2024 Virginia Medicaid

MEMBER ADVISORY COMMITTEE (MAC)

VIRGINIA'S MEDICAID PROGRAM

DMAS

MEDICAID MEMBER ADVISORY COMMITTEE

General MAC Meeting

October 21, 2024
10:00 AM - 12:30 PM

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1. Call to Order

2. Member Roll Call and Introductions

3. Minutes Approval: 06.10.2024 MAC Meeting

4. Presentation: The Value of Lived Experience Feedback in State Government and Beyond

5. Presentation: Eligibility 101

6. Public Comment

7. Closing Remarks and Announcements

8. Adjournment

Medicaid Member Advisory Committee (MAC) Meeting
October 21, 2024
Virginia Department of Medical Assistance Services

Virginia Medicaid
Member Advisory Committee
(MAC) Meeting:
General Meeting

Monday, October 21, 2024

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Accessibility Check-in Reminders: All Attendees

- Say your name each time you speak.
- Attendees are provided materials ahead of time and in an accessible format.
- Use a microphone to project your speech; if one is not available repeat questions when asked.
- Language access options provided upon request to include real time captioning.
- Spell acronyms and avoid or define terms, jargon, and idioms.
- Speak clearly; avoid speaking too fast, which is particularly helpful to individuals whose primary language is not the one in which you are speaking, sign language interpreters, and real time captioners.

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Accessibility Check-in Reminders: Speakers

- Summarize major points.
- Avoid reading word-for-word text on presentation slides unless you are reading a quotation.
- Give background and contextual information.
- Display key terms and concepts visually.
- Describe visuals such as images, objects, infographics, diagrams, and more so that non-visual participants can understand the information being presented.
  - **Example:** "On the screen is a diagram which represents the process flow which starts with..."
- Offer outlines and other scaffolding tools: connecting your presentation information by building upon what participates may already know.
- Give attendees time to process information; pause between topics, and after you ask for questions.

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Accessible, Inclusive Self-Introductions

Participants with vision take in a lot of information about the people and the environment around them. To offer context for all participants, visual and non-visual (people with blindness or low-vision, a brief description of yourself using a few sentences. At a minimum, include the following details:

- **Name**
- **Members** (the region and who you are representing on the MAC)
- **Organization and role**

You may also include your gender identity, your pronouns, your race or ethnicity, your skin color, hair color and style, whether you have facial hair, what clothing and jewelry you are wearing, and a short description of your background.

- **Member Example:**
  - My name is ___ from ___ region and I am representing ____. I am a black woman with curly black hair and round gold glasses wearing a red dress and snazzy black heels.
- **Speaker/Facilitator Example:**
  - My name is ___ with *(insert organization)* where I serve as the *(insert role)*. I am a Hispanic male with wavy brown hair wearing a blue button-down shirt and khaki pants with a gold apple watch and navy-blue loafers.

If presenting virtually, you can include the background color or setting.

- **Example:**
  - My name is ___ from ___ region and I am representing ____. I am a black woman with curly black hair and round gold glasses. I'm wearing a red blouse. Behind me is a gray wall with several framed pictures, next to a bookshelf.

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GENERAL MEETING AGENDA

October 21, 2024
10:00 AM - 12:30 PM

Presenter:
Natalie Pennywell, MPH, CHES
Outreach and Member Engagement
Virginia Department of Medical Assistance Services

AGENDA

Natalie Pennywell
Outreach and Member Engagement
Department of Medical Assistance Services (DMAS)

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Agenda

1. Call to Order

2. Member Roll Call and Introductions

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Welcome Remarks – DMAS Executive Leadership

Cheryl Roberts
Agency Director

Jeff Lunardi
Chief Deputy Director

Sarah Hatton
Deputy of Administration
and Coverage

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MEMBER ROLL CALL & INTRODUCTIONS

Presenter:
Natalie Pennywell, MPH, CHES
Outreach and Member Engagement
Virginia Department of Medical Assistance Services

MAC Members

- JoAnn Croghan
- Jacqi Dix (Virtual)
- Mark Dixon (Virtual)
- Sydnee Evans (Virtual)
- Lorri Griffin
- Chiquita Hubbard
- Sheila Johnson
- Leah Leuschner (Virtual)
- Brian Marroquin (Virtual)
- Bryan Roaché (Virtual)
- Kyung Sook Jun

Introductions

- Meeting Facilitator(s)
- Executive Leadership Team Member(s)
- MAC Support Staff
- Speakers

MEMBER ROLL CALL AND INTRODUCTIONS

Natalie Pennywell
Outreach and Member Engagement
Department of Medical Assistance Services (DMAS)
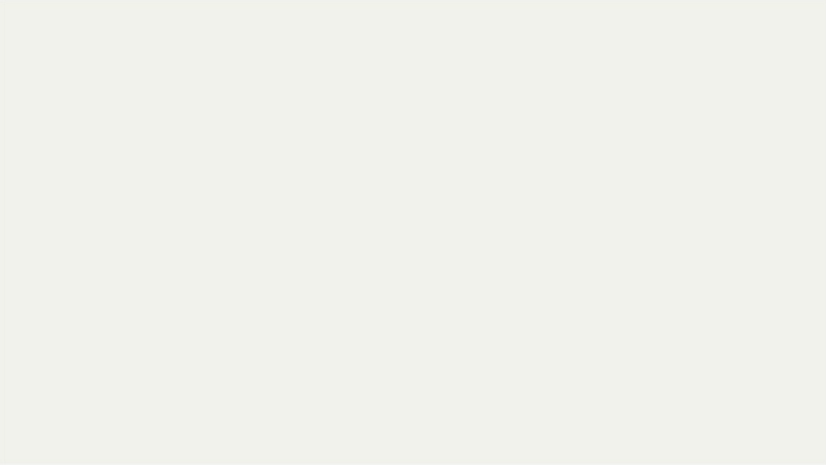
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Introduce yourself in the chat!

- Name
- Organization
- If you could eat one fall treat for the rest of your life what would it be and why?

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MAC Member Roll Call

- ❑ JoAnn Croghan
- ❑ Jacqi Dix (Virtual)
- ❑ Mark Dixon (Virtual)
- ❑ Sydnee Evans (Virtual)
- ❑ Lorri Griffin
- ❑ Chiquita Hubbard
- ❑ Sheila Johnson
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Introductions

❑ Meeting Facilitator(s)

❑ Executive Leadership Team Member(s)

❑ MAC Support Staff

❑ Speakers

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MINUTES APPROVAL

Presenter:
Natalie Pennywell, MPH, CHES
Outreach and Member Engagement
Virginia Department of Medical Assistance Services

MINUTES APPROVAL

Natalie Pennywell
Outreach and Member Engagement
Department of Medical Assistance Services (DMAS)

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The Value of Lived Experience Feedback in State Government and Beyond

Presenter:
Adam A. Creveling, MSW
Policy Specialist, Office of Trauma and Resilience Policy
Virginia Department of Social Services

The Value of Lived Experience Feedback in State Government and Beyond

Office of Trauma and Resilience Policy

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Let's Talk

❑ What is the impact of lived experience in the Medicaid Member Advisory Committee (MAC)?

❑ What personal or professional value have you obtained through your work with MAC?

Risk being seen in all of your glory. — Jim Carrey

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Benefits for Programs/Initiatives

❑ Improved ability to deliver responsive services

❑ Strengthened programs, tools, and resources

❑ Improved representation in decision-making processes and practices

❑ Increased priority communities' influence on decision-making processes and practices

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Benefits for Agency/System

❑ Directing funding and resources toward the concerns and needs of the priority communities

❑ Enhancing service and delivery infrastructure

❑ Informed and empowered groups of advocates

❑ Increased skills to speak directly to agencies and decision-makers

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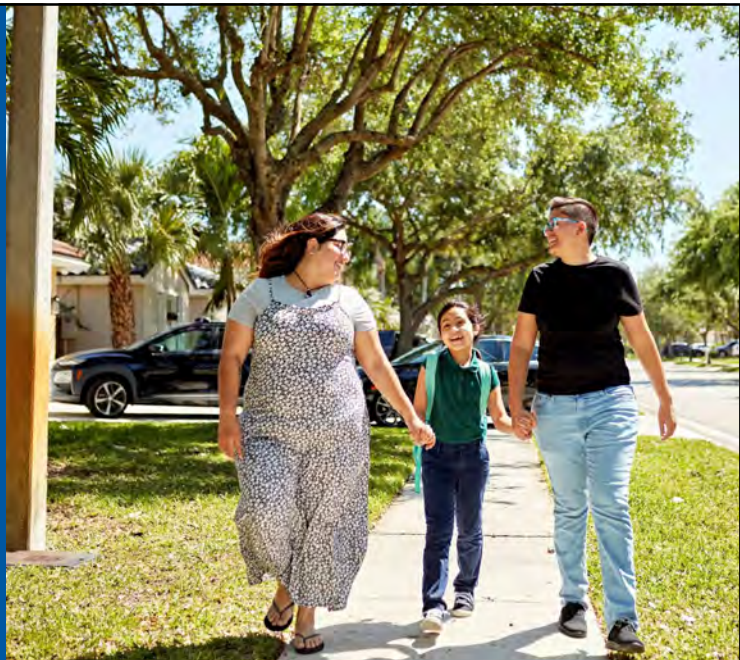
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LEx Groups at State Agencies

Department of Behavioral Health & Developmental Services:	Department of Medical Assistance Services:	Virginia Department of Education:	Virginia Department of Social Services:
• Behavioral Health Advisory Council • Peer Recovery Specialist Roundtable • Virginia Recovery Initiative (VRI)	• Behavioral Health Peer Recovery Support Workgroup • Members Advisory Committee (MAC)	• Center for Family Involvement (VCU--The Partnership for People with Disabilities) • I'm Determined Project (JMU Partnership) • Youth Empowerment Transition Council (PEATC Partnership)	• Lived Experience Advisory Board • Fostering Responsible Parents in Virginia • SAVES Lived Experience Advisory Council • SPEAKOUT--Youth Advisory Board • Parent Advisory Council

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LEx Groups at State Agencies (continued)

Virginia Department of Health:	VDSS Partners:
• Community HIV Planning Group • Equality & Inclusion Council • Status Neutral • Quality Management Advisory Group • Virginia Consumer Advisory Committee	• VOICES (Virginia Sexual and Domestic Violence Action Alliance) • Virginia Parent Council (Families Forward)

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Outcomes From LEx Feedback

- ❑ Drafting/editing provider manuals for service utilization
- ❑ Strategic planning
- ❑ Promoting best practices and program development/curriculum
- ❑ New program initiatives
- ❑ Legislative Action Summaries
- ❑ Amending or correcting program gaps or member hurdles
- ❑ Website design/project branding
- ❑ Information-sharing with agency leadership
- ❑ Informing project reports

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VDSS Lived Experience Community of Practice

- ❑ The Lived Experience (LEx) Community of Practice collaborates at a state-level on best practice strategies for centering the voices of those who have lived experience with challenges related to navigating diverse systems.

- ❑ The LEx Community of Practice includes individuals with different backgrounds across state agencies and organizations and aims to foster more compassionate and responsive systems that effectively address the needs of individuals and communities.

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Community of Practice LEx Definition:

People with lived experience are those directly impacted by the strategies that aim to address social, health, or other issues beyond the prospect of knowledge and skills.

Community of Practice Mission Statement:

Boards, commissions, councils, committees, or other similar groups should partner with people who are part of historically excluded communities and those who have been disproportionately impacted by policies, processes, practices, and systems that the group seeks to address. These individuals have the expertise and perspective necessary to determine what needs to change in our systems to achieve better outcomes.

Community of Practice Vision Statement:

Virginia's collective desired outcome is to become stigma and discrimination-free, promote inclusion and life in the community, respect for and protection of human rights, improve quality of life, and empower all persons with lived experience.

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LEx Video Project on Best Practices

❑ OTRP contracted with a media/production company to develop a video that will be shared at the local and state level as an educational tool.

❑ Will highlight strategies for best practices related to recruitment, engagement, co-leadership, and compensation of people with lived experience.

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Looking to the Future

❑ Compensation Guidance Document
❑ Advisory Council Best Practices Guidance Document
❑ Consistent Policy and Practice in re LEx Engagement Across State Agencies

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Questions or comments?

Adam.Creveling@dss.virginia.gov
or
otrp@dss.virginia.gov

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Eligibility 101

Presenter:
Sara Cariano
Division Director, Eligibility Policy & Outreach
Virginia Department of Medical Assistance Services

Kelly Pauley
Eligibility Policy Manager
Virginia Department of Medical Assistance Services

Medicaid and FAMIS
Eligibility 101

Eligibility Policy & Outreach Division
October 2024

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Medicaid & FAMIS Eligibility

- History of the Medicaid and FAMIS programs in Virginia
- Covered groups
- Eligibility requirements
  - Non-financial requirements
  - Financial requirements
- Application and renewal process
- Post-enrollment

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History

- Medicaid was established through the Social Security Act Amendments of 1965 and signed into law by President Lyndon B. Johnson on July 30, 1965.
- Virginia Medicaid was implemented on a statewide basis on July 1, 1969. It is jointly funded by the federal and state government.
- Children's Health Insurance Program (CHIP) was established through the Balanced Budget Act of 1997.
- Virginia General Assembly established Family Access to Medical Insurance Security (FAMIS), VA's CHIP, in 2000.

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Program Administration: Eligibility

- DMAS is the 'single state agency' responsible for the administration of Medicaid and CHIP in Virginia.
  - Sets policy and procedure related eligibility determinations and conducts appeals and state fair hearings.
- DMAS delegates authority to the Virginia Department of Social Services (VDSS) and local departments of social services (LDSS), the Cover VA Central Processing Unit (CPU), and Virginia's Insurance Marketplace to conduct eligibility determinations.
  - LDSS are the only entity delegated the authority to conduct eligibility determinations for ABD populations and perform case maintenance.*

*DMAS staff preform these functions for incarcerated individuals on behalf of at the Cover Virginia Incarcerated Unit.

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Eligibility Factors

- Medicaid and FAMIS have multiple coverage categories (also called eligibility or aid categories).

- Each category has unique eligibility criteria. Specific eligibility factors used depend on the eligibility category
  - Covered group definition (ex. Child, pregnant, over 65)
  - Non-financial requirements
  - Financial requirements

- States must evaluate eligibility for all categories at application and renewal, starting with those that provide the highest level of coverage.

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Eligibility Factors: Non-financial Eligibility

- Citizenship or eligible immigration status
  - Immigration status requirements differ for non-pregnant adults, pregnant adults, and children under 19.
- Virginia residency
- SSN or proof of application for one
  - Limited exception for certain legally residing children and pregnant individuals
- Assignment of rights/cooperation in the pursuit of medical support
- Institutional status (must be in an eligible institution)
- Eligibility category specific requirements
  - Age
  - Pregnancy or caregiver status
  - Disability and/or level of care need

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Eligibility Factors: Financial

Countable income
- Both earned and unearned

Resources
- Not evaluated for children, pregnant individuals, and non-ABD adult categories except Medically Needy groups.

Asset transfers
- Applied to those seeking Medicaid payment of long-term services and supports (LTSS).

The methodology used to countable income and resources is
not the same for all eligibility categories.

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Why may it be important to understand the differences in eligibility categories?

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Medicaid & FAMIS: Children & Pregnant Individuals

Children
- Medicaid for children <19
- FAMIS (CHIP)
- Deemed newborns
- Title IV-E Foster Care and Adoption Assistance
- Individuals < Age 21
  - Non-title IV-E Foster Care & Adoption Assistance
  - Department of Juvenile Justice
  - Individuals under age 21 in ICF or ICF/ID

Pregnant Individuals
- Medicaid for Pregnant Woman
- FAMIS (CHIP)
- FAMIS Prenatal (CHIP)

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Income Limits: Children & Pregnant Individuals

Household Size	Medicaid for Children & Pregnant Individual 148% FPL		FAMIS, FAMIS MOMS, FAMIS Prenatal 205% FPL	
	Monthly	Yearly	Monthly	Yearly
1	$1,858	$22,289	$2,573	$30,873
2	$2,521	$30,252	$3,492	$41,902
3	$3,185	$38,214	$4,411	$52,931
4	$3,848	$46,176	$5,330	$63,960
5	$4,512	$54,139	$6,250	$74,989
6	$5,176	$62,101	$7,169	$86,018
7	$5,839	$70,064	$8,088	$97,047
8	$6,503	$78,026	$9,007	$108,076
+ each add'l	$664	$7,963	$920	$11,029

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Continuous Eligibility (aka Continuous Coverage)

Children under 19

- Medicaid and FAMIS
- 12-months of protected coverage
- Coverage cannot be closed or reduced during this period unless an exception is met.
  - Such as turning 19, moving out of state, or the family requesting to end the coverage.
- New Continuous Eligibility (CE) periods begin at initial enrollment and each renewal
- Annual renewals are still required

Pregnant Individuals

- Medicaid and FAMIS MOMS provide continuous eligibility through 12-months postpartum.
- FAMIS Prenatal provides continuous eligibility through 60 days postpartum.

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Medicaid Covered Groups: Adults and Aged, Blind, & Disabled

Adults, non-ABD or Pregnant

- Medicaid Expansion (ages 19-64)
- Low-Income Families with Children (LIFC)
- Breast and Cervical Cancer Prevention and Treatment Act Group
- Former Foster Care Children Under Age 26 (if ages out of foster care at age 18, no income limit)
- Plan First (limited-coverage for family planning services)

Aged, Blind and Disabled (ABD)

- ABD with income <80% FPL
- SSI, Protected Groups, and Auxiliary Grant recipients
- Medicaid Works
- Hospice
- 300% SSI
- Medicare Savings Programs (limited coverage)
  - Qualified Medicare Beneficiary
  - Special Low-Income Beneficiary
  - Qualified Individual

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Income Limits: Medicaid Expansion & Medicaid Works

Household Size	Medicaid Expansion & Medicaid Works 138% FPL	
	Monthly	Yearly
1	$1,732	$20,783
2	$2,351	$28,208
3	$2,970	$35,632
4	$3,588	$43,056
5	$4,207	$50,481
6	$4,826	$57,905
7	$5,445	$65,330
8	$6,063	$72,754
+ each add'l	$619	$7,425

Medicaid Expansion
- Aged 19-64
- Not eligible for Medicare
- No asset limit

Medicaid Works
- Working individuals with disabilities
- Household size always one or two
- Asset limit:
  - $2,000/individual
  - $3,000/couple
- Once enrolled, allowed to earn more income and keep more assets

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Income Limits: Aged, Blind, & Disabled

Aged, Blind & Disabled, Income ≤ 80% FPL		
Household Size	Income Limit	Asset Limit
1	$1,004	$2,000
2	$1,363	$3,000

300% Supplemental Security Income (SSI)		
Household Size	Income Limit	Asset Limit
1	$2,829	$2,000

300% Supplemental Security Income Eligibility Category

- Special eligibility category for those who meet Medicaid's long-term services and support (LTSS) Level of Care requirements and all other requirements but have too much income.

- Individuals with income over 300% SSI will be reviewed using the Medically Needy eligibility category requirements.

- Always reviewed as a household of one.

- A "post-eligibility" review of income is done to determine the individual's patient pay, or the monthly amount they must contribute to the cost of their LTSS

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Income Limits: Medicare Savings Programs

Eligibility Category	Household Size	Income Limit	Asset Limit
Qualified Medicare Beneficiary (QMB)	1	$9,430	$9430
	2	$1,704	$14,130
Special Low Income Beneficiary (SLMB)	1	$1,506	$9430
	2	$2,044	$14,130
Qualified Individual (QI)	1	$1,695	$9430
	2	$2,300	$14,130
Qualified Disabled Working Individuals (QWDI)	1	$2,510	$4,000
	2	$3,407	$6,000

QMB
Medicaid will pay the Medicare Part A (if applicable) and Part B premiums and coinsurance and deductibles.

SLMB & QI
Medicaid will only pay the Medicare Part B premium.

QDWI
Medicaid will only pay the Medicare Part A premium. Must have been entitled to Social Security Disability benefits and lost eligibility due to work activity.

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Medicaid Covered Groups: Medically Needy

- Categories with Medically Needy coverage
  - Children under 19
  - Pregnant individuals
  - Aged, Blind and Disabled
- Individuals eligible for a medically needy spenddown must reduce their income below the applicable Medically Needy income limit by incurring medical expenses.
- Must meet all other Medicaid requirements
- Resource limits apply
- Eligibility for Medicaid begins the month that income is reduced below the limit and for the remainder of the spenddown period.
- Spenddown periods last one or six months

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What transitions seem most difficult?

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Application Process

Application submission

- Online: www.commonhelp.virginia.gov
- Phone, Cover VA: 1-855-242-8282
- In-person or mail: Local Department of Social Services

Processing time requirements

- Seven calendar days for pregnancy coverage
- 10 business days for individuals screened and diagnosed with breast or cervical cancer or pre-cancerous conditions through the Every Woman's Life Program.
- 90 days when disability determination is needed
- 45 days for all others

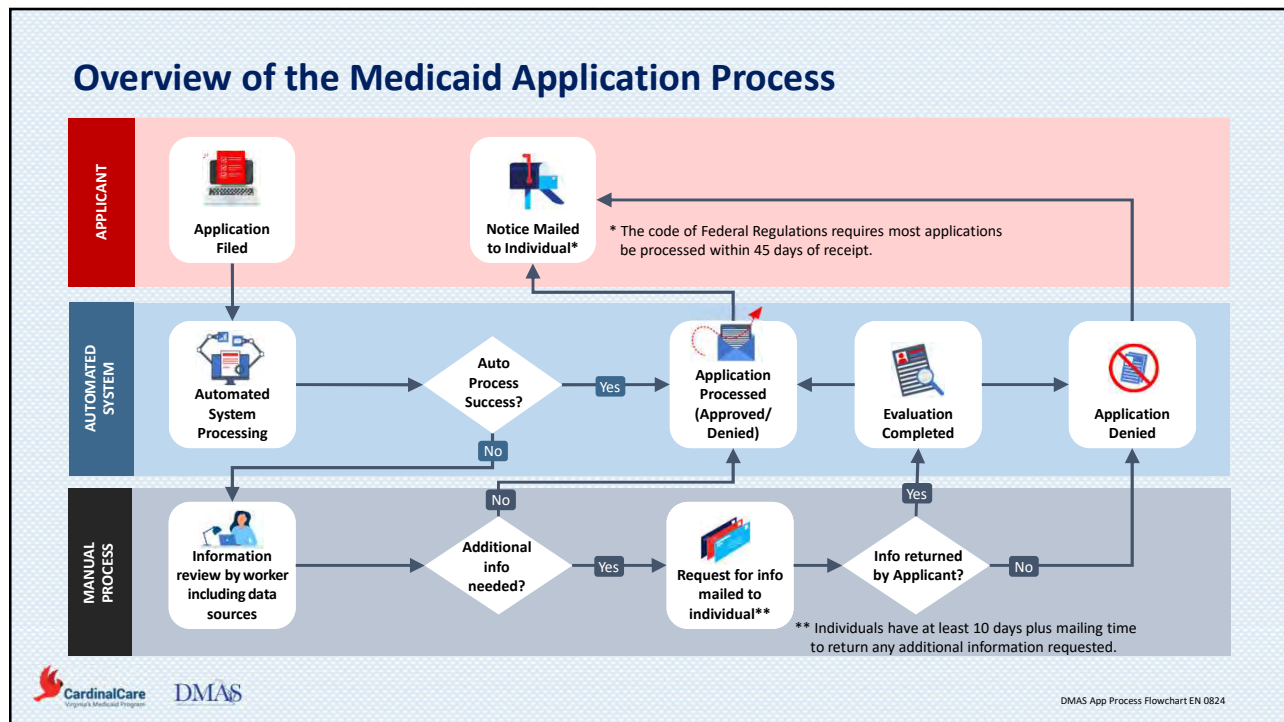**Coverage effective dates**

- First of the month the application was submitted (except QMB)
- Three months of retroactive coverage available in Medicaid categories (except QMB)
- No retroactive coverage in FAMIS categories except for newborns.

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Overview of the Medicaid Application Process

APPLICANT

Application Filed

Notice Mailed to Individual*

* The code of Federal Regulations requires most applications be processed within 45 days of receipt.

AUTOMATED SYSTEM

Automated System Processing → Auto Process Success? — Yes → Application Processed (Approved/Denied) ← Evaluation Completed → Application Denied

No

MANUAL PROCESS

Information review by worker including data sources → Additional info needed? — Yes → Request for info mailed to individual** → Info returned by Applicant? — No → (Application Denied)

Yes (Info returned → Evaluation Completed)

** Individuals have at least 10 days plus mailing time to return any additional information requested.

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DMAS App Process Flowchart EN 0824

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Application Process, cont'd

- Written notification must be provided:
  - To request additional information to determine eligibility, if needed
    - 10 days must be given to provide the information
  - To inform the applicant of the outcome of the eligibility determination
- Individuals who disagree with the eligibility determination can file an appeal
  - Information on how to file an appeal is included on each notice and at dmas.virginia.gov/appeals/applicant-member-appeals-resources/
    - Appeals Information Management System (AIMS) Portal: https://www.dmas.virginia.gov/appeals
    - Email: appeals@dmas.virginia.gov.
    - Phone:(804) 371- 8488
    - Fax: (804) 452- 5454
  - Must file the appeal within 30-days from the date the notice was received or have good cause for filing late.

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Virginia's Insurance Marketplace

- The 'No wrong door' policy means applications filed at the Marketplace can be used to determine Medicaid eligibility and visa versa.
  - Those eligible for Medicaid are not eligible for Marketplace financial assistance.

- If a Marketplace applicant is determined to be eligible for Medicaid, the approved application will be transferred to the Medicaid for enrollment.

- If a Marketplace applicant is found to likely eligible for Medicaid, the application will be transferred to Medicaid for an eligibility determination.

- If the state determines a person to be ineligible for Medicaid, application will be transferred to the Marketplace for an evaluation of eligibility for premium tax credits, and cost sharing reductions.

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Application Process: Long-Term Services and Supports (LTSS)

- Individuals must be screened and meet the required 'Level of Care' for Medicaid to pay for their LTSS, also often called Long-Term Care (LTC).
  - Medicaid members can be screened through an approved entity.
  - Non-members must request an LTSS screening *and* submit an application for Medicaid.
  - Individuals who have resided in an institution for more than 30-days are deemed institutionalized and, therefore meet the level of care need. If not already a Medicaid member, they must submit an application.
- Community-based screenings are conducted by the Local Department of Social Services (LDSS). Some LDSS offices also contract with the local health department.
- Hospitals, nursing facilities and PACE centers also conduct screenings for certain individuals in their care.
- Medicaid LTSS can be provided through:
  - Nursing facility
  - Home and Community Based Services (HCBS), through the Commonwealth Coordinated Care Plus (CCC+) waiver program or the Developmental Disability (DD) waiver program.
  - Program of All-Inclusive Care for the Elderly (PACE)

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Application Process: Developmental Disability Waivers

- Virginia has three Developmental Disability (DD) waivers that DMAS jointly administers with the Department of Behavioral Health and Developmental Services.
    - Building Independence (for those 18 and older)
    - Families and Individual Support
    - Community Living
- Individuals must meet diagnostic and financial criteria.
- The DD Waivers provide supports and services options for successful living, learning, physical and behavioral health, employment, recreation and community inclusion.
    - Some of these services and supports are not covered in regular Medicaid.

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Application Process: Developmental Disability Waivers

Diagnostic Screening
- Conducted by the local Community Services Board (CSB)

Waitlist
- Individuals who meet the diagnostic criteria are placed on the DD Waiver waitlist.
- Slots are given based on urgency of need, with those most in need receiving waivers first.

Medicaid Determination
- Individuals on the waitlist can be enrolled in Medicaid.
- Those not enrolled in Medicaid must have their Medicaid eligibility determined upon being approved for a DD waiver. If they are not Medicaid eligible, they cannot receive the DD waiver.
- Parental income does not count for the child once they have been approved for a DD waiver slot.

Enrollment
- Individuals must continue to meet the diagnostic criteria and Medicaid eligibility.

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Post-enrollment

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LTSS Patient Pay

- Patient pay is the member's expected share of the cost of LTSS care.
- The member pays the patient pay to the LTSS provider and the provider bills the state or state contracted Managed Care Organization the remainder of the Medicaid rate.
- The patient pay is calculated after the member's eligibility for LTSS has been determined. It is a new calculation that treats certain income differently than the calculation of income for eligibility purposes.
- A member can have a patient pay amount of $0.
- Income can potentially be diverted to a spouse who is not receiving Medicaid LTSS depending on living expenses and their income.
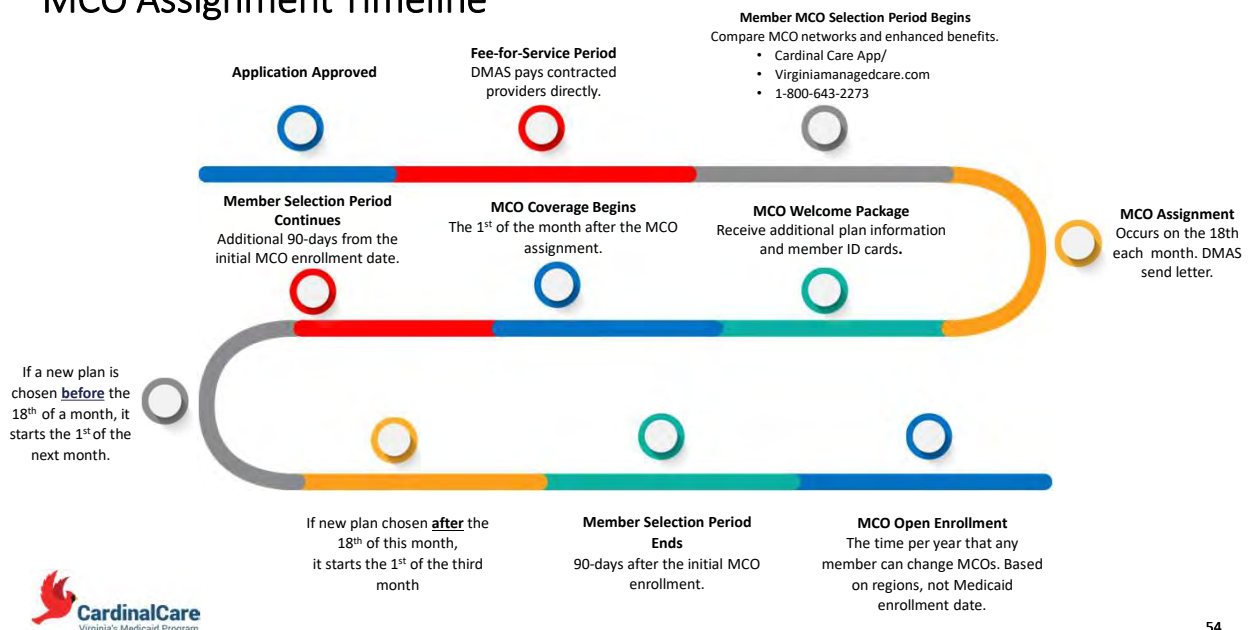
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Managed Care Enrollment

- Most Medicaid beneficiaries receive their benefits through a managed care organization (MCO).
- Members can select their MCO and will be assigned one if no selection is made.
  - Members are in fee-for service for an initial period before the MCO enrollment begins.
  - Members in limited benefit and premium assistance programs remain in fee-for-service.
- Members may change MCOs when they first enroll in Medicaid, during the annual MCO Open enrollment period, or for 'good cause.'
- All MCOs provide all mandatory Medicaid services.
  - Each also offers enhanced benefits.

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MCO Assignment Timeline

Member MCO Selection Period Begins
Compare MCO networks and enhanced benefits.
- Cardinal Care App/
- Virginiamanagedcare.com
- 1-800-643-2273

Application Approved

Fee-for-Service Period
DMAS pays contracted providers directly.

Member Selection Period Continues
Additional 90-days from the initial MCO enrollment date.

MCO Coverage Begins
The 1st of the month after the MCO assignment.

MCO Welcome Package
Receive additional plan information and member ID cards.

MCO Assignment
Occurs on the 18th each month. DMAS send letter.

If a new plan is chosen **before** the 18th of a month, it starts the 1st of the next month.

If new plan chosen **after** the 18th of this month, it starts the 1st of the third month

Member Selection Period Ends
90-days after the initial MCO enrollment.

MCO Open Enrollment
The time per year that any member can change MCOs. Based on regions, not Medicaid enrollment date.

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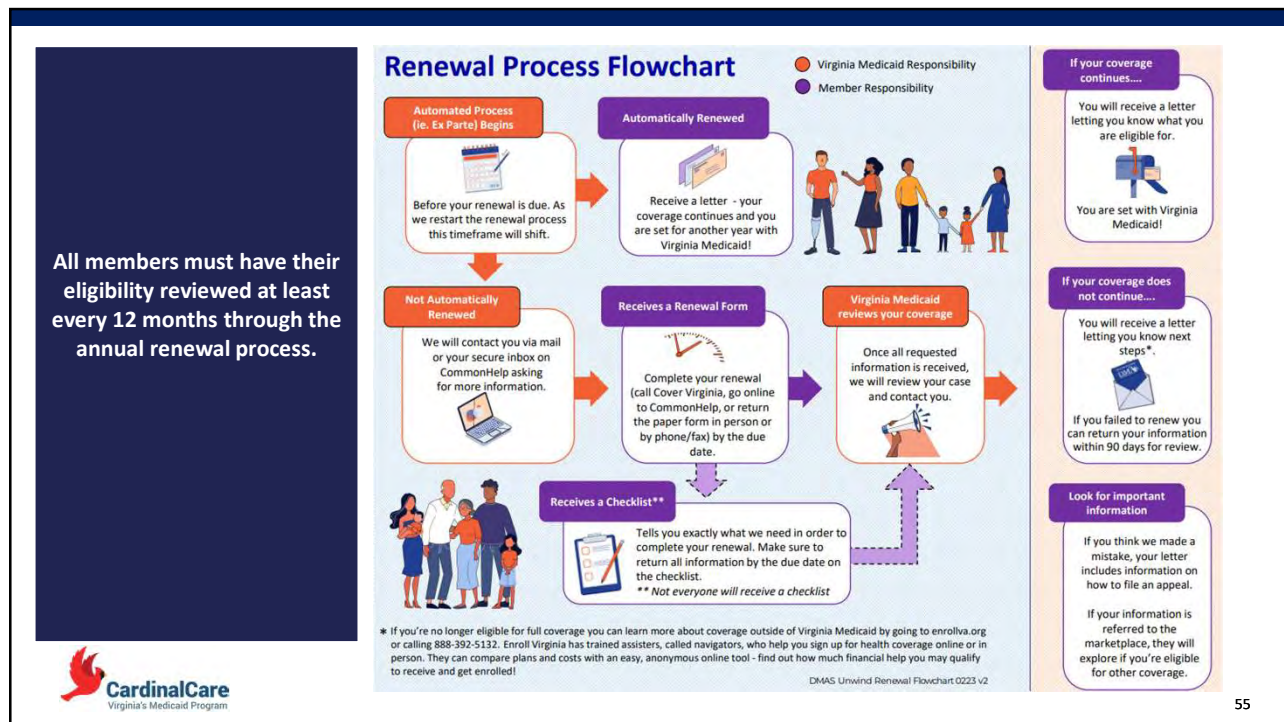
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Annual Renewal Process

- Member is mailed a prefilled renewal packet when the automatic renewal is not successful.
  - The renewal can be complete the same way as an application (online, telephonic, on paper and to the LDSS).
  - Must be submitted within 30-days.
- If additional information is needed, a verification check list will be mailed.
  - Member will have 10-days to provide the requested information.
- Members who are determined to still be eligible remain enrolled and are sent a notice of the renewal.
- Members found to be ineligible for their current coverage category must be reviewed for all other coverage categories before being terminated.
- Members who are not eligible or who are eligible for a lower level of coverage will be sent a notice of the decision. The notice must be:
  - Sent 10-days before the coverage is scheduled to reduce or end.
  - Include information on how to appeal the decision.

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Annual Renewal Process

- A prefilled renewal packet is mailed when the automatic renewal is not successful.
  - The renewal can be completed the same way as an application (online, telephonic, on paper and to the LDSS).
  - Must be submitted within 30-days.
- If additional information is needed, a verification checklist will be mailed.
  - Requested information must be returned within 10-days.
- Members determined to still be eligible remain enrolled and are sent a notice of the renewal.
- Members determined ineligible for their current coverage category must be reviewed for all other coverage categories before being terminated.
- Members who are ineligible or only eligible for a lower level of coverage will be sent a notice of the decision. The notice must be:
  - Sent 10-days before the coverage is scheduled to reduce or end.
  - Include information on how to appeal the decision.

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Annual Renewal Process

- If the renewal form or requested verifications are not returned, the coverage will be cancelled.

- This initiates a 90-day reconsideration period during which the necessary information can be return.
  - If found eligible, the coverage will be reinstated back the to date it closed.
  - If information is not returned within the reconsideration period, a new application will be required.

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What challenges have you experienced with the application process or renewal process?

Did you learn anything today that DMAS should communicate more clearly?

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DMAS Eligibility Policy Contacts

Sara Cariano, Eligibility Policy & Outreach Division Director
(804) 229-1306
Sara.cariano@dmas.virginia.gov

Kelly Pauley, Eligibility Policy Manager
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Alejandra Meade, Senior Eligibility Policy Specialist
(804) 584-9256
Alex.meade@dmas.virginia.gov

Yolanda Moore, Senior Policy Analyst
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Yolanda.moore@dmas.virginia.gov

Olesya (Lacy) Tereshin, Senior Policy Analyst
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Dana Thierry, Senior Policy Analyst
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dana.thierry@dmas.virginia.gov

Johnical Owens Haynes, Senior Policy Analyst
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johnical.haynes@dmas.virginia.gov

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PUBLIC COMMENT

Public Comment – Open to the Public

- Public comment period is 15 minutes.
- Those wishing to make a public comment must join via the WebEx link or in-person.
- Send a message to one of the hosts or place your full name and location in the comments to be recognized during this time.
- Each speaker will be granted only two (2) minutes to speak.

PUBLIC COMMENT

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MAC AGENCY SUPPORT

MAC Agency Support

Name, Position, MAC Role

- Sandra Coffey (Sandi), EPO Administrative Assistant, Steering Committee Member
- Norman Gaines, AV Specialist, Technology Support
- Sarah Hatton, Deputy of Administration and Coverage, Ex-Officio Member; Co-Facilitator
- Kristin Lough, Hearing Officer, Minutes
- Natalie Pennywell, Outreach & Community Engagement, Facilitator; Steering Committee
- Jesus Perez, Civil Rights Compliance Specialist, Closed Captioning
- Cheryl Roberts, Agency Director, Co-Facilitator
- Sonya Scott, ITS Operations Analyst, Technology Support
- Dorothy Swann, Outreach and Member Engagement Specialist, Steering Committee Member

DMAS Support Staff

Name	Position	MAC Role
Sandra Coffey (Sandi)	EPO Administrative Assistant	Steering Committee Member
Sarah Hatton	Deputy of Administration and Coverage	Ex-Officio Member; Co-Facilitator
Kristin Lough	Hearing Officer	Minutes
Natalie Pennywell	Outreach & Community Engagement	Facilitator; Steering Committee
Jesus Perez	Civil Rights Compliance Specialist	Closed Captioning
Cheryl Roberts	Agency Director	Co-Facilitator
Sonya Scott/Norman Gaines	ITS Operations Analyst/AV Specialist	Technology Support
Dorothy Swann (Dot)	Outreach and Member Engagement Specialist	Steering Committee Member

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Closing Remarks & Wrap-Up

Presenter:
Sarah Hatton
Deputy for Administration and Coverage
Virginia Department of Medical Assistance Services

Natalie Pennywell, MPH, CHES
Outreach and Member Engagement
Virginia Department of Medical Assistance Services

Closing Remarks

Sarah Hatton
Deputy of Administration and Coverage

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MAC Members Rolling Off

Thank you for your service to Virginia Medicaid!

☆ JoAnn Croghan
☆ Jacqi Dix (Virtual)
☆ Sydnee Evans (Virtual)
☆ Lorri Griffin
☆ Chiquita Hubbard
☆ Sheila Johnson
☆ Leah Leuschner (Virtual)
☆ Kyung Sook Jun

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2025 MEETING DATES

2025 Meeting Dates

- March 10, 2025
- June 09, 2025
- August 11, 2025
- October 20, 2025

2025 Meeting Location

- 600 E. Broad Street, Richmond, VA 23219
- In-Person w/ Virtual Option
  - Virtual information can be found on Virginia Regulatory Town Hall

2025 Meeting Time

- 10:00 AM - 12:30 PM

2025 Virginia Medicaid MAC Meetings

Dates

- March 10, 2025
- June 09, 2025
- August 11, 2025
- October 20, 2025

General MAC Meeting:
- 10:00 AM – 12:30 PM

Location:
- 600 E Broad Street, Richmond, VA 23219
- In-Person w/ Virtual Option
  - Virtual information can be found on Virginia Regulatory Town Hall

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Thank you! Do not hesitate to Contact Us!

Medicaid Member Advisory Committee (MAC)
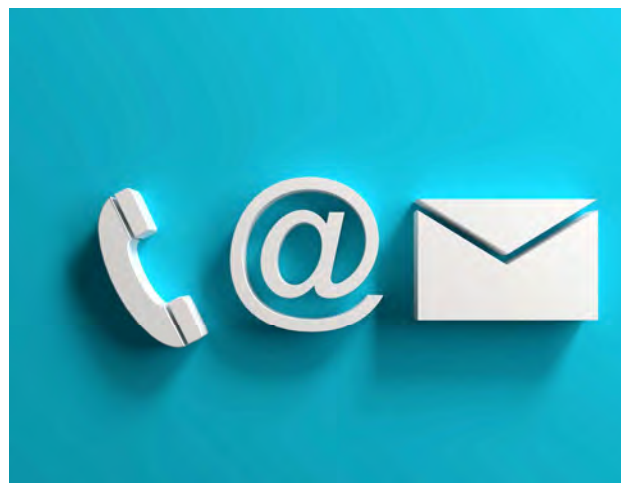Department of Medical Assistance Services (DMAS)
Commonwealth of Virginia
600 East Broad Street, Richmond, VA 23219
Email: mac@dmas.virginia.gov
Website: https://www.dmas.virginia.gov/for-members/member-advisory-committee/
Cover Virginia: https://coverva.dmas.virginia.gov/

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ADJOURNMENT

Presenter:
Natalie Pennywell
Outreach and Member Engagement
Virginia Department of Medical Assistance Services

Adjournment

- Don't forget to tell a friend about Virginia Medicaid MAC.
- Encourage a member to apply to be a MAC member.
  - **New members will be seated for 2025.**
- Do something outside and get an extra dose of Vitamin D, fresh air, and hints of fall this week!

See you on March 10, 2025!

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Meeting Notes

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Meeting Notes

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Medicaid Member Advisory Committee (MAC) Meeting
October 21, 2024
Virginia Department of Medical Assistance Services

Meeting Notes

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ADDITIONAL RESOURCES

Community of Practice LEx Definition:

People with lived experience are those directly impacted by the strategies that aim to address social, health, or other issues beyond the prospect of knowledge and skills.
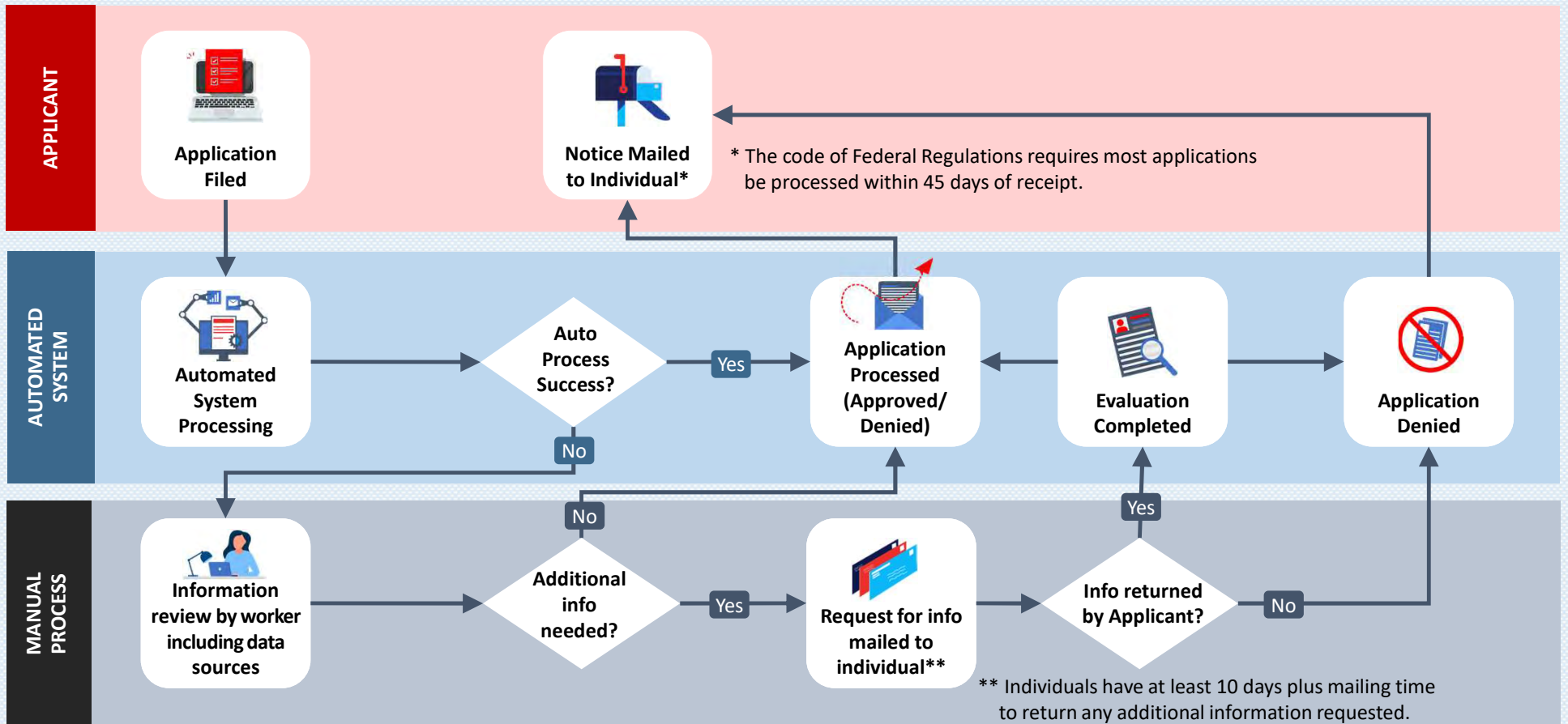
Community of Practice Mission Statement:

Boards, commissions, councils, committees, or other similar groups should partner with people who are part of historically excluded communities and those who have been disproportionately impacted by policies, processes, practices, and systems that the group seeks to address. These individuals have the expertise and perspective necessary to determine what needs to change in our systems to achieve better outcomes.
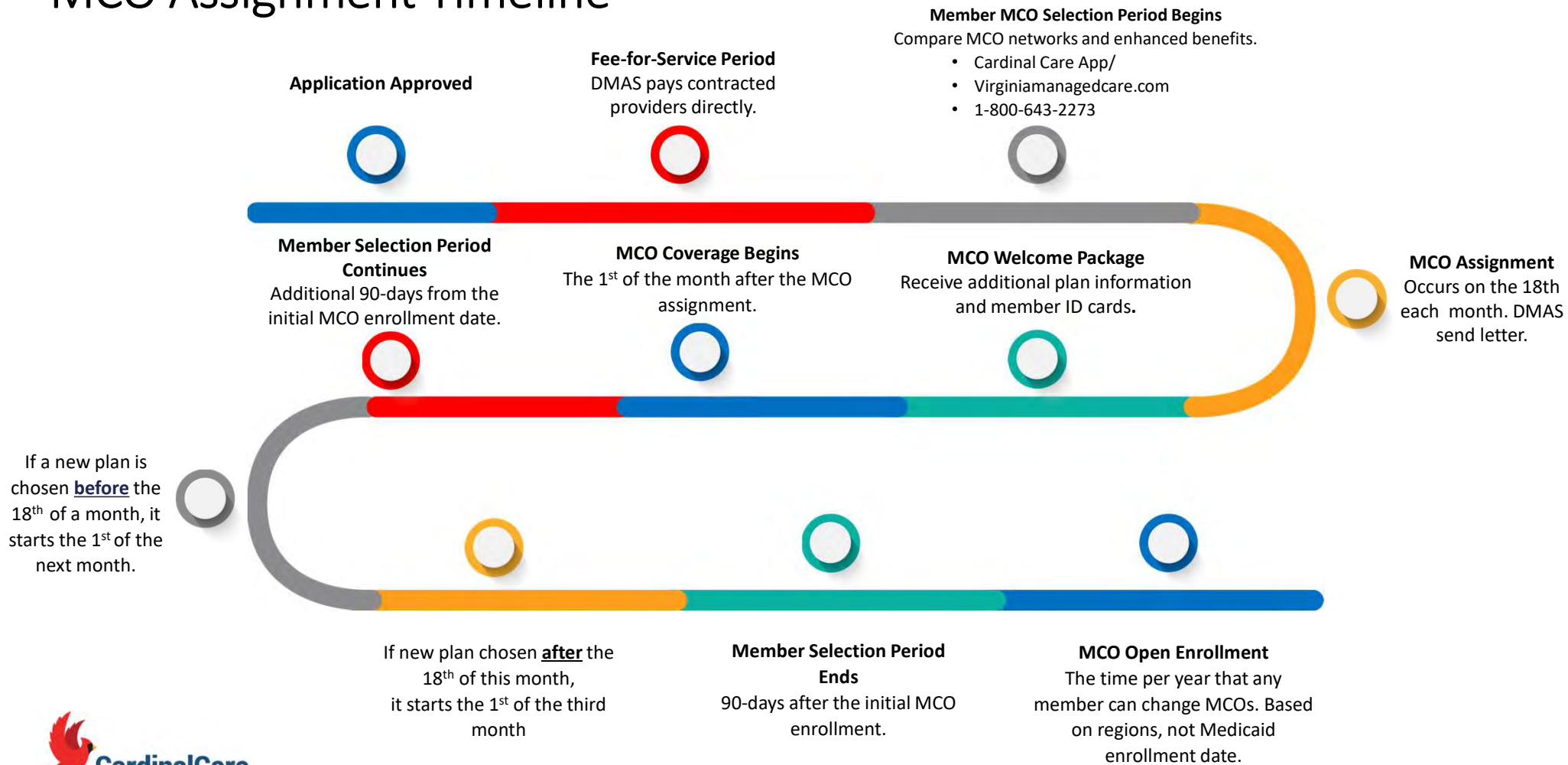
Community of Practice Vision Statement:

Virginia's collective desired outcome is to become stigma and discrimination-free, promote inclusion and life in the community, respect for and protection of human rights, improve quality of life, and empower all persons with lived experience.
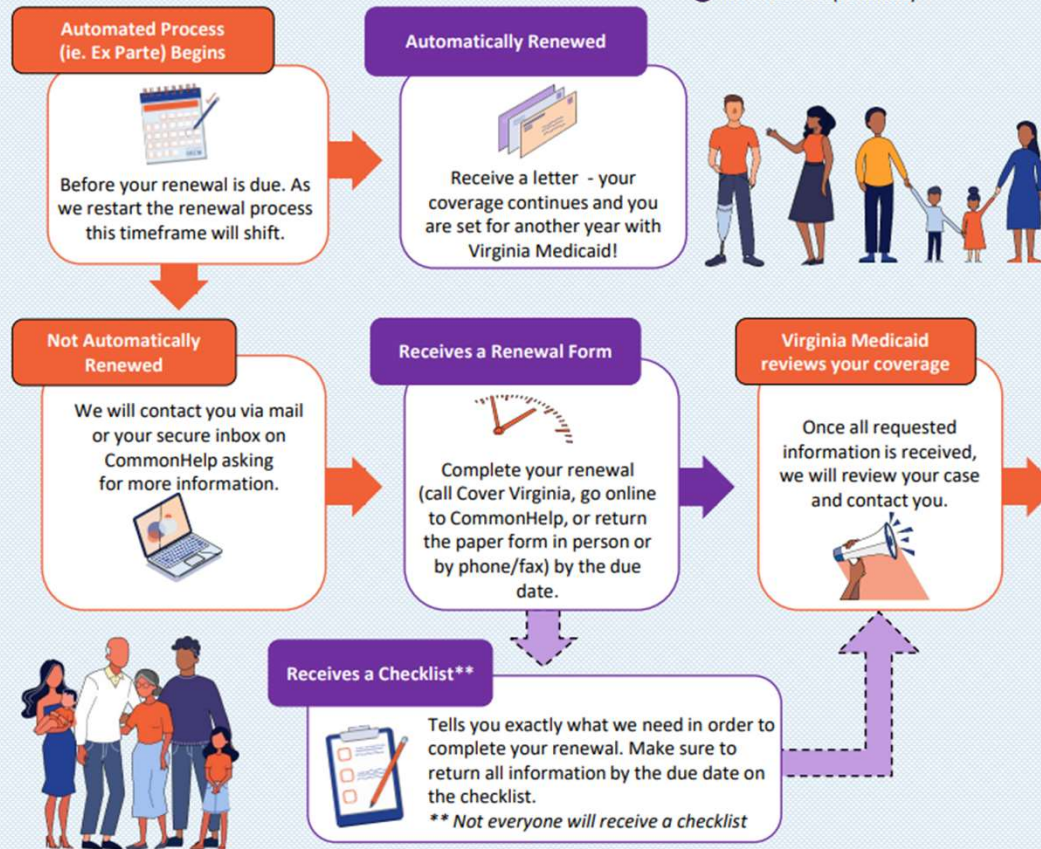
Overview of the Medicaid Application Process

APPLICANT

Application Filed

Notice Mailed to Individual*

* The code of Federal Regulations requires most applications be processed within 45 days of receipt.

AUTOMATED SYSTEM

Automated System Processing

Auto Process Success? — Yes → **Application Processed (Approved/ Denied)** ← **Evaluation Completed** → **Application Denied**

No

MANUAL PROCESS

Information review by worker including data sources

Additional info needed? — Yes → **Request for info mailed to individual**** → **Info returned by Applicant?** — No →

Yes

No

** Individuals have at least 10 days plus mailing time to return any additional information requested.

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DMAS

MCO Assignment Timeline

Member MCO Selection Period Begins
Compare MCO networks and enhanced benefits.
- Cardinal Care App/
- Virginiamanagedcare.com
- 1-800-643-2273

Fee-for-Service Period
DMAS pays contracted providers directly.

Application Approved

Member Selection Period Continues
Additional 90-days from the initial MCO enrollment date.

MCO Coverage Begins
The 1st of the month after the MCO assignment.

MCO Welcome Package
Receive additional plan information and member ID cards.

MCO Assignment
Occurs on the 18th each month. DMAS send letter.

If a new plan is chosen **before** the 18th of a month, it starts the 1st of the next month.

If new plan chosen **after** the 18th of this month, it starts the 1st of the third month

Member Selection Period Ends
90-days after the initial MCO enrollment.

MCO Open Enrollment
The time per year that any member can change MCOs. Based on regions, not Medicaid enrollment date.

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All members must have their eligibility reviewed at least every 12 months through the annual renewal process.

About Virginia's Medicaid Member Advisory Committee

Virginia is the second state to create a Medicaid Member Advisory Committee made up exclusively of members and their authorized representatives. Launched in April 2019, the group meets quarterly to provide the Medicaid Director with valuable feedback and recommendations on the agency's programs, policies, services and communications.

The committee members represent all regions of the state and a cross-section of Medicaid programs. Through their participation, they are helping to make Medicaid more accessible and effective in serving our larger membership.

VIRGINIA'S MEDICAID PROGRAM

DMAS