

How to help an individual keep TennCare coverage under the Standard Spend Down and/or HCBS waiver eligibility categories

Many of the sickest *Daniels* class members, as well as other TennCare enrollees undergoing the redetermination of their eligibility, have too much income to qualify for continued TennCare coverage under any category of eligibility that the State currently recognizes. However, the effect of recently enacted federal legislation requires the State to open or broaden eligibility to two categories of coverage for which many of these individuals would qualify. These two categories enable a person to qualify for TennCare with a higher level of *income* than is otherwise permitted.¹ This memo explains how to help clients establish their right to continued TennCare coverage under either or both of those categories.

The American Recovery and Reinvestment Act (ARRA)

The American Recovery and Reinvestment Act (ARRA), P.L. 111-5, was enacted in February 2009. ARRA authorizes funding for the Obama Administration's fiscal stimulus package. The law includes increased federal funding for states' Medicaid programs. If a state accepts the funding, as Tennessee has done for its Medicaid program (known as TennCare), the state must comply with certain conditions.

ARRA provides the additional funding by increasing the federal medical assistance percentage (FMAP), which is the percentage of a state's Medicaid payments that the federal government reimburses. In the case of TennCare, ARRA raises the FMAP from approximately 64% to approximately 74%. That means that, instead of paying roughly 64¢ of each dollar of TennCare expenditures, the federal government will cover 74¢. The FMAP increase applies to TennCare expenditures from October 1, 2008 through December 31, 2010. Tennessee will receive \$1.1 billion during that period in the form of ARRA enhanced federal match. See: State of Tennessee, *The Budget, Fiscal Year 2009-2010*, posted at <http://www.state.tn.us/finance/bud/bud0910/0910Document.pdf>, p. 72 of 626 [p. A-48 of printed version of same document, appended as Attachment 1]. See also: <http://www.tn.gov/tenncare/recovery/>

Section 5001(f)(1) of the Act imposes several conditions, one of which is the so-called maintenance of eligibility (MOE) requirement. A state cannot receive ARRA Medicaid funds if its Medicaid [or, in Tennessee, TennCare] "eligibility standards, methodologies, or procedures ... are more restrictive than the eligibility standards, methodologies, or procedures ... in effect on July 1, 2008." The Centers for Medicare and Medicaid Services (CMS), an agency within the federal Department of Health and Human Services, is responsible for overseeing states' compliance with federal Medicaid requirements, including the MOE. CMS has recently issued guidance concerning the application of the MOE provision

¹ Note that the *resource* limits (the amount and type of assets, e.g., savings account or motor vehicle, a person can own) remain the same as for other categories of adult eligibility for the TennCare program. The two categories of coverage that are the focus of this paper only afford individuals higher *income* limits, not increased resource limits.

As explained below, since July 1, 2008, Tennessee has illegally restricted eligibility for two categories for which many otherwise ineligible individuals would qualify. Because those restrictions violate the MOE, these individuals should be able to retain their TennCare.

Restrictions in TennCare Eligibility since July 1, 2008

Standard Spend Down Coverage

In April 2005, the State closed enrollment in its Medically Needy Spend Down program. The Governor announced that, if the federal courts granted relief from orders in two class actions, the State would grandfather the 100,000 enrollees then covered as Medically Needy. He promised that the State would also seek from CMS a special “waiver amendment” permitting TennCare to reopen Medically Needy coverage with new rules allowing the State to impose more stringent income eligibility limits than those authorized by federal Medicaid law. The waiver amendment would also enable the State to impose a quota on enrollment in that eligibility group. The courts granted the requested relief, and the Governor said he would seek federal approval for a waiver amendment as promised. The State continued to grandfather some of the individuals who were already in the Spend Down program when it closed in 2005.

CMS granted the requested waiver amendment in November 2006, acting under the authority of Section 1115 of the Social Security Act, 42 U.S.C. § 1315. The waiver provided for the redetermination of eligibility of the grandfathered individuals, known as the Transition Group, and the enrollment of new applicants who qualified for the new coverage, known as Standard Spend Down (SSD). The waiver established an enrollment cap of 105,000 people. The State did not reopen eligibility, however. In an October 5, 2007 cover letter extending the TennCare waiver, CMS referred to this eligibility category in the following language:

The State is required to complete its implementation of the Standard Spend Down (SSD) demonstration amendment, approved on November 14, 2006, within 1 year [from October 5, 2007], pursuant to the conditions set forth in the enclosed STCs. [Special Terms & Conditions].

Those STCs included STC 22, which provided:

22. Standard Spend Down (SSD) – Adult Non-State Plan Demonstration

Population Category. The SSD eligibility category is open to non-pregnant postpartum adults aged 21 or older who are Caretaker Relatives or Aged, Blind or Disabled. The financial eligibility criteria are the same as for the Medically Needy pregnant women and children eligible under the State plan. The SSD Demonstration eligibility group has an enrollment cap of 105,000, with a target enrollment of 100,000. The State shall establish eligibility and enroll individuals into the SSD group in accordance with the process set forth in Section XII [pages 70-71] of these STCs.

The STC spelled out the implementation process:

Upon implementation of the TennCare Standard Spend Down (SSD) demonstration amendment, the State will open SSD enrollment to two groups of individuals. One group (Category 1) consists of people who are not currently eligible for Medicaid and who meet the criteria for the new SSD program. The second group (Category 2) includes people who are in the Transition Group, have been found to be ineligible for any other Medicaid category, and meet the criteria for the new SSD program. Financial eligibility criteria for SSD will be based on criteria that apply to medically needy pregnant women and children eligible under the State Plan.

(p. 70; pertinent excerpts are appended as Attachment 2) Implementation would begin with the State redetermining the eligibility of the grandfathered individuals in the Transition Group (Category 2). When their eligibility status had been redetermined, the State was to enroll the new applicants who comprised Category 1. This group included individuals, known as “roll-overs”, who had been enrolled in TennCare in another category of eligibility and who were no longer eligible in that category.

“Once the State has reached its targeted enrollment of 100,000 persons, new open enrollment periods will be scheduled when enrollment in the SSD program drops to 90 percent of target enrollment.” The State’s decision to open or close enrollment [during these subsequent enrollment periods] is a matter of the State’s discretion. (p. 70) However, such discretion does not apply until the State has initially reached its targeted enrollment.

Section XII of the STCs require that, “The State will continue to follow this process throughout the Demonstration approval period [ending October 2010] unless modified through an approved Demonstration amendment.” [Attachment 2, p. 70] The SSD provisions of the waiver have not been amended and remain in effect.

Although the waiver provisions were not amended, the State’s fiscal year 2009 budget, which was adopted in June 2008, reduced funding for the SSD program from 100,000 to 20,000 slots.² In early calendar year 2008, TennCare required the people who had been grandfathered since the closure of Medicaid Spend Down in April 2005 to be tested against the eligibility requirements applicable to the TennCare Standard Spend Down waiver slots. That process was ongoing on July 1, 2008. Upon completion of the reassessment of the grandfathered enrollees, the remaining SSD slots were to be made available to new applicants, including enrollees who faced disenrollment from another category of coverage and sought to “roll over” into SSD.

Only 895 of the grandfathers qualified as of December 18, 2008, according a January 15, 2009 Quarterly Report (at page 7) submitted by the TennCare Bureau to the legislature’s TennCare Oversight Committee and Fiscal Review Committee. This report is posted at: <http://www.state.tn.us/tenncare/forms/leg0109.pdf>. [excerpt is Attachment 3] This left over 19,000 of the funded SSD slots available to new applicants and to current enrollees (including *Daniels* class members) seeking to “roll-over” into the category when their old coverage ends.

² The State fiscal year runs from July 1 through June 30.

The *Daniels* enrollees, as well as other “roll-overs” and new applicants, have never been tested against the SSD eligibility, however. In the FY 2010 Budget that the State adopted in June 2009, the legislature approved the Governor’s elimination of the 20,000 SSD slots that were funded and available as of July 1, 2008. See Governor’s Fiscal Year 2010 Budget, Volume II, p. 45, Item 8, posted at: <http://www.state.tn.us/finance/bud/bud0910/0910Reductions.pdf> [Attachment 4]

Home and Community Based Services Waiver

Federal law also authorizes the coverage of home and community bases services (HCBS) to qualifying individuals, who are elderly or disabled, who would otherwise require placement in a nursing home. Tennessee has had such a program, which is authorized under Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n. The program not only provides HCBS services but, because of its higher income limits, it affords some debilitated patients an opportunity to qualify for TennCare who might otherwise have too much income. Some of the sickest and most vulnerable *Daniels* class members who are being disenrolled would qualify under TennCare’s Section 1915(c) HCBS Waiver. However, they have not been allowed to qualify, because the State has tightened eligibility since July 1, 2008.

- 1) The State has restricted access to the HCBS waiver on the basis that all slots are filled for the balance of the federal fiscal year ending September 30. Many of the slots are not filled in fact, and the State’s method of counting denies access to slots that are unused. The State does this by counting a waiver slot as filled for the entire federal fiscal year if it is used even one day in the year. Thus, if a person enrolls October 1 and dies October 15, no one else can use the slot until the following October 1. This practice is inconsistent with the State’s representation in the waiver that it would not limit the number of participants at any point in time during the waiver year. (Waiver Appendix B-3: 1) [Attachment 5]
- 2) As of July 1, 2008, TennCare imposed a limit on the amount of services, such as home health services, that adult waiver participants could receive. These were service limits, not limits on eligibility. Thus, if an eligible person needed more services than those that were covered under the service limits, she could receive TennCare and waiver services, although she could not receive more services than the limits permitted. [1915 Waiver at Appendix B-3: 3, 4 (Attachment 5); Tennessee. Rule § 1200-13-1-.17(5) posted at <http://state.tn.us/sos/rules/1200/1200-13/1200-13-01.20090719.pdf> (Attachment 6)]

On July 23, 2008 the state issued a Policy Manual section that altered the way in which individual budget neutrality caps were calculated. The policy made two changes in the calculation of budget neutrality that now make it more difficult to qualify for HCBS and the TennCare program:

- The Policy converted the service limits into eligibility limits. Under the new policy a person who needs services that exceed the limits is ineligible to participate in the waiver, or to receive any TennCare services at all. [TennCare Policy Manual: Federal Assurances of Budget Neutrality for 1915(c) HCBS Waiver, (Attachment 7)]
- As of July 1, 2008, the state included in the calculation of budget neutrality only the cost of the HCBS services that the person received through the HCBS waiver

program. The state did *not* include the cost of other acute medical services (e.g., doctor visits, home health, etc.) that TennCare routinely covers and that are not delivered as part of the HCBS program. After July 1, 2008, that policy changed to include the cost of these other acute care services in the calculation of budget neutrality. The unfairness of the change is compounded by the fact that the Policy is imputing costs to the State for services that do not really alter the cost to the State. That is because these acute care services are now covered by a capitation payment, or monthly premium, which is paid to a managed care organization. The rate remains the same, even for patients who receive more care.³ These methodology changes make it more difficult to become eligible for TennCare through the HCBS waiver program.

**Authoritative federal guidance regarding the MOE requirements
makes clear that the TennCare restrictions violate ARRA**

In an August 19, 2009 letter to State Medicaid Directors, Cindy Mann, CMS Director of Medicaid and State Operations, described specific State policies that would violate the MOE requirement. Copies of the letter and attachments are appended as Attachment 8 and are available at:

<http://www.cms.hhs.gov/smdl/smd/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1227962&intNumPerPage=10>

Of particular relevance is the statement, at page 5, that

... reductions in the maximum number of waiver slots in an approved waiver would only be consistent with the Recovery Act MOE requirements if the State can demonstrate that the number of waiver slots available *is the higher of the number of waiver slots that were occupied as of July 1, 2008, or the number the State legislature actually funded as of that date.* (italics added)

The quoted language referred specifically to 1915 waivers, but the MOE provision applies with equal force to 1115 waivers, including the TennCare waiver amendment covering Standard Spend Down eligibles. Of particular relevance to the State's restriction on eligibility for the HCBS waiver is Ms. Mann's discussion, at pages 5-6, of the effect of changes in calculation of budget neutrality as it affects eligibility.

In order to draw down the ARRA enhanced funds, TennCare officials have had to certify that the State is in compliance with all ARRA requirements, including the MOE provision. As the August 19, 2009 CMS letter explains, the State's application for and acceptance of ARRA funds constitutes a "passive certification" that TennCare complies with all requirements of ARRA, including the MOE provision. In other words, proof that Tennessee has accepted ARRA enhanced matching funds is sufficient to establish that State officials have

³ A few enrollees who also qualify for Medicare may use home health services that Medicare covers. In those cases, TennCare only pays the patient share of costs, if any, that Medicare does not cover. For these patients, the cost to TennCare is negligible or non-existent.

certified that the TennCare current “eligibility standards, methodologies, or procedures” are no more restrictive than those in effect July 1, 2008.

Raising the MOE violations in individual TennCare eligibility appeals

The Tennessee Department of Human Services (DHS) determines eligibility for TennCare. If DHS notifies individuals that they have been determined to no longer be eligible for TennCare, they have a right to request an appeal and should do so immediately, making sure that they request continuation of benefits pending the appeal.

DHS can determine that an appeal does not raise a “valid factual dispute”, in which case the appeal will be denied without a hearing. If a person has a disability and needs accommodation of her disabilities, she should state that when appealing, as the state is required to provide a hearing in such circumstances. In any event, when appealing the person should also assert that she believes the State made a mistake in not considering her eligibility for Standard Spend Down and (if she is sufficiently impaired to need nursing home care) the HCBS program.

IF THE PERSON IS AFFORDED A HEARING, she should present evidence in support of her ARRA claims:

- **Evidence that the State has accepted ARRA Medicaid funds, which is necessary to invoke the MOE provision.** The evidence of the State’s receipt of ARRA funds is on the official state websites cited above. T.C.A. § 4-5-313(1) provides that, “The agency shall admit and give probative effect to evidence admissible in a court, and when necessary to ascertain facts not reasonably susceptible to proof under the rules of court, evidence not admissible thereunder may be admitted if it is of a type commonly relied upon by reasonably prudent men in the conduct of their affairs.” The website information may therefore come in under this provision. However, it is subject to objections based on authenticity and hearsay. It is therefore prudent well before the hearing to, if possible, ensure admission of this evidence by:
 - Negotiating a stipulation with DHS counsel; or, if opposing counsel refuses,
 - Use of affidavits as provided by T.C.A. § 4-5-313(2)
 - By issuing a request for admission (See T.C.A. § 4-5-311)
 - By subpoenaing a state official(s) under T.C.A § 4-5-311 who can testify to the information about Tennessee’s acceptance of ARRA Medicaid funding and the fact that the State is therefore subject to the MOE provision. Issuance of a subpoena should prompt opposing counsel to stipulate to the issue to save the inconvenience of having a state official testify to facts that the state cannot dispute.
- **A copy of the August 19, 2009 CMS letter to State Medicaid Directors.** This is important to not only confirm that the MOE provision requires the State to offer the SSD and HCBS coverage. The letter’s description of the “passive certification” procedure is proof that the State itself certifies that eligibility procedures in effect July 1, 2008 – including SSD and HCBS – remain in force.

- **Evidence that the SSD and/or HCBS slots were open as of July 1, 2008.** The documents cited above, including the October 5, 2007 waiver and the 1915(c) waiver provisions can be established by negotiating a stipulation with opposing counsel or by resort to the other alternatives that can be used to establish the ARRA funding facts discussed in the preceding paragraph.
- **Evidence that the State did not consider the enrollee for potential eligibility under SSD or (if applicable) HCBS.** This can be established by a DHS eligibility witness. The State should stipulate to the fact, since it is a matter of policy. If opposing counsel refuses to stipulate, you can establish that fact by one of the same alternatives outlined above. Instead of subpoenaing a TennCare manager, you would subpoena a DHS supervisor familiar with the *Daniels* redetermination process and the policies followed by the State.
- **Evidence that the individual meets the SSD eligibility criteria.** The waiver language quoted above provides that those criteria are the same as the criteria currently used for the Medically Needy Spend Down program for pregnant women and individuals under age 21. The rules establishing those criteria are Tennessee Comprehensive Rules 1240-3-3-.05 [resource limits] and .06 [income criteria], found at: <http://www.state.tn.us/sos/rules/1240/1240-03/1240-03-03.pdf>. More detailed guidelines and explanations are found in the DHS TennCare Medicaid and TennCare Standard Policy Manual, posted at <http://www.tennessee.gov/humanserv/adfam/StandardManual.pdf>, especially pp. 124 et. seq. Using those criteria as a checklist, gather and present documentation (e.g., qualifying medical expenses) and/or oral testimony that establish that the individual meets the requirements.
- **Evidence that the individual meets the HCBS eligibility criteria.** As noted above, this category covers people who are so medically impaired that they meet the preadmission evaluation (PAE) criteria that qualify them for care in a nursing facility. HCBS eligibility requirements are summarized at: <http://www.tennessee.gov/tenncare/long-elderly.html#2>. The best proof that an individual satisfies the PAE criteria is to have the local area agency on aging and disability obtain and evaluate a PAE application. The same website has information on how to contact the local agency. If you can get the PAE approved before the hearing, you should present it in evidence. You may not need to present other proof of the person's income or resources, *if* DHS has already correctly calculated the person's income and resources, and the DHS figures place the person within the financial criteria for HCBS eligibility. However, if the DHS figures inaccurately place the person over the HCBS income or resource limits, you should present proof of the correct income or resource amount(s).

If you are unable to arrange for a PAE evaluation before the hearing, either because there is not enough time or because the area agency won't conduct an evaluation (some refuse to do so because the HCBS slots are all full), present evidence at the hearing that the person's physician has found that the person needs nursing home care, and proof of efforts to apply for the PAE, which were rejected because the State has closed the program to new applicants.