TENNESSEE COMPTROLLER OF THE TREASURY

JUSTIN P. WILSON
Comptroller

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MEMORANDUM

TO: **Speaker of the House Beth Harwell**

FROM: **Comptroller Justin P. Wilson**
Chief of Staff Jason E. Mumpower

DATE: **December 6, 2017**

SUBJECT: **Review of TennCare Eligibility Determinations**

In summer 2017, news coverage reported that the monthly Social Security benefits of some TennCare enrollees had been suddenly and significantly reduced. When these members, whose Medicare coverage is funded by TennCare, were dropped from the TennCare rolls during the annual redetermination process, the Social Security Administration began deducting the cost of Medicare premiums from their benefits.

At your request, the Comptroller's Office has reviewed this matter. Although enrollees that receive Medicare coverage through TennCare make up a small portion of the TennCare population, TennCare does not have readily available statistics on the number of such members dropped from the rolls during the recent redetermination cycle. TennCare states that all such terminations brought to its attention were due to members not completing and returning the redetermination packet.

TennCare is developing a new computer system that is scheduled to become operational in 2019; in the interim, however, certain re-eligibility determinations have been done manually through a packet mailed to members. Because these determinations must be done on paper until the new system launches, our recommendations focus on making written and verbal communications more accessible for seniors:

- **TennCare should include simple and direct language in all written and verbal communications explaining that failure to return the redetermination packet could result in a reduction of the enrollee's Social Security benefits.** Some enrollees may be unaware that their Medicare premiums are paid through TennCare and so may not realize the potential consequences of not responding to TennCare mailings. TennCare should review its written communications and prominently feature language, both within the packets and on the outside of any envelopes, explaining the link between returning the TennCare redetermination packet and the enrollee's Social Security benefits.
- **TennCare should consider providing enrollees with self-addressed, postage-paid envelopes.** Such action could make the redetermination process more user-friendly.
- **TennCare should review the scripts used in robocall reminders and consider additional ways to contact enrollees through email or authorized representatives.** TennCare currently makes robocalls instructing members to look for the redetermination packet in the mail, and makes additional calls if members do not return the packet. TennCare should ensure the language in the calls emphasizes that the member's Social Security benefits may be reduced if the packet is

not returned. TennCare could also send reminders to enrollees' email addresses, if on file, or to any authorized representatives, such as a family member or caregiver.

Additional issues and concerns were considered as part of our review:

Enrollees receiving health insurance through TennCare may temporarily lose their coverage if their redetermination packet is submitted too close to the termination date. Following re-eligibility determinations, TennCare must update information in its system before a member's coverage is continued; if the redetermination packet is received close to the date coverage is scheduled to end, the update may not be processed until after the cutoff. Terminated members likewise do not have coverage during the appeal process. Although TennCare reimburses for medical services charged during this "gap," members must first pay for such services out of pocket, and may correspondingly forgo or delay needed services during this period.

The Comptroller's Office recommends that TennCare include language on communications that encourages members to mail their packets a certain number of days before the stated termination date. The language should also explain that if the packet is received close to this date, the member may temporarily lose coverage.

The redetermination packet mailed to members is 98 pages long and requires members to provide up to 17 pages of information. The packet includes 48 pages in English, 49 pages in Spanish, and an additional page referencing other languages. Although federal regulations require that TennCare use member information already available through other programs (SNAP or TANF, for example) to prepopulate forms for ease of use, the federal government is aware that TennCare will not prepopulate forms until its new system becomes operational, which is scheduled for early 2019. TennCare states that it will prepopulate eligibility forms the following year in 2020.

One family member may be deemed ineligible for TennCare benefits while other family members are approved. TennCare has identified opportunities for improvement with this aspect of the redetermination process, and has amended the contract with its vendor to require that documentation for all family members be linked earlier in the process. Additionally, TennCare states that its new eligibility determination system, estimated to launch in early 2019, will use a family-based, rather than individual-based, determination.

Enrollees may not have been able to update their addresses through the TennCare call center. Access has been added to allow call center employees to update information for all members that have been terminated except those receiving benefits in conjunction with Supplemental Security Income (SSI). Those members must update their addresses through the Social Security Administration.

The Comptroller's Office recommends that TennCare evaluate if there is a way to update its records and transmit changes to the Social Security Administration when members with SSI contact TennCare with address changes.

Call center wait times have been high at times, and call center staff may not have been able to confirm if TennCare received enrollees' redetermination packets. With 2,000 to 4,000 calls a day, average call times peaked at over 50 minutes; additionally, call center staff did not have access to records indicating receipt of a member's packet through the mail. TennCare has increased call center funding to raise capacity from 75,000 to 150,000 calls a month, and has provided for a daily update of information so that call center representatives can confirm whether TennCare has received an enrollee's packet.

It may take some time for an authorized representative to be approved, and until then, members must give verbal permission at the start of each phone call for the representative to be involved. Currently, authorized representatives, such as a family members or caregivers, must be designated in writing and approved by TennCare before the representative may have access to member information. TennCare is exploring technological solutions to allow representatives to be appointed by phone for more than the length of a single phone call.

Review of TennCare Eligibility Determinations

Per your request we have reviewed TennCare's redetermination process. First we have summarized the recent history of TennCare's redeterminations. Next we looked at what TennCare has done to date to address the problems encountered by enrollees.

History of TennCare's Redetermination Process Since 2014

The Affordable Care Act (ACA) changed how Medicaid eligibility is determined for certain groups of potentially Medicaid eligible individuals. Starting in January 2014, for most applicants, the ACA now requires states to assess (and verify when necessary) the applicants' Modified Adjusted Gross Income (MAGI) using new MAGI rules for determining household income and composition. For decades prior to the ACA's enactment, Tennessee used its Department of Human Services (DHS) eligibility computer system, ACCENT, to determine eligibility for two DHS programs (i.e., the Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families program (TANF) and for Medicaid.

Upon introduction of the new MAGI standards in the ACA, the State determined that it would not be possible to update the decades-old, legacy ACCENT system to make the drastic changes necessary to calculate income and household composition for determining Medicaid eligibility using the new MAGI rules. The State decided the best course was to procure a stand-alone computer eligibility system to determine Medicaid eligibility, i.e., the Tennessee Eligibility Determination System (TEDS). TennCare is currently in the process of building TEDS with its vendor Deloitte. Until TEDS is operational, eligibility determinations performed by the State are largely done manually. TennCare currently estimates that TEDS will be fully online by early 2019.

The ACA's introduction of the new MAGI standards for determining Medicaid eligibility also apply to redeterminations of Medicaid eligibility performed after January 2014. Federal law requires state Medicaid agencies to redetermine Medicaid eligibility each year to ensure that beneficiaries enrolled in Medicaid programs continue to meet eligibility criteria from year-to- year (with the exception for those eligible for Medicaid due to their status as qualifying to receive Supplemental Security Income benefits). If, through this redetermination effort, a member does remain eligible for the program, he or she is granted a new 12-month period of eligibility before being redetermined again. In recognition of the significant impact of the ACA on both new Medicaid eligibility determinations and redeterminations of Medicaid eligibility, CMS offered all states the opportunity to request and obtain a federal waiver of the annual redetermination requirement for 2014. Tennessee, along with most of the other states, requested and obtained this redetermination waiver in 2014. This waiver was in addition to the Tennessee- specific Mitigation Plan that TennCare entered into with CMS in 2013 to address the fact that TEDS would not be operational by January 2014.

Soon after obtaining the Redetermination Waiver, TennCare began working with CMS to develop a plan to restart redetermination efforts in calendar year 2015. The result of this work was the Tennessee Redetermination Plan that was formally submitted to CMS on December 8, 2014. This Redetermination Plan was approved verbally by CMS early in 2015, and formal approval was received on October 21, 2015. The broad impact of the Redetermination Plan was that CMS agreed that TennCare could restart its redetermination efforts in three phases. Phase one consisted of TennCare using members' SNAP information to redetermine their eligibility. While using SNAP was initially a one-time authorization, on August 31, 2017, CMS approved its use until the earlier of TEDS being fully online or January 1, 2019. Phase two consisted of identifying other segments of the member population that appeared likely to remain eligible for Medicaid and sending them a letter asking if there have been any changes to their household composition or income. TennCare redetermined as eligible those responding with an attestation that nothing changed in either their household composition or income. TennCare officials stated that all Medicare Savings Program members (a group to be discussed later in this document) were among those who were offered this self-attestation option in phase 2. Approximately 840,000 members were redetermined as eligible for another 12-month period through phases one and two. As of December 2015, approximately 425,000 members needed to receive renewal packets under phase 3.

For phase three, TennCare procured Maximus as a vendor to assist in performing redeterminations for the remainder of the TennCare population. TennCare officials stated that one primary concern as phase 3 was launched was making sure they were able to control the volume of redeterminations they initiated through packet mailings in order to provide an extra measure of caution in the process to ensure it was working properly for the benefit of TennCare enrollees. TennCare has reduced or paused the mailing of redetermination packets at times to work with Maximus to improve the process. TennCare has completed the first round of yearly required redeterminations for all members and is currently working on the second round of redeterminations. When members are sent redetermination packets, they have 40 days to complete and return the packet. If a request for additional information is sent, the member has 20 days to return that information. If a member fails to respond to the packet or to a request for additional information, an advance termination notice with appeal rights is sent to the member informing him or her that he or she has 20 days to complete and return the packet or requested information, and absent doing so, he or she will be terminated from the program by a certain date.

If a member has been terminated for failing to respond to a packet or a request for additional information, the member has 90 days from the date of termination to submit a packet or the requested additional information and, if found eligible, will have his or her coverage reinstated back to the date of termination. The effect of this so-called "gap-filling" is that the member will not experience a true break in coverage (meaning that if he or she incurs any medical expenses in their gap that are TennCare covered services, he or she can submit them for reimbursement to their Managed Care Organization (MCO) once the coverage is reinstated). Although Tennessee is not required by law to cover the gap in this scenario because TennCare has an approved waiver of retroactivity, TennCare officials stated that they choose to do so as a safeguard for enrollees given the manual nature of the process and the potential for occasional mistakes.

Tenncare officials also stated that they took steps to alert members of the importance of keeping their addresses updated with TennCare as the mailing of redetermination packets commenced. These steps included public service announcements, communications through the MCOs and advocacy groups, and including this messaging on TennCare's website. TennCare also created a video and flyer that were posted to TennCare's website and sent to advocates, providers, pharmacies, the Department of Human Services, and the Department of Health. In addition, TennCare had robocalls made to members selected to receive a redetermination packet in the mail to tell them to look for the packet and to remind them to be sure their address has been updated with TennCare. Robocalls are also made after a request has been sent to a member to return additional documentation and when a termination notice has been sent to the member for failure to respond to alert the member to the pending loss of coverage. If the robocalls are not answered, messages are left if the members have voicemail. TennCare officials stated that when packets are returned as undeliverable, Maximus will re-mail the packet to any forwarding address provided by the postal service. If there is no forwarding address, Maximus will then resend the redetermination packet to any updated address in the TennCare system or to the MCO-reported address (if different than the address in the TennCare system).

Title 42, *Code of Federal Regulations,* Part 435.1200(b)(3)(i) requires TennCare to minimize the burden on individuals during the eligibility and redetermination processes. During TennCare's redetermination efforts, several concerns have been expressed by members about the process. Below we discuss these concerns and actions taken by TennCare in response to the concerns.

Steps Taken by TennCare to Address Members' Concerns

Medicare Savings Program

Certain groups of individuals who qualify for Medicare are eligible for their state of residence to pay their Medicare premiums. This program is referred to as the Medicare Savings Program (MSP). In Tennessee, those MSP-eligible members may be enrolled in TennCare for the purpose of having TennCare pay the Medicare premiums on behalf of these individuals. For the purposes of enrolling and maintaining one's eligibility for the program, all MSP-eligible members are considered TennCare members and are required by law to undergo annual redetermination to maintain their MSP benefit.

One concern is that some members participating in the MSP are suddenly receiving reduced social security benefits without warning after TennCare determined they were no longer eligible for TennCare assistance. However, some members were later determined to still be eligible. When TennCare stops paying MSP premiums, the Social Security Administration (SSA) begins deducting the premiums from a member's social security benefits. Due to the time involved with TennCare sending eligibility files to the SSA, more than one month's premium could be deducted from a member's next SSA benefits payment. Members receiving this benefit have stated that they were unaware of this being a TennCare benefit, and therefore didn't understand that they needed to return the redetermination packet. TennCare has taken the following actions in response to these concerns.

TennCare has updated the envelope for the renewal packets to say in bold "Open and Act NOW! Important Health Insurance papers about TennCare, CoverKids, and Medicare QMB/SLMB are inside!" Previously, the envelope only read "Health Insurance Papers Inside, Open and Act Now!" Also, TennCare has updated their notification of approval letters and redetermination letters to explain that TennCare is paying for the Medicare Savings Program. For example, the updated approval letters say "you've been approved for a Medicare Savings Program (MSP). This means TennCare will help pay your Medicare costs!" Previously, the approval letter only read "you've been approved for a Medicare Savings Program."

TennCare also plans to start sending the Medicare Savings Program eligibility file to the Social Security Administration on a daily basis, instead of a monthly basis. This will allow the Social Security Administration to reinstate Medicare Savings Program coverage more quickly in their system and increase the speed of any premium refundings.

Redetermination Packet

Members have expressed concern about the size of the renewal packet. A copy of the current packet has been made available online by TennCare since August 2016. The entire document is ninety-eight pages long. Forty-eight pages are in English, forty-nine in Spanish, and one page references other languages. Of the forty-eight pages in English, ten pages require the completion of information by a member with one additional page if a member is American Indian or Alaska Native Family Member. There are another six pages to provide information for additional family members. The remaining pages are instructional.

Another concern expressed about the packet is that it's not prepopulated with information already available to TennCare. Title 42, *Code of Federal Regulations*, Part 435.916(a)(3) "Periodic renewal of Medicaid eligibility" requires the use of a prepopulated form that would provide the member with a renewal form containing information available to TennCare that is needed to renew eligibility. The Department of Health & Human Services – Centers for Medicare & Medicaid Services (CMS) has acknowledged in correspondence to TennCare that Tennessee has not completed implementation of new systems or functionality necessary to accomplish the redetermination and renewal of Medicaid eligibility in accordance with new Medicaid regulations set forth under the Affordable Care Act. TennCare officials stated that TEDS will start prepopulating members' renewal packets the year after their information is initially entered into TEDS at implementation. TennCare officials estimate that TEDS will be fully online in early 2019.

- Although TennCare has revised the language on its mailings to reference Medicare, TennCare should include simple and direct language in all written and verbal communications to MSP members explaining that failure to return the redetermination packet could result in a reduction of the member's Social Security benefits.
- TennCare should review the scripts used in robocalls to MSP members and emphasize that the member's Social Security benefits could be reduced if members do not return the packet.

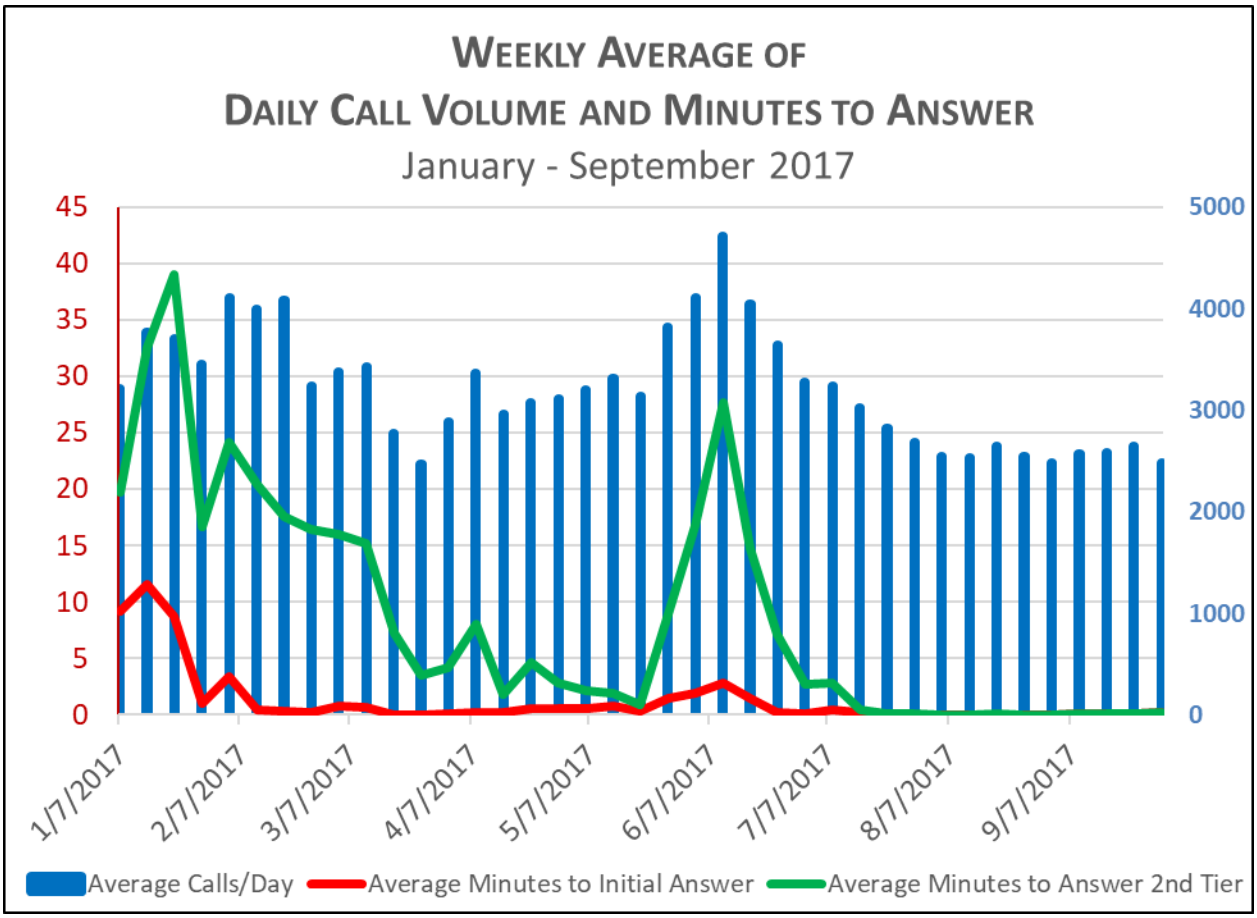
- To make the redetermination process more user friendly, TennCare might consider providing enrollees with self-addressed, postage-paid envelopes.
- TennCare officials stated that TEDS will allow members to choose an option to receive emails alerting them to log onto their TEDS accounts to provide redetermination or other information. TEDS will give members the option to complete forms online instead of having to complete a redetermination packet on paper and mail it in. TennCare should ensure that this option is communicated to all members. Having this option may help members who move frequently and reduce the time required by being able to complete an online form.
- Until TEDS is operational and forms may be completed online, TennCare could send alerts to members' email addresses, if on file, reminding them to complete the packet.
- As an additional way to reach members, TennCare could additionally contact authorized representatives by mail, phone, or email to inform them that a redetermination packet has been mailed to members and must be returned.

Individual/Family Member Eligibility Redeterminations

Concerns have been expressed about errors with linking individual eligibility redeterminations to family-based eligibility decisions. We discussed this concern with TennCare officials and were informed that TennCare determined that there were opportunities for improvement with the process of receiving redetermination packets. To improve the process, TennCare amended its contract with the eligibility redetermination processing vendor, Maximus. The amendment, effective September 30, 2017, mandates that documentation be linked to all relevant family members' cases within three business days after the packet is digitally scanned in to the document management system. The amendment also requires Maximus to have completed the digital scanning process within one business day of receipt at Maximus' processing center. Previously, the contractor's practice was to link documentation to additional family members at a later point in the process and a time requirement for linking documentation to all relevant family members' cases was not clearly defined. While TennCare's current systems are individual based, TennCare officials stated that TEDS will be case based which should help prevent one family member being determined ineligible for TennCare benefits when all other family members have been approved.

Call Center

Concerns have been expressed by members reporting up to multi-hour waits on the call-center line. We discussed this concern with TennCare officials and were informed that TennCare has implemented detailed oversight mechanisms with the contractor to monitor the call center wait times. Prior to October 1, 2017, TennCare used a tiered approach to call center operations where inquiries would be triaged with the first operator to answer the call and transferred to a more specialized operator, if necessary. The TennCare-provided call center statistics show that there were periods in 2017 where the wait time was in an unacceptable range. The chart below exhibits wait times for the calls to reach the first operator, and wait times for answers to subsequent transfers.



Beginning October 1, 2017, TennCare has abandoned the tiered approach to call center operations with a one-call approach as the new goal. The goal of the one-call approach is to improve customer satisfaction by providing complete assistance on the initial call to the call center without having to transfer the recipient to another operator. At the time of our review, it was too early to reach a conclusion about the effectiveness of the one-call approach, but TennCare officials are optimistic that it will provide an even better experience for call center users. In addition, effective October 1, 2017, TennCare increased funding for the call center for up to 150,000 inbound calls per month. Previously, base funding was provided for up to 75,000 inbound calls per month.

Members have also expressed concerns about the call center not being able to confirm if TennCare has received redetermination packets or other requested information. This was the case. TennCare has now made a change to correct this problem. The bar code on the packets or other requested information will update the system that documentation was received for all members linked to that documentation. This update is transferred daily to the call center so that call center operators have timely information.

Members Not Receiving Redetermination Packets or Other Notices

Members have expressed concern that their benefits were terminated without them receiving a redetermination packet or other notices. We discussed these concerns with TennCare officials. TennCare officials stated that they have looked at every termination brought to their attention by advocates, and that in all cases a written advance notice of termination was issued to the address of record before benefits were terminated. This includes members in the MSP. We observed that TennCare's interChange system maintains a record of the date that redetermination packets and advanced termination notices were sent. We also observed that the system used by Maximus upon mailing these packets and notices captures images of letters sent, including the addresses. The system also tracks address changes and the date addresses are updated.

Members that have lost TennCare coverage have also reported frustrations when trying to update their address with call center staff. Previously, call center staff could not update information in interChange for members who no longer had coverage. Call center staff can now update information in interChange in this situation with one exception not relevant to the annual redetermination process. Members receiving supplemental security income (SSI), who do not go through annual eligibility redeterminations but only have their eligibility reviewed if they lose their SSI coverage, need to contact the Social Security Administration to update their address since the daily data file received from SSA would undo anything TennCare has updated.

- TennCare should evaluate if there is a way to update its records and transmit changes to SSA when members with SSI contact TennCare with address changes.

Members Temporarily Losing Coverage when Packets Are Returned by the Termination Date

Concerns have been expressed that enrollees are being terminated from TennCare despite having returned their renewal packets by the date coverage is scheduled to end. TennCare officials acknowledged that this has happened when members fail to return their packets within the 40 days allotted to do so and then return their packets on or very close to the date their coverage is scheduled to end as a result of their prior failure to respond. In such circumstances, coverage is terminated until the receipt of the packet or other requested information is updated in the system and coverage reinstated. TennCare allows members an additional 10 days over the federal minimum to return packets or other information. To alert members that they may experience a short break in coverage if they return packets or other information close to or on the scheduled termination date, TennCare updated their notices. For example, the renewal packet reminder notice now states "What if you send us your Renewal Packet on time but we get it on or close to the due date? You may have a short break in coverage. But once we record your Renewal Packet as returned, we'll give your coverage back while we look at it."

- TennCare's response to this problem would not appear to be a preferred solution. Although enrollees can be given coverage back to the date they were disenrolled, they may have to go without needed medical services until that action is taken. Perhaps the due day could be coded into the bar code and then be sorted and processed by the due date.

- TennCare should consider updating its notices to state “What if you send us your Renewal Packet [or other required information] before your coverage ends but we get it on or close to the date your coverage is set to end?” to further help members understand the importance of timely submitting required packets or other information. Also, TennCare should consider including in their notices a recommendation that packets or other information be mailed/returned to TennCare a certain number of days before the date coverage is set to end. TennCare should select a number of days to include in the notices that officials believe would reduce the likelihood of members losing coverage under this circumstance.

Difficulties in Allowing an Authorized Representative to Discuss a Member’s Case

Concerns have been expressed over the length of time it takes to have authorized representatives approved to discuss a member’s case and get timely information from call center staff. Until approval is obtained, a member would need to give call center staff verbal authorization for each call for staff to speak to the member’s authorized representative. TennCare officials stated that they are investigating technological capabilities for authorized representatives to be appointed by phone for more than the duration of any given call.