



MEDIA RELEASE

STATE OF TENNESSEE
DEPARTMENT OF FINANCE & ADMINISTRATION

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CONTACT: MARILYN ELAM
615.532.8560 (OFFICE)
615.202.0701 (CELL)

FEDERAL GOVERNMENT APPROVES FIRST PHASE OF TENNCARE RESTRUCTURING DISENROLLMENT PROCEDURES MEET FEDERAL LAWS AND MEDICAID RULES

NASHVILLE — Late today, the U.S. Centers for Medicare and Medicaid Services (CMS) approved the first phase in the State of Tennessee's plan to restructure TennCare, allowing the State to move ahead with efforts to reduce enrollment in the financially troubled healthcare insurance program.

"Today's approval by the federal government is an important step in our efforts to gain financial control of TennCare," said Dave Goetz, commissioner of the Tennessee Department of Finance and Administration, which oversees the Bureau of TennCare. "No one wants to remove people from the program, but we've got to take steps to bring our costs in line with other states. We appreciate the federal government's swift action approving the procedures that will allow us to adjust enrollment."

Currently, TennCare provides healthcare coverage for 1.3 million enrollees, or 23% of the State's population — a greater percentage than any other State in the country. After enrollment reductions are complete later this year, at least 75% of TennCare's 1.3 million enrollees will continue receiving healthcare coverage, and Tennessee still will be among the top 10 states in the country in terms of the percentage of population covered by a taxpayer-funded health plan. TennCare is a more comprehensive version of Medicaid, the state and federal program for individuals and families with low incomes.

In technical terms, the federal government approved the State's procedures for reducing enrollment, including federally mandated requirements regarding notification of enrollees. In addition to seeking authorization of its procedures as part of the first phase in TennCare's restructuring, the State has asked CMS to approve a second phase that involves placing limits on benefits, similar to those found in other states. CMS is considering that request.

TennCare officials pledged to move carefully through the disenrollment process. "This is a complex process, but we've put a great deal of effort into ensuring that anyone who is expected to lose TennCare coverage will be afforded all due process rights throughout the restructuring effort," said J.D. Hickey, director of the Bureau of TennCare. "No one will experience any change in benefits or eligibility without first receiving advance notification from the State."

Details of the State of Tennessee's federal "waiver" application proposing changes to TennCare can be found on the TennCare Bureau's Web site at www.tennessee.gov/tenncare/TennCareupdates.htm.

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NOTE: Disenrollment briefing attached.

STATE CAPITOL, 1ST FLOOR
NASHVILLE, TN 37243
615.741.2401

Overview of Federally Approved Disenrollment Process

CMS has approved the State of Tennessee's process for disenrolling certain adults in the TennCare program. No enrollees will experience any immediate change in eligibility as a result of this approval. The timing of the disenrollment process depends on the outcome of current litigation on TennCare eligibility (*Rosen v. Goetz*).

The disenrollment process is designed to protect enrollees' rights under federal law. Each enrollee will be given the opportunity to establish that he or she is eligible for core Medicaid before losing coverage. Enrollees losing coverage will be given an opportunity to appeal.

The process approved for disenrollment is as follows:

- Before any disenrollment notice is mailed, the State will check records to determine if there is information that indicates an affected enrollee should maintain coverage.
- Later this spring, adult TennCare enrollees who are not currently in the core Medicaid program will receive a letter asking for any information showing that their income, health status or other eligibility-related factors have changed in order to determine if they are now eligible for core Medicaid.
- The state Department of Human Services will review information received in response to this letter and will make a new eligibility determination for any enrollee who responds.
- If, based on the new information, an enrollee meets Medicaid eligibility requirements, he or she will remain on the TennCare program.
- If an individual does not qualify for core Medicaid, he or she will receive a notice stating that TennCare coverage will end 20 days after the date of the disenrollment notice.
- Consistent with federal guidelines, an enrollee will be afforded full appeal rights if he or she is found to be to be ineligible for core Medicaid.
- If at any point during or after this process an individual meets eligibility requirements for core Medicaid, he or she will receive coverage under the restructured TennCare program.

NOTE: Non-pregnant adults enrolled in the "medically needy spend down" category will complete the remainder of their current coverage. As that coverage ends, they will be given a chance to show their circumstances have changed as outlined above. Also, they will be given full appeal rights if they are determined ineligible for core Medicaid. If at any point during this process or afterward an individual in this category should meet eligibility requirements for core Medicaid, he or she will be covered under the restructured TennCare program.