

REDETERMINATION PROCESS
FOR FORMER SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS

This document describes the processes Tennessee will use to redetermine eligibility for individuals who are no longer Supplemental Security Income (SSI) eligible but have continued to receive Medicaid benefits in Tennessee pursuant to the court ordered injunction in *Daniels, et. al. v. Tenn. Dept. of Health and Env't. et. al.*, No. 79-3107 (Dist. Tenn.) (hereinafter “former SSI recipients”). The process described in this document will also be used to conduct redeterminations of Medicaid eligibility going forward whenever an individual loses their SSI eligibility.

The State receives daily data feeds from the Social Security Administration (SSA) which notifies TennCare on the status of an individual’s Supplemental Security Income in Tennessee. When an individual’s SSI status changes to a non payment status, the individual is no longer receiving an SSI check and must have their Medicaid eligibility redetermined.

Process for redetermining eligibility of former SSI recipients in InterChange

1. Search for Prisoner Information
 - a. Through a data match with the Tennessee Department of Corrections, the State will ascertain which former SSI recipients are incarcerated in a state correctional facility or are a state prisoner in a county jail. Since these individuals cannot qualify for any category of Medicaid, the State will not conduct an ex parte eligibility review or otherwise attempt to establish their eligibility for another category of Medicaid. Instead, TennCare will send a notice to these identified individuals informing them that they are no longer eligible for Medicaid because they are incarcerated. The notice will provide recipients with a Medicaid termination date and inform them of their right to appeal if they believe the State has made a mistake (i.e. they are not in prison). If on appeal a recipient of a prisoner termination notice demonstrates he/she is not in prison and therefore could potentially be eligible for an open category of Medicaid, that individual will not have their Medicaid terminated until the full redetermination process described below has been completed.

2. Search for an active appeal with the Social Security Administration
 - a. The State will conduct a data match of the SSNs of individuals classified as former SSI recipients in InterChange with SSA data to determine whether the individual has an active appeal of the SSI termination (“SSI Appeal”) or is within 65 days of any decision by SSA that entitles the individual to seek further administrative appellate review since at all stages of an SSA appeal, an appeal has to be made to SSA within 65 days of a decision adverse to enrollee (60 days to appeal plus five days mail time).

- b. Recipients with active SSI appeals or who are within 65 days of any administrative appellate deadline will be flagged in InterChange and held pending resolution of their SSI appeal (i.e. when the recipient has no right to further administrative appeal and the SSA decision accordingly is the final administrative decision.) Once the SSI appeal has been resolved *or* 65 days to appeal to the next stage of SSA appellate review has passed and no appeal has been filed, the individual will be selected for ex parte review.
3. Recipients with active Medicaid cases in another open category of Medicaid
 - a. For some former SSI recipients, although SSI benefits were terminated, the individual at some point has separately been found to be eligible in a different Medicaid category and has an “active Medicaid case.” For these individuals, the State will query the InterChange database (which contains information on TennCare enrollees) to verify which former SSI recipients also have an active Medicaid case in a separate Medicaid category. These recipients will be automatically moved to their open Medicaid cases without further review and the designation as a former SSI recipient will be removed and the SSI case closed.
4. Ex Parte Review
 - a. The State will conduct a data match of the SSNs of individuals classified as former SSI recipients in InterChange with SSA data to determine whether the individual would qualify as Medicaid eligible in an open Medicaid category.¹
 - b. The State will conduct a data match of the SSNs of individuals classified as former SSI in Interchange with individuals classified as participants in the State’s Food Stamp or Families First (TANF) program in DHS’ ACCENT system (a database maintained by the Department of Human Services). In all instances when there is a match between a member of the inactive SSI population with an individual with an open Food Stamps or Families First record, the State will evaluate the individual’s information to determine whether they qualify for any open TennCare Medicaid categories. Any individual found to qualify for an open TennCare Medicaid category will automatically be moved to that category and their designation as a former SSI recipient will be removed and the SSI case closed.

¹ This determination will be whether (1) they lost SSI eligibility because of Social Security cost of living adjustments(s) (“COLA(s)”) but would be SSI eligible if the COLA(s) was/were disregarded (“Passalong” eligibles) or (2) they lost SSI eligibility for some reason other than a Social Security COLA, but would be eligible for SSI if the COLA(s) received since their SSI termination was/were disregarded (“Pickle” eligibles).

5. Request for Information

- a. When the above steps have been completed, and a further check of the SSA appeal data is run to insure that the member has no pending SSI appeal, all remaining individuals who have not yet qualified for Medicaid will receive a cover letter and Request for Information (“RFI”) informing them that their eligibility for TennCare Medicaid needs to be reverified and that they may be eligible for an open Medicaid category.
- b. The Request for Information will:
 - i. Inform members that their eligibility for TennCare Medicaid needs to be reverified and that they may be eligible for an open Medicaid category.
 - ii. Provide members with 30 days from the date of the Request for Information to provide the State with all of the necessary information for DHS to determine whether the individual is eligible for Medicaid (i.e., completion of an attached form and verifications). The Request for Information will inform members of the ways in which they may qualify for TennCare Medicaid. The Request for Information will include a form to be completed with the information needed to determine eligibility for TennCare Medicaid as well as a list of the types of proof needed to verify certain information.
 - iii. Inform members that if they do not submit information within 30 days from the Request for Information, DHS will be unable to find them eligible for TennCare Medicaid and the member will receive a Termination Notice prior to termination of their Medicaid coverage.
 - iv. Inform members that the State will have the discretion to extend the 30-day timeframe in which to submit information for good cause on a case-by-case basis, but such extensions will be limited to rare personal situations such as serious illness and DHS’ decisions on granting good cause exceptions will not themselves be fair hearable.
 - v. A cover letter to the RFI will ask the member whether he has an appeal pending with SSA regarding loss of SSI cash benefits. If a member asserts that he has a pending SSI appeal, the State will inform the member of what proof he needs to prove the existence of the appeal. Further, the State will verify this claim on a case-by-case basis with SSA, and if an SSI appeal is in fact pending, the

State will cease the redetermination process until the SSI appeal is resolved.

- c. Members with disabilities will have the opportunity to seek additional assistance in responding to the Request for Information. The Request for Information will be translated in Spanish, and additional translation assistance in other languages will be made available for individuals with limited English proficiency. Upon request, the State will also make special accommodations for individuals with qualifying assessments in the previous 12 months as SED or SPMI. Such accommodations will be provided to this population in accordance with the timelines and processes addressed in the State's policies and procedures. In addition, an SPMI/SED member of the *Daniels* class who has been selected for issuance of an RFI, through the steps discussed above, will be the subject of individual, targeted outreach by the Community Mental Health Center ("CMHC") that most recently provided services to that member, or by TPAL or its successor contracted advocacy organization. TennCare and the Department of Mental Health and Developmental Disabilities will identify the relevant CMHC for each SPMI/SED member who will be sent a *Daniels* RFI, and that information will also be provided to the contracted advocacy organization. Outreach to assist these members in navigating the redetermination process will be performed by the advocacy organization and/or the CMHC.
- d. If a member submits the requisite information during the 30-day time period following the Request for Information, he will retain his eligibility for TennCare Medicaid until DHS determines that the individual does not qualify for any open categories of Medicaid (and proper termination and appeal processes have been completed).
- e. If a member provides some but not all of the necessary information to DHS to determine whether the member qualifies for any open categories of TennCare Medicaid during the 30-day period following the Request for Information, the State will send the member a Verification Request. Verification Requests will inform members that they must submit the missing information to DHS within the 10 days from the date of the Verification Request in order for DHS to determine whether the member qualifies for any open categories of TennCare Medicaid. If a member submits all of the remaining requested information during this 10-day time period, the member will retain coverage until DHS determines that the individual does not qualify for any open categories of TennCare Medicaid (and proper termination and appeals processes have been completed). If no additional information is submitted (or if some but not all of the additional information is submitted), the member will retain coverage while DHS reviews the information the member has previously provided and makes an eligibility determination.
- f. If the State makes a determination that an individual is eligible for TennCare Medicaid, DHS will so notify the individual and that individual will be enrolled in the appropriate TennCare Medicaid category. The State will make the

determination that a member is no longer eligible for TennCare in the following two scenarios: (i) if a member submits information either during the 30-day period following the Request for Information or during the 10-day period following the Verification Request and upon review DHS determines that the member does not qualify for any open categories of TennCare Medicaid; or (ii) if the member does not submit the requisite information during the 30-day period following the Request for Information.

6. Termination notice

- a. Upon determination that a member is not eligible for TennCare Medicaid or if there is no response from a member to the RFI at all, following one further check of the SSA data to ensure the member does not have an SSI appeal pending, the State will issue a Termination Notice to that member 20 days in advance of the date upon which the member's coverage will be terminated.
- b. Termination Notices will:
 - i. Inform members that they will be terminated from TennCare as of the date specified in the notice (20 days after the date of the Notice) because they are no longer eligible for TennCare Medicaid and have not proven their eligibility for open TennCare Medicaid categories.
 - ii. Provide members with 40 days (inclusive of mail time) from the date of the notice to appeal factual disputes related to the action of termination and inform members how they may request a hearing.
 - iii. Inform members that if prior to the date of termination specified in the Termination Notice, a member appeals the action of termination, he will not lose eligibility for TennCare until the State determines that the member has not raised a valid factual dispute or the appeal is resolved.
 - iv. Inform members that they may submit new information to demonstrate Medicaid eligibility at any time after disenrollment. Such information will be treated as a new application for Medicaid. The member will not continue benefits pending the State's review and processing of this information.

7. Appeals Process

- a. Members will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice.

- b. The State will grant hearings only for those persons raising valid factual disputes related to the action of termination. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include:
- i. Member received the Termination Notice in error (e.g., he or she is currently enrolled in Medicaid and still meets the eligibility requirements for that category);
 - ii. The State failed to timely process information submitted by the member during the requisite time period following the Request for Information or Verification Request;
 - iii. The State granted a “good cause” extension of time to reply to the Termination Notice but failed to extend the time;
 - iv. Member requested assistance because of a health problem, mental health problem, learning problem, or disability, but the State failed to provide this assistance; or
 - v. The State sent the Termination Notice to the wrong address as defined under State law.
- c. The DHS staff will review the request for a hearing to determine if it is based on a valid factual dispute. An initial staff determination that the appeal is not based on a valid factual dispute will be reviewed by a DHS attorney and if confirmed, the attorney will send notification to the appellant informing him/her of the following: (i) that there is no indication of a valid factual dispute; (ii) that the appellant has 10 days in which to provide additional clarification of any issue of factual dispute or which his/her appeal is based; and (iii) unless such clarification is timely received, a fair hearing will not be granted.
- i. If the appellant does not respond within 10 days, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated.
 - ii. If the appellant submits additional information during this 10-day period and such information does not alter the attorney’s initial determination that there is not a valid factual dispute, a fair hearing will not be granted and DHS will send a second letter to the appellant dismissing the appeal. The enrollee will be terminated from the program.
 - iii. If the appellant provides additional information during the 10-day period that establishes a valid factual dispute, a second letter will be sent so advising the appellant and the appeal will proceed to hearing.

- d. When an enrollee requests a hearing prior to the date of termination as identified in the Termination Notice, TennCare Medicaid benefits will continue either until the State determines that the enrollee has not raised a valid factual dispute, or the appeal is resolved.
- e. If the member does not appeal prior to the date of termination as identified in the Termination Notice, the member will be terminated from TennCare Medicaid.
- f. If the member is granted a hearing and the hearing decision sustains the State's action, the State reserves the right to recover from the member the cost of services provided during the hearing process.