

Beneficiary Advisory Council (BAC) General Meeting



Dec. 8, 2025

Accessibility Check-In Reminders: All Attendees

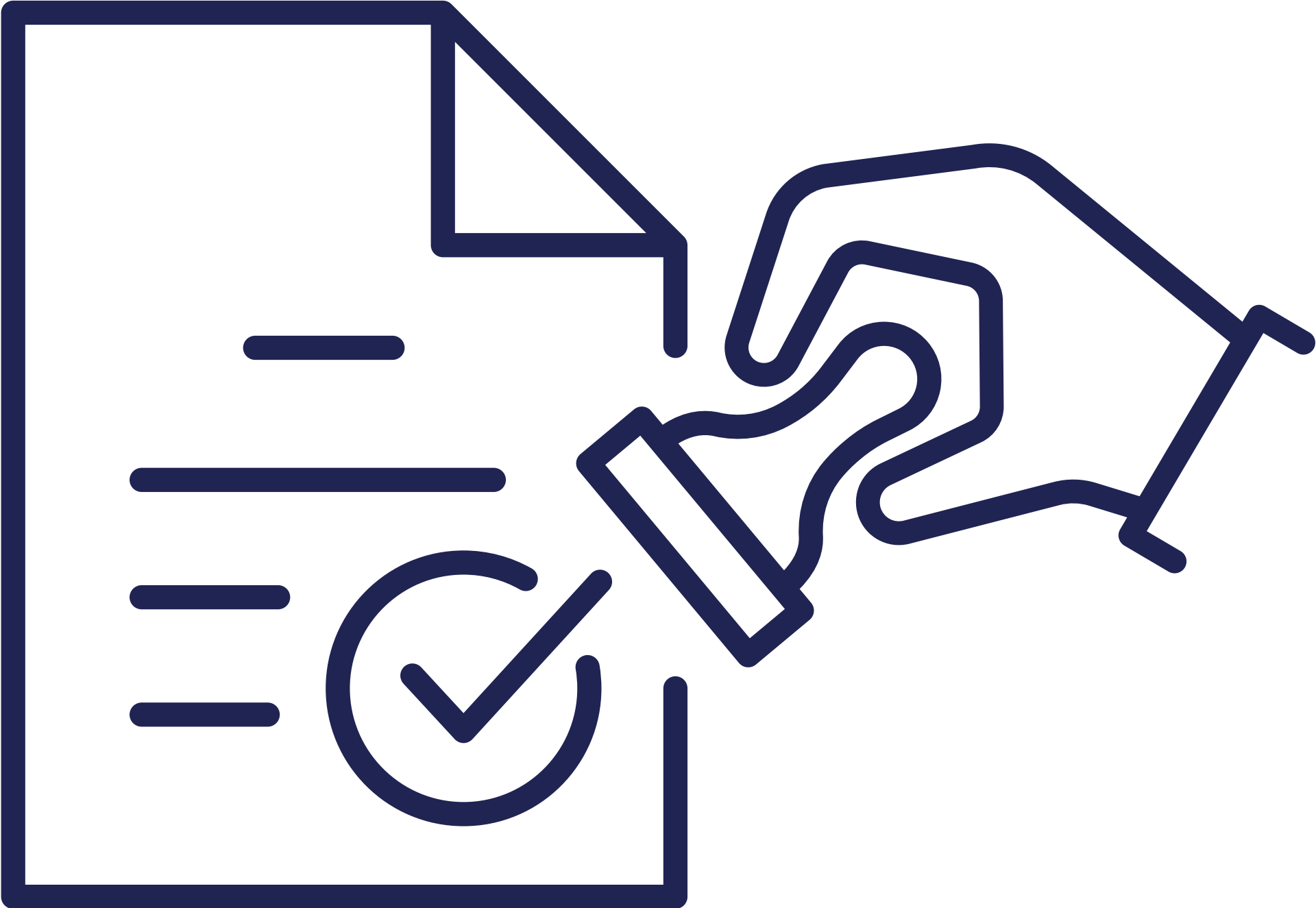
- Say your name each time you speak.
- Attendees are provided materials ahead of time and in an accessible format.
- Use a microphone to project your speech; if one is not available repeat questions when asked.
- Language access options provided upon request to include real time captioning.
- Spell acronyms and avoid jargon/idioms
 - Define or explain terms that are not common knowledge
- Speak clearly and slowly; this is helpful for individuals who are hard of hearing and those whose primary language is not the one in which you are speaking

Roll Call



Director Roberts' Remarks

September Meeting Minutes Approval



Presenter Introductions



Aneida Winston
Appeals Hearing &
Decision Manager

Appeals Division



Michael Puglisi
Client Agency
Relations Supervisor

Appeals Division

Looking Ahead

What do you want on the agenda for the 2026 meetings?



**Thank you, BAC
members!**



BAC Contact

bac@dmas.virginia.gov
804-371-8847



General Questions Cardinal Care Managed Care

- ccmc@dmas.virginia.gov



Appeals Overview

Aneida Winston
Michael Puglisi

Agenda

- Overview of Appeals
- Client Appeals
- Appeals Resources

The Purpose of Appeals

- Provide due process to applicants, members, and providers
- Afford an opportunity to be heard
- Guarantee a neutral review of agency action
- Render a decision in accordance with law



The Appeals Division has Two Core Functions

- Client Appeals:
 - Members enrolled with Virginia Medicaid or applicants seeking enrollment; case types include eligibility for Medicaid and service authorization
 - One level of appeal with DMAS for client appeals
 - First level of appeal conducted by the managed care organization (MCO) for medical appeals with next level at DMAS
- Provider Appeals:
 - Providers enrolled with Virginia Medicaid or seeking enrollment; case types include claims, billing, and audits
 - Two levels of appeal with DMAS: Informal and Formal

Appeals Information Management System (AIMS)

The DMAS Appeals Division has a system that simplifies the appeal process.

- AIMS has been designed to help us better manage and respond to appeals from both clients and providers, allowing us to provide better customer service to you
- AIMS enables clients, providers, and agencies to interact with us through an online portal. Applicants, members, and providers can file appeals, submit documents, and monitor the status of the appeal online throughout the process

Client Population and Appealable Issues

- There are nearly 1.9 million Medicaid and FAMIS clients in Virginia
- Client appeals involve eligibility for Medicaid or FAMIS benefits and medical necessity for every service / equipment that Medicaid covers

Eligibility Issues	Medical Issues
<ul style="list-style-type: none">• Agency Failure to Take Application• Asset Transfers• Citizenship/Alien Status• Excess Income• Excess Resources• FAMIS Eligibility Issues• Health Insurance Premium Payment• Patient Pay• Recipient Audit Unit Financial Recovery• Spousal Impoverishment• Timely Processing• Undue Hardship• Verifications	<ul style="list-style-type: none">• Adult Dental• Assistive Technology• Behavioral Health• Disability (Full & Limited)• Durable Medical Equipment• Drug Denials• Environmental Modifications• Mental Health Services• Nursing Facility Discharge• Personal Care Hours• PET /CAT/MRI Scans• Preadmission screenings• Private Duty Nursing• Surgical procedures• Orthodontics

Regulations that Govern Client Appeals

Code of Federal Regulations

Generally – 42 CFR Part 431, Subpart E

Managed Care – 42 CFR Part 438

Virginia Administrative Code

12VAC30-110 through 12VAC30-110-370

Medicaid Policy Manual

Chapter M16

Rules of the Supreme Court of Virginia

Code of Virginia Part Two A - Appeals Pursuant to Administrative Process Act

Essential Elements of Due Process

Goldberg v. Kelly, 397 U.S. 254 (1970)

- Right to receive adequate and timely written notice
- Right to present testimony and evidence to an impartial decision-maker
- Right to evaluate all documents relied upon by agency and to contest the agency's action
- Right to retain attorney or other representative
- Right to a decision solely on the legal rules and evidence adduced at hearing

De Novo State Fair Hearing

- DMAS conducts State Fair Hearings as *de novo* proceedings
- In a *de novo* proceeding, all information submitted during the initial review **and** during the DMAS appeal process will be considered to determine if the individual meets the criteria for approval of the requested eligibility / service(s)
- During the State Fair Hearing process, appellants may submit new documentation that was not considered during initial determination
- Agencies and contractors must review all documentation submitted by the appellant to determine whether the appeal should be resolved prior to the hearing

De Novo State Fair Hearing (Continued)

- Individuals with direct knowledge of the facts (including documents) for the appeal and the supporting authority must participate in the hearing (clinicians must be present for Medical appeals)
- If documentation from the appellant does not meet the requirement for approval, then the agency / contractor must explain why the appellant remains ineligible for approval during the appeal hearing
- Upon conclusion of the de novo proceeding, the hearing officer must make a new determination of eligibility or approval for services
- Appeals decision will consider the totality of all documentation to determine whether an approval can be made

Agencies Subject to Appeals Division Review

- Local Departments of Social Services
- Cover Virginia
- Health Departments
- Department of Aging and Rehabilitative Services
- Community Service Boards
- Department of Behavioral Health and Disability Services
- Managed Care Organizations (final adverse determinations)
- Acentra (service authorization contractor)
- ModivCare (transportation contractor)
- DentaQuest (dental and orthodontic benefits)
- Nursing Facilities
- Assisted Living Facilities (only if providing skilled nursing care)
- PACE Facilities
- Other DMAS Divisions (e.g., Fiscal, Program Integrity, Program Operations, Eligibility & Enrollment)

Notification Requirements under 42 CFR 431.210 and 12 VAC 30-110-70

- Denial notices must contain:
 - A statement of what action the agency intends to take
 - The reasons for the intended action (must be specific to the action)
 - The policy / regulation(s) that support the action
 - An explanation of appeal rights
 - Information regarding continued coverage

Notices must be mailed at least 10 days before the effective date of the intended action.

Client Appeal Request Timeframes

- Standard: Appeals must be filed within 30 days of receipt of notification of an adverse action (12VAC30-110-160)
 - Exception → Good Cause (12VAC30-110-170)
 - Appellant was seriously ill and was prevented from contacting the division
 - Appellant did not receive notice of the agency's decision
 - Appellant sent the Request for Appeal to another government agency in good faith within the time limit
 - Unusual or unavoidable circumstances prevented a timely filing
- Timeliness is based on postmark date, if mailed, or receipt date if delivered other than by mail
- DMAS must make its decision within 90 days of when the appeal is filed unless delay provisions apply
- MCO appeals have different timelines

Managed Care Organization (MCO) Client Appeals

- MCO client appeals are governed by regulations in the CFR - Chapter 438, Subpart F
- Timeframes for decision issuance and various other deadlines are different for MCO appeals
 - Each MCO must have an internal appeal process for clients
 - The internal appeal process must be exhausted with the MCO before filing an appeal with DMAS
 - It is important to include a copy of the MCO notice with the appeal request. Otherwise, the Appeals Division must contact the MCO to determine whether the internal appeal process was exhausted
 - If the internal appeal process was not exhausted, the DMAS appeal request is administratively dismissed
 - Clients have 120 days following the MCO appeal decision to request a DMAS State Fair Hearing (no good cause exception)
 - If a client elects to request a DMAS State Fair Hearing following the MCO appeal decision, the time utilized by the MCO to decide the internal appeal (which can be as long as 30 or even 44 days) is deducted from the 90-day timeline for issuance of the DMAS State Fair Hearing decision

Appeal Request Form

AIMS Portal

Appeal Information: What Are You Appealing?

Provide the Agency or MCO name that sent the adverse action or failed to act on your request.

Example Agency

If you received a Notice of Action, provide the date on the document.

09/01/2020 (mm/dd/yyyy)

If you received a Final MCO Decision, provide the date on the document.

11/30/2020 (mm/dd/yyyy)

Explain why you want a hearing. Be specific to help us understand why you are unhappy with the decision you received.

Enter specifics about why you want a hearing...

Are you a community spouse appealing the income or resource determination for your spouse?

(A Community Spouse is married to a person applying for or receiving Long Term Care (LTC) Medicaid Services.)

Yes No

Upload a Copy of your Notice

Browse

Additional Documentation

If you have additional documents you would like reviewed with your appeal, please provide them here by uploading the documents below. If you have a copy of your Notice of Action or final MCO decision, please upload it here.

Drop files here to upload

Paper Form

VIRGINIA MEDICAID / FAMIS CLIENT APPEAL REQUEST FORM

You may file your appeal online via the Appeals Information Management System (AIMS) portal by visiting <https://www.dmas.virginia.gov/appeals>

Last Name of Medicaid/FAMIS Appellant		First Name	Middle Initial	Suffix (Sr., Jr., II)
Mailing Address - Street or PO Box		Apt.	City	State and Zip
Date of Birth	Medicaid Member ID #	Client ID #	Primary Phone # with Area Code	Alternate Phone # with Area Code
Preferred Spoken Language	Preferred Written Language	Do you need an interpreter? Yes No	Email	
Do you need a reasonable ADA accommodation? Explain	What way would you like us to communicate with you? Email Mail	Have you already filed an appeal for the same issue (e.g. faxed and mailed)? Yes No		
Are you a community spouse appealing the income or resource determination for your spouse?			Yes No	
Did you receive a written notice from an agency? Yes No		Include a copy of the written notice you are appealing.		
Agency Name	Telephone			
Notice Dated	Case Worker			
Managed Care Organization (MCO)				
Are you appealing a decision by an MCO? Yes No				
If yes, you must first appeal to the MCO. If you disagree with the MCO's final decision, you can appeal that decision to DMAS.				
The agency (check all that apply):				
Denied my application or terminated my coverage for:		Medicaid	FAMIS	
Refused to take my application for:		Medicaid	FAMIS	
Failed to determine my eligibility within the time limit for:		Medicaid	FAMIS	
Requested repayment of benefits paid for medical services previously received.				
Declared me not disabled.		Important: Attach any documents you believe support your position in the appeal		
Took other action which affected my receipt of Medicaid, FAMIS or other medical services.				
Denied medical services or authorization for medical services. Name the service:				
Denied or terminated waiver services. Waiver name and service:				
Transferred or discharged from a nursing facility. Facility name and phone #:				
Write a brief statement about why you are requesting an appeal. Attach an additional page if you need more space.				
Important Information if Requesting Continued Coverage			Continued Coverage	
If the final appeal decision supports the agency's action, you may be expected to repay DMAS for all services received during the appeal process. For this reason, you may choose not to receive continued coverage.			If you had Medicaid coverage before your benefits were canceled, do you want continued coverage through the appeal process if you qualify? Yes No	
Authorized Representative				
Will the appellant be represented by another individual or an organization during the appeal process? If yes, fill out and return the Authorized Representative Form on page 3 of this Appeal Request. Yes No				
Signature of Appellant*			Date	
* See signing guidelines on Page 1				
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Authorized Representative Form

AIMS Portal

Create An Appeal

In this section, provide more information on the person who received the adverse action. An adverse action could be a denial of benefits, eligibility, service hours or another action for which you are appealing. The information in this section could be you or someone else. If you are filing an appeal for another person who received an adverse action, give us their information in this section.

Are you Filing for Someone Else? Yes No R

This is called an authorized representative. We may need to send you a document that will need a signature from the appellant telling us you can represent them. You will be notified if we need this document signed.

Your relationship to the appellant

Is the Appellant Deceased? Yes No

If the answer to this question is yes, you may have to provide additional documentation showing you are authorized to represent the Appellant's estate.

Do you have authorized representative documents you would like to include? Yes No

Authorized Representative Documents

Paper Form

**VIRGINIA MEDICAID / FAMIS APPEAL
AUTHORIZED REPRESENTATIVE FORM**

You can use this form to appoint an individual or organization to act as your authorized representative.
I understand:

- I can represent myself
- This authorization is voluntary and I have the right to refuse to sign or cancel it at any time
- This authorization will expire automatically when my Medical Assistance appeal is closed
- My signature does not waive my financial obligation if the appeal is decided in the agency's favor
- My authorized representative has access to all protected health information regarding my appeal and I agree that this information may be disclosed to other persons in connection with this appeal

Appellant Information (tell us about you)

Appellant Name: _____ Date of Birth: _____ Social Security #: _____

Medicaid Member ID #: _____ Phone: (____) _____

Authorized Representative Information (tell us about who you would like to represent you)

Authorized Rep Name or Organization _____ Phone Number (____) _____

Authorized Representative's Relationship to the Appellant: _____

Preferred written language (letters will be sent in this language) English Spanish

Authorized Representative's Address: _____

Signature of Appellant / Parent or Guardian of Minor Child: _____ Date: _____

For Organizations: The appellant must give written authorization to act on their behalf. For deceased appellants, provide documentation from the executor or administrator of the estate naming you as the Authorized Representative, this is needed to file an appeal.

If you are filing an appeal on behalf of an appellant who is unable to sign

To the best of my knowledge does the appellant have a legal guardian? Yes No

If the appellant is physically or mentally unable to sign tell us why _____

Is the appellant deceased? Yes No Your relationship to the deceased _____

To the best of my knowledge, the appellant does not have executor or administrator of their estate. Initial _____

Signature of Authorized Representative: _____ Date: _____

DMAS Appeals Division				
Email	Fax	Phone	Mail	AIMS Portal
appeals@dmas.virginia.gov	(804) 452-5454	804-371-8488	DMAS Appeals Division 600 E. Broad Street Richmond, VA 23219	https://www.dmas.virginia.gov/appeals

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Continued Coverage During the Appeal

- Legal Basis:
 - § 431.231 and 12VAC30-110-100 require that coverage be reinstated during the appeal in certain circumstances
 - Coverage must continue in the original aid category if a beneficiary requests a hearing not more than 10 days after the date of action, with an allowance for mailing time
 - Coverage must not be continued if the sole issue is a question of Federal or State law or policy
 - The DMAS Appeals Division will determine when continued coverage applies and will notify the local agency in writing
- Local agency responsibilities:
 - The local agency must reinstate services within three days of receiving notice and continue applicable coverage until a decision is rendered
 - The local agency must transmit a Notice of Action to the appellant and the Appeals Division clearly indicating that coverage has been reinstated as a result of the appeal

Ex parte Communication

- Oral or written communication made to or by a Hearing Officer off the record (outside of the hearing)
- Three essential elements:
 - Communication with the person hearing the case
 - Communication outside the presence of the other party
 - Communication regarding the merits of an active appeal

***Ex parte* communication is strictly prohibited!**

Appeal Summary Requirements

- The Agency who took the action must submit an appeal summary to summarize the specific action under appeal including:
 - Detailed description of action
 - All relevant documents
 - The results of the review of any documents submitted during the appeal. Since client appeal cases are all de novo, all documents must be reviewed, considered, and addressed in the appeal summary
- Typically submitted within a month of when the appeal was filed
- Must be uploaded to AIMS and provided to appellant

Pre-hearing Decisions

- Administrative Resolution
 - When an appeal is in progress, and the agency takes action to approve or reinstate coverage (rescind their action) because of new information or a new evaluation, a notice must be sent to the client with a copy uploaded to AIMS
 - This may resolve the issue and result in closure of the appeal, however, the Appeals Division will decide whether to terminate the appeal
 - The agency must complete an appeal summary unless the Appeals Division determines that the appeal is resolved
- Invalid
 - Authorized Representative
 - Good Cause
- Withdrawal
 - Oral and written are acceptable if transmitted directly to Appeals Division
- Administrative Dismissal
 - No right to an appeal to DMAS
- Abandon (if individual does not appear for hearing and does not submit good cause)

Schedule Letters

- Essential to due process: provides the location, date, time, and method of the hearing
- DMAS Appeals Division sends schedule letter to appellant, authorized representative, and agency
- Includes appeal summary due date
- The Appeals Division sometimes uses a conference line to conduct hearings
- Parties are expected to read the schedule letter and comply with instructions for the hearing
 - Failure to do so results in potential abandonment of appeal

Hearing Officer Responsibilities

- Conduct a fair and impartial hearing
- Maintain order
- Allow each side to present facts
- Keep the focus on the issue
- Gather evidence
- Research and analyze cases
- Issue written decision

Client Appeal Fair Hearing Proceedings

- Introduction of participants
- Explanation of process
- Agency testimony about the action taken, the reason, and authority
- Agency testimony on how new documentation affects decision (de novo process)
- Appellant testimony, presentation of evidence
- Hearing officer questions
- Agency response
- Closing remarks by hearing officer

Issuing Client Appeal Decisions

- Based on relevant facts, evidence, and testimony
 - Sustain
 - Reverse
 - Remand
- Must be rendered within the deadline as outlined earlier
- The client appeal decision is the final DMAS action
 - If the client disagrees, they may appeal to circuit court

Client Appeals Process At-A-Glance

An agency takes an adverse action and sends a notice that includes appeal rights to DMAS.



A client has 30 days, plus 5 days for mailing, from the date on the notice to submit an appeal request to DMAS. If good cause for a delay in appealing is provided an exception may be made. Managed Care Organization (MCO) appeals have different appeal timelines (120 days to file, no exceptions).



The DMAS Appeals Division notifies the agency of the appeal request.



The DMAS Appeals Division sends a schedule letter informing all parties of the date, time, and location of the hearing.



Prior to the hearing, the agency sends an appeal summary to the appellant and the DMAS Appeals Division hearing officer. The summary explains the agency's reason for the action and authority relied on.



The DMAS Appeals Division hearing officer holds a hearing on the scheduled date. The agency and appellant attend via telephone or in person, as determined by the DMAS Appeals Division.

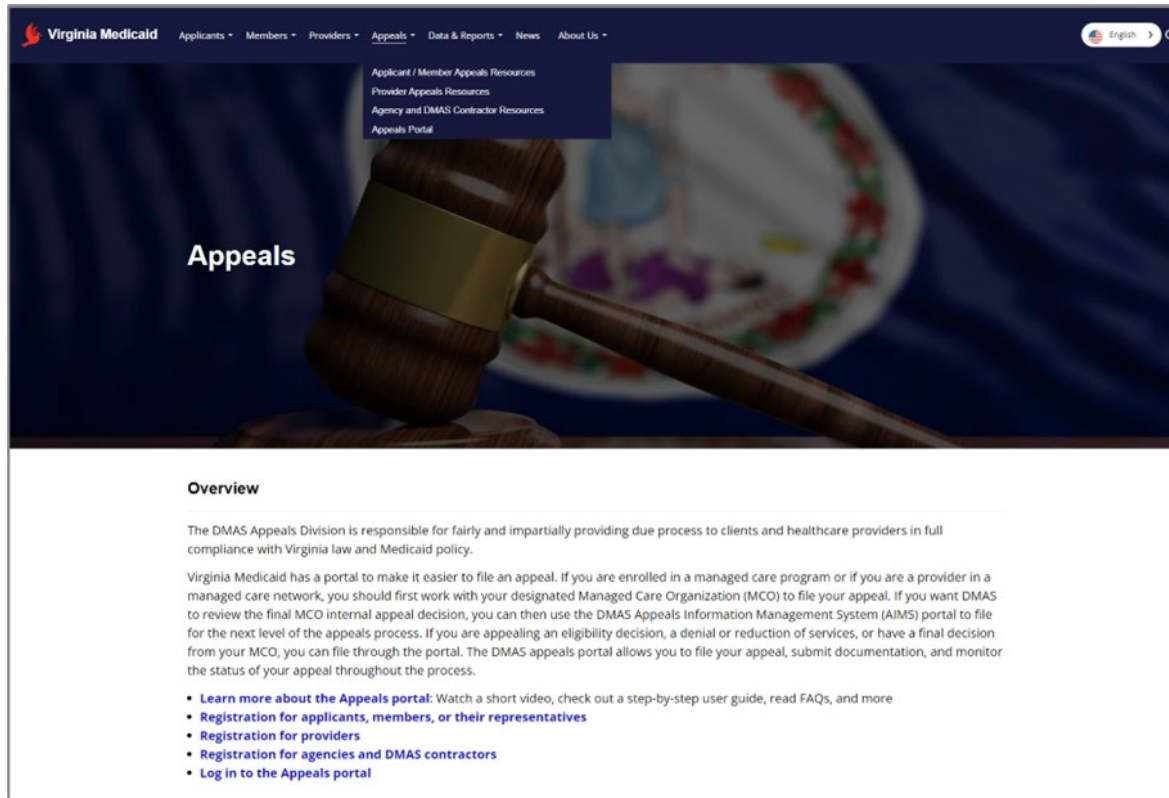


The DMAS Appeals Division issues a decision within required timeframe.

Appeals Resources

DMAS Appeals Webpage

<https://www.dmas.virginia.gov/appeals/>



- Provides an overview of client and provider Medicaid appeals
- Includes links for Applicants and Members to Client Appeal Frequently Asked Questions, a Client Appeal Overview, forms in English and Spanish, and more
- Contains a link to the Appeals Information Management System (AIMS) portal

AIMS Portal Training Website

<https://vamedicaid.dmas.virginia.gov/training/appeals>



The screenshot shows the MES Appeals Training website. On the left is a navigation menu with the following items: MES Quick Menu, EPS Home, MES Training Home, APPEALS Training Home, Applicants & Members (highlighted in dark blue), Providers, Agencies & DMAS Contractors, and CRMS Home. The main content area features the MES logo in the top left, the text 'Appeals Training' in the top right, and a large image of two women smiling while looking at a laptop. Below the image is the heading 'Appeals Portal Training Resources' and a welcome message: 'Welcome to the DMAS Appeals Training area. Click one of the links below to access step-by-step user guides, short videos, and frequently asked questions.' At the bottom, there is a section titled 'Appeals Learning Resources For...' with three links: Applicants & Members, Providers, and Agencies & DMAS Contractors.

MES

Appeals Training

MES Quick Menu

EPS Home

MES Training Home

APPEALS Training Home

Applicants & Members

Providers

Agencies & DMAS Contractors

CRMS Home

Appeals Portal Training Resources

Welcome to the DMAS Appeals Training area. Click one of the links below to access step-by-step user guides, short videos, and frequently asked questions.

Appeals Learning Resources For...

[Applicants & Members](#)

[Providers](#)

[Agencies & DMAS Contractors](#)

Appeals Division Contact Information

Appeals Division Phone: (804) 371-8488

Appeals Division Email: appeals@dmas.virginia.gov

Appeals Division Fax: (804) 452-5454

AIMS Help Phone: (804) 486-2865

AIMS Help Email: AIMSHelp@dmas.virginia.gov

Role	Name	Phone	Email
Division Director	John Stanwix	(804) 786-1505	John.Stanwix@dmas.virginia.gov
Assistant Division Director	Jessie Bell	(804) 625-3684	Jessie.Bell@dmas.virginia.gov
Customer Service and Intake Manager	Ann-Marie Brigil	(804) 225-4273	Ann-Marie.Brigil@dmas.virginia.gov
Appeals Hearing and Decision Manager	Aneida Winston	(804) 225-3819	Aneida.Winston@dmas.virginia.gov
Appeals IT Manager	Mari Mackey	(804) 482-7263	Mari.Mackey@dmas.virginia.gov
Client Agency Relations Supervisor	Michael Puglisi	(804) 774-2447	Michael.Puglisi@dmas.virginia.gov

DMAS' Business Hours are 8:00am – 5:00pm, Monday – Friday

Feedback & Questions

- How do you think applicants and members try to learn about the appeal process when they receive a denial?
- Is it clear where to find appeal resources?
- Are there specific resources that would be helpful to you?
- How else can we assist you in navigating the appeal process?