Public Necessity Rules
of
The Tennessee Department of Human Services
Medical Services Division

Chapter 1240-03-01
General Rules

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Technical And Financial Eligibility
Requirements For Medicaid

Standard Spend Down

Statement of Necessity Requiring Public Necessity Rules

I am herewith submitting amendments to the rules of the Tennessee Department of Human Services, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209.

The Centers for Medicare and Medicaid Services (CMS) approved the TennCare II Medicaid Section 1115 Demonstration Waiver on October 5, 2007. The approval is under the authority of section 1115(a) of the Social Security Act. Federal Waiver approval is conditioned upon TennCare's compliance with certain Special Terms and Conditions (STCs), including those relating to the Standard Spend Down (SSD) demonstration eligibility category.

TennCare's 1115 Demonstration Waiver amendment, signed on October 5, 2007, requires that Tennessee open eligibility to the demonstration SSD category that will be comprised of non-pregnant medically needy adults. In accordance with TennCare's Waiver agreement with the federal government, these rules are necessary to implement the required opening of the SSD eligibility category.

I have made the finding that the attached amendments are required by an agency of the federal government and adoption of the amendments through ordinary rulemaking procedures might jeopardize the loss of federal funds.

For a complete copy of these public necessity rules, contact: Phyllis Simpson, Assistant General Counsel, Tennessee Department of Human Services, Citizens Plaza Building, 400 Deaderick Street, 10th Floor, Nashville, TN 37243-1403, telephone number (615) 313-4731.

Virginia T. Lodge
Commissioner
Tennessee Department of Human Services

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Chapter 1240-03-01
General Rules

Amendments

Rule 1240-03-01-.02 Definitions, is amended by adding a new paragraph (2), so that as amended paragraph (2) shall read as follows:

(2) Definitions of terms or phrases utilized in Medicaid Spenddown, Standard Spend Down and TennCare Standard.

(a) Call-in Line. The toll-free telephone single point of entry used during a period of open enrollment (as announced by the Bureau of TennCare) to enroll new applicants in the Standard Spend Down Program (SSD).

(b) Caretaker relative. The father, mother, grandfather or grandmother of any degree, brother or sister of the whole or half-blood, stepfather, stepmother, stepbrother, stepsister, aunt or uncle of any degree, first cousin, nephew or niece, the relatives by adoption within the previously named classes of persons, and the biological relatives within the previous degrees of relationship, and the legal spouses of persons within the previously named classes of persons, even if the marriage has been terminated by death or divorce, with whom a child is living.

(c) Continuous eligibility. Enrollment in a Medicaid Medically Needy, Standard Spend Down or TennCare Standard eligibility category with no break in coverage.

(d) Continuous enrollment. Certain individuals determined eligible for the TennCare Program may enroll at any time during the year. Continuous enrollment is limited to persons in the following two (2) groups:

1. TennCare Medicaid enrollees; or

2. Individuals who are losing their Medicaid, who are uninsured, who are under 19 years of age, and who meet the qualifications for TennCare Standard as “Medicaid Rollovers” in accordance with the provisions of these rules.

(e) Open enrollment. A designated period of time determined by the Bureau of TennCare, during which individuals may apply for enrollment in TennCare Standard or Standard Spend Down.

1. The following individuals may apply for TennCare Standard as uninsured or medically eligible persons during a period of open enrollment:

(i) Uninsured individuals whose incomes fall within the poverty levels established for the period of open enrollment being held;

(ii) Individuals qualifying as medically eligible as defined in these rules and whose incomes fall within the poverty levels established for the period of open enrollment being held.

2. Individuals applying for the Standard Spend Down Program may apply during a period of open enrollment announced by the Bureau of TennCare in accordance with these rules.

(f) Standard Spend Down. The demonstration category composed of adults aged twenty-one (21) and older who are not eligible for Medicaid but who meet the requirements for Standard Spend Down that are outlined in these rules and those of the TennCare Bureau.

(g) TennCare Standard. That part of the TennCare program which provides coverage for Tennessee residents who are not eligible for Medicaid but who meet the requirements for TennCare Standard that are outlined in these rules and those of the TennCare Bureau.

(h) Transition Group. Existing Medically Needy Adults or non-pregnant adults twenty-one (21) or older enrolled as medically needy as of October 5, 2007, who have not yet been assessed for transition to the Standard Spend Down Demonstration population for non-pregnant adults twenty-one (21) or older.

Authority: TCA §§ 4-5-201 et seq., 4-5-202, 4-5-209, 71-1-105(12), 71-5-101, 71-5-103, and 71-5-111; 42 USC §§ 1395 et seq., and 42 U.S.C. §§ 1396 et seq. and TennCare II Medicaid Section 1115 Demonstration Waiver.

Chapter 1240-03-02
Coverage Groups Under Medicaid

Amendments

Rule 1240-03-02.03 Coverage of the Medically Needy, is amended by deleting the rule in its entirety and by substituting the following language, so that, as amended, the rule shall read as follows:

1240-03-02-.03 Coverage of The Medically Needy. The following groups of medically needy individuals, if otherwise eligible, are covered:

(1) Pregnant women in one or two-parent families who, but for income and resources, would be eligible as Categorically Needy (Families First/AFDC) and who meet the Medically Needy financial requirements shall remain eligible without regard to income changes and for two (2) full calendar months of postpartum coverage regardless of changes in circumstances.

(2) Aged, blind and disabled non-pregnant individuals age twenty-one (21) and older are no longer eligible for coverage as Medically Needy. Effective April 30, 2005 enrollment in the Medically Needy Category was closed to new enrollees except for children under age twenty-one (21) and pregnant women. Currently eligible Medically Needy Adults will be given the opportunity to apply for Standard Spend Down. Individuals who are subsequently approved will be given coverage for a period of twelve (12) months from their begin date.

(a) Prior to actual enrollment in Standard Spend Down, the Transition Group enrollees were looked at for eligibility in an open category of Medicaid through the ex parte review process. Transition Group enrollees not found eligible in an open category of Medicaid, will be selected for Standard Spend Down processing through the Request for Information (RFI) process.

(3) Children under age twenty-one (21), Caretaker.

(a) All children under age twenty-one (21) who meet the Medically Needy technical and financial eligibility requirements. The caretaker of such children is also covered if:

1. The caretaker is pregnant; or

2. The caretaker is under age twenty-one (21).

(b) Both parents of a dependent child, if both parents are under age twenty-one (21) may be covered, if otherwise eligible.

(c) Newborns of women in one or two-parent families are covered effective from date of birth and continue as long as the child is living with the mother and the mother is Medicaid eligible or if she would be Medicaid eligible, if she were pregnant, up to one (1) year.

(4) Pregnant women and children under twenty-one (21) are classified as Exceptional Medically Needy or Spenddown Medically Needy. Persons are exceptional Medically Needy if eligibility is due to their regular monthly income being equal to or below the medically needy eligibility standards.

(5) Whenever a pregnant woman or child under twenty-one (21) has income which prevents their qualifying as Exceptional Medically Needy eligibility on the basis of income, spenddown eligibility is determined pursuant to these rules.

(6) Individuals who meet Standard Spend Down (SSD) criteria:

(a) Tennessee residents who have been determined to be eligible for the Standard Spend Down (SSD) program.

(b) Individuals enrolled must meet the following criteria:

1. Must be aged twenty-one (21) or older;

2. Must not be pregnant; or

3. Must meet one of the following criteria:

(i) Be sixty-five (65) years of age or older; or

(ii) Be blind, as defined in rule 1240-03-03-.02(3); or

(iii) Be disabled, as defined in rule 1240-03-03-.02(4); or

(iv) Be a “caretaker relative” of a Medicaid-eligible dependent child as defined in T.C.A. § 71-3-153; and

4. Must meet the financial eligibility criteria for income and resources that apply to Medically Needy pregnant women and children eligible under the State plan. These criteria are found at rules 1240-03-03-.05 and 1240-03-03-.06.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-209, 71-1-105(12), 71-5-102, 71-5-106 and 71-5-109; 42 U.S.C.§ 1315, 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(ii), and 42 USC §1396a(e)(4) and (1)(1);.42 CFR § 435.831, 42 C.F.R. § 435.210 and 42 C.F.R. § 435.201; PL 100-485 § 401; and TennCare II Medicaid Section 1115 Demonstration Waiver.

Rule 1240-03-02-.04 Repealed, is amended by renaming the rule “Enrollment For Standard Spend Down Individuals ”, amending the Table of Contents accordingly, and by inserting the following language so that, as amended, the rule shall read as follows:

1240-03-02-.04 Enrollment For Standard Spend Down Individuals.

(1) Transition Group enrollees not found eligible in an open category of Medicaid, will be selected for Standard Spend Down processing through the Request for Information (RFI) process. The TennCare waiver gives the State the authority to establish an enrollment cap and to limit open enrollment periods to the number of individuals who can be admitted under the cap.

(2) Categories for enrollment in the Standard Spend Down (SSD) program are as follows:

(a) Category 1. People who are not eligible for Medicaid at the time the SSD program is implemented and who meet the criteria for the new SSD program. (Bureau of TennCare will announce open enrollment for SSD).

(b) Category 2. People who, at the time the SSD program is implemented, are eligible for Medicaid in a non-pregnant adult Medically Needy category, who have completed their twelve (12) months of Medicaid eligibility, who have been found to be ineligible for any other Medicaid category, and who have been determined to meet the criteria of the SSD program.

(3) Applicants in the above categories will be enrolled as follows:

(a) Category 1 (applicants who will be allowed to apply when announced by the Bureau of TennCare) will be enrolled only through a single toll-free telephone point of entry (the Call-in Line) initiated in periods of acceptance of new applications. In each open enrollment period, the State will determine a specified number of calls that it will accept through the Call-in Line based on the number of Category 1 applications that, together with projected pending applications from Category 2, the State estimates it can process within Federal timeliness standards. The number of calls to be accepted in open enrollment periods will also be based on the number of remaining slots available under the enrollment target and the number of slots necessary to reserve for non-pregnant Medically Needy adults in Category 2. The State will not accept or track calls received outside of open enrollment periods.

(b) For Category 2 individuals, the State will determine their SSD eligibility on a rolling basis in conjunction with their termination from Medicaid, and shall reserve sufficient slots within the enrollment target to ensure that all such persons who are eligible may be accepted in the SSD category.

Upon implementation of the SSD program, the State will review all Category 2 individuals for either eligibility in a new Medicaid category or approval as a Standard Spend Down eligible. After the review of all Category 2 individuals is complete and it is determined how many additional enrollees can be added to the SSD program without exceeding the enrollment cap, the State will begin enrolling persons in Category 1.

(4) New open enrollment periods as announced by the Bureau of TennCare. Once the State has reached its targeted enrollment, new open enrollment periods will be scheduled when enrollment in the SSD program drops to ninety percent (90%) of target enrollment. Any subsequent open enrollment periods will remain open until a pre-determined number of calls to the Call-in Line have been received. The number of calls to be received will be based on the State’s determination of the minimum number of applications necessary to fill open slots in the program and the number of applications the State estimates it can process in a timely manner in accordance with Federal

standards. The State's decision to open or close enrollment is a policy decision that is within the State's discretion and the State is not required to provide fair hearings for challenges to these decisions.

(5) Initial application period for Category 1 (as announced by the Bureau of TennCare).

The State will establish an initial target enrollment figure based on the State's determination of the minimum number of applications the State estimates it can process in a timely manner in accordance with Federal standards. The State's decision to open or close enrollment is a policy decision that is within the State's discretion and the State is not required to provide fair hearings for challenges to these decisions. A toll-free Call-in Line to receive requests for applications will be established and requests will be processed as follows:

(a) Callers to the Call-in Line will be asked for basic demographic information and will be assigned a unique identifier.

(b) After conducting a match to verify that callers are not already enrolled in TennCare Medicaid and if they are not Medicaid-eligible, the State will send each non-enrolled caller a written application form, accompanied by a letter advising the individual of the requirement to complete, sign, and return the application within thirty (30) days. (Those callers who are already enrolled in TennCare Medicaid will be sent letters advising them that they currently have benefits and need not apply.)

(c) Completed signed applications received by the State by the 30-day deadline established by the State will be evaluated for Medicaid eligibility and SSD eligibility. Applications received after the deadline will not be reviewed for SSD eligibility but will still be processed for Medicaid eligibility. There will be no "good cause" exception to the written application deadline set by the State. If the State does not receive an application by the deadline, the State will send the individual a letter advising him or her that since no application was received, the State will not make an eligibility determination for him or her, but the individual is free to apply for SSD during any open enrollment period and to apply for Medicaid at any time. No hearings will be granted to individuals concerning this process who have not timely submitted signed applications unless the individual alleges a valid factual dispute that he or she did submit a signed, written application within the deadline.

(d) Since all SSD applications received during an open enrollment period will be processed and either approved or denied, there is no requirement for the State to maintain a "waiting list" of potential SSD applicants. No applications submitted in one open enrollment period will be carried forward to future open enrollment periods. The State will determine SSD eligibility within the timeframes specified by Federal regulations at 42 C.F.R. 435.911; such timeframes will begin on the date a signed written application is received by the State.

(6) Effective date of eligibility. The effective date provisions outlined below only apply to SSD eligibility and do not apply to other categories of TennCare eligibility.

(a) The effective date of SSD eligibility for individuals whose enrollment is originally initiated through the Call-in Line and who submit a timely signed application will be the later of:

1. The date that their call was received by the Call-in Line; or

2. The date spenddown is met (which must be no later than the end of the one month budget period – in this case, the end of the month of the original call to the Call-in Line).

(b) The effective date of eligibility for Medically Needy pregnant women and children under age twenty-one (21) is the later of:

1. The date of application; or

2. The date that spenddown is met – in this case, the end of the month that the application is received by the Department of Human Services.

(7) Period of eligibility. All enrollees in the SSD demonstration category will have an eligibility period of twelve (12) months from the effective date of the eligibility. At the end of the 12-month period the enrollee will need to have his eligibility redetermined in order to establish SSD or Medicaid eligibility. The duration of the eligibility period for SSD eligibility is the same as that used for Medically Needy pregnant women and children in TennCare Medicaid.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-209, 71-1-105(12), 71-5-102 and 71-5-109; 42 U.S.C. §§ 1396et seq., 42 U.S.C. § 1396a(a)(10)(A)(ii), 42 U.S.C. § 1396a(e)(4) and 42 U.S.C. § 1315; and TennCare II Medicaid Section 1115 Demonstration Waiver.

Chapter 1240-03-03
Technical And Financial Eligibility Requirements For Medicaid

Amendments

Rule 1240-03-03-.06, Income Limitations For The Medically Needy, is amended by renaming the rule "Income Limitations For The Medically Needy And Standard Spend Down", amending the Table of Contents accordingly, and by deleting paragraph (4) in its entirety and by substituting the following language, so that as amended, paragraph (4) subparagraphs (a) and (b) shall read as follows:

1240-03-03-.06 Income Limitations For The Medically Needy and Standard Spend Down.

(4) Countable medical or remedial expenses for determination of spenddown eligibility.

(a) Medical and remedial expenses that remain unpaid, have not been written off by the health care provider, and that are the client's responsibility, may, pursuant to this paragraph (4), be applied to any excess income to reduce income in order to qualify for eligibility in the spenddown category.

(b) For new applicants during open enrollment periods as announced by the Bureau of TennCare or persons currently Exceptionally Eligible who did not meet spenddown criteria in order to qualify during their last eligibility determination, the following medical/remedial expenses will be counted toward the reduction of income in the Standard Spend Down coverage group:

1. Expenses incurred during the month of application, whether paid or unpaid;

2. Expenses paid during the month of application, regardless of when such bills were incurred;

3. Expenses incurred during the three (3) calendar months prior to the month of application whether paid or unpaid.

(i) Expenses paid during the three (3) calendar months prior to the month of application will not be counted unless such expenses were also incurred during those three (3) calendar months.

(ii) Any expenses incurred before the three (3) calendar months prior to the month of application will not be counted unless payment is made on those expenses during the month of application, in which case only the amount paid during the month of application is counted.

(iii) When any new applicants apply again after their first year of eligibility, countable medical or remedial expenses will be limited to the expenses incurred or paid as described in parts 1, 2 and 3(i) and (ii) to expenses for the new month of application and three (3) calendar months prior to the new month of application, plus any unpaid expenses that were previously verified and documented as part of this new spenddown process, i.e., only those expenses incurred or paid during the month of application and expenses incurred during the three (3) calendar months prior to that month of application. Verified expenses can be carried over as long as the individual remains continuously eligible, the expenses remain unpaid and are not written off by the provider. If the individual loses eligibility at any point, or if the individual ever qualifies as Exceptionally Eligible in the future, the carryover of unpaid medical expenses ends, and the individual is limited to the expenses listed in subparagraph (b)1, 2 and 3(i) and (ii).

(iv) When an Exceptionally Eligible individual re-applies, no carryover of expenses is permitted because spenddown criteria were not required to qualify as Exceptionally Eligible, and the individual is limited to the expenses listed in (b)1, 2, and 3(i) and (ii). If thereafter, the individual does have to meet spenddown criteria to re-qualify, then, for the continuous eligibility period thereafter, applicable expenses that were verified and documented in any eligibility determination, after the period in which the person qualified as Exceptionally Eligible, that remain unpaid will be counted. Any medical/ remedial expenses that otherwise may have been used to qualify for medically needy coverage under spenddown criteria in the period prior to the period in which the individual did not have to meet spenddown criteria to qualify for medically needy coverage cannot be carried over in order to establish eligibility.

(c) For current medically needy eligibles, the following medical/remedial expenses will be counted toward the reduction of income in medically needy coverage groups:

1. Expenses incurred during the month of application, whether paid or unpaid;

2. Expenses paid during the month of application, regardless of when such bills were incurred;

3. Expenses incurred during the three (3) calendar months prior to the month of application; whether paid or unpaid.

(i) Expenses paid during the three (3) calendar months prior to the month of application will not be counted unless such bills were also incurred during those three (3) calendar months.

(ii) Any expenses incurred before the three (3) calendar months prior to the month of application will not be counted unless:

(I) Payment is made on those expenses during the month of application, in which case only the amount paid during the month of application is counted; or

(II) All of the following are satisfied:

I. Those expenses were previously verified in order to meet spenddown criteria;

II. The individual has remained continuously eligible in a spenddown category since that time;

III. The individual met a spenddown criteria during each period of eligibility in order to qualify; and

IV. The expenses remain unpaid and have not been written off by the provider.

A. When the circumstances of subitem (II)IV exist, the carryover that has not been previously deducted from income for purposes of qualifying for spenddown can be applied. The carryover expense can include an unused portion or an entirely unpaid expense.

B. Only in cases of individuals who are currently eligible, expenses incurred before the three (3) calendar months prior to the initial month of application may be carried over, but only unpaid expenses that were previously verified and documented in the DHS eligibility data system as part of the spenddown process will be counted. Expenses that had not been provided earlier to determine eligibility cannot be counted.

C. To be counted, the expenses must have remained unpaid, and only the portions not used earlier to qualify under spenddown criteria are counted.

4. Not all expenses incurred during the entire continuous eligibility period will be counted towards spenddown eligibility. Only expenses identified in (c)1, 2 and 3 above including qualifying carryover expenses from earlier spenddown determinations will be counted.

5. When a gap in eligibility occurs or there is any period of eligibility in which the individual has no excess income, the individual must re-qualify under subparagraph (b) above.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 4-5-209, 71-1-105(12), 71-5-102 and 71-5-109; 42 U.S.C. §§ 1396et seq. and 42 U.S.C. § 1315; and TennCare II Medicaid Section 1115 Demonstration Waiver.

The public necessity rules set out herein were properly filed in the Department of State on the 24th day of January, 2008 and will be effective from the date of filing for a period of 165 days. These public necessity rules will remain in effect through the 7th day of July, 2008. (01-07-08; DBID 2808 through 2810)