



TennCare Operational Protocol

Chapter 2: Eligibility and Enrollment

Section 2.1
Overview of TennCare Eligibility

This chapter provides a description of the populations covered by TennCare. These include **Medicaid eligibles**, as well as “**demonstration eligibles.**”

“Medicaid eligibles” are persons who meet the criteria for one of the Medicaid categories covered by the TennCare program. Medicaid eligibles are enrolled in TennCare Medicaid. “Demonstration eligibles” are persons who do not meet the criteria for a Medicaid category but meet the criteria for one of the demonstration categories. These are persons who would not be eligible for Medicaid in the absence of the TennCare waiver, or demonstration. They are enrolled in TennCare Standard. The three major demonstration groups are:

- uninsured children under the age of 19;
- non-pregnant adults who meet criteria patterned after those of the Medicaid Medically Needy program; and
- the CHOICES 217-Like HCBS Group.

The eligibility groups are summarized in Table 2-1 and discussed in more detail in the Special Term and Condition # 17.

It is important to recognize that a person must meet the criteria for a TennCare category in order to be eligible for the program. Medicaid categories are established by federal law, with some categories being **mandatory** for states and some being **optional**. The demonstration categories, which are not established in federal law, must be formally approved by CMS as part of TennCare’s 1115 waiver. States do not have the option of simply choosing to cover certain people or certain groups of people without explicit federal approval.

**Table 2 - 1
Major TennCare Eligibility Categories**

TennCare Categories	Brief Description
<i>Mandatory Medicaid Categories</i>	
1931* recipients	Persons who meet certain criteria associated with the program that was formerly called Aid to Families with Dependent Children (AFDC), including people losing eligibility for welfare benefits due to income from employment, increased work hours or increased child or spousal support collections
Poverty level pregnant and postpartum women	Pregnant and postpartum women with incomes at or below 185% of poverty
Poverty level infants and children to age 19	Infants to under age 1 with incomes at or below 185% of poverty; children from age 1 to age 6 with incomes at or below 133% of poverty; children from age 6 to age 19 with incomes at or below 100% of poverty

TennCare Categories	Brief Description
Children in foster care or adoption subsidy arrangements	
SSI recipients, including persons in SSI-related groups	Low income persons who are aged, blind, or disabled
<i>Optional Medicaid Categories</i>	
Institutionalized individuals	Persons receiving care in Nursing Facilities, Intermediate Care Facilities for persons with Mental Retardation, or Home and Community Based waiver programs who have incomes below 300% of the SSI Federal Benefit Rate
Women under 65 who need treatment for breast or cervical cancer and who are not otherwise eligible for Medicaid	Women who have been screened at a site authorized by the Centers for Disease Control and Prevention and who have incomes that do not exceed 250% of poverty.
Medically needy pregnant women and children under age 21	Pregnant women and/or children who have incurred enough unreimbursed medical bills to meet the state's spend down level.
<i>Title XXI demonstration children¹</i>	
Uninsured children with incomes below 200% of poverty	Children who were either already eligible for TennCare or who "rolled over" after losing Medicaid eligibility and lack access to insurance.
<i>Other demonstration eligibles</i>	
Medically Eligible children who have incomes at or above 200% poverty	Uninsured children who were either already eligible for TennCare or who "rolled over" after losing Medicaid eligibility, who lack access to insurance, and who have been found to be Medically Eligible (uninsurable).
Standard Spend Down (SSD) enrollees	Adults age 21 and older who are not pregnant or post-partum; who are aged, blind, or disabled, or caretaker relatives of Medicaid-eligible children; and who have incurred enough unreimbursed medical bills to meet a "spend down" obligation similar to that of the Medicaid Medically Needy program or caretaker relatives of Medicaid-eligible children.
CHOICES 217-Like HCBS Group	Aged and/or disabled adults who meet the NF level of care requirement, are receiving HCBS, who would be eligible in the same manner as specified under 42 CFR 435.217, 435.236, and 435.726 of the Federal regulations and section 1924 of the Social Security Act, if HCBS were provided under a 1915(c) waiver.

*Section 1931 of the Social Security Act was established as part of the 1996 welfare reform law.
Source: STC # 17

2.1.1 TennCare Medicaid Eligibility

¹Title XXI is the Children's Health Insurance Program. Certain uninsured children in TennCare who meet the CHIP definition of a "targeted low income child" are counted as CHIP children, even though they participate in TennCare.

All persons who would be eligible for Medicaid under the eligibility rules specified in Tennessee's State Plan for Medical Assistance (provided in accordance with Title XIX of the Social Security Act) are eligible for TennCare.

Eligibility for Medicaid through the Supplemental Security Income (SSI) program is determined by the Social Security Administration (SSA). (SSI recipients are automatically eligible for TennCare.) Eligibility for all other TennCare categories is determined by the Department of Human Services.

Reference: See Rule 1200-13-13-.02(5) and STC # 17.

2.1.1.1 Technical eligibility criteria. Individuals applying for TennCare Medicaid must meet all of the technical requirements applicable to the appropriate category of medical assistance as described in the DHS – Division of Medical Services rule 1240-03-03-.02.

2.1.1.2 Access to Insurance. Unlike TennCare Standard enrollees, TennCare Medicaid enrollees are not prohibited from having other health insurance. The one exception to this is women in the Breast and/or Cervical Cancer group, who cannot have insurance that covers treatment for their breast and/or cervical cancer. Some enrollees may have health insurance through an employer, or may have purchased health insurance on their own. TennCare Medicaid enrollees are required to assign the benefits of such policies to the state.

2.1.1.3 Financial eligibility. Financial eligibility for Medicaid programs is generally determined based on "income" and "resources."

- **Income** means wages, pension payments, and similar sources of regular support. The family income level is calculated by DHS according to the current federal poverty level (FPL) standards, using definitions of "family" and "income" that are similar to those used for Families First/AFDC cash assistance applicants.
- **Resources** are assets such as cash, bank accounts, stocks, bonds, and property.

Many of the TennCare categories refer to incomes that are certain percentages of the FPL, which is updated annually. A copy of the FPL for the current year can be found at <http://aspe.hhs.gov/POVERTY/>

2.1.2 TennCare Standard Eligibility Groups

The non-Medicaid demonstration population for TennCare is the population enrolled in TennCare Standard. The following groups are included in TennCare Standard:

Group 1: Uninsured low-income children. These are children who are either already enrolled in TennCare Standard or who have lost Medicaid eligibility and have been able to transition to this group as "Medicaid Rollovers." They must lack access to insurance, be under age 19, and have family incomes that do not exceed 200% poverty. The children in Group 1 are considered

CHIP children² under the TennCare II extension. The costs of their services are paid for with Title XXI funds, rather than Title XIX funds.

Reference: See Rule 1200-13-14-.02(5)(a)1 and STC # 19.

Group 2: Uninsured Medically Eligible children. These are children who are either already enrolled in TennCare Standard or who have lost Medicaid eligibility and have been able to transition to this group as “Medicaid Rollovers.” They must lack access to insurance, be under age 19, and meet the criteria for the “Medically Eligible” category, which means they have a medical condition that effectively renders them “uninsurable.” There is no income limit. Generally, children in this group have family incomes at or above 200% of poverty, since they could be covered in Group 1 if their incomes were below 200% of poverty.

Reference: See Rule 1200-13-14-.02(5)(a)2 and STC # 19.

Group 3: Grandfathered uninsured children.³ These are uninsured children who were eligible for TennCare as of December 31, 2001, even if they had access to insurance, but whose family incomes were below 200% of poverty. In order to stay in this eligibility group, children must remain continuously enrolled, must continue to meet income standards, lack access to insurance, and be under the age of 19.

Group 3 is a "grandfathered" group from the TennCare waiver that ended in 2002. All of the persons in this "grandfathered" group will continue to be enrolled in TennCare as long as they are continuously enrolled in their “grandfathered” category and they continue to meet all program requirements. If there is a break in coverage for any reason, persons disenrolled from a "grandfathered" group will not be able to re-enroll in that group. They will be treated like new applicants if they apply again for TennCare. Persons in the "grandfathered" groups who become Medicaid-eligible will not be able to return to their "grandfathered" group when their eligibility for Medicaid ends. They will be allowed to apply for TennCare like other Medicaid Rollovers when their Medicaid ends.

Reference: See Rule 1200-13-14-.02(5)(a)3 and STC # 19.

Group 4: Standard Spend Down enrollees. These are non-pregnant adults aged 21 or older who fall into one of the following groups: people aged 65 and older, people with disabilities, people who are blind, or caretaker relatives of Medicaid-eligible children. They must meet spend down criteria patterned after those criteria used in the Medicaid Medically Needy program. This category will be open to new enrollees only when the state announces an open enrollment period.

Reference: See Rule 1200-13-14-.02(6) and STC # 21(a).

Group 5: Discontinued Demonstration Group. Within the demonstration population, there is a group called the Discontinued Demonstration Group which consists of uninsured and/or Medically Eligible (i.e., uninsurable) adults aged 19 or older who were enrolled in categories that were terminated by the state in 2005. The individuals in this group are being assessed for

² Tennessee has a type of CHIP program that is referred to as a “combination” CHIP program. There is a stand-alone component, which is called CoverKids, and there is a Medicaid component, which includes the children in Group 1 who have incomes at or below 200% of poverty.

³ Children in this group are counted as CHIP children, since their incomes are below 200% of poverty.

eligibility in open Medicaid categories to determine their continued eligibility for the program. At some point in the future, there will be no persons in this group, since those who are eligible in other Medicaid categories will have been moved to those categories.

Reference: See Rule 1200-13-14-.02(7) and STC # 23.

Group 6: CHOICES 217-Like HCBS Group. This group consists of individuals aged 65 and older or individuals aged 21 and older with physical disabilities who meet the nursing facility level of care criteria, who could have been eligible for HCBS under 42 CFR §§ 435.217, 435.236, and 435.726, and Section 1924 of the Social Security Act had the state continued its 1915(c) HCBS waiver for individuals who are elderly and/or physically disabled, and who need and are receiving HCBS as an alternative to nursing facility care. This group exists only in the grand divisions of the state where the CHOICES program has been implemented, and is subject to the enrollment target for CHOICES 2.

Reference: See STC # 21.

2.1.2.1 Technical eligibility criteria

All members of the demonstration population must meet the following technical eligibility criteria: they must be residents of the State of Tennessee, be United States citizens or legal resident aliens, have met Social Security enumeration requirements, and not be incarcerated.

Reference: See Rule 1200-13-14-.02(3).

2.1.2.2 Access to insurance

“Access to insurance” remains an important concept in TennCare Standard. Persons in TennCare Standard other than those in the Standard Spend Down program must lack access to health insurance. If employed, the individual must provide a statement from his employer concerning the availability of group health insurance. The types of policies that count as “insurance” and the types of policies that do not count as “insurance” for purposes of determining uninsured status are presented in Attachment B.

Reference: See Rule 1200-13-14-.02(3)(b) & (g).

2.1.2.3 Financial eligibility

What is counted as “income” for children in TennCare Standard is the same as that for TennCare Medicaid children. (See Section 2.1.1.) Resources are not counted for TennCare Standard children.

Enrollees in the Standard Spend Down program have the same spend down levels and resource requirements as pregnant women and children served in the Medicaid Medically Needy program. They must “spend down” to the state’s Medically Needy Income Standard (\$241 for a family of 1; \$258 for a family of 2; \$317 for a family of 3; etc.). Their resources cannot exceed \$2,000 for a family of 1 or \$3,000 for a family of 2.

2.1.3 TennCare CHOICES Eligibility Groups

TennCare CHOICES is the program which provides long-term care services through TennCare's managed care delivery system. The purpose of CHOICES is to demonstrate that long-term care services can be offered within the context of a managed care environment and can result in more options for people who are elderly or disabled and who would otherwise require nursing facility care. These options would allow eligible individuals to remain in their homes and communities rather than having to enter nursing facilities.

There are two principal eligibility groups for TennCare CHOICES.

- CHOICES 1 is for individuals receiving services in a Nursing Facility. These individuals are enrolled in TennCare Medicaid.
- CHOICES 2 is for individuals who meet the NF LOC and are receiving HCBS as an alternative to NF care. Those in CHOICES 2 may be enrolled in either TennCare Medicaid, if they are SSI-eligible, or TennCare Standard, if they are not SSI-eligible.

Reference: STC # 18.

The non-SSI group in CHOICES 2 is called the CHOICES 217-Like HCBS Group. The CHOICES 217-Like HCBS Group is composed of persons age 65 and older or adults age 21 and older with physical disabilities who:

- Meet the NF level of care requirement;
- Are receiving HCBS; and
- Who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236, and 435.726, and Section 1924 of the Social Security Act, if the HCBS were provided under a Section 1915(c) waiver. With the statewide implementation of CHOICES, the Bureau will no longer provide HCBS under a Section 1915(c) waiver.

Reference: STC # 21(b).

2.1.3.1 Enrollment in TennCare CHOICES

Enrollment procedures differ depending upon whether the person is already enrolled in TennCare Medicaid. Individuals not already enrolled in TennCare who wish to enroll in TennCare CHOICES must enroll through the state's Single Point of Entry (SPOE). TennCare has contracted with the Area Agencies on Aging and Disability (AAADs) to serve as the SPOEs across the state.

For those already enrolled in TennCare, individuals currently residing in a nursing facility (NF) and covered by Medicaid at the time that the CHOICES program is implemented in their grand division of the state will be in CHOICES 1 and will be allowed to remain in the nursing facility as long as they meet the level of care criteria and continue to be financially eligible. Individuals participating in the HCBS Waiver for the Elderly and Disabled will be moved to CHOICES 2 at the time of CHOICES implementation in their grand division.

Other TennCare enrollees who are not already participating in CHOICES may request enrollment in CHOICES through their MCOs. They may also be identified through other mechanisms that would trigger an assessment of their need for long-term care by the MCO.

The effective date of enrollment in TennCare CHOICES is established by TennCare based on a determination that an applicant is eligible for and can begin receiving long-term care services.

2.1.3.2 Enrollment targets for TennCare CHOICES

The purpose of having an enrollment target is to permit the CHOICES program to grow in a controlled manner, while assuring that the individuals enrolled in the program are served appropriately and cost-effectively within available state and federal resources. There will not be an enrollment target for CHOICES 1. An initial enrollment target of 7,500 for CHOICES 2 has been established by TennCare.

Once the enrollment target for CHOICES 2 is reached, TennCare may not enroll additional individuals in CHOICES 2 except as described below. A CHOICES Waiting List as described in Section 2.1.3.3 may be established when there are an insufficient number of slots to accommodate those wishing to receive HCBS through CHOICES 2.

2.1.3.2.3 HCBS as a cost-effective alternative

An MCO with a TennCare enrollee who meets the criteria for CHOICES 2, but who cannot enroll that individual in CHOICES 2 because the enrollment target for CHOICES 2 has been met, has the option, at its sole discretion, of offering HCBS as a cost-effective alternative to the individual under a plan of care. The use of HCBS as a cost-effective alternative would be appropriate if the individual, without HCBS, would be receiving services in a NF. While this individual would be receiving services outside the CHOICES 2 enrollment target, once a slot became available, the individual would be moved within the CHOICES 2 enrollment target at that time.

2.1.3.2.4 Transition from CHOICES 1 to CHOICES 2

An enrollee being served in CHOICES 1 who meets the requirements to enroll in CHOICES 2 can enroll in CHOICES 2 at any time such a transition can be accomplished, even if the CHOICE 2 enrollment target has been reached. This individual would be served in CHOICES 2 outside the enrollment target, but moved within the CHOICES 2 enrollment target at such time as a slot becomes available.

2.1.3.2.5 Reserve capacity

TennCare may reserve slots in CHOICES 2 for the phased-in implementation of the CHOICES program across the state. TennCare may also reserve slots in CHOICES 2 for individuals being discharged from a NF and for individuals being discharged from an acute care setting who are in imminent risk of being placed in a NF absent the provision of HCBS.

2.1.3.3 Waiting lists for TennCare CHOICES

The use of an enrollment target for CHOICES 2 as described above may mean there will be a waiting list for CHOICES 2. (There will not be a waiting list for CHOICES 1.) The waiting list will be managed on a statewide basis using a standardized assessment tool and in accordance with criteria established by TennCare. The waiting list is based on objective criteria and is applied consistently across the state.

2.1.3.4 Consumer direction

CHOICES members who have been determined by their MCO care coordinator, as a part of the needs assessment and plan of care processes, to require attendant care, personal care, homemaker, in-home respite services, companion care or other services specified by TennCare as eligible for consumer direction, will have the opportunity to exercise decision-making authority regarding the workers who deliver these services (i.e., consumer direction of HCBS). All CHOICES members requiring these services will be offered the option to participate in consumer direction of HCBS. The consumer direction option will be organized and administered in accordance with best practices principles recognized by CMS as reflected in Attachment E of the STCs.

Reference: See STCs # 18, # 21, 34 and Attachment E of the STCs.

2.1.4 TennCare and Medicare Eligibility

Some Medicare beneficiaries are also eligible for cost-sharing and Medicare premium assistance from TennCare. Individuals who have Medicare and are also TennCare Medicaid-eligible are called “dual eligibles.”

Categories of Medicare cost-sharing assistance are as follows:

- **Qualified Medicare Beneficiaries (QMBs).** These are Medicare beneficiaries whose income is less than or equal to 100% of poverty. If they are also eligible in a TennCare category, they are called **QMB-Plus’s**.
- **Specified Low Income Medicare Beneficiaries (SLMBs).** These are Medicare beneficiaries whose income is between 100% and 120% of poverty. If they are also eligible in a TennCare category, they are called **SLMB-Plus’s**.
- **Qualifying Individuals (QIs).** These are Medicare beneficiaries with incomes between 120% and 135% of poverty. They are not eligible for TennCare.
- **Qualified Disabled Working Individuals (QDWIs).** These are Medicare beneficiaries whose income is less than 200% of poverty. They are not eligible for TennCare.
- **Other Medicare/TennCare duals.** These are Medicare beneficiaries who do not belong in any of the above categories but who also qualify for TennCare.

Information about what TennCare covers for each Medicare eligibility group is contained in Chapter 3, entitled “Benefits and Cost Sharing.”

Reference: See Rule 1200-13-.17.

2.1.5 Aliens and Refugees

Qualified aliens and refugees continue to be eligible for TennCare if they meet Medicaid eligibility criteria, and they are enrolled in MCOs in the same manner as all other TennCare enrollees. Emergency services for undocumented aliens continue to be provided as federally mandated.

Reference: See the following Policy Statements for a more detailed explanation:

EED 06-002 – TennCare/Medicaid for Qualified Aliens

<http://www.tn.gov/tenncare/forms/eed06002.pdf>

EED 05-001 – Emergency Medical Services for Illegal and Ineligible Aliens

<http://www.tn.gov/tenncare/forms/eed05001.pdf>

<h2>Section 2.2</h2> <h3>TennCare Application Process</h3>
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2.2.1 Overview: Applying for TennCare Medicaid

Persons meeting Medicaid eligibility criteria can enroll at any time. All applicants for TennCare, except SSI recipients and children in state custody, must complete a written application and be interviewed by a worker with the Department of Human Services (DHS). SSI applicants apply through the Social Security Administration (SSA) and are automatically enrolled in TennCare Medicaid upon approval of SSI benefits. Children coming into state custody are enrolled through the Department of Children’s Services. They have access to an arrangement called “immediate eligibility,” which is discussed in Section 2.2.7.

Pregnant women can apply for presumptive eligibility status at local health departments and other sites designated by the Department of Health through the Title V agreement.⁴ If they meet the requirements, they become immediately eligible for 45 days of TennCare coverage. They must follow up with an application through DHS and be approved in order to continue benefits past the 45-day period.

Women who are under age 65, who are uninsured or have insurance which does not cover treatment for breast or cervical cancer, and who have been determined to be in need of treatment for breast or cervical cancer may be screened for presumptive eligibility for Medicaid by a Centers for Disease Control and Prevention (CDC) site such as the health department. Presumptive eligibility lasts for a period of 45 days. During the presumptive eligibility period, the woman must go to the DHS office to complete her application for enrollment in Medicaid. The DHS worker first evaluates the woman to determine if she is eligible for any other Medicaid category. If she is not eligible in another Medicaid category, the worker evaluates her for this optional Medicaid category to cover her during the time she needs treatment for cervical or breast cancer. A redetermination of eligibility will occur at least every 12 months and will be based on the need for continuing treatment for breast or cervical cancer, as determined by the woman’s treating physician.

Applicants, other than SSI applicants, usually complete a portion of the application prior to the actual face-to-face or telephone interview. During the interview, the DHS worker and the

⁴ Title V of the Social Security Act is a federal-state partnership which authorized the creation of the Maternal and Child Health programs, thereby providing the foundation and structure needed to meet the nation’s goals for healthy mothers and children. OBRA 1989 converted the Title V program into a block grant program, consolidating seven categorical programs.

applicant jointly complete the remainder of the application. Persons who are unable to complete the applicant sections of the full application are assisted by DHS workers during the interview process (see Section 2.2.9). Applicant information is keyed on-line during the interview (in most cases) or from a workbook manually completed by a DHS worker at a later time (only occasionally).

An online application is now available for people who want to apply for TennCare. It is accessible through both the TennCare web site and the web site for the Department of Human Services. Following the receipt of the electronic application, DHS will contact the applicant about scheduling an interview and obtaining any additional information that may be needed.

For access to the on-line application:

TennCare's website: <http://www.state.tn.us/tenncare>

DHS' website: <http://www.tennessee.gov/humanserv/>

The state's automated eligibility system (ACCENT) determines Medicaid eligibility by category based on the information entered. Medicaid eligibility is determined within the time periods provided for in federal regulations, and the applicant is notified by DHS of the result of this process. Appeals of denials of Medicaid eligibility are handled by DHS.

Reference: See Rule 1200-13-14-.02(1).

2.2.2 Overview: Applying for TennCare Standard

TennCare Standard is currently not available for open enrollment.

2.2.2.1 Uninsured child eligibility

Children under age 19 whose Medicaid eligibility is ending are screened for TennCare Standard. If the child lacks access to insurance and has income below the specified poverty level, he may be eligible for the TennCare Standard Uninsured category. If the child meets all the technical eligibility criteria for TennCare Standard and is ineligible solely because of excess income, the child is offered an opportunity to apply in the Medically Eligible (ME) category.

Uninsured children under age 19 whose Medicaid eligibility is ending but who qualify for TennCare Standard and who file timely applications will be allowed to move immediately into TennCare Standard as Medicaid Rollovers, assuming they meet the income and/or Medical Eligibility criteria in place at the time. They will not experience a break in coverage.

Reference: See Rule 1200-13-14-.02(5)(c).

2.2.2.2 Medical Eligibility

There are two options that a child may use to apply for Medical Eligibility. Both of the processes begin with an eligibility determination at the local Department of Human Services. Any child under age 19 whose Medicaid eligibility is ending, who is uninsured, and who meets all of the technical requirements for TennCare Standard but has income at or above 200% of poverty will be given an opportunity to apply as Medically Eligible by completing a special packet. The options for Medical Eligibility are shown in Table 2 – 2.

Reference: See Rule 1200-13-14-.02(5)(c)2.

Table 2 - 2
Options for Medical Eligibility

Options	General Description
Qualifying Medical Condition	The child must either have his physician attest that he has a medical condition on the TennCare list, <i>or</i> the child must submit, along with the completed application, appropriate medical records to support the attestation of a medical condition <i>not</i> included on the TennCare list, and a release for additional medical records, if necessary.
SED	<p>The child must have a current (within the past 12 months) assessment as SED (Seriously Emotionally Disturbed). He must provide attestation by a licensed mental health professional of the diagnosis that supports the basis for the TPG assessment, as well as the medical records to support that diagnosis.</p> <p>TennCare will review available encounter data and, if the encounter data shows that the person has been assessed as SED within the past year, he will not be required to submit additional medical information.</p>

For Option 1 (“Qualifying Medical Condition”), TennCare has prepared a list of diseases/conditions that will be used to determine Medical Eligibility (see Attachment C). The diseases/conditions selected represent serious and/or chronic conditions requiring continued monitoring and/or treatment. Due to the serious nature of these diseases/conditions, most Tennessee insurance companies will deny coverage to individuals with a medical history that includes one or more of these diseases/conditions.

“Medical records” are defined in *Tennessee Code Annotated (T.C.A.)* 63-2-101(c)(2) as “medical histories, records, reports and summaries, diagnoses, prognoses, records of treatment and medication ordered and given, x-ray and radiology interpretations, physical therapy charts and notes, and lab reports.” Applicants for Medically Eligible status are not required to submit all the medical records they may have. Rather, they are required to submit a copy of a current medical record or portion of a medical record that documents the existence of the medical condition they have said that they have. A lab test may be sufficient in some circumstances. However, the lab test cannot be “anonymous” — it must be clearly identified as belonging to the person applying for Medically Eligible status.

Each of the methods above requires the child to include with the completed application all supporting documentation. Only complete applications accompanied by the required supporting documentation will be processed.

Medically Eligible TennCare Standard enrollees must renew their TennCare eligibility on the same schedule as other TennCare enrollees. Renewing TennCare eligibility means updating information on income, family size, access to insurance, etc. However, the medical criteria for Medical Eligibility will not be verified annually for those who remain on the program without a break in coverage.

Reference: See Rule 1200-13-14-.02(5)(c)2.

2.2.2.3 Standard Spend Down (SSD) eligibility

The SSD eligibility category is designed for a certain number of non-pregnant/postpartum adults aged 21 or older who are caretaker relatives of Medicaid-eligible children, or are aged, blind, or disabled. The financial eligibility criteria are the same as for the Medically Needy pregnant women and children eligible under the Medicaid State Plan.

Reference: See Section 2.1.1 and STC #21(a).

When an “open enrollment” period is announced, DHS will establish a telephone “Call-In Line” as a single point of entry for those who think they may qualify as SSD. Calls will be accepted up to the point that DHS estimates it can process applications within Federal timeliness standards. Callers to the Call-In Line will be asked for simple demographic information and will be assigned a unique identifier. A match will be done to determine if the caller is already enrolled in TennCare Medicaid. If not, an application form with a letter instructing the caller to complete the form and return within 30 days to be considered for enrollment will be mailed. Callers who are determined to be already enrolled in TennCare Medicaid as Medicaid State Plan eligibles will be sent a letter informing them that they currently have benefits and that they do not need to apply. Additional information about enrollment in TennCare Standard Spend Down is found in Part III of Section XIII of the STCs.

Reference: See Section XIII – Part III of the STCs, and Rule 1200-13-14-.02(6).

2.2.2.4 CHOICES 217-Like HCBS Group eligibility

The CHOICES 217-Like HCBS Group is composed of persons age 65 and older or adults age 21 and older with physical disabilities who:

- Meet the NF level of care requirement;
- Are receiving HCBS; and
- Who would be eligible in the same manner as specified under 42 CFR §§ 435.217, 435.236, and 435.726, and Section 1924 of the Social Security Act, if the HCBS were provided under a Section 1915(c) waiver. With the statewide implementation of CHOICES, the Bureau will no longer provide HCBS for the elderly and disabled under a Section 1915(c) waiver.

An individual who is not currently enrolled in TennCare and wishing to apply for CHOICES 2 for HCBS must contact the Single Point of Entry (SPOE) in his area. The SPOE is the Area Agency on Aging and Disability (AAAD). A list of the AAADs and their contact information can be found on the web site of the Tennessee Commission on Aging and Disability: <http://tennessee.gov/comaging/localarea.html>

Once the SPOE has gathered the necessary information and reviewed it for Medicaid eligibility, DHS will make a determination of whether the individual meets the criteria of the Institutional category of eligibility or some other category of Medicaid. DHS will also determine the patient liability and whether any transfer of assets that may have occurred meets the requirements of the Deficit Reduction Act (DRA).

A current TennCare Medicaid enrollee who wants to participate in the CHOICES 2 program for HCBS must contact his MCO for a determination of eligibility for these services, i.e., appropriateness of receiving care in the home; whether the cost of services fits within the budget neutrality requirement. A person who is already Medicaid eligible shall not be required to file a new Medicaid application to qualify in an Institutional category (i.e., 217-Like demonstration population). Only additional information required by DHS to determine whether the person meets Institutional eligibility requirements and to calculate patient liability and assess transfer of assets under the DRA shall be required. Such information shall be submitted by the MCO as an attachment to the CHOICES Enrollment Form.

Reference: STC #21(b).

2.2.3 Effective Date of Eligibility

See Table 2 – 3.

Table 2 - 3
Effective Date of Eligibility for TennCare

Program	Eligibility Category	Effective Date of Eligibility
TennCare Medicaid	SSI eligibles	The date determined by the Social Security Administration in approving the individual for SSI benefits
TennCare Medicaid	All other Medicaid eligibles	The <u>date of the application</u> ,* or the <u>date of the qualifying event</u> (such as the date that a spend down obligation is met), whichever is <u>later</u> .
TennCare Medicaid	Presumptively eligible pregnant women or presumptively eligible women who have been found to need treatment for breast or cervical cancer	The date an application is approved at the Department of Health or at any alternative sites designated by the Department of Health.
TennCare Standard	Uninsured children under 19	The day following the close of the Medicaid segment of the individual's eligibility.
TennCare Standard	SSD eligibles (Call-in Group) — see Part III of Section XIII in the STCs	The date the call was received by DHS during an announced open enrollment period, assuming the person is ultimately determined eligible, or the date the spend down is met, whichever is later. The latest date by which spend down can be met is the end of the one-month budget period – in this case, the end of the month of the original call to the Call-In Line.

*The date of application for Medicaid is:

- The date a signed application form is received in the county DHS office. The "begin date" for Medicaid is the application date or the date all eligibility requirements are met, whichever is later (example: a child applies for Medically Needy coverage but does not meet "spend down" until two weeks after the application date) or
- The date a faxed application is received at DHS. Eligibility begins either the date of the fax or the date all eligibility requirements are met, whichever is later.

Reference: See Rule 1200-13-13-.02(5)(b).

2.2.4 Length of Eligibility Period

Once eligibility is established, it proceeds until a redetermination occurs. There are certain categories of eligibles that have automatic eligibility periods. These are as follows:

- **Pregnant women and newborns.** Pregnant women have TennCare Medicaid coverage for the length of their pregnancy, plus two months postpartum. The newborn is automatically given one year's eligibility in TennCare Medicaid if the mother was TennCare Medicaid-eligible on the day of birth. The newborn is placed in the same MCO as the mother unless the mother is in TennCare Select. In that situation, the child goes through the random assignment process.
- **Women receiving treatment for breast and/or cervical cancer.** A woman in this category remains eligible until she no longer requires active treatment for her cancer, as determined by her physician, or she turns 65 years old. Annual eligibility reviews are done based on information from the woman's physician that continued treatment is needed for breast and/or cervical cancer. TennCare's Office of the Chief Medical Officer is responsible for reviewing the information submitted by the woman's physician.
- **SSI beneficiaries.** Those individuals who are enrolled in TennCare Medicaid because they receive SSI benefits from the Social Security Administration remain TennCare-eligible for as long as they are eligible for SSI.
- **Medically Needy and SSD enrollees.** These enrollees get an automatic year of eligibility.

Changes in income, family status or living circumstances (including address changes) that occur in the interim periods between "begin" and "end" dates of coverage must be reported by the enrollee to his DHS worker within 30 days, in accordance with *T.C.A. 71-5-110*. Failure to report such changes in a timely manner may result in termination from the program.

References: See Rules 1200-13-13-.02(5) and 1200-13-14-.02(5) & (6).

2.2.5 Re-Establishment of Eligibility

Eligibility in all TennCare categories will have a "begin date" and an "end date." A person may remain on TennCare past his end date only if he is determined eligible through the redetermination process. All TennCare enrollees must re-establish their ongoing eligibility for TennCare on at least an annual basis. *Ex parte* reviews conducted by DHS, responses to Request for Information (RFI) notices, and/or interviews between the DHS worker and the enrollee are the means by which this is accomplished. Enrollees will be required to provide updated information on their employment, income, assets, family status and other pertinent issues.

The determination that an individual meets the medical criteria for Medical Eligibility for TennCare Standard will not be reverified every year, since most of the conditions are chronic conditions that are life-long. However, people who are Medically Eligible will still have to renew their TennCare coverage each year and provide updated information on residency, changes in income, and access to group health insurance.

2.2.6 Rollover Eligibility for Individuals under Age 19

If an enrollee under the age of 19 loses eligibility for TennCare Medicaid, he may apply for TennCare Standard and, if eligible, be enrolled in TennCare Standard without a break in coverage, unless the loss of eligibility is due to incarceration or non-resident status. People who enroll in this way are called "Medicaid Rollovers." (Persons who lose eligibility because they are incarcerated or who move permanently out-of-state are not eligible to continue on TennCare as "Medicaid Rollovers.")

Enrollees who are children under the age of 19 moving from Medicaid to TennCare Standard will receive the same benefits as were included in their TennCare Medicaid benefit package. Thereafter, these enrollees must reestablish eligibility for TennCare Standard at announced intervals, which will occur at least once within a 12-month period.

Reference: See Rule 1200-13-14-.02(5)(c) and STCs # 19 & # 20.

2.2.7 Presumptive Eligibility and Immediate Eligibility

Pregnant women. Presumptive eligibility for pregnant women is determined consistent with the standards and criteria followed by Tennessee Medicaid and in accordance with its approved Medicaid state plan. Presumptively eligible pregnant women have 45 days to complete the full eligibility determination process. During the presumptive period, the woman is considered to be a "temporary" Medicaid enrollee; if she does not go to DHS and become eligible in a Medicaid category, she will not be permitted to stay on TennCare when her presumptive period ends.

Women needing treatment for breast and/or cervical cancer. There is also presumptive eligibility for certain uninsured women identified by a CDC (Centers for Disease Control and Prevention) site as requiring the need for treatment for breast or cervical cancer. Women who are under age 65, who are uninsured or whose insurance does not cover treatment for breast or cervical cancer, and who have been screened at a CDC site and determined to be in need of treatment for breast or cervical cancer, may be determined to be presumptively eligible for Medicaid at the CDC site. They then go to their county DHS office for determination of eligibility beyond the 45-day presumptive period. Coverage in this category is limited to the period during which a woman requires treatment for the breast or cervical cancer. Coverage is provided to these women who would not otherwise be eligible for Medicaid.

Children. There is no presumptive eligibility for children, except that children entering state custody are deemed "immediately eligible" for TennCare while their TennCare applications are being processed. Should the result of the eligibility determination process be that the children are not eligible for TennCare, DCS will reimburse TennCare Select for any dollars spent on these children's behalf.

HCBS applicants. There is also an immediate eligibility process for persons applying to enroll in the Statewide Home and Community Based Services (HCBS) for the Elderly and Disabled program as set forth in State Rule 1200-13-1-.02(5). This allows an individual to begin receiving home and community based long-term care services sooner than he otherwise would, in order to avoid institutionalization. To qualify for immediate eligibility, a person must be applying for enrollment into the Statewide HCBS waiver program, be determined by TennCare to meet

eligibility criteria for admission to a Level I Nursing Facility (i.e., have an approved Pre-Admission Evaluation (PAE)), have submitted an application for financial eligibility determination to DHS, and be expected, based on preliminary review of financial information, to qualify for TennCare Medicaid. If the result of the eligibility determination performed by DHS is that the person is not eligible for TennCare Medicaid, any long-term care services provided will be reimbursed with state funds, and FFP will not be claimed.

Reference: See Rule 1200-13-13-.02(1)(e).

CHOICES applicants. Immediate eligibility under CHOICES is a mechanism by which the State can, based on preliminary determination of a person's eligibility for the CHOICES 217-Like HCBS Group, enroll the person into CHOICES Group 2 and provide immediate access to a limited package of HCBS pending a final determination of eligibility. To qualify for immediate eligibility, a person must be applying to receive covered HCBS, be determined by TennCare to meet the nursing facility (NF) level of care, have submitted an application for financial eligibility determination to DHS, and be expected to qualify for CHOICES 2 based on the review of the financial information provided by the applicant. Immediate eligibility shall only be for specified HCBS (no other covered services) and for a maximum of 45 days.

2.2.8 HIPAA Statement of Coverage

Enrollees losing eligibility for TennCare are provided with a Certificate of Creditable Coverage, as required under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended.

Individuals who voluntarily terminate their TennCare coverage will also be provided with a timely Certificate of Creditable Coverage. Should the former enrollee need an additional HIPAA Certificate(s), he may request one by calling the Family Assistance Service Center (FASC) at 1-866-311-4287.

2.2.9 Newborns

TennCare coverage is automatically granted to any infant born to a Medicaid-eligible mother, effective on the date of birth. If a newborn's mother is TennCare Standard-eligible, the child will *not* be automatically granted eligibility for TennCare Standard. The child must be determined Medicaid-eligible in his own right in order to qualify for TennCare.

The newborn will automatically be assigned to the same MCO as the mother, unless the mother is enrolled in TennCare Select. In that event, the newborn will go through the random assignment process. Parents or family representatives must take steps to get the infant enumerated for Social Security purposes, however, so that he will not fail the TennCare technical eligibility requirement that every enrollee have a valid Social Security Number.

For newborns, a hospital worker may provide to the mother, family member, or a family representative an SS5 Form (which is an application for a Social Security number/card) to complete for the purpose of obtaining a Social Security number for the newborn. The hospital worker or a DHS worker may assist in completing the SS5 Form. DHS is allowed to bypass the requirement that the newborn be enumerated if there is verification that an SS5 Form has been completed.

The MCO in which the mother is enrolled at the time of delivery will be responsible for the coverage and payment of all TennCare-covered services provided to the newborn, beginning at birth. Infants on TennCare Standard are automatically assessed for potential Medicaid eligibility at the mother's next annual visit at DHS for re-establishment of eligibility. New mothers may voluntarily present to their DHS worker for an assessment of Medicaid eligibility for their child at any time and, in fact, are encouraged to do so.

When a pregnant woman who is an undocumented alien qualifies for TennCare payment of the delivery of her newborn, the newborn is deemed eligible for one year of Medicaid coverage as long as the baby remains with the mother.

Reference: See DHS Rule 1240-3-2-.02(h).

Policy Statement: CON 08-002 Assignment of Newborns, Coverage and Billing

<http://www.tn.gov/tenncare/forms/con08-002.pdf>

2.2.10 Procedures for Accommodating Persons with Other Disabilities and Limited English Proficiency

Beginning in 2002, the Bureau's Division of Member Services has been meeting on a regular basis with various consumer advocacy groups and other interested individuals to continue a dialogue about TennCare and enrollee issues, especially those issues involving reaching enrollees with disabilities or limited English proficiency. These are issues that are important to both TennCare and the advocates. This group meets regularly to discuss advocacy/outreach issues. Such meetings continue to benefit both sides by providing a better understanding of the issues involved and improving communications with the TennCare enrollee population.

2.2.10.1 Individuals with limited English proficiency (LEP)

Both the Bureau of TennCare and the Department of Human Services have made a number of provisions to assist individuals with LEP as they navigate the TennCare eligibility processes.

Both agencies have applications available in English and Spanish. In addition, TennCare mails notices in English and Spanish, and DHS mails notices in English or Spanish, depending upon what the individual has indicated is his primary language. An insert in each mailing provides a toll-free phone number that individuals may call for assistance with translation. These inserts have this information in Arabic, Somali, Kurdish-Badinani, Kurdish-Sorani, Bosnian, and Vietnamese. In addition, all notices contain the number of the Family Assistance Service Center. Through that number, a connection can be made with the AT&T Language Line for translation services, if necessary.

The Bureau of TennCare also maintains a contract with Health Assist Tennessee (HAT), an advocacy organization that provides outreach and advocacy assistance to persons with limited English proficiency, as well as translation services to TennCare enrollees and applicants. HAT can also direct enrollees and applicants to local community translation resources.

The Department of Human Services (DHS) also provides translation services, through bilingual staff, a contract with the AT&T Language Line, and through contracted and volunteer community translators.

Both the Bureau of TennCare and DHS maintain access to text telephones for the hearing impaired, and DHS also has sign language interpreters and readers for the visually impaired on contract.

2.2.10.2 People with physical and other disabilities

The following strategies are in place to assist clients with a wide range of disabling conditions that might interfere with their ability to understand the eligibility process.

DHS has been performing eligibility determinations for Medicaid, Food Stamps, and its Families First program for many years. The Department has a lengthy list of accommodations that it has made and will continue to make available to the TennCare population. These accommodations include:

- Letting the enrollee/applicant designate a third party to represent him during the eligibility determination process;
- Conducting the interview with an individual over the phone;
- Conducting the interview at an alternative site that is easier for the enrollee/applicant to access;
- Conducting the interview outside of normal working hours; and
- In extreme cases, conducting the interview in the enrollee's home.

2.2.11 MEQC

TennCare has a contract with the Department of Human Services to conduct alternative Medicaid Eligibility Quality Control (MEQC) Projects on behalf of the single state agency.

At least annually, the state is required to submit a plan for a MEQC pilot project to the CMS Regional Office. When each pilot is complete, the state is to send a report to the CMS Regional Office, and shall submit a plan for the next pilot project. The MEQC pilots must be conducted in accordance with Federal law, regulations, and policy. This is done in compliance with the waiver STC # 25.

<p>Section 2.3 Enrollment Process</p>

2.3.1. Procedures for Enrollment into MCOs

At the time the application for TennCare is completed, the applicant selects a Managed Care Organization (MCO) from among those available in his area. All family members in the same case must enroll in the same MCO, except for children eligible to enroll in TennCare Select. Applicants who fail to select an MCO at their DHS interview are assigned to one that is available in the area in which they live. Once enrolled, TennCare eligibles have 45 calendar days (inclusive of mail time) from the date of the letter of their notification of MCO assignment to

change MCOs if they are dissatisfied with their MCO for any reason. After the 45-day change period, enrollees can only change MCOs based on proof of hardship criteria (see Attachment E). The procedure for making an MCO change after the initial 45-day period is described in Section 2.3.4 below. If the applicant is subsequently approved for TennCare Medicaid or TennCare Standard, enrollment in the MCO will be effective on the same day that coverage in the program becomes effective.

Individuals who are returning to TennCare after a lapse in eligibility will be reassigned to their former MCO if the lapse in eligibility has been for less than 63 days. This assignment is an initial assignment only; members are given 45 calendar days (inclusive of mail time) from the date of the letter informing them of their re-enrollment in TennCare to change MCOs if they wish. After the initial 45-day period, enrollees wishing to change MCOs must follow the procedure described in Section 2.3.4 below.

TennCare also permits changes to place all family members in the same MCO, unless one of the family members is in TennCare Select. The MCC Change Unit within the Division of Member Services reviews and issues decisions on MCO change requests related to medical or service access issues.

Immediately upon being notified of the enrollee's eligibility, MCOs issue individual identification cards to enrollees, which are used to access services from MCO network providers. Each MCO is also responsible for providing a Bureau-approved Member Handbook and a Provider Directory listing the providers participating in the MCO's network.

Attachment D lists the current MCOs with whom TennCare contracts for services to be provided to enrollees. This Attachment also lists the Dental and Pharmacy contractors participating in TennCare.

Reference: See Rules 1200-13-13-.03 and 1200-13-14-.03.

2.3.2 Procedures for Enrollment into TennCare Select

TennCare Select is a special Managed Care Contractor that operates statewide to serve certain enrollees identified by TennCare. TennCare Select is not an MCC that an enrollee can choose; rather, the state assigns certain enrollees to TennCare Select. These enrollees include:

- Children who are eligible for SSI;
- Children in state custody and children leaving state custody for six months post-custody as long as the children remain eligible;
- Children who are receiving care in a Nursing Facility (NF) or an Intermediate Care Facility for persons with Mental Retardation (ICF/MR). For children and adults in a Home and Community Based Services 1915(c) waiver for individuals with mental retardation, current enrollees may opt-in to receive services through TennCare Select, and new participants may opt-out of TennCare Select in order to receive services through another MCO.
- Enrollees living in areas where there is insufficient capacity to serve them.
- Enrollees living out-of-state temporarily.

SSI children and children in an institutional eligibility category can opt-out of TennCare Select if they wish and choose another MCC that serves the area where they live. All the other groups must remain in TennCare Select even if they wish to choose another MCC. Additional information about TennCare Select is found in Section 4.1.2.

Reference: See STC # 40 and Rules 1200-13-13-.03(1)(b) and 1200-13-14-.03(1)(b).

2.3.3 Procedures for Enrollment with the Dental Benefits Manager (DBM) and/or the Pharmacy Benefits Manager (PBM)

There is only one DBM and one PBM, so the state enrolls members with these contractors.

Reference: See STC # 39, and Rules 1200-13-13-.03 and 1200-13-14-.03.

2.3.4 Procedures for Changing MCOs

Enrollees are given their choice of health plans when possible. Once enrolled in an MCO, the new enrollee may change MCOs (if an alternate plan is available) within the first 45 calendar days (inclusive of mail time) from the date of the letter of enrollment and MCO assignment. An enrollee shall remain a member of the designated plan until he is given an opportunity to change MCOs once each year during an annual change period. The annual change period will occur each year in March for enrollees in West Tennessee, in May for enrollees in Middle Tennessee, and in July for enrollees in East Tennessee. Thereafter, an MCO change is permitted only during the annual change period unless the Bureau authorizes a change as a result of the resolution of an appeal requesting a hardship change, or the enrollee moves out of the area served by his MCO.

When an enrollee requests to change his MCO, the MCC Change Unit within the Division of Member Services reviews the request to change MCOs against the six "hardship criteria" (see Attachment E). If the six criteria are not met, a denial letter is issued, including the right to appeal the denial of the enrollee's request.

Enrollees, after requesting and obtaining the approval of the Bureau of TennCare, may be permitted to change enrollment to a different health plan. In the event an enrollee changes plans, the enrollee's medical care will be the responsibility of the original health plan until the date that the new MCO assignment is effective.

An enrollee must change MCOs if he moves outside the MCO's Grand Division and that MCO does not operate in the enrollee's new area of residence. Until the enrollee selects or is assigned to a new MCO, his medical care is the responsibility of the original MCO.

In the event an MCO withdraws from participation in TennCare and is no longer available, TennCare will randomly distribute the membership across the remaining plans available in the Grand Division. If the enrollee does not want the MCO that was randomly selected for them, the enrollee will have 45 calendar days (inclusive of mail time) from the date of the MCO assignment to change MCOs.

According to STC # 41, the following situations are not considered to be "hardships" for which an MCO transfer will be approved:

- The enrollee is unhappy with the current MCO or primary care provider (PCP), but there is no hardship medical situation (as defined by the state):
- The enrollee claims lack of access to services but the MCO meets the state's access standards;
- The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
- The enrollee is concerned that a current provider might drop out of the plan in the future; and
- The enrollee is a Medicare recipient who (with the exception of pharmacy) may utilize choice of providers, regardless of network providers.

Reference: See STC # 41 and Rules 1200-13-13-.03(2) and 1200-13-14-.03(2).

2.3.5 Procedures for Annual Notification of Members

In keeping with the notice requirements outlined in the federal managed care regulations at 42 CFR 438.10(f) and in their TennCare CRA, the MCOs are required annually to update and mail handbooks to those enrolled in their TennCare plan.

Section 2.4

TennCare MCC contracts specifically prohibit true marketing activities. TennCare uses the term “marketing” to mean member materials which includes any informational and outreach materials meant to familiarize enrollees with their TennCare benefits and how to use those benefits successfully.

2.4.1 Marketing Activities and Restrictions

Marketing guidelines are included in the Managed Care Organization contracts. Key points are summarized below.

Each MCO must submit a detailed marketing plan, all marketing materials, and a description of marketing activities to TennCare for review and approval prior to implementation or use. All written marketing materials must be worded at a reading level that does not exceed sixth grade and must be printed with a minimum font size of 12 points. Materials must be made available in English and Spanish and in the language of any other Limited English Proficiency group identified by TennCare that constitutes five percent of the TennCare population or 1,000 enrollees, whichever is less.

Written materials must be made available in alternative formats or appropriate interpretation services must be provided for persons with special needs.

MCOs are permitted to distribute approved material through mass media and through general activities that benefit the entire community, such as health fairs. Telephone calls, mailings or home visits to current enrollees are permitted only for the purpose of educating current enrollees about services offered by the MCO.

The following activities are prohibited:

- Use of materials or activities that mislead, confuse, defraud, or are unfair;
- Use of overly aggressive solicitation;
- Gifts and offers of material or financial gain as incentives to enroll;
- Compensation arrangements with marketing personnel that tie compensation to the number of persons enrolled;
- Direct solicitation of prospective enrollees; or,
- Use of independent marketing agents.

2.4.2 Monitoring of Enrollee Marketing Activities

The primary focus of monitoring activities is to assure that marketing materials are clearly written and include content that is both correct and appropriate. TennCare also permits MCOs to conduct various outreach activities like health fairs. Plans for these activities also require TennCare approval as part of marketing oversight. If complaints are reported by applicants or

enrollees, additional monitoring activities may include member surveys, random audits, or undercover observation of marketing activities.

2.4.2.1 Review and approval of enrollee marketing plans and activities

As set forth in the Contractor Risk Agreement (CRA), MCCs must submit detailed descriptions of all proposed marketing activities as well as copies of all marketing materials to be used. These include: advertisement copy; brochures; posters; fact sheets; video tapes; story boards for production of videos; audio tapes; newsletters; telemarketing scripts; and any other forms of advertisement as well as other forms of public contact such as participation in health fairs.

The marketing plans and materials are reviewed to ensure that proposed activities are permitted under state and federal marketing guidelines. TennCare will approve, deny or return the plan with comments within 15 days. Once approved marketing materials have been produced, copies of the final product must be submitted to TennCare.

2.4.2.2 Failure to adhere to contractual marketing guidelines

If TennCare believes that violations of the marketing guidelines have occurred, an informal investigation will be conducted and TennCare staff will determine the appropriate response. This response may include written warnings to the MCC, or initiation of corrective action.

MCCs are required to develop and implement corrective actions to remedy the marketing problem(s). Sanctions may be imposed until such time as the state is satisfied that the problem has been resolved.