DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

March 16, 2023

Stephen Smith
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Smith:

This letter is in response to Tennessee's request, originally dated April 29, 2022, and updated on February 24, 2023 for a waiver under section 1902(e)(14)(A) of the Social Security Act (the Act), that will protect beneficiaries in addressing the challenges the state faces as part of a transition to routine operations when the continuous enrollment condition ends. Section 1902(e)(14)(A) allows for waivers "as are necessary to ensure that states establish income and eligibility determination systems that protect beneficiaries." Such waivers are time-limited and are meant to promote enrollment and retention of eligible individuals by easing the administrative burden states may experience in light of systems limitations and challenges.

The ongoing COVID-19 pandemic and implementation of federal policies to address the PHE have disrupted routine Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment operations. Medicaid and CHIP enrollment has grown to historic levels due in large part to the continuous enrollment requirements that states implemented as a condition of receiving a temporary 6.2 percentage point federal medical assistance percentage increase under section 6008 of the Families First Coronavirus Response Act (P.L. 116-127).

Consistent with the March 3, 2022 Centers for Medicare & Medicaid Services (CMS) State Health Official (SHO) letter #22-001, "*Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency*," Tennessee has requested that CMS provide authority under section 1902(e)(14)(A) of the Act to temporarily permit the state to accept updated enrollee contact information from managed care plans without additional confirmation from the individual. The state has expressed the need for this authority in order to address systems and operational issues related to efficiently facilitating the renewal process in order to minimize unnecessary coverage losses. Specifically, the state cited concerns related to an unsustainable level of effort needed to update beneficiary contact information under current policy due to the state's eligibility systems, workforce shortages, and limited resources. Given that the state would not be able to partner with managed care plans to update beneficiary contact information without this authority, and lack of current beneficiary addresses would significantly undermine the state's ability to successfully renew eligible beneficiaries, this authority will protect beneficiaries in the aggregate by reducing the risk of procedural terminations for many beneficiaries.

Under Section 1902(e)(14)(A) of the Act, your request to partner with managed care plans to update beneficiary contact information is approved, as described and subject to the conditions below.

Partnering with Managed Care Plans to Update Beneficiary Contact Information

The authority provided in accordance with this letter will enable the state, during the period of time specified below, to accept updated in-state enrollee contact information from managed care plans without additional confirmation from the individual. Under this authority, the state will treat updated in-state contact information confirmed by and received from the plan as reliable and will update the beneficiary's case record with the new contact information without first sending a notice to the beneficiary address on file with the state in order to provide them with the opportunity to dispute the address change, as otherwise required under regulations at 42 C.F.R. § 435.916(d). The authority provided in accordance with this letter does not apply to out-of-state addresses received from managed care plans. The authority provided in accordance with this letter applies to both Medicaid and CHIP populations within the state.

In exercising the authority provided in this letter, the state will ensure that:

- The managed care plans only provide updated contact information received directly from or verified by the plan with the beneficiary, an adult who is in the beneficiary's household or family, or a beneficiary's authorized representative recognized by the health plan. The state will not accept contact information provided to the plan by a third party or other source if not independently verified by the plan with the beneficiary, an adult who is in the beneficiary's household or family, or a beneficiary's authorized representative recognized by the health plan; and
- The state will only update the beneficiary's contact information if the contact information provided by the managed care plan is more recent than the information on file with the state.

The authority provided in this letter is effective on March 18, 2023 and will remain effective until 14 months after the end of the continuous enrollment condition (i.e., May 31, 2024).

The authority provided in this letter is subject to CMS receiving your written acknowledgement of this approval and acceptance of this new authority and the terms described herein within 30 days of the date of this letter.

We look forward to our continuing work together as part of a transition to routine operations. If you have questions regarding this award, please contact Joe Weissfeld and Jessika Douglas in the Division of Enrollment Policy and Operations, at josef.weissfeld@cms.hhs.gov and jessika.douglas@cms.hhs.gov.

Sincerely,

Sarah deLone

Sarah deLone, Director,
Children and Adults Health Programs Group