2020

TennCare Enrollment Strategies for 2020

BEST PRACTICES GUIDE FOR HOSPITALS

TENNESSEE JUSTICE CENTER

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Introduction and Special Acknowledgement

In 2019, the Tennessee Justice Center (TJC) received a generous grant from the Annie E Casey Foundation to participate in the Southern Partnership to Reduce Debt (SPRD) project with fellow non-profit entities in the southern United States. While the SPRD project covers a wide variety of debt adversely impacting communities of color, our focus was exclusively on medical debt. Specifically, our work was designed to support the efforts to improve Tennessee hospital practices to reduce medical debt and improve health care coverage for the eligible but uninsured populations. The scope of our work included:

- Partnering with two hospital systems outside of Nashville, Tennessee, including one children's hospital to examine ways to increase public health coverage and prevent the accumulation of medical debt;
- Collaborating with both hospital systems and their revenue cycle departments and vendors to identify barriers to finding coverage who may be eligible under the Tennessee's Medicaid program, called TennCare; and
- Collaborating with both hospital systems to create strategies and develop processes to alleviate the barriers to enrolling into coverage.

The fruit of this work includes this guide as well as the resource titled, *Medical Debt Case Study: Using Medicaid Coverage to Prevent Medical Debt.* The case study is available upon request by contacting Rob Watkins, Staff Attorney, at 615-846-4712 or by email at rwatkins@tnjustice.org.

New Opportunities to Reduce Medical Debt & Uncompensated Care:

For families, medical debt is the leading cause of personal bankruptcy. For hospitals, medical debt represents unreimbursed costs, which are the main reason why Tennessee has the nation's highest rates of rural hospital closures per capita. And that's not all. Medical debt has become a public relations nightmare for hospitals, as the news media and elected officials blame hospitals for the financial plight of their uninsured, or und*er*insured patients.

Underlying the problem of medical debt is America's unique status as the only advanced industrial nation whose citizens do not all have health coverage. The Affordable Care Act reduced but did not eliminate the number of Americans without coverage. With rising costs, even insured families find themselves burdened with ruinous medical debt not covered by their insurance. The key to eliminating medical debt is ensuring that patients have coverage that is adequate to cover their medical expenses. In Tennessee, the legislature can start by joining the great majority of other states that have accepted federal Medicaid funding to expand coverage to low income families made eligible by the ACA. That would reduce the number of uninsured Tennesseans by nearly 20%.

Fortunately, hospitals need not wait on the political process to prevent or reduce their patients' medical debt. Nearly half of all uninsured Tennesseans are eligible but not enrolled (EBNE) in publicly subsidized health coverage. They are eligible for Medicaid or CHIP, or for subsidized coverage through the federal insurance exchange, healthcare.gov. They remain uninsured,

however, because they have not enrolled, or because the state erroneously terminated their coverage. Hospitals can play a crucial role by connecting these EBNE patients to coverage for which they qualify.

Recent changes in state policy make that much easier to do. By making the most of these new opportunities, hospitals can "do well by doing good." By adopting a thoughtful strategy to help EBNE patients (and prospective patients) gain coverage, hospitals turn bad debt into revenue and turn a public relations liability into a public relations asset. This guide outlines how hospitals can make the most of these new opportunities.

Because securing health coverage for the eligible but uninsured patients is so important for improving the health and financial well-being of low-income Tennesseans, we have given priority for many years to overcoming barriers to enrollment in TennCare and in Tennessee's Children's Health Insurance Program (CHIP), known as CoverKids. Professional assistance is often needed, due to the notoriously complex and arcane eligibility rules for those programs.

Complex rules especially affect children and adults with severe chronic conditions, because the lesser-known eligibility categories for which they qualify are so complicated that the state fails to screen for eligibility in those categories. This has serious financial implications for patients and providers alike, since these categories are supposed to cover uninsured patients among the sickest five percent of the population who incur over half of all medical expense.

As a 501(c)(3), public interest law firm, we have been helping vulnerable and low-income Tennesseans gain access to public health benefits for over two decades. We use individual client cases to identify and address systemic problems plaguing our clients. This boots on the ground approach provides unique insights into TennCare's processes as well as the ability to design specific strategies to address the "eligible but uninsured" population in Tennessee.

We have distilled our knowledge and experience into this best practices guide designed to help hospital financial counselors connect uninsured patients to public health benefits. Crafting a thoughtful enrollment strategy will prevent and often eliminate medical debt for patients while reducing the hospital system's uncompensated care risk. In this guide, you will learn how to use the recent changes to the TennCare eligibility rules and the Tennessee Eligibility Determination System (TEDS) to enroll more uninsured patients into health coverage.

Current Barriers to Coverage

In 2014, the Affordable Care Act (ACA) changed the rules governing eligibility for most people applying for Medicaid, known in Tennessee as TennCare. The changes were designed to streamline the application process, but serious barriers continue to impede many TennCare applicants:

- No Retroactive Coverage - Tennessee has a waiver of the retroactive coverage requirement in the federal Medicaid law, that for an eligible applicant, provides coverage up to 90-days prior to the date of application. In Tennessee, the coverage effective date is the date of

application. That makes it imperative that an application be submitted immediately, which can be problematic for those who enter the emergency room late in the evening.

- Low Reimbursement Rates - Medicaid reimbursement rates are much lower than Medicare and private insurance.
- Technology Challenges - The TennCare Eligibility Determination System (TEDS) quietly went live across the state on March 18, 2019. Within months, serious problems were exposed, many of which continue to lead to erroneous denials of original and renewal applications.
- Mass Disenrollment of Enrollees - A flawed annual renewal process called "Redetermination" erroneously led to 200,000 TennCare enrollees losing coverage in 2017-2018, and many remain without coverage. Most enrollees were terminated for procedural reasons, like failing to return the renewal packet, as opposed to being no longer categorically eligible for the program. Redeterminations are ongoing and, although improved, remain prone to error.

Strategies to Improve TennCare Enrollment

Health care providers who help their patients apply for Medicaid typically do so in order to obtain reimbursement for treatment and services provided. Since Tennessee does not provide retroactive coverage for those patients that apply, it is imperative that the application for Medicaid be made as soon as possible, and ideally, upon initial contact with the provider. Failure to submit a timely application increases the risk of patients being forced into bankruptcy and unable to obtain necessary care, and of charges being written off as uncompensated care.

The rollout of TEDS ushered in a new set of Medicaid eligibility rules that affect applications and renewals of existing coverage and doubled the time limits to respond to requests for more information. This is great news, but in order to maximize the opportunity, hospital administrators must understand the changes and adjust their workflow processes accordingly.

2019 TennCare Rule Change: "Valid" versus "Completed" Application

Prior to August 2019, an eligibility determination was made only upon the receipt of a "completed" application that required the submission of information and frequently burdensome documentation that often took days or weeks for patients to compile. These requirements created a significant barrier when applying for Medicaid coverage. Most uninsured patients did not have the necessary information needed to apply especially in an emergency situation. Often, this would delay the application process for several days and prevent coverage for the most expensive period of a patient's care.

The new rules greatly reduced the amount of information required to initially apply for coverage. TennCare rule 1200-13-20.05(7)(a) states eligibility is determined based on information contained on the *valid application* as well as information secured during the application process (emphasis added). A valid application is defined as:

- the single streamlined application form for all insurance affordability programs; and
- must include contact information; and

- be signed by the applicant, a responsible party or authorized representative.

Thus, all the information needed to apply is the applicant's contact information and signature. With regard to the signature requirement, anyone acting responsibly can sign the application on behalf of an incapacitated person. This can include hospital personnel.

2019 TennCare Rule Change: Reporting Timelines Extended

Another significant change doubled the time limit to respond to requests for more information. Under the new rules, current enrollees who are subject to redetermination (annual renewal process) or are applying for coverage have 20 days to provide required information to establish eligibility for either TennCare, CoverKids or Medicare Savings Programs. Requests for more information are commonly referred to as verifications and usually require the recipient to submit documentation. For example, a common verification request asks for payment stubs as proof of wages from working a job.

Under these rule changes, it should be easier and faster to apply for TennCare, and that is critical because the application submission date ultimately determines the effective date of coverage for eligible patients. Unfortunately, providing contact information along with a signature isn't enough to make a Medicaid or CHIP eligibility determination, so applicants will receive requests for more information from the state. While this creates an additional set of challenges operationally in order to establish eligibility, the extension of the deadline to respond will prove to be valuable.

The combined effect of both of these changes to the TennCare rules essentially increases the time to apply for coverage by 20 days, provided the application process is started upon the initial encounter with the provider. Thus, we strongly recommend hospital administrators examine their current processes to ensure that an application is submitted as soon as the patient's contact information is collected, and the patient or a responsible representative (which can include a hospital staff member or revenue cycle vendor) affixes his signature.

Hospital Presumptive Eligibility

In Tennessee, Hospital Presumptive Eligibility (HPE) allows hospital employees (but not third-party vendors) to make real-time, temporary TennCare eligibility determinations. Eligibility is based solely on information provided by the patient and doesn't require hospital employees to verify the accuracy. If determined eligible for HPE, the patient has temporary coverage for 62 days during which time, he/she must submit a full application for coverage. HPE is limited to the Medicaid categories that utilize the Modified Adjusted Gross Income (MAGI) methodology for determining eligibility. This methodology covers most Medicaid enrollees including children, pregnant women and caretaker relatives.

HPE has some strict rules that a hospital must comply in order to maintain participation in the program:

- the hospital must ensure that no less than 99% of individuals approved by the hospital for HPE actually complete and submit a full application for ongoing TennCare eligibility;
- the hospital must submit a Failure to Submit form for 100% of individuals the hospital approved for HPE who did not submit a full application for ongoing coverage.
- The hospital must make accurate eligibility determinations.
- Hospitals employees must make the HPE determination, not a third part designee like a revenue cycle vendor;
- Patients are limited to one period of HPE within a two-year period.

According to the Tennessee Medicaid State Plan, no less than 93% of all applicants made presumptively eligible shall be found eligible for full Medicaid benefits in year one, with the required approval proportion increasing to 95% and 97% in years two and three, respectively. Thus, a hospital faces termination of HPE privileges if greater than 7% of the applicants they made presumptively eligible in year one were not in fact Medicaid eligible after determination based on a regular Medicaid application.

While these challenges seem onerous, the state has streamlined the process making it much easier for hospital to abide by the requirements outlined in the State Plan. The Division of TennCare created a specific portal within the TEDS system for hospitals to make presumptive eligibility determinations. Using information provided by the patient, hospital employees can make an eligibility determination in real-time using the TennCare Access portal. Since the hospital is not required to verify the accuracy of the information reported, it can rely almost exclusively on the eligibility results generated by TennCare Access to meet the accuracy requirement.

The TennCare Access portal also makes it is easy for patients and hospital employees to submit a completed application for ongoing TennCare coverage as required by the State Plan. Only patients who are found eligible for HPE are required to formally complete the application process. Once a patient is determined eligible for presumptive eligibility, hospital staff is prompted by the system to continue the application process and submit a completed application. It is important to take this next step if at all possible. All that the patient must do is answer a few additional questions, and this requirement is satisfied as well. This is much easier and faster than applying through TennCare Connect or the Federal Marketplace.

The decision to participate in HPE should be seriously considered even if the hospital employs the services of a revenue cycle vendor. The TennCare Access portal streamlined the eligibility determination process, and by doing so, removed most of the risk to providers. Now, hospitals can easily help the patient complete the full application process while relying on the state's eligibility determination. Having an immediate eligibility determination and temporary TennCare coverage for 62 days as a payor source should lead to faster reimbursements, less debt and better health outcomes for patients.

For hospitals already participating in the HPE program, it is important to incorporate a protocol for monitoring coverage using the TennCare Connect Portal of TEDS. This portal is consumer facing

and differs from the portal used to make HPE determinations. TennCare Connect allows enrollees and new applicants to monitor their coverage as well as the application process. Since there is a strong likelihood that a patient whom a hospital has qualified for HPE will be asked for more information, a hospital can help monitor those verification requests on behalf of the patient. This is important because a patient may only have one HPE period within a two-year period.

Application Monitoring

To maximize Medicaid reimbursements, hospitals must do more than simply help a patient apply for coverage. Providers must be willing to monitor the application and renewal process, help the patient respond to verification requests, and check the state's eligibility for accuracy. In addition, providers must be willing to help the patient file the appropriate appeal when it appears the state fails to make a timely determination or renders an erroneous eligibility decision.

Monitoring the application process is vital to securing coverage, and TEDS makes it much easier to do via the TennCare Connect portal. Once a patient applies for initial coverage or submits a renewal, the patient and/or hospital can create an online account and link the application or renewal (see steps below). Once linked, the patient or provider can check the application status, review coverage, and see most correspondence that has been sent to the applicant. This includes reviewing verification requests seeking more information about the application like proof of income. An applicant's response to the request can also be uploaded to TennCare using the TennCare Connect portal. According to the Division of TennCare this is the fastest and most efficient way to send documentation.

Reporting Changes and Updating Applications

Since an application can be submitted to TennCare with very minimal information, situations will arise where a patient will be required to provide additional or missing information so the Division of TennCare can make an eligibility determination. Updating information contained in the application can be done online using the TennCare Connect portal. In addition, applicants can access and/or print a copy of the application that is being considered by the Division of TennCare.

Applicants and enrollees whose circumstances change while they are enrolled or their application is pending should report their changes using the portal as well. For example, patients can update their mailing address or inform the Division of TennCare of a change to the household size and/or income. It is important to note that TennCare rules require all applicants and enrollees to notify the Division within 10 days of any change that may affect their eligibility. We highly recommend using the TennCare Connect portal to report changes because it establishes a traceable record should issues regarding eligibility arise in the future.

Medicaid Categorical Knowledge

Simply applying for Medicaid coverage and accepting the state's eligibility determination without further review will lead to disappointing results. This is especially true for those for whom coverage is most needed. These are the children and adults who have severe chronic conditions and who may qualify for one of the lesser-known categories of Medicaid. Historically, TennCare

has struggled to accurately screen these populations for coverage, and those same challenges still exist today even after the rollout of TEDS.

Research has shown that over half of the medical expenses are incurred by the sickest 5% of the population. Many of these patients may qualify for Medicaid coverage in the disability-related categories of Medicaid and Medically Needy Spend Down for pregnant women and children, or by receiving institutional care in a hospital or nursing home for 30 consecutive days. Unfortunately, identifying patients who may qualify and screening them for eligibility is challenging for most financial counselors. We believe focusing special attention on these high cost patients is another pathway to reducing uncompensated care and achieving better health outcomes.

At the TJC, we readily provide education and training to advocates and financial counselors to help them identify potential coverage, especially the lesser known and often overlooked Medicaid categories. To help formulate an effective enrollment strategy that can be deployed across the enterprise, we created a cloud-based screening tool called AskJane! When combined with education and training, AskJane! helps advocates and financial counselors with varying Medicaid knowledge identify the potential coverage for the patient.

Lesser-Known Medicaid Categories

Even though TEDS has been created to effectively screen applicants for eligibility and redetermine eligibility for renewals, the system still cannot reliably screen individuals for all Medicaid categories. Specifically, TEDS cannot effectively screen former Supplement Security Income (SSI) recipients or patients who have been institutionalized for more than 30 consecutive days.

SSI is a Federal income supplement program that is designed to help aged, blind and disabled people with little or no income. It provides cash payments, so that recipients can meet basic needs like food, clothing and shelter. In Tennessee SSI eligibility automatically entitles someone to TennCare, as well. For SSI recipients who are eligible for Medicare, TennCare also automatically provides “buy-in” for them by covering their Medicare Parts A and B cost-sharing and applicable premiums.

Some SSI recipients lose their coverage because they start receiving Social Security benefits, such as old age, survivors or disability insurance, that raises their income above the SSI income threshold. For example, they may receive a survivor benefit based on a deceased parent’s or spouse’s income. This may cause the person to lose their SSI benefits on which their TennCare coverage depends. To protect these individuals, the following Medicaid categories provide TennCare coverage for former SSI recipients:

Disabled Adult Child (DAC)

Medicaid benefits are extended to individuals who would be eligible for SSI payments but for entitlement to OR increase in the amount of the Disabled Adult Child’s (DAC) Social Security benefits, which are not counted. When SSI recipients lose SSI eligibility because of this increase, they remain eligible for Medicaid if the following criteria are met.

Coverage Requirements:

- At least 18 years of age;
- Individuals must be U.S. citizens, U.S. nationals or eligible non-citizens with a Social Security Number;
- Receiving Social Security benefits as a DAC on the basis of blindness or disability which began before age 22;
- SSI was terminated after July 1987 because of the receipt of or increase in the DAC payment;
- The individual was at least 18 or older when SSI terminated;
- Income, after excluding their entire current Social Security benefit, is below the current SSI Federal Benefit Rate; AND
- Resources are below $2,000 for individuals and $3,000 for couples. If married, the recipient must be married to another DAC eligible person.

Disabled Adult Widow(er) (DAW)

TennCare Medicaid benefits are available to certain widows/widowers who would be eligible for Supplemental Security Income (SSI) payments if initial entitlement to and/or increases in their Social Security widow/widower benefit were disregarded. Widows/widowers who are eligible for TennCare Medicaid on the basis of their widow/widower status must meet the following criteria.

Coverage Requirements:

- Individuals must be U.S. citizens, U.S. nationals or eligible non-citizens with a Social Security Number;
- Was eligible for SSI based on their own disability;
- Is between the ages of 50 and 65;
- Was entitled to the Social Security Widow/Widower benefit any time after the age of 50;
- Received an SSI benefit the month before the Social Security Widow/Widower benefit began;
- Would be eligible for SSI if the Widow/Widower entitlement and all subsequent cost-of-living adjustments (COLAs) were disregarded;
- Is not entitled to Medicare Part A;
- Income is below SSI Federal Benefit Rate; AND
- Resources are below $2,000.

Pickle Passalong (Pickle)

TennCare benefits are available to individuals who would be eligible for SSI payments if increases in Social Security benefits due to cost-of-living adjustments (COLAs) were disregarded. To be eligible in the Pickle Passalong category, an individual must have been receiving (or technically eligible to receive) both Supplemental Security Income (SSI) and Social Security benefits simultaneously in the past.

Coverage Requirements:

- Individual must be a U.S. citizen, U.S. national or eligible non-citizen with a Social Security Number;
- Is currently receiving Social Security benefits (Old Age, Survivors, or Disability Insurance (SSDI));
- Is not currently receiving SSI;
- Was entitled to both OASDI and SSI benefits in the same month at some time after April 1977; and
- Has countable income (including in-kind income) equal to or less than the current SSI Federal Benefit Rate after deducting all COLAs received since the last month in which the individual was eligible for both OASDI and SSI; AND
- Resources are below $2,000 for individuals and $3,000 for couples.

Determining COLA Disregard Amount for Pickle:
Screening for Medicaid eligibility under the Pickle Amendment is quick and simple. The screening process will eliminate the great majority of those who are not eligible without the necessity of performing any mathematical calculations. For those who survive the initial screening and for whom mathematical calculations are required, the table below provides a simple formula for performing the necessary calculations. [NOTE: The table is updated each year. For years after 2020, go to https://healthlaw.org/?s=Pickle%20Amendment.]

Pickle Screening Questions:

1. Are you now receiving a Social Security check?
    a. If no, the person cannot be Pickle eligible.
    b. If yes, go on to the next step.
2. After April 1977, did you ever get an SSI check at the same time that you got Social Security, or did you get SSI in the month just before your Social Security started?
    a. If no, the person cannot be Pickle eligible.
    b. If yes, go on to the next step.
3. What is the last month in which you received SSI?
4. Look up the month in which the person last received SSI in the following table:

*If SSI was terminated during **this period**:*	*Multiply 2020 OASDI income by:*		*If SSI was terminated during **this period**:*	*Multiply 2020 OASDI income by:*		*If SSI was terminated during **this period**:*	*Multiply 2020 OASDI income by:*
May - June 1977	0.229		Jan 1991 - Dec 1991	0.519		Jan 2005 - Dec 2005	0.739
July 1977 - June 1978	0.243		Jan 1992 - Dec 1992	0.539		Jan 2006 - Dec 2006	0.770
July 1978 - June 1979	0.259		Jan 1993 - Dec 1993	0.555		Jan 2007 - Dec 2007	0.795
July 1979 - June 1980	0.284		Jan 1994 - Dec 1994	0.569		Jan 2008 - Dec 2008	0.813

July 1980 - June 1981	0.325		Jan 1995 - Dec 1995	0.585		Jan 2009 - Dec 2011	0.860
July 1981 - June 1982	0.361		Jan 1996 - Dec 1996	0.600		Jan 2012 - Dec 2012	0.891
July 1982 - Dec 1983	0.388		Jan 1997 - Dec 1997	0.618		Jan 2013 - Dec 2013	0.907
Jan 1984 - Dec 1984	0.402		Jan 1998 - Dec 1998	0.631		Jan 2014 - Dec 2014	0.920
Jan 1985 - Dec 1985	0.416		Jan 1999 - Dec 1999	0.639		Jan 2016 - Dec 2016	0.936
Jan 1986 - Dec 1986	0.429		Jan 2000 - Dec 2000	0.655		Jan 2017 - Dec 2017	0.939
Jan 1987 - Dec 1987	0.434		Jan 2001 - Dec 2001	0.678		Jan 2018 - Dec 2018	0.957
Jan 1988 - Dec 1988	0.453		Jan 2002 - Dec 2002	0.695		Jan 2019 - Dec 2019	0.984
Jan 1989 - Dec 1989	0.471		Jan 2003 - Dec 2003	0.705			
Jan 1990 - Dec 1990	0.493		Jan 2004 - Dec 2004	0.720			

Find the percentage that applies to that month. Multiply the present amount of the person's (and/or spouse's) Social Security (OASDI) benefits by the applicable percentage.

Add the figure that you have just calculated to any other countable income the person may have. If the resulting total is less than the current SSI Federal Benefit Rate ($803 in 2020, including a $20 disregard), the person is Pickle eligible, from the standpoint of income. However, the person must still satisfy separate TennCare resource and non-financial requirements listed above.

Section 1619(b) Continued Medicaid Eligibility

Many SSI beneficiaries would like to work but are concerned that they will lose Medicaid coverage. Section 1619(b) of the Social Security Act provides some protection for SSI recipients. While the Social Security Administration makes 1619(b) eligibility determinations, advocates and financial counselors should be aware of the program.

Coverage Requirements:

- Has been eligible for an SSI cash payment for at least 1 month;
- Still meets the disability requirement;
- Still meets all SSI eligibility requirements;
- Needs Medicaid benefits to continue to work; and
- Has gross earnings that are insufficient to replace SSI, Medicaid and publicly funded attendant care services. In 2019, the gross earnings for Tennessee residents cannot exceed $40,715.00. Usually, the 1619(b) income limit changes annually.

Institutional Medicaid

According to TennCare Rule 1200-13-20.08(5)(c), TennCare benefits are available to patients who are in a nursing facility and meet the medical level of care eligibility criteria for the TennCare program known as CHOICES, which covers long term services and supports for adults, or for ECF CHOICES, the TennCare program that covers long term services and supports for individuals with intellectual and/or developmental disabilities (IID/DD) **or are continuously confined to an institution for 30 consecutive days**. As of this writing, the TennCare Policy Manual Number 125.005 (dated July 2016) incorrectly requires that the patient be admitted to a nursing facility in order to qualify for coverage, when in fact inpatient care in a hospital also counts toward the 30-day institutional care requirement. The Policy Manual is in violation of TennCare administrative rules and federal law.

The Lawful Coverage Requirements:

- Individuals must be U.S. citizens, U.S. nationals or eligible non-citizens with a Social Security Number;
- Meet the medical level of care eligibility criteria for CHOICES or ECF CHOICES OR for hospitals be continuously confined in an institution for 30 consecutive days;
    a. Institution defined: An institution authorized by state law and organized to provide medical care, including nursing and convalescent care.
    b. Examples of medical institutions include hospitals, convalescent or progressive care centers, and Long-Term Care Facilities (LTCFs), providing both skilled and intermediate care.
- Patient's income is less than 300% of the SSI Federal Benefit Rate for an individual ($783, excluding a $20 disregard in 2020); and
- Patient's resources are below $2,000 for an individual.
- SPECIAL NOTE: for Institutional Medicaid, the patient's household size is always 1. A spouse is not considered a member of the patient's household. Thus, a spouse's income and share of any resource is excluded from the eligibility determination.

Using the Tools and Building the Record

The easiest way to help patients obtain coverage and secure reimbursement for services is to build a record for the patient that establishes the date of application and the patient's eligibility. Building and maintaining the record of the application process greatly improves the chances of approval or the likelihood of success on appeal.

In the pages that follow, we will show you where to apply for various TennCare programs as well as the best practice for applying. Following these steps will improve the likelihood of full reimbursement for services provided to eligible patients.

Where to Apply

One of the major tenets of the ACA is the concept of "no wrong door", meaning people could submit a single streamlined application for all insurance affordability programs on either the

Federally Facilitated Marketplace (FFM) or with the applicant's home state Medicaid agency. Prior to the launch of TEDS, healthcare.gov was the only way to apply for most categories of TennCare because Tennessee lacked a functioning computer system to make eligibility determinations. Now that TEDS is fully operational, people can apply either with the state or on the FFM using healthcare.gov.

The chart below indicates where to apply for benefits by program. Please note that some benefits programs may require submission of an application to more than one agency.

Program	**Where to Apply**
TennCare for Children ages 1-19	TennCare Connect, TennCare Access (HPE), Healthcare.gov
TennCare for Parents & Caretaker Relatives	TennCare Connect, TennCare Access (HPE), Healthcare.gov
CoverKids (CHIP)	TennCare Connect, Healthcare.gov
Medically Needy Spend Down	TennCare Connect
TennCare for Newborns	TennCare Connect, TennCare Access (HPE), Healthcare.gov
TennCare for Pregnant Women	TennCare Connect AND Local Health Department
Women with Breast & Cervical Cancer	TennCare Connect AND Local Health Department
CHOICES	Paper LTSS/MSP Application AND Area Agency on Aging and Disability if NOT on TennCare. If on TennCare, the enrollee's Managed Care Organization (MCO).
Medicare Savings Plans (MSP) (Includes QMB, SLMB, QI and QDWI)	TennCare Connect, Healthcare.gov
Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)	Social Security Administration
ECF CHOICES (for persons with intellectual or developmental disabilities)	If on TennCare, the enrollee's Managed Care Organization (MCO). If not on TennCare, apply online.

How to Apply

Applications for TennCare can be filed in the following ways:

- Online submission:
  - TennCare Connect portal (consumer facing portal)

    - TennCare Access portal (hospital presumptive eligibility)
    - Healthcare.gov
- Telephone:
    - TennCare Connect: 1-855-859-0701
    - Marketplace: 1-800-318-2596
- Fax paper applications: 1-855-315-0669
- Mail to:

  TennCare Connect
  P.O. Box 305240
  Nashville, TN 37202-5240

When applying for coverage with TennCare, the application file date is the date a valid application is received whether submitted online or by fax. For phone applications, the application file date is the date a valid application is completed telephonically. For applications that are mailed to TennCare, the application file date is the date a valid application is received. For applications placed through the Marketplace, the application file date is the date provided by the FFM, unless documentary evidence of an earlier application date exists.

Generally, the application file date becomes the effective date of coverage for those applicants determined eligible for TennCare or CoverKids. Thus, it is important to submit a valid application on the initial encounter with the uninsured patient.

When possible, we recommend applying with TennCare directly using one of the TEDS portals as opposed to healthcare.gov or by mail. Hospitals participating in HPE should have their employees use the TennCare Access portal, while third party vendors and hospitals not participating in HPE should use the TennCare Connect portal to submit applications. To avoid the possibility of technical errors caused by the transfer of information from healthcare.gov to TEDS, we recommend only using Healthcare.gov to apply for coverage when TennCare's online portals are unavailable.

How to Apply – TennCare, CoverKids and Medicare Savings Programs (QMB, SLMB, QI, QDWI)

TennCare Connect Portal

Website	**TENNCARE CONNECT**
Step 1	IMMEDIATELY submit an online application via TennCare Connect https://tenncareconnect.tn.gov/services/homepage and the appropriate agency, when applicable (e.g local health department). Submit as complete an application as possible but DO NOT DELAY submission for another day to gather necessary information or supporting documentation. You can guard the effective date by submitting a "valid" application that consists of the patient's contact info. and a signature by the patient or any responsible adult (including hospital employee).

Step 2	Record the application tracking number. Capture an image of the acknowledgment of the application submission and date. Save image as a PDF.
Step 3	Verify and/or link the application to the applicant's TennCare Connect account.
Step 4	Have the patient provide copies of paystubs (if any) or proof of other income from all household members for the last 8 weeks. If possible, place copies in the patient record as part of the application process.
Step 5	If the patient was not born in the U.S., have the patient provide copies of their immigration documents. If possible, place copies in the patient record as part of the application process. Proof of immigration status is not required for pregnant women applying for CoverKids (See Appendix 1).
Step 6	Record the date (i.e. mm/dd/yyyy) for 45 calendar days from the application date in the patient record. Inform the patient of this date. This is the **application deadline date**: the deadline for TennCare to make a determination on the application.
Step 7	Have the patient sign TennCare's HCFA Authorization of Representative Organization form. Add the form to the patient's record. You may need this form later, if appeals are necessary. Complete this step even if the patient has designated you as the person assisting with an online application.
Step 8	Periodically, login into the patient's TennCare Connect account to check the status of the application on the MY APPLICATIONS tab as well as any verification requests from TennCare located on the MY LETTERS tab. Please note any deadlines referenced in any letters received from TennCare.
Step 9	If necessary, report changes including missing information from the initial application using the MY CHANGES tab.
Step 10	If necessary, upload documentation in response to verification requests as needed. Take a screenshot and save as a pdf as proof the document was successfully uploaded.
Step 11	Check the status of the application by contacting the patient and by checking the patient's TennCare Connect Account on the deadline date. Confirm whether the patient received a decision on the application from TennCare. If not, file a Delay Appeal (see item #5).
Step 12	If at any time during the application process the applicant receives a denial of eligibility that you believe is incorrect, file an Eligibility Appeal.

TennCare Access Portal

Website	TENNCARE ACCESS (Hospital Presumptive Eligibility)
Step 1	Complete a Hospital Presumptive Eligibility (HPE) online application using your TennCare Access account. If the patient is eligible for HPE, also submit a full application and record the application tracking number. If ineligible for HPE, submit an application using TennCare Connect. (see instructions above)
Step 2	If eligible for HPE, create an online TennCare Connect account and link the HPE application to the account. To link the account use the patient's date of birth and social security number to search for the application. NOTE: the application reference number is not the same as the patient's personal ID for TennCare purposes.
Step 3	Have the patient provide copies of paystubs (if any) or proof of other income from all household members for the last 8 weeks. If possible, place copies in the patient record as part of the application process.
Step 4	Have the patient provide copies of a qualified immigration status. If possible, place copies in the patient record as part of the application process.
Step 5	Have the patient sign TennCare's HCFA Authorization of Representative Organization form. Add the form to the patient's record. You may need this form later, if appeals are necessary or you want to speak with TennCare Connect on the patient's behalf.
Step 6	Periodically, login into the patient's TennCare Connect account to check the status of the application on the MY APPLICATIONS tab as well as any verification requests from TennCare located on the MY LETTERS tab. Please note any deadlines referenced in any letters received from TennCare.
Step 7	If necessary, report changes including missing information from the initial application using the MY CHANGES tab. Take a screenshot and save as a pdf as proof that the date the changes were made.
Step 8	If necessary, upload documentation in response to verification requests as needed. Take a screenshot and save as a pdf as proof the document was successfully uploaded.
Step 12	If at any time during the application process the applicant receives a denial of eligibility that you believe is incorrect, file an Eligibility Appeal.

Federal Marketplace

Website	HEALTHCARE.GOV

Step 1	Complete an online application via healthcare.gov and the appropriate agency, when applicable.
Step 2	Record the application identification number, save a PDF or print the Eligibility Results letter and/or capture an image of the acknowledgment of the application submission and date.
Step 3	If more information is needed, explain to the patient what information must be submitted to the Marketplace.
Step 4	Have the client provide copies of paystubs (if any) or proof of other income from all household members for the last 8 weeks. If possible, place copies in the client's file as part of the application process.
Step 5	Record the date (i.e. mm/dd/yyyy) for 45 calendar days from the application date in the client file. Inform the patient of this date. This is the **application deadline date**: the deadline for TennCare to make a determination on the application.
Step 6	Have the client sign TennCare's HCFA Authorization of Representative Organization form. Add the form to the client's file. You may need this form later, if appeals are necessary or you want to speak with TennCare Connect on the patient's behalf.
Step 7	Check back in with the client on the application deadline date. If the client has not received a determination, file a Delay Appeal (see item #5).

By Phone

By Phone	
Step 1	Complete an application by phone with TennCare Connect at 1-855-259-0701 or the Health Insurance Marketplace at 1-800-318-2596. Have a third person listen to the application process as it occurs so he/she can corroborate that the application was made via telephone. Record the 3rd person's name and contact information in the patient's record. Record the date/time of day of the application phone call in the patient's record. Get the name of the TennCare Connect representative who took the application by phone and record in the patient's record.
Step 2	In the patient's file, record in the patient's TEDS application tracking number or the Healthcare.gov application ID number.
Step 3	Provide the patient with TJC's TennCare Income Verification handout (See Appendix 2). Have the patient provide copies of paystubs (if any) or proof of other income from all household members for the last 8 weeks. If possible, place copies in the patient record as part of the application process.

Step 4	If the patient was not born in the U.S., provide the patient with TJC's Citizenship/Immigrations Status Verification Handout (See Appendix 3). Have the patient provide copies of verifications. If possible, place copies in the patient record as part of the application process.
Step 5	Complete an online TennCare Connect account and link the application to the account.
Step 6	Periodically, login into the patient's TennCare Connect account to check the status of the application on the MY APPLICATIONS tab as well as any verification requests from TennCare located on the MY LETTERS tab.
Step 7	If necessary, report changes including missing information from the initial application using the MY CHANGES tab.
Step 8	If necessary, upload documentation in response to verification requests as needed. Take a screenshot and save as a pdf as proof the document was successfully uploaded.
Step 9	Record the date (i.e. mm/dd/yyyy) for 45 calendar days from the application date in the patient record. Inform the patient of this date. This is the **application deadline date**: the deadline for TennCare to make a determination on the application.
Step 10	Have the patient sign TennCare's HCFA Authorization of Representative Organization form. Add the form to the patient's record. You may need this form later, if appeals are necessary or you want to speak with TennCare Connect on the patient's behalf.
Step 11	Check back in with the patient on the application deadline date. If the patient has not received a determination, file a Delay Appeal (see Item #5).

By US Mail

By US Mail	
Step 1	Complete a paper application and send Certified Mail with Return Receipt to: TennCare Connect P.O. Box 305240 Nashville, TN 37202-5240
Step 2	Place copies of the application proof of mailing in the patient's record. After you receive it, add to the patient's record the postal receipt proving delivery.

Step 3	Have the patient provide copies of paystubs (if any) or proof of other income from all household members for the last 8 weeks. If possible, place copies in the patient record as part of the application process.
Step 4	If the patient was not born in the U.S., have the patient provide copies of their immigration documents. If possible, place copies in the patient record as part of the application process.
Step 5	Record the date (i.e. mm/dd/yyyy) for 45 calendar days from the application date in the patient record. Inform the patient of this date. This is the **application deadline date**: the deadline for TennCare to make a determination on the application.
Step 6	Have the patient sign TennCare's HCFA Authorization of Representative Organization form. Add the form to the patient's record. You may need this form later, if appeals are necessary or you want to speak with TennCare Connect on the patient's behalf.
Step 7	Check back in with the patient on the application deadline date. If the patient has not received a determination, follow Delay Appeal (see item #5).

TennCare Connect (Newborn Presumptive Eligibility)

Remember to also complete an application on TennCare Connect by following one of the methods above.

Step 1	Complete Newborn Presumptive Eligibility process, OR fax the Birth Reporting Form to TennCare Connect at 1-855-315-0669 OR help the patient call TennCare Connect at 1-855-259-0701 and file for Newborn Presumptive Eligibility.

Breast & Cervical Cancer AND Presumptive Eligibility for Pregnant Women – Local Health Department

Step 1	Provide patient with address and contact information of local Health Department. Tell patient to go there to apply for Breast and Cervical Cancer Screening or Presumptive Eligibility for Pregnant Women. The health department can use TennCare Access for both programs to help people apply as well as submit a full application.
Step 2	Verify and/or link the application to the applicant's TennCare Connect account. Check to make sure the patient filed a full TennCare application, in addition to the presumptive eligibility application.

Step 3	Have the patient sign TennCare's HCFA Authorization of Representative Organization form. Add the form to the patient's record. You may need this form later, if appeals are necessary or you want to speak with TennCare Connect on the patient's behalf.
Step 4	Periodically, login into the patient's TennCare Connect account to check the status of the application on the MY APPLICATIONS tab as well as any verification requests from TennCare located on the MY LETTERS tab.
Step 5	If necessary, report changes including missing information from the initial application using the MY CHANGES tab.
Step 6	If necessary, upload documentation in response to verification requests as needed. Take a screenshot and save as a pdf as proof the document was successfully uploaded.
Step 7	Follow up with the patient to obtain copies of any documents issued by the Health Department and save in the patient's record. Check back in with the patient on the application deadline date. If the patient has not received a determination, follow Delay Appeal (See item #5)

CHOICES – Area Agency on Aging and Disability (AAAD)

Step 1	Complete the paper LTSS/MSP application and fax to TennCare Connect at 1-855-315-0669. Save a copy of the fax receipt in the patient record.
Step 2	Help the patient call AAAD at **1-866-836-6678** and say he/she wants to apply for CHOICES. If possible, ask for the Pre-Admission Evaluation, or "PAE" (a required assessment of whether the patient's functional impairments qualify him/her to receive nursing home or equivalent home care) to be completed while the patient is in the hospital.
Step 3	Verify and/or link the application to the applicant's TennCare Connect account.

Step 4	Have the patient sign TennCare's HCFA Authorization of Representative Organization form. Add the form to the patient's record. You may need this form later, if appeals are necessary or you want to speak with TennCare Connect on the patient's behalf.
Step 5	Periodically, login into the patient's TennCare Connect account to check the status of the application on the MY APPLICATIONS tab as well as any verification requests from TennCare located on the MY LETTERS tab.
Step 6	If necessary, report changes including missing information from the initial application using the MY CHANGES tab.
Step 7	If necessary, upload documentation in response to verification requests as needed. Take a screenshot and save as a pdf as proof the document was successfully uploaded.
Step 8	Follow up with the patient to obtain copies of any documents issued by the AAAD or other State agencies and save in the patient's record. If a patient's PAE is denied and you believe they are medically eligible, contact TJC for assistance at (615) 255-0331.
Step 9	Record the date (i.e. mm/dd/yyyy) for 90 calendar days from the application date in the patient record. Inform the patient of this date. This is the **application deadline date**: the deadline for TennCare to make a determination on the application.
Step 10	Check back in with the patient on the application deadline date. If the patient has not received a determination, follow Delay Appeal (See item #5).

Special Note About Applying for the Disability Related Categories of Medicaid

As of December 2019, the TennCare Connect portal does not capture the necessary information to determine eligibility for the disability related categories of Medicaid. These categories include: Disabled Adult Child (DAC), Disabled Adult Widow(er) (DAW), and Pickle Passalong. Although the portal inquires whether the applicant is currently receiving or will receive SSI in the future, it fails to inquire whether the applicant ever received SSI in the past, information that is vital to determine eligibility for those overlooked categories.

Enrollment staff should ask patients if they ever received SSI in the past but are not longer receiving it. If the answer is, "yes", follow the steps to apply using one of the methods outlined above. If the applicant is denied, promptly file an eligibility appeal indicating the person should be screened for one of the applicable disability related categories of Medicaid described above.

Special Note About Applying for Institutional Status Medicaid

Patients become eligible for Institutional Status Medicaid if they require the medical level of care for the CHOICES program by meeting the minimum Pre-Admissions Evaluation (PAE) score, **OR being continuously confined in an institution or combination of institutions, like a hospital and/or nursing facility, for more than 30 days**. For patients who are uninsured and in the hospital for 30 consecutive days, their income must be less than 3X the SSI Federal Benefit Rate with resources less than $2,000. Only patient's income and share of the resources count toward eligibility. To be clear, a PAE is not required for patients who have been admitted to hospital and/or nursing facility for 30 days or more. If it appears the patient meets these requirements, apply using these steps on day 30:

Step 1	Call TennCare Connect at 1-855-259-0701 and ask to be transferred to the TEDS unit. Tell them you want to apply over the telephone for a patient.
Step 2	Tell them specifically, that you are applying for Institutional Medicaid based on the patient being in the hospital for more than 30 days, and there isn't a way to do that using TEDS.
Step 3	If there is push back, ask to speak with a supervisor. If needed, you can cite the TennCare Rule 1200-13-20-.08(5) at page 70.
Step 4	Ask the TennCare representative how to submit the medical record that proves the patient has been in the hospital for 30 days. Document the person you speak to including the date and time of day.
Step 5	If possible, have another financial counselor listen in on the call as well.
Step 6	An appeal may have to be filed but applying over the telephone will preserve the application date.

Step 7	Contact the TJC at 615-255-0331 so we can help monitor this application.

Special Note About Verification Requests

When a patient receives a verification request for information like proof of income or immigration status, it is important that you follow the directions contained in the verification request. This includes submitting the page that contains a QR code (a square two-dimensional barcode). The page that contains the QR code should be the first page of a fax transmission (no cover page), or first page of the file uploaded to TennCare Connect. Since uploaded documents and faxes are linked to an account using the QR code, this increases the likelihood all of the documents will be associated with the correct account in a timely manner.

Appeals

In many cases, applications are processed successfully, and patients receive TennCare coverage. In some cases, however, applications may be delayed, or they may receive erroneous decisions. In these situations, the patient may require an appeal, and it is one way to have the case reviewed by a specialist at TennCare to determine eligibility. A properly completed appeal form that establishes eligibility often resolves the case without the need for a hearing. Simply follow the steps below to file an appeal.

Delay Appeals

If the patient has not received a determination within 45 days of application (or 90 days for CHOICES), file a delay appeal by following these steps:

Step 1	Fill out TennCare's Eligibility Appeal Form. Check the box indicating the application is delayed in Section 5. List the date of application and application ID in Section 7.
Step 2	Locate proof of application from the patient's record: • TennCare Connect Application ID, OR • Marketplace Eligibility Results letter, OR • Screen capture showing date of application, OR • Copy of paper application, certified mail receipts and fax receipt, OR • Notes from patient record showing date of application phone call.
Step 3	Fax Eligibility Appeal form with proof of application and TennCare's HCFA Authorization of Representative Organization form to TennCare Connect at **1-855-315-0669.** Save a copy of the fax and fax receipt in the patient's record.

Step 4	Ask the patient to contact you if he/she receives follow-up requests from TennCare. Check in with the patient in 45 (or 90) days from the delay appeal date.

Delay Appeal Follow-up

After receiving an appeal of a delayed application (and, if the existence of a delayed application cannot be confirmed from records already available to the state, proof the person filed a delayed application), TennCare has 45 days (or 90 days for CHOICES appeals) to either hold a hearing or make a determination. Again, TennCare is holding very few, if any of these hearings and is instead seeking to make a decision. TennCare may send the patient verification requests for proof or more information by phone or mail. They may ask for proof of the patient's household income, proof of application, or proof of citizenship or immigration status. **These requests require applicants to return the requested information within 20 days.** For this reason, it is extremely important to preserve proof of application and store proof of household income in the patient record, if possible.

Fax requested information to HCFA Eligibility Appeals at **1-844-563-1728**. Save a copy of the fax receipt in the patient record.

When a delay appeal has been resolved, patients will receive a notice informing them that their appeal has been closed because a decision has been made on their case. Patients should receive another notice in the next few days with their decision. If your patients do not receive their decision within 10 days of receiving the appeal closed notice, please contact TJC at (615) 255-0331.

Possible Outcomes and Eligibility Appeals

Once an application or delay appeal has been submitted, there are several possible outcomes ranging from the patient being determined eligible to the patient being denied for a variety of reasons. However, there are several erroneous outcomes that can be corrected provided the proper documentation was collected. Below you will find common eligibility outcomes. Resolving these issues favorably for the patient can, in certain situations, result in reimbursement for prior treatment as well as coverage for future services like follow-up care the patient may need.

Outcome	**What to Do**	**What to Attach**
Approved for TennCare with coverage backdated to date of application.	Check to make sure client is active in TennCare database.	
Approved for TennCare, but coverage start date is wrong.	• Prepare TennCare's Eligibility Appeal form. Explain that the patient is	• Proof of earlier application from patient record*;

	appealing an erroneous effective date of coverage. • Attach relevant documents and release form, and fax to TennCare Connect at 1-855-315-0669. • Retain proof of submission of appeal in patient's record	• TennCare HCFA Authorization of Representative Organization form.
Denied TennCare because requested income and/or citizenship/immigration status verification not received.	• Prepare TennCare's Eligibility Appeal form. If submitted requested verification, say when and attach proof of submission. If did not submit because did not receive request for the information, explain that in the appeal. • Attach relevant documents and release form, and fax to TennCare Connect at 1-855-315-0669. • Retain proof of submission of appeal in patient's record.	• Proof of income and/or citizenship/immigration status from patient record; • Proof of previous submission of income information (fax receipt or screen shot if uploaded), if available; • TennCare HCFA Authorization of Representative Organization form.
Appeal closed because requested proof of application not received.	• Prepare TennCare's Eligibility Appeal form. If submitted requested proof, say when and attach proof of submission. If did not submit because did not receive request for the proof, explain that in the appeal. • Attach relevant documents and release form, and fax to TennCare Connect at 1-855-315-0669.	• Proof of application from the patient record*: • Proof that application was submitted on earlier date (fax receipt or screen shot if uploaded), if available; • TennCare HCFA Authorization of Representative Organization form.

	• Retain proof of submission of appeal in patient's record.	
Denied TennCare because of household income.	• Confirm the patient is financially eligible for TennCare (call TJC if unsure). • Prepare TennCare's Eligibility Appeal form. • Attach relevant documents and release form, and fax to TennCare Connect at 1-855-315-0669. • Retain proof of submission of appeal in patient's record.	• Proof of application from the patient record*; • Proof of household income from the patient record; • TennCare HCFA Authorization of Representative Organization form.
Denied TennCare because the patient does not meet a TennCare category.	• Confirm the patient is financially and categorically eligible for TennCare (call TJC if unsure). • Prepare TennCare's Eligibility Appeal form. • Attach relevant documents and release form, and fax to TennCare Connect at 1-855-315-0669. • Retain proof of submission of appeal in patient's record.	• Proof of application from the patient record*: • Proof of household income from the patient record; • TennCare HCFA Authorization of Representative Organization form.
Denied TennCare because the patient is not a U.S. Citizen or Eligible Immigrant.	• Confirm the patient is financially and categorically eligible for TennCare (call TJC if unsure). • Prepare TennCare's Eligibility Appeal form. • Attach relevant documents and release form, and fax to TennCare	• Proof of U.S. Citizenship or qualified status; • Proof of application from the patient record*; • Proof of household income from the patient record; • TennCare HCFA Authorization of

	Connect at 1-855-315-0669. • Retain proof of submission of appeal in patient's record.	Representative Organization form.

*Proof of Application May Include:

- Marketplace Eligibility Results letter, OR
- Screen capture showing date of application, OR
- Copy of paper application, certified mail receipts and fax receipt, OR
- Notes from patient record showing date of application phone call

Possible Problems

In some instances, TennCare rejects eligibility appeals for failure to raise a valid factual dispute. In these cases, the appellant receives a notice dismissing his/her request for a hearing because "you did not tell us about a mistake that, if you're right, means you are eligible for TennCare." The notice allows 10 days for the appellant to submit additional information to TennCare in writing. If a patient receives this notice, please contact the Tennessee Justice Center for assistance at (615) 255-0331.

Glossary of Terms and Acronyms You Will Likely Encounter

Acronym	Definition
ACA	Affordable Care Act, also known as "Obamacare"
CHIP	Children's Health Insurance Program – a program provides free or low-cost health coverage for more than 7 million children up to age 19. Also called CoverKids in Tennessee.
CMS	Centers for Medicare and Medicaid Services, the federal agency that oversees Medicaid and the federally facilitated Marketplace.
COLA	Cost-of-Living Adjustment that Social Security makes each January 1st to adjust OASDI and SSI benefits by the amount of prior year's inflation rate.
FFM	Federally Facilitated Marketplace – an organized marketplace for health insurance plans operated by the U.S. Department of Health and Human services. The FFM operates the Marketplace website (www.healthcare.gov) and call center.
HCBS	Home and Community Based Services – Supportive services that enable individuals to remain at home or in the community who would otherwise require care in a nursing facility.

HCFA	Health Care Finance and Administration – the Tennessee agency that administers Medicaid (TennCare) and the Children's Health Insurance Program (CHIP), known in Tennessee as CoverKids.
HIPAA	Health Insurance Portability and Accountability Act – a law that, among other things, contains safeguards to protect the confidentiality and security of personally identifiable healthcare information.
LTSS	Long Term Services and Supports – medical and non-medical services, provided either in nursing facilities or through HCBS, to adults with severe chronic functional limitations. In Tennessee, TennCare covers LTSS through the CHOICES program.
MCO	Managed Care Organization - health plans that provide health care in return for a predetermined monthly fee and coordinate care through a defined network of physicians and hospitals.
MSP	Medicare Savings Programs – programs that help low-income individuals with some of the out-of-pocket costs for Medicare, including Medicare Part A and Part B premiums, deductibles, copayments, and coinsurance. Includes QMB, SLMB, QI1 and QDWI.
OASDI	Old Age, Survivors and Disability Insurance – Social Security pension programs administered by the federal Social Security Administration.
PAE	Pre-Admission Evaluation – Medical evaluation assessing an applicant's needs in regard to activities of daily living. Part of the screening process for the CHOICES program.
QMB	Qualified Medicare Beneficiary -- One type of MSP: a Medicaid program for people with Medicare who need help in paying for Medicare services. The person with Medicare must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A and Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.
SLMB	Specified Low-Income Medicare Beneficiary - One type of MSP: Medicaid program for people with Medicare that pays only the Medicare Part B premium (and qualifies the person for the Medicare Part D prescription drug plan financial Extra Help program).
SSI	Supplemental Security Income - a program administered by Social Security that pays monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older. In Tennessee, individuals are automatically eligible for TennCare upon enrolling in the SSI program. SSI is therefore the

	primary route to TennCare eligibility for adults who have disabilities or are over 65, and who do not otherwise qualify as caretakers for minor children.
SSDI	Social Security Disability Insurance – a social insurance program administered by Social Security that pays monthly benefits to people who have sufficient work histories and who become unable to work due to disability. Includes Medicare coverage after 2 years (in most cases). SSDI is one of the Social Security pension programs known collectively as OASDI.
THC or TNHC	Tennessee Health Connection – state-run call center to assist people with the status of their benefits applications.

Helpful Resource Contact Information

Area Agencies on Aging and Disabilities (AAAD)	1-866-836-6678
AmeriGroup	1-800-600-4441
BlueCare	1-800-468-9698
Blue Cross Blue Shield of TN	1-877-942-2144
Cigna	1-800-997-1654
Community Health Alliance	1-888-415-3332
CoverKids	1-866-620-8864
CoverRx	1-866-268-3779
Family Assistance Service Center	1-866-311-4287 or 615-743-2000
Get Covered Hotline	1-844-644-5443
Health Assist	1-800-269-4038
HCFA Eligibility Appeals Unit	1-844-202-5618
Humana	1-615-221-2155
Marketplace Hotline	1-800-318-2596
Medicare	1-800-633-4227
Mental Health Crisis Line (Statewide)	1-800-809-9957
SHIP (State Health Insurance Assistance Program)	1-877-801-0044 or 1-866-836-7677
Social Security Administration	1-800-772-1213
TennCare Bureau	1-800-342-3145 or 615-507-6000
TennCare Advocacy Program	1-800-758-1638
TennCare Fraud and Abuse Line (TennCarefraud@state.tn.us)	1-800-433-3982 Fax: 615-256-3852
TennCare Long-Term Care and Services	1-877-224-0219
TennCare Select	1-800-263-5479
TennCare Solutions Unit (TSU)	1-800-878-3192
TennCare Spanish-speaking Information Line	1-800-254-7568

TennCare TTY for persons with speech and hearing impairments	1-800-779-3101 or 615-313-9240
TennCare Connect	1-855-259-0701 Fax: 1-855-315-0669
Tennessee Justice Center	1-877-608-1009 or 615-255-0331
United HealthCare Community Plan	1-800-414-9025

Mailing Addresses & Fax Numbers

HCFA (Eligibility and Delay Appeals)
PO Box 23650
Nashville, TN 37202
FAX: 1-844-563-1728

TennCare Connect
PO Box 305240
Nashville, TN 37202
FAX: 1-855-315-0669

Health Insurance Marketplace
465 Industrial Blvd
London, KY 40750-0061

Still Have Questions?
Contact the Tennessee Justice Center at (615) 255-0331. We will provide you with some additional information and strategies to try, but due to exceptionally high case volume we may be unable to accept individual cases at this time.

Appendix

Appendix 1 – Immigration status not required for pregnant women applying for CoverKids
Appendix 2 – Income Verification Handout
Appendix 3 – Citizenship/Immigration Status Verification Handout

APPENDIX 1

Sample Letter for Citizenship Status

Name: Jane Doe

Date: 10/15/2019

DOB: 01/01/1991

SSN: 111-11-1111

Person ID: 111111111

Dear TennCare Appeals Unit:

My name is Jane Doe. I applied for CoverKids on XYZ date. I am not submitting proof of citizenship because I am only applying for CoverKids as a pregnant woman.

Sincerely,

Jane Doe (signature)*

Jane Doe (printed name)

Note: If relevant, note that patient is responding to a request for more information and the date on which this information is due.

APPENDIX 2

You applied for TennCare, Medicare Savings Programs or CHOICES.

TennCare might ask you for proof of your income for the month you applied and the month before. Please give the hospital proof of your income **for the past 8 weeks.** The hospital will save this information for you in case TennCare asks for it later.

Here are some types of income and what can count as proof:

Type of income	Proof
Income from a job	Paystubs from the past 8 weeks; OR a letter from your employer showing how much you make
Self-employment income	Copies of your latest tax returns or bank statements from your business
Social Security payments	Letters from Social Security that show your check amount
Unemployment	Letters or statements from the unemployment office
Other income	Papers or bank statements that show any other income you received over the past 8 weeks

You *don't* need to show proof of income from SSI or child support.

If you have **no** income, look for a copy of your termination notice from your last job, if you have it.

You should receive a decision on your application by _____.
If you don't receive a decision by that date, call your doctor's office/hospital.

APPENDIX 3

You applied for TennCare.

TennCare might ask you for proof of your **citizenship or immigration status**. Please look for the documents on this page. Give a copy of the documents to the person helping you with your application at the hospital. They will save this information for you in case TennCare asks for it later.

Here are some of the things that count as proof of citizenship:

- US Passport
- Certificate of Naturalization
- Certificate of US Citizenship
- Valid Tennessee Drivers License
- Tribal enrollment card or other official documents from a recognized American Indian Tribe.

If you can't find these kinds of proof, turn in *any* papers you have that show you were born in the U.S. (like birth certificate, adoption records, etd.) AND one of the following:

- Driver's license (any state)
- School ID caard with photo
- Voter registration card
- U.S. military card or draft record
- Other government-issued ID card
- American Indian Tribal documents

Here are some things that count as proof of immigration status:

- Permanent Residetn card (aka "Green Card")
- Arrival/Departure record (I-94 or I-94A)
- Refugee Travel Document (I-571)
- Other government papers that show your status

You should receive a decision on your application by: _____

If you don't receive a decision by that date, call the person who helped you apply for TennCare.