CardinalCare
Virginia's Medicaid Program

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

Monday, October 21, 2024

DMAS

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.

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.

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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AGENDA

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

DMAS

Agenda

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

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 AND INTRODUCTIONS

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

DMAS

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?

MAC Member Roll Call

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

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MINUTES APPROVAL

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

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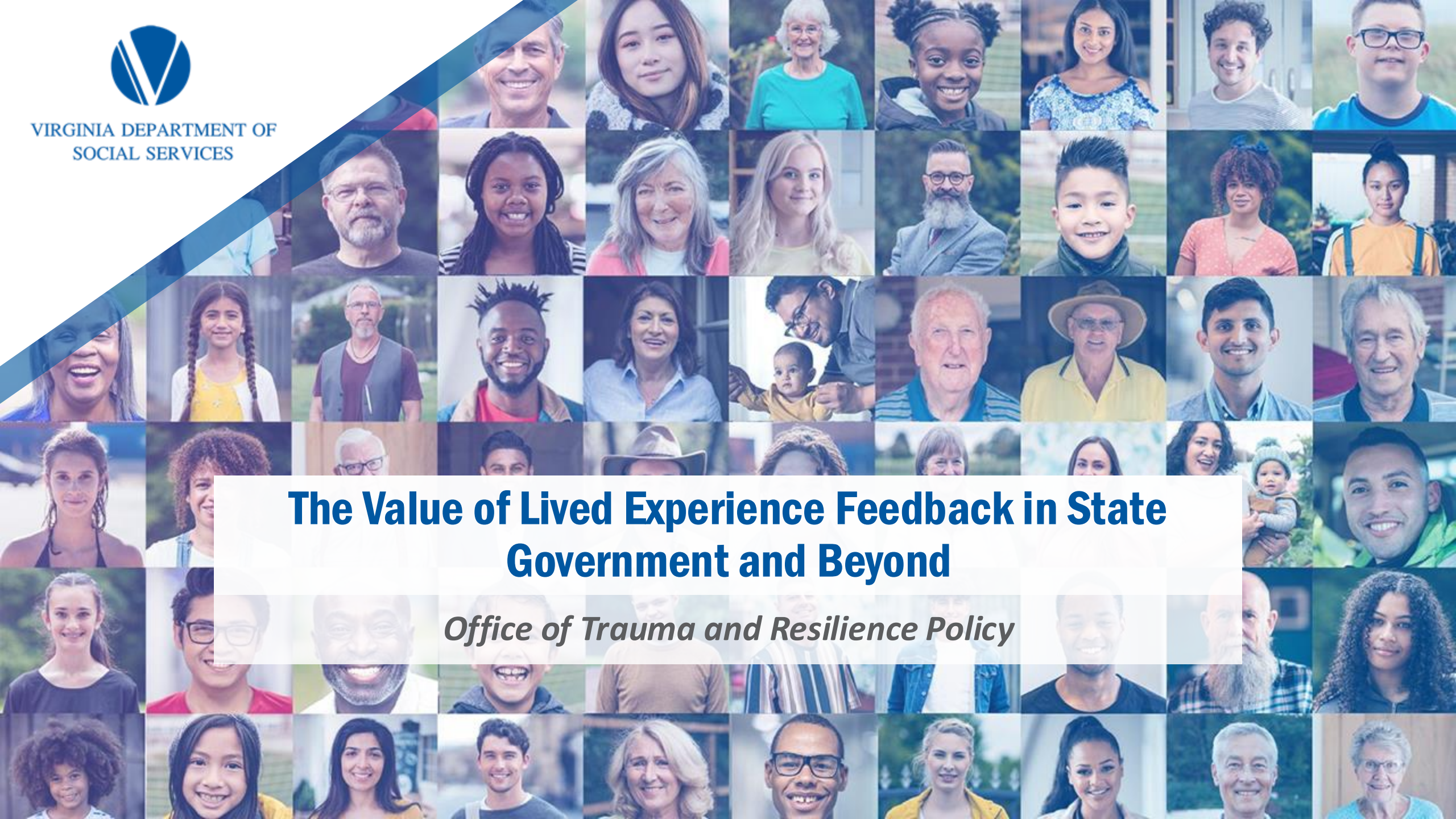
VIRGINIA DEPARTMENT OF SOCIAL SERVICES



The Value of Lived Experience Feedback in State Government and Beyond

Office of Trauma and Resilience Policy

Let's Talk

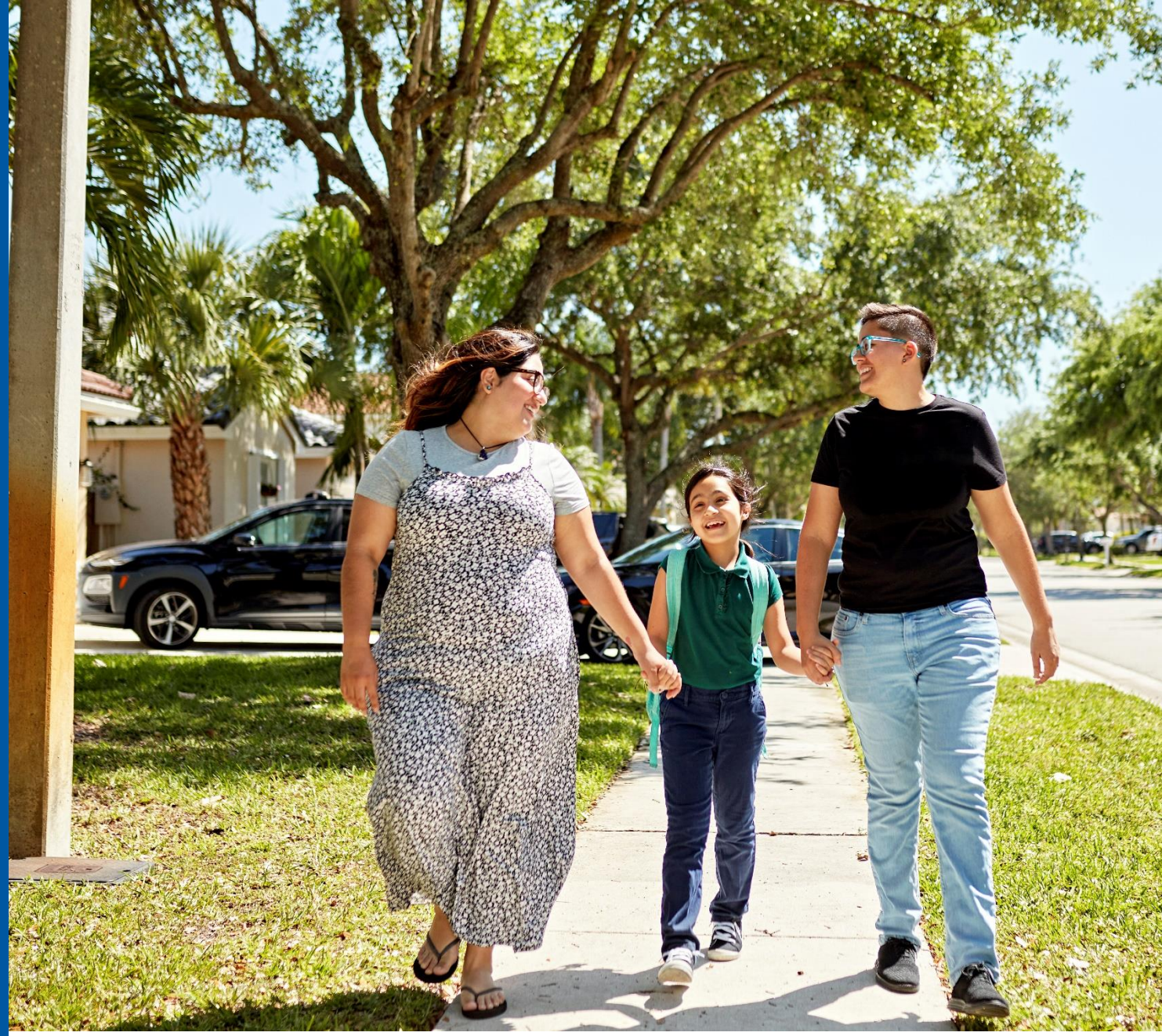
How do you interpret the integration and value of lived experience at the state level?

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

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



The LEx Community of Practice, is a collaborative group from various agencies with access to individuals from diverse backgrounds and expertise. Members regularly gather to exchange insights on effective strategies and best practices for prioritizing the voices of those with lived experience. Their goal is to overcome challenges in accessing services and to develop policy and practice that promotes more compassionate and responsive systems that better meet the needs of individuals and communities.

When we say LEx, who are we talking about?

Lived experience (LEx) is knowledge based on someone's perspective, personal identity, and history, beyond their professional or educational experience. People with lived experience are those directly impacted by social, health, or other issues and the strategies that aim to address those issues.

LEx Groups at State Agencies

Department of Behavioral Health & Developmental Services:

- Behavioral Health Advisory Council
- Peer Recovery Specialist Roundtable
- Virginia Recovery Initiative (VRI)

Department of Medical Assistance Services:

- Behavioral Health Peer Recovery Support Workgroup (ARTS)
- Members Advisory Committee (MAC)

Virginia Department of Education:

- Center for Family Involvement (VCU--The Partnership for People with Disabilities)
- I'm Determined Project (JMU Partnership)
- Youth Empowerment Transition Council (PEATC Partnership)

Virginia Department of Social Services:

- Lived Experience Advisory Board
- Fostering Responsible Parents in Virginia
- SAVES Lived Experience Advisory Council
- SPEAKOUT--Youth Advisory Board
- Parent Advisory Council

LEx Groups at State Agencies (continued)

Virginia Department of Health:

- Community HIV Planning Group
- Equality & Inclusion Council
- Status Neutral
- Quality Management Advisory Group
- Virginia Consumer Advisory Committee

VDSS Partners:

- VOICES (Virginia Sexual and Domestic Violence Action Alliance)
- Virginia Parent Council (Families Forward)

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

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.

Looking to the Future

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

Let's Talk

How has your perspective evolved through your involvement on the Medicaid Member Advisory Committee (MAC) by sharing your lived experience (LEx)?

Questions or comments?

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

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Medicaid and FAMIS Eligibility 101

Eligibility Policy & Outreach Division

October 2024

DMAS

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.

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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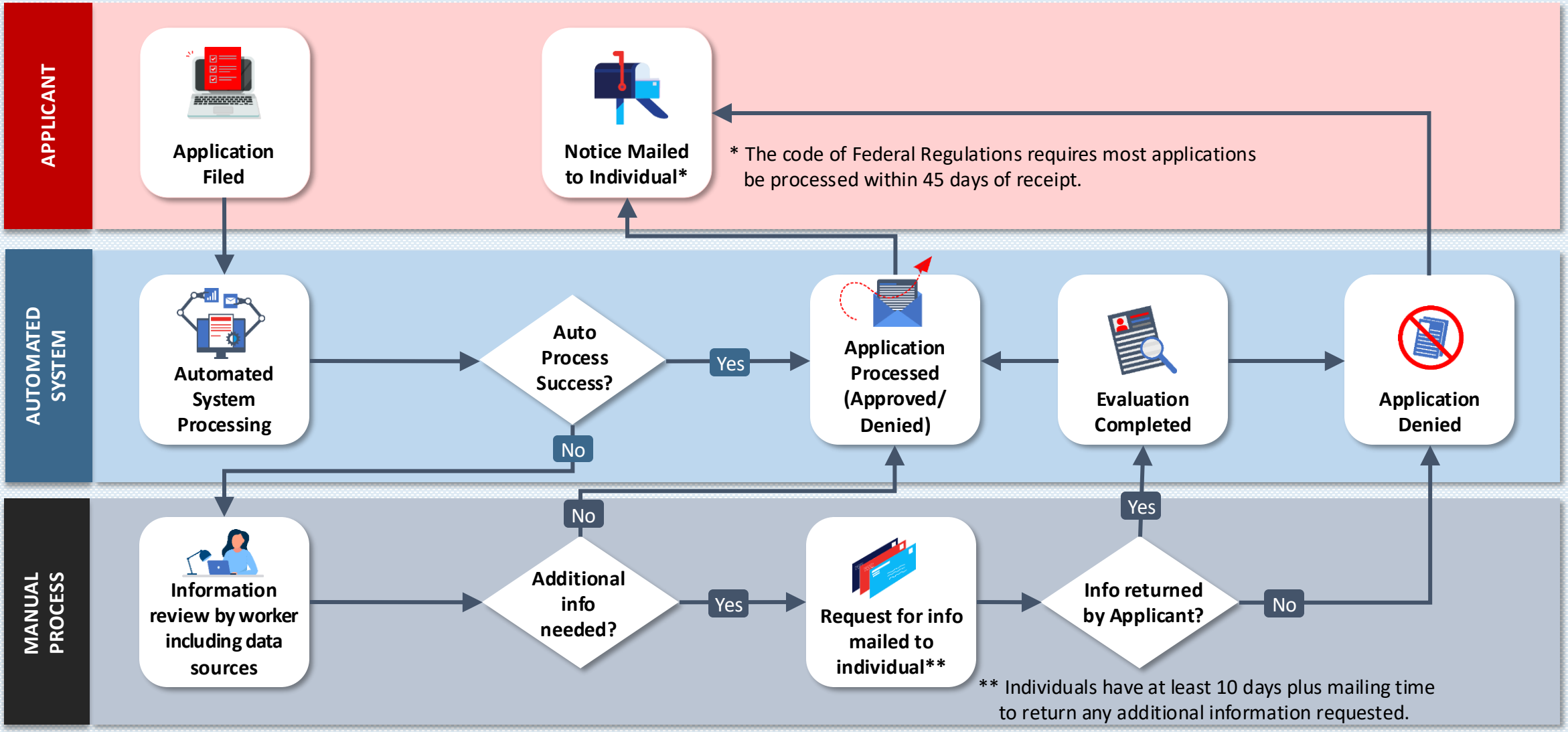
Overview of the Medicaid Application Process



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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.

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)

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.

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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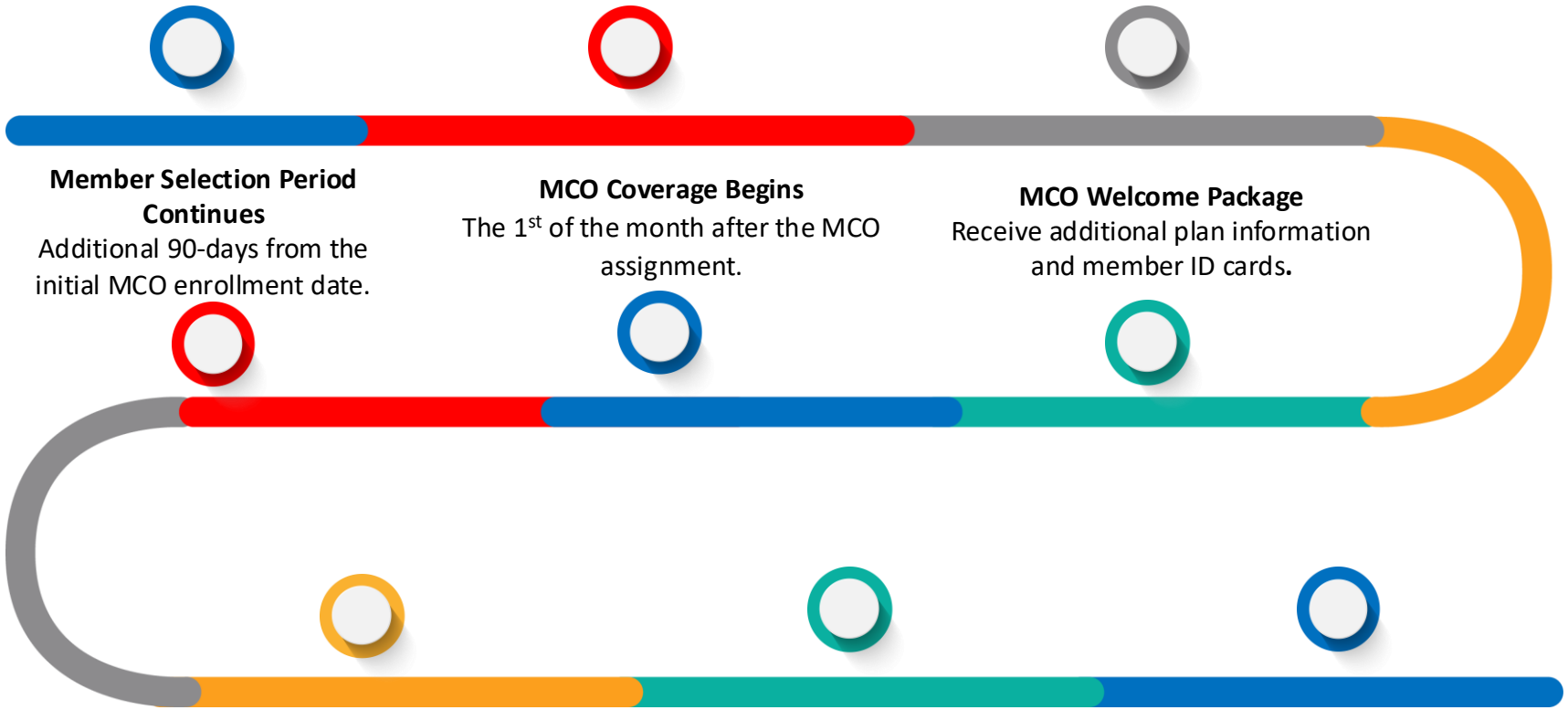
LTSS Patient Pay

- 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.

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.

MCO Assignment Timeline



Application Approved

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

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

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.

Renewal Process Flowchart

Virginia Medicaid Responsibility
Member Responsibility

Automated Process (ie. Ex Parte) Begins

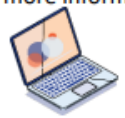
Before your renewal is due. As we restart the renewal process this timeframe will shift.

Automatically Renewed

Receive a letter - your coverage continues and you are set for another year with Virginia Medicaid!

Not Automatically Renewed

We will contact you via mail or your secure inbox on CommonHelp asking for more information.



Receives a Renewal Form

Complete your renewal (call Cover Virginia, go online to CommonHelp, or return the paper form in person or by phone/fax) by the due date.

Virginia Medicaid reviews your coverage

Once all requested information is received, we will review your case and contact you.

Receives a Checklist**

Tells you exactly what we need in order to complete your renewal. Make sure to return all information by the due date on the checklist.

*** Not everyone will receive a checklist*

∗ If you're no longer eligible for full coverage you can learn more about coverage outside of Virginia Medicaid by going to enrollva.org or calling 888-392-5132. Enroll Virginia has trained assisters, called navigators, who help you sign up for health coverage online or in person. They can compare plans and costs with an easy, anonymous online tool - find out how much financial help you may qualify to receive and get enrolled!

DMAS Unwind Renewal Flowchart 0223 v2

If your coverage continues....

You will receive a letter letting you know what you are eligible for.

You are set with Virginia Medicaid!

If your coverage does not continue....

You will receive a letter letting you know next steps*.

If you failed to renew you can return your information within 90 days for review.

Look for important information

If you think we made a mistake, your letter includes information on how to file an appeal.

If your information is referred to the marketplace, they will explore if you're eligible for other coverage.

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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.

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.

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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Virginia's Medicaid Program

DMAS Eligibility Policy Contacts

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PUBLIC COMMENT

- 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.

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 & Member 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

Closing Remarks

Sarah Hatton

Deputy of Administration and Coverage

MAC Members Rolling Off

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

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

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/

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!