Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELETRONIC ONLY

May 5, 2014

Bill Brooks
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health Operations
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, TX 75202

RE: LA SPA 13-0052-MM4 RAI Response
Single State Agency

Dear Mr. Brooks:

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 13-0052-MM4 with a proposed effective date of December 31, 2013. The purpose of this amendment is to address single state agencies' delegation of appeals and determinations. We are providing the following additional information as requested in your RAI correspondence dated March 26, 2014.

A1
ICA Waiver Section

1. In the box requesting a description of the "organizational structure/nature and extent of responsibility being delegated":
   a. Please inform us if there is a written agreement in place between the Division of Administrative Law (DAL) and the Department of Health and Hospitals (DHH). If yes, please inform if the written agreement describes the responsibilities between the two parties required in federal regulations at 431, subpart E. If there is no written agreement in place, please describe any other written documentation in state statute, regulations, or policies that describe the roles and responsibilities of each agency with respect to adjudicating Medicaid fair hearings.

      Response: Yes. There is a written Memorandum of Understanding in place between DHH and DAL and describes the responsibilities of each party in accordance with 42 CFR 431, Subpart E. The information has been added to the SPA.

   b. Please describe the extent of DHH's review of DAL's decisions. Can the Department overturn findings of fact or only overturn legal conclusions limited to the proper application of federal or state Medicaid law or policy? If the Department also overturns findings of fact, please describe and or provide some scenarios where the state might decide to do so.

Bienville Building • 628 North 4th Street • P.O. Box 629 • Baton Rouge, Louisiana 70821-0629
Phone #: 225/342-9509 • Fax #: 225/342-5568 • *WWW.DHH.LA.GOV*
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Response: DHH retains final decision making authority on decisions adverse to DHH/Medicaid (i.e. those that vary, amends or modifies the initial decision rendered by DHH). Both findings of fact and legal conclusions are reviewable by the DHH Administrative Review Unit (ARU). In Louisiana, the courts tend to give deference to the Administrative Law Judge's (ALJ) factual findings, but the legislative standard for judicial review of ALJ's factual findings in Louisiana is a preponderance of the evidence standard. The primary focus of the DHH ARU is to ensure uniform, proper, fair statewide application of Medicaid laws, regulations and policy. The DAL primarily emphasizes "independence" of the ALJ with respect to final decision-making authority. An example of overturning an ALJ's factual finding is a factual determination by the ALJ that the adverse notice from DHH stated that the appellant failed to meet a "categorical" eligibility requirement for Medicaid. If the notice had in fact proposed closure due to the failure to meet a "category" or "categorical" requirement, the recommended decision would have been approved. However, the word "category" (or "categorical") was not used on the notice. That notice actually proposed closure due to ineligibility for any "program".

There are other specific instances in which ALJs factual determinations are wrong and utilized as the basis for an erroneous conclusion. For example, ALJs have made a factual finding (on more than one occasion) that an individual has been receiving Medicaid Long Term Care services since prior to December 2006 with no break in service (which meets a nursing facility level of care under the "service dependency" pathway), when the agency has specifically testified that the ALJ's factual finding is not accurate, and there were no allegations at the hearing that there had been no break in services. Some ALJs have made factual determinations regarding nursing facility level of care assessments based solely on the testimony of a witness with a financial interest in the outcome (i.e., a paid Direct Service Worker), without analyzing or addressing contemporaneous documentation prepared by an unbiased trained assessor, or other uncontested facts that contradict the factual situation alleged by biased witness.

c. Finally, please clarify if the appellant has an opportunity to request a review (even if not *de novo*) from DHH, can he/she express disagreement with the decision and/or present evidence about why he or she might disagree with the decision?

Response: An individual who has received a decision from DHH can contact the Department and ask for an explanation of and/or express disagreement with the decision. If information or evidence is presented within a reasonable period (or prior to the hearing if a formal appeal was requested) by the individual that may affect the decision, a reconsideration of the decision is done. If an appeal request of their eligibility decision is filed, DHH has the authority to reverse or rescind the adverse action prior to the hearing. To this effect DHH has instituted a formal review process of negative case action taken which takes into account the appellant's reasoning for appeal and any additional documentation presented to ensure the decision was correct. If not, DHH rescinds the adverse decision and sends back to the eligibility worker for reconsideration and a new decision.

The appellant can also offer additional evidence into the record during the hearing. Once the hearing record is closed, no additional evidence is considered. If the appellant is dissatisfied with the final decision, their only legal remedy is an appeal at the district court.

d. Please clarify if DAL makes decisions for all applicant and beneficiary fair hearings. We note that the state only refers to applicants and enrollees; enrollees usually imply individuals enrolled in managed care plans. We seek to clarify if the state is also using DAL to hear fair hearings of any fee-for-service beneficiary issues. If yes, please clarify by including the term "beneficiary" in this box to explain the organizational arrangement/nature and extent of authority being delegated.

Response: The DAL does make decisions for applicant and beneficiary fair hearings for all of Medicaid. Prior to having managed care plans, the State referenced individuals in the Medicaid program as enrollees. The term has been corrected in the SPA.

2. Establishing a review process. Please clarify if the state will use the process outlined above to also review OMEA appeals decisions.

Response: It is not the State's intent to review OMEA appeal decisions.

A2

Medicaid Agency Description

1. Please list the division responsible for reviewing DAL's fair hearing decisions and describe the division's role in that review.

   Response: The information has been added to the SPA.

2. Eligibility Field Operations. In the description of your Eligibility Field Operations, please include additional detail on the relationship between the regional divisions and DHH, e.g., are the regional divisions apart of DHH, are regional staff employees of DHH.

   Response: The Eligibility Field Operation regional divisions are state employees of DHH within the Bureau of Health Services Financing (BHSF) which administers the Medicaid program. The information has been added to the SPA.

Entities that conduct eligibility determinations

1. Please clarify for which populations the Title IV-A agency makes eligibility determinations.

   Response: The Title IV-A agency makes eligibility determinations for Parent/Caretakers under 42 CFR 435.110, the Infants and Children under age 19 under 42 CFR 435.118, Adoption Assistance and Foster Care payments under Title IV-E under 42 CFR 435.145, Children with Non-IV-E Adoption Assistance group under 42 CFR 435.227, and Reasonable Classification of Individuals under Age 21 placed in foster care homes by public agencies under 42 CFR 435.222. If this description is not sufficient, the State requests additional guidance for proposed language.

Entities that conduct fair hearings

1. OMEA. We do not need this level of detail about OMEA. Please delete the second paragraph of the OMEA description.

   Response: The information has been removed from the SPA.

Attachments

Statement related to the OMEA Memorandum of Agreement (MOA)

When you respond to this request for additional information and resubmit the SPA into the Medicaid Model Data Lab (MMDL), please submit the statement related to the OMEA MOA that CMS sent the state on 3/19/14.

Additionally, when you resubmit the SPA into MMDL, please review for accuracy, and submit the superseding pages document that CMS sent the state on 3/19/14.

Response: The statement related to OMEA MOA and the superseding pages documents for this SPA have been resubmitted into the MMDL.

Please consider this a formal request to begin the 90-day clock. We trust that this additional information will be sufficient to result in the approval of the pending plan amendment. We look forward to working with your office to make the necessary revisions to our Medicaid State Plan to ensure compliance going forward.

As always, we appreciate the assistance of Ford Blunt in resolving these issues.

If further information is required, you may contact Darlene Adams at Darlene.Adams@la.gov or by phone (225) 342-3881.

Sincerely,

J. Ruth Kennedy
Medicaid Director

Attachment (1)

JRK:DA:SSJ

c. Darlene Adams
Ford Blunt