Renewal of Retroactive Eligibility Waiver
STC 68 Evaluation Report
March 1, 2016

Table of Contents

I. About This Report 2

II. Executive Summary 3

III. Introduction 6

IV. Policy and Operational Context 7

- A. Foundational to TennCare 7
- B. Prepares Consumers for Private Coverage 7
- C. Avoids Major Disruption and Significant Investments in Scarce State Resources 8
- D. Distinguishing Retroactive Eligibility from Current Practice 8
- E. Commitment to Continuity of Coverage 8

V. Changes Since Creation of STC 68 9

VI. Evaluation Approach and Development of Alternative Measures 11

VII. Results 15

VIII. Conclusion 19

Appendix: Technical Specifications 20

Renewal of Retroactive Eligibility Waiver
STC 68 Evaluation Report
March 1, 2016

I. About This Report

This report has been prepared by Manatt Health (Manatt) under a contract with the Tennessee Division of Health Care Finance and Administration, Bureau of TennCare, to assist and advise the State in the evaluation of the eligibility and enrollment processes that are required by Special Term and Condition (STC) 68 in the TennCare waiver. The report is based on discussions with TennCare leadership staff; an analysis of available data; and a review of applicable TennCare eligibility determination policies and procedures conducted in the spring and summer of 2015, as well as a review of general issues being experienced by all states in implementing the new eligibility determination policies required by the Affordable Care Act (ACA).

Renewal of Retroactive Eligibility Waiver
STC 68 Evaluation Report

March 1, 2016

II. Executive Summary

As required by STC 68, this analysis provides available data on Tennessee's eligibility determination system with the intent of informing CMS's decision-making on continuation of the State's twenty-two year old waiver of retroactive eligibility. Since the content of STC 68 was developed in 2012, many of its proposed measures do not fit with the current on-the-ground reality of how the Affordable Care Act (ACA) has actually been implemented. In all Federally Facilitated Marketplace (FFM) states, not just in Tennessee, data are not available to respond to many of the measures. As a result, it was necessary to develop alternative measures for this analysis.

Along with providing results on the alternative measures, this analysis describes the policy and operational context for the retroactive waiver in Tennessee and explains why Tennessee is seeking CMS approval to continue its twenty-two year old waiver. From the perspective of TennCare officials, elimination of the waiver is fundamentally incompatible with Tennessee's managed care environment; unnecessary to protect beneficiaries – especially because in the redetermination process implemented following the enactment of ACA TennCare provides post-enrollment retroactive eligibility – and problematic from a policy and an operational perspective.

Policy and Operational Context

Foundational to TennCare: To effectively manage care, individuals must be recognized as Medicaid beneficiaries and connected to a system of care. By waiving retroactive eligibility, the State maintains an incentive for eligible individuals to enroll in coverage before they get sick, allowing them to establish themselves with providers and receive important preventive care.

Prepares Consumers for Private Coverage: In the context of the ACA, it is more important than ever that TennCare not weaken incentives for Tennessee residents to enroll in coverage and that they can comply with the individual mandate. Beneficiaries should not be acculturated to receiving coverage retroactively when this does not happen in the private market.

Avoids Major Disruption and Drain on State Resources: After twenty-two years with a waiver of retroactive eligibility, it would consume significant financial and human resources if Tennessee had to establish a new system to provide retroactive eligibility. It could overburden already strained State staff and divert limited resources from more critical priorities, such as continued development of a Medicaid eligibility determination system.

Distinguishing Retroactive Eligibility from Current Practice: While Tennessee currently provides Medicaid beneficiaries with coverage back to the date of application, it is important to distinguish this practice from retroactive eligibility. Current practice encourages consumers to sign up for coverage by offering them protection from medical bills only after they have applied for Medicaid.

Commitment to Continuity of Coverage: TennCare has actively promoted continuity of

coverage for eligible individuals who have enrolled in Medicaid and established a relationship with health care providers. In designing a redetermination process following the enactment of ACA, the State decided to provide retroactive coverage to the date of termination for individuals who lose Medicaid for "failure to respond" to documentation requests, but who subsequently follow up within 90 days of the termination and are determined eligible. Unlike retroactive eligibility more generally, this "post enrollment retroactive eligibility" promotes continuity of coverage without creating potential incentives for people to defer enrolling in coverage until after they incur medical bills.

Evaluation Approach and Results

Manatt worked with TennCare staff to review the State's eligibility and enrollment policies and processes; to identify IT systems that could provide useful data; and to analyze the available data. Based on this systematic assessment, Manatt in conjunction with TennCare identified alternative measures – data and analytics from current systems as well as from nationally-recognized sources – that would permit an evaluation of the effectiveness of its eligibility determination systems and processes. These include data on growth in Medicaid enrollment by eligibility category; enrollment in Medicaid among children enrolled in SNAP (as an indicator of the State's participation rate); and Tennessee-specific data from a national study on Medicaid participation rates among eligible children.

The results, displayed in Table 1, show that TennCare has experienced strong enrollment growth and effectively reached a high share of eligible children, an important indicator of the State's overall performance. These results are consistent both with the latest CMS analysis – which shows Tennessee with the highest rate of Medicaid enrollment growth among states that have not expanded Medicaid (over 25 percent between July-September 2013 and December 2015)[1] – and with the annual beneficiary survey conducted by the University of Tennessee for TennCare – which in 2015 shows only 1.5 percent of Tennessee children under the age of 18 were uninsured, the lowest ever during the 22 years of the survey.[2]

[1] "Medicaid & CHIP: December 2015 Monthly Applications, Eligibility Determinations and Enrollment Report," *Centers for Medicare & Medicaid Services*, February 29, 2016. https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/december-2015-enrollment-report.pdf.

[2] The University of Tennessee-Knoxville, Center for Business & Economic Research, The Impact of TennCare: A Survey of Recipients, October 2015

Table 1: Measures of Enrollment Growth in TennCare

Measure 1: TennCare Enrollment by Month and Eligibility Category, January 2014 – April 2015	TennCare saw a **14 percent increase** in monthly enrollment between January 2014 and May 2015, from 1.2 million to 1.4 million enrollees.
Measure 2: TennCare and SNAP Recipient Overlap, April 2015	Of the 536,507 Tennessean children enrolled in SNAP in April 2015, **91.2 percent** were also enrolled in TennCare.
Measure 3: Share of Eligible Child Population Enrolled in TennCare, 2013	In 2013, participation in Medicaid or CHIP in Tennessee was **90.9 percent**. This is statistically significantly higher than the national average of 88.3 percent.

In sum, TennCare is experiencing robust enrollment gains – it has the highest rate of enrollment in Medicaid among non-expansion states and continues to have a strong track record of enrolling a high share of eligible children.[3] The waiver of retroactive eligibility has contributed to these successes by allowing TennCare to deliver a strong, consistent message that it is important to enroll in and use coverage as intended. For Tennessee, a change in the retroactive eligibility waiver would represent a major step backwards.

[3] "Medicaid & CHIP: December 2015 Monthly Applications, Eligibility Determinations and Enrollment Report," *Centers for Medicare & Medicaid Services*, February 29, 2016. https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/december-2015-enrollment-report.pdf.

III. Introduction

Tennessee is the only state in the country where all Medicaid beneficiaries receive their care through managed care. The State's waiver of retroactive eligibility is a foundational feature of its Medicaid program that has been in place for twenty-two years. It allows the State to serve beneficiaries through full-risk managed care plans; to create incentives for consumers to enroll in coverage promptly without waiting until illness strikes, which is consistent with commercial coverage and Qualified Health Plan coverage; and to operate its managed care program efficiently. CMS authorized the State's waiver of retroactive eligibility in the original TennCare waiver in 1994, and it has continued this waiver authority in all subsequent renewals.

In the 2013 extension of TennCare, CMS added STC 68, which requires a comprehensive evaluation of TennCare's eligibility determination system aimed at assessing the ongoing need for a waiver of retroactive eligibility. In this report, Manatt describes the role of the retroactive eligibility waiver in the State's Medicaid program and the rationale for continuing it; reviews the approach used to evaluate the TennCare eligibility determination system; and provides available data on key eligibility and enrollment issues.

For the reasons discussed in this report, Tennessee is seeking CMS approval to continue its waiver of retroactive eligibility; the discontinuation of this longstanding waiver would be deeply problematic from a policy and an operational perspective and fundamentally incompatible with Tennessee's managed care environment. In addition, a chief concern raised in the InsureTN debate – the State's effort at Medicaid expansion – is that the federal government could make modifications to the Medicaid program at any time. Termination of the State's long-standing retroactive eligibility waiver could lend credibility to that concern and significantly impede the prospect of Medicaid expansion in the foreseeable future.

Fortunately, Tennessee's Medicaid program is operating well without retroactive eligibility. Tennessee has the highest rate of Medicaid enrollment growth in the country among non-expansion states as of December 2015 and the State's uninsurance rate is at its lowest level in over a decade.[4,5] TennCare is committed to actively promoting continuity of coverage for eligible individuals who have enrolled in Medicaid and established a relationship with health care providers. Tennessee officials, in designing a redetermination process to be implemented following enactment of ACA, made the policy decision to provide post-enrollment retroactive eligibility. As described in more detail below, this decision virtually eliminates the possibility that anyone with significant ongoing health needs who continues to meet eligibility requirements will experience a gap in coverage as a result of being disenrolled after failing to receive and/or read redetermination materials sent to them.

[4] "Medicaid & CHIP: December 2015 Monthly Applications, Eligibility Determinations and Enrollment Report," *Centers for Medicare & Medicaid Services*, February 29, 2016. https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/december-2015-enrollment-report.pdf.

[5] In 2015, 6.6% of Tennessee residents were uninsured. The University of Tennessee-Knoxville, Center for Business & Economic Research, The Impact of TennCare: A Survey of Recipients, October 2015.

IV. Policy and Operational Context

A. Foundational to TennCare

Over the past twenty years, Tennessee has built a Medicaid program that provides care for all of its beneficiaries through an integrated, full-risk managed care model. As outlined in other evaluations of TennCare, the State has worked hard to ensure that managed care organizations deliver high quality health services and are held accountable for managing utilization and costs and ultimately improving health outcomes.[6] A key feature of the State's successful approach to managed care is the waiver of retroactive eligibility. By eliminating retroactive eligibility, the State ensures there is an incentive for eligible individuals to enroll in coverage before they get sick, allowing them to establish themselves with providers and receive important preventive care. TennCare's perspective is there is no way to effectively manage the care of individuals who were not even recognized as Medicaid beneficiaries, much less connected to a system of care. As a result, the State's waiver is considered a foundational feature of the State's approach to actively managing the care of TennCare beneficiaries.

B. Prepares Consumers for Private Coverage

Although it pre-dated the Affordable Care Act by close to twenty years, the waiver of retroactive eligibility has taken on new importance in Tennessee now that consumers face an obligation to secure coverage under the Affordable Care Act (ACA). Under the ACA, everyone is expected to have insurance or pay a fine (unless they meet limited exemption criteria). The law establishes a single, annual open enrollment period for Marketplace plans and a limited set of circumstances in which people can secure coverage outside of this open enrollment period. Marketplace plans are only available on a prospective basis, and, in fact, there can be a lag of as much as six weeks between signing up and when coverage begins.

In light of these new ACA "rules of the road," it would be a disservice to TennCare beneficiaries to acculturate them to receiving coverage on a retroactive basis. After they leave Medicaid, they still must comply with the ACA coverage mandate and it is important that they are prepared to use Marketplace plans and other sources of private insurance as required. They will not be able to wait until they get sick to sign up for a Marketplace plan and, in fact, they may be required to wait several months to secure coverage if they miss the open enrollment period. In the context of the ACA, it is more important than ever that TennCare's eligibility rules continue to create incentives for Tennessee residents to enroll in coverage *before* they incur medical bills and to comply with the individual mandate.

---

[6] "Medicaid & CHIP: December 2015 Monthly Applications, Eligibility Determinations and Enrollment Report," *Centers for Medicare & Medicaid Services*, February 29, 2016. https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/december-2015-enrollment-report.pdf.

C. Avoids Major Disruption and Significant Investments in Scarce State Resources

On a more practical level, a decision by CMS to revoke TennCare's longstanding waiver of retroactive eligibility would require significant eligibility system changes and increase costs. It would require a major investment by the State of administrative dollars, as well as of time from leadership, IT staff and contractors, and policy and operational staff. The State would have to modify existing eligibility systems, develop new policies, procedures and notices, and provide training to eligibility workers and call center staff. The effort would consume significant financial and human resources, potentially overburdening already strained State staff and diverting limited resources and focus from other critical priorities, most notably continued development of a Medicaid eligibility determination system.

D. Distinguishing Retroactive Eligibility from Current Practice

Tennessee currently provides Medicaid beneficiaries with coverage back to the date of application, but it is important to distinguish this practice from retroactive eligibility. The current practice encourages consumers to sign up for coverage by offering them protection from medical bills once they have applied for Medicaid. It ensures they are covered for the period between the date of application and the date of eligibility determination. This is entirely different from making it possible for someone to wait until after they incur medical bills to apply for coverage.

From an administrative perspective, it is important to highlight that the current practice largely relies on capitation payments to managed care plans, but this approach would not be viable if the retroactive eligibility waiver were revoked. Managed care organizations cannot be expected to accept full risk for enrollees/services they had no opportunity to manage, for up to the three month retroactive eligibility period.

E. Commitment to Continuity of Coverage

TennCare has actively promoted continuity of coverage for eligible individuals who have enrolled in Medicaid and established a relationship with health care providers. Like many other states, following the enactment of ACA and the need to focus on the significant changes required by that new law, Tennessee delayed conducting renewals until relatively recently, allowing beneficiaries to maintain continuity of coverage while Tennessee developed its renewal policies and operational procedures. In developing those policies and procedures, Tennessee has decided to provide coverage retroactive to the date of termination for individuals who were terminated for "failure to respond" to documentation requests, but who subsequently follow up within 90 days of the termination and are found to be eligible. This decision reflects the State's commitment to eliminating avoidable gaps in coverage at redetermination. Unlike beneficiaries who have not yet applied for Medicaid, the individuals who are benefiting from this new policy are already known to TennCare, have established themselves with providers and begun to receive important preventive care. From TennCare's

perspective, it is entirely different to implement a policy to improve continuity of coverage for individuals who already have signed up for Medicaid versus providing retroactive eligibility to new applicants in a way that could undermine incentives to enroll promptly.

TennCare anticipates that this new policy has virtually eliminated the possibility that anyone with significant ongoing health needs who continues to meet TennCare eligibility requirements will experience a gap in coverage as a result of failing to receive and/or read redetermination materials sent to them. It is very unlikely that such individuals would not have at least one encounter with the healthcare system in the 90 days following termination, at which point they become aware of their lapse in coverage. This is especially true because when TennCare implemented prescription limits in 2005, it stopped allowing for more than a one-month supply whenever a prescription or refill is dispensed. Thus a person who takes a prescription to the pharmacy to be refilled or who attempts to see his physician after disenrollment will quickly learn what has happened and will still have time to contact the State and initiate the reinstatement process. This policy will go a long way towards ensuring continuity of care for those who are users of health care services, even when they do not respond in a timely way to renewal requests.

V. Changes Since Creation of STC 68

The content of STC 68 was created in 2012, prior to implementation of the major provisions of the Affordable Care Act. At the time, the federal government and states had no experience with how eligibility systems would work in practice; the country had yet to experience the troubled roll out of healthcare.gov and many of the state-based Marketplace systems, and “flat files” and “account transfers” were not yet part of the common parlance. As a result, the measures listed by CMS in STC 68 often do not fit with the current on-the-ground reality of how the ACA has actually been implemented in Tennessee and around the country.

Most notably, Tennessee and other states that rely on the Federally Facilitated Marketplace do not control key elements of the eligibility determination process even though the measures in STC 68 assume that a state can evaluate all aspects of the process. It is important to highlight that the mismatch between the measures included in STC 68 in 2012 and the on-the-ground reality of how the ACA has been implemented is not a Tennessee-specific issue, but rather reflects the bifurcated nature of eligibility determinations in all states that use the FFM. In all FFM states, including Tennessee, it is not possible for the State to review data on key issues, such as the following:

- ***Incomplete Applications*:** The FFM does not provide data on the number of people who start applications, but are unable or unwilling to complete them.
- ***Denied Applications:*** The FFM does not provide any information on applications that have been denied Medicaid, thereby preventing visibility into the full universe of applications submitted.

Since all Modified Adjusted Gross Income (MAGI) applications in Tennessee are submitted via the FFM, deficiencies in the availability and reliability of these FFM data elements are particularly acute and directly preclude the State from responding to the kinds of measures that were given as examples in STC 68.

While Tennessee currently is in the position of relying on the FFM for the vast majority of MAGI eligibility determinations, it is moving aggressively to procure a state-of-the-art eligibility determination system consistent with the goals and requirements of the ACA. The new system will be known as the Tennessee Eligibility Determination System or TEDS. In the meantime, to supplement the work of the FFM, Tennessee has also developed a host of State databases and manual processes for enrollment of MAGI populations and taken numerous steps to protect coverage for all Medicaid beneficiaries pending completion of its eligibility determination system. These include policy changes to protect coverage; manual fixes and workarounds; and the use of eligibility systems built for the non-MAGI population.

As a result of the shift in the policy and systems landscape since the creation of STC 68, in Tennessee and around the country, it often is not possible to secure useful, reliable data on certain measures. Each STC 68 measure is identified below with an explanation of whether it was feasible to produce reliable data.

(A) Evaluation of eligibility determinations by type, e.g., application, redetermination, transfer to the Exchange.

For this measure, Manatt used Tennessee data to evaluate the applicants ultimately determined eligible for TennCare between January 2014 and April 2015. The data, however, cannot be used to identify eligibility determinations by type because they do not include detailed information on MAGI applications submitted through the FFM. The FFM provides Tennessee with data on the applications with inconsistencies, but it does not provide Tennessee or other states with data on applications that are denied or that have not been fully processed. To fully respond to this measure, Tennessee would need information on all of the applications submitted through the FFM.

The State's new eligibility system (TEDS) is expected to be able to provide data on evaluation of eligibility determinations by type when it is completed. For now, Tennessee is relying on the MMIS (InterChange) and the State's human services eligibility system (ACCENT) to evaluate eligibility and initiate coverage for non-MAGI applicants. These two systems were not built to provide analytical data, and cannot be used for this purpose.

Finally, Tennessee does not currently transfer applications to the Exchange (i.e., FFM) when someone is found ineligible for Medicaid. Tennessee, however, does provide such consumers with written information on how to apply for coverage through the FFM in its denial letter.

(B) Evaluation of Medicaid denial and termination reasons.

Denials. Tennessee was not able to provide Manatt with meaningful data on denials. The FFM, which is the source of all MAGI applications in Tennessee, does not provide Tennessee nor any

state with data on denials. In addition, the State's MMIS and ACCENT systems do not allow the State to conduct an analysis of non-MAGI TennCare denials. Once TEDS is operational, the State will be better equipped to produce denial and termination data.

Terminations. Until recently, Tennessee has been continuing the coverage of many Medicaid beneficiaries until it could conduct redeterminations. The policy, which was encouraged by CMS across all states, was designed to promote stability in Medicaid for beneficiaries while the State continues to improve and implement eligibility system changes. As a result, there have been relatively few terminations to date, with the primary reasons for termination being death, voluntary withdrawal, and moving out-of-state. Since the reasons for terminations have been so few, an analysis of termination data did not seem useful at this time. Tennessee, however, anticipates being able to produce data on terminations once TEDS is functional and has been in use for a period of time.

(C) Evaluation of average application processing times and timeliness.

Tennessee currently relies on the FFM for the processing of most applications, many of which receive immediate determinations. Most importantly, Tennessee does provide coverage retroactive to the date of application.

(D) Evaluation of reasons for disenrollment and internal churn.

As discussed above, Tennessee has adopted a transitional policy of continuing Medicaid coverage while it continues work on its eligibility determination system. An analysis based on this small, narrowly-defined subset of beneficiaries would not generate representative findings. Once TEDS is operational and the State has been conducting redeterminations for a sustained period, the State should be better able to assess disenrollment and internal churn.

(E) Evaluation of seamless transition between Medicaid, CHIP or the Exchange, as applicable.

A seamless transition between Medicaid, CHIP, and the Exchange is a future goal, however the interaction of the FFM and multiple State systems does not allow for a seamless transition currently or for the State of Tennessee to gather meaningful data on transitions. As mentioned previously, Tennessee does not currently transfer application data from Medicaid denials to the FFM for processing and the FFM is not yet equipped to act on such transfers. TEDS, however, is being designed to promote smooth transitions and, once it is operational, Tennessee should have data to evaluate its effectiveness in this regard.

VI. Evaluation Approach and Development of Alternative Measures

To prepare this report, TennCare retained Manatt to work with State staff to review the State's eligibility and enrollment policies and processes; to identify IT systems that could provide useful data; and to analyze the available data. Conducted collaboratively by Manatt and TennCare staff, the work consisted of the following steps:

Renewal of Retroactive Eligibility Waiver
STC 68 Evaluation Report
March 1, 2016

1. In-Depth Review of Eligibility Determination System

As a first step and continuing over the course of several months, Manatt and TennCare staff conducted a comprehensive review of how Tennessee's eligibility determination system is currently working. Through a series of intensive working sessions, Manatt and TennCare policy, program and systems staff conducted a systematic review of the eligibility and enrollment policies and processes. Manatt and TennCare staff documented seven eligibility and enrollment scenarios to better understand the workflows, timeline, data systems implicated, and the data elements available. The review also identified the key policy strategies that Tennessee has adopted to ensure relatively seamless coverage for eligible beneficiaries as it continues build TEDS, including:

- **Extension of redeterminations.** Like many states, TennCare delayed redeterminations while the State was focused on complying with the extensive new requirements of the ACA. The State is now in the midst of phasing in renewals.

- **FFM application assistance.** TennCare contracts with the Department of Human Services to offer in-person application assistance from certified application counselors in offices local to each of Tennessee's 95 counties. These offices are equipped with computer kiosks and telephones that can be used by applicants who lack access to such technology or who need assistance is using it. In-home application assistance for disabled individuals is also available through Tennessee's Area Agencies on Aging and Disability.

- **Processing applications for Long Term Services and Supports and Medicare Savings Programs directly.** Tennessee encourages individuals applying for Long Term Services and Supports and Medicare Savings Programs to apply directly to the State. These applications are processed using the ACCENT system. Applications can be mailed or faxed and are processed by a centralized team of eligibility specialists.

- **Expanding presumptive eligibility for pregnant women.** Tennessee makes presumptive eligibility determinations for pregnant women through local health departments across the State using processes that were in place prior to passage of the ACA. In early 2014, when TennCare staff identified that pregnant women were having problems enrolling in Medicaid through the FFM, Tennessee began extending the length of their PE period, allowing them to access vital prenatal care while awaiting their full eligibility determination from the FFM. More recently, in order to facilitate full Medicaid eligibility determinations for women

granted presumptive eligibility, TennCare expanded its partnership with the Department of Health to establish a process whereby trained staff in local health departments offer assistance to pregnant women in filing FFM applications following a presumptive eligibility determination.

- **Deemed eligibility for newborns.** Tennessee confers "deemed eligibility" to babies born to women enrolled in TennCare when they give birth. Such births are reported to TennCare through a telephone call to TennCare's eligibility call center.

- **Establishing a special presumptive eligibility procedure for newborns.** In August 2014, Tennessee implemented a newborn presumptive eligibility process to address difficulties non-Medicaid eligible mothers were encountering at the FFM when attempting to enroll newborns that were not eligible for deeming. These mothers were unable to complete the identity proofing process established by the FFM resulting in delays in obtaining coverage. Under Tennessee's approach, individuals may use a one-page application form to apply for newborn presumptive eligibility at any qualified entity (including birthing centers and hospitals across the state). The qualified entity makes the presumptive eligibility determination, issues the appropriate notice to the applicant and electronically transmits the data for approved cases directly to TennCare for immediate enrollment. Additionally, pregnant enrollees in CoverKids (Tennessee's CHIP program) can call to report the newborn's birth and the CoverKids contractor will enroll the newborn in CoverKids or TennCare as appropriate.

- **Breast and cervical cancer presumptive eligibility.** Tennessee also makes presumptive eligibility determinations for individuals with breast and cervical cancer through local health departments located throughout the State.

- **Implementation of a process to resolve data inconsistencies.** In September 2014, Tennessee developed a manual process to resolve applications with data inconsistencies that had been pended at the FFM as a result of such inconsistencies. This action was needed after CMS informed Tennessee that such applications were being pended indefinitely at the FFM because the FFM had no way to resolve the inconsistencies. These inconsistencies are now routinely forwarded from the FFM to Tennessee for resolution.

- **Establishment of a special eligibility determination process for emergency medical services.** During this interim period (while Tennessee is heavily reliant on the FFM as it works to implement its own MAGI compliant eligibility system), Tennessee monitors to the extent possible the degree to which the FFM is

meeting the needs of residents of the State. Through this monitoring it identified a group of applicants, immigrants potentially eligible for emergency medical services, who it felt could potentially benefit from an additional eligibility pathway. Given the relatively small numbers of such applicants, Tennessee elected to begin accepting these applications directly from Tennessee hospitals in June 2015, processing them manually using MAGI in the cloud.

- **Reinstatement of coverage for beneficiaries who miss renewal deadlines**. In the redetermination process implemented following the launch of the ACA, the State decided to reinstate coverage to the date of termination for individuals undergoing reverification who: (1) submit documentation within the 90 days following a termination for "failure to respond," and (2) are subsequently determined eligible for TennCare. This policy reflects TennCare's effort to maintain stable coverage for beneficiaries, and is different from providing retroactive eligibility to new applicants who have not yet established a relationship with a managed care organization and/or providers. It is designed to promote continuity of care by eliminating the possibility that anyone with significant ongoing health needs who continues to meet TennCare eligibility requirements will experience a gap in coverage as a result of failing to receive and/or read the reverification materials sent to them.

2. Review of IT Systems

TennCare also conducted an updated assessment of the data that could be produced from its current IT systems. As CMS is aware, Tennessee is in the midst of creating a centralized Medicaid/CHIP eligibility system known as TEDS that remains under development. Because of unanticipated problems, the State is now relying on the FFM for most MAGI eligibility determinations and the Department of Human Services' ACCENT system for non-MAGI cases, neither of which is owned or controlled by TennCare. In addition, the State uses Access databases to operationalize selected aspects of eligibility determinations, such as to track individuals with an inconsistency identified by the FFM. As explained in detail above, while the State has been able to leverage multiple systems and mitigations that involve manual processes to conduct eligibility and enrollment determinations, existing systems do not allow for securing comprehensive or consistent data on the eligibility and enrollment experience.

3. Identify Appropriate Measures and Collect Data

In the third stage, TennCare and Manatt identified measures in response to STC 68 for which it was feasible to gather reliable data and which were appropriate in light of the State's current circumstances. All of the factors described above – the FFM as the

primary route to coverage for MAGI populations, the multiple systems involved in eligibility and enrollment, the manual nature of several processes, and the mitigations that TennCare has employed to protect beneficiaries – impacted the technical feasibility of producing data and the overall reliability and relevance of the measures proposed by CMS in STC 68.

Based on this systematic assessment, Manatt in conjunction with TennCare identified alternative measures – data and analytics from current systems as well as from nationally-recognized sources – that would permit an evaluation of the effectiveness of its eligibility determination systems and processes. Manatt worked with TennCare to identify three measures (reviewed with CMS in April 2015), define technical specifications and protocols (see Appendix), and collect data:

- *TennCare monthly enrollment by eligibility category* – These data allow for analysis of enrollment trends across major eligibility groups since January 2014, as well as for a high-level assessment of the effect of key eligibility and enrollment policies on specific categories of TennCare members.

- *TennCare and SNAP recipient overlap* – These data provide an indication of whether TennCare-eligible children are participating in TennCare, using children enrolled in SNAP as a proxy for children who are eligible for TennCare. A high overlap rate indicates that a substantial share of eligible children are enrolled in TennCare, while a low rate indicates that eligible children remain uncovered and subject to incurring unpaid medical bills that otherwise might be reimbursed if retroactive eligibility were in place in TN.

- *Share of eligible children enrolled in TennCare* – These data from a nationally-respected source benchmarks Tennessee's Medicaid participation rates among eligible children against other states.

The outcomes of these measures are reported below. A detailed discussion of the technical specifications for each measure is in the Appendix.

VII. Results

The data results on the three measures, outlined below, indicate that Tennessee continues to experience strong enrollment growth in TennCare. The data also show that the State has a strong track record of effectively reaching a high share of eligible children. These results are consistent with the latest CMS report, which shows Tennessee with the highest rate of

Medicaid enrollment growth among states that have not expanded Medicaid (over 25 percent between July-September 2013 and December 2015).[7]

The strong enrollment gains have occurred even though the State's new eligibility system is still under development. They reflect the impact of policies adopted by Tennessee to protect beneficiaries as it completes its new eligibility determination system, including the use of presumptive eligibility and continued coverage of beneficiaries until such time as redeterminations can be conducted efficiently. TennCare officials also believe that the waiver of retroactive eligibility has encouraged people to apply for coverage in advance of requiring medical care, contributing to higher participation rates in coverage and allowing Tennessee to build an effective managed care system.

Measure 1: TennCare Enrollment by Month and Eligibility Category, January 2014 – April 2015	TennCare saw a **14 percent increase** in monthly enrollment between January 2014 and May 2015, from 1.2 million to 1.4 million enrollees.
Measure 2: TennCare and SNAP Recipient Overlap, April 2015	Of the 536,507 Tennessean children enrolled in SNAP in April 2015, **91.2 percent** were also enrolled in TennCare.
Measure 3: Share of Eligible Child Population Enrolled in TennCare, 2013	In 2013, participation in Medicaid or CHIP in Tennessee was **90.9 percent**. This is statistically significantly higher than the national average of 88.3 percent.

Measure 1: Enrollment Growth by Eligibility Group

As shown in the table below, Tennessee has experienced rapid enrollment growth since implementation of the ACA. Between January 2014 and April 2015, total TennCare enrollment grew from 1.2 million to 1.4 million. The vast majority of the enrollment growth occurred among MAGI groups, which jumped from 906,484 to 1,066,285, an increase of 17.6 percent. In comparison, the number of non-MAGI individuals increased by a far more modest 2.4 percent to 331,643 in May of 2015. The single largest source of enrollment growth was among families with children; 134,000 low-income children and parents have been added to coverage since January 2014.

Although starting from a smaller base, enrollment among pregnant women also has jumped significantly. This reflects TennCare's decision to aggressively use presumptive eligibility to enable pregnant women to secure coverage quickly and easily, and working around any problems they encounter enrolling through the FFM.

[7] "Medicaid & CHIP: December 2015 Monthly Applications, Eligibility Determinations and Enrollment Report," *Centers for Medicare & Medicaid Services*, February 29, 2016. https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/december-2015-enrollment-report.pdf.

Renewal of Retroactive Eligibility Waiver
STC 68 Evaluation Report
March 1, 2016

Eligibility Group	Jan 2014	Feb 2014	March 2014	April 2014	May 2014	June 2014	July 2014	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	March 2015	April 2015
Families with Children	882,708	883,451	902,389	913,436	920,560	929,727	938,897	949,455	959,917	965,891	973,921	987,552	998,814	1,007,501	1,013,682	1,018,431
Pregnant Women	21,502	21,620	22,504	23,274	24,327	25,347	26,421	27,411	28,249	28,893	29,592	30,828	31,792	32,506	33,247	34,048
PW PE	2,274	3,112	4,266	5,332	6,277	7,413	8,390	9,356	10,404	11,367	12,114	12,908	13,830	14,288	15,245	15,991
Foster Care/ Adoption	19,514	19,414	20,007	20,447	20,888	21,390	21,678	21,931	22,395	22,788	23,129	23,522	23,924	24,065	24,552	24,676
Aged	37,269	36,994	36,956	36,982	36,958	37,061	37,169	37,214	37,232	37,303	37,252	37,216	37,018	36,557	36,225	35,960
Disabled	233,958	234,028	234,657	235,262	235,808	236,307	237,061	237,891	238,479	238,571	238,696	238,716	238,752	238,401	238,085	237,930
Medically Needy	29,507	29,529	29,544	29,490	29,439	29,433	29,428	29,412	29,391	29,352	29,323	29,289	29,225	28,955	28,911	28,880
Uninsurable	1,994	2,012	2,011	1,997	1,997	1,996	1,995	1,992	1,991	1,978	1,974	1,970	1,965	1,958	1,954	1,952
Other	1,716	1,785	1,857	1,913	1,985	2,042	2,098	2,149	2,187	2,241	2,299	2,350	2,393	2,433	2,494	2,555
Grand Total	1,230,442	1,231,945	1,254,191	1,268,133	1,278,239	1,290,716	1,303,137	1,316,811	1,330,245	1,338,384	1,348,300	1,364,351	1,377,713	1,386,664	1,394,395	1,400,423

Measure 2: Enrollment of SNAP Children into Medicaid

One powerful measure of the effectiveness of an eligibility system is the rate at which eligible individuals are enrolled in coverage. It is difficult to generate such participation rates because there is no accurate, comprehensive and timely source of data on who is eligible for Medicaid (i.e., the denominator of the participation rate is missing). In the absence of such data, TennCare has gathered information on the participation of SNAP children in Medicaid. Nearly all, if not all, SNAP children can and should be eligible for Medicaid.[8] In Tennessee, children enrolled in SNAP are not automatically enrolled in Medicaid. Taken together, these two factors mean that data on the extent to which SNAP children also are enrolled in Medicaid offers a measure of the participation of eligible children in TennCare.

As of April 2015, 489,380 of the 536,507 children enrolled in SNAP were also enrolled in Medicaid, a participation rate in Medicaid among SNAP children of 91.2 percent. There are reasons why this participation rate may vary for other groups of children, such as children in families that have not sought SNAP. Similarly, it is possible that participation rates are lower for adults. However, data are not available to test these possibilities, leaving the Medicaid participation rate among SNAP children as the best proxy available for the effectiveness of the Tennessee eligibility determination system. Notably, as discussed further below, the participation rate in Medicaid among SNAP children is nearly identical to the broader estimated participation rate among all Medicaid-eligible children generated by the Urban Institute (although these data are not as current as the SNAP measure).

Measure 3: Participation Rate Among Eligible Children

One issue with data produced solely by TennCare is that it cannot offer insight into how the State is performing relative to other states. Also, as noted above, the participation rate among SNAP children could be distorted by exclusion of children whose families have not applied for SNAP. Measure 3, therefore, is a complementary measure based on an Urban Institute analysis of participation rates in Medicaid and CHIP across states. Specifically, the Urban Institute Health Policy Center looked at eligibility and participation for a sample of over 1.4 million children across the United States, based on 2008 and 2012 American Community Survey data. It found that participation in Medicaid/CHIP in Tennessee was 90.9 percent, which is statistically significantly higher than the national average of 88.3 percent. Again, it is possible that the participation rate of other eligibility groups differs notably from that of children, but the Urban Institute analysis does not provide data on other populations.

[8] It is theoretically possible that differences in household composition rules and income counting methodologies could result in a child being eligible for SNAP, but not Medicaid, but such an event is likely to be extremely rare.

VIII. Conclusion

Even in the face of significant IT challenges, TennCare is experiencing robust enrollment gains – it has the highest rate of enrollment in Medicaid among non-expansion states and continues to have a strong track record of enrolling a high share of eligible children. The waiver of retroactive eligibility has contributed to these successes by allowing TennCare to deliver a strong, consistent message that it is important to enroll in and use coverage as intended. The approach adopted by Tennessee two decades ago – emphasizing the importance of enrolling in coverage before a medical problem arises – provides a strong springboard for the culture of coverage introduced by the ACA. For Tennessee, a change in the retroactive eligibility waiver would represent a major step backwards, while diverting limited financial and human resources from completion of TEDS, and potentially impeding any prospect for extension of Medicaid to low-income adults for the foreseeable future.

Appendix: Technical Specifications

Measure 1: TennCare Monthly Enrollment, by Eligibility Category

Description

Monthly count of TennCare enrollment from January 2014-present, segmented into nine major eligibility categories:

- Families with Children
- Pregnant Women
- Pregnant Women Presumptive Eligibility
- Foster care / Adoption assistance children
- Aged
- Disabled
- Medically Needy
- Uninsurable
- Other

Purpose

To provide basic data on the rate of enrollment growth in Tennessee since January of 2014 across major eligibility groups.

Source

TennCare enrollment data generated from InterChange system, the Medicaid Management Information System (MMIS) in Tennessee.

Methodology

TennCare staff generated a count of unique beneficiaries enrolled by month from the InterChange system. In light of various changes in State eligibility and enrollment policies and practices that occurred in 2013 and to generate a consistent series of data for the enrollment trend, this measure is based on monthly enrollment between January 2014 and the most current complete month for which data are available (April 2015 as of the time of this writing).

To segment enrollment by eligibility category, TennCare staff generated monthly enrollment counts of each unique eligibility group classification, based on the combination of two variables - Aid Code and Category Code - which together determine unique eligibility categories as stored in the InterChange system.

To determine categories for analysis, we reviewed each of the unique application classifications found in the InterChange System between January 2014 and April 2015. Upon evaluation of these combinations, the unique eligibility classifications in the InterChange system were grouped into nine major eligibility categories. The categories are designed to allow for analysis

of enrollment trends across major eligibility groups , as well as to assess the effect of key eligibility and enrollment policies, such as Tennessee's use of presumptive eligibility for pregnant women:

- **Families with Children**: Children covered under the poverty-based eligibility groups; Caretaker relative; CHIP children. MAGI group.
- **Pregnant Women**: includes eligibility categories for women who are pregnant and categorically needy or under the poverty line. MAGI group.
- **Pregnant Women Presumptive Eligibility**: includes pregnant women presumptive eligibility category. MAGI group.
- **Foster Care/Adoption**: Includes foster care and adoption assistance eligibility categories. Non-MAGI group.
- **Aged**: Includes all eligibility categories for aged individuals, including aged individuals who are institutionalized. Non-MAGI group.
- **Disabled**: Includes all eligibility categories for non-aged disabled individuals, including SSI-related coverage and individuals who are institutionalized. It also includes the standard spend down groups for people with disabilities. Non-MAGI group.
- **Medically Needy**: Includes eligibility categories for children under 21 and pregnant women who are medically needy. Non-MAGI group.
- **Uninsurable**: Includes uninsurable individuals who qualify for coverage under the TennCare waiver. Non-MAGI group.
- **Other**: A small number of miscellaneous categories, including breast and cervical cancer eligibility category. Non-MAGI groups.

Assumptions

No notable assumptions.

Measure 2: TennCare and SNAP Recipient Overlap

Description

Percentage of children age 0-19 enrolled in SNAP in April of 2015 (point-in-time) who are also enrolled in TennCare.

Purpose

This measure provides an indication of whether TennCare-eligible children are participating in TennCare, using children enrolled in SNAP as a proxy for children who are eligible for TennCare. A high overlap rate would indicate that a substantial share of eligible children are enrolled in TennCare, while a low rate would indicate that eligible children remain uncovered and subject to incurring unpaid medical bills that otherwise might be reimbursed if retroactive eligibility were in place in TN. his measure is designed to provide a more current measure of participation

rates than are available from Urban institute' s analysis of survey data (Measure 3), leveraging the relationship between SNAP and TennCare eligibility for children.

Sources

TennCare enrollee data generated from the InterChange system (TennCare enrollment system) and monthly SNAP recipient data provided to TennCare by the Tennessee Department of Health (DHS) generated from the ACCENT system (SNAP enrollment system).

Methodology

To determine the percentage of SNAP beneficiaries likely eligible for Medicaid who are enrolled in TennCare, it is first necessary to identify a matched cohort based on eligibility criteria for the two programs. For the analysis contemplated (% of TennCare-eligible SNAP beneficiaries enrolled in TennCare) it is necessary to identify a population where TennCare eligibility is nearly identical to or consistently more generous than SNAP eligibility. This approach will protect against inappropriately undercounting TennCare penetration by constructing a measure that includes only SNAP beneficiaries who are almost certainly eligible for TennCare.

Beneficiary income eligibility for children age 6-19 is roughly equivalent between SNAP and TennCare Medicaid (130% FPL for SNAP and 133% FPL for TennCare). Children in younger age groups have higher income eligibility thresholds for TennCare (195% FPL for children age 0-1 and 142% FPL for children age 1-5). Children age 0-19 above TennCare Medicaid levels are eligible for TennCare Standard up to 211% FPL.[9] SNAP has asset tests that do not apply for TennCare, which has no asset tests. As such, on both income eligibility and asset tests, TennCare eligibility is consistently more generous than SNAP eligibility for children age 0-19, thus it is appropriate to include all children age 0-19 in the SNAP match analysis. See page 26 for an illustration of TennCare and SNAP eligibility criteria for children age 0-19.

Utilizing SNAP enrollment data provided by DHS to TennCare on a monthly basis, a cohort of children age 0-19 enrolled in SNAP are identified. Recipient age for purposes of this analysis is calculated based on their recorded date of birth (reported on the DHS monthly file) and the first day of the month reflected in the SNAP file. This will produce the most conservatively defined age 0-19 cohort.

To identify TennCare beneficiaries enrolled in SNAP, DHS-provided SNAP beneficiary records for recipients in the child cohort that are linked to TennCare enrollee records from InterChange for the same time period (focal month) using social security numbers. Roughly one percent of the SNAP records for the months evaluated have missing social security numbers, meaning that they cannot be matched to TennCare records and so must be excluded from the analysis.

To account for application processing for newly enrolled members of up to 45 days, the analysis needs to be run at least two months after the focal month in question. So, for example, an analysis run in June of a given year would evaluate SNAP members enrolled in April from the

[9] Children in excess of TennCare Medicaid eligibility limits but below 211% FPL are eligible for TennCare Standard.

April DHS file, matched against all TennCare beneficiaries in Interchange with TennCare coverage in April.

Using the matched data, it is possible to count the number of SSNs enrolled in both TennCare and SNAP in any given month for the child cohort. The percentage of SNAP beneficiaries age 0-19 enrolled in TennCare is calculated as:

[Count of SNAP beneficiaries in child cohort in focal month also enrolled in TennCare in focal month] / [Count of SNAP beneficiaries in child cohort in focal month]

Assumptions

Assumes that the difference in income counting methodologies and household composition rules between SNAP and Medicaid are minimal and do not result in additional children being eligible for SNAP who are not eligible for Medicaid. To the extent this assumption is erroneous, it would artificially drive down the participation rate, resulting in the measure understating TN's success in enrolling eligible children.

Assumes that the TennCare participation rate for the entire population is similar to the participation rate for children enrolled in SNAP. It is possible that the participation rate for eligible children may in fact be higher than the participation rate for the entire population, given outreach programs for children, as well as a greater participation rate in general among children. In addition, beneficiaries enrolling in one program (SNAP) are more likely to enroll in another program (TennCare) than the general population. Even with these caveats, however, we believe the measure is a reasonable indication of TennCare participation rates that provides useful insight into the functioning of the TennCare eligibility determination system when combined with the data in Measure 3.

Measure 3: Share of Eligible Child Population Enrolled in TennCare

Description

Percentage of eligible children enrolled in TennCare. Point in time estimate (CY2012).

Source

2015 Urban Institute Analysis, using 2012 American Community Survey (ACS) data.[10] The University of Minnesota's Integrated Public Use Microdata Series (IPUMS) was used for the analysis.

Purpose

To provide benchmark data from a nationally-respected source on Tennessee's Medicaid participation rates. Since these data are not available past 2012, they are designed to be used in conjunction with the SNAP data presented in measure 2.

---

[10] Kenney GM, Haley JM, Anderson N, et al. Children eligible for Medicaid or CHIP: who remains uninsured, and why? Academic Pediatrics. 2015.

Methodology

This measure reports the results of a study by the Urban Institute, which looks at the number of uninsured children who are eligible but not participating in either Medicaid or the Children's Health Insurance Program (CHIP), by state. The analysis used in this study was produced using the Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model. The Urban Institute Health Policy Center's ACS Medicaid/CHIP Eligibility Simulation Model estimates program eligibility on a statewide basis, based on eligibility requirements, including the amount and extent of income disregards. The analysis only provides data on children and cannot be used for participation rates among eligible adults.

The Urban Institute analysis looked at eligibility and participation for a sample of over 1.4 million children across the United States, based on 2008 and 2012 American Community Survey data. This analysis found that the participation in Medicaid or CHIP in Tennessee was 90.9 percent. This is statistically significantly higher than the national average of 88.3 percent.

Assumptions

This measure assumes that the participation rate for the entire eligible population is similar to the participation rate for eligible children. As noted above, we believe that the participation rate for eligible children may in fact be higher than the participation rate for the entire Medicaid population for a range of reasons. However, this is the best data that exists on Tennessee and other states' Medicaid participation rates and they offer insight into the effectiveness of Tennessee's eligibility determination system.

(1) RESULTS: TennCare Enrollment by Month and Eligibility Category, January 2014 – April 2015

Eligibility Group	Jan 2014	Feb 2014	March 2014	April 2014	May 2014	June 2014	July 2014	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	March 2015	April 2015
Families with Children	882,708	883,451	902,389	913,436	920,560	929,727	938,897	949,455	959,917	965,891	973,921	987,552	998,814	1,007,501	1,013,682	1,018,431
Pregnant Women	21,502	21,620	22,504	23,274	24,327	25,347	26,421	27,411	28,249	28,893	29,592	30,828	31,792	32,506	33,247	34,048
PW PE	2,274	3,112	4,266	5,332	6,277	7,413	8,390	9,356	10,404	11,367	12,114	12,908	13,830	14,288	15,245	15,991
Foster Care/ Adoption	19,514	19,414	20,007	20,447	20,888	21,390	21,678	21,931	22,395	22,788	23,129	23,522	23,924	24,065	24,552	24,676
Aged	37,269	36,994	36,956	36,982	36,958	37,061	37,169	37,214	37,232	37,303	37,252	37,216	37,018	36,557	36,225	35,960
Disabled	233,958	234,028	234,657	235,262	235,808	236,307	237,061	237,891	238,479	238,571	238,696	238,716	238,752	238,401	238,085	237,930
Medically Needy	29,507	29,529	29,544	29,490	29,439	29,433	29,428	29,412	29,391	29,352	29,323	29,289	29,225	28,955	28,911	28,880
Uninsurable	1,994	2,012	2,011	1,997	1,997	1,996	1,995	1,992	1,991	1,978	1,974	1,970	1,965	1,958	1,954	1,952
Other	1,716	1,785	1,857	1,913	1,985	2,042	2,098	2,149	2,187	2,241	2,299	2,350	2,393	2,433	2,494	2,555
Grand Total	1,230,442	1,231,945	1,254,191	1,268,133	1,278,239	1,290,716	1,303,137	1,316,811	1,330,245	1,338,384	1,348,300	1,364,351	1,377,713	1,386,664	1,394,395	1,400,423

(2) TennCare and SNAP Eligibility Criteria Comparison

	TennCare		**SNAP**	
	Income Eligibility*	Asset Test	Income Eligibility	Asset Test
Age 0 to 1	TennCare Medicaid: *195% FPL* TennCare Standard: *195-211% FPL*	n/a	General Population: *130% FPL* Households with member who is disabled or 60 years of age: *165% FPL*	General Population: *$2,250* Households with member who is disabled or 60 years of age: *$3,250*
Ages 1 to 6	TennCare Medicaid: *142% FPL* TennCare Standard: *142-211% FPL*	n/a		
Ages 6 to 19	TennCare Medicaid: *133% FPL* TennCare Standard: *133-211% FPL*	n/a		

* Children may also qualify for TennCare through the Medically Needy (TennCare Medicaid) and Medically Eligible (TennCare Standard) groups; the income eligibility thresholds aren't included here, but this group is included in the analysis.

(3) RESULTS: SNAP and TennCare Recipient Overlap, April 2015

Overview	
Total Children Enrolled in SNAP	536,507
Total SNAP Children Also Enrolled in TennCare	489,380
Percent of SNAP Children Enrolled in TennCare	**91.2%**

Detailed Analysis

	SNAP Children by TennCare Enrollment	% of SNAP Children by TennCare Enrollment
SNAP Children Enrolled in TennCare	**489,380**	**91.2%**
Families with Children	463,741	86.4%
Pregnant Women	828	0.2%
PW PE	413	0.1%
Foster Care/ Adoption	4,680	0.9%
Aged	-	0.0%
Disabled	18,680	3.5%
Medically Needy	871	0.2%
Uninsurable	158	0.0%
Other	9	0.0%
SNAP Children Not Enrolled in TennCare	**47,127**	**8.8 %**
Total SNAP Children	**536,507**	**100%**