IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

A.M.C., by her next friend, C.D.C., *et al.*, Plaintiffs, v. STEPHEN SMITH, in his official capacity as Deputy Commissioner of Finance and Administration and Director of the Division of TennCare, Defendant.	Civil Action No. 3:20-cv-00240 Chief District Judge Crenshaw Magistrate Judge Newbern

DECLARATION OF KIMBERLY HAGAN IN OPPOSITION TO PLAINTIFFS' MOTIONS FOR CLASS CERTIFICATION AND FOR A PRELIMINARY INJUNCTION

I, Kimberly Hagan, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. My name is Kimberly Hagan. I am the Director of Member Services for the Division of TennCare, which is the single state Medicaid agency that in partnership with the Centers for Medicare and Medicaid Services ("CMS") oversees the Tennessee state Medicaid program known as TennCare. This is a position I have held since June 1, 2016. Prior to that I served as the Eligibility Policy Administrator for Member Services. I have worked in Medicaid Eligibility Policy since February 2007 and have worked for the Division of TennCare since December 2000. In my current position, my responsibilities include: overseeing TennCare eligibility policy; eligibility processing generally to include processing new applications, eligibility redeterminations, and eligibility reverifications following a member or system reported change of information; overseeing eligibility appeals; and overseeing the development and

implementation of the new Tennessee Eligibility Determination System ("TEDS"). In total I have almost 20 years of experience with the TennCare program. I am submitting this declaration in support of the State's Opposition to Plaintiffs' Motion for Class Certification and Motion for a Preliminary Injunction.

I. Background Information on the TennCare Program and Medicaid Eligibility

A. General TennCare Information

2. TennCare provides health care for approximately 1.5 million Tennesseans and operates with an annual budget of approximately $12.7 billion. TennCare members are primarily low-income pregnant women, children, and individuals who are elderly or have a disability. As of May 19, 2020, out of its approximately 1.5 million members, 1,004,528 are children and caregivers eligible in a MAGI[1] eligibility category, 31,347 are individuals eligible in the Institutional Medicaid category, 206,057 are individuals eligible on the basis that they receive SSI-cash payments from the Social Security Administration, and 22,728 are eligible in an SSI-related category.[2] There are also 118,376 individuals who are receiving benefits through the Medicare Savings Program ("MSP"), a program through which TennCare will pay some or all of an individual's Medicare premiums, and 120,377 individuals receiving dual TennCare and MSP benefits. TennCare operates under a Section 1115 waiver from CMS that enables TennCare to operate as an integrated, full-risk, managed care program. All TennCare members (with exception of members with MSP-only coverage) are assigned a Managed Care Organization ("MCO") that manages their care and oversees the provision of medical, behavioral, dental, and pharmacy

[1] MAGI stands for Modified Adjusted Gross Income.

[2] SSI-related categories refer to categories of Medicaid eligibility available to individuals who currently receive Social Security benefits and formerly received SSI benefits. They represent only 1.7 percent of Medicaid beneficiaries in Tennessee.

benefits. There are approximately 1,280 TennCare employees, and of those, 724 work directly in eligibility. Of the 724 Member Services employees, 228 work in appeals related to eligibility. In addition, TennCare contractors operate two call centers, collectively known as TennCare Connect, that employ approximately 400 workers and that enable Tennesseans to apply for coverage, renew coverage, file eligibility appeals, and update their address or other information. Under normal circumstances, TennCare processes approximately: 400,000 applications per year; 100,000[3] annual eligibility renewals per month; and 200,000 eligibility reverifications per month as required by TennCare's receipt of new information. Since March 19, 2019, there have been 147,897 appeals related to an eligibility issue (denial, termination, effective date, or delay) and of those 80,855 were appeals related to terminations of eligibility.

3. Historically, with minor exceptions, all Medicaid eligibility determinations in Tennessee, including initial applications for coverage and the state and federally required annual redeterminations of eligibility, were conducted by the State Department of Human Services ("DHS") on behalf of TennCare using a decades-old legacy mainframe eligibility system known as ACCENT. The process for gathering relevant information to be manually input into ACCENT was an almost entirely paper-driven one with no ability to submit information online or over the phone, no ability to provide members with access to their own accounts through a member portal, and little or no ability for the State to individualize or change notices. The State could not conduct real-time eligibility determinations, it had no way to auto-renew eligibility, and it had very limited ability to verify information without requiring the submission of documentation by the member or

[3] This number has fluctuated as TennCare has paused and restarted redeterminations in response to events such as the initial implementation of the Affordable Care Act's new eligibility rules in 2014 and currently in response to the COVID-19 pandemic. Under normal circumstances, however, TennCare will be processing approximately 100,000 annual eligibility renewals a month.

manual research by caseworkers. Further, once a member was on the program, it was also very difficult for the State to react to reported changes in information that might impact that member's Medicaid eligibility (e.g. an increase or decrease in income or resources, loss of Supplemental Security Income ("SSI") or a natural life event for an enrollee such as the end of a pregnancy or a birthday). As a result, members often stayed on the program even after the State had received information suggesting they were no longer eligible.

4. In anticipation of changes to the State's eligibility processes required by the Federal government starting January 1, 2014 following the enactment of the Affordable Care Act ("ACA"), and with the knowledge that ACCENT would not be able to be reprogrammed to comply with those ACA mandated changes, in 2012, the State began the procurement process for designing and building a new eligibility determination system to replace ACCENT, the Tennessee Eligibility Determination System or "TEDS." Starting in 2013, TennCare began the process of moving all eligibility determinations and eligibility-related appeals from DHS to TennCare. Today, DHS has no involvement in Medicaid eligibility determinations or appeals although DHS is under contract with TennCare to provide in-person assistance to TennCare applicants and members at each of the DHS County Offices.

B. Federal Medicaid Eligibility Requirements

5. In order for individuals to be eligible for Medicaid, they must first meet what is called "categorical" eligibility. Categorical eligibility means that an individual is within a category of persons who are eligible for Medicaid (for example, children, caretaker relatives, pregnant women, and the disabled). If an individual satisfies the categorical eligibility requirements, TennCare must then determine whether she meets the income standard applicable to her eligibility category. In some categories, individuals are also reviewed against a resource/asset standard as

well.[4] If an individual meets the categorical income and asset standards, and assuming all other eligibility requirements have been met, such as residency and citizenship requirements, that individual will be determined eligible for Medicaid whether on an initial application or upon a reverification of current eligibility. Eligibility determinations are also hierarchy-based, meaning an attempt is made to place an individual in the category with the most comprehensive benefit package for which the individual might be eligible first. For example, children are first considered for enrollment in Medicaid versus CHIP.[5]

6. As noted, starting January 1, 2014, the ACA made several significant changes to how Medicaid eligibility is determined. First, all states were required to begin using Modified Adjusted Gross Income ("MAGI") rules for calculating income and household composition for pregnant women, children and caretaker relative Medicaid eligibility categories (MAGI categories) and for a state's CHIP program. Other categories of eligibility (non-MAGI categories) were unchanged by the ACA and states could maintain their existing methods of calculating income and household composition for those categories. Examples of non-MAGI categories include SSI recipients, children in foster care, Institutional/HCBS[6], medically needy, and SSI-related categories (Pickle, Disabled Adult Child ("DAC"), and Widow/Widower ("W/WW")), *see* Complaint, Doc. 1 at ¶47 (describing the three SSI-related categories).

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[4] The chart available at the following link sets forth various TennCare eligibility categories and the income and resources levels individuals must meet before they can be determined or redetermined eligible for TennCare. ANNUAL AND MONTHLY INCOME IN DOLLARS (Apr. 2020), https://bit.ly/3gI7mF4.

[5] CHIP stands for Child Health Insurance Program. The CHIP program provides health coverage for uninsured children and teens who are not eligible to be enrolled in Medicaid. In Tennessee the CHIP program is known as CoverKids.

[6] HCBS stands for Home & Community Based Services.

7. The most complicated of the new MAGI calculation rules imposed by the ACA are the modifications it made to the way household composition is determined. This calculation is important because it identifies the number of individuals that should be counted in an applicant's household, which in turn affects the amount of income that household may have and still qualify for Medicaid. Historically, households were determined by looking at who was living in the home and who financially was contributing to the expenses of the home. Dependent children were used in the calculation. MAGI rules changed how household composition is calculated to more closely conform to the rules of the Internal Revenue Service ("IRS") about who filed taxes and who is claimed as a dependent. With these modifications, household composition may be different for virtually every member of a family. MAGI rules also changed the types of income that count toward determining income and reduced the number of deductions that can be claimed to a single five (5) percent reduction in income if an individual is at the upper threshold of the Federal Poverty Level ("FPL") for an eligibility category.

8. While the ACA did in some respects simplify the rules, Medicaid eligibility remains a highly complex determination with numerous rules and requirements. There are still many different eligibility categories, and each involves different eligibility criteria that in turn give rise to different potential obstacles to eligibility. Determining the eligibility of a newborn child born to a mother already on TennCare, for example, is a very different exercise than determining the continued eligibility of a child who has grown too old for (i.e., "aged out of") her eligibility category, or redetermining the eligibility of an individual with disabilities who has lost her SSI entitlement to Medicaid coverage.

II. The Tennessee Eligibility Determination System ("TEDS")

A. Designing TEDS

9. The process of designing and implementing TEDS took several years. It was not until April 1, 2019 that TEDS began processing all applications, annual renewals, and reverifications of eligibility prompted by change information. TEDS became operational statewide with full functionality, including the ability to track and process appeals, on May 30, 2019. Thus, TEDS has only been fully functional for a year. The length of time it took to design and implement TEDS was in part due to the need to change the vendor who was designing the system (TennCare switched from Northrop Grumman to its current vendor Deloitte), but it was mainly a function of the incredible complexity of the Medicaid program, the need to design a system that could review and evaluate eligibility for every category of TennCare, CoverKids, and MSP available in Tennessee, the need to design a system that can apply eligibility rules and generate appropriate notices (those notices also had to be designed and programmed), and the need to design a system capable of interfacing with other databases used for the verification of eligibility information (e.g. interfaces with the Federal Data Hub, the IRS, the Social Security Administration, the Federal Department of Homeland Security, Tennessee State Benefits Administration, and the Federal Department of Labor to name but a few).[7] TEDS also had to be designed to provide applicants and

[7] The databases that TEDS interfaces with to verify data varies depending on whether it is processing a new application, performing an annual renewal, or determining eligibility following a reported change. For new applications, TEDS can access the following databases: Annual Household Income, Verify Current Income, Department of Labor – Quarterly Wages, Department of Labor – Unemployment Insurance, Equifax – TALX (the employment verification system at the Health Resources & Services Administration), SSA Composite, Verify Lawful Presence, SAVE (an electronic immigration status verification system), SSA's State Online Query System ("SOLQ"), Asset Verification Service, and the State Verification & Exchange System ("SVES"). For annual renewals and eligibility reverifications following a reported change, in addition to the databases accessed for new applications, TEDS also interfaces with the Beneficiary and Earning Data Exchange ("BENDEX") and the Public Assistance Reporting Information System

members with access to an online portal. TennCare chose also to design a smartphone application for members to make it easier to check their accounts, submit information to TennCare, and renew coverage. TEDS also had to be capable of processing applications, annual renewals, and change reverifications regardless of how the information was provided—telephonically, online, or on paper. The TEDS design also includes a provider portal through which approved providers may enter information about applicants and members. Finally, TEDS was designed to include an integrated appeals component to track appeals filed, issue appropriate notices in those appeals, and allow for TennCare to provide continuation of benefits when required.

10. TennCare used a multi-faceted approach to oversee the development and implementation of TEDS. First, TennCare followed guidelines and checklists provided by the Centers for Medicare and Medicaid Services ("CMS"), the federal agency that regulates Medicaid programs, in the implementation and development of TEDS. Second, TennCare utilized multiple vendors to oversee the development and implementation of TEDS in order to provide appropriate checks and balances throughout the process. Each vendor had responsibility for a different aspect of the project to ensure TEDS met the State's goals and vision, as well as the expectations of CMS. Third, TennCare employed industry standard methods for testing and quality assurance across all phases of the project. This multifaceted approach enabled TennCare to successfully implement TEDS with CMS approval. TennCare's Chief Information Office, Hugh Hale, describes the TEDS development and implementation process in detail in his Declaration.

("PARIS"). In addition, for annual renewals, TEDS interfaces with the Renewal and Redetermination Service. Whether or not TEDS accesses any of these also depends on what information an individual has provided. For example, TEDS will not access Social Security Administration SSN verification data if the applicant's SSN has already been verified.

11. In addition to the aforementioned planning, requirements gathering, design, development, and testing, TennCare underwent extensive steps to implement Organizational Change Management ("OCM") procedures to help both state staff and contractors prepare for working in the new TEDS system. TennCare worked with experts in the OCM industry to develop a new organization chart to fit our new way of doing business. We worked with staff to ensure they were prepared and bought in to the changes they would experience. One way we did this was by hosting work-force transition meetings. These meetings were scheduled just prior to beginning to work in TEDS and was where they learned more about how they would perform their work based on their specific role in TEDS. We also talked about TEDS early and often through the change management process. We identified TEDS Change Agents who met monthly to learn about TEDS first and spread news about upcoming changes. We hosted bi-annual Town Hall sessions with every Member Services employee to set expectations and show new TEDS functionality as it became available. TennCare also hosted Management Alignment Workshop meetings for managers to learn about how to best help their staff transition into working solely from TEDS. Even with all of this preparation, it was a difficult task to transition over 700 state employees and about 400 contractors to begin working in TEDS. Change is hard for many people and adapting to a new system that collects more data than ever and automatically applies rules to make eligibility determinations was difficult. Although some staff loved the new system right away and adapted quickly, others did not and have required additional assistance over the last year.

12. With TEDS, TennCare can evaluate individuals for eligibility in every category of eligibility available in Tennessee, even esoteric ones like Pickle, DAC, and W/WW that account for less than two (2) percent of all TennCare's members. In many cases, using the database interfaces built into TEDS, TennCare can make automated, real-time eligibility determinations

because, for the first time ever, TEDS enables TennCare to conduct large-scale verifications of information such as income and resources. For annual renewals and reverifications prompted by new information, since March 19, 2019, TennCare has performed over two (2) million eligibility reverifications through TEDS without requiring individuals to return an annual renewal packet or a pre-termination questionnaire in order to keep their TennCare coverage. For individuals who cannot have their eligibility automatically renewed during the annual renewal process, for the first time ever, TEDS issues pre-filled renewal forms to reduce the information that members must provide, and those forms can be returned to TennCare by mail, fax, phone, online or can be submitted in person at any DHS county office. Members can also submit additional requested verification information by mail, by fax, by taking a picture with their phone and uploading it to the mobile app, or through the TennCare Connect member portal. The portal allows members to access information on their case, such as who TennCare believes is included in their household and the income and resources TennCare is counting for the family. Members can also view the notices TennCare has sent them, and they can upload required documentation directly into TennCare Connect, which is then automatically visible in the TEDS case, eliminating the need to mail or fax the documents. Of course, if an individual needs in-person assistance, it remains available to them at every state DHS county office statewide where DHS staff will assist members in filling out required forms online or providing assistance in faxing the forms or other required verifications to TennCare.

13. A significant advantage of TEDS over prior eligibility processes is that much of the eligibility decision-making is automated. Beyond allowing for automated, no-touch eligibility renewals and real-time eligibility decisions, the automation substantially reduces worker error. The State's legacy eligibility determination system, ACCENT, and the interim eligibility processes that

were in place before TEDS became operational relied to a large degree on manual data entry, manual eligibility analysis, manual case authorization, and manual issuance of notices. TEDS has eliminated most of these manual processes and the inevitable human error they entailed. And, importantly, when worker intervention is required, various safeguards have been built into TEDS to prevent or identify common worker errors prior to an action affecting a member or applicant. Working with its vendor, Deloitte, TennCare has made modifications and changes to TEDS whenever areas for improvement are identified, unanticipated issues arise, or TennCare learns of a problem with how the system is functioning. The TEDS design will never be complete because TennCare and Deloitte are constantly improving TEDS functioning, adding capabilities, correcting issues, and making the system more efficient. TEDS is now on its ninth major release since first being made operational, meaning that there have been nine major system upgrades with a tenth major release scheduled for July 2020. This is in addition to numerous change requests that result in smaller updates to TEDS in between major releases. More change requests and adaptations are planned as TennCare continues to respond to feedback from workers, members, providers, and others on improving the system.

14. One example of how TEDS prevents worker error involves one of the rarest and easiest eligibility categories for a worker to overlook, the "Pickle" category (individuals eligible under the Pickle Amendment, Pub L. No. 94-566 §503, 90 Stat. 2667 (1976)).[8] There are currently only 19,967 individuals eligible in this category, less than 1.4 percent of the 1,447,580 enrollees receiving full Medicaid or CHIP benefits. Unlike similar SSI-related categories known as the

[8] To be eligible in this category, an individual must have at some time since 1977 been authorized to receive Social Security and SSI benefits in the same month, and would currently be eligible for SSI if the Social Security Cost of Living Adjustments ("COLAs") received since their SSI termination were disregarded.

Disabled Adult Child ("DAC") and Widow/Widower ("W/WW"), which also require an individual to have received both SSI and Social Security benefits, the Social Security Administration ("SSA") does not flag potential Pickle eligible individuals on the State Data Exchange ("SDX") file that SSA sends to the states with SSI information. Because potential Pickle-eligible individuals are not flagged on the SDX, there is no data element that TEDS can react to in order to automatically load information about prior SSI benefits. To address concerns that a worker might miss this category of eligibility error because it is not flagged, TEDS was designed to create a "Pickle task" for eligibility workers to alert them whenever an individual may be eligible in the Pickle category that requires them to enter data into the SSI-related screens in TEDS. TEDS was further updated after initial implementation so that a worker now cannot approve or deny eligibility on a case until this "task" is resolved. This modification to TEDS was made on July 28, 2019 with the fifth major TEDS release. Of course, workers may still enter the wrong information or misread the SDX data file causing the system to incorrectly calculate Pickle income, but TEDS has been specifically designed and modified to reduce errors in identifying Pickle eligibility.

15. Another example of how TEDS can be leveraged to prevent worker error is a planned modification to TEDS to prevent the inadvertent and unintentional termination of coverage when an eligibility worker is merging cases where members of the same household are on different cases or a member has more than one case in TEDS. In such situations, the worker is supposed to add the member(s) from one case to the other case such that eligibility is terminated in the old case and then the member(s) is added to the new case so that the entire household is consolidated on the same case. We found that, on occasion, workers close the eligibility in the old case but fail to approve eligibility on the consolidated case. This results in the member losing eligibility inappropriately, albeit unintentionally. The case of Plaintiff K.A. illustrates how this

issue could arise. K.A.'s birth was reported to TennCare through a new member portal application on October 11, 2019 rather than as an update to the family's existing case, which caused the no-touch authorization process in TEDS to put him on a new case in TEDS unlinked to his mother. His mother, J.Y., called TennCare Connect to have K.A. added to her case on December 18, 2019, and an eligibility worker attempted to do so that same day. However, the worker failed to authorize eligibility for K.A. in the new case, so when K.A.'s old case was closed, K.A.'s TennCare coverage was unintentionally terminated. This error was caught and corrected on December 30, 2019, and then on February 27, 2020, K.A.'s coverage was backdated to the date it was erroneously, albeit unintentionally, cut off. To prevent this sort of worker error in the future, TennCare has worked with Deloitte to implement a modification to TEDS that precludes termination of coverage in the old case until the coverage in the new case is authorized. This modification is scheduled as part of the TEDS 10.0 release in July 2020. In the interim, until this automated fix can be implemented, TennCare will be running daily processes in TEDS to identify cases that may have experienced this error and correcting those cases and restoring eligibility as necessary. Of course, TennCare will also correct any such cases that are brought to our attention through the appeals process or other avenues that members and their advocates have for bringing issues to our attention.[9]

B. Worker Training

16. Although TEDS has greatly reduced the opportunity for worker error, no system that relies on humans can ever be completely error free. TennCare has taken great pains to ensure appropriate training of its eligibility workers. All new employees start with a 3-day policy class which typically occurs in their first week on the job. The two primary learning objectives for this

[9] Plaintiffs' counsel has in fact recently brought two such potential cases to the attention of TennCare's General Counsel, and we have promptly corrected both of them.

training are to identify the key criteria (financial and non-financial) used to determine eligibility in each category and locate specific policies and supporting documents used to determine eligibility, process renewals, and resolve appeals. The following week, all new employees attend a system class, which is a 4-day training session in our computer lab in which they learn how to navigate TEDS. We offer a combination of lecture, live demonstrations, and hands-on training. Employees learn how to process cases and troubleshoot issues. This training is highly interactive; employees participate in guided practices with the instructor and then complete independent practices and knowledge checks to reinforce key concepts covered in a segment of the course. Depending on their role in the organization, for some employees this is the end of their training. For employees in some of our specialized units, training continues for an additional one (1) to six (6) days. All of the classes offered are available to existing employees who would like a refresher or who have changed roles and need to focus on a different aspect of the eligibility process.

17. In addition to the above, all new workers go through digital and in-person sessions where they work side-by-side with an experienced worker or manager so the new worker can watch the more experienced worker process cases and the more experienced worker can in turn monitor how the new worker processes cases. This step in the training lasts a minimum of two weeks, but will last longer if it is deemed necessary. This method of training and evaluation also takes place if issues are identified with a particular worker regardless of how long they have worked for TennCare. All staff are designated as experienced or not-experienced in TEDS. A not-experienced designation means that any case that individual processes must undergo secondary review by a manager or other staff designated as experienced before action can be taken on the case. All new staff are designated as not-experienced until a manager determines that staff member has demonstrated the capability to properly process cases without the need for secondary review. This

determination is based in part on the new worker meeting quality and production goals. It usually takes no longer than four months for a new worker to be designated as experienced, but they are still closely monitored for any deficiency.

18. Apart from this new worker training, as I discuss in Paragraph 11 above, all workers who were experienced in the eligibility and appeals systems and processes pre-TEDS went through an extensive Organizational Change Management process to transition them into using TEDS.

C. Converting Eligibility Data into TEDS

19. In order for TennCare to begin operations in TEDS, the Medicaid eligibility information on its members previously stored in TennCare's Medicaid Management and Information System (known as interChange), had to be moved or "converted" into TEDS. Because the way different databases store and maintain information differs, the process of moving this eligibility data into TEDS was a complex undertaking. One challenge that had to be overcome, for example, arose from the fact that, in interChange, eligibility information was maintained in cases that would not necessarily match the household or family case-based system that would be used going forward in TEDS. Thus, under certain circumstances, multiple cases from interChange were merged with other cases from interChange to create a single TEDS case with multiple members on the case. The single TEDS cases were created by doing a case number comparison, spousal identification, and a household composition comparison of cases in interChange to be merged into a single case. Not all cases in interChange however could be merged into a single TEDS case, and thus had to be converted as-is from interChange into a standalone case in TEDS.

20. Using the household composition comparison as an example, cases in interChange that did not have the same number of persons could not be merged. If for example one case in interChange had three people—two of whom are also identified on another case with a different

person—these cases could not be merged because the household members had to be an exact match on all persons, not just a subset of them. In this scenario, two cases were converted to TEDS, one case for three household members and another case for the two household members.

21. The conversion process also had to deal with the fact that all household members that could potentially impact a person's eligibility for Medicaid were not always present on the existing interChange cases. In order to build complete and correct household composition and ensure a member's current/ongoing eligibility, the conversion process had to look at data from the Federal Marketplace and the DHS ACCENT system to identify additional household members that should be added to a converted interChange case. In addition, the correct household relationships had to be converted into TEDS, and the Federal Marketplace and ACCENT sometimes had conflicting household data.

22. In order to convert the eligibility data into TEDS while addressing to the greatest extent possible the challenges noted above, TennCare, along with its vendor, Deloitte, designed rules to govern the logic of conversion, completed the conversion process in waves, and waited to move the entirety of the TennCare population into TEDS until the first two waves worked successfully.

23. In order to limit eligibility errors arising from the conversion of data into TEDS, TennCare performed a "benefits match" process on converted cases to confirm that TEDS placed members in the same or a higher eligibility category as they had in interChange. If this "benefits match" resulted in the member being immediately selected for disenrollment because TEDS did not identify them as eligible in the same or higher category, TennCare marked those converted cases as being in a "conversion status." For cases in a "conversion status," automated eligibility rules that would normally run and could negatively impact a member's eligibility status do not

apply. A case remains in "conversion status" until either the enrollee makes contact with TennCare to report a change or the enrollee gets selected for annual redetermination. When TennCare completed its final conversion from interChange in May 2019, there were 180,120 cases involving 342,200 members in "conversion status." As of April 26, 2020, there were 71,053 cases in "conversion status" involving 138,358 members.

24. For the SSI population (both SSI recipients and members eligible in the SSI-related categories), the benefit match process was slightly different in that TennCare matched the converted SSI cases against the SDX data from the Social Security Administration available in interChange. If SDX data in interChange showed an individual was no longer receiving SSI-cash payments (i.e. not in an SSI active pay status in Tennessee), that case was moved out of conversion status to enable the system to send those cases through an *ex parte* eligibility review. (I explain the *ex parte* process in greater detail below at ¶ 59(c)). TennCare converted 213,488 SSI cases into TEDS. Of those, 205,596 moved out of conversion status following a benefit match with SDX data showing the individuals in those cases were in SSI active pay status (i.e., they were receiving SSI cash payments in Tennessee). These individuals continued on the program with no change to their eligibility status. A total of 6,628 individuals identified as not receiving SSI cash payments (and thus not eligible in the SSI category) based on the match with SDX data. TEDS subjected those cases to an *ex parte* eligibility review to determine whether those individuals were still eligible for TennCare in another category. As of April 27, 2020, 3,855 out of the 6,628 individuals (58%) who were placed in inactive-SSI status were eligible for either TennCare or MSP and 2,773 individuals have been disenrolled from the program (42%). In addition, during conversion, 1,224 SSI cases were kept in "conversion status" because they had pending eligibility appeals with SSA that predated the conversion into TEDS. As discussed in Paragraph 35(a) below, TennCare is running

all of these 6,628 individuals through a process developed with SSA officials to be sure that TennCare has correct SSI data for all of them, and if any of the 2,773 individuals who no longer have active coverage are found to in fact be Medicaid eligible by virtue of receiving SSI, those individuals will have their coverage reinstated through this process.

25. Overall TennCare converted 973,753 cases, involving 1,930,389 individuals, into TEDS, not counting the millions of ineligible individuals whose information was converted into TEDS as well. Naturally, with any data conversion of this size and complexity some problems related to conversion did occur despite TennCare's best efforts.

a. For example, in some instances the correct family groups were not created in TEDS. We saw this issue with several of the named Plaintiffs. In the case of A.M.C., she was converted into TEDS based on a Medicaid application that was submitted to Healthcare.gov with her grandmother, uncle, and mother identified as being in the same household and her grandmother, as opposed to her mother, listed as the head of household. This outdated information was corrected on December 17, 2019 following a call to the TennCare Connect Call Center by A.M.C.'s mother.

b. Likewise, Plaintiffs D.D., T.E.W., S.D.W., Y.A.D., Z.M.D., and X.M.D. also experienced a conversion issue related to an incorrect family group. They were converted into TEDS with another family because the two families shared the same interChange case number. This caused TennCare to load the address of record for the other family in TEDS, which lead to notices being sent to the wrong address. This conversion issue was corrected on October 17, 2019 for D.D., T.E.W., S.D.W., Z.M.D., and X.M.D. when the correct address for these Plaintiffs was updated in TEDS, and was corrected for Y.A.D. on March 4, 2020 when he was added to the correct case with the correct address.

c. Plaintiffs D.R., J.Z., M.X.C., and J.C., also did not convert into TEDS as one family group. D.R. and M.X.C. were converted into one case and J.C., who had his own interChange case unconnected to his family, was converted into his own case in TEDS. J.Z. did not have TennCare eligibility at the time of conversion so was not added to any case until an application was submitted for him on February 8, 2019. These conversion issues were corrected on April 26, 2019 when D.R. and her three children were all added to the same case.

d. Plaintiff S.L.C. experienced a problem related to conversion in that her living arrangement, based on the information available in interChange and ACCENT, was converted into TEDS as indicating she was residing in a nursing facility, which was not accurate as she was residing in the community with her parents and receiving HCBS through the Employment and Community First ("ECF") CHOICES program. This conversion meant that information about her receipt of HCBS was not loaded into TEDS.

e. Plaintiffs Michael Hill and Kerry Vaughn experienced a problem arising from conversion related to their designation as a Disabled Adult Child ("DAC"). They were converted into TEDS as being eligible in the Pickle, not DAC, category. In interChange all SSI-related eligibility categories had the same eligibility designation code so upon conversion into TEDS, the information on whether an individual was a Pickle, DAC, or W/WW designee was pulled where possible from the prior eligibility system, ACCENT. In some instances, the DAC designation did not properly get pulled from ACCENT because the enrollee had multiple SSA claim records and the individual ended up being converted into TEDS as a Pickle designee. This later gave rise to incorrect eligibility determinations if not caught by a TennCare worker, as Pickle and DAC income disregards are calculated differently. TennCare has reviewed every case in which an individual's eligibility data was converted into TEDS as Pickle who either no longer has

Medicaid coverage or has MSP-only coverage to determine if there were any individuals similarly situated to Plaintiffs Hill and Vaughn who should have been found eligible as a DAC. Nine additional cases were identified in this review and those individual's DAC eligibility was reinstated.

26. While occasionally a problem relating back to conversion still comes up in individual cases, for the most part, these one-time issues have been resolved. These errors will not be repeated in the future – conversion has already happened, and new eligibility cases are created directly in TEDS. Thus, to the extent any of the named Plaintiffs experienced problems with the conversion and creation of cases initially in TEDS, those problems will not be repeated and there is no danger that Plaintiffs or other TennCare members will experience them in the future.

D. TEDS Quality Control Processes

27. TennCare closely monitors the operation of TEDS and eligibility determinations generally, whether based on initial applications or eligibility reverifications, to ensure that TEDS is functioning appropriately. I personally receive a TEDS daily operations report that allows me to monitor at a high level how TEDS is functioning and that alerts me to any significant deviations in the data.

28. TennCare also monitors TEDS and its eligibility processes through a Quality Control Team. Since its inception, TEDS has had a "Quality Control task" feature that allows workers to identify errors in cases they are processing by creating a "task" for the Quality Control Team to review and resolve. The types of errors identified could be worker error, whether by a TennCare employee or a contractor, or a potential system error that a worker identifies while processing a case. After the Quality Control Team receives a task, the Team reviews the case to determine the nature of the error. If the issue is a worker error, the Team notifies that individual

and that individual's supervisor so that education and potentially additional training can be done. If the issue is a system error, the defect is logged for resolution by Deloitte. Since TEDS March 19, 2019, 3,538 Quality Control tasks have been completed by the Quality Control Team.

29. The Quality Control Team is also responsible for conducting Medicaid Eligibility Quality Control ("MEQC") audits and the triennial Payment Error Rate Measurement ("PERM") audits that are required by and get reported to CMS. The MEQC audit is done in two intervening years between the PERM triennial audit. The current MEQC audit will look at cases that were processed between January 1, 2020 and December 31, 2020. We are currently gathering samples for this audit and have not yet begun performing reviews, but the audit will focus on the accuracy and timeliness of eligibility determinations for both active and inactive Medicaid (MAGI and non-MAGI) and CHIP cases. All aspects of eligibility, including the correctness of an eligibility determination, will be reviewed, including, but not limited to: income, resources, resource assessments, timeliness of determination, notices, household composition, residency, post-eligibility treatment of income age, and completeness of documentation. The sample size will be 848 cases, half of which are active and half of which are inactive.

30. The PERM is a triennial audit and the Quality Control Team is currently in the process of working on the audit for 2020. The PERM audit reviews claims payments, data processing, and eligibility decisions, but the focus of the eligibility review is on whether individuals were properly found eligible for the program, so cases in which eligibility was denied or terminated are not included in the sample. Due to the COVID-19 pandemic, the 2020 PERM is currently indefinitely on hold. PERM errors over a certain threshold will result in repayment of federal funds to CMS.

31. We also identify potential issues through the appeals process. If the Appeals group sees a pattern of the same issue coming up in cases this can lead TennCare to investigate whether there is a systemic problem in TEDS. We similarly look for patterns and the potential for systemic problems in cases that get brought to our attention by advocacy and legal organizations, such as TNCSA, Family and Children's Services, TJC and Legal Aid, or through cases brought to our attention by state legislators, through TennCare's Office of Civil Rights, and through communications with providers. As we have expanded our TennCare Access partner portal to more and more providers, our vendor KPMG has worked to develop relationships with these facilities so each one has a designated point of contact that they can reach out to directly with questions or problems. This has proven to be a useful avenue in the identification of potential systemic issues.

32. We also hold routine meetings between TennCare staff and Deloitte regarding the functioning of TEDS. For example, the TEDS Incident and Release Management team meets three (3) times a week to discuss potential system defects identified by staff, analyze the research into potential system defects, and schedule proposed fixes and required modifications to TEDS. There is an MMIS/TEDS working group that meets once a week to oversee the interface between interChange and TEDS and ensure the interface (including approvals and terminations) is working appropriately.

33. Every year the Tennessee Comptroller of the Treasury also performs a financial and compliance audit that looks at the TennCare eligibility processes. In the most recent audit, which covered of portion of the time that TEDS was operational, the Comptroller tested a "nonstatistical

random sample of 61 members to determine if management appropriately determined the members' eligibility using TEDS" and the Comptroller found "no problems."[10]

34. It is by digging into the details of what has happened in individual cases that are brought to our attention through all of the avenues described above that we sometimes determine that TEDS processes or logic should be modified, that a notice that should be edited or not issued, or, that there is opportunity for additional worker training. The review and evaluation of TEDS functioning and efforts to continually improve upon the system is ongoing and will continue for as long as TEDS is operational.

E. Changes to TEDS Since it Went Operational

35. TennCare strived to identify potential issues and perfect the functioning of TEDS before TEDS went live by running cases in a test environment that sought to simulate issues that might arise and notices that would need to be generated once TEDS was operative. But, invariably with a system of this size and complexity that houses eligibility information for millions of individuals, receives and processes data from numerous outside data sources, and applies extremely complex Medicaid eligibility rules, appeals rules, and issues myriad notices that must reflect hundreds, if not thousands, of different circumstances, some issues with TEDS were not discovered until after TEDS went live.

a. One problem that was discovered after the system went live concerned the SDX information TennCare had received from the SSA. TEDS used this data upon converting the SSI population as described in Paragraph 24 above to determine whether members were still receiving SSI payments. However, a very small percentage of individuals were identified on the

[10] PERFORMANCE AUDIT REPORT: SPECIAL PROJECT; STATE OF TENNESSEE SINGLE AUDIT FOR THE YEAR ENDED JUNE 30, 2019 87 (Mar. 23, 2020), https://bit.ly/2M7BziF.

SDX file as not currently receiving SSI (and thus no longer automatically eligible for Medicaid) even though subsequent information received from other sources demonstrated they were in fact receiving SSI-cash payments and should not have had their SSI-Medicaid closed. The named Plaintiffs who fall into this category are Vivian Barnes, Carlissa Caudill, and Johnny Walker. While this was not technically an issue with TEDS, as TEDS responded correctly to the data SSA provided, upon discovering this issue, TennCare worked with SSA officials to develop a process through which TennCare sends its current SSI eligibility information to SSA when we have reason to doubt the SDX information and SSA provides updated information on who is in fact receiving SSI-cash payments in order to validate the SDX data and correct any errors that may have come to the State on the SDX file. This process was to commence in March but was postponed due to COVID-19 and the moratorium the State has placed on disenrollments from TennCare. The process began instead on April 21, 2020 and will be finalized before the moratorium ends.

b. Another issue with TEDS that TennCare discovered since it went live involved a gap in the programming logic for when TEDS would link the report of a newborn's birth to a mother on TennCare. Children born to mothers on TennCare automatically receive TennCare eligibility for a year. We discovered that in some cases when births were reported through the member portal or provider portal without the mother's information and went through a no-touch approval process, TEDS was not automatically linking the newborn to her mother. This resulted in effective dates for coverage as of the date of application rather than the date of birth. TennCare has since implemented several modifications to TEDS to correct this error, one that was implemented on April 16, 2020 with the 8.1.2 release of TEDS, and another that will go in effect in July 2020 with the 10.0 update to TEDS. In the meantime, TennCare has been running daily processes in TEDS to try to identify and correct the effective dates until the final systems change

can be implemented. Named Plaintiffs K.A. and E.I.L. were affected by this issue but have both had their coverage effective dates corrected. K.A.'s coverage effective date was corrected on February 27, 2020, and E.I.L.'s coverage effective date was corrected on March 4, 2020, both before the Complaint was filed. Further, the TennCare Appeals group was alerted to this potential issue so that all appeals related to the effective date of coverage for newborns get sent to the Appeals Resolution Unit for review and correction even if the appeal is untimely.

c. As detailed in Paragraph 15 above, another modification to TEDS that TennCare is working with Deloitte to implement in July 2020 is an improvement to TEDS that will prevent a worker who is moving a member's eligibility from one case to another from inadvertently causing a termination in coverage by closing the prior case until eligibility is authorized in the new case.

d. TennCare also determined that some of its notices needed to be changed or updated and, in some instances, TEDS needed to be reprogrammed not to issue notices in certain circumstances that could cause confusion. For example, following the conversion of SSI cases into TEDS, for those cases in which the individual was identified as no longer being in an active SSI-cash pay status, in order to start the *ex parte* process and begin reviewing those individuals for other categories of potential TennCare coverage, a new TEDS SSI-transitional placeholder case has to be created. When these new SSI-transitional cases were created, TEDS issued Notices of Decision ("NODs") informing the individuals that they were approved for Medicaid. Those approval notices were supposed to have been suppressed (i.e., not issued) in the original TEDS design, but this was not included in the original programming. The intent was to suppress the NODs in this situation because the member was not actually being newly approved for coverage– the creation of the new SSI-transitional case was simply a vehicle for TEDS to send these

individuals through the *ex parte* eligibility review process. TennCare realized that issuing an NOD approving Medicaid in this circumstance would be confusing to its members, especially in the many cases where the member receives another notice around the same time informing them that their "coverage will end soon" and asking for additional information to see if they can keep coverage. (A description of the purpose and content of this notice, called a Preterm Notice, is provided in Paragraph 59(e) and (f) below). TEDS was corrected to suppress these NODs where the creation of a new case does not change the member's coverage. This change went into effect on August 25, 2019, with the 5.1 release of TEDS. While TEDS was built on a case-based system that ties segments of eligibility to a specific case,[11] TennCare fully recognized that from its members' perspective, whether they had eligibility in an SSI-case or an SSI-transitional case was irrelevant. Named Plaintiffs who received these NODs before such notices were suppressed in TEDS are Vivian Barnes and Fultz.

e. Another TEDS defect and related notice issue that TennCare discovered and corrected involved the granting of continuation of benefits ("COB") when an individual filed a timely appeal. This TEDS defect was not allowing appeal workers to update the "COB timely" field in TEDS, which resulted in COB not being granted in some instances when it should have been and in the wrong information on COB being included in the appeal acknowledgment notice that gets mailed to individuals letting them know their appeal has been received and is being

[11] A detailed explanation of how a case-based system works is more involved than can be readily and easily explained here, but the important points are (1) a case generally includes all family members, but there are exceptions; (2) multiple cases often must be created when an individual's eligibility category changes (for example, when a member loses SSI and will thus retain coverage only if she is eligible in a non-SSI category), or when a coverage effective date needs to be backdated; and (3) if TennCare had elected to do away with this case-based system, it would have cost the state over $500 million more to design and build TEDS because TEDS was built off a design already in place in Georgia that used this case-based system.

processed. TEDS was modified to correct this issue on August 25, 2019 in the TEDS 5.1 release. Plaintiffs who were impacted by this issue and received the wrong appeal acknowledgment notices and COB determinations before the defect was corrected are Clarissa Caudill, D.R., J.Z., and M.X.C. Each, however, received a correct notice and COB once the defect was identified and corrected. All similarly situated appellants also received corrected COB and corrected notices.

f. TennCare also discovered after TEDS was live that the system was not appropriately determining eligibility in some instances for some children who should be eligible for Transitional Medicaid ("TM"). Transitional Medicaid provides one year of coverage for enrollees who lose eligibility in the Caretake Relative or mandatory Child MAGI categories of eligibility due to increased earnings and whose household income prior to losing eligibility was at or below the current Caretaker Relative income standard. TEDS was granting Transitional Medicaid to parents but not to children in certain circumstances where verifications were outstanding**.** This has since been corrected with an update to TEDS on February 23, 2020 in the eighth major TEDS release. Plaintiffs impacted by this issue before it was corrected were S.F.A., J.L.T., and A.L.T.

g. Another change to TEDS that has been implemented involves review for the SSI-related categories of eligibility after TennCare receives a change in information making the member ineligible in her current category of coverage (change-mode reverifications). While TEDS has always screened for and reviewed for eligibility in those categories, and, in fact, since March 19, 2019, TennCare has found 17,107 individuals eligible in one of the SSI-related categories, to address Plaintiffs' concern that sometimes these categories of eligibility get overlooked, TennCare has updated the Preterm Notice by adding a question: "Do you get Social Security benefits now and also got SSI checks in the past?" While TennCare should be able to

access this information without asking its members, to be certain we do not inadvertently miss anyone, we decided to add this question to the notice.

h. TennCare has also updated TEDS as part of the ninth major release on May 8, 2020 to enable TEDS to automatically evaluate and approve eligibility in the Pickle category for members that do not have a D or W indicator (an indicator that lets states know who may be eligible in the Disabled Adult Child or Widow/Widower categories, which as noted in Paragraph 14 above is not present for potential Pickle eligible individuals) on the SDX file but for whom TEDS can still determine the SSI termination date.

i. TennCare has also updated TEDS with its 9.0.1 release on May 14, 2020 to address an issue where the latest social security income record from the SSA's SDX file was not loading properly causing it to appear that a member did not qualify for the W/WW eligibility category because the member did not appear to be receiving any social security income. This was the problem experienced by Plaintiff Cleveland.

j. TennCare is also addressing a gap in TEDS programming that involved instances in which an individual's social security income is not received before the *ex parte* reverification process triggers a Preterm Notice. TEDS would not identify that individual as potentially eligible in the Pickle category (because there was no social security income present at that time), would mark the individual as "not Pickle," and would not create a task for a worker to review that individual for Pickle eligibility. This occurred with Plaintiff Fultz. In the tenth major release of TEDS in July 2020, TennCare will be updating TEDS to trigger Pickle tasks when later updates to social security income would warrant the need for such a task and to reset the prior "not Pickle" determination so that a Pickle eligibility review can be done before a member who may be eligible in the Pickle category is issued a termination notice.

k. TennCare is working to update the "Pickle task" logic in TEDS to ensure that a previous review for Pickle eligibility by an eligibility worker will not prevent the system from creating a new Pickle review task at a later time (such as if a new application is submitted) to reduce the possibility of a worker missing potential Pickle eligibility.

l. TennCare is working to modify TEDS in the July 2020 release to also require TEDS to load DAC and W/WW indicators from the SDX file even in cases where the member is not currently receiving SSI Medicaid. As currently programmed, TEDS only loads this data into the SSI detail screens of members who are actively receiving SSI-cash. This modification to TEDS is intended to help prevent worker mistakes in evaluating individuals for the DAC and W/WW categories.

III. The Requirement that Members Update TennCare with Address Changes

36. In 2014, when the State was making significant changes to the TennCare program to bring it into compliance with the new requirements of the ACA, TennCare sought and obtained a waiver from CMS that exempted TennCare from performing annual eligibility redeterminations. Subsequently, in 2016 when TennCare was ready to restart performing the required redeterminations, because TEDS was not yet operational, TennCare received CMS approval for conducting a modified redetermination process utilizing in part the contractor Maximus. Because annual eligibility redeterminations had been placed on hold for almost two years, prior to mailing out renewal packets as part of the Maximus process, TennCare conducted an extensive outreach and public relations campaign to encourage individuals to update and maintain their addresses with TennCare. Information was included on TennCare's website, in flyers that were distributed and posted in DHS and DOH County offices, at providers' offices, and at pharmacies. There were also quarterly meetings with the advocacy community, at least eight newsletters were distributed to the

advocacy community with this information, and a YouTube video was created and disseminated. In addition to the foregoing, TennCare had its MCOs contact all their members to remind them of their obligation to keep their information, including their address, up-to-date with TennCare.

37. The requirement that TennCare members must keep the State informed about their address (along with other information about their family that could impact their Medicaid eligibility) is longstanding. When TennCare eligibility determinations were being made by DHS, members were required to report address changes to that agency, and since 2014, members have been told to report all such changes to TennCare directly. TennCare's rules set forth this requirement. *See* Tenn. Comp. R. & Regs. 1200-13-20-.03(2)(a).[12] The notices TennCare sends to its members instruct them to submit changes, including address changes, to TennCare via the TennCare Connect Call Center, the TennCare Connect member portal, fax, mail, or the mobile app. *See, e.g.*, P-Ex. 1-J, P-Ex. 3-E, P-Ex. 4-C, P-Ex. 5-B. TennCare has stressed the importance of keeping addresses up-to-date with the advocacy community that works with TennCare members. TennCare emphasizes this requirement on its website, and each of the MCOs' member handbooks inform members of their obligation to report address changes to TennCare. This same information is on each MCO's website. Periodically, TennCare also creates and distributes flyers to MCOs, providers, and sister agencies such as DHS and the Department of Health encouraging people to report current addresses directly to TennCare. We have attempted to make the process of reporting address changes as simple and as easy as possible. In every call to TennCare Connect,

[12] Plaintiffs cite a prior TennCare Rule that pertained to eligibility requirements when DHS conducted eligibility determinations to suggest that enrollees are still told to report address changes to DHS. That prior Rule was explicitly superseded by Chapter 1200-13-20 of the Rules, which state in pertinent part that "[t]his Chapter preempts any other TennCare Rules pertaining to eligibility determination to the extent they are in conflict."

one of the very first items verified is the member's address, and if the address in the system is no longer accurate, the TennCare Connect agent will update the address in real-time on the call.

38. Apart from occasional worker error such as not updating an address correctly, TennCare has not found any systemic evidence of problems with its mailings. Plaintiffs' assertions in this regard were proven unsubstantiated by the Comptroller of Tennessee's audit of TennCare's prior redetermination process. In auditing TennCare's prior redetermination process, which was a much more manual, much more paper-intensive, and less enrollee-friendly process than the current process under TEDS, the Comptroller concluded that TennCare "substantially performed the established eligibility redetermination process as required by federal regulations and appropriately removed children from TennCare and CoverKids with only minor exceptions."[13] The Comptroller "did not note any problems with either of [TennCare's] mailing processes," *id.* at 12. The Comptroller also found that "[A]ll members tested were appropriately terminated based on the documented reason," *id.* at 15; that 97% of those disenrolled due to excessive income were correctly determined to be ineligible, *id.* at 16; and that TennCare "appropriately processed appeals and documented its final administrative action for each member tested," *id.* at 23.

39. Federal regulations also require states to conduct eligibility redeterminations whenever they receive information that may affect the eligibility of an individual. Prior to the creation of TEDS, TennCare with very limited exceptions (responding to a death, a move out of state, or a request for voluntary withdrawal) was unable to respond to reports of changes in information that might affect its members' eligibility. For example, when TennCare received information from the Social Security Administration that an individual was no longer receiving

[13] TENN. COMPTROLLER, PERFORMANCE AUDI REPORT, SPECIAL PROJECT: DIVISION OF TENNCARE'S REDETERMINATION PROCESS AND THE IMPACT ON CHILDREN'S ENROLLMENT 11 (Feb. 2020), https://bit.ly/2APHVRz.

SSI and thus would no longer be automatically eligible for TennCare in the SSI category, TennCare had to wait until the annual eligibility renewal process in order to react to that reported change. As is explained in greater detail below in Paragraph 59, TEDS now allows TennCare to react immediately to reported changes. Thus, in TEDS there are two eligibility reverification processes and workflows—one that occurs in "renewal mode" when a member is going through annual eligibility redetermination and one that occurs in "change mode" when a member is having their eligibility reverified following a reported change. I describe both in greater detail below and how those processes will function once the COVID-19 moratorium on terminations from TennCare is over.

IV. TennCare's Eligibility Reverification Processes Using TEDS

40. TennCare began using TEDS to conduct the required annual eligibility renewals ("renewal mode" reverifications) in November 2018 and the required eligibility reverifications following a reported change ("change mode" reverifications) in October 2018. Those two processes have evolved since that time, with improvements and changes being made as TennCare gained information from the first year of operation of TEDS. As previously noted, TennCare will continue to improve those processes as times goes on whenever TennCare determines that updates or changes are warranted.

41. Currently due to the COVID-19 pandemic, Tennessee, like most other states, has chosen to place a moratorium on disenrollments from its Medicaid and CHIP programs consistent with the Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (Mar. 18, 2020). This means that the annual eligibility renewal process has been suspended and that the change-mode reverification process will only allow for members' eligibility to be reverified. While Preterm Notices seeking additional information to enable TennCare to reverify eligibility are still

going out, no one is being terminated in change-mode[14] and no termination notices will be issued until the moratorium is lifted. The moratorium will lift when the President deems the national COVID-19 emergency to be over. Even at that time, disenrollments will not immediately commence. TennCare will need to develop and implement a plan to restart the required annual eligibility renewal and change information reverification processes and address the case backlog that will have built up during the moratorium. TennCare will also need to reprogram TEDS to once again allow renewal packets and termination notices to issue. Thus, even when the national emergency is over, it will take some time before TennCare will start disenrolling anyone from the TennCare program. Even if the disenrollment process could start the day after the national emergency ends, which for reasons outlined above would be impossible, the absolute soonest an individual could be disenrolled would be 20 days later because they would have to first be sent a Notice of Decision ("NOD") denying continued coverage and providing a 20-day advance notice of when their coverage will end. And then only if the individual didn't file an appeal in time to request continuation of benefits would eligibility be terminated. The timeline is even longer for individuals going through annual redetermination as they have 40 days to return their renewal packets and of course they also receive a 20-day advance termination notice before coverage ends. This all assumes that TennCare doesn't need to request additional information, which would take the timeline before an individual was terminated out even further.

[14] The exceptions to this are terminations for members who request to be disenrolled, deaths, and individuals who have moved out of state.

A. Redeterminations in Renewal-Mode

42. The process that TennCare, using TEDS, will follow for conducting renewal-mode reverifications once the COVID-19 moratorium lifts and TennCare has a plan in place to deal with the annual renewal backlog will be as follows:

a. First, TEDS will identify members who are due for an annual eligibility review. Only members who have not had their eligibility reviewed in the past 12 months and are eligible in a category for which annual renewals are required are included. This means that if a member has undergone a change-mode reverification within the last 12 months, and been reapproved for coverage, the member will not be identified as needing an annual renewal-mode eligibility reverification. And, any member who is eligible in an SSI or SSI-related category (Pickle, DAC, W/WW), per CMS guidance, is exempt from annual redeterminations. TEDS will automatically select the members for an annual renewal by looking for members whose annual certification period expires that month or expired in a previous month.

43. Once a renewal group is identified, TEDS will send those members through a "no-touch" automatic review process. This means that TEDS will attempt to auto-renew those members' eligibility in their current eligibility category based on the information TennCare has available or can access through approved databases and automatically populate into the member's case. Currently the databases that TennCare can access and use to auto-renew eligibility in renewal-mode are set forth above on page 7 in footnote 7.

44. Plaintiffs have suggested that TennCare not only should, but is required, to use SNAP and WIC data maintained by separate state agencies to determine eligibility as part of the *ex parte* process. That suggestion is contrary to both TennCare's CMS approved verification plan, a copy of which is attached hereto as Exhibit A, and CMS's guidance on the use of SNAP to

determine Medicaid eligibility. The verification plan, which TennCare had to submit to CMS for approval, specifically identifies WIC and SNAP as data sources that it will not be using. CMS is, therefore, fully aware that TennCare is not using these types of data in its eligibility determinations. This is consistent with CMS's guidance on using SNAP data, which sets forth very specific criteria that must be met in order to use that data. TennCare determined that it was not able to comply with those criteria at this time and therefore does not rely on SNAP data in eligibility determinations or redeterminations. The information that TennCare could get from WIC are data points for which TennCare takes self-attestation so that data source is also not relevant.

45. Members who can be auto-renewed through the no-touch process will receive a Notice of Decision ("NOD") informing them they are still eligible for coverage. The template for creating a NOD is attached hereto as Exhibit B. Any member who cannot be auto-renewed through the no-touch process will receive a pre-populated renewal packet. At the same time the renewal packet is mailed (or a notification of the renewal packet being available through the member portal is emailed if the member has chosen to receive electronic notices), TennCare will send a list of those individuals, sorted by relevant MCO, to the assigned TennCare MCOs in order for them to conduct outreach and provide assistance to their members as needed. MCO outreach varies by MCO, but generally the outreach includes the following:

a. Each MCO, using an auto dialer program, attempts to reach its members by phone and will leave a voicemail message alerting them of the need to renew their TennCare eligibility and how they can get assistance. The call attempts are made on different days and at different times to increase the chance of successfully reaching the members.

b. Some of the MCOs utilize text and email messaging for members who have agreed to receiving messages in that manner.

c. For members who are receiving case management through their MCOs, who are typically the more medically and behaviorally fragile members, case managers will contact those members directly to inform them about the redetermination process and offer assistance as needed.

d. For TennCare members who are receiving Long Term Services and Supports in their home or another residential setting, the plan going forward is to conduct their annual eligibility renewals at the same time the MCOs are in their homes conducting the required annual update to that member's plan of care.

46. The renewal packet and a cover letter will be addressed to each member's head of household and mailed to each member's head of household's address of record as well as any authorized representative in the case. If the packet is returned to TennCare as undeliverable, TennCare will re-mail the packet to the member's MCO-reported address, if different from the TennCare address of record. TennCare also pays the U.S. Postal Service ("USPS") to send automated updates to TennCare if a member changes their address with the post office. TennCare receives this address information through an interface and automatically updates a member's record, and the USPS will automatically forward the mail to the new address. TennCare will also re-mail a packet if a member contacts TennCare Connect and indicates they did not receive one.

47. A cover letter and renewal packet template that is used to build the notice sent to a member is attached hereto as Exhibits C and D. The cover letter tells the head of household whose eligibility in the household is being renewed and explains the ways in which their coverage can be renewed (online, by phone, by mail, and by fax). The renewal packet also informs the household that they can receive in-person assistance at a county DHS office. The letter also explains how the packet has been pre-populated with information TennCare already has, what to do if any of the

information is incorrect, how to attach paper if more space is needed, and what form to fill out if there is someone living in the house who does not have coverage and wishes to apply. The letter also explains how to request an instruction guide to help fill out the renewal packet, and the types of coverage available. The letter, like all of TennCare's notices, is printed in English and Spanish (unless the member has requested to receive only one language) and explains ways to get help with the letter if the recipient has a health problem, learning problem or a disability. It provides a special phone number for individuals with a mental illness that need help with the letter. Every letter is accompanied by two attachments, a Special Help notice and a Foreign Language Assistance notice, attached hereto as Exhibits E and F respectively. The letter states prominently in bold the due date for returning the information requested in the attached renewal packet.

48. The content of the renewal packet will vary depending on each member's specific circumstances and is individualized to those circumstances. For example, the information in the renewal packet will be different for a member in an institutional category of eligibility and a member who is in a non-aged, blind, or disabled category. Likewise, information that is included and requested about employment, resources and unearned income will vary again depending on whether TennCare has a record of any of this information. There is information that will only be included if TennCare is missing citizenship information on a member, information that will only be included if TennCare does not have a language preference recorded for a household, and information that will be included if there are individuals up for renewal who are younger than twenty-two (22). In total there are at least twenty (20) different variable fields that may or may not be included in the renewal packet depending on the specific renewal circumstances.

49. There is some information that is always included in a renewal packet. (This is indicated on the template by the notation "<Trigger Condition: Always>"). The renewal packet

always: (1) tells members where and how to provide the information being requested; (2) tells members that if they do not have all of the information being requested when it is time to send in the renewal packet, to send it anyway and that TennCare will determine what facts it still needs and send the member a follow up letter; (3) tells members ways they can get help with the packet by calling TennCare Connect, going online to TennCare's website, or going in person to their local DHS County office; (4) for members receiving care at a local community mental health center, the letter informs them that they can get help by contacting that center; (5) asks members if there are other people living with them who are not listed in the pre-populated fields identifying who TennCare has included in the member's household; (6) asks for the member to confirm their correct home and mailing address and phone number; (7) asks whether anyone in the household is in a hospital, nursing facility or needs nursing home care either in a nursing home or at home, and whether anyone in the household is getting Home and Community Based Services ("HCBS"); (8) asks whether anyone in the home needs hospice care, has Medicare and wants to get or keep getting Medicare cost sharing ("MSP"), and whether anyone in the household is pregnant or under twenty-one (21); and, (9) asks if during the last thirty (30) days did anyone receive any other income such as Social Security.

50. If a member going through renewal is receiving Long Term Services and Supports, the renewal packet will ask for confirmation about the type of support, the living location, and the date care started. Additional outreach for such individuals will also be conducted through nursing facilities in which those members reside. When TennCare provides its MCOs with the list of individuals being sent renewal packets, the MCOs in turn provide those lists to the relevant nursing facilities that then help their clients complete the renewal packets. Nursing facilities also have the

option of using the provider portal created in TEDS (called TennCare Access) to complete the packets online for their clients.

51. Members have forty (40) days to respond to this notice and provide the facts and information requested in the renewal packet. If the member returns the packet and it contains sufficient information to reapprove them in their current category or to find them eligible in a different category, TennCare will do so.

52. If a member returns the packet and the member has any type of social security income (this income is identified based on the information TennCare already has or that the member provided in the renewal packet), TEDS is designed to require an eligibility worker to review that member for all SSI-related categories, including the Pickle category. This entails looking at information TennCare has from SSA related to SSI-cash payments this member may have previously received.[15] For members who are potentially eligible in the DAC or W/WW category, there will be a flag in TEDS pulled from the SSA's SDX file and the SSI income data will be automatically loaded. The SSA does not provide such a flag for potential Pickle eligible individuals, so TEDS cannot automatically load that income data. To account for this, TEDS requires workers to conduct this review for anyone currently receiving social security income. The case cannot be authorized (i.e., resolved) until this review is complete. Once a case is authorized,

[15] TennCare does not ask about SSI income in the renewal packet in keeping with the expectation in the ACA that States, to the extent it is practicable, efficient, and cost effective, not require members to submit information the State has in its own records or can obtain electronically through an approved verification plan. TennCare has to send renewal packets to members who may be eligible in one of these SSI-related categories because current income and resource information must be verified and the State does not have the latest information for these members, many of whom may be transitioning from a category for which resource information never needed to be reviewed (e.g., an individual previously eligible in a MAGI category potentially transitioning into an SSI-related category).

TEDS will issue the member a NOD with an eligibility determination. If a member's coverage is being terminated because they are no longer eligible in any category, the NOD will tell them the reason their coverage is ending and the specific date their coverage will end along with the legal citation supporting this decision. It will also provide them with appeals rights, explain how to file an appeal, as well as the deadline to do so in order to keep benefits pending appeal resolution (a 20-day deadline), and the deadline for appealing on time (a 40-day deadline). If a member is maintaining coverage or receiving coverage in a new category, that information will also be provided in the NOD.

53. The appeal rights information included in a NOD explains how to file an appeal and provides the toll-free phone number to TennCare Connect, a link to TennCare's website where an appeal form can be downloaded, the mailing address, a fax number, and even information that an appeal can be submitted on plain paper. Members are informed that someone who has the legal right to act for them can also file an appeal on their behalf and are provided a link to the page on TennCare's website that identifies and provides contact information for Legal Aid and Legal Services offices that can provide assistance. The NOD provides examples, geared to the specific reason for the termination of coverage, of the types of mistakes that TennCare may have made that would entitle a member to a fair hearing. The notice informs members that "[a]n appeal is one way to fix problems in TennCare or tell us if you think we made a mistake." The notice does not tell members that they can request a good cause exception to the appeal filing deadlines because TennCare has determined, in its considered judgment, that including such information could be detrimental to some members who might then fail to file a timely appeal when they do not in fact have good cause. TennCare, however, does grant good cause exceptions and has done so 1,916 times since March 19, 2019.

54. If a member returns her renewal packet before coverage ends, but TennCare needs more facts or proof to determine eligibility, TennCare will send an Additional Information ("AI") notice. A sample template of such a notice is attached hereto as Exhibit G. AI notices may ask for information pertinent to the eligibility determination concerning topics such as income, resources, or medical expenses. Like the renewal notices, the specific contents of the AI notice will vary depending on a member's specific circumstances and how they have responded to the questions asked in the renewal packet. For example, proof of resources will only be requested if the renewal packet response identifies such resources or left those responses blank and the information is relevant to the eligibility determination; proof of medical expenses will only be requested in an eligibility category where they could be relevant to an eligibility determination. Members have twenty (20) days to respond to an AI notice unless an extension has been granted, which they routinely are when requested. Ultimately, if a member does not return whatever the necessary requested additional information was, TennCare will issue a NOD to that member terminating their coverage for a failure to provide the facts and information necessary to be reviewed fully and potentially approved for continued coverage. The NOD will also provide a termination reason, if possible, based on whatever information TennCare does have. For example, if TennCare was requesting verification of income because it appears the member is over income, the NOD will also explain that the member is losing coverage due to being over income.

55. All individuals on a case who are going through annual renewal will be included on the NOD. As a result, the NOD may contain both approvals and terminations or partial approvals (e.g., an MSP approval) and partial terminations (e.g., a termination of full Medicaid coverage). These decisions are based on each individual's specific circumstances so it is very possible that one member of a family may be approved while another may be denied. This is

particularly true if one individual on a case needed to submit additional information and did not, but that information was not needed for other individuals on the case.

56. If the information a member has provided in the renewal packet suggests the member may be eligible for Long Term Services and Supports ("LTSS"), either because they are in a nursing home, are receiving HCBS, or wish to receive nursing home or HCBS care, the follow-up AI notices and process TennCare will follow will be specific to that circumstance. As an initial step, an eligibility worker will look in what is known as TPAES (the "TennCare Pre-Admission Evaluation System") to see if a Pre-Admission Evaluation ("PAE") has been conducted for the member. A PAE verifying that a member needs the requisite level of care at home or in a nursing home is required for a member to be eligible for one of the LTSS programs. If a member has been in a nursing facility or other institution for 30-days and is requesting nursing home care, a PAE is not required. If a current PAE does not exist in TPAES and the member is requesting HCBS, the member will be referred to their local Agency on Aging and Disability ("AAAD") for assistance in getting a PAE. If the member is requesting nursing home care but has not met the 30-day confinement requirement, the nursing home is contacted to assist the member in getting a PAE. Ultimately for CHOICES enrollment, there must be both an approved PAE for the requested level of care and an approved Institutional Medicaid application. For members requiring an approved PAE, an Additional Information notice will be issued asking the member to submit a PAE along with required income and resource information. For members that do not require a PAE, an Additional Information notice will be issued asking the member to submit income and resource information.

57. If a member fails to timely return the renewal packet, she will be sent a Notice of Decision that her coverage will end on a specified termination date (20-days in advance) because

she failed to respond to the renewal packet. The member, however, is also told that she can still submit her renewal packet, and if she submits it, TennCare will review it to see if she still qualifies. If the member does in fact provide TennCare with the facts and information requested prior to the termination date, eligibility is reinstated while the renewal packet is reviewed and an eligibility decision made, and another NOD approving or terminating coverage is issued. If the member is again found to be ineligible, the NOD will provide full appeal rights and a new termination date. If the member returns the packet within 90-days of the member's termination date, but after she has been disenrolled, TennCare will review that information, determine eligibility, and, if the member is found eligible, backdate eligibility to the date of termination. The policy to backdate coverage is entirely elective on the part of TennCare. It is not required by federal law, as TennCare has a retroactive eligibility waiver, but TennCare nevertheless provides this benefit to its members. Any renewal packets returned after the 90-day reconsideration period will be treated as new applications. Plaintiffs are correct that TennCare does not include information in its notices about the 90-day reconsideration period, but similar to good cause, TennCare has determined in its considered judgement that including such information could be detrimental to its members by deterring them from getting their renewal packets in on time. The timely submission of renewal packets and the timely filing of appeals is in our member's best interest to help ensure they do not have a break in coverage.

58. TennCare provides its MCOs with a list of their members who are receiving failure to respond termination notices so that the MCOs can conduct additional outreach to those individuals. Once again, nursing facilities are notified so they can assist in filling out the packet, which they have an incentive to do if they wish to keep getting paid for that client's care.

B. Eligibility Reverifications In Change-Mode

59. The change-mode reverification process that will be in place once the COVID-19 moratorium lifts will be as follows:

a. Whenever TennCare receives a report of a change of information that could affect eligibility, an eligibility review will be triggered. Member reported changes include changes to income, resources, or household composition (e.g., a caretaker adult reporting she is no longer caring for a child). Natural changes include a member's birthday or pregnancy ending. Interface reported changes include the SSA providing information to TennCare that an individual is no longer receiving SSI-cash payments or has received a cost of living increase to their income.

b. A reported change will also trigger TEDS to issue a Case Change Notice, a template of which is attached hereto as Exhibit H. The purpose of this notice is to alert members to the change that was made, such as an update to an address, the addition of a person to the member's household, a change in name, date of birth, SSN, resources, or income (whether an increase or decrease) to name a few examples, so that if a mistake was made the member will know to contact TennCare. For changes to income, name, and SSN, for privacy reasons, the change notice does not detail the specific change that was made but informs the member to call TennCare Connect or go online to their member account to confirm the change that was made. These change notices are not notices of adverse action; no benefits are being changed and members do not lose eligibility based on these notices. It is only if the reported change impacts eligibility that a subsequent notice will be issued as discussed below.

c. Once a reported change triggers an eligibility review, the first step will be for TEDS to automatically assess eligibility for that member to determine whether the member can

be automatically reverified as eligible in their current eligibility category. If the member cannot be automatically reverified in her current category, the member will then go through an *ex parte* review process to determine whether she is eligible in another category. The databases that TEDS will interface with to verify information and attempt to determine eligibility will depend on what change has been reported. For example, if a woman reports an end to pregnancy, her income has already been verified and TEDS will not need to interface with any income-related databases. If, however, the reported change is related to income, TEDS would interface with databases to verify income information. For individuals transitioning from the SSI-Medicaid category because they have lost their SSI entitlement, TEDS will assess them for all categories of eligibility including other SSI-related categories (Pickle, DAC, W/WW). The process will be much as it was just described, except in this situation, if the SDX file received from SSA has a D or W (indicating a potential DAC or W/WW) indicator, the system will update the SSI-related detail screen in TEDS with the relevant date and income information and will evaluate the member for all categories of eligibility, including DAC or W/WW, without having to request additional information from the member. If a D or W indicator is not present on the SDX file, and the system is not able to auto populate a date SSI ended, then the system will update the SSI-related detail screen in TEDS with a "needs Pickle review" indicator and will trigger a Pickle task for worker evaluation when a member is not eligible in a category above Pickle. A case will not be authorized (meaning eligibility will not be terminated) if there is a Pickle task pending.

d. If a member is found to be eligible for Medicaid or MSP through automatic reverification and/or following an *ex parte* review, TennCare will send that member a NOD with information on these eligibility determinations. If the member is being transitioned from one type of MSP coverage to another lesser coverage, such as Qualified Medicare Beneficiary ("QMB") to

Specified Low-Income Medicare Beneficiary ("SLMB"), the NOD will inform the member that she can appeal that decision.

e. If a member's eligibility cannot be reverified, the next step will be to send that member a Preterm Notice. A template of that notice is attached hereto as Exhibit I. The notice informs members that "We checked our records and the coverage you have now will end soon. Why? We think your circumstances may have changed and you may not qualify anymore." If the member is transitioning from having previously received SSI, the Preterm Notice will tell them "You are no longer getting SSI checks and we need to see if you qualify for coverage in another way."

f. The Preterm Notice will ask nine specific questions geared to elicit information necessary to review for all categories of eligibility:

1. Do you live in a medical facility or nursing home? Or do you need home care either in a nursing home or at home?

   ☐ **Yes** ☐ **No**
   If yes, tell us who _____

2. Do you need hospice care?

   ☐ **Yes** ☐ **No**
   If yes, tell us who.__ _____

3. Do you live with at least one child under the age of 18 (or is the child 18 and a full time student) **and** are you the main person taking care of this child?

   ☐ **Yes** ☐ **No**

   If yes, tell us their name: _____ relationship to you: _____

4. Were you in foster care at age 18 or older in Tennessee?

   ☐ **Yes** ☐ **No**
   If yes, tell us who.__ _____

5. Are you under age 65 and getting treatment now or do you need treatment for breast or cervical cancer?

   ☐ **Yes** ☐ **No**

   If yes, tell us who.__ _____

6. Are you pregnant?

   ☐ **Yes** ☐ **No**

   If yes, have you or anyone else in your home gotten care or medicine in the last 3 months **and** have bills (paid or unpaid) related to that care or medicine? Or have you paid for any medical bills this month (no matter how old they are)?

   ☐ **Yes** ☐ **No**

   If yes, tell us who.__ _____

7. If you're under age 21 do you have medical bills?

   ☐ **Yes** ☐ **No**

   If yes, have you or anyone else in your home gotten care or medicine in the last 3 months and have bills (paid or unpaid) related to that care or medicine? Or have you paid for any medical bills this month (no matter how old they are)?

   ☐ **Yes** ☐ **No**

   If yes, tell us who.__ _____

8. Do you have or can you get health insurance through a job or through a family member's job?

   ☐ **Yes** ☐ **No**

   If yes, tell us who. _____

9. Do you get Social Security benefits now and also got SSI checks in the past?

   ☐ **Yes** ☐ **No**

   If yes, tell us who. _____

g. Members can respond to the Preterm Notice questions by phone, online, mail, or fax. The notice identifies the specific date by which they must respond (20-day deadline) and lets members know that if they do not respond by that deadline the coverage they have now will end.

h. TennCare recently added the ninth question in response to Plaintiffs' concern that SSI-related categories can be overlooked. We did not previously ask this question because the ACA discourages States from seeking information from members if it is available from another source such as SSA.

i. If a member responds to the Preterm Notice, does not answer yes to any of the questions, and TennCare has no other information in its files to support the member's ongoing eligibility, a NOD will issue with information on why the member is losing coverage (e.g. they are over-income), the details of the transition to a lower category of eligibility or a termination date in twenty (20) days from the date of the NOD, and appeal rights in both instances as described in Paragraph 53 above.

j. If a member responds affirmatively to any one of the nine questions, the workflow and what additional information TEDS will request will depend upon the specific question answered. If, for example, the member has answered affirmatively to the question "Do you live in a medical facility or nursing home? Or do you need home care either in a nursing home or at home?" that will prompt a referral to the relevant nursing facility or a AAAD to provide assistance in evaluating the member for eligibility in CHOICES or ECF CHOICES and will enable TennCare to evaluate the member for eligibility in the institutional Medicaid category.

k. If a member fails to respond to the Preterm notice by its specified deadline, TEDS will automatically issue a NOD with a termination decision that explains the member is losing coverage because of a failure to respond. The NOD will also inform the member if TEDS was able to approve the member in a lower benefit category. The NOD as previously explained will provide the specific termination date, all the relevant dates by which the member must appeal, and an explanation of how and where to file an appeal.

C. Assistance Provided to Members Going Through Annual Eligibility and Reverification Prompted by an Information Change

60. There are numerous ways in which TennCare provides assistance to its members, including its disabled members, who are going through either an annual eligibility renewal or a reverification of their eligibility following a reported change. First, the design of TEDS itself allows members to renew or reverify their eligibility from home (or really anywhere) over the phone or online. Individuals are no longer required to appear in person at a DHS office. Members can upload documents directly to TennCare via the online TennCare Connect member portal or by taking a picture with their phone using a mobile app, or alternatively may mail, fax, or submit information in person at a DHS County office. TEDS enables TennCare to conduct a much more robust *ex parte* process and to automatically verify information to a much greater extent than it could previously, which in turn reduces the burden on applicants and members to gather documents and submit proof to TennCare. For example, since March 19, 2019, TEDS has been able to automatically renew the eligibility for 128,229 members through the renewal-mode, no-touch, *ex parte* process and has reverified eligibility 2,079,055 times in change-mode without requiring any additional information from the member.

61. Two TennCare contractors operate the Call Centers, collectively known as TennCare Connect, that are open from 7:00 a.m. to 7:00 p.m. Central Time 5 days per week. TennCare Connect agents are trained to assist callers with questions about TennCare generally and about members' cases specifically. The TennCare Connect Call Center can help explain what a notice means; it can take responses to the Preterm Notice or Renewal Packet over the phone; and it can refer callers who request assistance to outside entities with whom TennCare contracts to provide assistance.

62. TennCare maintains a contract with the Tennessee Community Services Agency ("TNCSA") to provide advocacy services to TennCare applicants and members. TNCSA operates a contact center that uses a toll-free advocacy line for the purpose of providing information and assistance pertaining to TennCare eligibility, including assistance and information related to redetermination. In fact, two of the Plaintiffs in this case contacted or had someone contact TNCSA on their behalf.

63. One of the options available to individuals who call TNCSA's toll-free number is to select a line that that is specifically for individuals with mental illness and/or alcohol or drug dependencies. TNCSA also operates a toll-free line for persons with speech and/or hearing impairments. Information about the availability of this assistance is included in TennCare's notices.

64. TennCare maintains a contract with the Department of Human Services, which as discussed previously, enables TennCare applicants and members to receive in-person assistance in the completion of TennCare applications and/or renewal packets. DHS will accept applications, renewal packets and verification documents on behalf of TennCare and fax such documents to TennCare. Each DHS County Office has phones and computers available for applicant and member use as well.

65. TennCare maintains a contract with each of the state's nine Tennessee Area Agencies on Aging and Disability ("AAADs"). These contracts provide that for individuals whose eligibility is ending or for individuals who are going through renewal, the AAAD will assist in assessing eligibility for the CHOICES and ECF CHOICES programs. The contracts require the AAADs to assist members referred to them who are going through redetermination by conducting face-to-face visits within five business days of an initial phone contact, assisting members with

completing the renewal packet, assisting members with gathering and copying all required documentation for redetermination purposes, and assisting members with submitting the completed renewal packet and applicable supporting documentation to TennCare.

66. TennCare provides assistance for individuals with hearing impairments through a specialized phone line with the Tennessee Relay Services.

67. As discussed in Paragraph 58 above, TennCare has also engaged its MCOs to help with outreach to members going through redetermination.

68. TennCare includes information on the locations, phone numbers, and ways a member can obtain assistance in its notices and on its website.

69. I understand that Plaintiffs allege that the current eligibility redetermination process is at least as challenging for TennCare members to successfully complete as the process TennCare had in place following the Sixth Circuit's decision in *Rosen v. Goetz,* 410 F.3d 919 (6th Cir. 2005). That is simply not true. For all the reasons described above and in Paragraphs 9, 12 to 15, the TEDS redetermination process is far superior. The redetermination process cited by Plaintiffs was entirely paper-based, with no ability to auto-renew members without even requiring a renewal packet and no option to renew eligibility online or over the phone. Members were required to travel to a DHS County office or mail in their packets. The renewal packet was not pre-filled; the State had no way to verify income and resource information other than requiring the submission of paper verification documents; and the State had very little ability to tailor its notices to the specific circumstances of a particular case—all of which is possible using TEDS. In addition to all these features, TennCare also provides all the sources and types of assistance detailed above to its members going through redetermination.

V. The TennCare Eligibility Appeal Process Under TEDS

70. TennCare eligibility appeals, like applications and renewals, are processed and tracked in TEDS. The appeals module of TEDS became fully operational in May of 2019 and all new appeals (with the exception of some effective date appeals related to FFM applications) have been processed in TEDS since that time. TennCare accepts eligibility appeals over the phone, by mail, or by fax although the most common method is by phone through a call to TennCare Connect. Pursuant to federal regulation, appeals must be resolved within ninety (90) days from when the appeal is filed. Due to the volume of eligibility appeals TennCare receives, this deadline at times requires TennCare to prioritize certain appeals because it is not possible to schedule all of the appeals for hearing before the ninety-day deadline. Appeals in which the appellant does not have current eligibility (i.e., where there is no continuation of benefits ("COB")) are prioritized over appeals in which the appellant does have current eligibility such that missing the 90-day deadline will not have an adverse impact on that appellant. The oldest appeals without continuation of benefits are also prioritized over newer appeals.

71. Once an appeal is filed, it will go through the following general workflow:

a. The appeal request is filed by TennCare Connect in TEDS and forwarded to the TennCare Appeals Operation Group ("AOG") where the appeal is then registered and an appeal acknowledgment letter is issued from TEDS. A template copy of that notice is attached hereto as Exhibit J.

b. For appeals involving termination of benefits, AOG will determine whether the appeal has been filed in time for the appellant to receive continuation of benefits ("COB"). If so, COB will be granted pending the outcome of the appeal and the appellant will be informed of the COB decision in the appeal acknowledgement letter. If the appeal was filed too late to request

COB or doesn't involve the termination of benefits, AOG will next determine whether the appeal was filed timely (i.e. it was filed within 40 days of the Notice of Decision). If an appeal is timely, the acknowledgment letter will tell the appellant that she appealed after her coverage ended and that she will not have coverage during her appeal, but that if TennCare decides she qualifies through working her appeal, her coverage will be reinstated.

c. If an appeal is untimely, AOG will look to see if facts exist to support, in TennCare's discretion, a good cause exception to the filing deadlines. Because of the importance of filing deadlines in running an efficient and effective appeals process, particularly one that processes thousands of appeals every month, good cause exceptions are limited to extraordinary circumstances. A good cause exception to the filing deadline may be granted if the appellant alleges a hospitalization, incarceration, rehabilitation, references the loss of a spouse or child, being out of the country for an extended period of time, or a disaster such as a house fire that destroyed documentation and correspondence. Good cause also may be granted if the appellant tried to update her address but TennCare did not make the update and mailed the notice to the wrong place or if TennCare has other evidence of an error related to the mailing of a notice. Mere allegations of non-receipt without more, however, do not automatically qualify an appellant for a good cause exception. The fact that the appellant did not realize she had lost coverage for forty (40) or more days demonstrates that she likely did not have medical expenses during that time or she would have learned of the loss of coverage, and an appellant can immediately reapply for TennCare at any time and be reapproved if she is in fact eligible for coverage. Since March 19, 2019, out of the 147,897 eligibility-related appeals filed, 6,910 (4.7 percent) have been closed as untimely.

d. If an appeal is determined to be untimely and TennCare does not exercise its discretion to grant a good cause exception, a notice closing the appeal as untimely will be sent to the appellant. This notice informs the appellant that if she disagrees with the decision, she can file a petition for review in Chancery Court within 60 days. The notice also informs appellants that if they were appealing something else or if they think their issue is not fully resolved to call TennCare Connect and provides the appeal clerk's phone number. And every untimely notice includes the following language: "Do you have a health, mental health, or learning problem, or a disability? And did that problem make it hard for you to file your appeal on time? Or did something very bad happen to you or a close family member (like a serious illness or death)? If so, tell us in writing why you could not file your appeal on time. If we agree, your appeal may be reopened."

e. After the AOG clerk's office determines if an appeal is timely or not, the appeal is sent to the Resolution Unit where they review the case to determine whether there are any clear errors that can be corrected. If an error is found at this stage in the appeal, it will be corrected, whether the appeal is timely or not.

f. Assuming the appeal is timely filed or a good cause exception granted, the appeal will continue forward with a legal review. In addition to looking for potential errors, legal review determines whether the appeal raises a valid factual dispute. A valid factual dispute arises when the appellant alleges a factual mistake that if resolved in favor of the appellant would entitle the appellant to relief. Assertions that an appellant did not receive a NOD are typically deemed to raise a valid factual dispute entitling the appellant to a fair hearing. If it is not clear from the appeal what mistake of fact the appellant is alleging, AOG will issue a Valid Factual Dispute additional information notice requesting more information to clarify the factual mistake being alleged. A template copy of this notice is attached hereto as Exhibit K. An exception to the typical rule that

an assertion that a NOD was not received raises a valid factual dispute is when a termination is based on a failure to respond to a renewal packet. In those situations, as described in Paragraph 71, the process is to resend the packet via Federal Express to the address the appellant provided on appeal to enable the appellant the opportunity to submit the renewal packet during the 90-day reconsideration period. Those appellants will also be sent a Valid Factual Dispute additional information notice to provide more detail on what mistake they are alleging TennCare made.

g. Appellants have ten days to provide the requested information identifying the mistake of fact TennCare made. Examples of such mistakes are included in the notice. Allegations that TennCare incorrectly determined an individual was not eligible for coverage are treated as valid factual disputes, but assertions that challenge TennCare policy or the law (e.g., claims that non-citizens should be covered) are not treated as a valid factual dispute and such appeals will be closed. Applications of facts to law or policy are considered valid factual disputes. For example, questions of whether an appellant is over income, is a U.S. citizen or eligible immigrant, or is in a group TennCare covers would all be considered valid factual disputes if an appellant were denied for one of those reasons and would proceed to a fair hearing.

h. A template of the notice closing an appeal for failure to raise a valid factual dispute is attached hereto as Exhibit L. In this notice, appellants are told that if they disagree with the decision, they can petition for review in Chancery Court.

i. Of the 80,855 appeals related to a termination of benefits that have been filed since March 19, 2019, only 776 (or less than 1 percent) have been closed because they failed to identify a factual mistake TennCare had made. Of the thirty-five (35) named Plaintiffs, only three of them, J.S.T, A.S.T, and Clarissa Caudill had their appeals closed by the valid factual dispute process. In all three instances it was because they didn't respond to the request for

additional information about what mistake they were alleging TennCare made in denying/terminating their coverage.

j. During review by the Resolution Unit in AOG, TennCare will also resolve an appeal related to the failure to respond to a renewal packet (unless the appellant alleges she did return the packet in which case the appeal is not closed) by resending the renewal packet, via Federal Express, to the address provided on the appeal. A template copy of an appeal resolution notice is attached hereto as Exhibit M. If the appeal is filed before coverage ends, TennCare informs the appellant that her appeal has been resolved by sending another renewal packet and that the appellant will keep her coverage for now but needs to return the renewal packet by a specific date or her coverage will end. Further, the notice informs appellants that even if they do not get the renewal packet in before their coverage ends, they can return it by the 90-day deadline and TennCare will review it to determine if they still qualify for coverage. If the appeal is filed after coverage has already ended, the notice will inform appellants that their appeal is resolved by sending them another renewal packet and providing them the 90-day deadline for submitting that packet to have TennCare determine if they still qualify. The notice informs appellants if they get the packet in by that deadline and they still qualify, they will not have a break in coverage.

72. If an appeal presents a valid factual dispute and has not otherwise been able to be resolved, it will proceed to a hearing before an administrative judge. Before the hearing is held, the appellant will be sent a Notice of Hearing that informs the appellant about what happens at a fair hearing, the date and time of the hearing, how to request an in-person hearing, and how to contact TennCare with questions about the hearing.

73. Once a fair hearing is held before an administrative judge, an order will issue, and if the appellant disagrees with the decision, she can seek to have the Initial Order reconsidered by

the Administrative Judge. She can also seek review by the TennCare Commissioner's Designee, or she can file a petition for review in Chancery Court, or all of the above.

VI. Eligibility Statistics Under TEDS

74. Whether through the redetermination process (renewal-mode) or through an eligibility review following a reported change (change-mode), since March 19, 2019 TennCare, counting unique members (not instances), has conducted 1,597,891 eligibility reverifications (541,679 renewal mode redeterminations and 1,056,212 change mode reverifications).[16] As of April 17, 2020, there were only 179,037 individuals who were eligible for TennCare, CoverKids, or MSP on or after March 19, 2019, but are not eligible today (apart from individuals who voluntarily withdrew from the program, have died, or have moved out of state). Thus, only 11.2 percent of the total number of individuals who were subject to an eligibility review conducted by TennCare since March 19, 2019 are not currently on the program.

VII. The TEDS Mailing Process

75. I understand that Plaintiffs allege there are systemic issues with TennCare's mailing of notices to its members, but as I addressed in part in Paragraphs 36 to 38 above, TennCare has not found any evidence to support this assertion.

76. As explained in Paragraph 37, TennCare requires members to keep their addresses current with TennCare, informs members of that obligation in numerous ways, and enables members to update their address in real-time with one call to TennCare Connect or online through the member portal. In addition, TennCare has paid the United States Postal Service to furnish it

[16] This number reflects, to the extent possible, unique members who have gone through reverification. Since many members have gone through more than one eligibility reverification since March 19, 2019, if this number were not limited to unique members, to the extent possible, it would be significantly higher.

with address changes that are provided by members to the Post Office instead of TennCare and updates TEDS with that new address information as well. Further, when TennCare receives returned mail, it attempts to re-mail the information by looking for other possible addresses in numerous sources including MCO information, interChange, and ACCENT.

77. TennCare has also taken great pains to track the number and type of notices generated by TEDS against the number and type of notices that get electronically forwarded to the print vendor, Taylor Communications. Taylor tracks each notice it prints, places in envelopes and delivers to the commingler, Pitney Bowes, which is a certified workshare mail partner of the U.S. Postal Service. All of the mail contains bar codes that get scanned at each step in the process, and verification and reconciliation reports are created. A copy of the Document Output Management Plan detailing the steps involved in the file transfer, printing, and mailing of notices to members along with the quality control safeguards that are in place is attached hereto as Exhibit N. Taylor Communications in turn monitors Pitney Bowes to ensure that it is complying with its contractual obligations. Taylor uses two key metrics to track Pitney Bowes' performance. First, Taylor requires Pitney Bowes to maintain a minimum threshold of ninety (90) percent readability (with a 95 percent goal) on its first scans of mail by its presorting equipment. The higher percentage of mail read by the presorting equipment the first time, the quicker the mail is delivered. Second, Taylor tracks Pitney Bowes' cycle time for delivery of mail to recipients, which should occur within two to four days.

78. The only support that Plaintiffs have provided for their claim that TennCare is systemically misdirecting or not mailing notices to correct addresses are the assertions of some of the named Plaintiffs. But even in the majority of those cases an examination of the facts demonstrates the inaccuracy of those claims. For example, the following Plaintiffs or their

representatives—A.M.C., J.S.K., J.C.K., M.S.K., M.N.S., D.C.S., S.L.T., T.J.T., A.L.T., J.L.T., and F.T.—all admit to either contacting entities other than TennCare Connect to update or inquire about their address or only updating their address after receiving a termination notice. This is entirely inconsistent with the directions they have been provided by TennCare, their MCOs, and the notices they admit to receiving, all of which inform members they are to contact TennCare Connect promptly with any change in information, including address.

79. Other Plaintiffs claim in the Complaint not to have received notices, but a review of call recordings to TennCare Connect reveal they did receive the notice in question. This is true for at least Vivian Barnes and K.A.

IX. The Individual Named Plaintiffs' Cases

80. In preparing this Declaration, with the assistance of my staff, I have reviewed the case files in TEDS along with other information, such as notices, appeals records, and call recordings, available for each of the named Plaintiffs to understand what happened in each of these cases, to identify whether any problems they experienced were related to issues with TEDS, and if so, whether the issue had already been identified and corrected or is scheduled to be corrected in upcoming updates to TEDS. I also determined whether any issues they experienced arose from worker error, and if so, whether additional training was required.

81. As an initial matter, six (6) of the thirty-five (35) named Plaintiffs during the period relevant to this lawsuit (March 19, 2019) did not receive a termination notice and never lost their TennCare coverage. This includes Plaintiffs J.C.K., M.S.K., M.A.C., T.J.T., S.L.T., and F.T. Five (5) additional Plaintiffs never lost coverage – S.L.C., M.X.C., Y.A.D., E.I.L., and Kerry Vaughn. All but three of the named Plaintiffs (Vivian Barnes, Charles Fultz, and William Monroe) had Medicaid coverage at the time the Complaint was filed.

82. The three cases TennCare resolved after the filing of the Complaint were considered pursuant to TennCare's routine, long-standing practice of reviewing any case that is brought to TennCare's attention in which an error is alleged and correcting any errors that are found. Had Plaintiffs' counsel brought these three individual's cases to the TennCare General Counsel's attention rather than filing the Complaint (as they have with other cases including some of the other Plaintiffs) the same outcome would have occurred. As it stands, TennCare knows of no individual who is eligible for TennCare but is not currently enrolled or in the process of being enrolled. Of course, if any such individual came to TennCare's attention, TennCare would enroll that individual once she applied and was found eligible.

83. The remaining thirty-two (32) Plaintiffs had their eligibility restored or maintained through the normal processes in place to identify and correct errors that may arise in the processing of millions of eligibility cases every year. In my nearly twenty (20) years of experience with TennCare, I have learned that is inevitable that some mistakes will be made in processing the enormous volume of cases that TennCare handles each year. Despite best efforts to reduce worker error through training, oversight, and the automation of processes, human error will always be a factor as long as humans are involved. Likewise, despite our best efforts to prevent any system errors in the design and implementation of TEDS, it is inevitable that a system this complex that took years to design and build will have some unforeseen flaws or missed design elements that will have to be addressed, particularly during the first year of operation.

84. Based on my review of the Plaintiffs' cases, this is precisely what happened here. The Plaintiffs' cases reflect some unforeseen flaws or gaps in the TEDS design, some design errors that had already been identified and corrected or scheduled to be corrected before the Complaint was filed, as well as some idiosyncratic instances of worker error. Many of problems experienced

by Plaintiffs stemmed from the one-time conversion of eligibility data into TEDS, and thus will not recur. None of the Plaintiffs' cases reflect ongoing systemic problems that have not already been addressed or are scheduled to be addressed, and before TennCare corrected the errors found, they affected a very small percentage of TennCare members, as demonstrated by the hundreds of thousands of annual eligibility reviews and millions of eligibility reverifications after a reported change that TEDS has processed without incident.

Plaintiff A.M.C.

85. A.M.C. first obtained TennCare eligibility as a newborn but lost this eligibility on July 19, 2018 through the redetermination process in place prior to TEDS when her family failed to respond to a renewal packet. A.M.C. was sent the renewal packet multiple times. The first packet was sent on March 19, 2018, to her then address of record, which is the same address that was provided for her on the first appeal filed on her behalf. The second packet was sent on April 18, 2018, to a new address, which is the same as the address of record TennCare has for her today. When an appeal was filed, a reprint of the packet was sent via Federal Express to the same address as the first packet and another reprint of the packet was sent via Federal Express to the second address, which is her address of record today. A.M.C.'s family did not return any of these packets. Instead, on September 23, 2018, A.M.C. regained temporary TennCare eligibility through TennCare's hospital presumptive eligibility ("HPE") process. This process permits a qualified hospital to grant temporary TennCare eligibility, but A.M.C. was required to submit a full-Medicaid application in order to retain that eligibility. I understand Plaintiffs have alleged that A.M.C. did not have eligibility when she left the hospital, but that is not what TennCare's official records show. It is possible that A.M.C.'s eligibility did not show up in the system during the two

days she was in the hospital because at that time it took two days for the system transaction to display.

86. A.M.C.'s mother submitted a Medicaid application for A.M.C. on September 25, 2018, through the hospital revenue maximizer known as Parallon, in which A.M.C.'s mother identified Parallon as A.M.C.'s authorized representative. For this reason, subsequent notices were mailed both to A.M.C.'s address of record and to her authorized representative. The application process in place at that time, which was before TEDS, required this application to be submitted to and processed by the Federally Facilitated Marketplace ("FFM") (also known as heathcare.gov). The FFM determined Medicaid eligibility in MAGI categories for the State until TEDS was operational. Following that process, when the application was received by TennCare from Parallon, TennCare forwarded the application to the FFM. If the FFM had found A.M.C. eligible, the FFM would have provided that approval information to TennCare, which did not occur.

87. I also understand that Plaintiffs have alleged that A.M.C.'s eligibility was terminated without notice, but when an individual receives presumptive eligibility, like HPE, a termination notice is not necessary because HPE is temporary and the HPE approval notice clearly states that her eligibility will end on a specific date if she fails to submit a full Medicaid application.

88. Although A.M.C.'s eligibility should have ended pursuant to TennCare's Rules on November 24, 2018, A.M.C. actually retained her HPE until August 5, 2019 despite the fact that TennCare (erroneously as it was later discovered) had no evidence of a full Medicaid application having been submitted because TennCare provided an additional 90-days of presumptive eligibility to any member who converted into TEDS with presumptive eligibility, and A.M.C.'s presumptive eligibility had not been terminated at the time of conversion. TennCare's Rules also limit the number of times an individual can receive HPE to once every two years, which is why

A.M.C. could not receive HPE coverage again when she was hospitalized in September 2019 after her initial HPE segment was closed.

89. While I understand Plaintiffs have alleged that TennCare sent a renewal packet to A.M.C.'s family in early 2019, no such renewal packet was sent. Rather, in April 2019, A.M.C. and her family had their eligibility data converted into TEDS and, as noted above, A.M.C. was converted with ongoing eligibility in the hospital presumptive eligibility category. Her presumptive eligibility was closed when TennCare ran a batch update in TEDS to identify and close open segments of presumptive eligibility that had been held open for additional time at conversion.

90. On August 8, 2019 and September 25, 2019, two different NODs were issued to A.M.C.'s family ostensibly denying applications for TennCare by A.M.C. Both contained errors. In fact, A.M.C. had not applied for coverage at those times and the NODs erroneously stated that she was not in a group that TennCare covered. This notice defect stemmed from a programming flaw in TEDS that treated a member who previously had presumptive eligibility as applying in that category again and then finding the member ineligible for presumptive eligibility because the member did not qualify in that group. This notice defect issue was corrected with an update to TEDS as part of the TEDS 6.1 release on November 3, 2019.

91. No appeals were filed in response to these NODs. These notices were mailed to the attention of A.M.C.'s grandmother, who TennCare still had identified in TEDS as the head of household,[17] but the notice was mailed to A.M.C.'s current address of record that has been

[17] As I explain in Paragraphs 25(a), A.M.C., her mother and sister were converted into TEDS on a case with A.M.C.'s grandmother and uncle. These individuals had all been listed on an early FFM application as living in the same household and generally speaking it can be to a member's benefit to be in a household with more rather than fewer members for eligibility purposes, depending on the relationship.

provided by her mother to TennCare Connect on at least the following occasions – August 21, 2018, August 21, 2019, December 4, 2019, and December 17, 2019. In addition, these notices were mailed to the authorized representative, Parallon, that A.M.C.'s mother had identified to TennCare in an earlier application.

92. Even if the claim that A.M.C.'s mother never received these notices was accurate, following the issuance of the first denial notice, A.M.C.'s mother contacted the TennCare Connect Call Center on August 21, 2019. A.M.C.'s mother was offered the opportunity to appeal at that time, but contrary to what is alleged in the Complaint, she declined to appeal and subsequently never filed an appeal. As I discuss below, A.M.C.'s mother also did not file a new application until November 18, 2019. Further, even had A.M.C.'s mother chosen to appeal, A.M.C. would not have been eligible for continuation of her TennCare coverage because her last eligibility was presumptive eligibility, which is temporary coverage that is not entitled to COB. Applicants for new coverage also cannot get COB.

93. On November 8, 2019, when processing a task in TEDS that had remained open since adding A.M.C.'s newborn sister to the case on September 23, 2019, an eligibility worker proactively marked A.M.C. as applying for coverage even though no actual application had been submitted. The case was pended for income verifications for A.M.C.'s mother and an Additional Information notice requesting this information was mailed on November 13, 2019. It was not until November 18, 2019 that a new application was actually submitted for A.M.C., almost three months after A.M.C.'s mother contacted TennCare Connect and was offered the opportunity to file an appeal. These applications were in process when A.M.C.'s mother next contacted TennCare Connect on December 4, 2019, to inquire about the status of her daughter's applications. She was informed that TennCare was waiting for the return of proof of income, and the agent explained

that a letter from A.M.C.'s mother stating she does not work would suffice. No appeal was filed on this call. A.M.C.'s mother called TennCare Connect again on December 17, 2019, to inquire about the status of her daughter's applications, and she was once again informed that TennCare was waiting for proof of income. A.M.C.'s mother claimed on that call that this was the first she had heard of the need for proof of income even though she was told about it on her prior call. She was again informed that she could submit a letter explaining she has no income. TennCare Connect once again advised A.M.C.'s mother to submit a letter stating she had no income. The agent even explained how she could upload it on her smartphone with the TennCare Connect app. No appeal was filed on this call.

94. The requested proof of income was submitted through the TennCare Connect member portal on December 17, 2019. On that same December 17, 2019 call, however, A.M.C.'s mother asked that she and her daughters be moved into their own case separate and apart from A.M.C.'s grandmother and uncle. This generated another Additional Information notice requesting verification of A.M.C.'s and her sisters' residency. This again placed the case in a pending status while TennCare awaited a response to this information request, which was due by January 8, 2020. On February 18, 2020, TJC sent a letter to TennCare's General Counsel regarding A.M.C. and expressing concern that she was listed in the wrong household and that she should be eligible for Medicaid. In response to this letter, TennCare reviewed A.M.C.'s case and coverage was authorized on February 20, 2020. A NOD confirming this fact was mailed on February 24, 2020. No appeals related to these applications were filed. The only appeal filed was an effective date appeal filed on February 28, 2020, which was after A.M.C.'s coverage had been approved, alleging a gap in her coverage from November 17, 2019 to December 1, 2019. That segment of eligibility

had in fact been approved on February 21, 2020, so this appeal was ultimately closed because TennCare had already provided A.M.C. with complete relief.

95. During the processing of this case TennCare discovered that an application for Medicaid had been submitted on A.M.C.'s behalf to the FFM (this presumably was the September 25, 2018 application discussed above) and was sent to TennCare on October 22, 2018 to resolve an income inconsistency on the application. The application adjudication process in place prior to TEDS missed this application and thus it was never adjudicated. No delayed application processing appeal was ever filed with respect to this application, but with the discovery of this missing application, on February 21, 2020, TennCare backdated A.M.C.'s coverage to October 22, 2018 (the date the FFM application was submitted on her behalf) and all gaps in her eligibility were filled at that time.

Plaintiff K.A.

96. K.A. received TennCare coverage when a TennCare Connect member portal application was submitted for him on October 11, 2019. He was approved through TEDS "no-touch" automatic approval process for Child MAGI. There was a system issue with the no-touch process at the time, however, that did not properly link K.A. to his mother and thus did not identify the effective date of K.A.'s coverage as his date of birth, but instead, started coverage from the date his birth was reported. As I explain in Paragraph 35(b) above, the no-touch process issue had been identified long before the Complaint in this case was filed and was corrected with the release of TEDS 8.1.2 on April 16, 2020, and this same issue would not happen today.

97. Although it was an error to not start K.A.'s TennCare coverage from his date of birth, he was sent a NOD approving him for TennCare that clearly identified the start date of his coverage as October 11, 2019 and providing information on what to do if that start date was wrong.

He had until November 24, 2019 to file an appeal to correct the mistake. This notice was sent to the same address of record as K.A.'s mother, which is the same address at which the family had received numerous notices with no returned or undeliverable mail. On a call with TennCare Connect on December 18, 2019, J.Y. acknowledged receiving this notice.

98. An appeal was not filed until November 26, 2019, which was past the appeal deadline, so this appeal was closed as untimely on December 5, 2019. While information was provided in the appeal closure notice and in subsequent calls to TennCare Connect on how to file a petition for review in Chancery Court, no such petition was filed.

99. Although Plaintiffs allege that K.A.'s mother attempted to submit an appeal before the appeal deadline by calling TennCare Connect and that TennCare refused to process that appeal, there is no evidence in TennCare's files supporting this allegation. The first call to TennCare Connect following K.A.'s birth was on November 26, 2019. An appeal was filed on that call, and there was no reference to a prior attempt to appeal.

100. If this issue were to arise today, it would likely be identified through an enhanced escalation procedure TennCare implemented in late February/early March 2020 with TennCare Connect to identify and send to TennCare for resolution cases in which significant medical issues are alleged. TennCare has invested in a software solution that allows TennCare Connect agents, when they have identified a case presenting issues that should be escalated for further review, to input information directly into an online tool that creates tasks for potential resolution by TennCare eligibility workers. The TennCare eligibility workers have more ability than the TennCare Connect agents to resolve cases such as by approving eligibility and backdating coverage. It is precisely in cases such as K.A.'s where a medical issue is alleged that a case will be escalated to eligibility workers within TennCare to resolve as appropriate.

101. The other issue that K.A. experienced, which I discussed in Paragraph 15 above, was an unintentional termination of his coverage when a worker attempting to merge K.A. into the same case as his mother and brother failed to authorize eligibility for K.A. in the new case resulting in K.A. losing coverage when coverage in his old case was terminated. This error was identified and corrected on December 30, 2019 and TennCare backdated K.A.'s coverage to December 19, 2019, the date it was erroneously, albeit unintentionally, cutoff. As previously explained, to prevent this sort of worker error in the future, TennCare worked with Deloitte to modify TEDS to not allow coverage in an old case to be terminated until coverage in the new case is authorized. This fix will be part of the TEDS 10.0 release in July 2020.

102. J.Y. filed another appeal on K.A.'s behalf on February 13, 2020 to again try and correct his effective date of coverage. As a result of this appeal, K.A.'s coverage was backdated on February 27, 2020 to his date of birth, and his appeal was closed on March 5, 2020. In their Complaint, Plaintiffs complain that this appeal was closed without a hearing and without corrective action to restore K.A.'s coverage back to the date of his birth, but that is precisely what TennCare did, which is why the appeal closed, making this particular complaint puzzling. As for the fact that K.A.'s effective date of coverage shows up as December 20, 2019 in the TennCare Connect member portal, that is the start date of his coverage in the case he was merged with his mother and brother. K.A. has coverage back to his date of birth as reflected in another case in TEDS that was created specifically to provide him the correct effective date.

103. While TJC wrote to TennCare's General Counsel, Drew Staniewski, about K.A.'s case on March 4, 2020, by the time TennCare received that letter K.A.'s issue had been resolved. If that had not been the case, however, I am confident we would have reviewed his case and

corrected any errors as we do with any case that is brought to TennCare's attention through this informal process.

Plaintiff S.F.A.

104. Plaintiff S.F.A.'s data was converted into TEDS on March 19, 2019 identifying S.F.A. as eligible in the Child-MAGI category. On April 11, 2019, S.F.A.'s mother called TennCare Connect to update S.F.A.'s social security number, change her address, and report an income change. Following this call, S.F.A. was mailed an Additional Information request notice telling her family they needed to verify her father's income and that this information was due on May 5, 2019. This notice was mailed to the address that S.F.A.'s mother had just provided to TennCare Connect and at which S.F.A.'s mother acknowledges receiving other notices. This notice was not returned as undeliverable. When no response to this request for income verification was received, on July 3, 2019, TennCare mailed S.F.A. a NOD informing her family that her coverage would end on July 23, 2019 if an appeal was not filed by that date and that they had until August 12, 2019 to file a timely appeal.

105. As explained in Paragraph 35(f) above, S.F.A., like her mother should have been granted Transitional Medicaid in this NOD and not terminated from the Program when the requested income verifications were not provided. TEDS was updated as part of the eighth major release on February 23, 2020 to address this issue, so if this situation were to arise again in the future, this problem will not repeat itself.

106. On July 24, 2019, S.F.A.'s mother called TennCare Connect claiming she had just learned that S.F.A. had lost coverage and asking to file an appeal. An appeal was filed, but it was too late for S.F.A. to get COB pending the outcome of the appeal. When S.F.A.'s mother called TennCare Connect on August 15, 2019, to inquire about the status of her daughter's appeal, she

was told it was in progress but that she could always file a new application. A new application for S.F.A. was filed that same day.

107. On September 20, 2019, TennCare Connect received a letter from TJC regarding S.F.A., in which it was alleged that S.F.A. had not received the request for additional information and providing some of the requested income information for S.F.A.'s father. TJC subsequently sent a letter to TennCare Connect on October 18, 2019 alleging that S.F.A. had not received the NOD or several other notices although each one had been mailed to S.F.A.'s address of record, none were returned as undeliverable, and other notices to that address were allegedly received. TJC also emailed the TennCare Appeals Clerk on October 31, 2019, to inquire about the status of S.F.A.'s appeal, which had gone beyond the 90-day deadline for resolution. On November 4, 2019, the TennCare Appeals group granted a good cause exception because the appeal was taking more than 90-days to process, and COB was added to S.F.A.'s appeal. Then on November 6, 2019, after determining S.F.A.'s father had been reported as out of the household so his income was no longer needed and after verifying S.F.A.'s mother's income through an online data source, S.F.A. was reapproved for Child-MAGI coverage with her coverage backdated to July 24, 2019.

108. Subsequently, on December 10, 2019, TennCare received information from the SSA that S.F.A. was approved for SSI-cash benefits starting January 4, 2019 following an appeal to the SSA of an earlier denial. Upon receipt of this information, TennCare made S.F.A. eligible in the SSI Medicaid category. I understand that Plaintiffs allege that TennCare continued to deny S.F.A. coverage even though she was eligible by virtue of her receiving SSI, but TennCare in fact started her SSI coverage as soon as that information was provided to TennCare by the SSA. S.F.A. has no gap in her Medicaid coverage. S.F.A. went from coverage in the Child-MAGI category directly into the SSI-Medicaid category. Plaintiffs also incorrectly allege that S.F.A. was

terminated from TennCare on January 28, 2020 without notice, but S.F.A. was not terminated from TennCare. The coverage in her Child-MAGI case was closed because she gained SSI-Medicaid eligibility. When her appeal was resolved on November 6, 2019, S.F.A.'s coverage was backdated to July 24, 2019 and she has had continual coverage since that date.

Plaintiff Vivian Barnes

109. Ms. Barnes's eligibility data was converted into TEDS on May 18, 2019, as a non-SSI cash recipient, meaning she had previously, but was no longer, receiving SSI-cash payments. She was identified as being QMB eligible. As explained above in Paragraph 35(a), while it was determined that Ms. Barnes was in eligible for SSI-Medicaid based on information later received from SSA, the information TennCare had at the time of conversion of eligibility data into TEDS from the SSA's SDX file indicated she was no longer eligible for SSI Medicaid because she was over the SSI resource limit. This change prompted TEDS to create a non-SSI transitional case for Ms. Barnes and to send her through the *ex parte* reverification process to see if she qualified in any other category.

110. The creation of this new case caused a NOD to issue on June 11, 2019, telling Ms. Barnes she was eligible for Medicaid and denying her QMB because she "was already getting TennCare or CoverKids in another case." As explained in Paragraph 35(d) above, this should not have occurred, and TEDS has since been reprogrammed to ensure that NODs will not be issued when the *ex parte* reverification process initiates.

111. A Preterm Notice was also issued on June 11, 2019. That notice informed Ms. Barnes that "Your coverage will end soon" and gave as the reason that "You're not in a group covered by TennCare or CoverKids." The notice identified one of those groups as "people who are getting or who used to get SSI checks." Ms. Barnes responded to this notice on June 21, 2019.

112. An eligibility worker processed Ms. Barnes's response, including processing a "Pickle task" that TEDS generated to alert the worker to the need to evaluate Ms. Barnes for the Pickle category. The eligibility worker, however, erroneously closed that task and marked Ms. Barnes as being "not-Pickle." TEDS then applied eligibility rules using that designation and Ms. Barnes was not found eligible in any other category and was thus issued a NOD on July 22, 2019, approving her for ongoing QMB coverage, but terminating her Medicaid coverage because "You're not in a group covered by TennCare or CoverKids." The notice again identified one of those groups as "people who are getting or who used to get SSI checks." The NOD gave Ms. Barnes until August 12, 2019, to appeal and keep her coverage during her appeal and until August 31, 2019, to file a timely appeal. No appeal was filed.

113. Ms. Barnes' daughter, Ms. Surrett, next contacted TennCare Connect on October 28, 2019, because she had questions about her mother's eligibility. Contrary to what Plaintiffs' alleged in their Complaint, Ms. Surrett acknowledged on this call that Ms. Barnes did receive the prior July 22, 2019 notice informing her that her Medicaid was ending on August 31, 2019, but that they did not appeal because Ms. Surrett read the notice to indicate that her mother still had coverage (and she did have QMB coverage). On this call, Ms. Surrett did not request to file an appeal and no such request was denied. The TennCare Connect agent did not suggest an appeal because it would have been dismissed as untimely; instead, the agent suggested that Ms. Barnes should reapply. The agent attempted to determine whether there were other eligibility groups in which Ms. Barnes could qualify and referred Ms. Surrett to the AAAD to inquire about getting in-home care for her mother. Ms. Surrett was also identified in TEDS as Ms. Barnes authorized representative on this call.

114. Ms. Surrett contacted the Call Center again on November 1, 2019, to inquire about her mother's benefits and to find out if she needed to reapply. At no time on this call did Ms. Surrett request to file an appeal, and no such request was denied. The agent advised Ms. Surrett that because her mother received a notice telling her to appeal by August 31, she would recommend reapplying for benefits. She also advised Ms. Surrett to contact the Social Security Administration and see if they could submit an application for her mother. The agent also offered to connect Ms. Surrett to TennCare's Application Processing Call Center to submit a new application. In these situations, we do advise agents to offer a new application to preserve the application date, because even if an appeal is filed, that appeal may not be successful and the earlier a new application is filed the sooner an individual may receive benefits and the earlier the effective date of that coverage will be. Had Ms. Surrett, nevertheless, asked to file an appeal, that request would have been granted.

115. An application was submitted for Ms. Barnes on November 15, 2019 through the TennCare Connect member portal. The application correctly identified Ms. Barnes as receiving both SSI and SSDI, but unfortunately, once again a worker failed to properly process this application and once again Ms. Barnes was approved for QMB coverage but denied eligibility for TennCare because she was not found to be in a group covered by TennCare. This same worker also failed to finish processing Ms. Barnes's November 15, 2019 application (it was sent for "authorization" but never actually "authorized"), so the notice informing Ms. Barnes she was again denied for Medicaid did not issue until March 2, 2020. This notice, however, like her previous notices contained appeal rights alerting her and her authorized representative to file an appeal if they thought TennCare had made a mistake. No appeal from this denial was filed.

116. Ms. Barnes did file an earlier delay appeal on January 3, 2020 because she had not received a decision on her November 15, 2019 application. That appeal was processed and closed when the delay Ms. Barnes had appealed about was resolved by the adjudication of her application. Ms. Barnes was issued a NOD on January 15, 2020 finding her eligible for continued QMB coverage. That notice contained appeal rights, but again no appeal was filed.

117. On January 23, 2020, TJC called TennCare Connect on behalf of Ms. Barnes to inquire about her eligibility. The TJC representative was informed that Ms. Barnes was approved for QMB but denied for Medicaid. The agent offered to file an appeal for Ms. Barnes and the TJC representative declined. On this call, and subsequent calls to TennCare Connect by TJC on January 31, 2020 and February 21, 2020, no request to file an appeal was made.

118. Ms. Barnes also received a NOD on March 2, 2020 denying her eligibility for Medicaid. That notice contained appeal rights, but again no appeal was filed.

119. Throughout this period, it is my understanding that no one from TJC attempted to contact TennCare's General Counsel's office to try to resolve Ms. Barnes' case despite the fact that for years an informal process has been in place by which advocates, including TJC, could bring cases to TennCare's attention that needed special review. I personally have worked on several such cases. Certainly this case, with its unique set of facts (TennCare's system showing Ms. Barnes ineligible for SSI and Ms. Barnes having confirmation from SSA that she is receiving SSI) was the kind of idiosyncratic case I would have expected TJC to bring directly to the General Counsel's attention. We did not hear about this issue, however, until Ms. Barnes was identified as a Plaintiff in this case. When we learned of her allegations, TennCare did what it normally would do (and would have done had TJC contacted TennCare's General Counsel), and reviewed Ms. Barnes case and reapproved her for Medicaid.

120. There certainly were mistakes made in Ms. Barnes' case. It was worker error to miss the fact that she was receiving SSI, and the worker should have at least reviewed her for Pickle eligibility, or better yet, escalated the issue so the problem with her SSI data could have been identified sooner and corrected with SSA. Her application should have been processed in a more timely manner, and her delay appeal should have provided a complete response on her eligibility decision, rather than assessing her for QMB only. It is my view, however, that it is the incredibly unique posture of her case that contributed to these errors. Eligibility workers do not process SSI eligibility, so it is not something they have to deal with or confront problems about on a regular basis. SSI eligibility is determined by the SSA and loaded automatically into TEDS. TEDS erroneously identified Ms. Barnes as a non-SSI recipient because the SSA's SDX file indicated Ms. Barnes was no longer receiving SSI, and that initial error in the SSA data set off an unfortunate chain of events. As explained in Paragraph 35(a), working with the SSA, we have identified a solution to this problem. I am confident that this specific set of circumstances is highly unlikely to occur with Ms. Barnes or anyone else again. Of course, had Ms. Barnes filed an appeal based on any of the NODs she received, this issue with her SSI coverage likely would have been caught sooner and resolved.

121. In the extremely unlikely event that Ms. Barnes were to encounter a problem with her SSI-eligibility again in the future, apart from TennCare's appeal process, TennCare's improved escalation process would be much more likely catch this issue and route the case to a specialized team of eligibility workers within TennCare to resolve.

Plaintiff Clarissa Caudill

122. Ms. Caudill's eligibility data was converted into TEDS on May 18, 2019 indicating she was no longer receiving SSI-cash payments based on data from the SSA's SDX file. Based on

this, a transitional SSI Medicaid case was opened for her to enable TEDS to send her through the *ex parte* process to determine if she qualified for another category of Medicaid. On May 30, 2019, a Preterm Notice issued informing Ms. Caudill that her coverage would be ending soon but that TennCare wanted more information to see if she still qualified. Her coverage was identified as ending because she was not in a group covered by TennCare, which listed people who are getting or used to get SSI checks. Ms. Caudill was given until June 19, 2019 to respond to the Preterm Notice and informed that if she did not her coverage would end.

123. An appeal was filed on June 13, 2019, and Ms. Caudill was provided continuation of her Medicaid benefits pending the outcome of that appeal. The appeal acknowledgement letter issued on June 19, 2019, did incorrectly tell Ms. Caudill that she appealed after her coverage had ended based on system defect at that time that was not allowing appeal workers to update the "COB timely" field. This defect resulted in the wrong information on COB being included in the appeal acknowledgment notice. However, correct information about the status of her continuation of benefits was issued on July 31, 2019, and as discussed above in Paragraph 35(e), the system defect that caused this issue was corrected on August 25, 2019 in the TEDS 5.1 release.

124. On June 24, 2019, TennCare received Ms. Caudill's responses to the Preterm Notice questionnaire in which she answered no to all questions but one. In response to the question about whether she was getting treatment now or needed treatment for breast or cervical cancer, Ms. Caudill responded yes, but wrote in that she had stage-4 COPD and other health issues. Based on the information provided in the Preterm Notice response, on August 15, 2019, a NOD was issued terminating Ms. Caudill's Medicaid coverage starting September 4, 2019. The reason given was that she was not in a group covered by TennCare, which listed people who are getting or who used to get SSI checks. She was given until September 4, 2019 to appeal and keep coverage during

her appeal and until September 24, 2019 to file a timely appeal. Ms. Caudill filed a second appeal on August 19, 2019.

125. In response to the first appeal that Ms. Caudill filed, TennCare sent her a letter, mailed to her address of record to which all other notices had been sent, asking her to identify the mistake she thought TennCare had made in ending her coverage. It provided a list of examples of what could constitute a mistake that included TennCare saying "you are not in a group we cover. But you think you are in a group we cover. Some of those groups are: children under age 21, pregnant women, caretaker relatives of minor children, people who are getting or who used to get SSI checks . . ." She was given until August 20, 2019 to respond to this letter. No response was sent in and the notice was not returned as undeliverable, so on September 6, 2019, her appeal was closed because she didn't give TennCare the facts needed to work her appeal. Her COB was discontinued at that same time. This was an error. COB should have continued because of the second appeal, but the worker who closed Ms. Caudill's first appeal did not update the COB field in TEDS based on the erroneous assumption that Ms. Caudill's COB would automatically continue without further action. The appeal closure notice informed Ms. Caudill that if she disagreed with the decision, she could file a petition for review in Chancery Court. No such petition was filed.

126. On that same day, Ms. Caudill called TennCare Connect to inquire about her appeal being closed and was informed her coverage was not active. It was suggested she reapply, which Ms. Caudill did through the TennCare Connect member portal. She then submitted another application through the TennCare Connect member portal on September 30, 2019. Both of those applications were denied through the TEDS no-touch authorization process because Ms. Caudill did not group into any category of Medicaid eligibility. It is important to reiterate here that an individual cannot apply for SSI Medicaid directly to the State. TennCare grants SSI-Medicaid

automatically to anyone the SSA has identified as being in an active SSI-cash payment status, which based on the information TEDS had at conversion from the SDX file did not include Ms. Caudill. TEDS does not evaluate for SSI-eligibility upon a new application because that is not how an individual obtains SSI-eligibility. Entitlement to SSI is determined exclusively by the SSA. Ms. Caudill also was not eligible for any SSI-related categories (Pickle, DAC, W/WW) because she is not receiving any social security income, which is why TEDS denied her as not being in any group that TennCare covers.

127. On October 17, 2019, TJC submitted a letter to TennCare Connect and TennCare Appeals on Ms. Caudill's behalf in her open second appeal informing TennCare that Ms. Caudill receives SSI benefits and should be eligible for TennCare. The letter asked TennCare to determine why it is not recognizing her SSI eligibility. This was the first time an issue with Ms. Caudill's SSI benefits was raised with TennCare, and on November 6, 2019, Ms. Caudill's SSI information was manually reviewed and it was confirmed that she was receiving SSI-cash payments so a new case was created to restore her SSI-Medicaid coverage and the gap in her coverage was closed. A NOD approving her coverage was mailed to Ms. Caudill on November 8, 2019. On November 12, 2019, a notice was sent closing her August 19, 2019 appeal because the issue she had appealed was resolved and she had been provided complete relief.

128. This case presents a very uncommon problem in which there was an issue with the SSI data on the SDX at the time of conversion into TEDS. Because conversion is not going to happen again, this issue will not repeat itself. Further, it appears that the appeals process worked as intended in providing an opportunity to identify a mistake that had been made and providing TennCare the opportunity to fix that mistake, which TennCare did months before the Complaint was filed. Finally, as explained in Paragraph 35(a) above, TennCare has worked with SSA officials

on a process to identify any other individuals whose information on the SDX may have been wrong at the time of conversion so that TennCare can correct any errors that may still exist.

Plaintiff Rhonda Cleveland

129. Ms. Cleveland's eligibility data was converted into TEDS on May 18, 2019 identifying her as an active SSI-cash recipient. Ms. Cleveland remained in that status until information was received from SSA on August 26, 2019 that she was no longer receiving SSI-cash payments. This triggered the *ex parte* process on November 12, 2019 for Ms. Cleveland. While TEDS did recognize that Ms. Cleveland was potentially eligible in the SSI-related Widow/Widower category, due to an error in how TEDS was loading social security data from the SDX into TEDS, social security income did not get loaded into Ms. Cleveland's case. TennCare worked with Deloitte on reprogramming TEDS to address this issue. The correction was implemented in TEDS on May 15, 2020 with the 9.0.1 release as I discuss in Paragraph 35(i) above.

130. Because no social security income was loaded into TEDS for Ms. Cleveland, which is required for eligibility in the SSI-related categories, TEDS generated a Preterm Notice for her on November 14, 2019, with a December 4, 2019 response date. The notice informed Ms. Cleveland that "you are no longer getting SSI checks and we need to see if you qualify in another way." Ms. Cleveland called to complete the Preterm questionnaire on November 19, 2019. Because her social security income information had not loaded into TEDS, it appeared that she was ineligible for Medicaid because she was not in any group that TennCare covers, and a NOD terminating her coverage starting December 30, 2019 was issued for that reason. The notice informed Ms. Cleveland that she had until December 30, 2019 to appeal if she wanted to keep her coverage pending her appeal. An appeal was not filed until January 8, 2020.

131. TennCare acknowledged Ms. Cleveland's appeal on January 10, 2020, but because she had not appealed in time for COB, she could not keep her benefits pending the appeal. On March 4, 2020, TennCare mailed Ms. Cleveland a notice informing her that TennCare was sending her appeal to hearing. On March 15, 2020, the TennCare Appeals group reviewed her case in preparing for hearing, updated her social security information, and approved her for ongoing coverage in the W/WW category. TennCare backdated Ms. Cleveland's eligibility to the date she lost coverage. She has no gap in coverage, and her appeal was closed because she was provided complete relief.

132. Ms. Cleveland's case represents an example of the appeals process working as intended. When she was erroneously denied coverage because TennCare did not recognize her eligibility in the W/WW category due to the TEDS defect described above, she was given an opportunity to file an appeal and raise that mistake with TennCare. Upon processing her appeal, the mistake was corrected, and her coverage was restored. Plaintiffs' assertion that she remains at risk of harm because she will be subject to redetermination each year is wrong for at least four reasons. First, SSI-related categories are not subject to the annual redetermination process based on CMS guidance. Second, Ms. Cleveland did not lose her coverage due to annual redetermination, but because TEDS did not correctly react to her initial receipt of Widow/Widower benefits from SSA. Third, because her initial entitlement to W/WW benefits from SSA is a one-time occurrence it will not repeat itself since she is now on TennCare in the W/WW category, and fourth, TennCare has modified TEDS to address the defect that caused TEDS to not identify Ms. Cleveland's eligibility in the W/WW category in the first instance.

Plaintiff S.L.C.

133. Plaintiff S.L.C.'s eligibility data was converted into TEDS on May 18, 2019 with eligibility in the Institutional Medicaid category along with an indicator pulled from ACCENT that she was residing in a nursing home. This was not accurate as S.L.C. was actually residing at home with her parents. S.L.C. was eligible in the Institutional Medicaid category because she is enrolled in the ECF CHOICES program and receiving HCBS. On June 26, 2019, S.L.C. and her father called TennCare Connect to inform TennCare that S.L.C. was moving and to update her address. As part of that update to S.L.C.'s residential address, the TennCare Connect agent changed her living arrangement indicator from "nursing home" to "home" rather than to "HCBS," which would have been accurate. With no HCBS indicated and no HCBS information having been loaded into TEDS at conversion, this triggered TEDS to issue a NOD on August 12, 2019, approving S.L.C. for QMB coverage and issuing a Preterm Notice to S.L.C. because it appeared like she was no longer in a group that TennCare covered and more information was needed to see if she could qualify in another category. Since S.L.C. does receive social security income, TEDS did generate a Pickle review task to alert the eligibility worker processing her case that she needed to be screened for SSI-related categories. When the eligibility worker completed this task, the worker missed the fact that S.L.C. should actually still be eligible in the Institutional category as she is enrolled in and receiving HCBS through the ECF CHOICES program. The worker also incorrectly screened S.L.C. for Pickle, missing the fact that if S.L.C. were eligible in any SSI-related Medicaid category it would be as a DAC not a Pickle. However, no DAC indicator had been loaded into TEDS so there was nothing to prompt or otherwise notify the worker to review for DAC eligibility.

134. Although S.L.C. timely responded to the Preterm notice, she incorrectly answered "no" to the question about whether "do you need home care either in a nursing home or at home?" Based on her response and the erroneous Pickle review done by the eligibility worker, a NOD was mailed to S.L.C. on September 11, 2019 informing her that her Medicaid coverage would end on October 1, 2019 unless she appealed by that date. A timely appeal was filed on September 16, 2019, and COB was granted.

135. On October 29, 2019, TJC submitted a letter to TennCare appeals explaining why they believed S.L.C. was eligible as a DAC with no mention being made of Institutional Medicaid or S.L.C.'s enrollment in the ECF CHOICES program. On November 27, 2019, S.L.C.'s SSI information and social security information were reviewed by the TennCare Appeals group, she was granted benefits as a DAC, and her appeal was closed. S.L.C. never lost Medicaid coverage and was never at risk of being disenrolled from the ECF CHOICES program.

136. While it was certainly correct to continue S.L.C.'s Medicaid coverage and close her appeal when her coverage was approved, she should not have been placed in the DAC category but rather should have had her Institutional Medicaid category reinstated as that is the category for individuals receiving services through the ECF CHOICES program. Because this problem originated with an issue in the "living arrangement" data in TEDS from conversion, and conversion has already happened and will not reoccur, the chances of S.L.C. experiencing the same problem in the future is extremely unlikely. And, while we would prefer for there to be no worker errors, this case demonstrates the appeals process working as intended. It provided an opportunity to appeal a mistake and have that mistake addressed. Further, to prevent the possibility of a similar update to a living arrangement causing anyone to risk losing coverage, we are working on a modification to TEDS that will trigger a notification whenever an LTSS living arrangement is

changed to "home" so the TennCare Eligibility group, which specializes in Institutional eligibility, can validate this is an appropriate transition out of the Institutional category.

Plaintiff D.D. and Family

137. D.D. and her family's eligibility data was converted into TEDS on April 27, 2019. As explained in Paragraph 25(b) above, D.D.'s family was incorrectly merged with another family during conversion because they both had the same case number in interChange. This stems from an error that occurred in 2017, when a non-related baby was added to D.D.'s case through a manual, keying error by a worker when adding D.D.'s then-newborn child to her case. This caused the two families to have the same case number and to have their eligibility converted into TEDS together. As a result of this incorrect merger, TEDS did not have accurate address information for D.D. and her family and was sending all notices to an incorrect address. Because D.D. was not getting notices, she understandably did not respond to requests for information. The lack of response, however, caused TEDS to terminate her coverage and that of her five children in error on August 26, 2019.[18]

138. D.D. called TennCare Connect on August 29, 2019, when she learned that her daughter, T.E.W., did not have coverage. D.D. was informed by TennCare Connect that her whole family had lost coverage. Because there did not appear to be a case for D.D. and her family in the system (at this point they had been removed from the other family's case at that family's request), the agent advised D.D. to apply for coverage. D.D. submitted a new application over the phone that day. No request to file an appeal was made and no request to appeal was denied. That said,

[18] Technically, D.D.'s son Y.A.D. never lost coverage. He was issued a termination notice (mailed to the incorrect address on August 26, 2019) but he never in fact lost coverage because TEDS granted him Transitional Medicaid until his coverage was updated and added to his family's case on March 4, 2020.

given the issues being alleged, the TennCare Connect agent should have escalated this case for further review. It is my belief that under the enhanced escalation process we have in place now that a case such as this would get elevated to TennCare directly for resolution.

139. D.D. did file an appeal through a call to TennCare Connect on September 4, 2019. On October 17, 2019, following a good cause review based on the allegations of TennCare sending the notices to the wrong address, COB was granted to D.D. and her five children. On November 22, 2019, the Appeals group approved ongoing benefits for D.D. and her children. Their appeals were closed with notices sent to the family informing them of this fact.

140. While there is no dispute it was an error for D.D. and her family to have been merged with another family upon conversion into TEDS, this was a one-time, idiosyncratic mistake related to the families having the same case number in interChange. Again, while there is no dispute D.D.'s family should not have lost coverage between August 27, 2019 and October 17, 2019, when COB was granted, the appeals process provided an opportunity for D.D., and later her representatives at TJC, to raise the mistake with TennCare, have TennCare review the facts of this case, and correct the error.

Plaintiff Charles E. Fultz

141. Mr. Fultz's data was converted into TEDS on May 18, 2019, from interChange as an active SSI-cash recipient. Because Mr. Fultz was not in fact receiving SSI-cash payments, on June 6, 2019, TEDS opened up an SSI-transitional coverage case for him to send him through the *ex parte* process in order to review him for other possible categories of eligibility. At the time the *ex parte* review was ran in TEDS, no social security income had been received and added to Mr. Fultz's case from the SSA SDX or BENDEX data. Because no social security income data was present at the time the *ex parte* process was ran, TEDS designated Mr. Fultz as "not Pickle." This

meant a "Pickle task" was not created to alert an eligibility worker to review him for the Pickle category of eligibility. This also caused TEDS to issue a Preterm Notice to Mr. Fultz that same day. The BENDEX data was received June 12, 2019 and loaded to his case at that time, but this was after Mr. Fultz was designated in TEDS as "not Pickle."

142. Like Ms. Barnes, Mr. Fultz received a NOD informing him that he had continued Medicaid but was denied QMB on the same day that he received the Preterm Notice informing him that his coverage would end soon and that TennCare needed more information to determine whether he was eligible in another category. As noted above, the error with the NOD issuing in these circumstances has been corrected and that notice would not issue today.

143. Mr. Fultz responded by phone to the Preterm Notice on June 19, 2019, but due to TEDS previously designating him as "not Pickle" TEDS continued to treat Mr. Fultz as not grouping in the Pickle eligibility category and no new "Pickle task" prompting review for the Pickle eligibility category was generated. This meant that when Mr. Fultz's case was finalized on July 1, 2019 and a NOD terminating his benefits was issued on July 3, 2019, the reason identified for why he was no longer eligible was that he did not group into any category covered by TennCare. This programming gap in TEDS is being corrected with the tenth major release in July 2020. Following that update to TEDS, both a Pickle task requiring a review for eligibility in the Pickle category will be created when TEDS receives updated information about a member's social security income and a prior designation as "not Pickle" will be reset to prevent the system and workers from overlooking this potential eligibility category.

144. The NOD mailed to Mr. Fultz on July 3, 2019, informed him he needed to appeal by July 23, 2019 to keep coverage during his appeal, and that he had until August 12, 2019 to file

a timely appeal. The NOD contained information on how to file an appeal and provided in bold several times the number for TennCare Connect to call to appeal or get assistance.

145. On August 9, 2019, Legal Aid submitted a letter to TennCare filing an appeal on Mr. Fultz's behalf, but this letter got mislabeled by a worker as proof of insurance instead of an appeal. As a result, an appeal was not actually opened. Had an appeal been correctly opened, Mr. Fultz would not have been eligible for COB, as he missed that filing deadline. On August 9, 2019, Mrs. Fultz and a TJC representative called TennCare Connect to check on the status of Mr. Fultz's eligibility and to have TJC added to his case as his authorized representative. On this call the TennCare Connect agent informed TJC and Mrs. Fultz that an appeal was not showing up in the system, but since the appeal was filed that day, it could take a day or two to register. The agent's statement was true in most circumstances, and if Mrs. Fultz or TJC had called back a few days later, they would have realized that the appeal was not filed. There is no record, however, of TJC calling TennCare Connect again to check on this case, file an appeal, or inquire about the status of the appeal.

146. Because of the August 9, 2019 call to TennCare Connect in which Mrs. Fultz verified Mr. Fultz's income and added TJC as an authorized representative, a Change Notice was issued to Mr. Fultz on August 13, 2019. A copy was also sent to TJC as the authorized representative. This notice did not identify the specific income change (which was the verification of Mr. Fultz's income on August 9, 2019) because TEDS is designed not to include specific income information in notices for privacy reasons. On August 21, 2019, Mrs. Fultz called TennCare Connect to inquire about the August 13, 2019 Change Notice. The TennCare Connect agent did not refuse to provide information about the income change. Rather, she attempted to explain what the Change Notice was and asked Mrs. Fultz if her husband had recently been found eligible for

the program. The agent informed Mrs. Fultz about a NOD that had been issued the day before finding him ineligible for Medicaid. After receiving that information, Mrs. Fultz ended the call.

147. The NOD referred to in the August 21, 2019 call issued on August 20, 2019. It reapproved Mr. Fultz for SLMB but denied him once again for Medicaid on the basis that he was not in a group that TennCare covers. Legal Aid submitted a second letter to TennCare on August 27, 2019, requesting an appeal for the termination of Mr. Fultz's Medicaid coverage. An appeal was opened in response to this letter, but it was then closed as untimely on September 12, 2019 as the appeal deadline from the first NOD terminating his Medicaid coverage was August 12, 2019. The TennCare appeals worker who processed Mr. Fultz's case could have treated this second appeal request as a timely appeal of the NOD dated August 20, 2019 even though that NOD dealt with a denial not a termination and the letter referenced an appeal of the termination of Mr. Fultz's coverage. But whether or not the decision to close this appeal as untimely was correct, the appeal closure letter sent to Mr. Fultz did inform him that if he disagreed with the decision, he could file a petition for review in Chancery Court and further told him if he was appealing something else to call TennCare Connect right away. No further contact with TennCare Connect was ever made by Mr. or Mrs. Fultz, by TJC, or Legal Aid, and no appeal was filed with Chancery Court. TJC also did not reach out to TennCare's General Counsel through the informal process established to address cases just like this. The next time this case was raised with TennCare was when TJC filed the Complaint.

148. Had TJC contacted TennCare sooner, we would have done what we did upon learning of Mr. Fultz's case when the Complaint was filed. We reviewed his facts, identified the error that was made, and reinstated his TennCare coverage.

149. There is no dispute that errors were made in Mr. Fultz's case, but the initial set of systems issues that prevented TEDS from recognizing his potential eligibility in the Pickle category, is one that TennCare will be correcting with the July 2020 release of TEDS. Because the issues experienced by Mr. Fultz stemmed in part from the one-time conversion of eligibility data into TEDS, in part from system issues that will be corrected shortly, and because Mr. Fultz has now been correctly identified as eligible in the Pickle category, it is highly unlikely that he would experience any similar problems in the future.

Plaintiff Michael Hill

150. Mr. Hill's data converted into TEDS on January 19, 2019 indicating he had eligibility in the Pickle category. This was an error related to the conversion of data from interChange. Mr. Hill should have been converted by TEDS as being eligible as a DAC. Mr. Hill did not have MSP benefits either before or after conversion, but because he is eligible in an SSI-related category, TennCare does pay his Medicare Part B premiums.

151. Subsequently, and unrelated to the conversion into TEDS, on February 6, 2019, Mr. Hill received a notice regarding his pharmacy benefit informing him that because he has Medicare to pay for his prescription drugs starting March 9, 2019, TennCare would no longer be paying. It is longstanding TennCare policy and federal law that anyone who is enrolled in Medicare is considered to have access to Medicare prescription drug coverage and TennCare therefore does not pay for prescription drugs. This notice about Mr. Hill's drug benefit prompted Mr. Hill's sister to call TennCare Connect on February 19, 2019 and file an appeal. While an appeal was accepted, as that appeal related to a benefits issue not an eligibility issue, the appeal was transferred to TennCare's medical services appeals process.

152. On February 25, 2019, an MSP application was submitted for Mr. Hill. Plaintiffs take issue with the advice given to Mr. Hill's sister to have her brother file this MSP application, but since he was not receiving MSP benefits, it is puzzling why they would object to a suggestion that he submit an application to see if he could qualify for this program. However, in processing that application, a worker did erroneously deny Mr. Hill for MSP coverage for not having Medicare Part A when he should have been denied as being over income for the MSP program. The worker also reviewed Mr. Hill for eligibility in the Pickle category rather than the DAC category. As a result, Mr. Hill was determined to be over income for continued Medicaid coverage. While this was worker error, there was no DAC indicator in TEDS to alert the worker to conduct that review because at that time TEDS was not loading DAC or W/WW indicators from the SDX file for individuals who did not have active SSI coverage. (Mr. Hill's SSI coverage had been inactive for years). TEDS is being updated in July 2020 to begin loading these indicators into the SSI detail screen in TEDS even for inactive SSI individuals to help prevent this sort of worker oversight going forward.

153. Based on this worker error, a NOD denying Mr. Hill eligibility for MSP benefits and informing him his Medicaid coverage would end on June 12, 2019 unless he appealed by that date was mailed to Mr. Hill and his authorized representative on May 23, 2019. An appeal was timely filed on his behalf by his sister on May 28, 2019, and COB was granted pending the outcome of the appeal. On June 7, 2019, TJC sent a letter to the TennCare appeals group providing information supporting Mr. Hill's eligibility in the DAC category.

154. On July 18, 2019, a worker, in adding an authorized representative to Mr. Hill's case, inadvertently changed the income in Mr. Hill's case causing a Case Change Notice to be issued on July 22, 2019. This also caused another denial notice to issue on September 27, 2019

when this case change was eventually authorized on September 25 ,2019. This worker error also caused Mr. Hill's COB to be inadvertently canceled and caused TennCare's interChange system to send an automated message to CMS that TennCare was no longer paying for Mr. Hill's Medicare Part B premiums.

155. Prior to Mr. Hill's COB being inadvertently canceled, his sister contacted TennCare Connect on July 26, 2019, about the Case Change notice her brother had just received. Contrary to what Plaintiffs allege in the Complaint, the agent was able to tell Mr. Hill's sister what income TennCare had on record for Mr. Hill. The agent was also able to confirm that an eligibility appeal had been filed, but because neither Mr. Hill's sister nor the agent could find the appeal number for that appeal the agent was unable to provide any information about Mr. Hill's appeal. However, on July 31, 2019, Mr. Hill was mailed a letter informing him that his appeal was being sent to hearing.

156. On October 16, 2019, in response to the NOD issued on September 27, 2019 denying Mr. Hill for QMB and indicating his coverage for Medicaid had ended on July 18, 2019, another appeal was filed on Mr. Hill's behalf. On October 18, 2019, an inbound call was received from TJC regarding Mr. Hill's pending appeal and raising a concern with the status of his COB. Appeals immediately investigated, found the error that had occurred on September 25, 2019 that had inadvertently terminated COB on Mr. Hill's case, and reinstated Mr. Hill's coverage making sure that coverage was backdated so he had no gap. This in turn prompted interChange to send an automated message to CMS that TennCare was paying for Mr. Hill's Medicare Part B premiums, and the amounts for the premiums withheld in October and November 2019 were deposited back into Mr. Hill's account on November 14, 2019. Mr. Hill then remained in pending appeal status with full coverage due to COB until April 17, 2020, when his social security information was

reviewed, and his coverage was reinstated in the DAC category. Mr. Hill remains over income for MSP benefits.

157. While it is not TennCare's desire to have any appeal in pending status for this long, due to the volume of appeals TennCare receives, we at times have prioritized cases in which a member has lost their coverage over those, like Mr. Hill's, where COB has been granted and the member continues to receive healthcare coverage while the appeal is waiting to go to hearing or otherwise be resolved. Further, because Mr. Hill initially lost eligibility related to the conversion of eligibility data into TEDS, Mr. Hill has no likelihood of encountering this particular problem again as that was a one-time event that will repeat itself as the conversion of data into TEDS is complete.

Plaintiff J.S.K. and Family

158. J.S.K. and his family's eligibility data converted into TEDS on May 18, 2019. J.S.K.'s wife (J.C.K.) and his son (M.S.K.) both have TennCare coverage as active SSI-cash recipients. They have never lost their coverage or received a termination notice suggesting they were going to lose their coverage. Contrary to what the Complaint alleges, there is no evidence that J.S.K. also receives SSI. Rather, J.S.K. has eligibility as a Caretaker Relative, and his children M.N.S. and D.C.S. have eligibility in the Child-MAGI category.

159. On July 11, 2019 an annual renewal packet was mailed to J.S.K and his two children, M.N.S. and D.C.S., to their address of record at the time. Based on information since received, it appears this was not the family's most current address, but the address had not been updated with TennCare before TennCare mailed the July 11, 2019 renewal packet, a fact which the Complaint acknowledges. The renewal packet gave the family until August 20, 2019 to respond. The renewal packet was not returned as undeliverable and was likely forwarded by the

Post Office to the family's new address as TennCare pays for the USPS to forward mail and the Complaint again acknowledges the family received the renewal packet, albeit after the deadline to respond.

160. On August 25, 2019, since no response had been received on the renewal packet, TEDS automatically terminated coverage for J.S.K., M.N.A. and D.C.S. and issued a NOD with the mail date of August 28, 2019 informing J.S.K. that his coverage and that of his children M.N.S. and D.C.S. would be ending on September 17, 2019 unless they appealed by that day. The NOD was sent to the original address of record as no changes to that address were reported as of the time TEDS generated the NOD on August 25, 2019.

161. On August 26, 2019, J.C.K. called TennCare Connect to complete the renewal packet over the phone for J.S.K., M.N.S. and D.C.S., and report a change in address. Due to a worker error, although the renewal packet response was captured in TEDS, which should have been sufficient to reinstate J.S.K., M.N.S. and D.C.S.'s benefits, the final step to make the changes effective (authorizing the case in TEDS) was not taken and the family did not regain their coverage. An appeal was not filed until September 24, 2019, which was too late for COB. Since then, TEDS has been updated to identify such worker errors and authorize cases in these circumstances to reinstate benefits; thus, this particular issue would not arise today.

162. On December 17, 2019, the Appeals Resolution team reviewed the case, processed the renewal packet response that had been submitted on August 26, 2019, and approved coverage for J.S.K., M.N.S., and D.C.S. All gaps in coverage were closed. On December 26, 2019, their appeals were closed because they had been found eligible for TennCare and had been provided complete relief in their appeal. This is another example of the appeal process allowing members

to identify mistakes that had been made and allowing TennCare the opportunity to correct those mistakes.

Plaintiff E.I.L.

163. E.I.L.'s birth was reported to TennCare on July 30, 2019, through the TEDS partner portal, TennCare Access, which is a portal through which providers such as hospitals can input presumptive eligibility information for members. E.I.L.'s deemed newborn coverage was approved through the TEDS no-touch authorization process on August 6, 2019. Similar to Plaintiff K.A. discussed above, there was a system issue with the TEDS no-touch process that did not correctly start coverage from the date of E.I.L.'s birth but instead from the date his birth was reported. Like K.A., E.I.L. was sent a NOD approving his new coverage and providing a start date that was not his date of birth. That notice gave until September 17, 2019 to file an appeal if E.I.L.'s family (or authorized representative, to whom a notice was also mailed), believed the start date was wrong. No appeal was filed until January 14, 2020, and that appeal was closed on January 21, 2020 as untimely. TennCare subsequently discovered that while the partner portal application provided an updated mailing and residential address, only the residential address got updated in TEDS. When the appeal was filed, however, no allegation was made of a bad address so there were no facts to prompt a good cause review. TEDS was updated on October 6, 2019 to allow both a mailing address and a residential address to be input through the provider portal so this issue would not repeat itself today.

164. The August 19, 2019 NOD and other notices, such as a renewal packet sent to the other members of E.I.L.'s family, were mailed to the address TennCare had on file, which was their residential address. Contrary to what Plaintiffs allege, there were not several attempts by E.I.L.'s mother to correct this address issue. E.I.L.'s mother made two calls to TennCare Connect,

one on February 14, 2020 and one on February 29, 2020, and, as of February 21, 2020 she was getting mail at her correct address.

165. On February 28, 2020, TJC sent a letter to TennCare Connect and TennCare Eligibility Appeals asking that the appeal for E.I.L. be reopened to address the effective date issue because they contended that E.I.L.'s mother had not gotten appropriate notice. On March 4, 2020, TennCare reviewed E.I.L.'s case and corrected the effective date of his coverage to his date of birth. On March 4, 2020 E.I.L.'s appeal was reopened, and the appeal was closed again on March 17, 2020 because TennCare had already corrected the start date of E.I.L.'s TennCare coverage and provided him complete relief.

166. In addition to reprogramming TEDS to ensure that coverage is started for deemed newborns from the date of birth, the TennCare Appeals group has also been instructed to correct effective dates for newborns in this situation even if their appeal is untimely. Because this relates to E.I.L.'s birth, there is absolutely no likelihood of this problem repeating itself for E.I.L. in the future.

Plaintiff William Monroe

167. Mr. Monroe's eligibility data converted into TEDS on April 6, 2019 with Mr. Monroe as QMB eligible. He did not have any Medicaid coverage at that time and had been QMB-only eligible since at least 2013. In July 2019, his case was selected for annual renewal and, because his income could not be automatically verified, he was sent a renewal packet with an August 20, 2019 due date. The renewal packet was mailed to his address of record, which is the same address he has today and that has been confirmed for him numerous times.

168. When Mr. Monroe did not respond to his renewal packet, he was sent a NOD informing him that his QMB coverage would be ending on September 17, 2019 unless he

completed the renewal packet or filed an appeal by that date. Mr. Monroe's sister-in-law called TennCare Connect on September 9, 2019 and completed a phone renewal. Based on his sister-in-law's responses to the questions in the renewal packet, it appeared that Mr. Monroe wished to be evaluated for Institutional Medicaid so that he could receive HCBS. An Additional Information notice was mailed on September 11, 2019 requesting financial resource information, expense information, and an approved PAE so that TennCare could evaluate Mr. Monroe for Institutional Medicaid. The due date to submit this requested information was October 1, 2019.

169. On September 12, 2019, an appeal was filed on Mr. Monroe's behalf by TJC. The section of the appeal form that asks "What kind of coverage is the appeal for?" was marked "QMB" not TennCare, although in the section of the form where the appellant can write in the mistake they think TennCare made TJC stated: "Mr. Monroe received no renewal notice and believes he is still eligible for QMB and Medicaid through the Pickle Amendment." This appeal was timely and requested continuation of Mr. Monroe's QMB benefits, and COB was granted on the case on September 18, 2019. However, prior to COB being granted, TennCare's interChange system, which communicates with CMS regarding the TennCare members for whom TennCare is paying Medicare premiums, had already sent that same day to CMS information that Mr. Monroe had lost his QMB coverage and that TennCare was no longer paying his Medicare premiums. At the time this occurred, interChange was only capable of sending one (1) transaction per month per person, which meant that, once it was communicated that Mr. Monroe had lost his QMB coverage, although that coverage was continued that same day, CMS did not get that information until the following month. The result of this is that, although TennCare did grant COB to Mr. Monroe, CMS would have deducted his Medicare premiums from his social security check in October but refunded that money in October as well. In February or early March 2020, TennCare gained the

ability to send more than one (1) transaction per month per member to CMS regarding Medicare premiums, so if a similar situation were to arise today, Mr. Monroe or similarly situated individuals would not have their Medicare premiums deducted once COB is granted.

170. On September 16, 2019, although Mr. Monroe's sister-in-law had already completed the renewal packet for him, a representative from TJC called TennCare Connect with Mr. Monroe to complete his renewal. Since the renewal responses from the September 9, 2019 call had not yet been processed, the TennCare Connect agent took Mr. Monroe's renewal information a second time. Notably, on this call with Mr. Monroe and TJC there was no request for additional assistance, no reference to him possibly being eligible in the Pickle category, and, when asked specifically if he had ever received SSA income related to SSI income, he said he only received social security of $809 per month. The TennCare Connect agent also explained that a PAE was still needed for Mr. Monroe and offered to provide him and his TJC representative with the number for his AAAD to get assistance obtaining that PAE. This call resulted in an Additional Information notice being issued to him on September 25, 2019 with an October 15, 2019 due date seeking information needed to determine his eligibility and once again asking for a PAE.

171. On September 30, 2019, in response to the Additional Information notice, Mr. Monroe's TJC representative submitted a letter on his behalf stating that Mr. Monroe does not have a trust, life insurance, burial resources, property, or other resources except for a checking account. The letter indicated that Mr. Monroe was having difficulty gathering the remainder of the requested proof and requested in-person assistance. TJC also reached out to the TennCare Civil Rights Division to request assistance in completing a CHOICES application for Mr. Monroe. Because TJC did not have a signed release from Mr. Monroe or his legal representative, this request was forwarded to the TennCare General Counsel's office. TennCare's Deputy General Counsel

immediately reached out to TJC to obtain a release, and upon receipt, informed TJC that a referral had been made to the AAAD to contact Mr. Monroe regarding his PAE.

172. On October 10, 2019, following the referral by TennCare for a face-to-face visit, a representative from the Northwest AAAD went to Mr. Monroe's home, interviewed him, and performed a functional assessment. Subsequently on October 14, 2019, at the request of TJC for an accommodation, the due date for submitting the information requested from Mr. Monroe, most importantly an approved PAE, was extended to October 29, 2019. On October 28, 2019, the Northwest AAAD did submit a PAE for Mr. Monroe to TennCare with a total acuity score of two (2). An acuity score of nine (9) is required to meet nursing home level of care and qualify for HCBS. As a result, Mr. Monroe's PAE was denied. A notice of denial to receive HCBS through the CHOICES program was issued to Mr. Monroe on October 29, 2019 giving him thirty (30) days to appeal that decision. No such appeal was filed. I understand Plaintiffs have alleged that the AAAD did not assess Mr. Monroe's eligibility for any other category of TennCare coverage, but that is not the responsibility of the AAAD. They do not determine Medicaid eligibility. They perform functional assessments and submit PAEs to TennCare for approval. They can also provide assistance in submitting an application, but Mr. Monroe did not need that assistance as he had an application pending.

173. On October 29, 2019, Mr. Monroe was also mailed a NOD approving him for QMB coverage but denying him for Medicaid in the Institutional Category because he did not have an approved PAE. An additional NOD was mailed to Mr. Monroe on November 4, 2019 following receipt by TennCare of the denied PAE and once again approving him for QMB but denying him for the Institutional Medicaid category. No appeals from these NODs were filed. The last correspondence that TennCare received from TJC regarding Mr. Monroe was an email on

November 1, 2019, stating that "We are glad that Mr. Monroe was approved for QMB and that his premiums were not withheld from his social security check this month. Thank you for all your help."

174. On March 13, 2020, an application was submitted via the TennCare Connect Member Portal indicating Mr. Monroe wished to apply for Medicaid. Because Mr. Monroe already had existing QMB coverage, this application was sent to an eligibility worker to process. That worker attempted multiple times to contact the authorized representative from TJC listed on the application to clarify what Mr. Monroe was applying for, but her voicemail was full, and the worker was unable to leave a message. The worker was able to contact Mr. Monroe, who indicated he needed in-home assistance, so another referral was made to the AAAD to evaluate him again for a PAE. This application was in the process of being worked when Plaintiffs filed their Complaint. On March 27, 2020, an Additional Information notice was issued seeking bank statements and an approved PAE. On April 3, 2020, TennCare received a letter from TJC stating that Mr. Monroe was not requesting an evaluation for HCBS through the CHOICES program and requesting he be evaluated in the Pickle category. Subsequently on April 8, 2020, Mr. Monroe was approved for Medicaid in the Pickle category. Throughout, he has kept his QMB eligibility.

175. While it was not consistent with TennCare policy for the eligibility workers who worked on Mr. Monroe's renewal case to not review SSI-income data and screen Mr. Monroe for potential Pickle-eligibility, there were several contributing factors that set this case apart from most other cases involving this type of eligibility determination. First, Mr. Monroe had not recently lost SSI-eligibility. He had been on the program for years receiving benefits in an MSP category, which is not full Medicaid, and so the focus was on reviewing him for continued eligibility for MSP. Second, the vast majority of members receiving MSP benefits are not eligible in an SSI-related

category, such as Pickle, so it is not the primary category that workers consider. Third, his responses to the renewal packet suggested he wished to be reviewed for HCBS through the CHOICES program, which sent his renewal and his appeal down that path as opposed to focusing on potential Pickle eligibility. Fourth, when TennCare had contact with Mr. Monroe's authorized representative regarding his renewal packet, even his TJC representative was focused on QMB and HCBS and did not reference potential Pickle eligibility until April 2020. When Mr. Monroe ended up filing an application for full Medicaid, shortly before the Complaint was filed, I have no reason to believe that he would not have been found eligible for Medicaid in the Pickle-category based on that application irrespective of the Complaint. Now that Mr. Monroe is receiving Medicaid in the Pickle category, he will not be subject to the annual renewal process in the future for that category and there is no reason to believe that he will experience the same problems in the future when his QMB eligibility needs to be reviewed.

Plaintiff Linda M. Rebeaud

176. Ms. Rebeaud's eligibility data converted into TEDS on April 27, 2019 with Ms. Rebeaud receiving Medicaid coverage in the Breast and Cervical Cancer ("BCC") category of eligibility. On May 31, 2019, Ms. Rebeaud was issued a BCC annual renewal packet. This is similar to the standard annual renewal packet but specifically designed for the BCC category of eligibility. It is a much shorter packet that seeks information from a treating physician verifying the treatment plan the member is undergoing because eligibility in the BCC category requires the member to be in active treatment. Ms. Rebeaud was given until August 31, 2019 to return this information.

177. Separately, on May 29, 2019, as part of the conversion process of eligibility data into TEDS, a treatment form previously submitted on August 14, 2018, was reviewed by a

TennCare nurse who determined that Ms. Rebeaud was no longer receiving active treatment for breast cancer and entered this information into TEDS. As a result, TEDS mailed a Preterm Notice to Ms. Rebeaud on June 3, 2019 informing her that TennCare believed her circumstances had changed, that she was no longer receiving treatment for breast or cervical cancer, and that she needed to respond to the Preterm questionnaire by June 23, 2019 or her coverage would end.

178. When Ms. Rebeaud did not respond to the Preterm Notice by June 23, 2019, on June 26, 2019, TEDS automatically issued a NOD informing Ms. Rebeaud that because she was not receiving treatment for breast or cervical cancer and because she did not send in the facts TennCare needed to determine if she still qualified for coverage, her coverage would end on July 16, 2019 unless she appealed by that date. On July 2, 2019, TennCare received Ms. Rebeaud's response to the BCC renewal packet (i.e. her treatment plan) and on July 10, 2019 TennCare received Ms. Rebeaud's response to the Preterm questionnaire with the question asking whether she was in active treatment for breast or cervical cancer marked yes. The information provided, however, was submitted late and required TennCare to follow up with Ms. Rebeaud's doctor to get clarification on her treatment plan. Thus, subsequently on July 17, 2019, her coverage was terminated. At this time, TEDS did not have a process to automatically reinstate cases if verifications were returned during the advance termination period. This functionality was introduced in TEDS on July 28, 2019 with the fifth major TEDS release.

179. Ms. Rebeaud's coverage was reinstated when TennCare received a presumptive eligibility approval for BCC from the Department of Health on August 12, 2019. The worker processing this case should have seen that Ms. Rebeaud's coverage had been terminated on July 17, 2019 and filled the gap in her coverage at that time, but that did not occur. Subsequently, on September 20, 2019, an appeal was filed seeking to have this gap in her coverage filled. The

Appeals group reviewed the appeal, agreed a mistake had been made, and filled the gap in Ms. Rebeaud's coverage from July 17, 2019 to August 12, 2019.

180. While I understand that Plaintiffs have alleged that Ms. Rebeaud is at risk for this happening to her again in the future because she must undergo annual renewal in the BCC category, that is inaccurate because the problem that led to Ms. Rebeaud losing coverage—the issuance of a Preterm Notice related to the review of an older treatment plan as part of the data conversion into TEDS—will not reoccur. Further, as noted above, in the event Ms. Rebeaud were to again return verification information late but prior to her advance termination date, TEDS is now capable of identifying this issue and reinstating coverage.

Plaintiff D.R. and Family

181. For this family of five, D.R. (mother) and her four children—J.Z. (age 8), M.X.C. (age 6), J.C. (age 1) and M.A.C. (newborn)—there have been no issues with the TennCare coverage for M.A.C. ,who has had deemed newborn coverage from her date of birth since it was reported to TennCare on August 12, 2019. M.X.C. received a termination notice, but her coverage was never in fact terminated due to open coverage in another case. There were periods of loss of coverage or failure to timely determine coverage under the TEDS change-mode reverification process for D.R. and her two sons, J.Z. and J.C.

182. On January 19, 2019, D.R. and her daughter M.X.C.'s eligibility data was converted into the same case in TEDS. D.R.'s son J.C.'s eligibility data converted into his own case because he had a separate case in interChange at the time of conversion and there was nothing to tie the family together and allow their interChange cases to convert into TEDS together. D.R.'s other son, J.Z., did not have active coverage at the time D.R.'s data was converted into TEDS so he was not added to her case at that time. J.Z. had lost coverage on April 5, 2018 in the prior redetermination

process in place before TEDS because he failed to respond to his renewal packet. However, a February 8, 2019 FFM application for J.Z. was transferred from the FFM to TennCare to resolve because of an income inconsistency on that application. When that application had not been adjudicated, on April 26, 2019, D.R. filed a delayed application processing appeal for J.Z.

183. On April 26, 2019, in the process of working on the FFM application for J.Z., a TennCare worker added J.C. (son) and J.C.H. (father) to D.R. and M.X.C.'s case. The addition of J.C.H. caused TEDS to issue an Additional Information notice for verification of J.C.H.'s income that was due by May 22, 2019. This Additional Information notice requesting the required income verifications was mailed to the address record on May 2, 2019 and informed the family the date by which they needed to respond and provided numbers to call if they had any questions or needed assistance. This notice was not returned as undeliverable. When no information was received in response to this request, a worker reviewed the case on May 23, 2019, and TEDS approved J.Z. for coverage from February 8, 2019 through April 26, 2019. This approval occurred because a worker did not enter data to establish J.C.H.'s relationship to J.Z. before April 26, 2019. The system logic treated J.C.H. as just having been included in J.Z.'s household for purposes of household composition on April 26 ,2019 and that his income was not available to J.Z. before that date. On May 28, 2019, TEDS issued a NOD to D.R., J.Z., M.X.C. and J.C. informing the family that J.Z.'s last day of coverage was April 25, 2019, that D.R.'s and M.X.C.'s coverage would end on June 17, 2019 if they did not appeal by that date, and denying J.C. for coverage. J.C. was denied coverage as opposed to having coverage terminated because he did not already have coverage on the case that was the subject of the NOD. The reason given for each of these decisions was the failure to provide the facts requested in the May 2, 2019 Additional Information request notice.

184. With the issuance of this NOD resolving the February 8, 2019 application, the delay appeal filed on April 26, 2019 was closed because the FFM application that was the subject of that delay appeal had been processed and a decision on that application provided. A notice was mailed to D.R. informing her of this fact.

185. D.R. filed new appeals on June 12, 2019 in response to the May 28, 2019 NOD. Continuation of benefits for these appeals were granted on June 26, 2019 to D.R., on July 3, 2019 to J.Z. and M.X.C. and on July 5, 2019 to J.C. As explained in Paragraph 35(e) above, due to a TEDS defect that had not yet been corrected, the appeal acknowledgement letters sent to D.R., J.Z, and M.X.C. incorrectly stated that they would not receive COB pending the resolution of their appeals. On June 28, 2019, TJC emailed TennCare's General Counsel about this case and requested that COB be granted to the family while their appeals were pending. At this point, however, COB had already been granted to D.R. and as noted was subsequently added for the remainder of the family shortly thereafter, which TennCare's General Counsel confirmed to TJC by email on July 8, 2019. Corrected appeal acknowledgment letters confirming they had COB were also mailed to the family once the defect in TEDS was corrected.

186. On July 30, 2019, notices were sent out informing D.R. and her family that they would be receiving a fair hearing on their appeals. The appeals were subsequently set for hearing on September 26, 2019. TJC requested a continuance of those hearings to enable D.R. to gather the requested income verification information that TennCare had requested. The Administrative Judge to whom these appeals were assigned granted that request. The appeals were then reset for hearing on November 21, 2019, but on November 18, 2019, TJC requested that the appeals be withdrawn.

187. On September 26, 2019 the requested proof of income for J.C.H. that had been requested on May 2, 2019 was received, and on December 5, 2019, D.R., J.Z., M.X.C. and J.C. were all approved for ongoing Medicaid coverage.

188. While there was deviation from standard procedure in not processing the FFM application received on February 8, 2019 in a timely manner, TennCare identified and corrected those errors as part of the appeals process, provided COB, and filled any gaps in coverage, and processed the required income information as soon as it was submitted. This case demonstrates the appeals process working to allow mistakes to be identified and corrected.

Plaintiff T.L.T. and Family

189. For this family of five, there have been no issues with the TennCare coverage for T.J.T. (father), S.L.T. (mother), and F.T. (newborn). Of the other two children, A.L.T. and J.L.T., only A.L.T. has alleged issues with the current TEDS redetermination process. J.L.T had lost coverage in July 2018 for a failure to respond to a renewal packet sent to him as part of the prior redetermination process. J.L.T. regained coverage when an application submitted through the TennCare Connect member portal on September 30, 2019 was approved on February 19, 2020.

190. T.J.T., S.L.T, and A.L.T.'s eligibility data converted into a case in TEDS with open Medicaid coverage on April 27, 2019. F.T., a newborn, was added to that case on June 7, 2019. On May 2, 2019, an application for Medicaid coverage was submitted over the phone with TennCare Connect for J.L.T. Subsequently on May 6, 2019, a notice requesting information was mailed to the family seeking proof of income for T.J.T. and S.L.T. and citizenship information for J.L.T. in order to verify that T.J.T., S.L.T. and A.L.T. still qualified for coverage and to assess J.L.T. for coverage. A response was due by May 26, 2019. This notice was mailed to their address

of record, which is the same address they have today, and the same address that was provided on the application, and the notice was not returned as undeliverable.

191. When no response was received, TennCare was able to reauthorize coverage for T.J.T, S.L.T., and F.T. TennCare was able to reauthorize coverage for T.J.T. and S.L.T. through the Transitional Medicaid category discussed in Paragraph 35(f) above that provides one year of transitional coverage. Because there is no income threshold for Transitional Medicaid, TennCare was able to authorize this coverage for T.J.T and S.L.T. without the submission of the requested proof of income that was the subject of the May 6, 2019 Additional Information notice because they both had Caretaker Relative eligibility. As a newborn, F.T. was able to be reauthorized in the Deemed Newborn category. J.L.T was denied because the necessary requested information had not been returned for him and he was not already on the program. The NOD also informed the family that, because the requested information had not been returned, A.L.T.'s coverage would be ending on June 27, 2019 unless she appealed by that date. J.L.T. and A.L.T. were both denied in error. As previously explained, at that time TEDS was not automatically granting Transitional Medicaid to children, like A.L.T. and J.L.T., when it was authorizing Transitional Medicaid for the parents. This system issue, however, was identified and corrected in an update to TEDS with TEDS 8.0 release on February 20, 2020 and would not happen today.

192. Appeals were filed for J.L.T. and A.L.T. on June 18, 2019, and A.L.T. was granted continuation of benefits on July 17, 2019 with a corrected appeals acknowledgment notice issued on July 31, 2019 informing the family of that coverage. While today, A.L.T. would receive COB automatically because she filed her appeal before her coverage ended, at that time, not all of the appeals functions in TEDS had been implemented and her appeal did not receive automatic COB.

193. On August 1, 2019, both A.L.T and J.L.T. were sent letters asking them to tell TennCare what mistake they were saying TennCare made. Those notices reiterated that they were denied or terminated coverage because they did not provide the information that was requested by the May 26, 2019 deadline and asked them to tell TennCare if they did in fact send that information in or if they did not get the request for that information. They were given until August 21, 2019 to respond to this notice. No response was provided. As a result, on August 28, 2019, J.L.T.'s appeal was closed, and an appeal closure notice was issued on August 30, 2019. On August 30, 2019, A.L.T.'s appeal was closed, and her COB was discontinued with an appeal closure notice issuing on September 4, 2019. I understand Plaintiffs have alleged they did submit information in response to this VFD notice, but there is no record of any information being returned before the August 21, 2019 deadline and no record of any calls to TennCare Connect before that date.

194. On August 30, 2019, T.J.T. did call and speak with the Appeals Clerk and was told the appeals were closed but he said he would send the requested information anyway. He then submitted a letter on September 3, 2019. Under current appeals process, the late submission of information in response to a letter asking for more information about the mistake TennCare made would create a task for the Appeals group legal review team to resolve.

195. August 30, 2019, TennCare issued the family another notice requesting income information for the family, this time with a due date of September 19, 2019. Proof of income was received for S.L.T. on September 18, 2019, but not for T.J.T. Then on September 30, 2019, a member portal application was filed for J.L.T. and A.L.T., and another notice requesting income information for T.J.T. (father) was mailed on November 15, 2019, with a December 5, 2019 due date. On the due date, an employer separation notice for T.J.T. was submitted together with a statement that T.J.T. is a full-time student and stay-at-home father. This is the sort of information

that members are required to update with TennCare and told to do so in many of the notices that this family received. T.J.T.'s income was partially updated in the system but the eligibility worker processing the case failed to note that a written statement attesting to no income had been received. Subsequently another notice requesting T.J.T.'s income and tax information with a December 30, 2019 due date was issued.

196. While there was no response to the last information notice, on January 6, 2020, when TEDS was running an automated batch update to resolve outstanding Additional Information notices in existing cases, A.L.T.'s eligibility was automatically updated and approved for Child-MAGI starting February 1, 2020. This approval caused a NOD to issue on January 8, 2020, but that NOD did not include J.L.T. because a system defect, that has since been fixed, marked him as no longer applying for coverage.

197. On January 13, 2020, S.L.T. called TennCare Connect, which is the first contact that TennCare Connect had with the family since the appeals for a failure to respond were filed on June 18, 2019. The TennCare Connect agents offered to file a delayed application appeal for her, but she declined and said she would have TJC do that. On January 21, 2020 the case was updated to reflect T.J.T.'s current job status. On February 18, 2020, a representative from TJC reached out to TennCare's General Counsel and provided information about this case, and then on February 19, 2020, TennCare was able to approve J.L.T. for Child-MAGI coverage with an effective date of September 30, 2019 and was able to backdate A.L.T.'s coverage to September 30, 2019 as well.

198. Other than the information outlined here, we have no evidence that this family returned the requested information in 2019 as I understand Plaintiffs have alleged occurred. Further, even if the family provided documentation in 2018, the 2019 requests for income information were necessary because TennCare is required to verify current income in determining

eligibility. That said, there was a delay in processing the September 30, 2019 application. When this delay was brought to TennCare's attention, the September 30, 2019 application was reviewed, coverage was authorized, and all gaps in coverage were closed.

Plaintiff Kerry Vaughn

199. Ms. Vaughn's eligibility data converted into TEDS on January 19, 2019 with Ms. Vaughn eligible in the Pickle category when she should have converted into TEDS with eligibility as a DAC. Because TEDS identified Ms. Vaughn as Pickle eligible based on the converted data, when updated income information was received from SSA causing her case to be reviewed by an eligibility worker, that worker continued to treat Ms. Vaughn as potentially Pickle eligible instead of analyzing her income under the DAC income standards. As a result of the data conversion error and a worker not identifying the error, TEDS issued a NOD informing Ms. Vaughn that her Medicaid coverage would end starting May 30, 2019 because she was over the monthly income limit for the Pickle category.

200. Ms. Vaughn timely filed an appeal on May 16, 2019 and COB was granted. TennCare confirmed on July 29, 2019 that Ms. Vaughn would receive a fair hearing on her appeal, and her appeal remained in pending status, with Ms. Vaughn receiving full coverage while her appeal was pending. On April 17, 2020, Ms. Vaughn was approved for ongoing DAC coverage and her appeal was closed. As noted previously, while it is not TennCare's desire to have any appeal in pending status for this long, due to the volume of appeals TennCare receives, we have prioritized cases in which a member has lost their coverage over those, like Ms. Vaughn's, where COB has been granted and the member continues to receive healthcare coverage while the appeal is waiting to go to hearing or otherwise be resolved. Further, because this was an issue related to the conversion of eligibility data into TEDS, Ms. Vaughn has no likelihood of encountering this

particular problem again. She is now correctly identified in TEDS as having eligibility in the DAC category; she is exempt from annual eligibility renewals since her eligibility is in an SSI-related category, and if her income needs to be reviewed in the future based on income updates from SSA it will be as a DAC not as Pickle eligible individual.

Plaintiff Johnny Walker

201. Mr. Walker's eligibility data converted into TEDS on May 18, 2019, and, like Plaintiffs Barnes and Caudill, based on data in the SSA's SDX file, it appeared that Mr. Walker was no longer receiving SSI-cash payments and thus was no longer automatically eligible for SSI-Medicaid. Based on this, TEDS created a transitional SSI Medicaid case for Mr. Walker and sent him through the *ex parte* review process to see if he was potentially eligible in another Medicaid category.

202. On June 11, 2019, a Preterm Notice was mailed to Mr. Walker at his address of record informing him that his coverage would be ending soon but that TennCare wanted more information to see if he could keep coverage. The reason his coverage was identified as ending was that he was not in a group covered by TennCare, which listed people who are getting or used to get SSI checks. Mr. Walker was given until July 1, 2019 to respond to the Preterm Notice. The notice contained information on ways and places Mr. Walker could get help if he didn't understand the notice. Because Mr. Walker did not respond to the Preterm Notice, on July 5, 2019, a NOD was mailed to his address of record informing him that because he did not respond to the letter sent to him asking for more facts to see if he qualified, his coverage would be ending on July 25, 2019. Information on how to appeal, the need to appeal by July 25, 2019 to keep his coverage, and the need to appeal by August 14, 2019 for the appeal to be timely were included in the NOD.

203. When no late response to the Preterm Notice was submitted and no appeal was filed, Mr. Walker's coverage ended on July 25, 2019. On August 20, 2019, Mr. Walker's sister called TennCare Connect on his behalf and filed an appeal over the termination of his coverage and requested that the Preterm Notice be re-mailed to him, which TennCare did on August 22, 2019. The response to the Preterm Notice was received by TennCare on September 17, 2019, but since Mr. Walker's coverage had already been terminated no action was taken in response to this returned questionnaire.

204. On September 23, 2019, Mr. Walker's appeal was closed as untimely because it was filed past the 40-day deadline for filing a timely appeal. Then on October 4, 2019, an application was filed for Mr. Walker through the TennCare Connect member portal. Similar to Plaintiff Caudill, however, Mr. Walker's application was denied through the TEDS no-touch authorization process because Mr. Walker did not group into any category of Medicaid eligibility because he does not receive social security income and was not requesting long term services and supports.

205. On October 10, 2019, TJC wrote to TennCare's General Counsel about Mr. Walker's case pointing out that Mr. Walker receives SSI benefits and should be eligible for Medicaid on that basis. This information was reviewed and on October 11, 2019, Mr. Walker's SSI-Medicaid coverage was restored back to the date of termination.

206. This case, like that of Plaintiffs Barnes and Caudill, presents a very uncommon problem in which there was an issue with the SSI data on the SDX at the time of conversion into TEDS. Because conversion is not going to happen again, this issue will not repeat itself. Further, as I explained in Paragraph 35(a) above, TennCare has developed a process with SSA to correct this issue for any similarly situated individuals.

I declare under penalty of perjury that the foregoing is true and correct.

Dated May 29, 2020

Kimberly Hagan

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been served via the Court's electronic filing system on this 29th day of May, 2020.

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