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State/Territory Name: Tennessee

State Plan Amendment (SPA) #: 19-0003-MM1

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, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Division of Medicaid and Children's Health Operations

December 19, 2019

Gabe Roberts
Director
Department of Finance & Administration
310 Great Circle Road
Nashville, TN 37243

Re: Approval of State Plan Amendment TN-19-0003

Dear Gabe Roberts:

On March 29, 2019, the Centers for Medicare and Medicaid Services (CMS) received Tennessee State Plan Amendment (SPA) TN-19-0003 to make changes to Hospital Presumptive Eligibility (HPE), modifications to Presumptive Eligibility (PE) for Pregnant Women, the Eligibility Process Reviewable Unit, and the state's election to end the option to provide Presumptive Eligibility to children under age 1..

We approve Tennessee State Plan Amendment (SPA) TN-19-0003 on December 19, 2019 with an effective date(s) of March 18, 2019.

In addition to submission of the Eligibility Process RU and removing the state plan option to provide PE to children under age 1, this amendment proposes to replace the paper PE application with an online application hospitals and qualified entities must use to make PE determinations, and removes the CHIP eligibility and enrollment Administrative Contractor as a qualified entity to make PE determinations for pregnant women.

We note that the state has provided assurances that it provides HPE and PE coverage consistent with 435.1102(b)(2)(A) and (B), except when an individual does not submit a full Medicaid application during the PE period, in which case we understand the state provides an additional 5 days of PE coverage. This is due to the state's eligibility system designed to ensure that all full Medicaid applications submitted during the PE period are registered prior to running a term batch and coverage is not erroneously terminated in such cases.

Please note that accompanying the approval of SPA 19-0003 is the enclosed companion letter regarding the need for Tennessee to make modifications to its HPE and PE for Pregnant Women Online Application (online portal). Tennessee will provide dates for completion of outstanding changes within 60 days of approval of this SPA, and will implement a revised HPE and PE for Pregnant Women online application addressing CMS concerns by the dates listed in the companion letter.

Name	Date Created	
TN 19-0003 Companion Letter Exhibit A	12/19/2019 5:16 PM EST	

If you have any questions regarding this amendment, please contact Tandra Hodges at Tandra.Hodges@cms.hhs.gov.

Sincerely,

Davida R. Kimble

Acting Deputy Director

Division of Medicaid and Children's Health Operations

RAI

CMS is issuing this Request for Additional Information (RAI) pursuant to Section 1915(f) of the Social Security Act (added by P.L. 97-35). This request has the effect of stopping the 90-day time period for CMS to act on the material. A new 90 day time frame will not begin until we receive your response to this request.

In accordance with our guidelines to all State Medicaid directors dated January 2, 2001, and subsequently reiterated in the August 16, 2018 Center for Medicaid and CHIP Services Informational Bulletin, if a response to a formal request for additional information from CMS is not received from the state within 90 days of issuance, CMS will initiate disapproval of the SPA or waiver action.

In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will defer federal financial participation (FFP) for state payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

Submission Package TN2019MS0003O
Authority Eligibility
State TN

Agency Name Department of Finance & Administration
Submission Date Mar 29, 2019
Priority Code P2

All Questions

Question ID	Reference	CMS question to the State	Policy/Regulation	State Response
1	State agencies must have established mechanisms and procedures to provide to hospitals who make PE determinations with Medicaid eligibility information consistent with statute and regulations.	Please explain how the state complies with the rules at 435.1102(b)(1)-(3) requiring the agency to have established mechanisms and procedures to provide hospitals electing to make PE determinations with Medicaid eligibility information, HPE determination approval and denial notices, and all other tools necessary to make PE determinations and implement HPE consistent with statute and regulations.	435.1102(b)(1)-(3)	Tennessee has provided detailed responses to each requirement of 435.1102(b)(1)-(3). Detailed responses regarding how Tennesee has established mechanisms and procedures to provide hospitals electing to make PE determinations with Medicaid eligibility information are addressed in the responses to questions 2, 5, and 8. Detailed responses regarding the HPE approval and denial notices are addressed in the responses to questions 7 and 23. Detailed responses regarding all other tools necessary to make PE determinations and implement HPE consistent with statute and regulation are addressed in the responses to questions 2, 5, 13, 14, 15, 16, and 24.
2	State agencies must provide hospitals electing to make PE determinations with Medicaid eligibility information and all other tools necessary to make PE determinations and implement HPE consistent with statute and regulations.	Please explain how the state trains hospitals participating in PE, and ensures that the hospitals have what they need to adequately train new providers on making presumptive eligibility determinations consistent with statute and regulations.	435.1102(b)(1)-(3)	Hospitals received training on presumptive eligibility through webinars. Materials are provided to hospitals and posted to the state Medicaid agency's website to give new employees an explanation of presumptive eligibility. Training videos are currently being developed that will allow new hospital employees the opportunity to view training as a supplement to the existing materials.
3	For individuals determined to be presumptively eligible, if a Medicaid application is not filed by the last day of the following month, PE will end on the last day.	In response to CMS comments, the state explained HPE/ PE coverage start and end dates consistent with 435.1102(b)(2)(A) and (B). However, the state explained that the state	435.1102(b)(2)(iv)(A)	Individuals who receive services between 11/30-12/5 will still be considered to be eligible. If a provider reviews existing systems to see if the individual is still eligible, the system will

Question ID	Reference	CMS question to the State	Policy/Regulation	State Response
		runs a batch to see if a full Medicaid application has been submitted after the end of the second month, and that the term date will actually be the 5th of the next month The state explained this gives the state a few days to ensure that all new applications are registered before running the term batch. The state provided the example of a PE application filed on 10/30 and coverage should end on 11/30 if no full application is submitted, since the state runs the batch to check for full applications on 12/5, the closure of the PE is actually on 12/5. Please explain based on the example above what happens if the individual receives services between 11/30 and 12/5 due to the PE case still being active in the state's eligibility system. Will providers checking PE eligibility see an active PE case in the state's eligibility system during that time period? Will payment for services provided during that time period be provided?		display the individual as eligible. Payment for services provided during this time period will be provided. The batch operates in this fashion in order allow time for the eligibility to be transferred to the member's MCO.
4	For individuals determined to be presumptively eligible, if a Medicaid application is filed by the last day of the following month, PE will end on the day that a decision is made on the full Medicaid application.	Please confirm that for individuals determined eligible for HPE or PE for PW who apply for full Medicaid during the PE period and are denied full Medicaid, the state's eligibility system is able to end PE coverage on the date of the full Medicaid determination denial, even if it is mid-month.	435.1102(b)(2)(iv)(B)	The State confirms that individuals who are eligible for HPE or PE, who subsequently apply for full Medicaid, and are denied full Medicaid are terminated upon the date of the full Medicaid denial, even if the denial occurs mid-month.
5	State agencies must provide hospitals electing to make PE determinations with Medicaid eligibility information and all other tools necessary to make PE determinations and implement HPE consistent with statute and regulations	HPE Training Materials: Part 2 Slides 8 and 9-These slides references the Hospital PE cover sheet, Presumptive eligibility PDF, HPE affidavit for failure to submit form, HPE worksheet, HPE step-by-step instructional guide. Please provide	435.1102(b)(1)-(3)	The Hospital PE Coversheet, Presumptive Elgiibility PDF, HPE Affidavit for failure to submit form, HPE Worksheet, and HPE Step-by-Step instructional guide are attached to this submission.

Question ID	Reference	CMS question to the State	Policy/Regulation	State Response
		CMS with copies of these materials.		
6	Qualified entities make the H/PE determination.	HPE Training Materials: Part 2 Slide 11-explain the purpose and process described for checking and correcting incorrect applications, and explain the Errata sheet submission process. Please explain the information providers obtain from "checking and correcting" HPE applications after the provider has made the HPE determination.	435.1102(a)	Providers often will monitor HPE applications they submit to verify that the eligibility has been granted. If a provider notices that an individual's name or demographic information is incorrect, they will contact TennCare by emailing the errata sheet to TennCare noting the required update. If the provider notices that any other error has occurred in the HPE determination, they will contact TennCare to correct the HPE determination via email. This ensures the State will have correct information in its eligibility system.
7	The agency must establish procedures to ensure qualified entities provide notice in writing of the PE determination at the time the determination is made.	HPE Training Materials: Part 2 Slide13-explains the state will send approved HPE beneficiaries the approval notice. Please explain if approved beneficiaries are provided with immediate notice of the HPE approvals, and explain how beneficiaries determined eligible for HPE can access coverage and services prior to receipt of the approval notice sent by the state agency.	435.1102(b)(2)(i)	Hospitals are required to give HPE approved individuals a print out of the Application Summary notifying them of their approval for HPE. The Application Summary clearly states that they have been approved with the approval date and the date the coverage will end if a TennCare application is not submitted. An additional Approval notice is mailed to the PE Enrollee. If a hospital approves the HPE, the individual is encouraged to use the pharmacy services through the hospital that day, if they require a prescription. Providers are also able to view the individual's eligibility in a provider-facing online portal in two to three business days after the approval.
8	The agency must provide qualified entities with information and ensure presumptive eligibility determinations are made consistent with statute and regulations.	The HPE RU and supporting materials do not explain non-citizen eligibility rules. Please explain how providers are trained on non-citizen eligibility rules.	435.1102(b)(1); 435.1102 (b)(3)	Providers receive training regarding non-citizen eligibility rules in the HPE Step-by-Step Instructional guide.
9	Applicants may only be asked to provide	HPE Online Application Screen Shots	435.907(e)(1)	A change will be made to mark the Living

Question ID	Reference	CMS question to the State	Policy/Regulation	State Response
	information necessary to make an eligibility determination.	The state provided an explanation of why it requests applicants for full Medicaid to select from the living arrangements dropdown list, but applicants for HPE should not be required to provide this information since it is not needed to make an HPE eligibility determination. Please mark this question as optional on the application, and provide a timeline for when this change will be made.		Arrangement question as optional on the PE application. This change will occur with the 7.0 Release of the State's eligibility determination system, scheduled for December 2019.
10	Applicants may only be asked to provide information necessary to make an eligibility determination.	HPE Online Application Screen Shots The state indicated in written responses that it will make a change in its system to only ask the citizenship and non-citizen status questions only of individuals applying for HPE, and that this question will not appear for non-applicant household members. Please provide a timeline of when this change will be made.	435.907(e)(1)	The State has made this change. Citizenship and non-citizen status questions are now only asked of individuals applying for coverage.
11	Applicants may only be asked to provide information necessary to make an eligibility determination, and states may not require verification of the conditions for PE.	HPE Online Application Screen Shots Because states must accept self-attestation of all factors of eligibility, the application should not have mandatory questions requesting an applicant, an applicant household member, or a non-applicant household member's immigration document type or immigration document number. Please change these questions to indicate they are not required.	435.907(e)(1); 435.1102 (d)(2)(e)	Tennessee has added an option in the drop down to select "Not Currently Available". If an applicant does not wish to provide immigration information or does not have it readily available, he can select this option and move forward with submitting his PE application.
12	The state has elected a reasonable estimate of MAGI-based income to determine household income.	HPE Online Application Screen Shots The state has requested feedback on how to provide instructions explaining who to include in the HPE household. The instructions should be revised on the HPE	435.1102(a)	The Hospital PE Online application will be updated to remove the language that suggests including "everyone" in the household. Additional language will be added to clarify who should be included in the household. This change

Question ID	Reference	CMS question to the State	Policy/Regulation	State Response
		application to explain that other relatives or friends should not be included in the HPE applicant's household, even if they live with the applicant, since these individuals would not be considered part of the individual's Medicaid household and should not be listed on the application.		will be implemented in Release 7.0 of the State's eligibility determination system, currently scheduled for December 2019.
13	States may not require verification of the conditions for PE.	Pregnancy Presumptive Eligibility Guide 2019 Page 7- the instructions state that an applicant must declare she is pregnant, and may be requested to present documentation of her pregnancy, but she is not required to do so. In addition to the requirement that self-attestation must be accepted for all factors of eligibility, states may not request documentation of pregnancy unless the state has information that is not reasonably compatible with such attestation. 42 CFR 435.956(e). Please remove the instructions stating that applicants may be requested to present documentation of her pregnancy for PE applications.	435.1102(d)(2)(ii)	The State has updated its materials to reflect this suggestion.
14	The agency must provide qualified entities with information and ensure presumptive eligibility determinations are made consistent with statute and regulations.	Pregnancy Presumptive Eligibility Guide 2019 Page 7 and 8-Ineligible non-citizen status- The instructions state that all LPRs who have been in that status less than 5 years are ineligible for PE and TennCare. This is inaccurate, as LPRs who adjusted from an immigration status that is exempt from the 5 year waiting period, such as refugees and asylees, are exempt from the 5 year waiting period. Please revise the instructions at page 7, and the instructions in the left column on page 8 to indicate that LPRs who adjusted from one of the	435.1102(b)(1) and (3)	The State has updated its materials to reflect these suggestions.

Question ID	Reference	CMS question to the State	Policy/Regulation	State Response
		humanitarian statuses listed in the left hand column on page 8 are exempt from the five year waiting period.		
15	The agency must provide qualified entities with information and ensure presumptive eligibility determinations are made consistent with statute and regulations.	Pregnancy Presumptive Eligibility Guide 2019 Page 8- Abused Immigrants with a VAWA petition are qualified non-citizens, but they subject to the 5 year waiting period. Please revise the table to explain that individuals with an approved VAWA petition are eligible for Medicaid if they have been in that status for 5 years.	435.1102(b)(1) and (3)	The State has updated its materials to reflect this suggestion.
16	The agency must provide hospitals with information needed to make eligibility determinations consistent with the statute and regulations.	Pregnancy Presumptive Eligibility Guide 2019 Page 8- the instruction in the right column indicate that LPRs who have been in the US for less than 5 years are ineligible, but should be revised to say that LPRs who have been in that status for less than 5 year are ineligible	435.1102(b)(1) and (3)	The State has updated its materials to reflect this suggestion.
17	Applicants may only be asked to provide information necessary to make an eligibility determination.	Pregnancy Presumptive Eligibility Guide 2019 Page 15- Living arrangements is not needed to make a PE eligibility determination and should not be a required field. Please change this to an optional question.	42 CFR 435.907(e)(1)	A change will be made to mark the Living Arrangement question as optional on the PE application. This change will occur with the 7.0 Release of the State's eligibility determination system, currently scheduled for December 2019.
18	Applicants may only be asked to provide information necessary to make an eligibility determination.	Pregnancy Presumptive Eligibility Guide 2019 Page 16- The instructions say to complete the Individual Information screen for each household members. Questions on residency, citizenship, or pregnancy status should not appear for non-applicant household members.	435.907(e)(1)	The State has modified the portal so that citizenship is no longer asked of anyone who was not applying. The State will implement a change so that residency will not be asked for anyone who is not applying; this change will be completed as part of the 7.0 release of the State's eligibility determination system, currently scheduled for December 2019. Pregnancy status is not asked of individuals who

Question ID	Reference	CMS question to the State	Policy/Regulation	State Response
				are not applying for presumptive eligibility.
19	Applicants may only be asked to provide information necessary to make an eligibility determination, and states may not require verification of the conditions for PE.	Pregnancy Presumptive Eligibility Guide 2019 Page 15- Because states must accept self-attestation of all factors of eligibility, the application should not have mandatory questions requesting an applicant, an applicant household member, or a non-applicant household member's immigration document type or immigration document number. Please change these questions to indicate they are not required.	435.907(e)(1); 435.1102 (d)(2)(e)	Tennessee has added an option in the document type field to allow an applicant to select "Not Currently Available". If an applicant does not wish to provide immigration information or does not have it readily available, they can select this option and move forward with submitting their PE application
20	Applicants may only be asked to provide information necessary to make an eligibility determination.	Pregnancy Presumptive Eligibility Guide 2019 Page21- The renewal of coverage question and request to renew coverage should not be a required field since it does not apply to PE. Please remove the asterisk or move this to the full Medicaid application flow. It is CMS' understanding that the state has agreed to make a change to this section. Please explain how the state will correct this, and provide a timeline for when this will be done.	435.907(e)(1)	The renewal of coverage question is not asked during the presumptive application process. It is only asked during the full Medicaid flow after an individual chooses to apply for full Medicaid.
21	Applicants may only be asked to provide information necessary to make an eligibility determination.	Pregnancy Presumptive Eligibility Guide 2019 Page 21- The voter registration question should not be mandatory for PE applicants	435.907(e)(1)	The voter registration question will be changed so that it is not mandatory.
22	The qualified entity that makes the PE determination based on a PE applicant's attested information.	Pregnancy Presumptive Eligibility Guide 2019 Page 22-Please explain the process for submitting and tracking the status of a PE "application." Because it is the qualified entity that makes the PE	435.1102(a)	The application tracking number is used by applicants and authorized representatives to check on the status of their application. Individuals can call TennCare and check on the status of their application by

Question ID	Reference	CMS question to the State	Policy/Regulation	State Response
		determination, explain what information this tracking feature provides.		providing this number or their person information.
23	States must establish procedures to ensure qualified entities provide immediate notice of the PE determination in writing.	Pregnancy Presumptive Eligibility Guide 2019 Page 23-the guide lacks instructions on providing immediate notice of the PE determination in writing, as is required in 435.1102(b)(2). Please describe the state's procedures to ensure qualified entities provide immediate notice of PE determinations, and describe the state's procedures of ensuring individuals determined eligible for PE can access coverage and services on the date of the PE approval, and provide CMS with copies of the PE approval and denial notices	435.1102(b)(2)	PE applicants receive immediate notice of the PE determination in written form on the Application Summary. The Application Summary includes information on the individual's HPE approval or denial. If the individual is approved for PE, they will receive an additional PE Approval notice in the mail.
24	Notice and fair hearing rights do not apply to determinations of presumptive eligibility.	Pregnancy Presumptive Eligibility Guide 2019 Page 25-provides information on eligibility appeals. Notice and fair hearing rights do not apply to determinations of presumptive eligibility. 435.1102(e). Please remove instructions on providing information on eligibility appeals and explain that this does not apply to PE determinations.	435.1102(e)	The State has updated its materials based on this suggestion.
25	Applicants may only be asked to provide information necessary to make an eligibility determination.	PE Application Screen Shots The following questions should not be asked on the PE application: "Date this person plans to return; immigration document type and alien number/immigration document number; pregnancy due date; and living arrangements.	435.907(e)(1)	The referenced questions are optional on the PE Application. Below is why each question is needed on the screen: "Date this person plans to return": This question is used to determine Tennessee Residence. If an individual is temporarily out of state, this question is used to determine the date they plan to return to the state. Individuals who are temporarily out of state are considered

Question ID	Reference	CMS question to the State	Policy/Regulation	State Response
				Tennessee residents. "Immigration Document Type and alien number/immigration document number": If this information is available, and if the individual chooses to provide it, then it facilitates the State's ability to verify the individual's immigration information via SAVE or VLP when the full Medicaid application is submitted. This alleviates the burden on the applicant to provide proof later on when the full application is submitted. "Pregnancy Due Date": This field allows Tennessee to set the correct certification period for the individual upon approval for full Medicaid. This field is not required to be answered by the applicant. This field auto populates 10 months from the application date if this field is not answered. "Living Arrangement": This field will be optional on the screen. If the individual chooses not to answer this question it will be defaulted to "At Home" in the State's eligibility system.
26	Applicants may only be asked to provide information necessary to make an eligibility determination.	The state has confirmed it will move the question "is this person applying for coverage" up in the application flow so it appears before the questions on pregnancy, citizenship and residency appear. Please provide a timeline for when this change will occur.	435.907(e)(1)	The State has modified the portal so that citizenship is no longer asked of anyone who was not applying. The State will implement a change so that residency will not be asked for anyone who is not applying; this change will be completed as part of the 7.0 release of the State's eligibility determination system, currently scheduled for December 2019. Pregnancy status is not asked of individuals who are not applying for presumptive eligibility.

Submission Package was updated by the State in accordance with the response above

- (•) Yes
- ( ) No

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | TN2019MS0003O | TN-19-0003

Package Header

Package ID	TN2019MS0003O	**SPA ID**	TN-19-0003
Submission Type	Official	**Initial Submission Date**	3/29/2019
Approval Date	12/19/2019	**Effective Date**	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name:	Tennessee	**Medicaid Agency Name:**	Department of Finance & Administration

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | TN2019MS0003O | TN-19-0003

Package Header

Package ID TN2019MS0003O
SPA ID TN-19-0003
Submission Type Official
Initial Submission Date 3/29/2019
Approval Date 12/19/2019
Effective Date N/A
Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID TN-19-0003

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Eligibility Process	3/18/2019	N/A
Presumptive Eligibility	3/18/2019	N/A
Presumptive Eligibility for Children under Age 19	3/18/2019	TN 14-0005
Presumptive Eligibility for Pregnant Women	3/18/2019	TN 16-0002
Presumptive Eligibility by Hospitals	3/18/2019	TN 14-0011

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Section 4, Page 79a, Item 4.33; Attachment 4.33-A

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | TN2019MS0003O | TN-19-0003

Package Header

Package ID TN2019MS0003O
SPA ID TN-19-0003
Submission Type Official
Initial Submission Date 3/29/2019
Approval Date 12/19/2019
Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives This SPA ends the state's limited presumptive eligibility program for children younger than age 1. The SPA also makes adjustments to the state's hospital presumptive eligibility process and modifies the list of entities qualified to make presumptive eligibility determinations for pregnant women.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2019	$0
Second	2020	$0

Federal Statute / Regulation Citation

42 CFR Part 435, Subpart L

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | TN2019MS0003O | TN-19-0003

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Superseded SPA ID	N/A		

Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | TN2019MS0003O | TN-19-0003

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Indicate whether public comment was solicited with respect to this submission.

- (●) Public notice was not federally required and comment was not solicited
- ( ) Public notice was not federally required, but comment was solicited
- ( ) Public notice was federally required and comment was solicited

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | TN2019MS0003O | TN-19-0003

Package Header

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Superseded SPA ID	N/A		

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- ○ Yes
- ◉ No

Medicaid State Plan Eligibility

General Eligibility Requirements

Eligibility Process

MEDICAID | Medicaid State Plan | Eligibility | TN2019MS0003O | TN-19-0003

Package Header

Package ID	TN2019MS0003O	**SPA ID**	TN-19-0003
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Superseded SPA ID	N/A		
	User-Entered		

The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining, verifying and renewing eligibility, and furnishing Medicaid.

A. Submission of Application

☑ 1. The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person. These modes of submission are available to all individuals applying for coverage, including those who may be eligible based on the applicable Modified Adjusted Gross Income (MAGI) standard and those who may be eligible on a basis other than MAGI.

2. The agency also accepts applications by other electronic means:

○ Yes ◉ No

☑ 3. The agency ensures that any application or supplemental form is accessible to persons who are limited English proficient and persons who have disabilities, consistent with 42 CFR 435.905(b).

Eligibility Process

MEDICAID | Medicaid State Plan | Eligibility | TN2019MS0003O | TN-19-0003

Package Header

Package ID	TN2019MS0003O	**SPA ID**	TN-19-0003
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Approval Date	12/19/2019	**Effective Date**	3/18/2019
Superseded SPA ID	N/A		
	User-Entered		

B. Establishment of Outstation Locations

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals:

1. Parents and Other Caretaker Relatives,

2. Pregnant Women, and

3. Infants and Children under Age 19.

C. MAGI Renewals

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable MAGI standard are performed as follows, consistent with 42 CFR 435.916:

1. Once every 12 months

2. Without requiring an in-person interview

3. Without requiring information from the individual if the agency is able to determine eligibility based on reliable information contained in the individual's account or other more current information available to the agency

4. If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, the agency:

a. Provides the individual with a pre-populated renewal form containing the information available to the agency (including information gathered from electronic data sources).

b. Provides the individual with a reasonable period of time from the date of the prepopulated renewal form to respond and provide any necessary information. The time period used by the state is:

○ i. 30 days

◉ ii. More than 30 days

The number of days is:

40

c. Permits an individual, or authorized person acting on behalf of the individual, to submit the renewal form via the internet website described in 42 CFR 435.1200(f) (d), by telephone, via mail, and in person.

d. Verifies information provided by the beneficiary in accordance with 42 CFR 435.925 through 435.956

e. Reconsiders eligibility, without requiring a new application, for individuals who are terminated for failure to submit the renewal form or necessary information if the individual subsequently submits the renewal form. For this purpose, the renewal form is accepted within the time period after the termination date selected below:

◉ i. 90 days

○ ii. More than 90 days.

Eligibility Process

MEDICAID | Medicaid State Plan | Eligibility | TN2019MS0003O | TN-19-0003

Package Header

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Approval Date 12/19/2019
Effective Date 3/18/2019
Superseded SPA ID N/A

User-Entered

D. Renewals on a Basis Other than MAGI

☑ Redeterminations of eligibility for individuals whose financial eligibility is not based on the MAGI standard are performed as follows, consistent with 42 CFR 435.916:

1. Frequency:

☑ a. Once every 12 months

☐ b. Once every 6 months

☐ c. Other, more frequent than once every 12 months

2. Without requiring information from the individual, if the agency is able to determine eligibility based on reliable information contained in the individual's account or other more current information available to the agency.

3. If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, the agency:

☑ a. Provides the individual with a renewal form

i. The renewal form is pre-populated with information available to the agency (including information gathered from electronic data sources).

◉ Yes ○ No

ii. As part of this process, the agency:

(1) Provides the individual with a reasonable period of time from the date of the renewal form to respond and provide any necessary information. The time period used by the state is:

○ (a) 30 days

◉ (b) More than 30 days

The number of days is: 40

(2) Permits an individual, or authorized person acting on behalf of the individual, to submit the renewal form using the following methods:

☑ (a) Via the internet website described in 42 CFR 435.1200(f)

☑ (b) By telephone

☑ (c) Via mail

☑ (d) In person

☑ (e) By other means

Description: By fax

(3) Verifies information provided by the beneficiary in accordance with 42 CFR 435.925 through 435.956

(4) Reconsiders eligibility, without requiring a new application, for individuals who are terminated for failure to submit the renewal form or necessary information if the individual subsequently submits the renewal form. For this purpose, the renewal form is accepted within the time period after the termination date selected below:

◉ Yes ○ No

(a) 90 days

(b) Other

b. Utilizes an alternative process to redetermine eligibility.

Eligibility Process

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	User-Entered		

E. Determination of Ineligibility

☑ 1. Prior to making a determination of ineligibility, the agency considers all bases of eligibility, consistent with 42 CFR 435.911

☑ 2. For individuals determined ineligible for Medicaid, the agency determines potential eligibility for other insurance affordability programs and complies with the procedures set forth in 42 CFR 435.1200(e)

F. Assistance with Application and Renewal

☑ The agency provides assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient, consistent with 42 CFR 435.905(b)

Eligibility Process

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G. Notices

☑ 1. The agency provides individuals with a choice to receive notices and information in an electronic format or by regular mail, in accordance with 42 CFR 435.918.

☑ 2. The agency provides applicants with timely and accurate notice of any approval or disapproval of Medicaid eligibility, which includes, but is not limited to: the basis and effective date of eligibility, the circumstances and procedures for reporting a change that may impact eligibility, the level of benefits and services approved, any applicable premiums or cost sharing, appeal rights, and if applicable, the amount of medical expenses which must be incurred to establish eligibility.

☑ 3. The agency makes notices, as well as cards evidencing eligibility for medical assistance, available to an individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

Notices and cards are made available through the following method(s)

If an individual does not have a residence address, they can enter a mailing address, such as a PO box, or can choose to receive materials electronically. If an individual is homeless, they are not required to provide a residence address. The mailing address they can enter can be the shelter where they sometimes reside, their local DHS office, or any place where they could access mail. If they have no way to access mail, then the address that will be input for them will be the TennCare address.

☑ 4. The agency provides beneficiaries with timely and adequate notice of proposed adverse action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid, and sends corresponding notice(s) to the individual at least 10 days prior to the action's effective date, as described in 42 CFR 431.211.

☑ 5. All notices provided by the agency are written in plain language. To ensure that notices are clear and undertstandable to consumer, the agency:

- ☑ a. Utilizes an in-house readability and plain language review process
- ☐ b. Contracts with an outside entity to complete a readability and plain language review
- ☐ c. Other

Eligibility Process

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H. Authorized Representatives

☑ 1. The agency permits applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with individuals' application and renewal of eligibility and other ongoing communications with the agency.

☑ 2. The agency requires that, as a condition of serving as an authorized representative, a provider or staff member or volunteer of an organization affirms that he or she will adhere to the regulations in 42 CFR 431, subpart F and at 45 CFR 155.260(f) (relating to confidentiality of information), §447.10 of this chapter (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

☑ 3.Designations of authorized representatives are accepted through all of the modalities described in 42 CFR 435.907(a) and are permitted at application and at other times. The agency accepts electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission.

I. Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

J. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Presumptive Eligibility

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User-Entered

The state provides Medicaid services to individuals during a presumptive eligibility period following a determination by a qualified entity.

Presumptive eligibility covered in the state plan includes:

Eligibility Groups

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Presumptive Eligibility for Children under Age 19	☐	☐	○	CONVERTED
Parents and Other Caretaker Relatives - Presumptive Eligibility	☐	☐	○	NEW
Presumptive Eligibility for Pregnant Women	☑	☑	○	APPROVED
Adult Group - Presumptive Eligibility	☐	☐	○	NEW
Individuals above 133% FPL under Age 65 - Presumptive Eligibility	☐	☐	○	NEW
Individuals Eligible for Family Planning Services - Presumptive Eligibility	☐	☐	○	NEW
Former Foster Care Children - Presumptive Eligibility	☐	☐	○	NEW
Individuals Needing Treatment for Breast or Cervical Cancer - Presumptive Eligibility	☐	☐	○	NEW

Hospitals

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Presumptive Eligibility by Hospitals	☑	☑	○	APPROVED

Presumptive Eligibility

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	User-Entered		

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- Presumptive Eligibility for Children under Age 19

Medicaid State Plan Eligibility

Presumptive Eligibility

Presumptive Eligibility for Children under Age 19

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The state provides Medicaid coverage to children when determined presumptively eligible by a qualified entity.

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Group No Longer Covered

Covered Through	3/17/2019	**Terminated As Of**	3/18/2019

Medicaid State Plan Eligibility

Presumptive Eligibility

Presumptive Eligibility for Pregnant Women

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Superseded SPA ID	TN 16-0002		
	System-Derived		

The state covers ambulatory prenatal care for individuals qualifying as pregnant women under 42 CFR 435.116 when determined presumptively eligible by a qualified entity.

A. Presumptive Eligibility Period

1. The presumptive period begins on the date the determination is made.
2. The end date of the presumptive period is the earlier of:
    a. The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
    b. The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.
3. There may be no more than one period of presumptive eligibility per pregnancy.

B. Application for Presumptive Eligibility

☑ 1. The state uses a standardized screening process for determining presumptive eligibility.

☐ 2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.

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

☑ 4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Name	Date Created	
PP_Screenshots_PEOnly_12182019	12/19/2019 9:56 AM EST	

C. Presumptive Eligibility Determination

The presumptive eligibility determination is based on the following factors:

1. The woman must be pregnant.

2. Household income must not exceed the applicable income standard at 42 CFR 435.116.

◉ a. A reasonable estimate of MAGI-based income is used to determine household income.

○ b. Gross income is used to determine household size.

☑ 3. State residency

☑ 4. Citizenship, status as a national, or satisfactory immigration status

Presumptive Eligibility for Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | TN2019MS0003O | TN-19-0003

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System-Derived

D. Qualified Entities

1. The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group. A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements.

2. The following qualified entities are used to determine presumptive eligibility for this eligibility group:

☑ Other entity the agency determines is capable of making presumptive eligibility determinations

Name of entity	Description
Selected FQHCs	Selected FQHCs in high volume areas
County health departments	Offices of the Department of Health located in each of Tennessee's 95 counties

☑ 3. The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved.

4. A copy of the training materials has been uploaded for review during the submission process.

Name	Date Created	
PE Desk Guide 121719	12/17/2019 12:56 PM EST	

Presumptive Eligibility for Pregnant Women

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E. Additional Information (optional)

Medicaid State Plan Eligibility

Presumptive Eligibility

Presumptive Eligibility by Hospitals

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☑ The state provides an assurance that it has policies and procedures in place to enable qualified hospitals to determine presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

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

A. Qualifications of Hospitals

A qualified hospital is a hospital that:

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

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

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

◉ Yes ○ No

Presumptive Eligibility by Hospitals

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B. Eligibility Groups or Populations Included

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

1. Pregnant Women
2. Infants and Children under Age 19
3. Parents and Other Caretaker Relatives
4. Adult Group, if covered by the state
5. Individuals above 133% FPL under Age 65, if covered by the state
6. Individuals Eligible for Family Planning Services, if covered by the state
7. Former Foster Care Children
8. Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

The state limits qualified hospitals for this group to providers who conduct screenings for breast and cervical cancer under the state's Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program.

◉ Yes ○ No

☐ 9. Other Medicaid state plan eligibility groups:

☐ 10. Demonstration populations covered under section 1115

Presumptive Eligibility by Hospitals

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C. Standards for Participating Hospitals

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

(•) Yes ( ) No

[x] The state has a standard requiring that a percentage of individuals who are determined presumptively eligible submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Percentage of individuals submitting a regular application:

99.00%

[x] The state has a standard requiring that a percentage of individuals who are determined presumptively eligible be determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Percentage of individuals found eligible for Medicaid

97.00%

D. Presumptive Eligibility Period

1. The presumptive period begins on the date the determination is made.
2. The end date of the presumptive period is the earlier of:
   - The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
   - The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.
3. Periods of presumptive eligibility are limited as follows:

( ) a. No more than one period within a calendar year.

(•) b. No more than one period within two calendar years.

( ) c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.

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

( ) e. Other reasonable limitation:

Presumptive Eligibility by Hospitals

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E. Application for Presumptive Eligibility

☑ 1. The state uses a standardized screening process for determining presumptive eligibility.

☐ 2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.

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

☑ 4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Name	Date Created	
PP_Screenshots_PEOnly_12182019	12/19/2019 9:58 AM EST	

F. Presumptive Eligibility Determination

The presumptive eligibility determination is based on the following factors:

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

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

◉ a. A reasonable estimate of MAGI-based income is used to determine household income.

○ b. Gross income is used to determine household size.

○ c. Other income methodology

☑ 3. State residency

☑ 4. Citizenship, status as a national, or satisfactory immigration status

Presumptive Eligibility by Hospitals

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G. Qualified Entity Requirements

☑ 1. The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals.

2. A copy of the training materials has been uploaded for review during the submission process.

Name	Date Created	
Hospital PE Training Presentation 12.13.19	12/17/2019 12:47 PM EST	
HPE Step-By-Step Instructional Guide v13	12/17/2019 12:48 PM EST	
HPE FAQ v.16	12/17/2019 12:48 PM EST	
Hospital PE Worksheet v06	12/17/2019 12:50 PM EST	

H. Additional Information (optional)

Participating hospitals shall ensure no less than 99% of individuals approved for PE actually completed and submitted the full application for ongoing TennCare eligibility. Applicants who choose not to apply for full coverage will not count against the 99% application standard.

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

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