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State/Territory Name: Tennessee

State Plan Amendment (SPA) #: 13-0001-MM4

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

May 19, 2017

Wendy Long, MD
Director, Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, TN 37243

Reference: Title XIX State Plan Amendment, 13-0001-MM4

Dear Dr. Long:

We have reviewed the State's proposed amendment to the Tennessee State Plan submitted under Transmittal Number 13-0001, on December 10, 2013. This State Plan Amendment (SPA) describes the single state agency and other entities responsible for administering or implementing the Medicaid state plan. This SPA also updates the single state agency's delegations for appeals and eligibility determinations. We have approved the amendment for incorporation into the Tennessee State Plan with an effective date of October 1, 2013.

In our process of reviewing this SPA, Tennessee informed us that, prior to September 26, 2014, the state did not conduct fair hearings related to MAGI-based eligibility determinations. Under section 1902(a)(3) of the Social Security Act, a state plan must provide for an opportunity for a fair hearing before the single state agency to any individual whose claim for medical assistance under the state plan is denied or is not acted upon with reasonable promptness. As of September 26, 2014, we understand the state began to conduct fair hearings related to MAGI-based eligibility determinations within the Medicaid agency. As it has been described to us, this fair hearing process complies with section 1902(a)(3) of the Act. In addition to this approval of SPA 13-0001 today, CMS is also approving SPA 17-0002 today, which states that, effective September 26, 2014 Tennessee is conducting fair hearings related to MAGI-based eligibility determinations within the Medicaid agency.

In this SPA, the state Medicaid agency attests that it has responsibility for determination of eligibility for families, adults, children under age 21, aged, blind, and disabled. This responsibility applies to both initial eligibility determinations for applicants and renewals for beneficiaries. CMS continues to work with the state to move towards full implementation of its responsibilities to conduct eligibility determinations of applications for families, adults and children under the age of 21 and full implementation of the state's responsibilities related to renewals of eligibility.

A copy of the Medicaid State Plan Eligibility Summary Page and approved plan pages are enclosed with this letter.

If you have questions, please contact Kenni Howard at (404) 562-7413 or by email at Kenni.Howard@cms.hhs.gov.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures

Medicaid State Plan Eligibility

TN.0573.R00.00 - Oct 01, 2013

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: Tennessee

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

TN-13-0001

Proposed Effective Date

10/01/2013 (mm/dd/yyyy)

Federal Statute / Regulation Citation

42 CFR 431.10; 42 CFR 431.11; 42 CFR 431.12; 42 CFR 431.50

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Character Count:150 out of 2000

This SPA implements the Affordable Care Act's provision for addressing the single state agency's delegation of eligibility determinations and appeals.

Governor's Office Review

- (•) Governor's office reported no comment
- ( ) Comments of Governor's office received

Describe:

○ No reply received within 45 days of submittal

○ Other, as specified
Describe:

Signature of State Agency Official

Submitted By:	Aaron Butler
Last Revision Date:	May 9, 2017
Submit Date:	Dec 10, 2013

BACK CONTINUE

Medicaid Administration

State Name: Tennessee

OMB Control Number: 0938-1148

Transmittal Number: TN - 13 - 0001

State Plan Administration Designation and Authority	A1

42 CFR 431.10

Designation and Authority

State Name: Tennessee

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: Department of Finance & Administration

Type of Agency:

- ○ Title IV-A Agency
- ○ Health
- ○ Human Resources
- ◉ Other

Type of Agency: State Fiscal Agency

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

State of Tennessee Executive Order No. 23 (October 19, 1999)

The single state agency supervises the administration of the state plan by local political subdivisions.

○ Yes ◉ No

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

○ Yes ◉ No

☒ Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

◉ Yes ○ No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY): 02/01/17

The type of responsibility delegated is (check all that apply):

☐ Determining eligibility

☒ Conducting fair hearings

☐ Other

Name of state agency to which responsibility is delegated:

Department of Human Services

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

The Department of Finance & Administration (F&A) delegates to the Department of Human Services (DHS) authority to conduct fair hearings on all appeals pertaining to non-MAGI-related financial eligibility determinations. DHS has acknowledged and agreed in writing that it will administer the appeals process and adjudicate appeals in a manner that is consistent with applicable federal and state laws, rules, regulations, policies, and guidance governing the Medicaid program. F&A delegates final decision-making authority on non-MAGI-related appeals to DHS. After the DHS Hearing Officer has issued an appeals decision, either the appellant or F&A may request a review of the decision by a Commissioner's Designee who was not involved in the initial determination. In such cases, if the Commissioner's Designee modifies or overturns a DHS Hearing Officer's decision, the Commissioner's Designee's decision constitutes final agency action.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

The functions delegated to DHS are specified in a written contract between F&A and DHS; this contract describes the coordination of responsibilities between the two agencies. F&A retains oversight of the State Plan, the development and issuance of policies, rules, and regulations on program matters. F&A requires that every applicant is informed in writing of the fair hearing process and how to obtain information about pursuing an appeal. F&A has the authority to review and audit resolutions of appeals and, if errors are identified, to reopen final determinations of eligibility to correct such errors.

Remove

Date waiver granted (MM/DD/YY): 02/01/17

The type of responsibility delegated is (check all that apply):

☐ Determining eligibility

☒ Conducting fair hearings

☐ Other

Name of state agency to which responsibility is delegated:

Department of State

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

The Department of Finance & Administration (F&A) is the single state agency responsible for administration of the Medicaid program in Tennessee. F&A delegates to the Department of State authority to sit as trier of fact and issue initial orders for fair hearings pertaining to services or benefits, including appeals related to the preadmission evaluation (PAE) process and level of care criteria for nursing facility services. Under the terms of this delegation, evidentiary hearings are held before impartial Administrative Law Judges (ALJs) housed within the Department of State. The Department of State's ALJs issue initial orders. After an ALJ has issued an initial order, either the appellant or F&A may request a review of the decision by the Commissioner of F&A or his designee. F&A retains the authority to review all decisions made by ALJs to determine whether their decisions are contrary to applicable law, regulations, or policies. The Commissioner's Designee is responsible for reviewing conclusions of law contained in ALJs' orders to determine if they conflict with TennCare rules or policies. The Commissioner's Designee has the authority to set aside conclusions of law if the record contains evidence that the conclusions of law are misapplied or incorrectly written. If the Commissioner's Designee modifies or overturns an ALJ's decision, the Commissioner's Designee's decision constitutes final agency action. Pursuant to Doe v. Ferguson, F&A cannot overturn an ALJ's decision pertaining to nursing facility services.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

The Department of State's role in benefit-related Medicaid fair hearings is provided for in state law, at Tennessee Code Annotated § 4-5-301 and § 71-5-113. F&A retains oversight over the State Plan, and the development and issuance of policies, rules, and regulations on Medicaid program matters. The role and authority of the Department of State's ALJs are dictated by the Tennessee Uniform Administrative Procedures Act.

When an individual experiences a denial or an adverse action, F&A requires that the individual be informed in writing of the fair hearing process and about how to pursue an appeal. F&A is also responsible for ensuring that individuals know how they can directly contact F & A to obtain information about appeals.

F&A provides assurance that it oversees the fair hearing process delegated to the Department of State to ensure compliance with federal and state Medicaid law, regulations and policies including: issuing fair hearing decisions, conflicts of interest and improper incentives, and the safeguarding of confidentiality. F&A will institute corrective action, as needed, which could include modifying or reversing hearing decisions, as well as taking more systemic action such as providing training for the hearing officers and issuing clarifications of policy.

Add

☐ The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

☒ The Medicaid agency

☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

☒ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

Medicaid Administration

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- ☐ The Medicaid agency
- ☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☒ The Federal agency administering the SSI program

  Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

  - ☒ Medicaid agency
  - ☐ Title IV-A agency
  - ☐ An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- ☐ Medicaid agency
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☒ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

  Name of entity: HHS Appeals Entity

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

◉ Yes ○ No

State Plan Administration
Organization and Administration

A2

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

Department of Finance and Administration

The Department of Finance and Administration is the Single State Agency. There are a number of divisions within the Department, most of which support the maintenance and improvement of the State's fiscal health (Accounts, Budget, Administration); manage State-provided insurance benefits (Benefits Administration); manage the State's information needs (Information Resources, Enterprise Resource Planning); oversee certain public health programs and initiatives (Health Care Finance and Administration); or manage other State resources.

Bureau of TennCare

The Bureau of TennCare is the unit within the Single State Agency with responsibility for administering the State Medicaid program. As the program that accounts for the single largest portion of the state budget, it is appropriate that the Bureau of

TennCare be housed within the Department of Finance and Administration. The Director of the Bureau is a Deputy Commissioner of Finance and Administration who reports directly to the Commissioner and to the Governor.

The Bureau of TennCare is organized into units with responsibilities for specified aspects of the TennCare program. The director of each of the units within the Bureau reports to the Bureau Director and his Deputy Director. The Bureau of TennCare currently consists of the following major organizational units: Communications, Financial Operations, Information Systems, Long-Term Services and Supports, Managed Care Operations, Member Services, Non-Discrimination Compliance/Health Care Disparities, Office of the General Counsel, Office of the Medical Director, Operations, and Policy.

Communications.

This unit coordinates all communications – internal and external – for the TennCare program. This unit serves as point of contact for the news media with TennCare, and coordinates media and other communications-related matters with other state departments that have relevance to TennCare. In addition to media engagements, the Communications Division oversees communications with external stakeholders, including health care associations, advocates, members of the General Assembly, and others as needed. This unit develops and writes all news releases, media advisories, public service announcements, and public communications, including the TennCare website. The Communications Director and Public Information Officer coordinate all media interactions and communications and the Webmaster oversees the Bureau's external website and the intranet.

Financial Operations.

The Chief Financial Officer oversees this Division, which is responsible for developing and monitoring TennCare's budget and for working with actuaries to implement fiscal forecasting and to develop actuarially sound rates for risk-based contracts. This Division is responsible for preparing and submitting fiscal reports to CMS, such as the CMS-64, and for monitoring budget neutrality for the TennCare Demonstration. Fiscal Operations oversees the processing of all contracts and contract amendments between TennCare and its vendors, including the Managed Care Contractors (MCCs), and monitors sub-recipient contracts and grants. This Division is responsible for a wide variety of administrative activities including supply and equipment invoice payment, revenue collection, processing payment for all TennCare contracts and grants, and other administrative activities. This unit includes an Office of HealthCare Informatics/Statistics that provides reports and analytical support to TennCare's business operations and decision making in the areas of financial management, medical management, contracting, and operations. Areas of particular interest include cost and utilization reporting, cost-driver and outlook analysis, statistical support and methodology development, information technology solutions of decision support applications, and data warehousing. Responsibility for third party liability collections is housed within this Division.

Information Systems (IS).

IS is responsible for the activities of the TennCare Management Information System (TCMIS), including the recording of eligibility and enrollment information, claims/encounter processing, data analysis, data reporting, and other system functions. In the performance of these duties, the IS Division serves as contract administrator for the MMIS facilities management contractor. IS is responsible for electronic data interchange (EDI) generally and for processing provider updates from the MCCs and production of drug rebate data. The Medicaid Eligibility Unit within IS serves as a liaison with CMS and the MCCs on various operations and functions and maintains the TCMIS Recipient Eligibility file. This unit is also responsible for monitoring batch updates of files received from the FFM and the Social Security Administration, as well as monitoring internal jobs and reviewing daily outbound 834 plan enrollment files. The Notification Unit ensures the quality of a variety of outgoing TCMIS production enrollee notices. The Claims Processing Unit is composed of three distinct areas of responsibility, consisting of fee-for-service claims processing (such as processing of Medicare crossover claims), MCC monthly capitation payments, and the mailing of Daniels notices. In addition, the Claims Processing Unit is responsible for developing and processing all system enhancements and modifications to both fee-for-service processing and MCC capitation payments. An infrastructure team provides support for end-user access, meaning ensuring that users have desktops and peripherals needed to perform day-to-day activities and that systems are installed and maintained correctly.

Long-Term Services and Supports (LTSS).

This Division oversees TennCare's LTSS programs and services, including institutional services and home- and community-based service (HCBS) alternatives. The LTSS Operations Unit is responsible for level of care determinations for long-term services and

supports, compliance with federal PASRR regulations, IT liaison and project management of all LTSS initiatives, as well as the Division's business analysis, process improvement and training activities. The LTSS Quality and Administration Unit provides administrative oversight and conducts quality monitoring activities of entities contracted to operate the State's Medicaid-reimbursed LTSS programs and services, including the CHOICES Managed LTSS program, three Section 1915(c) waivers for individuals with intellectual disabilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), a Money Follows the Person (MFP) Rebalancing Demonstration, and the Program of All-Inclusive Care for the Elderly (PACE). The LTSS Audit and Compliance Unit performs critical oversight and monitoring of contracted entities to ensure compliance with federal and state program requirements. Core responsibilities include data collection, validation and analysis, and desk and on-site audit processes to ensure program integrity, identify and correct deficiencies in a timely manner, and provide actionable information to program staff in order to support continuous quality improvement.

Managed Care Operations.

The Division of Managed Care Operations is responsible for overseeing TennCare's contracts with the Managed Care Organizations (MCOs) providing medical services, behavioral health services, and most long-term care services and supports to TennCare enrollees. This includes developing and finalizing contracts and contract amendments and monitoring contract compliance, as well as reviewing subcontracts, reviewing marketing materials disseminated by the MCOs, and assessing sanctions for contract non-compliance when appropriate. In addition, this office is responsible for working with the Attorney General's Office to identify and follow up on instances of provider fraud and abuse.

Member Services.

TennCare's Division of Member Services oversees functions related to eligibility and enrollment, eligibility renewals, medical appeals, and communication with program enrollees and applicants. The Member Services Division determines eligibility for applicants eligible on a basis other than MAGI or SSI. (MAGI-based eligibility determinations are conducted by the FFM, and SSI-based eligibility determinations are conducted by the Social Security Administration.) This Division also processes all appeals for medical, behavioral health, pharmacy, and dental services filed by TennCare enrollees. This includes assessing the timeliness of these appeals, processing requests for continuation of benefits while appeals are pending, requiring TennCare's managed care organizations to take corrective action when appropriate, and preparing cases for hearing before an Administrative Law Judge (ALJ) as needed. The Member Services Division coordinates the drafting and mailing of all notices sent to program enrollees on TennCare-related matters.

Non-discrimination Contract Compliance/Health Care Disparities.

The Office of Non-Discrimination Contract Compliance/Health Care Disparities is responsible for the coordination and monitoring of TennCare's compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, and the Age Discrimination Act of 1975. This Office's monitoring applies to TennCare and its contractors. It is this Office's responsibility to document, investigate, and resolve all allegations of discrimination received by TennCare related to the provision of covered services for enrollees with regard to federal and state civil rights laws. It is the responsibility of this Office to draft contract language applicable to the compliance of TennCare contractors with federal civil rights laws. This Office also provides technical non-discrimination compliance training for TennCare and its contractors.

Office of the General Counsel (OGC).

TennCare's OGC is responsible for providing legal counsel to the Bureau. This includes the legal oversight of the development, implementation, and monitoring of TennCare's contracts with its MCCs and other contractors, grantees, subcontractors, and vendors. OGC attorneys and staff also work with other TennCare units to ensure compliance with federal/state laws, regulations, court rulings, and consent decrees. OGC reviews all nondiscrimination, HIPAA and program integrity matters. OGC is vested with ensuring compliance with all litigation hold and document retention requirements. OGC ensures all public records requests are timely responded to. OGC assists in researching and drafting TennCare rules and policies, and assists in providing explanations for rules and policies to the General Assembly. OGC works with the Office of the Attorney General, other state agencies, and outside counsel on legal proceedings involving TennCare. OGC litigates at administrative hearings for persons requesting admission to nursing facilities or home- and community-based waiver programs, makes statewide Probate Court appearances to defend TennCare claims to recover funds from estates of persons who received LTSS coverage, and provides claims information to courts or plaintiffs' counsel to recover funds paid by TennCare for medical care provided when another person is liable for the injury.

Office of the Chief Medical Officer.

The Office of the Chief Medical Officer provides medical direction for the TennCare program and provides oversight of the medical, pharmacy, and dental services delivered through a network of managed care contractors. This Office's key activities include the development of medical policy and monitoring access to care, service quality, and health outcomes. This unit monitors provider network adequacy and serves as a resource to providers throughout the state in regard to the operation of the TennCare program. With respect to ensuring quality of care, this unit works with the External Quality Review Organization (EQRO) to monitor MCC performance. Areas of particular focus include compliance with EPSDT standards, analysis of appeals data, and comparison of quality indicators and satisfaction across MCOs. This Office also serves as the Bureau's primary liaison with the Department of Children's Services and assists in the development and review of children's services and behavioral health policy.

Operations.

TennCare's Operations division is responsible for all facilities management, administrative services, project management, executive support, and is the audit liaison. The Operations division also contains a legislative unit that monitors state legislative activity affecting TennCare by reviewing bills and analyzing their potential impact on the TennCare program, meeting with legislative offices and General Assembly Members to convey TennCare's position on pending legislation, and maintaining working knowledge of state and federal laws, rules, and regulations. The Office of Human Resources is contained in this division as well and is responsible for providing effective and efficient customer-focused service and support in the areas of personnel transactions and organizational development, including benefits, payroll, and employee development.

Policy.

TennCare's Policy Office prepares program proposals with CMS regarding waiver-related matters; ensures that appropriate rules are filed to support the TennCare program; maintains the Medicaid State Plan by ensuring that State Plan Amendments are filed appropriately; conducts policy research and produces policy statements to interpret program activity; and is responsible for ensuring that all reports required by the demonstration waiver agreement with CMS are produced accurately and on time.

Office of Inspector General

The Office of Inspector General (OIG) is an independent office within the Department of Finance and Administration that is tasked with identifying, investigating, and prosecuting persons who commit fraud against TennCare. OIG furnishes information to educate the public about fraud and abuse laws pertaining to health care in Tennessee, cooperates with other local, state, and federal agencies in order to effectuate its mission and assists in the criminal prosecution of individuals and the civil recovery of funds that are a result of health care fraud and abuse.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

There are a number of other executive departments which directly contribute to the successful operation of Tennessee's Title XIX Medicaid Demonstration project. These departments are mentioned both to clarify roles and responsibilities and to reinforce the complexity and interconnectedness of the entities that administer healthcare for the citizens of Tennessee.

DEPARTMENT OF HUMAN SERVICES

The Department of Human Services (DHS) maintains offices in each of Tennessee's 95 counties. TennCare contracts with DHS to provide application assistance and to facilitate the application process through the availability of computer kiosks located in all 95 counties. DHS conducts non-MAGI eligibility appeals under a written agreement with the state Medicaid agency.

DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

The Tennessee Department of Intellectual and Developmental Disabilities (DIDD) is responsible for providing services and supports to Tennesseans with intellectual disabilities. DIDD provides services directly or through contracts with community providers in a variety of settings. These settings range from institutional care to individual supported living arrangements in the community. DIDD provides services to TennCare enrollees participating in home and community based waiver and self-determination waiver programs, and provides services related to the Preadmission and Resident Review.

DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The Department of Mental Health and Substance Abuse Services (DMHSAS) plans for and promotes the availability of a comprehensive array of high-quality prevention, early intervention, treatment, habilitation, and rehabilitation services and supports for individuals and families needing mental health or substance abuse services. DMHSAS provides consultation on the behavioral health component of the TennCare program, and obtains attestations from psychiatric residential facilities on compliance with CMS standards on the use of seclusion and restraint.

DEPARTMENT OF HEALTH

The Department of Health coordinates activities in the health departments in each of Tennessee's 95 counties, which provide significant care to the TennCare population. In addition, the Department of Health conducts outreach and screening for TennCare's EPSDT program. The Department of Health contributes significantly to the success of the TennCare dental program by conducting a statewide, school-based, oral health evaluation and screening program. The Department of Health makes determinations of presumptive eligibility for pregnant women and individuals needing treatment for breast and/or cervical cancer. The Department oversees licensing for hospitals, nursing facilities, ambulatory surgical centers, and other health care facilities in Tennessee.

DEPARTMENT OF COMMERCE AND INSURANCE

The Tennessee Department of Commerce and Insurance (TDCI) protects the integrity of the TennCare program by overseeing, examining, and monitoring the Managed Care Organizations (MCOs) participating in the TennCare program. TDCI's TennCare Oversight Division ensures that the MCOs under contract with the state are in compliance with statutory and contractual requirements relating to their financial responsibility, stability, and integrity. The responsibilities of this division include reviewing and analyzing financial status, market conduct activities, and compliance with federal and state law, rules, and regulations as they apply to TennCare's MCO operations. The division also oversees the independent review of provider claims denial program.

DEPARTMENT OF CHILDREN'S SERVICES

The Tennessee Department of Children's Services (DCS) is Tennessee's Title IV-E agency. DCS coordinates care for children who are in the custody of the state of Tennessee or at risk of being in the custody of the state. DCS provides residential treatment and targeted case management services for TennCare-eligible children in state custody, and conducts EPSDT outreach activities. Under an agreement with the state Medicaid agency, DCS makes eligibility determinations for children entering state custody or in adoption assistance agreements.

DEPARTMENT OF EDUCATION

The Tennessee Department of Education oversees Tennessee's K-12 public school system. The Department supports TennCare by conducting EPSDT outreach activities.

DEPARTMENT OF STATE

Administrative Law Judges (ALJs) housed within the Department of State sit as triers of fact and issue initial orders for fair hearings pertaining to services and benefits, including appeals related to the preadmission evaluation (PAE) process and level of care criteria for nursing facility services.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- ○ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ◉ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ○ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

The Federally Facilitated Marketplace (FFM) determines eligibility for Medicaid for groups of individuals whose income eligibility is determined based on MAGI income methodology and who apply through the FFM. The FFM does not assign an individual who is determined eligible for Medicaid using MAGI methodology to a specific eligibility group, determine cost-sharing (if applicable), or assign a benefits package; these functions are performed by the single state agency.

Remove

Type of entity that determines eligibility:

- ○ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ◉ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for Supplemental Security Income recipients.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ◉ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

The HHS appeals entity conducts Medicaid fair hearings for individuals whose Medicaid eligibility has been determined and found ineligible for Medicaid by the Federally-facilitated Marketplace (FFM). These are individuals whose income eligibility is determined based on MAGI income methodology and who applied for health coverage through the FFM.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

○ Yes ○ No

State Plan Administration Assurances	A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

☑ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☑ All requirements of 42 CFR 431.10 are met.

☑ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.

☑ The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

☑ There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

☑ There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

☑ When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

☑ The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

V.20160722

BUREAU OF TENNCARE ORGANIZATIONAL CHART