STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

July 14, 2014

Cindy Mann
Director of the Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Blvd., Mail Stop S2-26-12
Baltimore, MD 21244-1850

I write in response to your letter dated June 27, 2014.

I certainly share your underlying concerns about the need to ensure that individuals have access to apply for the services to which they are entitled. To this end, Tennessee has enrolled more than 126,300 members between January and May 2014 (including approximately 12,600 non-MAGI enrollees, 18,700 deemed newborns, and 95,000 determined to be eligible through the FFM under the MAGI rules). While there are still improvements to be made, we are currently enrolling individuals at the highest rate in nearly 20 years, since the first year of TennCare. A small percentage of applicants have had difficulty completing the enrollment process, but almost all of those problems have been the result of flaws in the federal government's healthcare.gov website (the federally-facilitated marketplace or "FFM"). Working collaboratively with the CMS Region IV Office to address these concerns, TennCare has devoted an enormous amount of human and material resources to mitigate the challenges with the federal system. As a result of these efforts, Medicaid enrollment in Tennessee has proceeded more smoothly since the implementation of the Affordable Care Act than in many other States, a number of which have tens and even hundreds of thousands of backlogged applications.

All of us at TennCare also share your goal that the federal and state eligibility processes work as intended. We are particularly concerned, however, that the eligibility process not be more difficult than necessary for Tennesseans. This in large part explains our reticence about the federal request to implement a manual eligibility process for certain Medicaid eligibility categories. In your letter, you singularly (and incorrectly) attribute our hesitancy to unease about the potential costs of a manual process. In fact, our reservations about a manual process reflect concerns that go beyond resource issues. As noted, fundamentally, we do not want to make the application process more difficult for Tennesseans when they already have the option to receive a near-real-time eligibility determination via the FFM. Thus, we have deep misgivings about implementing a separate, redundant process that would then require Tennesseans to submit far more in the way of paper verifications. This is particularly true when the information that we would

need to verify (through requests for additional information) is immediately available to the FFM via the federal data services hub, thereby allowing the FFM to render a determination much more quickly and with far fewer verification requests of applicants. These requests for verifications will only further delay application processing and lead to unnecessary backlogs at the State. In essence, the implementation of the manual process at this juncture would likely increase the time required for an eligibility determination and increase the application burden on residents vis-à-vis the FFM, which is hardly to the benefit of the applicants for these programs.

In addition to our strenuous objections on behalf of applicants in Tennessee, we have several more practical concerns about your request. First, the timeline to implement a manual approach largely overlaps with the timeline to implement our eligibility system, the new Tennessee Eligibility Determination System (TEDS). Re-allocating resources away from the implementation of our permanent solution to a short-term "fix" has clear risks with only dubious potential benefits. Second, the availability of a new manual process could very well divert applicants from the FFM process that has worked for the vast majority of applicants. Indeed, the implementation of a manual process would likely occur during the open enrollment period, which is a time of year that both federal and state officials most want applicants to use the FFM (i.e., so that applicants with household members eligible for premium tax credits can enroll in that program and qualified health plans). If the FFM is unable to process certain types of applications, then the appropriate remediation is with the FFM and not with shifting the burden to applicants hoping to enroll.

Your letter suggests that the State is not in compliance with its obligations under Section 1943 of the Social Security Act, 42 C.F.R. §§ 435.907, 435.949, and 435.1200, and the Tennessee State Plan with regard to the streamlined eligibility and enrollment process. We must respectfully disagree. Upon the implementation of TEDS, the State will begin conducting its own automated MAGI determinations. In the interim, the State is complying with its obligations under the statute and regulations by collaborating with the FFM to provide applicants with access to the enrollment process on line through the State's website and healthcare.gov.

As a formal matter, I am also obliged to correct several mistaken assertions in your letter. I would call your attention to five specific misstatements or mischaracterizations that warrant revision:

- First, you incorrectly state on the first page that, with only one partial exception, Tennessee is not meeting any of the seven critical success factors listed. In point of fact, the record says just the opposite. For example, your own website acknowledges that Tennessee has converted existing income standards to MAGI (success factor #2) and, indeed, we were one of the ten pilot states chosen to test the feasibility of potential conversion methodologies. Additionally, we conveyed state-specific eligibility factors and rules to the FFM on August 30, 2013 (success factor #3). Further, we have repeatedly demonstrated the ability to accept application files from the FFM (part of success factor #5). We have also offered to

respond to inquiries from the FFM on current Medicaid coverage through an established 270/271 eligibility verification process (success factor #6), an offer which CMS declined to take up. While some of your individual points may arguably have merit, many appear to be greatly exaggerated.

- Second, your characterization of the State's compliance efforts at the end of the same paragraph is mistaken. You incorrectly suggest that the State "has repeatedly expressed reluctance to deploy resources toward adopting mitigation solutions" when, in fact, Tennessee has dedicated substantial staff resources to work with the CMS Region IV staff to resolve case concerns pending at the FFM for extensive periods, particularly in cases in which the affected applicants have acute clinical concerns requiring medical services. For example, we became aware that pregnant women were unable to obtain coverage for which they were eligible because of the FFM's inability/failure to adjudicate eligibility and transmit these records to the State – and we immediately reached out to CMS to work collaboratively to resolve hundreds of such cases. Similarly, when we became aware that mothers not on TennCare at the time they gave birth were experiencing difficulty enrolling their eligible infants born in Tennessee through the FFM we approached CMS about implementing presumptive Medicaid eligibility for newborns. Originally CMS informed us that this would not be a viable option. As a result, on June 19th, we submitted a SPA to CMS in an attempt to achieve a similar end by providing 12 continuous months of eligibility, following birth, to CHIP infants. It should be noted that just today we received word from CMS that our original request to provide presumptive Medicaid eligibility to newborns has been revisited and now appears approvable, so we will be modifying an existing SPA not yet approved by CMS in order to pursue this option. In addition, we have worked closely with stakeholders to ensure that many non-MAGI applications continue to come to the State as opposed to the FFM, and we have deployed additional agency resources to handle this volume. The larger point that I want to make is that the State has not only shouldered its own responsibilities, but also has devoted substantial resources to mitigating the problems arising from the federal marketplaces flaws. We will continue to do so – but in a way that makes sense for those we serve.

- Third, and contrary to your assertions on the first page, Tennessee is not currently using the CMS flat file as part of our mitigation plan. The State implemented a contingency work-around on April 24th which includes loading MAGI eligible recipients from the H15 Account Transfer directly to our MMIS. As you are aware, the State's flat file waiver expired on April 24th and the State did not request a renewal of this waiver. We believe the H15 is a technically superior process that allows us to expedite enrollment.

- Fourth, regarding your comments on the second page, the State does indeed provide direct application assistance in every county in Tennessee. As we have explained to multiple CMS officials (as well as a variety of advocacy and

professional organizations) on numerous occasions, state residents can go to the Department of Human Services' offices in any and all of Tennessee's 95 counties to get in-person assistance from a trained state employee. While we do offer self-service computer kiosks and telephones at DHS offices (and do so in all counties), we also provide substantial face-to-face help to applicants who apply for benefits using the federally-facilitated marketplace (again, at DHS offices in all counties). I would (again) underscore that all of this has been true since January 1, 2014. Additionally, we have worked to ensure that over 350 DHS staff completed the training to become certified application counselors. This training was completed by April 2014 and today there is at least one CAC available to provide assistance in every one of Tennessee's 95 counties. Further, we have contracted with the Area Agencies on Aging and Disabilities to provide in-person, in-home assistance with certain populations of applicants for whom such assistance is needed. Given your mistaken comments in this regard, I wanted to bring these details to your attention.

- Fifth, you note that TEDS implementation has slipped, though you omit any mention of the context. As you know, Tennessee's eligibility system was an over 20 year-old mainframe system and given the substantial changes to eligibility criteria mandated by the ACA, we had to competitively procure the build out of an entirely new system (as opposed to modifying an existing system). While our vendor has experienced delays in the implementation of TEDS, late-in-the-game release of federal guidance and subsequent "clarifications" and federal process changes have partially contributed to these delays by requiring us to establish work-arounds and redirecting resources from TEDS implementation. That said, we too are frustrated with our vendor's delays with TEDS and are working diligently with our vendor to correct these and successfully implement this system as expeditiously as possible. As such, as we have discussed previously, we are bringing in an internationally recognized consulting firm to evaluate our vendor's progress to date and to provide us with an objective third party assessment of the project timeline, which we will then share with CMS. We will remain focused on the goal of a successful implementation without distraction, but we will not go-live with a system that has not been adequately tested.

As you requested I have attached a summary of our updated mitigation plan (which we reiterate is an interim solution pending completion of TEDS), which is also being submitted today to the CALT folder as directed by your prior correspondence. As you can see, we have deployed numerous solutions since January to improve on our current processes and continue to offer solutions that will offer further improvements. For example, we have given extensive thought to hospital presumptive eligibility (HPE) and the types of "workarounds" for HPE that you specifically reference in your letter. Because implementing HPE in Tennessee is not a straight-forward proposition in the current environment, we are requesting two specific HPE workarounds as part of our mitigation plan. We set forth the rationale for these workarounds in our cover letter for the State Plan Amendment for HPE, which I am also attaching.

We would appreciate your expedited consideration of our requests and our overall, updated mitigation plan. We share your sense of urgency about these issues, and we have tried to develop creative yet operationally feasible solutions. Given the current operational limitations of the FFM and the discretion that HHS has under the relevant statutes, we believe ours to be reasonable and approvable requests. To be clear, though, our ability to operationalize an HPE program is fully contingent upon HHS's approval of the State's entire mitigation plan. Of course, we are willing and able to discuss these requests with you at your convenience.

Sincerely,

Darin Gordon
Deputy Commissioner for Health Care Finance & Administration
and Director, Bureau of TennCare

Attachments

Attachment:
Mitigation Planning for
January 1, 2014
(updated July 14, 2014)

Tennessee previously submitted a Mitigation Plan to CMS in 2013 detailing certain steps the State would take in the event Tennessee's vendor would not have the new eligibility determination system available on January 1, 2014 as planned. Pursuant to Director Mann's request in her June 27, 2014 letter to the State, Tennessee submits the following updated mitigation plan.

1. Tennessee will continue to operate in a "Determination" model with CMS determining Modified Adjusted Gross Income (MAGI) eligibility for all Tennessee applicants as has been the case since October 1, 2013.

2. The State will continue using the Federally Facilitated Marketplace (FFM) for MAGI eligibility determinations as has been the case since October 1, 2013. Callers will continue to be referred to healthcare.gov and the FFM Call Center to complete an application for MAGI Medicaid categories. If an applicant sends a copy of a paper single-streamlined application to the State, applications will continue to be mailed by the State to the FFM or applicants will be instructed how to mail paper applications to the FFM. See #8 below for information regarding non-MAGI eligibility determinations.

3. As of January 1, 2014, the State established kiosks in all Department of Human Services (DHS) county offices. Kiosks are pointed to healthcare.gov and applicants are utilizing the kiosks to apply to the FFM. The State will continue utilizing this process. On March 17, 2014, the State began having some of its DHS staff in all DHS county offices begin training to become Certified Application Counselors (CACs) as well. To date, approximately 350 DHS workers have become CACs. While basic in-person navigation assistance of healthcare.gov has been available from DHS front desk staff at these offices since January 1, 2014, CACs have been made available to provide in-person assistance in all 95 counties since April 2014. The State will also continue making available the handouts explaining all the ways to apply for Medicaid for those applicants that want to complete their application at home or another location that have been available since January 1, 2014.

4. Since the beginning of the year, the State has provided phones near the kiosks in all DHS county offices. Phones are available for applicants to use to call the FFM Call Center to file a phone application and also if they encounter any issues with their web application to healthcare.gov. The State will continue making these phones available.

5. In an effort of continuing to improve the eligibility process, the State had established in-person, in-home application assistance in cooperation with eight of the State's nine Area Agencies on Aging and Disabilities (AAAD) by April 29, 2014. (The ninth AAAD signed its contract to provide such services on May 21, 2014).The AAADs had previously worked with individuals needing Long Term Service and Supports to assist them in compiling the information necessary to apply for Medicaid. They are continuing that function while also working with individuals to apply through the FFM if they may be eligible for Medicaid.

6. As has been the case since January 1, 2014, if the FFM determines that the application is MAGI eligible, the FFM sends a notice to the applicant and electronically transmits the eligibility record to HCFA[1] and HCFA loads the record into InterChange.[2] Subsequently, in keeping with the process that has been in place for years, InterChange will assign the Managed Care Organization (MCO), generate the notice to the member and send the 834 to the MCO. The State has loaded 95,000 recipients through this process to-date. This process will continue.

7. As has been the case since January 1, 2014, if the FFM determines that the application is not MAGI eligible, but may be non-MAGI eligible, the FFM electronically transmits the record to HCFA. In addition to other call center functions, HCFA uses its call center to outreach to these members to ask a series of basic questions and request further information for resource determination if appropriate. Once the information is received from the applicant, a centralized team of Eligibility Specialists processes the application for all non-MAGI categories that the applicant may be eligible for. This process will continue.

8. As has been the case since January 1, 2014, the State allows individuals requesting Long Term Service and Supports to apply directly to the State without requiring those applicants to go to the FFM first. In early January after Tennesseans experienced challenges in applying for Medicare Savings Programs through Healthcare.gov, the State modified this application so that applicants seeking eligibility for MSP could use it to apply directly to the State as well. Individuals requesting these benefits would rarely be eligible in a MAGI category and are able to fax or mail applications directly to the State for processing. These applications are also provided to the centralized team of Eligibility Specialists to process the application for all non-MAGI categories. This process will continue.

9. If the team of Eligibility Specialists determines the applicant is eligible, ACCENT[3] will generate a transaction to InterChange. This process has not changed from the process that existed in 2013.

10. If the team of Eligibility Specialists determines the applicant is not eligible, ACCENT will send a denial notice to the applicant.

11. ACCENT will continue to generate all existing notices to Medicaid applicants.

12. If ACCENT sends an approval to InterChange, as has occurred historically, InterChange will assign the MCO, generate the notice to the member, and send the 834 to the MCO.

13. As noted in the prior mitigation plan, the State was previously in discussions with local Navigators about a referral process for individuals who are struggling to complete the FFM application process. The State had hoped to establish a warm transfer of these individuals to the Navigators for specialized assistance. Since the State has established CACs in all of

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[1] "HCFA" refers to the Division of Health Care Finance & Administration, which encompasses the Bureau of TennCare. HCFA is part of Tennessee's Department of Finance & Administration (F&A).
[2] InterChange is the State's Medicaid Management Information System (MMIS).
[3] Accent is the eligibility system operated by the Tennessee Department of Human Services (DHS), primarily for Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps). Prior to 2014, DHS performed Medicaid eligibility determinations using the Accent system. HCFA is temporarily using Accent to perform non-MAGI eligibility determinations until TEDS is operational.

the DHS county offices, a referral process to local Navigators has not been necessary. This is our preferred approach as it negates the need for referral to offsite resources.

14. In early 2014, the State was receiving hundreds of calls per day from pregnant women who had been receiving presumptive eligibility from the State, but who had not received a final eligibility determination from the FFM. The State began working with its CMS Desk Officer to try to work through these cases to determine whether an application had been filed and whether an eligibility determination had already been made. It was through this discussion that the State realized CMS did not have the system capability to notify the State when a presumptively eligible pregnant woman had applied to the FFM so that the State would maintain the woman's Medicaid eligibility while the application was pending. In light of the deficiency in the FFM functionality, the State notified CMS, in April, that it would be willing to continue the presumptive eligibility for these women until the FFM identified a mechanism to notify the State of the pending applications and final dispositions of these applications. In agreement with CMS, the State also began sending files to CMS in April of those women whose presumptive eligibility was extending as a mechanism for CMS to notify the State when those cases had completed an eligibility determination. To date, the State has received very few responses on these applications and CMS has given no indication of a target date for resolution of the primary problem.

15. In early 2014, the State also heard from stakeholders regarding difficulties non-Medicaid eligible mothers were encountering with the FFM when attempting to enroll newborns who are not eligible for "deeming". These mothers are unable to complete the identity proofing process established by the FFM, with resulting delays in obtaining eligibility and needed checkups and immunizations, which are critical in the first few months of life. In light of these concerns, the State originally proposed implementing presumptive eligibility for newborns, but was informed by CMS that this would not be a viable approach to the problem. Subsequently, the State has proposed encouraging these women to apply to the State CHIP program, CoverKids, which has existing authority to cover the unborn child. To this end, the State submitted a state plan amendment to CMS on June 19, 2014 requesting authority to provide these children 12 months of CHIP eligibility from date of birth to ensure the child receives all necessary checkups and immunizations during the first year of life. On June 25, 2014, the State submitted an updated budget page for this state plan amendment to start the 90-day clock on this state plan amendment. The State then discussed implementing this state plan amendment with CMS personnel on a June 25, 2014 SOTA call and then again on a July 1, 2014 call with the CMS CHIP team. While we understand that the State may provide 12 months of coverage starting with the unborn enrollment, we are concerned that we would be forcing the pregnant woman to choose between prenatal care and coverage for her newborn when determining when she should apply for eligibility. The State believes the requested state plan amendment will alleviate this potential conflict for the pregnant woman and help ensure newborns in Tennessee are given the best opportunity for a healthy start to life. It should be noted that just today, in a conference call with Tennessee, CMS officials indicated that they now do believe that presumptive Medicaid eligibility for infants is something they could approve, so we are in the process of re-evaluating our options and will be modifying an additional SPA, which coupled with changes that we will continue to pursue through our CHIP SPA should address this problem with the FFM.

16. As relayed to CMS during a conference call on February 6, 2014, Tennessee's then-current intention was to design and implement a Hospital Presumptive Eligibility (HPE) process. As was discussed on that call, it was not a question of "if" but "when" the State would be in a

position to dedicate the resources necessary to design a workable HPE solution. As everyone is aware, at that time, numerous other issues were demanding every state's resources and attention, including Tennessee's. In this phone call, CMS acknowledged that it was reasonable that Tennessee would need to postpone implementation of HPE in order to prioritize certain other aspects of post-January 1 implementation. However, since the date of that call and as evidence of the State's intention as communicated on that call, Tennessee has devoted substantial time and resources to develop what the State believes is a workable HPE process given the shortcomings of the FFM and its inability to communicate with the State about the status of individuals' applications. To this end, the State now proposes to implement a Hospital Presumptive Eligibility (HPE) process with two workarounds. The State will be requesting the authority to limit the presumptive eligibility period to 45 days. At the end of the 45 day period, the individual's eligibility would be terminated unless a Medicaid approval has been received from the FFM. Based on the issue noted above related to presumptive eligibility for pregnant women, the State does not believe the FFM has the capability to communicate its eligibility decisions in all situations, leaving the State financially responsible when the FFM denies an applicant and the information is not communicated to the State.

We request that CMS exercise its authority to assure that only individuals meeting Tennessee eligibility standards remain on the Medicaid program. The default end date would apply only in the event the State had not received from the FFM an eligibility approval for the individual. This would be an interim, not permanent measure. The State would operate under this authority only until the FFM is able to reliably transmit denial information to the State or the State's vendor successfully implements its new eligibility system.

The State further requests that CMS allow the State to simplify notice processes for HPE recipients. The State would propose to send a single notice to the applicant at the time HPE is established. This notice would inform the applicant of their approval for temporary Medicaid coverage for the established period of 45 days and encourage them to apply to the FFM for ongoing coverage as soon as possible. The notice would also provide the MCO assignment to the applicant and the contact information for their assigned MCO. The important difference in this notification is that it would provide the eligibility start date and end date for the applicant and no additional notification of termination would be sent.

17. Finally, in an effort to gain confidence in the go-live timing of the eligibility determination system (TEDS) currently under development by Northrop Grumman (NG), the State is in the process of finalizing a contract with an internationally recognized consulting firm to perform an analysis of the current project plan and implementation timeline, the results of which will be shared with CMS.

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Cindy Mann
Director of the Center for Medicaid and CHIP Services
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7500 Security Blvd., Mail Stop S2-26-12
Baltimore, MD 21244-1850

Dear Director Mann:

As I indicated in related correspondence, we are submitting the attached State Plan Amendment (SPA) related to hospital presumptive eligibility (HPE). As you might imagine, implementing HPE in Tennessee is not a straight-forward proposition, and it clearly requires several "workarounds" to HPE of the type that you reference in your letter dated June 27, 2014. I summarize below the nature of our concerns about HPE and then explain our two specific workaround requests that would allow us to implement HPE successfully.

The federal rules seem to establish a relatively open-ended period of HPE enrollment. A strict reading of the implementing rules would require the State to keep open the HPE enrollment period until the day on which a decision is made on the individual's application (if the applicant filed a Medicaid application). 42 CFR §§ 435.1101 and 1110. Individuals in an HPE enrollment period would, therefore, retain coverage until the State receives clear information about the final disposition of the underlying application. In Tennessee, this means that the State would continue to cover the individual in an HPE period until the federally-facilitated marketplace (FFM) provides the State with the final determination (i.e., an approval or denial).

The overall federal approach to HPE makes two key assumptions. Specifically, the federal government's implementing rules assume a context in which the FFM is determining eligibility within 45 days and rendering a notice as required by 42 CFR §§ 435.912 and 913, respectively. Further, the federal rules impliedly assume that the entity determining eligibility (i.e., the FFM) would communicate such determinations (inclusive of denials) to the State.

Owing to the FFM's flawed launch and ongoing operational challenges, neither of these two assumptions reflect the currently reality. As numerous case examples from Tennessee and other states illustrate, the FFM is not always determining eligibility within the timeframes described in the federal rules. Even in those instances in which the FFM accurately determines eligibility and

renders a timely decision, the FFM does not transmit denial information to the State. Consequently, the State often does not receive timely eligibility decisions from the FFM – and the State lacks a feedback mechanism with the FFM allowing it to close the HPE enrollment period in such cases.

At least in the current operational context, a literal application of the implementing rules yields results that conflict with other statutes. For example, assume that the FFM denies eligibility for an individual that the State presently covers under an HPE enrollment period. The federal rules at § 435.1101 would arguably require the State to continue the HPE enrollment period indefinitely (because the FFM does not currently transmit denial information to the State). Yet, such outcomes are in clear conflict with the objectives of the HPE program (which clearly envisions an eligibility end date coterminous with the FFM denial) and the separate statutory goal of ensuring program integrity. *See, e.g.,* Improper Payments Information Act of 2002 (Pub. L. 107-300) *as amended*.

Fortunately, the enabling legislation for HPE provides HHS with discretion to avoid such outcomes. The final clause of the HP provision states that the program shall operate "subject to such guidance as the Secretary shall establish...." 42 USC § 1396a(a)(47)(B). This clause provides the discretion necessary to prevent the situations described above.

We request that HHS exercise this authority to prevent such outcomes in Tennessee. Specifically, we request that HHS authorize the State to provide for a default eligibility end-date 45 days after the effective date of the HPE enrollment. This default HPE end-date would apply only in the event that the State has not received from the FFM an eligibility approval for the individual in an HPE enrollment period prior to the default end-date. Further, this would be an interim, not permanent, measure: The State would operate under this authority only until (a) the FFM is able to render timely determinations and reliably transmit denial information to the State; or (b) the State successfully implements its new eligibility system.

We further request that HHS allow the State to simplify notices to HPE enrollees while the above measure remains in effect. During this period, HHS would allow the State to provide a single notice that includes the start and end dates of eligibility along with information about the importance of applying to the FFM. After extensive discussion, we conclude that this is the only way that we would be able to operationalize the program in the short-term. Moreover, we believe that we can craft language so that the notice (a) reinforces to HPE enrollees the critical importance of completing their application via the FFM; and (b) reduces the duplicative and confusing materials that the applicant is likely to receive from the qualified entity, the State, and the FFM within a short period of time. Again, this would only be an interim measure.

Our proposed approach accomplishes the purposes of the HPE program while balancing the competing statutory objectives. Individuals would soon be able to receive presumptive determinations from qualified entities -- and maintain eligibility for a period as long as that contemplated under the timely determination rules at § 435.912. At the same time, the State

would be able to minimize payments on behalf of individuals whom the FFM has determined to be ineligible.

With respect to the attached State Plan Amendment, I want to note several specific caveats to our submissions. First, and consistent with our workaround requests above, we would not define the end of the presumptive eligibility as described on p. 2 of the SPA while our interim workarounds are in effect; we explain this further in the detailed limitation to the presumptive eligibility period that we include on p. 3 of the SPA. Second, we have not completed the HPE application and will, therefore, submit this to CMS at a later date. I mention this because the SPA template does not allow us to uncheck the relevant box on p. 3 stating that we are attaching the application form (which, for reasons explained, we are not). Third, we have not yet communicated any decisions about requirements to hospitals because we are refining the Memorandum of Agreement and training materials; for this reason, we cannot yet make the attestation on p. 3. We continue our work on both of these program components, but we did not want to delay the submission of the SPA (or the discussion with you about our workaround requests) pending completion of these more *pro forma* items. Finally, I want to clarify for the record that the State does not currently cover the following pre-checked eligibility groups listed p. 1 of the SPA: the adult group, individuals above 133% FPL under age 65, and individuals eligible for family planning services.

As I explained in my response to your June 27th letter, we would appreciate your expedited consideration of our requests and our overall mitigation plan. We share your sense of urgency about these issues, and we have tried to develop creative yet operationally feasible solutions. Given the current operational limitations of the FFM and the discretion that HHS has under the relevant statutes, we believe ours to be reasonable and approvable requests. To be clear, though, our ability to operationalize an HPE program is fully contingent upon HHS's approval of the State's entire mitigation plan. Assuming that we receive CMS's consent to our requests and approval of our mitigation by August 15, 2014, we would ask for an effective date for of October 1, 2014 for this SPA. Of course, we are willing and able to discuss these requests with you at your convenience.

Sincerely,

Darin Gordon
Deputy Commissioner for Health Care Finance & Administration
and Director, Bureau of TennCare

Attachment

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals — S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

(•) Yes ( ) No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

■ A qualified hospital is a hospital that:

■ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

■ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

(•) Yes ( ) No

■ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

■ Pregnant Women

■ Infants and Children under Age 19

■ Parents and Other Caretaker Relatives

■ Adult Group, if covered by the state

■ Individuals above 133% FPL under Age 65, if covered by the state

■ Individuals Eligible for Family Planning Services, if covered by the state

■ Former Foster Care Children

■ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

☐ Other Family/Adult groups:

☐ Eligibility groups for individuals age 65 and over

☐ Eligibility groups for individuals who are blind

☐ Eligibility groups for individuals with disabilities

☐ Other Medicaid state plan eligibility groups

☐ Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

Medicaid Eligibility

◉ Yes ○ No

Select one or both:

☒ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards: 100% of all individuals determined to be presumptively eligible must complete a regular application within five (5) calendar days of the beginning of the presumptive eligibility period. Additionally, 100% must submit all requested verification documents and otherwise respond to requests for additional information within five (5) calendar days of receipt of said requests. Thus, a hospital faces termination of HPE privileges if any applicant that they made presumptively eligible did not follow through and fully complete the Medicaid application process within the prescribed timeframes.

☒ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Description of standards: No less than 93% of all applicants made presumptively eligible shall be found eligible for full Medicaid benefits in year 1, with the required approval proportion increasing to 95% and 97% in years 2 and 3, respectively. Thus, a hospital faces termination of HPE privileges if greater than 7% of the applicants they made presumptively eligible in year 1 were not in fact Medicaid eligible after determination based on a regular Medicaid application.

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

○ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

◉ Other reasonable limitation:

	Name of limitation	Description	
+	Limitation #1	No more than one period of hospital presumptive eligibility (HPE) within two calendar years.	X

Medicaid Eligibility

+	Limitation #2 (interim measure)	The State will provide for a default eligibility end-date 45 days after the effective date of the HPE enrollment. This default HPE end-date will apply only in the event that the State has not received from the federally-facilitated marketplace (FFM) an eligibility approval for the individual in an HPE enrollment period prior to the default end-date. This will be an interim, not permanent, measure: The State will operate under this authority only until (a) the FFM is able to render timely determinations and reliably transmit denial information to the State; or (b) the State successfully implements its new eligibility system. While this interim measure is in effect the State will provide a single notice that includes the start and end dates of eligibility along with information about the importance of applying to the FFM.	X

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

◉ Yes ○ No

○ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

◉ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

☒ The presumptive eligibility determination is based on the following factors:

☒ The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

☒ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☐ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement