The Medicaid Application Process

David L. McGuffey[1]
Elder Law Practice of David L. McGuffey, LLC
202 W. Crawford Street, Suite B
Dalton, Georgia 30720
(706) 428-0888
www.mcguffey.net

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[1] Mr. McGuffey is a Certified Elder Law Attorney (NELF), and limits his practice to Elder Law. He is admitted to practice in Georgia, Tennessee and Michigan, and is admitted to practice before the Eleventh Circuit Court of Appeals, the Sixth Circuit Court of Appeals, District Courts for the Northern District and Middle District of Georgia, and the Eastern District of Tennessee. He presently serves as Chair, Tennessee Bar Association Elder Law Section, and as Vice Chair, Association of Trial Lawyers of America Nursing Home Litigation Group. He is actively involved in his community, serving on the Board of Directors of the Northwest Georgia Healthcare Partnership, the Georgia Chapter of the Alzheimer's Association (Local Northwest Georgia area); and the Ross Woods Adult Day Care Clinic. Mr. McGuffey is a member of the National Academy of Elder Law Attorneys and various other legal organizations.

I. Introduction

Medicaid is a means-tested entitlement program. The Medicaid program became law in 1965 as a jointly funded cooperative between the Federal and State governments to assist States in providing adequate medical care to eligible persons.[2] Federal contributions to each State are based on a State's willingness to finance covered medical services and a matching formula. Each State designs and administers its own program under broad Federal rules. The Centers for Medicare & Medicaid Services (CMS), within the U.S. Department of Health and Human Services (HHS), is responsible for Federal oversight of the program. In FY2002, total Federal and State spending on Medicaid reached $248,722,620,322, slightly exceeding total outlays for Medicare.[3] No other means-tested cash or non-cash program comes close to approaching this spending level. In fact, of all federally supported social programs, only Social Security costs more.

In 1994 the State of Tennessee implemented a new health care reform plan called TennCare.[4] TennCare extended coverage to the Medicaid population and coverage to individuals who were determined to be uninsured or uninsurable, using a system of Managed Care Organizations (MCO). Effective July 1, 2002, the Bureau of TennCare moved eligibility determination for TennCare Standard to the Department of Human Services. Eligibility now extends to adults whose income is less than 100% of poverty and children whose income is less than 200% of poverty and individuals who are determined to be medically eligible.[5] The determination of medical eligibility is made by an independent contract agency. The Tennessee Department of Finance and Administration administers the State's TennCare program and contracts with the Department of Human Services to determine eligibility for more than 40 different Medicaid-eligible groups and the new TennCare Standard program.[6]

Mary Smith: A Typical Medicaid Case

Mary Smith is a 75-year-old widow. She owns the farm she and her husband bought in 1948 (a home with 30 acres of contiguous property; potential commercial use; basis: $30,000; FMV: $250,000). Her primary income is a monthly Social Security check of $580,[7] but she also has $30,000 in savings and about $12,000 in mutual funds. She receives interest on the savings account. Last winter Ms. Smith fell and broke her hip, which left her confined to a wheelchair and no longer able to take care of herself. She has since suffered from recurrent urinary tract infections and suffers from delirium. Her condition has declined since then.

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2 *See* the Social Security Amendments of 1965 (P.L. 89-97), *generally*, 42 U.S.C. § 1396 et seq.

3 *See* Kaiser Family Foundation: *State Health Facts Online*: http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Total+Spending%2c+2002. In Tennessee, total spending in 2002 was 5,806,629,787. *Id*.

4 Tenncare is a Section 1115 waiver program. *See* http://www.cms.hhs.gov/medicaid/1115/tn1115tc.asp.

5 Regarding the 2004 Poverty Guidelines, *see* http://www.cms.hhs.gov/medicaid/eligibility/pov0104.pdf.

6 http://www.state.tn.us/humanserv/medi.htm.

7 If Mary's income was less than $564 per month (the SSI amount in 2004), then after her countable assets were "spent down," she would be eligible. *See* http://www.ssa.gov/OACT/COLA/SSIamts.html.

Although she has Medicare and an AARP Medi-Gap policy, she still owes about $5,000 for medical expenses not covered by her policy. Since being released from the hospital six months ago, she has been cared for by her family at home. Because her condition continues to deteriorate, her doctor has recommended a local nursing home that offers appropriate services for her needs.

Mary's family decides to place her in a nursing home, but they are unsure how to pay for it. Ms. Smith has no long term care insurance and Medicare will not pay for her long term care because she does not need the skilled level of care. (Also, there is no qualifying hospital stay). The facility her family has chosen charges $120 a day for the level of care that Ms. Smith needs. Ms. Smith's savings and investments will pay for only few months of care, so her family decides to apply for Medicaid. By calling the local Department of Human Services in the county where the nursing home is located, her family learns that Ms. Smith must meet the eligibility requirements to be approved for Medicaid: categorical need, medical need and financial need.

Opportunity to Apply

The opportunity to apply for Medicaid is extended to every individual who wishes to do so. *Medical Assistance Manual, Vol. I, Ch. 1, § II.B.1.*[8] *See also* 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.906.

Who May Apply

- The individual who requires assistance (the applicant);
- The applicant's responsible party;
    - The applicant who is unable to actively participate in the application process may be represented by his/her responsible party (R/P).[9] The R/P may be a relative, friend, guardian, conservator, or any individual in a position to know of the applicant's circumstances;
    - An individual confined to a long term care facility who has no relative or friend to act in his/her behalf may be represented by the facility administrator or another of its employees;
- The party acting on behalf of a deceased individual;
    - An application may be filed for deceased clients if they would have been eligible the month the application was filed or in any of the 3 months immediately preceding the filing month (i.e., the retroactive period).

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[8] References to the Medical Assistance Manual are based on the unofficial version reproduced by the Elder Law Section of the Tennessee Bar Association. A PDF version of that manual can be accessed online by Elder Law Section members. You should consult with your local caseworkers for manual updates.

[9] The phrase "responsible party" is used elsewhere in the long-term care setting and may have different meanings. For example, 42 C.F.R. § 483.10 authorizes a legal surrogate to exercise a nursing home resident's rights on his/her behalf even where there is no adjudication of incompetence. The phrase should not be confused with Social Security's "representative payee."

- The applicant who is an employee or relative of an employee of the Department of Human Services;
    - Eligibility must be determined by a supervisor other than the employee, or the employee's immediate supervisor, or an employee assigned to the Confidential Caseload. The District Director must be notified of the pending/actual application and will assign it to an appropriate non-involved supervisory staff member. The staff member may be the local or district office.
    - The case record for the employee or employee's relative must be kept in secure files in the local or district offices, as applicable. The case record must be inaccessible to other staff.

See Medical Assistance Manual, Vol. I, Ch. 1, § II.B.2; 42 C.F.R. § 435.908.

> **Comment**: In the example cited above, Mary, her family or their attorney may apply for benefits. If the attorney does so, good practice suggests that the law firm secure a Limited Power of Attorney at the time the client signs the fee agreement (or engagement letter). The law firm should also secure release forms from clients allowing it to obtain other necessary information such as medical records and financial information.[10]

Filing the Application

Applications for Medicaid and TennCare Standard may be obtained at the Department of Human Services with locations in each of Tennessee's 95 counties.[11] Applications are available in English or Spanish and can be mailed or taken to your local Department of Human Services office.[12] Office locations can be found at http://www.state.tn.us/humanserv/st_map.htm. After filing a signed application, an interview will be scheduled with an Eligibility Counselor. Certain documents may be requested such as Social Security cards, (except for undocumented aliens), birth certificates, bank statements, insurance policies, pay stubs, tax returns and medical bills. All Medicaid/TennCare applicants are required to meet citizenship requirements, provide a social security card or apply for one, be a resident of Tennessee, assign third party benefits and be willing to apply for other benefits.[13] If any individual needs assistance in providing any of the above items, assistance will be offered at the time of the interview. Applications are processed in 45 days except disability-based cases, which are allowed up to 90 days processing time.[14]

The application process, requires a showing that the applicant meets three eligibility criteria: technical (or categorical), medical and financial. As noted above, eligibility is reviewed by agencies designated by the Governor. *See* T.C.A. § 71-5-106(a).[15] In Tennessee, the

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[10] T. Begley & J. Jeffreys, *Representing the Elderly Client: Law & Practice* § 16.02[B] (Panel 2003) (hereinafter, "Begley").

[11] 42 U.S.C. § 1396a(a)(1).

[12] The application is also online at: http://www.state.tn.us/humanserv/hs-0169.pdf.

[13] These issues are addressed *infra*.

[14] http://www.state.tn.us/humanserv/medi.htm#apply.

[15] The text of Section 106 reads, in part: "The departments of health and human services, as may be designated by the governor, shall make the determination of eligibility under this part, subject to approval of the

Department of Human Services (Division of Medical Services), makes the determination of Medicaid eligibility.[16] *See* T. Takacs, *Elder Law Practice in Tennessee, 2nd Edition* § 5.05(b) (LexisNexis 2004) (hereinafter "Takacs"); *See* Tenn. Comp. Rules & Regs, Rule 1200-13-12-.02(1)(b); and 1200-13-13-.02(1)(b).

Pre-filing Considerations: Spousal Resource Assessment

In spousal cases (those where one spouse is healthy[17] and the other is institutionalized)[18], a resource assessment may be sought prior to filing of the Medicaid application. *See* Takacs, *supra*, § 8.02(a). *See also* 42 U.S.C. § 1396r-5(c)(1)(B); *and see* D. McGuffey, *The CSRA, MMMNA and Related Issues*, http://www.mcguffey.net/communityspouse.pdf.

The purpose of the resource assessment is two-fold:

- To fix the "snapshot" date; and
- To set aside the Community Spouse Resource Allowance (CSRA).

Initially, all assets (*see* Financial criteria, *infra*) are categorized as countable or exempt. Countable assets are valued. However, the couple's asset pool may change over time, so the issue becomes "which value" is used in conjunction with the eligibility determination. The "snapshot date" is the day that the institutionalized spouse became a patient in a health care facility for more than 30 continuous days. *See* Takacs, § 8.02(b); Tenn. Comp. R. & Regs. Ch. 1240-3-3-.02(9).

Documents typically requested during the resource assessment include:

- Identity papers: Social Security cards, driver's license, Medicare cards, and birth certificates;[19]
- Proof of residence: Rent receipts, mortgage payment book, property tax statement, homeowner's insurance;
- Marital status: Marriage certificate;
- Citizenship status: Birth certificate, passport, immigration papers;
- Utility expenses: Utility bills or cancelled checks;
- Life insurance: Policies; statements;
- Prepaid funeral: Contracts, policies;

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finance, ways and means committees of the senate and the house of representatives and the general welfare, health and human resources committee of the senate and the general welfare committee of the house of representatives. Such determination of eligibility may be accomplished through contractual agreement with agencies of the federal government."

[16] 42 U.S.C. § 1396a(v). The State must apply the definition of disability and blindness found in [42 U.S.C.] § 1382c(a).

[17] The Community Spouse, 42 U.S.C. § 1396r-5(h)(2).

[18] The Institutionalized Spouse, 42 U.S.C. § 1396r-5(h)(1).

[19] The CDC has information on its website regarding where to write for vital records. For Tennessee, that information is posted at: http://www.cdc.gov/nchs/howto/w2w/tennesse.htm.

- Income: Payroll check stubs, W-2 forms, 1099 forms, employer's statements, Social Security benefit statements, pension or retirement benefit statements;
- Resources: Bank account statements, certificates of deposit, savings bonds, motor vehicle titles, deeds, brokerage account statements, mutual fund statements.[20]

The CSRA is a portion of the couple's assets that is set aside for the benefit of the Community Spouse. In Tennessee, the CSRA is called the "Protected Resource Amount." Under the default rules, one-half of the couple's assets is set aside for the Community Spouse. The default rules are bracketed by a maximum and minimum CSRA.[21] In 2004, the maximum CSRA is $92,760 and the minimum CSRA is $18,552.[22] If the couple is required to spend down assets to enable the Institutionalized Spouse to qualify for Medicaid, they will want to spend the Institutionalized Spouse's countable assets rather than the CSRA.

Timing: When to File the Application

There are two considerations with a Medicaid application. The first is to avoid filing an application during a look-back period if the amount of the transfer would result in a penalty in excess of the look-back period. The second is to avoid any possibility of committing a criminal offense.[23] Good practice suggests that no application be filed during any penalty period.[24] An additional timing consideration relates to the "**Blumberg election**,"[25] which is covered separately in the Medicaid Planning session of this seminar.

- If an applicant transfers assets within the lookback period for less than fair market value in a transaction that is not exempt (e.g., does not involve a spouse, or transfer of principal residence to a sibling with equity interest who has resided in home for at least one year, transfer to blind or disabled child), then a penalty will apply.[26] The inquiry begins as of the baseline date, which is the later of the date the transfer was made, or the date of application for Medicaid benefits. The state then "looks back" for 36 months (or back 60 months in the case of a transfer to or from a trust) to determine whether there were transfers for less than fair market value during that period. 42 U.S.C. §1396p(c)(1)(A). If so, then a penalty (or disqualification) period is imposed which is roughly equivalent to the value of nursing home care that was given away. For example, if the applicant transferred assets valued at $50,000 to his child, and then finds herself needing nursing home care three months later, then the transfer for less than fair market value must be disclosed if she applies for Medicaid benefits on admission. She will be denied benefits for a period of time equal to the value of the asset divided by the average monthly cost of nursing home care as determined by the state. As of July 2004, the state determined that average cost to be $3,394 per month, so the applicant will be disqualified for 14 months.[27] By waiting another eleven months before applying for Medicaid, the applicant

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20 Takacs, *supra*, § 6.08(a).
21 42 U.S.C. § 1396r-5(f)(2).
22 For the current year's numbers, *see* http://www.cms.hhs.gov/medicaid/eligibility/.
23 Begley, *supra*, § 16.02[D].
24 Takacs, *supra*, § 7.02(a).
25 *Blumberg v. Tennessee Dep't of Human Servs.*, 2000 Tenn. App. LEXIS 709 (2000).
26 Exempt transfers are listed at 42 U.S.C. § 1396p(c)(2).
27 Fractions are dropped.

can avoid the imposition of the “look back” entirely. If the applicant requires nursing home care during that period of time, she will have to pay for it privately.

- Using the same example as before, assume the gift was $200,000. The penalty period would be 58 months. If the gift is made and, 37 months later a Medicaid application is filed, then the gift is beyond the lookback period and is ignored for eligibility purposes. It is worth noting, however, that while the lookback period is capped, the penalty period is not. Thus, if the applicant makes the $200,000 gift and applies for Medicaid 35 months later, her penalty is 58 months from the date of the transfer.
- A gift can be cured by returning a transferred asset to the applicant. *Medical Assistance Manual, Vol. I, Ch. 15, §IV.C.3.d*; *see also* Takacs, *supra*, § 7.02(a)(2).
- *Bolton v. State Dep't of Human Servs.*, 2003 Tenn. App. LEXIS 435. To better understand the issues in this appeal, an overview of the applicable Medicaid laws is helpful. The Tennessee Medicaid program provides medical assistance to low income persons who are in need of medical care. *See* Tenn. Code Ann. § 71-5-106 (1995). In order to qualify for benefits under the program, an applicant must have no more income or assets than is permitted under Medicaid's maximum income and asset eligibility requirements. The Medicaid program anticipates that, in order to qualify for benefits, some applicants will transfer assets to family members or others, thereby lowering the value of [*4] the assets they own to a level below the maximum set out in the applicable regulations. *See In re: Conservatorship of Groves*, 109 S.W.3d 317, 2003 Tenn. App. LEXIS 112, 2003 WL 288436, at *23 (Tenn. Ct. App. Feb. 11, 2003) (noting that the Medicaid and TennCare programs "anticipate that persons seeking benefits may attempt to pauperize themselves in order to qualify for benefits"). Therefore, anyone who applies for Medicaid benefits must disclose any transfer for less than market value that occurred after the "look-back" date, which is the date thirty-six months (or three years) n2 prior to the application for benefits. n3 *Id.*; Tenn. Comp. R. & Regs. Ch. 1240-3-3-.03(3)(b); 42 U.S.C. § 1396p(c)(1)(B)(1) (Supp. 2002). **If such a transfer was made, the applicant is ineligible for benefits for a period of time referred to as a "penalty period," which is calculated by dividing the uncompensated value of the transferred asset by the average monthly cost of nursing home care**. Tenn. Comp. R. & Regs. ch. 1240-3-3-.03(3)(b).
- The snapshot date and resource assessment are described above. If an application for Medicaid is not filed for an extended period following the resource assessment, values assigned to given assets may require re-assessment, because market values of some assets may differ dramatically in just a few months. According to the Medical Assistance Manual, assets are “evaluated according to their equity value,” i.e. the current fair market value in the local market minus any liens or other encumbrance. *Medical Assistance Manual, Vol. I, Ch. 15, §I.B.3* (12/19/91). In Tennessee, the rules of evidence allow an owner of personal property to testify as to its value to him or her. *See* Rule 701(8), Tennessee Rules of Evidence; *Merritt v. Nationwide Warehouse Co.*, 605 S.W.2d 250 (Tenn. App. 1980); *Airline Construction, Inc. v. Barr*, 807 S.W.2d 247 (Tenn. App. 1990), *cert. denied* (Tenn. 1991); *Adair v. Scalf*, 2003 WL 261932 (Tenn. App. 2003).

In-person Application

If the individual or his/her responsible parties applies in person, the date on which the applicant applies and signs the application is the filing date.

The individual may apply in person at the local community office of the Department of Human Services located in the county where he/she resides; or if confined to a long term care facility, in the county where the long term care facility is located; or a hospital, which may or may not be the county of residence. *Medical Assistance Manual, Vol. I, Ch. 1, § II.B.3.a*; *see also* 42 C.F.R. § 435.914.

Some applicants may walk in or drop off documents. The procedure applicable in these cases is addressed in DHS Bulletin No. 25 (June 29, 2004).

Telephone Request

The individual may request an application by telephone and one will be mailed to him/her within 24 hours of the request.

He/she should return the application either by mail or in person to the county office as specified at *Medical Assistance Manual, Vol. I, Ch. 1, § II.B.3.a* (*supra*). The date the application is received in the county office is the application filing date. *Medical Assistance Manual, Vol. I, Ch. 1, § II.B.3.b*.[28]

Application filed at Hospital

If the client applies for assistance at a hospital, the hospital Case Manager (CM) should register the client and determine through statewide clearance whether he/she is active in the hospital county, or another county.

If it is determined that the client already has an active case, the worker responsible for the active case should be contacted to let him/her know that the client is applying for additional benefits at the hospital. *Medical Assistance Manual, Vol. I, Ch. 1, § II.B.3.d.*

County Responsibility

If the applicant moves before an eligibility determination is completed, the application remains in the county where it was originally filed for processing. After processing, it is transferred to the new county of residence. *Medical Assistance Manual, Vol. I, Ch. 1, § II.B.3.c.*

Written Application Required

A written application signed by the applicant or his/her responsible party is required. *Medical Assistance Manual, Vol. I, Ch. 1, § II.B.4. See also* 42 C.F.R. § 435.907.

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[28] Bulletin No. 25 (June 29, 2004), states: "when an individual is not seen by a caseworker, the county office will record when an application or information is received in the county office."

It is good practice to complete the application and submit it with all of the necessary exhibits attached. Begley, *supra*, § 16.02[E]. Experience suggests that another way of proceeding is to take all necessary information to the in-person interview and provide it *as it is requested*. The Case Worker may not need or want all of the information in your possession.

Assistance with the Application

The applicant may be assisted in completing the application by any individual(s) of his/her choice.

The Case Manager may assist the applicant in completing the application if:

- The applicant requests assistance; **and**
- The Case Manager documents the request in the case record.

See Medical Assistance Manual, Vol. I, Ch. 1, § II.B.5; *see also* 42 C.F.R. § 435.908.

Typically, nursing home residents are not capable of completing the application, either for physical or mental reasons. Thus, nursing facilities often approach a family member about becoming the resident's "responsible party." The responsible party terminology should not be confused with "representative payee," which is the Social Security Administration's term for someone who receives a Social Security or SSI check on behalf of a recipient who is unable to manage his or her own funds.

Interview Requirement

A face-to-face interview at application is required with either the applicant; or the applicant's responsible party if the applicant is unable to participate in the application process. *Medical Assistance Manual, Vol. I, Ch. 1, § II.B.6.*

The manual notes that a telephone interview of home visit can be conducted if the applicant or his/her responsible party is unable to come to the county office for a face-to-face interview.

Establishing the Applicant's Identity

The Manual indicates that Case Workers must: Establish the applicant's identity through the verification of his/her Social Security account number and at least one other piece of identification such as a driver's license. They must also determine whether the applicant has ever applied for benefits under another name or has an alias. *Medical Assistance Manual, Vol. I, Ch. 1, § II.B.7.*

Processing Time Limit

Federal regulations specify the following maximum time limits for processing the application. A notice should be mailed:

- For individuals applying on the basis of disability: within 90 days from the application filing date;
- For all other applicants: 45 days from the application filing date.

See Medical Assistance Manual, Vol. I, Ch. 1, § II.B.9; *see also* 42 C.F.R. § 435.911.

The time limits for processing an application can be exceeded in certain cases, such as the following:

- If there is an administrative or other emergency beyond the Case Manager's control; or
- The applicant delays or fails to take a required action in a timely manner; or
- An examining physician delays of fails to take a required action in a timely manner.

Adequate Notice

Once eligibility is determined, a notice is generated and sent to the applicant and his/her responsible party which includes: the decision regarding the individual's eligibility; and, if eligibility is denied, the specific reasons for the denial and citations of specific regulations that support the action.

Medical Assistance Manual, Vol. I, Ch. 1, § II.B.10.

Information Released; HIPAA Notice

Tenn. Comp. Rules & Regs, Rule 1200-13-13-.02(2)(c) provides that by applying for TennCare Medicaid, an applicant grants permission and authorizes release of information to the Bureau, or its designee, to investigate any and all information provided, or any information not provided if it could affect eligibility, to determine TennCare eligibility; and if approved, what cost sharing, if any, may be required of the applicant as found in these rules. Information may be verified through, but not limited to, the following sources:

- The United States Internal Revenue Service (IRS);
- State income tax records for Tennessee or any other state where income is earned;
- The Tennessee Department of Labor and Work Force Development, and other employment security offices within any state whereby the applicant may have received wages or been employed;
- Credit bureaus;
- Insurance companies;
- Any other governmental agency, or public or private source of information where such information may impact an applicant's eligibility or cost sharing requirements for the TennCare Program.

The Department may share protected health information (PHI) supplied by the applicant, or the sources listed above, with others. TennCare's (HIPAA)[29] privacy notice is posted at: http://www.state.tn.us/tenncare/Members%20Privacy.htm.

Effective Date of Coverage

Eligibility for Medicaid/Tenncare benefits begins on the date of application if the individual is eligible on that date; or the date on which the individual meets all eligibility requirements, whichever is later. This date is called the start date, the effective date or the beginning date. *Medical Assistance Manual, Vol. I, Ch. 1, § III.A*; 42 C.F.R. § 435.914.

Retroactive eligibility, for up to three months, is authorized if the applicant met eligibility criteria during that period. 42 C.F.R. § 435.914(a).

II. Eligibility Criteria

Ordinarily, eligibility is covered separately and will be covered in more detail by other speakers. The purpose here is to identify issues that should be considered when preparing the application and any necessary appeals.

A State may not impose any eligibility requirement that is prohibited under Title XIX of the Social Security Act [42 U.S.C. § 1396]. 42 C.F.R. § 435.401(a); Tenn. Comp. R. & Regs. Ch. 1240-3-3-.01 et seq.; Tenn. Comp. Rules & Regs, Rule 1200-13-12-.02.

Medicaid eligibility is established when all eligibility criteria are met. Medicaid eligibility criteria are threefold: Technical criteria (including Categorical eligibility); Medical criteria; and Financial criteria.[30]

Technical criteria

To establish technical eligibility for nursing home Medicaid, an applicant must be 65 or older, a U.S. Citizen or lawfully admitted alien, a resident of Tennessee and have been treated for a continuous period of 30 days in a medical facility. 42 C.F.R. § 435.211; Tenn. Comp. Rules & Regs, Rule 1240-3-3-.02; and 1200-13-13-.02.[31] Technical eligibility criteria and the citations are summarized as follows:

- A U. S. citizen or an alien admitted for permanent residence or permanently residing in the U.S. under color of law (including any alien lawfully present in the U.S. under section

[29] Health Insurance Portability and Accountability Act of 1996. *See, generally*, D. McGuffey, *An Overview: What is HIPAA?: A Patient Advocate's Perspective (2003)*, http://www.mcguffey.net/HIPAA.pdf.

[30] Regan, Morgan & English, *Tax, Estate & Financial Planning for the Elderly* §10.03 (Matthew Bender & Company, Inc. 2003) (hereinafter, "Regan"); *see also* Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov/medicaid/eligibility/criteria.asp.

[31] http://www.state.tn.us/sos/rules/1240/1240-03/1240-03-03.pdf.

203(a)(7) or 212(d)(5) of the Immigration and Nationality Act. *See* 42 C.F.R. § 435.406 (citizens) and 435.408 (aliens).[32]

- A resident of Tennessee with an established residence in this state and an intent to remain in Tennessee. *See* 42 C.F.R. § 435.403.[33]
- Age 65 or older, blind, and/or disabled (Disability is determined under Social Security guidelines). *See* 42 C.F.R. § 435.520 (age); 435.530 to 531 (blindness); 435.540 to 541 (diasability).
- Under age 21 or caretaker of a child deprived of parental support. See 42 C.F.R. § 435.220 to 435.229.
- Enumeration – have a valid social security number or filed an application for a number. 42 C.F.R. § 435.910; Tenn. Comp. Rules & Regs, Rule 1240-3-3-.02(10); *see also Medical Assistance Manual, Vol. I, Ch. 5, § I.A.*

In addition, Medicaid eligibility can be divided into three groups, which are also called classes of assistance, each having it own financial criteria: (a) mandatory categorically needy; (b) optional categorically needy; and (c) medically needy. A State must allow an individual who is eligible for more than one category of Medicaid to have his eligibility determined for the category he selects. 42 C.F.R. § 435.404.

The Health and Human Service's website[34] describes the first two groups, jointly, as follows:

- Recipients of Families First Cash Assistance;
- Pregnant women and certain children of a specified age (to age 19) whose family gross income does not exceed the Federal Poverty Level Income Standard. If a woman is eligible during her pregnancy, she will receive two months of postpartum coverage;
- Medicaid only - Ineligible for Families First because of a requirement which does not apply in Medicaid;
- Transitional Medicaid - Medicaid is available for 18 months after a participant leaves the Families First Program;
- Newborns are eligible for their first year when born to a Medicaid eligible woman. Caretakers of Deprived SSI-eligible children;
- Recipients of Supplemental Security Income (SSI);[35]
- Institutionalized individuals: aged, blind or disabled who would be SSI or FF eligible except for their institutionalization. Individuals receiving Home and Community Based Services (HCBS) are considered institutional;

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[32] The following documentation should be sufficient to establish citizenship: birth certificate, U.S. Passport, United States Citizen Identification Card, Report of Birth Abroad of a Citizen of the United States, Certification of Birth issued by a foreign service post. Begley, *supra*, 16.04[D]. *See also* Regan, *supra*, § 10.04.

[33] 42 C.F.R. § 435.403(d) defines: *Who is a resident*? *See also* Regan, *supra*, § 10.04 ("If the person is over 21 and not capable of stating intent, the state of residence is the state in which the individual is living or is physically present.").

[34] http://www.state.tn.us/humanserv/medi.htm#groups. *See also, Medicaid Manual, Vol. I, pages 2-7*.

[35] Tennessee is an SSI State, meaning that all persons who qualify for SSI also qualify for Medicaid. The Medicaid Manual provides that Medicaid is automatically extend to SSI recipients and no separate eligibility determination is required, *citing* 42 C.F.R. § 435.120. *See* Tenn. Comp. Rules & Regs, Rule 1200-13-12-.02(1)(c).

- SSI Pass-Along or Title II terminations: individuals who receive Social Security and lost SSI eligibility since 4/1977, and who would still be eligible for SSI if their cost of living adjustments were deducted. Includes Disabled Adult Children (DAC);
- Pickle Cases : Individuals who receive Social Security, and lost SSI since 4/1977, for any reason and would be eligible if cost of living adjustment were disregarded. Includes Disabled Widow(er)s who lost SSI due to elimination of the actuarial reduction factor; those at age 60 who lost SSI due to Title II retirement entitlement or who became eligible for Title II due to change in SSA Disability criteria for widow(er)s effective 1/1/1991, and who do not have Medicare coverage;
- Qualified Disabled Working Individuals (QDWI) - disabled working individuals under age 65 and entitled to Medicare premium paid (Part A), if income < 200% of poverty and resources do not exceed 200% of the SSI limit. [Effective 7/1/1990];
- Qualified Medicare Beneficiary (QMB) coverage provides Medicaid coverage of Medicare covered services by paying the Medicare premium, coinsurance and deductibles of eligible individuals. The individual must be eligible for Medicare Part A (hospital insurance) and meet income and resource standards;
- Special Low Income Medicare Beneficiary (SLMB) pays Part B premium only for individuals whose income is equal or less than 120% poverty level and meet resource test;
- Qualifying Individuals (QI1) pays Part B premium on "first come, first served" basis as allowed by 100% federally financed state allocation if all requirements are met for SLMB except that income is greater that 120% of poverty level but does not exceed 135% of poverty level;
- Qualifying Individuals (QI2) pays the cost differential due to the shift of home health services from Part A to Part B Medicare coverage for individuals meeting QI1 criteria but exceeds 135% of poverty and is equal to or less than 175% of poverty.

Federal law defines **Mandatory categorically needy** at (42 U.S.C. § 1396a(A)(10)(A)(i)) and defines **Optional categorically needy** at (42 U.S.C. § 1396a(a)(10)(A)(ii)). At the State's option, **Medically Needy** individuals may also be served. (42 U.S.C. § 1396a(a)(10)(C)). The Department of Human Services website[36] describes the following "medically needy" categories:

- Medical Assistance for Children - children who are under the age of 21 who meet technical and financial requirements. Their caretakers are eligible if deprivation exists or the caretaker is pregnant or under age 21.
- Pregnant women - pregnant women who meet Medically Needy technical and financial requirements during their pregnancy, if eligible will also receive the two months post partum coverage.
- Children in Psychiatric Facilities - children under age 21 receiving active inpatient treatment in an accredited psychiatric facility or program.
- Non-institutionalized Aged, Blind, or Disabled Individuals - those individuals in private living arrangements meeting SSI eligibility requirements except for income greater than the SSI-FBR or Medically Needy income standards and who have large medical expenses.

[36] http://www.state.tn.us/humanserv/medi.htm#needy. *See also, Medicaid Manual, Vol. I, pages 8 and 9.*

- Institutionalized Aged, Blind or Disabled Individuals - Those individuals confined to long term care facility or medical facility or enrolled in Home and Community Based Services for at least 30 consecutive days and whose income does not exceed 300% of the SSI-FBR and who have large medical expenses.[37]
- Spenddown Program - Medically Needy individuals are those who have medical bills greater than their income and meet all technical requirements of the Medicaid program.

A detailed review of specific eligibility criteria for each class of assistance is beyond the scope of these materials. It should be noted, however, that each class of assistance is unique. For example, eligibility for nursing home Medicaid takes into account financial limits on income and assets; other programs limit the inquiry to income.

An applicant must satisfy all eligibility criteria to be approved for Medicaid benefits. 42 U.S.C. § 1396(a)(34); 42 C.F.R. § 435.914; Tenn. Comp. Rules & Regs. Rules 1240-3-2-.02(f); 1240-3-2-.03(2); 1200-13-12-.02; and 1200-13-13-.02; *Medical Assistance Manual, Vol. I, Ch. 1, § III.A.* The effective date of eligibility for benefits is the date of application, if the person meets all of the eligibility requirements on that date, or on the date when eligibility criteria are met if later. Retroactive eligibility for up to three months. *Medical Assistance Manual, Vol. 1, Ch. 16, § I.C and IV.A.a & b.* Processing of the application by both DHS and Tenncare should be completed within 45 days, absent authorized delays, such as a delay in receiving medical results or examination findings to be submitted by the applicant's physician, or waiting for verification of financial data by the applicant. 42 C.F.R. § 435.911; *Medical Assistance Manual, Vol. I, Ch. 1, § II.B.9.*

Medical Criteria

General Rule

Each State is responsible for the administration and enforcement of Pre-screening and Annual Resident Reviews (PAS).[38] The purpose of the PAS is to determine whether institutional placement (if applicable) is appropriate.[39] While medical eligibility is evaluated for each class of assistance, and eligibility criteria varies, here we limit the inquiry to nursing home Medicaid. The inquiry would be different, for example, in the context of a Katie Beckett waiver.

An applicant must demonstrate that he or she meets the medical criteria for Medicaid eligibility. A separate application form, called a "Pre-Admission Evaluation" must be completed and sent to the Tenncare Bureau for processing and approval.[40] The PAE needs to be approved within 90 days of the person's admission to the nursing facility. Tenn. Comp. Rules and Regs Rule 1200-13-1-.10(2)(e) (Oct. 2003). The individual must also undergo a Pre-Admission

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[37] In 2004, 300% of the SSI rate is $1,692. For States without a Medically Needy Spenddown program, such as Georgia after September 1, 2004, a Qualified Income Trust (or Miller Trust), 42 U.S.C. § 1396p(d)(4)(B), moves them into this category.

[38] Begley, *supra*, § 16.02[H]; 42 C.F.R. § 483.104.

[39] 42 U.S.C. § 1396r(e)(7).

[40] http://www.state.tn.us/tenncare/form/PREADMISSION%20EVALUATION%20FOR%20NURSING%20FACILITY%20CARE%202.pdf.

Screening and Annual Resident Review (PASARR) Level 1 assessment by the Tennessee Department of Mental Health and Mental Retardation to determine if there is a need for mental health services that can only be provided in a long term care setting. Tenn. Comp. Rules and Regs. Rule 1200-13-1-.10(2)(h) (Oct. 2003); *Smith v. Chattanooga Medical Investors, Inc.*, 62 S.W.3d 178 (Tenn. App. 2001).

To demonstrate medical eligibility for nursing home care, the applicant must need long term nursing home care. Two levels of nursing care are reimbursed by Medicaid: Medicaid Level 1 and Medicaid Level 2. Tenn. Comp. Rules and Regs Rules 1200-13-1-.10(4) & (5) (Oct. 2003). Level 2 is known as "skilled nursing care," and is covered in part by Medicare.[41] Each is outlined below:

Pursuant to Rule 1200-13-1-.10(4), to establish eligibility for Medicaid Level 1 Care in a Nursing Facility:

> (b) An individual must meet both of the following criteria in order to be approved for Medicaid reimbursed Level 1 care in a Nursing Facility:
>
> 1. MEDICAL NECESSITY OF CARE: Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.
>
> 2. NEED FOR INPATIENT NURSING CARE: The individual must have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. The individual must be unable to self-perform needed nursing care and must meet or equal one or more of the following criteria on an ongoing basis:
>
> (i) TRANSFER - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis. (daily or multiple times per week).
>
> (ii) MOBILITY - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.
>
> (iii) EATING - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.
>
> (iv) TOILETING - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).
>
> (v) EXPRESSIVE AND RECEPTIVE COMMUNICATION - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of

[41] Medicare will pay for 100% of days 1 through 20 if the necessity for skilled care continues following a qualifying hospital stay. If additional skilled care is necessary, then after the nursing home resident pays the daily co-pay (in 2004, $109.50), Medicare pays the balance. Some Medi-gap policies provide coverage for the daily co-pay. It should be noted, however, that Medicare days are not guaranteed; if skilled care is no longer necessary, Medicare coverage terminates.

pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.

(vi) ORIENTATION - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).

(vii) MEDICATION ADMINISTRATION - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.

(viii) BEHAVIOR - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement).

(ix) SKILLED NURSING OR REHABILITATIVE SERVICES - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit. The intent is that the above criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.

3. If an individual who seeks admission to a Nursing Facility has an established and persistent pattern of aggressive behavior that has previously endangered the health or safety of others, there must be a statement attached to the PreAdmission Evaluation that describes such pattern of behavior and outlines specific care needs for the individual to ensure the health and safety of others.

(c) For continued reimbursement of Medicaid Level 1 care in a Nursing Facility, an individual must continue to be financially eligible for Medicaid reimbursement for Nursing Facility Care and must meet both of the following continued stay criteria:

1. MEDICAL NECESSITY OF CARE: Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.

2. NEED FOR INPATIENT CARE: The individual must have a physical or mental condition, disability, or impairment that continues to require the availability of daily inpatient nursing care.

(d) A Nursing Facility Eligible admitted to a Nursing Facility before the effective date of this rule must meet continued stay criteria in effect at the time of admission.

Pursuant to Rule 1200-13-1-.10(5), to establish eligibility for Medicaid Level 2 Care in a Nursing Facility:

(5) Criteria for Reimbursement of Medicaid Level 2 Care in a Nursing Facility:

(b) An individual must meet both of the following criteria in order to be approved for Medicaid reimbursed Level 2 care in a Nursing Facility:

1. MEDICAL NECESSITY OF CARE: Care in a Nursing Facility must be expected to improve or ameliorate the individual's physical or mental condition, to prevent a deterioration in health status, or to delay progression of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis.

2. NEED FOR INPATIENT SKILLED NURSING OR REHABILITATIVE SERVICES ON A DAILY BASIS: The individual must have a physical or mental condition, disability, or impairment that requires skilled nursing or rehabilitative services on a daily basis or skilled rehabilitative services at least five days per week when skilled rehabilitative services constitute the primary basis for the approval of the PreAdmission Evaluation. The individual must require such services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit. In addition, the individual must be mentally or physically unable to perform the needed skilled services or the individual must require skilled services which, in accordance with accepted medical practice, are not usually and customarily selfperformed. For interpretation of this rule, the following shall apply:

(i) Administration of oral medications, ophthalmics, otics, inhalers, subcutaneous injections (e.g., fixed-dose insulin, subtherapeutic heparin, and calcitonin), topicals, suppositories, nebulizer treatments, oxygen administration, shall not, in and of itself, be considered sufficient to meet the requirement of (5)(b)2.

(ii) Nursing observation and assessment, in and of itself, shall not be considered sufficient to meet the requirement of (5)(b)2. Examples of nursing services for which Level 2 reimbursement might be provided include, but are not limited to, the following:

(I) Gastrostomy tube feeding;
(II) Sterile dressings for Stage 3 or 4 pressure sores;
(III) Total parenteral nutrition;
(IV) Intravenous fluid administration;
(V) Nasopharyngeal and tracheostomy suctioning;
(VI) Ventilator services.

(iii) A skilled rehabilitative service must be expected to improve the individual's condition. Restorative and maintenance nursing procedures (e.g., routine range of motion exercises; stand-by assistance during ambulation; applications of splints/braces by nurses and nurses aides) shall not be considered sufficient to fulfill the requirement of (5)(b)2. Factors to be considered in the decision as to whether a rehabilitative service meets, or continues to meet, the requirement of (5)(b)2. shall include, but not be limited to, an assessment of the type of therapy and its frequency, the remoteness of the injury or impairment, and the reasonable potential for improvement in the individual's functional capabilities or medical condition.

These conditions are expected to be continual and ongoing, and not a matter of an isolated lapse or exceptional occurrence. *See Jaco v. Department of Health, Bureau of Tenncare*, 1999 WL 346241 (Tenn. App. 1999).

Financial Eligibility

Tennessee Medicaid Allowances for 2004	
Resource Allowance for an Individual	$2,000.00
Resource Allowance for Couple (both husband and wife are in a nursing home)	$3,000.00
Minimum Community Spouse Resource Allowance (CSRA)	$18,552.00

Tennessee Medicaid Allowances for 2004	
Maximum Community Spouse Resource Allowance (CSRA)	$92,760.00
Minimum Monthly Maintenance Needs Allowance (MMMNA)	$1,562.00
Maximum Monthly Maintenance Needs Allowance (MMMNA)	$2,319.00
Nursing Home Resident's Monthly Personal Needs Allowance	$30.00
Shelter Standard	$468.60
Standard Utility Allowance	$187.00
Divestment Penalty Divisor	$3,394.00

Table 1

In general terms, financial eligibility criteria for various classes of assistance is available at http://www.state.tn.us/tenncare/eligible.html. *See also* Takacs, *supra*, § 5.05(c). Most often, when Medicaid Planning is done, it centers on financial criteria. Therefore, financial eligibility criteria and rules are covered in a different session.

III. Appealing a Denial

The State Plan must provide an opportunity for a fair hearing before the State agency to any individual who is denied benefits or whose application is not acted upon with reasonable promptness. 42 U.S.C. § 1396a(a)(3). The State Plan provides that hearings are available which meet the requirements of 42 C.F.R. Part 431, Subpart E.[42] *See*, *generally*, Tenn. Comp. R. & Regs. Ch. 1200-13-15.

Pursuant to 42 C.F.R. § 431.200, applicants must have an opportunity for a fair hearing if their application is denied or not acted on promptly. A hearing must also be provided if the State takes action to suspend, terminate or reduce services.

- The hearing system must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional standards specified in this subpart. 42 C.F.R. § 431.205(d).
    - *Goldberg v. Kelly*, 397 U.S. 254 (1970). The fundamental requisite of due process of law is the opportunity to be heard." *Grannis v. Ordean*, 234 U.S. 385, 394 (1914). The hearing must be "at a meaningful time and in a meaningful manner." *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965). In the present context these principles require that a recipient have timely and adequate notice detailing the reasons for a [*268] proposed termination, and an effective opportunity to defend by confronting any adverse witnesses and by presenting his own arguments and evidence orally. These rights are important in cases such as those before us, where recipients have challenged proposed terminations as resting on incorrect or misleading factual premises or on misapplication of rules or policies to the facts of particular cases.

[42] http://www.cms.hhs.gov/medicaid/stateplans/State_Data/TN/4.2/X_001.pdf. The appeal form is online at http://www.state.tn.us/tenncare/medappeal.html.

- The Agency must issue and publicize its hearing procedures. 42 C.F.R. § 431.206(a).
- The applicant must be informed of certain information including the right to use legal counsel. 42 C.F.R. § 431.206(b).
- Ten (10) days advanced notice must be provided, 42 C.F.R. § 431.211, with certain exceptions, 42 C.F.R. § 431.213.
- The agency must grant an opportunity for a hearing (42 C.F.R. § 431.220) to:
    - Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness.
    - Any recipient who requests it because he believes the agency has taken an action erroneously;
    - Any recipient who requests it because he or she believes a skilled nursing facility has erroneously determined that he or she must be transferred or discharged.
    - Any individual who requests it because he or she believes the State has made an erroneous determination with regard to the preadmission and annual resident review requirements of section 1919(e)(7) of the Act [42 U.S.C. § 1396r(e)].

Under the state's procedural regulations, the appeal must be filed within 90 days from the date of mailing of the denial notice. *Medical Assistance Manual, Vol. I, Ch. 1, VI,A.1*. If the state action involves termination of benefits, the recipient may continue receiving the benefits pending the final decision if the hearing request is filed within 10 days of the mailing date of the notice. *Medical Assistance Manual, Vol, I, Ch. 1, VI.A.2*. There are some limitations on this: if the only issue being raised on appeal is a matter of law, where the state's interpretation of the law, regulations or policy are at issue, the appeals referee may so find at the hearing and discontinue benefits immediately. A change in the recipient's status that renders him or her ineligible that is unrelated to the initial appeal, and which the client has not appealed, will also be grounds for immediate cessation of benefits. In addition, the recipient must be told that if the state's decision denying benefits is upheld, the cost of these continued benefits will be recouped from the recipient. *Medical Assistance Manual, Vol. I, Ch. 1, VI.A.3.c*. The request for a hearing can be made orally or in writing. However, oral requests are to be confirmed in writing by mailing the applicant an appeal form to fill out and return. The date of the telephone request will be used as the date of filing. *Medical Assistance Manual, Vol. I, Ch. 1, VI.A.4*. After the appeal is filed, the Department will then offer the person the chance for a prehearing conference to resolve the complaint and work things out if possible. If resolution is reached, the hearing request can be withdrawn.

The hearing will be conducted by a hearing officer employed by DHS but not involved in making the original decision or denial or termination. The applicant/recipient has the right to inspect the agency's case file on him or her before the hearing and to review any documents or records that DHS is intending to submit at the hearing. The applicant/recipient further has the right to present witnesses and submit relevant evidence, to confront and cross-examine adverse witnesses, to rebut or dispute evidence submitted by the state and to make opening and closing arguments. 42 CFR §§431.242(a)-(e)

In the event of an adverse decision by the hearing officer, the applicant/recipient must receive notice of the decision which advises him or her of the right to either appeal the decision to the Commissioner of DHS in writing within 10 days after the mailing date of the decision or to request Reconsideration from the hearing officer. 42 CFR §431.232. Both the Petition and the appeal should state the grounds therefore; request of the Petition for Rehearing does not eliminate the right to request an appeal; if rehearing is denied, then the applicant/recipient may request appeal within 10 days of mailing of the disposition rendered on the Petition for Reconsideration. Tenn. Comp. Rules and Regs. Rule 1240-5-9-.01.

If the unfavorable decision is upheld by the Commissioner, the Tennessee Uniform Administrative Procedures Act, T.C.A. §4-5-301 et seq., provides for judicial review by the "aggrieved" applicant/recipient. Under the TUAPA, in cases involving DHS, a petition for judicial review must be brought in Davidson County or in the county where the applicant/recipient resides. T.C.A. §4-5-322(b)(1). The petition must be filed within 60 days of the final order entered by jurisdiction. *United Steel Workers of America v. Tennessee Air Pollution Control Correction*, 896 S.W.2d 577 (Tenn. App. 1994). The TUAPA also states that the petition is to be served in conformance with the rules of civil procedure. T.C.A. §4-5-322. In the case of *Jaco v. Department of Health, Buruau of Medicaid*, 950 S.W.2d 350 (Tenn. 1997), the lower court dismissed petitioner Jaco's Petition for Judicial Review because he failed to secure issuance of a summons for service on the Tennessee Attorney General within 60 days of the date of the final agency order. Counsel for Jaco had in fact mailed copies of the petition to both DHS and the Attorney General within the 60 day period, but had delayed in issuing the summons for another two months. The Tennessee Supreme Court agreed with Jaco that all the statute required was that the petition be filed within 60 days, as was done, and that service either then or thereafter should be conducted in accord with the rules of civil procedure. To be safe and to avoid such quibbles, simultaneous filing of the petition and issuance of summonses to both the Tennessee Attorney General and the Department of Human Services would seem the best course.

The standard of review before the courts under the TUAPA is that of determining whether the agency's action is "arbitrary or capricious" such that it is a whole. T.C.A. §4-5-322(h). The burden of proving initial entitlement to benefits is on the applicant, but if benefits have been reduced or cut off, the burden is on the Department to prove action is supported by the record. No additional evidence will be received by the Court - the record will consist of testimony and evidence offered before the hearing officer. T.C.A. §4-5-332(g). Thus, the record must be fully developed at the administrative level. Failure to submit evidence a party knew or should have known with the exercise of due diligence will not be allowed in at the point of judicial review and will not be grounds for remand to the hearing officer for further development of the record. *See Miller v. Tennessee Department of Human Services*, 2001 WL 278001 (Tenn. App. 2001). Grounds for reversal of the agency's decision are set out in T.C.A. §4-5-322(h):

- the agency decision violates constitutional or statutory law;
- the agency's decision exceeds its statutory authority;
- the agency's decision was made using an illegal procedure; the agency's decision is "arbitrary or capricious or characterized by an abuse of discretion";
- the agency's decision is not supported by substantial evidence when viewing the record as a whole.

Appealing a denial based on Medical Criteria

The applicant and his or her "designated correspondent" will both receive a copy of the "written notice of denial" by certified mail in the event that the PAE is denied by the agency. Tenn. Comp. Rules and Regs. Rule 1200-13-1-.10(7)(b)(1) (Oct. 2003); Doe v. Word, 1987 WL 108974 (M.D. Tenn. 1987). A copy will also be sent by fax to the nursing home. The applicant will then have 30 calendar days in which to appeal the decision and request a "Commissioner's Administrative Hearing" in writing to the Bureau of Tenncare. Tenn. Comp. Rules and Regs Rules 1200-13-1.10(7)(a) (Oct. 2003). As with the fair hearings involved in the financial eligibility process, the administrative hearings are conducted in accordance with the provisions of the TUAPA. As with the fair hearings, the evidence submitted at the administrative hearing will again be the only record available to the court should the applicant pursue judicial review.

The applicant has the burden to establish the existence of the medical criteria outlined above (or applicable to the particular class of assistance) by a preponderance of the evidence. It has been the experience of a number of advocates representing clients who are applying for Medicaid for long term care that the state has been becoming increasingly stringent with respect to the evidence required to meet the applicant's burden. For example, although Tennessee does follow the "treating physician rule" in Medicaid cases, which is the rule that gives greater weight to the opinion of an applicant's treating physician than to the opinion of a consulting applicant's doctor. *Conner v. Rudolph*, 1996 WL 591176 (Tenn. App. 1996). To begin with, if the applicant's doctor is not familiar with the continuum of long term care and the other options that exist besides nursing homes, the agency will not be bound to accord greater weight to his or her opinion. *Harden v. Wadley*, 1996 WL 135327 (Tenn. App. 1996). Also, the applicant's doctor may not have the personal knowledge necessary to testify as to what services are actually being provided on a daily basis. It is therefore essential to have the Director of Nursing at the nursing home facility or a designee from the nursing staff to testify at the hearing and to bring the patient's charges to document provision of the required level of care on a daily, recurrent, ongoing basis. *Wheeler v. Tennessee Department of Health, Bureau of Medicaid*, 1987 WL 5172 (Tenn. Ct. App. 1987). Should an issue arise concerning whether the appellant's needs could be met at a lower level of care, it will be important to have expert testimony from someone familiar with the long term care options available in the community to testify concerning why none of them, as a practical matter, will be sufficient to meet the applicant's needs. If the applicant has in fact been admitted to a home for the aged or to an assisted living facility prior to coming to the nursing home, then the effort should be made to produce records and testimony from the staff at that facility to document the inability to meet the applicant's needs.

- *Shupe v. Rudolph*, 1995 Tenn. App. LEXIS 613 (Tenn. Ct. 1995).
    - The evidentiary basis for the hearing examiner's conclusion is unclear. As noted previously, neither Dr. Khatri nor the consulting physician, Dr. Rinehart, opined that plaintiff could perform light work as ultimately found by the hearing officer. Despite this, DHS suggested that the hearing officer based her conclusions upon "the consultative examination report of Dr. Darrel Rinehart...." Dr. Rinehart found, based upon only one examination, that plaintiff had no restrictions and could do any type of work, apparently including heavy construction. However, the ALJ clearly rejected that opinion after reviewing the medical evidence and, particularly, after listening [*22] to and observing plaintiff at the administrative hearing. Contrary to the suggestion made by the defendant, the hearing officer simply rejected both medical opinions and evaluated the medical

evidence on her own. **Note, however, that the hearing officer "is not a medical professional and thus she is not at liberty to substitute her own impression of an individual's health for uncontroverted medical opinion**." *Torres v. Secretary of Health & Human Servs.*, 791 F. Supp. 342, 344 (D. P.R. 1992). **The DHS is not to reject medical evidence by "simply having the Administrative Law Judge make a different medical judgment.**" F*rankenfield v. Bowen*, 861 F.2d 405, 408 (3rd Cir. 1988). (Emphasis added).

- **The ALJ is not a doctor and is not qualified to evaluate medical data or express a medical opinion**. *Reed v. Secretary of Health & Human Servs.*, 804 F. Supp. 914, 919 (E.D. Mich. 1992). We find nothing in this record to establish that the hearing officer possessed any specialized medical knowledge enabling her to review medical records and reach an opinion as to someone's condition. If this were the situation, there would be no reason to solicit opinions from either treating or consulting physicians in Medicaid [*23] proceedings. (Emphasis added).

V. Working with the County Medicaid Department

The best advice we can give in working with local Medicaid workers is to preserve your credibility. It is one thing to take an aggressive position and fight for your clients. It is wholly different for the Medicaid caseworker to feel as though they were misled.[43]

When you take the Medicaid application to your caseworker, take your entire file with you. We suggest that you take copies of the relevant sections of the Medicaid Manual that support your position. Take the time necessary to educate your caseworker concerning the merits of your case. If the caseworker disagrees with your position and you believe the position is meritorious, then appeal the decision. However, if the position lacks substantial merit (e.g., the "pig rule"),[44] remember that you may be making "bad law" for the rest of us when you take the position up.

[43] Under Tennessee Code Annotated (T.C.A.) 71-5-118 it is a felony offense to obtain TennCare coverage under false means or to help anyone get on TennCare under false means.

[44] *Hogs are fed and pigs are slaughtered*.