Tennessee Supreme Court Access to Justice Commission

Tennessee Faith & Justice Alliance Volunteer Attorney Training Monday, April 27, 2015

Michele Johnson, Executive Director

Tennessee Justice Center

Agenda

- TJC- 5 minutes
- Binta B. – 15 minutes
- Wilson appeals- 10 minutes
- Choices- 5 minutes
- Questions- 5 minutes


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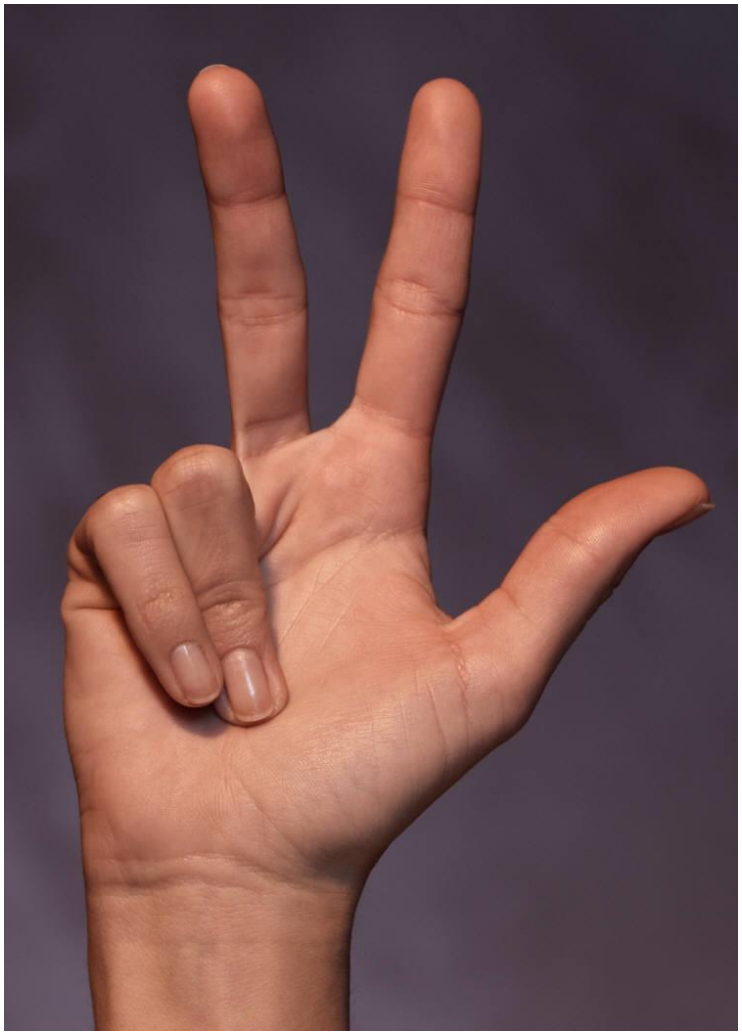
Tennessee



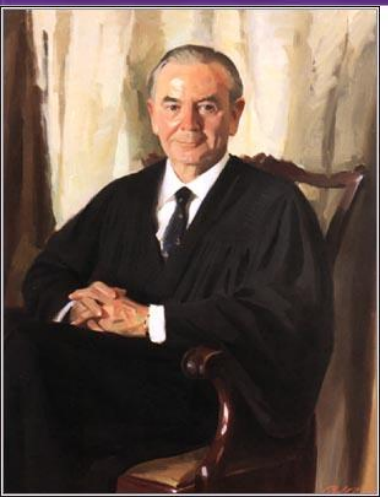
1.Get TNeans covered.

2. System = the law

3. Connecting every day realities to decision makers

Binta B. case

https://www.youtube.com/watch?v=aPOtSxFO46M



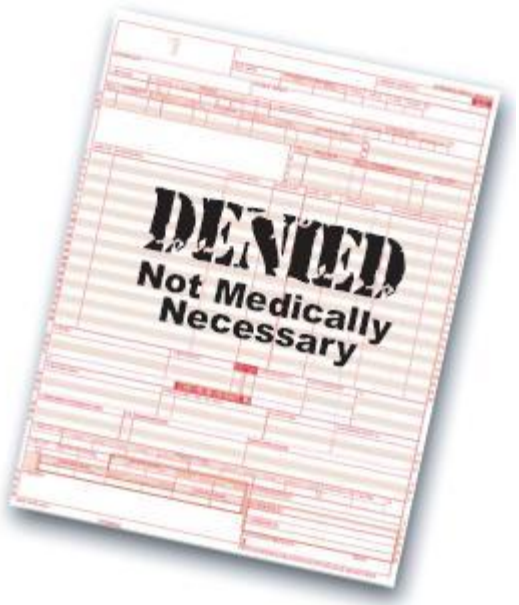
Goldberg v. Kelly (1970)

- Timely & adequate notice of reasons for proposed action
- Hearing: meaningful time & in meaningful manner
- Effective opportunity to defend by confronting adverse witnesses & presenting arguments & evidence
- Right to legal counsel
- Right to statement from the decisionmaker

TennCare Legal Authorities

- 42 USC §§ 1396 *et seq*.
- 42 CFR §§ 430 *et seq*.
- State Medicaid Manual
- "Dear State Medicaid Director" letters
- TennCare Rules, Chapter 1200-13-01 *et seq*.
- Tennessee Uniform Administrative Procedures Act, Chapter 1360-04-01 *et seq.*
- *Grier/Binta B.* Consent Decree

Medical Necessity Standard



Definition of Medical Necessity

1. Recommended by licensed provider
2. Required to diagnose or treat a medical condition
3. Must be safe and effective
4. Must be the least costly alternative for diagnosis or treatment that is adequate for the medical condition
5. Must not be experimental or investigational

Who decides what is "adequate"?

Medical opinions shall be evaluated as follows:

i. Where the treating provider's opinion is consistent with the defendants' or MCC's opinion **or** objective evidence, **it shall be accorded controlling weight**.

Who decides what is "adequate"?

(ii) Where the treating provider's opinion is:

(A) well-supported with clinical and laboratory findings derived from an examination of the enrollee or enrollee's medical records, **and** objective evidence; or

(B) well-supported with clinical and laboratory findings derived from an examination of the enrollee or the enrollee's medical records, **but not** with objective evidence, **the opinion shall be accorded controlling weight**, even if it is inconsistent with the defendants' or MCC's opinion or objective evidence;

Who decides what is "adequate"?

(ii)(B) . . . provided, however, that the treating provider's opinion does not **significantly deviate** from the defendants' or MCC's opinion or objective evidence. If the treating provider's opinion significantly deviates from the defendants' or MCC's opinion or objective evidence, the defendants or MCCs may require the treating provider to further explain his or her opinion.

Who decides what is "adequate"?

IV. In the event the defendants or MCCs require further explanation from the treating provider . . .

A. the treating provider's opinion shall be accorded **controlling weight**, if the treating provider submits an explanation or other clinical or objective evidence and the **defendants or MCCs deem such additional information to be sufficient to cure the original deficiency.**

Practice Tip 1

Best witness: A treating provider who will stand by his or her recommendation. A provider can testify in person, by phone, or by declaration.

Practice Tip 1

UAPA 4-5-313:

Serve at least 10 days prior to hearing

"The accompanying affidavit of [treating provider] will be introduced as evidence at the hearing in [name of case]. [Treating provider] will not be called to testify orally and you will not be entitled to question such affiant unless you notify [attorney] at [address] that you wish to cross-examine such affiant. To be effective, your request must be mailed or delivered to [attorney] on or before [7 days after delivery]."

Practice Tip 1

UAPA 4-5-313:

"Unless the opposing party, within seven (7) days after delivery, delivers to the proponent a request to cross-examine an affiant, the opposing party's right to cross-examination of such affiant is waived and the affidavit, if introduced in evidence, **shall be given the same effect as if the affiant had testified orally**."

Practice Tip 2

Explain to the treating provider the importance of medical records.

Opinions must be “well-supported with clinical and laboratory findings derived from an examination of the enrollee or enrollee’s medical records.”

Notice

Required Notice

Notice is required if services are:

- Denied
- Terminated
- Suspended
- Reduced
- Delayed

The MCC must give at least 30 days and no more than 40 days notice that a service is to be stopped or reduced.

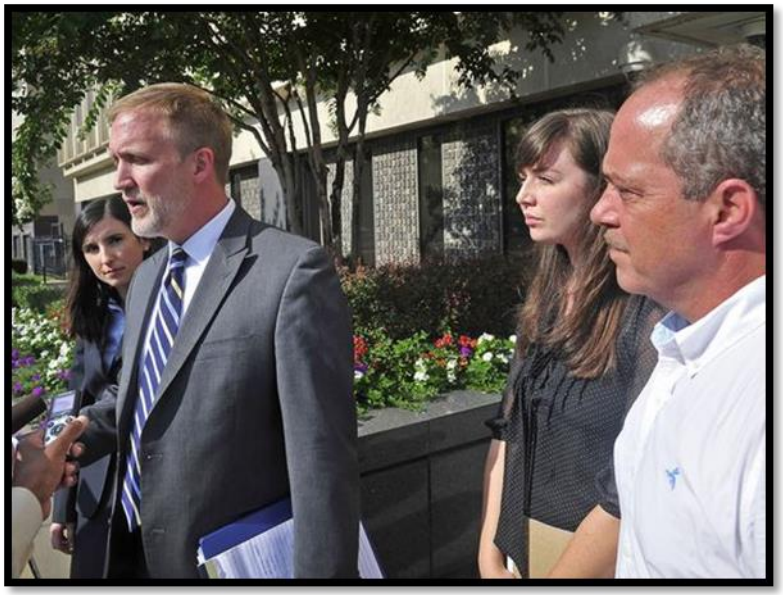
Written Notice Requirements

- Type, amount & service at issue
- Statement of reason for action taken
- Identification of clinicians consulted
- Medical records relied upon for decision
- Which element of medical necessity definition is not met
- Information about the appeal process

Effect of Notice Violations

"No adverse action affecting TennCare benefits shall be effective unless the defendants and/or others acting on their behalf have complied with the notice requirements . . . ."

TennCare Wilson Appeals



Patients in Tenncare limbo sue for benefits

Tom Wilemon,
twilemon@tennessean.com

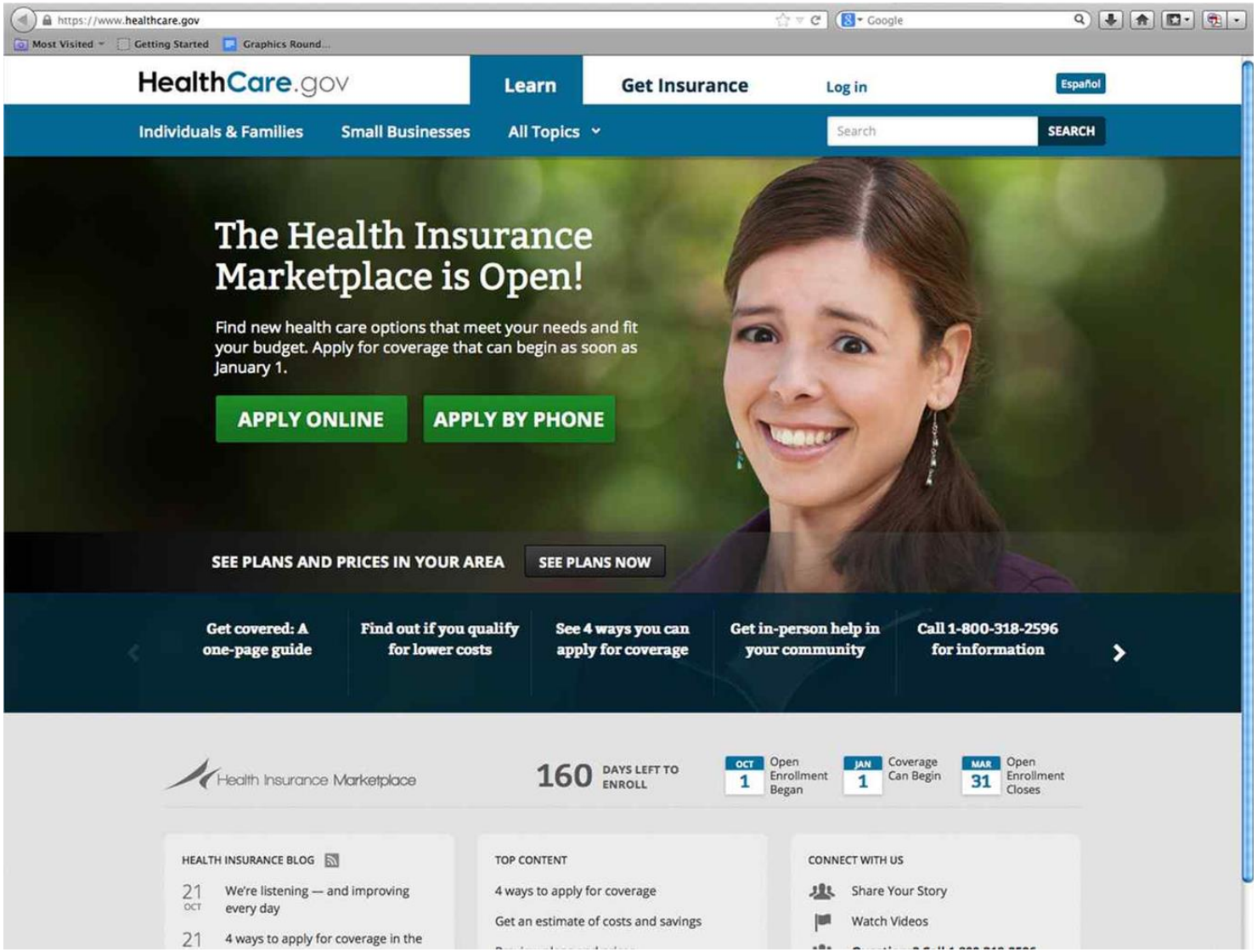
9:56 p.m. CDT July 23, 2014

(Photo: John Partipilo / File / The Tennessean)

Babies who went without medical coverage, a mother of three with high blood pressure and a woman with kidney failure are among the plaintiffs in a federal lawsuit filed today contending that TennCare illegally denied them Medicaid benefits.

Three nonprofit legal firms — the Southern Poverty Law Center, the Tennessee Justice Center and the National Health Law Program — are representing the plaintiffs. TennCare has also come under fire from the federal director of Medicaid programs, who this month sent a letter putting the agency on notice that it had failed to abide by its legal obligations. The suit comes after TennCare Director Darin Gordon sent a defiant response to that letter, blaming many of the state's problems on the federal website healthcare.gov.

Lawyers for the plaintiffs said Tennessee was the worst state in the nation for fulfilling its Medicaid obligations. They are asking a judge to give the suit class-action status, which would broaden the impact of any legal decisions to other people similarly affected, and to prevent the state from refusing to process Medicaid applications within the legally required 45-day period.


https://www.healthcare.gov
Most Visited
Getting Started
Graphics Round...
Google
HealthCare.gov
Learn
Get Insurance
Log in
Español
Individuals & Families
Small Businesses
All Topics
Search
SEARCH
The Health Insurance Marketplace is Open!
Find new health care options that meet your needs and fit your budget. Apply for coverage that can begin as soon as January 1.
APPLY ONLINE
APPLY BY PHONE
SEE PLANS AND PRICES IN YOUR AREA
SEE PLANS NOW
Get covered: A one-page guide
Find out if you qualify for lower costs
See 4 ways you can apply for coverage
Get in-person help in your community
Call 1-800-318-2596 for information
Health Insurance Marketplace
160 DAYS LEFT TO ENROLL
OCT 1 Open Enrollment Began
JAN 1 Coverage Can Begin
MAR 31 Open Enrollment Closes
HEALTH INSURANCE BLOG
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Ripped from the headlines

Her pro bono attorney said…

- "Representing pro bono clients in the TennCare appeals eligibility and effective date appeals has been a rewarding experience. It has provided me with an opportunity to represent people in a true moment of need, and the feeling of usefulness in being able to assist them, is far greater than the minimal amount of time it requires to handle one of the appeals." - Liz Sitgreaves

Applying for TennCare

- Tennessee requires nearly all applicants for TennCare/Medicaid to apply through the federal marketplace.

- Only exceptions are:
  - Presumptive Eligiblity (PE) program*
  - CHOICES long-term care program
  - Medicare Savings Programs (QMB, SLMB, QI).

*PE is only available for pregnant women, women with breast or cervical cancer, and newborns.

"Reasonable Promptness"

Federal law requires TennCare to determine an applicant's eligibility "with reasonable promptness," defined as **no longer than 45 days** (or 90 days for the CHOICES program).

Applicants' Right to a Hearing

Federal law requires TennCare to provide an opportunity for a fair hearing to anyone whose application is "denied or is **not acted upon with reasonable promptness.**"

Wilson v. Gordon

On July 27th, TJC, Southern Poverty Law Center, & National Health Law Program filed suit against TennCare on behalf of all Tennesseans who have been waiting for more than 45 or 90 days for TennCare to tell them whether or not they are eligible.

Wilson v. Gordon Class

"All individuals who have applied for Medicaid (TennCare) on or after October 1, 2013, who have not received a final eligibility determination in 45 days (or in the case of disability, 90 days), and who have not been given the opportunity for a 'fair hearing' by the State Defendants after these time periods have run."

http://www.tnjustice.org/tenncare-suit/class/

Wilson v. Gordon Order

"The Defendants are ordered to provide the Plaintiff Class with an opportunity for a fair hearing on any delayed adjudication. Any **fair hearing shall be held within 45 days** after the Class Member requests a hearing and provides Defendants with proof that an application was filed."

If the application is for CHOICES, the hearing must be held within 90 days of the request.

http://www.tnjustice.org/tenncare-suit/order/

Real client with real hearing


WE NEED
YOU

What is CHOICES?

CHOICES is the state's long-term care program for the elderly and adults (over 21) with disabilities.

It provides home and community-based services (HCBS) or institutional care.

CHOICES 1:Nursing home care

CHOICES 2: Full array of HCBS

CHOICES 3: At-risk group, up to $15,000 HCBS

Who can get CHOICES?

Medical Eligibility – Threshold for HCBS

To qualify for CHOICES in community (CHOICES 2 or 3), an individual must be over 65 or have a *physical* disability.

This can be a barrier to people under 65 who have health needs that do not meet TennCare's physical disability definition (e.g., dementia).

Who can get CHOICES?

Medical eligibility is based on a Pre-Admission Evaluation (PAE). PAE is looking at individual's need for:

- assistance with Activities of Daily Living (ADLs), &
- skilled or rehabilitative services.

Who can get CHOICES?

ADLs:

- Transfer
- Mobility
- Eating*
- Toileting
- Incontinence Care
- Catheter/Ostomy Care
- Orientation
- Expressive Communication
- Receptive Communication
- Self-Administration of Medication*
- Behavior*

See PAE Manual, pp. 19-25, for definitions.
* Definitions changed in 2014.

Who can get CHOICES?

Skilled or rehabilitative services:

- ventilator
- tracheostomy
- complex wound care
- physical or occupational therapy
- other skilled services required at a greater frequency, duration, or intensity than practical with daily home health visit.

See PAE Manual, pp. 25-27.

Who can get CHOICES?

Bottom line: it's hard to qualify for CHOICES 1 or 2. The state closed choices 3.

Typical problems that need you!

Problem 1: Denied medical eligibility for CHOICES (Or only eligible for CHOICES 3, but need 1 or 2.)

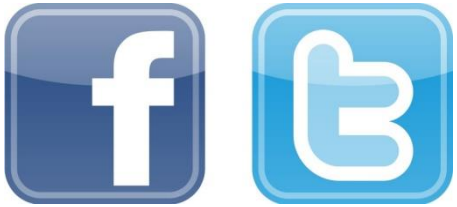
Problem 2: Delay (more than 90 days) getting a decision on application

Problem 3: Denied financial eligibility for CHOICES

Thank you for being here today.

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

-Martin Luther King, Jr.



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