TennCare Appeals
What is TennCare?

The state of Tennessee’s Medicaid program.

It is state and federally funded.
TennCare

• Is a managed care model
• Has different health plans, called Managed Care Organizations (MCO)
  – United Healthcare Community Plan
  – Amerigroup
  – BlueCare
  – TennCare Select
Two Categories of Appeals

1. Eligibility appeals
   • Denials
   • Delays
   • Effective Date

2. Medical service appeals
   • Denials / terminations
   • Delays
   • Reductions

- Timely and adequate notice of the reasons for the proposed action
- Hearing at a meaningful time and in a meaningful manner
- Effective opportunity to defend by confronting adverse witnesses and presenting arguments and evidence orally
- Right to have legal counsel
- Right to a statement from the decisionmaker
Eligibility Appeals
Eligibility Appeals

- Denials
- Delays
- Effective Date
TennCare Categories
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).

See: 42 USC 1396a(a)(8)
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.”
“Single Streamlined Application”
No Wrong Door

Complete single application

Determine eligibility

Enrolled in correct program!

Single Application

In-Person Assistance

Exchange

Medicaid

CHIP

tnjustice.org
Accent System (DHS)
TEDS
TennCare Eligibility Determination System
A GLITCH IN GOVERNMENT

COMPUTER FAILURES ENTANGLE TENNESSEE

Systems meant to help children, the poor and the uninsured sidelined by costly defects, delays

It's become a broken record in Tennessee: When state government uses any computer system to deliver services, mistakes and glitches are the rule rather than the exception.

By Tony Gonzales
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In Tennessee, investigations into how state agencies provide services to eligible applicants can be fraught with problems. The state’s computer systems have been plagued by glitches that have caused delays and errors in the delivery of services.

The problems started with the implementation of TennCare, the state’s Medicaid program, which uses a computer system to process applications for eligibility.

But the problems haven’t stopped there. Other state agencies, such as the Department of Transportation and the Department of Education, have also struggled with computer systems that don’t work as intended.

The result is a system where services are often denied to eligible applicants, and those whose applications are approved may face delays and other problems.

The Tennessee Justice Center, a non-profit organization that advocates for fair and effective state government, has been monitoring these problems for years.

In a recent report, the center found that the state’s computer systems are causing delays and errors in the delivery of services to eligible applicants.

The center recommends that the state invest in better computer systems and that it develop a plan to address the problems that are causing these delays and errors.

In the meantime, those who are relying on state services need to be aware of the problems that they may encounter and be prepared to take action if they are denied services or experience delays.

tnjustice.org
State lays off 121 workers

Department of Human Services eliminates 256 vacant positions; more layoffs planned

By Chas Sisk
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The state Department of Human Services has laid off 121 workers responsible for administering food stamp and welfare payments in Tennessee and eliminated 256 vacant positions.

The department said Monday that the workers were let go Friday as part of an effort to rethink how the state administers its Temporary Family Assistance programs. Officials also said in a news release that caseloads had decreased.

All of the workers who were laid off were probationary employees, meaning they had been in their positions less than 12 months. They were given 10 days' severance pay.

The workers were still in training or had taken on limited case work assignments and clerical duties, a spokeswoman for the department said. The Family Assistance division continues to employ about 2,400 people.

DHS officials said they plan more layoffs but have not yet determined what positions would be cut. Gov. Bill Haslam's 2014-15 budget, which the General Assembly approved this spring, calls for eliminating an additional 154 vacant positions.

Under Haslam, the state has cut more than 4,000 positions from its payrolls, bringing the total workforce down to about 43,000 workers.

Reach Chas Sisk at 615-259-8283 and on Twitter @chasissk.
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Get lower costs on health insurance

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Get help with your application

tnjustice.org
Melissa Wilson

- Caretaker of three grandchildren
- Monthly income of $1056
- Suffers from kidney failure, lupus, hypertension, osteoporosis
- Requires 17 prescription drugs
- Applied for TennCare on February 10, 2014
- No determination as of July 23, 2014 (163 days)

“My doctor ... has even called to TennCare to let them know that without TennCare coverage I will die.”

MELISSA WILSON, of Cookeville
TENNCARE ON TRIAL

BACKLOGS, TWIN BABIES AND A $200K HOSPITAL BILL

Had TennCare worked the way it is supposed to, full-time father...
CHILDREN LEFT IN TENCARE LUNCH

Emily Barron, left, with her husband, Chris Williams, and 3-month-old son, Cameron Williams, says healthcare.gov and TennCare "have turned their backs on us, really."
June 27, 2014 Letter from CMS

Over the past nine months, CMS has engaged with Tennessee on multiple occasions to express concerns about the continued delays in implementing TEDS and the downstream impact those delays are having on the state’s ability to enroll eligible individuals into Medicaid. We know Tennessee shares these concerns. In light of these delays we have also repeatedly shared our concerns about the lack of an in-state mitigation plan that would allow people to apply for coverage based on MAGI rules directly to the Tennessee Medicaid agency. As you know, all states were required to begin processing applications based on MAGI rules effective October 1, 2013. The state has repeatedly expressed reluctance to deploy resources toward adopting mitigation solutions for in-state applications.
STATE HAS 10 DAYS TO ADDRESS ACA FAILURES
TennCare defiant on fed demands

Agency takes corrective actions but still blames federal website

By Tom Wilenon
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Although TennCare Director Darin Gordon blamed a federal website for the hurdles Tennesseans face applying for Medicaid, the agency will take some corrective actions demanded by a federal official.

The state agency will enable hospitals to temporarily enroll pregnant women in Medicaid. It will take actions to keep newborns and children who qualify for coverage from falling through the cracks. And TennCare will hire a consulting firm to analyze the problems with its behind-schedule $35.7 million computer system.

However, it will not provide face-to-face help for people trying to apply for coverage through the state Medicaid system and will, instead, continue sending people to the federal Health Insurance Marketplace to do that.

“People have had difficulty completing the enrollment process, and most of those problems have been the result of flaws in the federal government’s healthcare.gov website,” Gordon wrote in his letter to the federal official that accompanied TennCare’s corrective measures.

Cindy Mann, the federal director of Medicaid programs, had given TennCare 10 business days to respond to the concerns in a June 27 letter. She put TennCare on notice that it had failed to provide services for people as required by federal law.

The computer system is the crux of the problems, but Mann noted that Tennessee had stopped providing people with face-to-face help in applying for Medicaid and had no systems for hospitals to temporarily enroll pregnant women who probably qualify for coverage.

Gordon included paragraphs to “correct several mistaken assertions” in Mann’s letter.

“The larger point that I want to make is that the state has not only shouldered its own responsibilities, but also has devoted substantial resources to mitigating problems arising from the federal marketplace flaws,” Gordon wrote. “We will continue to do so — but in a way that makes sense for those we serve.”

He contends that the state does provide direct application assistance in every county by having self-service computer kiosks and people who meet the federal criteria to counsel people on enrolling at healthcare.gov. However, Mann said in her letter that the state should do more.

The state is closer to coming to an agreement with Mann on coverage

» AGENCY, 10A
HEALTH CARE

PATIENTS SUE TENNCARE OVER DENIED BENEFITS

Lawyers say TN is worst in fulfilling Medicaid duties

By Tom Wilemon
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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 Wednesday contending that TennCare illegally did not grant 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 also has come under fire from the federal director of Medicaid programs, who this month put the agency on notice that it had failed to abide by its legal obligations. TennCare Director Darin Gordon's defiant response blamed many of the state's problems on the federal website healthcare.gov.

Lawyers for the plaintiffs said Tennessee is the worst state in the nation for fulfilling its Medicaid obligations. They are asking a judge to give the suit class-action status, which

"My doctor ... has even called to TennCare to let them know that without TennCare coverage I will die."
MELISSA WILSON, of Cookeville

"I am worried that without it, she won't be able to see her children grow up."
RICKY REYNOLDS, of Lafayette, about his wife, April

TENNCARE, 9A
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/
Wilson v. Gordon Order

In Reality...

The state has said they will not be holding hearings about delay appeals. Instead, they will make determinations within 45/90 days.

The state is holding hearings on appeals of eligibility denials and incorrect effective dates of coverage.
Medical Service Appeals
Medical Service Appeals

• Denial of a medicine
• Reduction of home health hours
• Discharge from Residential Treatment Facility
• “We can’t find a speech therapist”
• Missed nursing shifts
• “You can’t see an out-of-network specialist”
Medical Necessity Standard
Tennessee’s New “Medically Necessary” Standard: Uncovering the Insured?
by Andy Schneider

The New Tennessee Standard Compared

There does not appear to be any precedent for – or operational experience with – the new Tennessee “medically necessary” standard in either the public or private sector. Existing databases suggest that the new Tennessee standard is substantially more restrictive than those used by other state Medicaid agencies, by Medicare, by Federal Employee Health Benefits (FEHBP) contractors, and by private sector plans.
Definition of Medical Necessity
TennCare Rule 1200-13-16

1. Service must be recommended by licensed provider

2. Service must be required to diagnose or treat a medical condition

3. Service must be safe and effective

4. Service must be the least costly alternative for diagnosis or treatment that is adequate for the medical condition

5. Service must not be experimental or investigational
“Diagnose or treat”

Medical care which . . .

(a) if not provided, would have a significant and demonstrable adverse impact on quality or length of life.

(b) is essential in order to treat the significant side effects of another medically necessary treatment.

(c) is essential . . . to avoid the onset of significant health problems or significant complications that, with reasonable medical probability, will arise from that medical condition in the absence of such care.
“Safe and effective”

(a) The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the enrollee’s needs.

(b) The reasonably anticipated medical benefits of the item or service must outweigh the reasonably anticipated medical risks based on:
   1. The enrollee's condition; and
   2. The weight of medical evidence as ranked in the hierarchy of evidence . . . .
“Hierarchy of evidence”

(a) Type I: Meta-analysis done with multiple, well-designed controlled clinical trials;

(b) Type II: One or more well-designed experimental studies;

(c) Type III: Well-designed, quasi-experimental studies;

(d) Type IV: Well-designed, non-experimental studies; and,

(e) Type V: Other medical evidence defined as evidence-based

1. Clinical guidelines, standards or recommendations from respected medical organizations or governmental health agencies;
2. Analyses from independent health technology assessment organizations; or
3. Policies of other health plans.
A medical item or service is not experimental or investigational if the weight of medical evidence supports the safety and efficacy of the medical item or service in question as ranked in the hierarchy of evidence.
An alternative course of diagnosis or treatment may include observation, lifestyle, or behavioral changes or, where appropriate, no treatment at all when such alternative is adequate for the medical condition of the enrollee.
Who decides what is “adequate”?

Grier/Binta B. Consent Decree
Treating Provider Rule
(Section C(7))
Who decides what is “adequate”? 

Grier/Binta B. Consent Decree
Treating Provider Rule
(Section C(7))
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.

Trust Me, I’m a Doctor
Practice Tip 1

UAPA 4-5-313:

Serve at least 10 days prior to hearing

“The accompanying affidavit of [treatting provider] will be introduced as evidence at the hearing in [name of case]. [Treatting 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
Notice is required if services are:

- Denied
- Terminated
- Suspended
- Reduced
- Delayed
Written Notice Requirements

• Type and amount and service at issue
• Statement of reason for action taken by MCC
• Identification of clinicians consulted by MCC
• Medical records relied upon for the decision
• Which element of the 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 . . . .”
Effect of Notice Violations

Defendants may provide one corrected notice, which must be delivered prior to the issuance of the notice of hearing.

Notice violation = “defendants shall immediately provide or require their contractor to provide the TennCare covered service as issue in the quantity and duration prescribed.”
Practice Tip 3

• Examine the notice carefully. Defendants are bound by the reasons for the adverse action given in the notice.

• No issue switching.
Continuation of Benefits

If an enrollee files a timely appeal of a termination or reduction of an ongoing service, MCO must provide continuation of benefits pending appeal (on request).

Exceptions:
• Enrollee has met benefit limit (ex. 5 prescriptions)
• Non-covered service
• Provider-initiated actions (after a second opinion)
Timing
Timing

Denial of Services →

Recipient has 30 days from receipt of notice to appeal, or 10 days if service is requested to continue during appeal →

MCC has 14 days to inform recipient in writing of its reconsideration (but this is not mandatory) →

If MCC affirms its denial, TennCare Bureau will review →
Timing (cont.)

If TennCare affirms the MCC’s denial, TennCare’s Legal Solutions Unit will schedule a hearing ➔

Administrative Law Judge from the Secretary of State’s Administrative Division will make a final determination at hearing.

“Grier Date” - Entire process must be completed within 90 days of recipient’s appeal (31 days for expedited appeal)
Practice Tip 4

Do not toll the *Grier* date beyond any delay attributable to the enrollee.
• Most likely a phone hearing will be scheduled, but recipients always have a **right** to an in-person hearing.

• Request for an in-person hearing should NOT toll *Grier* date.
Evidence at Hearing

• Evidence must be “substantial and material”

• Recipient generally bears the burden of demonstrating that the requested service is medically necessary

• Decisions must be based on an individualized determination, not industry guidelines or utilization control criteria.
After the Hearing

• ALJ will issue an initial order in writing.

• TennCare may overturn the ALJ’s order.

• ALJ’s opinion may be appealed within 15 days of initial entry of the order.

• ALJ’s final order may be appealed within 60 days in Chancery Court
TJC is a non-profit, public interest law and advocacy firm serving TennCare families.

We focus on policies and cases where the basic necessities of life are at stake, and where our advocacy can benefit families statewide.

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