint audits between DMAS and MCOs will occur but that DMAS will primarily audit MCOs to ensure that they are conducting appropriate compliance reviews.

Ms. Mahmoud returned to Mr. Cobb's argument regarding documentation deficiencies and stated that in recent cases courts have not analyzed whether or not the billed services were provided but rather focused on whether the provider has complied with documentation requirements. Ms. Mahmoud argued that documentation deficiencies are not minor or immaterial. She provided a few examples of how auditing documentation have identified fraud, waste and abuse. Mr. Cobb stated that there are also examples that would favor providers but that he did not feel that utilizing discussion time to pit example versus example was a productive use of time. Instead Mr. Cobb stated that the Workgroup should focus on the topic mandated by the General Assembly and noted that DMAS has discretion in interpreting its own manuals.

Ms. Gobble from the Office of the Attorney General noted that DMAS' discretion is limited, and cannot be unfettered. She explained that some of the Department's policy manual requirements are based on federal regulations which cannot be bent, further that a substantial compliance standard does not have federal approval and finally that it is imperative that DMAS be consistent in its audits and appeal decisions and not issue arbitrary and capricious decisions. She further noted that manual provisions cannot be interpreted inconsistently from underlying state or federal regulatory requirements.

Mr. Rosenthal interjected and stated that it is absolutely impossible to be consistent with each case as there are nuances to each set of facts. Ms. Fidura also noted that when a provider has questions regarding the policy manuals they are encouraged to contact the DMAS helpline. She stated that the answers provided by the helpline are variable and inconsistent and a reliance on a helpline answer is not defensible on appeal. She stated

the fact that a helpline exists is proof that there are instances where interpretation is necessary. Mr. Rawlings expressed that the issue boils down to what is stated within the policy manual, what is defined by DMAS policy and how is "adequate" documentation defined. Ms. Blow reaffirmed Mr. Rawlings' statement arguing that providers need more guidance from DMAS on what is considered sufficient.

Mr. Rosenthal asked the Workgroup if they could return to an idea expressed during the first meeting, the idea of settling cases at the informal level. Ms. Mahmoud explained that DMAS is willing to have settlement discussions occur at the informal level, but to maintain the neutrality of the Informal Appeals Agent, the settlement would be negotiated by DMAS attorneys who are authorized by the Office of the Attorney General (OAG) to represent DMAS during the appeal process. Ms. Mahmoud made it clear that settlements would have to be based on the merits of each case and not to settle for the sake of convenience. Some questions were raised about whether this can extend the timeframe to make a decision on the informal appeal and whether providers could settle one issue but proceed to appeal on other issues. DMAS stated that it would look into these questions. DMAS also agreed to notify the provider community that settlements could be offered during the informal appeal process. The notification might come in the form of a DMAS Medicaid Memo with overpayment letters including a reference to the memo.

Mr. Wilmoth stated that providers would like to know what DMAS audits have seen as main categories of deficiencies. He suggested that DMAS share appeal results, such as posting issues on the website. He stated that provider education can lead to adjustment in practices and bring providers further into compliance. Mr. Elie noted that the Department could educate providers more about the process of sharing the audit matrix and ensure when audit points are selected that they are clearly black and white issues with clear guidance within the policy manuals.

Mr. Metallo interjected and returned to Matt Cobb's issue that the Workgroup "is not addressing the General Assembly's mandate." Mr. Metallo stated that within the materials provided to the group was an initial draft of the report to the General Assembly, he noted that due to a printing error the report did not have the "DRAFT" watermark on it. He stressed that the report is currently a draft, that DMAS welcomes edits and comments from the group, and stressed that DMAS posted discussion topics on the Virginia Regulatory Town Hall to garner comments from both the Workgroup and members of the public. Mr. Metallo reiterated that the major concern of the Appeals Division within DMAS is to ensure that federal and state laws, regulations and policies are applied consistently and that a substantial compliance/material breach standard moves the Department away from a consistent objective standard. Mr. Cobb thanked Mr. Metallo for the clarification about the report and asserted that the report should be the product of the entire Workgroup.
Mr. Russel explained that he is a part of the Workgroup because he is a durable medical equipment provider. He stated that it is helpful to know what points DMAS has audited on and what has been overturned on appeal. Mr. Wilmoth echoed Mr. Russel's comments, adding that sharing audit points with the provider community allows the providers to better understand DMAS' policies. Ms. Fidura followed up by asking if it was possible for DMAS to categorize its audit findings.

Mr. Russel reiterated that DMAS is evolving into a more managed care program. Ms. Gore agreed that the movement will be a tremendous shift. Mr. Russel asked how closely will MCOs follow DMAS policy manuals. Ms. Gore stated that DMAS policy manuals should be the floor for compliance and any and all differences within MCO policies should be above and beyond the minimum laid out within the DMAS manuals. Ms. Gore stated that it would be good to have feedback from the provider community when more MCO audits occur. Mr. Rosenthal clarified that providers will still need to go through the MCO internal appeal process before appealing to DMAS.

The topic then shifted back to the possibility of settling appeals at the informal level. A Workgroup member asked if the settlement process could be explained in the final overpayment letter. Ms. Gore stated that

announcements of this nature are typically set forth in a DMAS Medicaid Memo to all providers. Ms. Fidura requested that all future overpayment letters contain a reference to the DMAS Memo. She also asked for the Workgroup to see a copy of the Memo before it is issued.

Workgroup members asked if DMAS and the provider are undergoing a settlement at the informal appeal level would that "stop the clock" on the 180-day deadline within the Virginia Administrative Process Act in which the Informal Appeals Agent is required to issue a decision. Ms. Gore responded that would be an issue to take to the General Assembly and perhaps the Workgroup could request that DMAS have authority to issue emergency regulations to extend that time frame in instances where a settlement is being pursued.

Mr. Garrett stated that the Medicaid Fraud Control Unit of the Office of the Attorney General receives approximately one quarter of their cases based on referrals from DMAS audits. He stated that a move to a substantial compliance standard may cause some issues in identifying potential fraud for referral to the OAG. Mr. Rosenthal responded that even if a material breach standard was adopted, DMAS staff could still refer cases to the OAG for criminal evaluation.

Ms. Fidura stated that it would be helpful if DMAS informs providers in advance of the audit process what elements will be deemed important. She said DMAS should look to provider manuals to see if the audit points are clear issues with unambiguous policy guidance. Mr. McCormick emphasized that in instances where DMAS loses an appeal due to a failure on the policy manual the manual is amended for further clarification. Mr. McCormick stressed this process will continue. Ms. Gore also noted that DMAS is currently evaluating and updating all of its provider manuals and encouraged the providers present to provide feedback.
The Workgroup stated that it would be helpful if audit points were posted publically on the DMAS website. Mr. Elie noted that he will ensure that Program Integrity's Annual Report is more prominently displayed on the DMAS website and will look into creating a "Top 10" list of the top ten most common audit findings as the Workgroup requested.

One member of the public had signed up to comment for the open meeting: Anthony Sandifer. He explained that he has been a DMAS provider for five years. He expressed an opinion that the DMAS Provider Helpline is useless, at times operators are only willing to read the Manual to him and not offer any interpretation. He also noted that at other times a helpline operator would inform him that he was limited to five questions and finally that some operators were rude and would hang up on him. He suggested sending a "new provider packet" to providers when they are first approved by DMAS. He stated that new providers do not go back to read old Provider Memos published by the Agency as providers are not aware of which memos are good resources and they do not have the time to read all of the memos ever published.

Mr. Palmore asked for a third meeting to discuss the draft report. Mr. Cobb also requested a third meeting. Ms. Gore stated that DMAS would revise the report to reflect the information discussed at this meeting and to include a draft of the memo discussing settlement. That report would be distributed to the Workgroup members, who would then individually send any proposed edits to DMAS. A third meeting would likely be scheduled for the end of October. At that point the Workgroup adjourned.

Appendix D.

Meeting of the Medicaid Appeals Workgroup
600 East Broad Street, 13th Floor Board Room
Richmond, Virginia

October 31, 2017
Minutes

Present:
Workgroup Members:
Steve Rosenthal, Esq.
Matt Cobb, Esq.
Jeffery Palmore, Esq.
Brent Rawlings, Esq.
Brian Wilmoth
Jennifer Fidura
Matt Russel
Tamara Blow, Ed.D, R.N.
Kim Piner, Esq. (OAG)
Jennifer Gobble, Esq. (OAG)
Jill Costen, (OAG)
William Clay Garrett, Esq. (OAG)
Shreen Mahmoud, Formal Appeals Representative (DMAS)
Louis Elie, Program Integrity Division Director (DMAS)

DMAS Staff:
Suzanne Gore, Deputy Director for Administration
Brian McCormick, Policy Division Director
Sam Metallo, Appeals Division Director
John Stanwix, Formal Appeals Supervisor
Susan Puglisi, Senior Policy Advisor
Josh Lief, Provider and Medical Cases Manager

Speakers:
Brian McCormick
Sam Metallo

CALL TO ORDER

Brian McCormick the Department of Medical Assistance Services (DMAS) Policy Director called the meeting to order. Mr. McCormick went over the Agenda, stating that Susan Puglisi would start the meeting with a vote on the last meeting minutes and then Sam Metallo would give a brief overview of the draft report and then the Workgroup would discuss the report.

Ms. Puglisi noted that she only received one edit to the draft minutes which was added. A motion and a second were made to adopt the minutes. No Workgroup members expressed opposition to the minutes and the motion was carried.

Mr. Metallo then thanked the Workgroup for the productive discussion the Workgroup has engaged in. He noted that DMAS and the Workgroup have agreed on a process to settle cases at the informal appeal level where appropriate. Additionally, he noted that the providers on the Workgroup seemed to voice an opinion that they wanted more methods and tools to avoid the appeals process. Mr. Metallo stated that the Workgroup and DMAS have worked together to develop plans to address this issue, shortening the period audited, revising the preliminary findings letter and strengthening the exit conference process. Mr. Metallo stated that he remains

concerned that substantial compliance standard would cause inconsistent decisions to be issued by Hearing Officers and that such inconsistency would in turn cause final agency decisions to be inconsistent because the Director of DMAS can only reject a recommended decision if there is an error of law or of policy. He then thanked the workgroup and turned the presentation over to Ms. Puglisi.

Ms. Puglisi asked the Workgroup if they wanted to walk through the report paragraph by paragraph or have more of an open discussion. The group elected for an open discussion.

WORKGROUP DISCUSSION

Mr. Palmore started the discussion by expressing concern with the method that DMAS had presented responses to the provider comments. He stated the method created the impression that DMAS has the final say on the report and asserted that the report is required to be the product of the workgroup, not DMAS. Ms. Gore replied that DMAS completed the draft in an effort to facilitate the workgroup's discussion. Ms. Gore explained that the final report can be updated to reflect any changes made by the workgroup. Mr. Palmore added that he wanted the report to state that it is a suggestion of the workgroup to amend the regulatory authority to extend the informal appeal deadline.

Mr. Rosenthal expressed a concern that the report did not address the mandate of the General Assembly to develop a plan for non-material breaches of the DMAS provider agreement. He stated that a material breach standard should be applied at the audit level and throughout the appeal process. He also stated that although DMAS' policy manual discusses the need for adequate documentation, the word "adequate" was removed from the report. Ms. Mahmoud noted that although the phrase "adequate documentation" is listed in Chapter VI of the manuals, there is also a requirement to comply with DMAS policies. She stated that most retractions are based on the auditor's finding that a specific policy was not followed. Mr. Garrett contended that focusing on the word "adequate" gives the false impression that some documentation requirements, including those mandated by the federal government, can be waived.

Ms. Mahmoud explained that DMAS is trying to avoid inconsistent decisions by various hearing officers, comply with the requirement of CMS to payback the federal share of an overpayment, and focus on the audit process because doing so is addressing the mandate. Mr. Rosenthal continued to disagree with the position that the draft report addressed the General Assembly's mandate. He claimed that the report does nothing to protect providers who make innocent mistakes. Ms. Mahmoud responded by stating that DMAS' agreement to seek provider input about the policies being audited will help avoid any surprises to providers. The discussion continued about whether there will be any type of minor mistake where DMAS will decide not to retract.

Ms. Gore stated that DMAS is attempting to address the issues discussed by developing some proposals throughout the process, getting input from the providers before audits begin, and through allowing settlements at the informal appeal level. She requested that the workgroup give these proposals some time to work. Mr. Rosenthal agreed with this approach as long as DMAS was willing to return to the issue of a substantial compliance or material breach standard in the future.

Mr. McCormick noted that the discussion thus far had taken up much of the time scheduled for the meeting and asked if anyone else had any points to raise. Mr. Russel stated that the only two avenues for interpretation of a DMAS requirement are for a provider to review the Manual or call the DMAS Helpline. He stated that it would be good if the Helpline calls are recorded so that a provider could refer back to the advice if they were subsequently audited. Ms. Gore expressed that issues with interpretation could also be brought up during the review period prior to the next audit cycle. Mr. Elie explained that auditors are typically looking at clear requirements and that most times the documentation simply is not present.

Mr. Wilmoth stated that he likes the idea of education by DMAS on audit points. He asserted that small providers are the ones who suffer the most from audits. He wants to make sure the focus is on preventing audit retractions rather than ending up in the appeals process.

Mr. Cobb stated that the draft report still needed to be addressed since it had not been approved yet by the workgroup. Ms. Gobble explained that it would be difficult for a workgroup with various viewpoints to come to a complete consensus on the issue of material breach. She proposed having different sections of the report for the various interests represented on the workgroup. Mr. Garrett expressed his opinion that the draft was well-balanced, especially considering the plan of action proposed by DMAS.

Ms. Gore suggested removing the portions with the various viewpoints and instead have the report focus on the plan. Ms. Fidura supported this approach. Mr. Rawlings asked for a more detailed description of the proposal and included an idea that the minutes for each meeting could be attached to the report as an appendix. Ms. Gore stated that the details of the proposed approach would be to: have an introduction paragraph on the meeting dates, explain the group was unable to come to a consensus due to various viewpoints on the application of material breach, list the proposed action steps, and note that DMAS will continue engaging the provider community and the bar association to address the plan for material breach and monitor the plan of action. The draft report would be sent to the workgroup members by November 3rd, with comments returned by November 8th, in order to allow DMAS time to finalize the report and submit it to the General Assembly after appropriate review by the Secretary of Health and Human Resources. The workgroup voted unanimously to approve this proposed course of action.

Near the conclusion of the meeting, Mr. Rosenthal asked that the minutes reflect that he submitted a Final Agency Decision issued in 2014, in which the Director of DMAS ruled in favor of the provider due to a finding that the audit finding was not a material breach of the provider participation agreement. He asked that the Decision be incorporated into the meeting minutes by reference.

Mr. Brian McCormick then adjourned the meeting.

Appendix E.

MEDICAID MEMO

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

http://www.dmas.state.va.us

TO: All Medicaid Service Providers

MEMO: Special

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

DATE:

SUBJECT: Informal Appeal Settlement Process

This Medicaid Memo is designed to provide information regarding the process for submitting a request to enter into settlement negotiations during an informal appeal filed pursuant to 12 VAC 30-20-540. All settlements shall be subject to the final approval of the Office of the Attorney General ("OAG") in accordance with Virginia Code § 2.2-514.

Process for Submitting a Proposed Settlement

1. Any request to enter into settlement negotiations shall be submitted in writing to the Director of the DMAS Appeals Division, who shall then refer the request to one of the DMAS' Appeal Representatives authorized by the OAG to represent DMAS in administrative proceedings.

2. The Appeal Representative assigned to handle the request shall contact the provider to discuss the terms of the proposed settlement.

3. Once the terms of the proposed settlement are negotiated, the Appeal Representative shall communicate those terms to the Director of DMAS

    A. If the Director of DMAS wishes to pursue the settlement, the Appeal Representative will communicate this to the provider and the Informal Appeals Agent ("IAA"), and submit the settlement for the OAG's approval.

    B. If the OAG approves the settlement, the Appeal Representative will communicate the same to the parties and the IAA, and the appeal will be withdrawn by the provider after the OAG-approved settlement is fully endorsed by the parties.

C. If the Director of DMAS does not wish to pursue the settlement or if the OAG does not approve the settlement, the Appeal Representative will communicate the same to the parties and the IAA, who will then continue processing the informal appeal

D. If DMAS does not wish to pursue the settlement, the Appeal Representative will communicate this to the provider and the IAA, who will then issue the informal appeal decision by the regulatory deadline.

Deadline for Submitting a Settlement Proposal

There is no authority to stay the deadlines set forth in the informal appeal regulations, 12 VAC 30-20-500 to 540. In order to ensure sufficient time for a settlement proposal to be reviewed by the Director of the Agency and the OAG and for the informal appeal decision to be issued by the regulatory deadline, the settlement proposal shall be submitted no later than 20 calendar days after the regulatory deadline for filing the case summary. The Director of the Agency and the OAG shall indicate whether the settlement has been approved or rejected no later than 50 calendar days after the regulatory deadline for filing the case summary.