

TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT  
DOE v. WORD SETTLEMENT IMPLEMENTATION PLAN

I. Redefining the Basis for the Decision

- A. Within 30 days of the entry of a settlement, TDHE will publish a notice of rule making and a draft of a proposed, new medical criteria for PAE approval at the ICF level of care. Within 60 days, the same will be done for ICF/MRs and, within 90 days, at the SNF level of care.
1. The intent, objective, and goal of these revisions is to create medicolegal criteria of simplified design, of better clarity for laymen, of ease in application, of movement toward a "bright line" distinguishing levels of care (i.e. home for the aged, ICF, SNF), and of logical development when analyzing such a case.
  2. The criteria will further revise the application procedure in an attempt to eliminate the present volume of retroactive appeals by separating the TDHS determination of financial eligibility for nursing home care, represented by the Form 2362, from the TDHE determination of medical eligibility, represented by the PAE form, and allowing the two procedures to flow independently.
  3. The criteria will be submitted to the judges of the Administrative Procedures Division for informal comment before a final proposal is published.
  4. The criteria will also clarify the circumstances under which a facility may legally seek private payment from a Medicaid applicant.
- B. On August 21, 1986, TDHE will propose that the Board for Licensing Health Care Facilities authorize the initiation of rule-making upon a draft revision of the entire chapter regulating residential homes for the aged. This revision is expected to distinguish two levels of appropriate care and, at least to some extent, narrow the present gap between the highest level of care permitted in a home for the aged and the minimal level of required care justifying PAE approval.

II. Training Those who will Input the Decision

- A. Upon completion of the medical criteria rule-making and any procedural rule-making appropriate to implement this settlement, multiple training sessions will be conducted by TDHE for all those involved with the PAE process.

1. First, in-service training will be conducted for TDHE staff at Medicaid, Health Care Facilities, and Patient Care Advocates.
  2. Next, training for providers, medical personnel, and advocates will be conducted at geographically-convenient locations.
  3. The training will concentrate upon implementation of the new rules, but will also advise participants of Medicaid's expectations and probable policy interpretations.
  4. OGC and the Administrative Procedures Division have already agreed to participate with Medicaid. Co-sponsorship of such training programs and possible involvement as trainers will be considered for the Tennessee Health Care Association, Commission on Aging and area ombudsmen, Tennessee Hospital Association, Tennessee Association of Legal Service Agencies, Tennessee Medical Association, Tennessee Nurses' Association, and the organization of long-term care social workers.
- B. The ICF Manual will be revised to accord with the new rules and made available to anyone requesting a copy.

### III. Reaching a Final Administrative Decision

- A. The PAE Form will be amended to allow the identification of a single other person to receive copies of all materials pertaining to the PAE application. If the recipient has been adjudged incompetent, this correspondent will be the appointed guardian, but, in all other cases, the recipient will elect whether another is named and identify that person (e.g. relative, friend, advocate). If the "applicant" is a facility or provider, rather than the recipient, both the applicant and recipient will also receive copies of all such correspondence. The form will also state that the recipient has the right to communicate, in writing, directly with the Bureau of Medicaid, without regard to the identity of the original applicant. These amendments to the Form will be implemented within four (4) months of this settlement.
- B. Internal administrative review (i.e. "desk top review") will be completed within a set time frame. Such review period begins with the Bureau of Medicaid's actual receipt of the original PAE form and concludes with the final administrative decision, i.e. approval or denial.
1. PAE applications will complete the process of internal administrative review no later than eight (8) working days from their receipt.
  2. To facilitate such review, applicants, especially medical providers and health care facilities, will be trained and encouraged to provide all current and pertinent information, including medical records not

normally forwarded with the PAE form. Such applicants will be encouraged to retain copies of any submissions, should they be necessary for future consultation.

3. Further, applicants will be encouraged to file a PAE application as soon as a current resident is believed to be applying for Medicaid and will be required to immediately file a PAE application whenever an applicant for admission or a current resident is approved as financially-eligible for Medicaid. Should these PAE's be approved before TDHS certifies financial eligibility for nursing home care by issuing Form 2561, then the applicant must update the PAE every 30 days until such approval is received.

C. The Request for Further Information. (TDHE Form Letter DD214) will be eliminated.

1. If further information is needed in order to reach a decision upon a PAE application, the application will be denied.
2. If the missing information can be specifically identified in a particular case (e.g. "in order to fairly evaluate your need for nursing home care, we need records indicating why you were treated at St. Thomas Hospital during December, 1985, what happened to you while hospitalized, and what your condition was when you were discharged"), its absence will be cited as a reason for the denial.
3. If the missing information cannot be identified or its existence is not known (such as the case of the uninformative and facially-invalid PAE), its absence obviously cannot be noted.
4. The Notice of Denial will advise that the applicant has two options; either appeal or submission of further information within 30 days. If further information is submitted during this period or a clear indication is made that further information is forthcoming, and there is no indication that the recipient wishes to appeal pending review of the information, the application recycles through the steps outlined above in III(B) with a full review of the entire record and any denial followed by a new Notice of Denial. Any explicit or implicit assertion of the right to appeal will be treated as an appeal, whether or not further information accompanies the request. Such a submission will be evaluated for impact upon the decision to deny while the appeal progresses and, when appropriate, result in an approval, despite the pendency of the appeal.
5. For these purposes a "request for hearing" shall be defined, as at 42 CFR § 431.201, as a clear expression by the recipient, or his authorized representative, that he wants the opportunity to present his case to a reviewing authority.

6. Although "at risk", a facility will not be permitted to discharge a current resident who has been denied, if they request a hearing to appeal the denial.

D. Applicants must immediately inform the recipient and the recipient's designated representative upon being advised that a PAE application has been approved. The applicant must also advise of the effective date of the approval.

E. The Bureau of Medicaid will retain all documents received which refer to the PAE, at whatever stage of its process, and will not return the PAE to the applicant or recipient, if it is denied. If a PAE is approved for the date originally requested, the form and documents may be returned to the applicant for processing.

#### IV. Communicating the Final Administrative Decision

A. A letter or notice denying the PAE will be drafted in as simple format and language as is practical to communicate the information needed, and will be sent to the recipient, the applicant (if not the recipient), and the representative, if any, was named on TDHS Form 2562.

1. Denial notices will include a statement of the recipient's right to receive all Medicaid services, other than in-patient nursing home care. These notices will explain that the recipient's denial is based upon medical criteria, not financial eligibility. Whenever a denial is issued, the applicant facility will be required to forward all current and pertinent medical records to TDHE.

2. Denial notices will explain the option of administrative reconsideration upon the receipt of additional information (see III(c)4, above), advise that such new information will be evaluated and may result in approval of the PAE, tell the consequence of a failure to appeal (i.e. the administrative decision becomes a final decision upon the facts then known and upon the applicant's medical status upon the date of the PAE), inform that the request for a hearing must be in writing and include essential identifying information, and declare that the request for a hearing must be mailed to the Bureau of Medicaid within 30 days.

3. Notice will be given that, if a hearing is requested, the Bureau of Medicaid will examine the recipient's medical records and will physically examine the recipient. Thus, TDHE must be advised of any change in the recipient's location, as well as any major change in the recipient's health. The Notice will also state the time limitations and expectations, should a hearing be requested, and briefly outline the steps in the hearing process.

4. Denials will either incorporate, or enclose, a statement by the Tennessee Commission on Aging, advising recipients of available advocacy services for the elderly and legal services' agencies with addresses and telephone numbers.

B. Notices of Denial will include particulars, specific to the individual recipient.

1. These Notices of Denial will list the evidence reviewed in reaching the decision (e.g. "this decision was based only upon the facts stated on your PAE form", "...and Dr. Alzeheimer's report of January 1st," or "...and a physical examination made by Nurse Doctor on May 31st"). NOTE: Although probably not required by due process, this list should assist the recipient or applicant in determining whether further information should be submitted (e.g. "I thought they knew about my heart attack last month"), and preserves a record of the information then available, which would assist OGC in identifying missing pieces of a case file; permit an applicant's advocate to make decisions about discovery, investigation, and preparation; allow the administrative judge to appreciate the data available to the agency when an initial denial was made, in possible contrast to the evidence that may emerge at the hearing; may present a "defense" when a denial is based upon the best information then available, even though this later proves incomplete or inaccurate; and ease a decision as to whether the agency may switch reasons for the denial upon "newly-discovered evidence".
2. The Notice will recite the exact language of the specific medical criteria rule, or rules, upon which the agency bases its denial and which the agency opines that the recipient has failed to satisfy. No longer will a copy of the entire regulatory chapter accompany the denial. The reference will be as specific as possible, and as narrow as possible (i.e. reference to a subsection would be preferred to citation to a full rule), but must be multiple, if the decision is based upon the recipient's failure to satisfy more than one regulatory requirement.
3. The Notice will recite the particular facts shown in the total administrative record then known, which the agency finds support its legal conclusion that the recipient does not meet the regulatory medical care criteria.
4. Whenever a denial is issued, Medicaid will advise TDHE's Patient Care Advocacy Unit, who will monitor any transfer arrangements.

- C. A PAE denial will not be ripe to be heard in a contested case proceeding unless TDHS has previously certified the recipient's financial eligibility for nursing home care. Upon the TDHS approval, a new PAE may be submitted for initial evaluation, including any circumstances which may have changed since the last consideration. PAE denials issued before the TDHS Form 2562 has been

approved will be moot and may not be appealed, as the recipient's circumstances may change significantly before financial eligibility and as both approvals are necessary to grant relief.

## V. Contesting The Final Decision

### A. Before the hearing

1. Upon receipt of a request for a hearing, Medicaid's Medical Review Unit (MRU) will, within 5 working days, copy and transmit copies of the entire file to the Medicaid supervising attorney at OGC, to the medical professional (usually a regional nurse) who will visit the recipient's health care facility to inspect medical records, and to the physician who will perform the physical examination. If pertinent records are found, copies will be made and distributed, along with any impressions or other findings of the nurse/reviewer, to MRU, OGC, and the examining physician. MRU will determine whether this new information merits reconsideration of the decision and, if so, promptly complete this review, immediately advising both other TDHE groups if the decision is to approve.
2. MRU will then route its completed file to the Bureau Medical Director, who will review the final administrative decision.
3. The above two steps will be completed within 30 calendar days of the receipt of the request for a hearing.
4. Preferably within this same 30 days, but no later than 45 calendar days from the Bureau of Medicaid's receipt of the request for hearing, the designated physician will physically examine the recipient and transmit these findings to both MRU and OGC. This physician will have the authority to approve the PAE and will be TDHE's expert witness during the hearing.
5. On the 30th calendar day after Medicaid's receipt of the request for hearing, the OGC attorney assigned will transmit the case to the Administrative Procedures Division and will schedule a hearing in accord with APD's travel schedule, preferably between the 45th and 60th days.
6. Administrative Judges will, in the exercise of their independent discretion, make optimal use of pre-hearing conferences to narrow contested issues, to expedite the hearing, and to advise advocates of their expectations for the proof of facts and of their previous legal rulings in similar cases.

7. OGC's Medicaid supervising attorney, in consultation with the attorney assigned and with the approval of either the Deputy General Counsel, or General Counsel, may recommend to the Director of Medicaid that a PAE be granted due to insufficiency of the expected proof or by interpretation of law when applied to the facts known.

B. At the hearing

1. Except when evidence has been newly-discovered, TDHE will be bound by the legal reason stated in the Medicaid Notice of Denial. When new evidence is discovered subsequent to the issuance of the denial, but before the hearing, and when such evidence supports a new legal basis for the denial, TDHE/OGC will, in writing, advise the applicant, the recipient, the recipient's representative, the recipient's advocate, and the Administrative Judge at the earliest possible opportunity, but no later than 10 days before the case is scheduled to be heard. When new evidence, supporting another legal basis for the denial, is first and unexpectedly discovered during the course of the hearing or during the 10 days immediately before the contested case proceeding, the additional cause will be subject to the Administrative Judge's leave and discretion upon the OGC attorney's motion to amend.
2. To assist the Administrative Judge in expediting a ruling, \_\_\_\_\_ will arrange for a cassette tape recording to be made of the testimony, in addition to the official transcript recorded by the court reporter. This unofficial tape will be given to the Judge at the conclusion of the proof and may be used to refresh the Judge's memory during their preparation of the Final Order. Any conflicts will, of course, be resolved in favor of the official transcript. Expert witnesses will be asked to spell medical terms for clarity during the preparation of a Final Order.

C. After the hearing

1. While reserving the right to exercise their discretion in individual cases, the Administrative Judges will not routinely order the preparation of an official transcript, but will order a fragment or whole transcript only in closely contested cases dependent upon close interpretations of the testimony.
2. Although the Uniform Administrative Procedures Act allows an Administrative Judge 90 days after the hearing during which to issue an order, APD agrees to expedite PAE Final Orders, to issue them as soon as possible, and to target their issuance for within 30 days of the close of the proof.
3. The Final Order will be served by APD upon the applicant, recipient, representative, and advocate at the addresses provided by OGC upon the Litigation Transmittal Form.

4. If a Final Order has not issued by the 90th day following Medicaid's receipt of the request for a hearing, Medicaid will contingently approve the PAE, despite the pendency of the case and without the issuance of a judicial order. The PAE will be automatically granted, effective on the date shown on its face; the appropriate persons notified of this action; and, if the recipient then resides in a nursing home and a claim is submitted, the facility reimbursed for nursing home care retroactive to the first day of residence or the date of PAE approval, whichever date is the latter. This approval and the dependent reimbursement of the facility will continue until a Final Order issues to deny the application and the period to request reconsideration of the Final Order has expired. If the PAE is denied by the Final Order, there will be no recoupment of monies paid under this provision. If the PAE is approved by the Final Order, but eligibility is found to have begun on a date later than that shown on the face of the PAE, reimbursement during the earlier interval will not be recouped. The contingent approval upon the 90th day will neither moot the pending case, nor be evidence of medical criteria to be considered during the case, but is simply self-executing relief pending the outcome of the litigation. However, this provision will not apply if the delay is consequence of the continuance of a hearing, granted at the request of the recipient/applicant, or if the Administrative Judge finds that the delay is attributable to the recipient's inaction.