

Department of State
Division of Publications
 312 Rosa L. Parks Ave., 8th Floor, Snodgrass/TN Tower
 Nashville, TN 37243
 Phone: 615-741-2650
 Email: publications.information@tn.gov

For Department of State Use Only

Sequence Number: 01-08-21
 Rule ID(s): 9449
 File Date: 1/11/2021
 Effective Date: 4/11/2021

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Department of Finance and Administration
Division:	Division of TennCare
Contact Person:	George Woods
Address:	Division of TennCare 310 Great Circle Road Nashville, TN 37243
Phone:	(615) 507-6446
Email:	george.woods@tn.gov

Revision Type (check all that apply):

- Amendments
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that ALL new rule and repealed rule numbers are listed in the chart below. Please enter only ONE Rule Number/Rule Title per row.)

Chapter Number	Chapter Title
1200-13-21	CoverKids
Rule Number	Rule Title
1200-13-21-.02	Definitions
1200-13-21-.04	Enrollment and Reassignment
1200-13-21-.05	Benefits
1200-13-21-.06	Exclusions
1200-13-21-.07	Cost Sharing
1200-13-21-.08	Disenrollment
1200-13-21-.09	Review of CoverKids Decisions
1200-13-21-.10	Providers

Place substance of rules and other info here. Please be sure to include a detailed explanation of the changes being made to the listed rule(s). Statutory authority must be given for each rule change. For information on formatting rules go to

<https://sos.tn.gov/products/division-publications/rulemaking-guidelines>.

Chapter 1200-13-21 CoverKids Table of Contents is amended by inserting new rule number and title "1200-13-21-.04 Enrollment and Reassignment" following rule number "1200-13-21-.03 Eligibility" and renumbering existing rule "1200-13-21-.04 Benefits" as rule "1200-13-21-.05 Benefits", and is further amended by inserting new rule number and title "1200-13-21-.06 Exclusions" following renumbered rule "1200-13-21-.05 Benefits" and renumbering subsequent rules appropriately so that, as amended, the Table of Contents shall read as follows:

1200-13-21-.01 Scope and Authority
1200-13-21-.02 Definitions
1200-13-21-.03 Eligibility
1200-13-21-.04 Enrollment and Reassignment
1200-13-21-.05 Benefits
1200-13-21-.06 Exclusions
1200-13-21-.07 Cost Sharing
1200-13-21-.08 Disenrollment
1200-13-21-.09 Review of CoverKids Decisions
1200-13-21-.10 Providers

Statutory Authority: T. C. A. §§ 4-5-202, 4-5-203, 4-5-204, 71-5-105, 71-5-109 and 42 C.F.R. Part 455 Subpart E.

Rule 1200-13-21-.02 Definitions Paragraph (1) Covered services is amended by deleting the definition and replacing it with a new definition so as amended Paragraph (1) shall read as follows:

- (1) Covered services. Benefits and services listed in this Chapter and provided for enrollees in the CoverKids program by an MCO, DBM, PPA or other entity under contract with the Division of TennCare.

Rule 1200-13-21-.02 Definitions Paragraph (2) CoverKids is amended by deleting the period at the end of the definition and inserting the punctuation and language ",and administered through the Division of TennCare, which provides health coverage for children under nineteen (19) years of age and pregnant women, who do not have health insurance and do not qualify for TennCare." so as amended Paragraph (2) shall read as follows:

- (2) CoverKids. The program created by T.C.A. §§ 71-3-1101, et seq., its authorized employees and agents, as the context of this Chapter requires, and administered through the Division of TennCare, which provides health coverage for children under nineteen (19) years of age and pregnant women, who do not have health insurance and do not qualify for TennCare.

Rule 1200-13-21-.02 Definitions Paragraph (3) CoverKids network is amended by deleting the language "the Plan Administrator or Dental Benefits Manager" and replacing it with the language "an MCO, DBM, PPA or other entity under contract with the Division of TennCare" and is further amended by deleting the last sentence so as amended Paragraph (3) shall read as follows:

- (3) CoverKids network. A group of health care providers that have entered into contracts with an MCO, DBM, PPA or other entity under contract with the Division of TennCare to furnish covered services to CoverKids enrollees.

Rule 1200-13-21-.02 Definitions is amended by inserting a new Paragraph (4) CoverKids Pregnant Women and by renumbering existing Paragraph (4) and subsequent paragraphs appropriately so as amended Paragraph (4) shall read as follows:

- (4) CoverKids Pregnant Women. The part of the CoverKids program that provides coverage for the unborn children of pregnant women with no source of health coverage who meet the CoverKids eligibility requirements.

Rule 1200-13-21-.02 Definitions Paragraph (4) renumbered as (5) CoverKids provider is amended by deleting the definition and replacing it with a new definition so as amended Paragraph (5) shall read as follows:

- (5) CoverKids provider. A health care provider who accepts as payment in full for furnishing benefits to a CoverKids enrollee the amounts paid pursuant to an approved agreement with a TennCare contractor. Such payment may include copayments from the enrollee or the enrollee's responsible party. A CoverKids provider, including an Out-of-State Emergency Provider as defined in Rule 1200-13-13-.01, must be enrolled with TennCare and must abide by all CoverKids rules and regulations, including requirements regarding provider billing of patients as found in Rule .10. CoverKids providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in the federal Medicare, Medicaid or CHIP programs.

Rule 1200-13-21-.02 Definitions is amended by inserting a new Paragraph (9) Managed Care Organization (MCO) and by renumbering existing Paragraph (9) and subsequent paragraphs appropriately so as amended Paragraph (9) shall read as follows:

- (9) Managed Care Organization (MCO). An appropriately licensed Health Maintenance Organization (HMO) approved by the Division of TennCare as capable of providing medical, behavioral, and long-term care services which has signed a Contractor Risk Agreement, as defined in 1200-13-13-.01, with the Division of TennCare and operates a provider network to provide covered services to CoverKids enrollees.

Rule 1200-13-21-.02 Definitions Paragraph (9) renumbered as (11) Non-CoverKids provider is amended by deleting the language and punctuation "Plan Administrator's or Dental Benefits Manager's network." and replacing it with new language and punctuation "network of a TennCare-contracted MCO, DBM or PPA or other entity contracted to administer CoverKids benefits." so as amended Paragraph (11) shall read as follows:

- (11) Non-CoverKids provider. A health care provider of non-emergency services that does not participate in the network of a TennCare-contracted MCO, DBM, or PPA or other entity contracted to administer CoverKids benefits.

Rule 1200-13-21-.02 Definitions Paragraph (11) renumbered as (13) Plan Administrator or PA is amended by deleting the paragraph and replacing it with a new paragraph so as amended Paragraph (13) shall read as follows:

- (13) Pharmacy Plan Administrator (PPA). The entity responsible for the administrative services associated with providing pharmaceutical related covered services to CoverKids enrollees.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

Chapter 1200-13-21 is amended by inserting a new Rule 1200-13-21-.04 Enrollment and Reassignment and renumbering existing Rule .04 and all subsequent rules appropriately so as amended the new Rule .04 shall read as follows:

1200-13-21-.04 Enrollment and Reassignment.

- (1) Enrollment. CoverKids enrollees are enrolled into MCOs for the provision of covered medical and behavioral health services, a DBM for provision of covered dental services, and a PPA for administration of covered pharmacy services. Enrollment procedures differ according to the type of managed care entity, the geographic area, and the number of managed care entities operating in each geographic area.
- (a) Managed Care Organizations (MCOs).
1. Individuals or families determined eligible for CoverKids shall select an MCO at the time of application. The MCO must be available in the Grand Division, as defined in Rule 1200-13-13-.01, in which the enrollee lives. All family members living in the same household and enrolled in CoverKids must be assigned to the same MCO. An enrollee is given his choice of MCOs when possible. If the requested MCO cannot accept new enrollees, the Division of TennCare will assign each enrollee to an MCO that is accepting new enrollees.
 2. A CoverKids enrollee may change MCOs one (1) time within the initial ninety (90) calendar days (inclusive of mail time) from the date of the letter informing the enrollee of his MCO assignment, if there is another MCO in the enrollee's Grand Division that is currently accepting new enrollees. No additional changes will be allowed except as otherwise specified in this rule. An enrollee shall remain a member of the designated plan until he is given an opportunity to

change once each year during an annual change period. The annual change period will occur each year in March for enrollees in West Tennessee, in May for enrollees in Middle Tennessee, and in July for enrollees in East Tennessee. Thereafter, an MCO change is permitted only during an annual change period, unless the Division of TennCare authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment as specified in paragraph (2)(b) below. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until he is enrolled in the requested MCO.

3. Each MCO shall offer its enrollees, to the extent possible, freedom of choice among CoverKids providers. If after notification of enrollment the enrollee has not chosen a primary care provider (PCP), one will be selected for him by the MCO. The period during which an enrollee may choose his primary care provider shall not be less than fifteen (15) calendar days.
4. In the event a pregnant woman entering an MCO's plan is:
 - (i) Receiving medically necessary prenatal care the day before enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the MCO's provider network until such time as the MCO can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health.
 - (ii) In her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the MCO shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period. Reimbursement to an out-of-network provider shall be as set out in Rule .10.
- (b) Dental Benefits Manager (DBM). Children enrolled in CoverKids shall be assigned to the DBM under contract with the Division of TennCare to provide dental benefits through the CoverKids Program.
- (c) Pharmacy Plan Administrator (PPA). CoverKids enrollees shall be assigned to the PPA under contract with the Division of TennCare to provide pharmacy benefits for both medical and behavioral health services through the CoverKids Program.

(2) Reassignment.

- (a) Reassignment to an MCO other than the current MCO in which the CoverKids enrollee is enrolled is subject to another MCO's capacity to accept new enrollees and must be approved by the Division of TennCare in accordance with one of the following:
 1. During the initial ninety (90) day period following notification of MCO assignment as described at paragraph (1), a CoverKids enrollee may request a change of MCOs.
 2. A CoverKids enrollee must change MCOs if he moves outside the MCO's Grand Division, and that MCO is not authorized to operate in the enrollee's new place of residence. Until the CoverKids enrollee selects or is assigned to a new MCO and his enrollment is deemed complete, his medical care will remain the responsibility of the original MCO.
 3. If an enrollee's MCO withdraws from participation in the CoverKids Program, TennCare will assign him to an MCO operating in his Grand Division, if one is available. The enrollee will be provided notice of the change and will have ninety (90) days to select another MCO in his Grand Division.
 4. An enrollee shall be given an opportunity to change MCOs once each year during an annual change period. Only one (1) MCO change is permitted every twelve (12) months, unless the Division of TennCare authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until enrolled in the requested MCO. If an enrollee changes MCOs during an annual change period, all family members living in the same household and enrolled in CoverKids shall also be changed.

- (b) A CoverKids enrollee may change MCOs if the Division of TennCare has granted a request for a change in MCOs or an appeal of a denial of a request for a change in MCOs has been resolved in his favor based on hardship criteria.
1. The following situations will not be determined to be "hardships":
 - (i) The enrollee is unhappy with the current MCO or PCP, but there is no hardship medical situation (as stated in Part 2 below);
 - (ii) The enrollee claims lack of access to services but the plan meets the state's access standard;
 - (iii) The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
 - (iv) The enrollee is concerned that a current provider might drop out of the plan in the future;
 - (v) The enrollee's PCP is no longer in the MCO's network, the enrollee wants to continue to see the current PCP and has refused alternative PCP or provider choices offered by the MCO.
 2. Requests for hardship MCO reassignments must meet all of the following six (6) hardship criteria for reassignment. Determinations will be made on an individual basis.
 - (i) An enrollee has a medical condition that requires complex, extensive, and ongoing care; and
 - (ii) The enrollee's specialist has stopped participating in the member's current MCO network and has refused continuation of care to the enrollee in his current MCO assignment; and
 - (iii) The ongoing medical condition of the enrollee is such that another physician or provider with appropriate expertise would be unable to take over his care without significant and negative impact on his care; and
 - (iv) The current MCO has been unable to negotiate continued care for this enrollee with the current specialist; and
 - (v) The current provider of services is in the network of one or more alternative MCOs; and
 - (vi) An alternative MCO is available to the enrollee (i.e., has not given notice of withdrawal from the CoverKids Program, is not in receivership, and is not at member capacity for the member's region).
- (c) Requests to change MCOs submitted by CoverKids enrollees shall be evaluated in accordance with the hardship criteria referenced in Subparagraph (b) above. If an enrollee's request to change MCOs is granted due to hardship, all family members living in the same household and enrolled in CoverKids will be assigned to the new MCO. Upon denial of a request to change MCOs, enrollees shall be provided notice and appeal rights as described in applicable provisions of Rule .09.
- (d) The Division of TennCare shall only accept a request to change MCO assignment from the affected enrollee, his parent, guardian, or spouse.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

Rule 1200-13-21-.04 renumbered as 1200-13-21-.05 Benefits Paragraph (2) is amended by deleting the word "and" preceding the word "vision" and inserting the punctuation and language ", and hearing aids and cochlear implants" following the words "vision services" so as amended Paragraph (2) shall read as follows:

- (2) Mothers of eligible unborn children who are over age 19 receive all benefits listed in Paragraph (1), subject to the same limitations and as medically necessary, except chiropractic services, routine dental services, vision services, and hearing aids and cochlear implants are not covered for these enrollees.

Rule 1200-13-21-.04 renumbered as 1200-13-21-.05 Benefits is amended by deleting current Paragraph (4) and inserting a new Paragraph (4) so as amended Paragraph (4) shall read as follows:

- (4) An MCO or DBM may provide non-covered items or services as cost effective alternatives to covered items or services. Such cost effective alternative services may be provided because they are either (1) alternatives to covered CoverKids services that, in the judgment of the MCO or DBM, are cost-effective or (2) preventative in nature and offered to avoid the development of conditions that, in the judgment of the MCO or DBM, would require more costly treatment in the future. Cost effective alternative services are not covered services and are provided only at the discretion of the MCO or DBM, subject to approval by the Division of TennCare.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

Chapter 1200-13-21 is amended by inserting a new Rule 1200-13-21-.06 Exclusions and renumbering existing Rule .06 and all subsequent rules appropriately so as amended the new Rule .06 shall read as follows:

1200-13-21-.06 Exclusions.

- (1) The services and items set out in the TennCare Medicaid Exclusions Rule 1200-13-13-.10(1) and (3)(b) are excluded from coverage by the CoverKids program.
- (2) In addition to the services and items excluded by Paragraph (1), the following services, products and supplies are also excluded from coverage by the CoverKids program:
- (a) Audiological therapy or training
 - (b) Beds and bedding equipment as follows:
 - 1. Powered air flotation beds, air fluidized beds (including Clinitron beds), water pressure mattress, or gel mattress
 - 2. Bead beds, or similar devices
 - 3. Bed boards
 - 4. Bedding and bed casings
 - 5. Ortho-prone beds
 - 6. Oscillating beds
 - 7. Springbase beds
 - 8. Vail beds, or similar beds
 - (c) Biofeedback
 - (d) Cushions, pads, and mattresses as follows:
 - 1. Aquamatic K Pads
 - 2. Elbow protectors
 - 3. Heat and massage foam cushion pads
 - 4. Heating pads

5. Heel protectors
 6. Lamb's wool pads
 7. Steam packs
- (e) Diagnostic tests conducted solely for the purpose of evaluating the need for a service which is excluded from coverage under these rules
 - (f) Ear plugs
 - (g) Floor standers, meaning stationary devices not attached to a wheelchair base and not built into the operating system of a power wheelchair that are designed to hold in an upright position an enrollee who uses a wheelchair and who has limited or no ability to stand on his own
 - (h) Food supplements and substitutes including formulas
 - (i) Humidifiers (central or room) and dehumidifiers
 - (j) Medical supplies, over-the-counter, as follows:
 1. Alcohol, rubbing
 2. Band-aids
 3. Cotton balls
 4. Eyewash
 5. Peroxide
 6. Q-tips or cotton swabs
 - (k) Nutritional supplements and vitamins
 - (l) Purchase, repair, or replacement of materials or equipment when the reason for the purchase, repair, or replacement is the result of enrollee abuse
 - (m) Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:
 1. Explanation of continuing medical necessity for the item, and
 2. Explanation that the item was stolen or destroyed, and
 3. Copy of police, fire department, or insurance report if applicable
 - (n) Radial keratotomy
 - (o) Reimbursement to a provider or enrollee for the replacement of a rented durable medical equipment (DME), as defined in 1200-13-13-.01, item that is stolen or destroyed
 - (p) Repair of DME items not covered by CoverKids
 - (q) Repair of DME items covered under the provider's or manufacturer's warranty
 - (r) Repair of a rented DME item
 - (s) Standing tables

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

Rule 1200-13-21-.05 renumbered as 1200-13-21-.07 Cost Sharing Paragraph (2) Subparagraph (a) is amended by deleting existing Part 4. and renumbering existing Part 5. as Part 4. and is further amended by adding the parenthetical phrase "(well-child visits)" following the word "assessments" so as amended Part 4. shall read as follows:

4. Routine health assessments (well-child visits) and immunizations given under American Academy of Pediatrics guidelines.

Rule 1200-13-21-.05 renumbered as 1200-13-21-.07 Cost Sharing Paragraph (3) is amended by deleting the language "5 percent" and replacing it with the language "five percent (5%)" so as amended Paragraph (3) shall read as follows:

- (3) An enrollee's annual cost sharing obligations shall not exceed five percent (5%) of his household's annual income.

Rule 1200-13-21-.05 renumbered as 1200-13-21-.07 Cost Sharing is amended by adding new Paragraphs (5) and (6) so as amended Paragraphs (5) and (6) shall read as follows:

- (5) Children receiving hospice services are exempt from all copay requirements.
- (6) Pregnant enrollees are exempt from all copay requirements.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

Rule 1200-13-21-.07 renumbered as 1200-13-21-.09 Review of CoverKids Decisions Paragraph (2) is amended by deleting the words "Health Services" in the first sentence and replacing them with the words "Adverse Medical and Dental Benefit Determination" and is amended by deleting the word "health" wherever it appears in the second sentence and replacing it with the words "medical and dental" and is further amended by deleting the language "the following provisions:" and replacing it with the language "Rule 1200-13-13-.11, except that enrollees shall not be entitled to continuation of benefits pursuant to 42 CFR § 457.1260." so as amended Paragraph (2) shall read as follows:

- (2) Adverse Medical and Dental Benefit Determination Matters. A parent or authorized representative of a CoverKids enrollee may request review of a CoverKids action to delay, deny, reduce, suspend, or terminate medical and dental services, or a failure to approve, furnish, or provide payment for medical and dental services in a timely manner, according to Rule 1200-13-13-.11, except that enrollees shall not be entitled to continuation of benefits pursuant to 42 CFR § 457.1260.

Rule 1200-13-21-.07 renumbered as 1200-13-21-.09 Review of CoverKids Decisions Paragraph (2) is amended by inserting a new Paragraph (3) immediately preceding Subparagraphs (a) through (e) and by renumbering subsequent paragraphs appropriately so as amended Paragraph (3) shall read as follows:

- (3) Adverse Pharmacy Benefit Determination Matters. A parent or authorized representative of a CoverKids enrollee may request review of a CoverKids action to delay, deny, reduce, suspend, or terminate pharmacy services, or a failure to approve, furnish, or provide payment for pharmacy services in a timely manner, according to the following provisions:

Rule 1200-13-21-.07 renumbered as 1200-13-21-.09 Review of CoverKids Decisions Paragraph (3) Subparagraph (a) is amended by deleting the word "health" wherever it appears and replacing it with the word "pharmacy" so as amended Subparagraph (a) shall read as follows:

- (a) Notice. Any decision denying or delaying a requested pharmacy service, reducing, suspending or terminating an existing pharmacy service, or failure to approve, furnish or provide payment for pharmacy services in a timely manner shall be in writing and must contain the reason for the determination, an explanation of review rights and procedures, the standard and expedited time frames for review, the manner of requesting a review, and the circumstances under which

existing pharmacy services may continue pending review unless there is question that the existing pharmacy services are harmful.

Rule 1200-13-21-.07 renumbered as 1200-13-21-.09 Review of CoverKids Decisions Paragraph (3) Subparagraph (b) is amended by inserting the word "Pharmacy" before the words "Plan Administrator" and by deleting the language "(PA) or Dental Benefits Manager (DBM)" and replacing it with the parenthetical "(PPA)" and is further amended by deleting the language "PA or DBM" wherever it appears and replacing it with the acronym "PPA" so as amended Subparagraph (b) shall read as follows:

- (b) Pharmacy Plan Administrator (PPA) Review. A parent or authorized representative may commence the review process by submitting a written request to the PPA within 30 days of issuance of written notice of the action or, if no notice is provided, from the time the enrollee becomes aware of the action, not to exceed six (6) months from when the action occurred. The PPA will review this request and issue a written decision within 30 days of receipt of this request. Expedited reviews (within 72 hours) will be available for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines the medical situation to be life threatening or would seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. This determination should be made in legible writing with an original signature.

Rule 1200-13-21-.07 renumbered as 1200-13-21-.09 Review of CoverKids Decisions Paragraph (3) Subparagraph (c) is amended by deleting the language "PA's or DBM's" wherever it appears and replacing it with the acronym "PPA's" so as amended Subparagraph (c) shall read as follows:

- (c) State Informal Review. After the PPA's internal review is completed, the parent or authorized representative of an enrollee who disagrees with the decision may request further review by telephone or by submitting a letter or form to the Division of TennCare, CoverKids Appeals, which must be received within 8 days of the PPA's decision. The Appeals Coordinator will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator will request review by the state's independent medical consultant and a written decision will be issued within 20 days of receipt of the request for further review.

Rule 1200-13-21-.07 renumbered as 1200-13-21-.09 Review of CoverKids Decisions Paragraph (3) Subparagraph (e) is amended by deleting the words "health or dental" and replacing them with the word "pharmacy" and further is amended by deleting the language "PA or DBM" wherever it appears and replacing it with the acronym "PPA" so as amended Subparagraph (e) shall read as follows:

- (e) Time for Reviews. Review of all non-expedited pharmacy services appeals will be completed within 90 days of receipt of the initial request for review by the PPA. Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours at each of the PPA and State levels) for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines the medical situation to be life threatening or would seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. This determination should be made in legible writing with an original signature.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers Paragraph (1) is amended in Subparagraph (a) by deleting the word "rule" and replacing it with the word "Chapter" and Paragraph (1) is further amended by deleting the language "PA or DBM" wherever it appears in Subparagraphs (a) through (c) and replacing it with the language "MCO, DBM, or PPA" so as amended Paragraph (1) Subparagraphs (a) through (c) shall read as follows:

- (a) All CoverKids providers, as defined in this Chapter, must accept as payment in full for provision of covered services to a CoverKids enrollee, the amount paid by the MCO, DBM, or PPA, plus any copayment required by the CoverKids program to be paid by the individual.
- (b) Any non-CoverKids providers who furnish CoverKids covered services by authorization from the MCO, DBM, or PPA must accept as payment in full for provision of covered services to CoverKids enrollees the amounts paid by the MCO, DBM, or PPA plus any copayment required by the

CoverKids program to be paid by the individual.

- (c) CoverKids will not pay for non-emergency services furnished by non-CoverKids providers unless these services are authorized by the MCO, DBM, or PPA. Any non-CoverKids provider who furnishes CoverKids Program covered non-emergency services to a CoverKids enrollee without authorization from the MCO, DBM, or PPA does so at his own risk. He may not bill the patient for such services except as provided in Paragraph (3).

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers Paragraph (2) Subparagraph (a) is amended by deleting the language "PA or DBM" wherever it appears and replacing it with the language "MCO, DBM, or PPA" so as amended Subparagraph (a) shall read as follows:

- (a) When the MCO, DBM, or PPA authorizes a service to be rendered by a non-CoverKids provider, payment to the provider shall be no less than 80% of the lowest rate paid by the MCO, DBM, or PPA to equivalent participating CoverKids network providers for the same service, consistent with the methodology contained in Rule 1200-13-13-.08(2)(a).

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers is amended by inserting new Paragraphs (3) and (4) and renumbering existing Paragraph (3) as Paragraph (5) and all subsequent Paragraphs appropriately so as amended new Paragraphs (3) and (4) shall read as follows:

- (3) Participation in the CoverKids program will be limited to providers who:
 - (a) Accept, as payment in full, the amounts paid by the MCO, DBM, or PPA, including copays from the enrollee, or the amounts paid in lieu of the MCO, DBM, or PPA by a third party (Medicare, insurance, etc.);
 - (b) Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice, or licensure by the Tennessee Department of Mental Health and Substance Abuse Services, if appropriate;
 - (c) Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);
 - (d) Agree to maintain and provide access to the Division of TennCare and/or its agent all CoverKids enrollee medical records for ten (10) years from the date of service or upon written authorization from TennCare following an audit, whichever is shorter;
 - (e) Provide medical assistance at or above recognized standards of practice; and
 - (f) Comply with all contractual terms between the provider and the MCO, DBM, or PPA (as appropriate) and CoverKids policies as outlined in federal and state rules and regulations and CoverKids provider manuals and bulletins.
 - (g) Failure to comply with any of the above provisions (a) through (f) may subject a provider to the following actions:
 1. The provider may be subject to stringent review/audit procedures, which may include clinical evaluation of services and a prepayment requirement for documentation and justification for each claim.
 2. The Division of TennCare may withhold or recover payments to an MCO, DBM, or PPA in cases of provider fraud, willful misrepresentation, or flagrant noncompliance with contractual requirements and/or CoverKids policies.
 3. The Division of TennCare may refuse to approve or may suspend provider participation with a provider if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the US Title XX Services Program.

4. The Division of TennCare may refuse to approve or may suspend provider participation if it determines that the provider did not fully and accurately make any disclosure of any person who has ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the US Title XX Services Program since the inception of these programs.
5. The Division of TennCare shall refuse to approve or shall suspend provider participation if the appropriate State Board of Licensing or Certification fails to license or certify the provider at any time for any reason or suspends or revokes a license or certification.
6. The Division of TennCare shall refuse to approve or shall suspend provider participation upon notification by the US Office of Inspector General Department of Health and Human Services that the provider is not eligible under Medicare, Medicaid, or CHIP for federal financial participation.
7. The Division of TennCare may recover from an MCO, DBM, or PPA any payments made by an enrollee and/or his family for a covered service, in total or in part, except as permitted. If a provider knowingly bills an enrollee and/or his family for a covered service, in total or in part, except as permitted, the Division of TennCare may terminate the provider's participation in CoverKids.

(4) Solicitations and Referrals

- (a) MCOs, DBMs, PPAs, and providers shall not solicit CoverKids enrollees by any method offering as enticements other goods and services (free or otherwise) for the opportunity of providing the enrollee with CoverKids-covered services that are not medically necessary and/or that overutilize the CoverKids program.
- (b) An MCO, DBM, or PPA may request a waiver from this restriction in writing to the Division of TennCare. TennCare shall determine the value of a waiver request based upon the medical necessity and need for the solicitation. The MCO, DBM, or PPA may implement the solicitation only upon receipt of a written waiver approval from TennCare. This waiver is not transferable and may be canceled by TennCare upon written notice.
- (c) CoverKids payments for services related to a non-waivered solicitation enticement shall be considered by the Division of TennCare as a non-covered service and recouped. Neither the MCO, DBM, PPA nor the provider may bill the enrollee for non-covered services recouped under this authority.
- (d) A provider shall not offer or receive remuneration in any form related to the volume or value of referrals made or received from or to another provider.

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers Paragraph (3) renumbered as Paragraph (5) Subparagraph (b) Part 1, Subpart (iii) and Part 2. are amended by deleting the language "PA or DBM" wherever it appears and replacing it with the language "MCO, DBM, or PPA" so as amended Paragraph (5) Subparagraph (b) Part 1, Subpart (iii) and Part 2. shall read as follows:

- (iii) The enrollee's MCO, DBM, or PPA has provided confirmation to the provider that the enrollee has reached his benefit limit for the applicable service.
2. The provider submits a claim for service to the MCO, DBM, or PPA and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. After informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee for services within that same exhausted benefit category without having to submit claims for those subsequent services for repeated MCO, DBM, or PPA denial. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by CoverKids, the provider may bill the enrollee for that service.

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers Paragraph (4) renumbered as Paragraph (6) Subparagraphs (b) and (e) are amended by deleting the language "PA or DBM" wherever it appears and replacing it with the language "MCO, DBM, or PPA" so as amended Paragraph (6) Subparagraphs (b) and (e) shall read as follows:

- (b) The claim submitted to the MCO, DBM, or PPA for payment was denied due to provider billing error or a CoverKids claim processing error.
- (e) The provider failed to submit or resubmit claims for payment within the time periods required by the MCO, DBM, PPA, or CoverKids.

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers is amended by inserting new Paragraphs (7) through (9) following existing Paragraph (4) renumbered as Paragraph (6) and renumbering subsequent Paragraphs appropriately so as amended new Paragraphs (7) through (9) shall read as follows:

- (7) Providers may seek payment from a person whose CoverKids eligibility is pending at the time services are provided if the provider informs the person that CoverKids assignment will not be accepted whether or not eligibility is established retroactively.
- (8) Providers may seek payment from a person whose CoverKids eligibility is pending at the time services are provided. Providers may bill such persons at the provider's usual and customary rate for the services rendered. However, all monies collected for CoverKids-covered services rendered during a period of CoverKids eligibility must be refunded when a claim is submitted to CoverKids if the provider agreed to accept CoverKids assignment once retroactive CoverKids eligibility was established.
- (9) Providers of inpatient hospital services, outpatient hospital services, skilled nursing facility services, independent laboratory and x-ray services, hospice services, and home health agencies must be approved for Title XVIII Medicare in order to be certified as providers under the CoverKids program; in the case of hospitals, the hospital must meet state licensure requirements and be approved by the Division of TennCare as an acute care hospital as of the date of enrollment in CoverKids. Children's hospitals and State mental hospitals may participate in CoverKids without having been Medicare approved; however, the hospital must be approved by the Joint Commission for Accreditation of Health Care Organizations as a condition of participation.

Rule 1200-13-21-.08 renumbered as 1200-13-21-.10 Providers is amended by inserting new Paragraph (11) following existing Paragraph (5) renumbered as Paragraph (10) so as amended new Paragraph (11) shall read as follows:

- (11) All claims must be filed with an MCO, DBM, or PPA and must be submitted in accordance with the requirements and timeframes set forth in the MCO, DBM, or PPA's contract.

Statutory Authority: T.C.A. §§ 4-5-203, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Division of TennCare (board/commission/other authority) on 11/12/2020 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 08/14/2020

Rulemaking Hearing(s) Conducted on: (add more dates). 10/06/2020

Date: November 12, 2020

Signature: 

Name of Officer: Stephen Smith

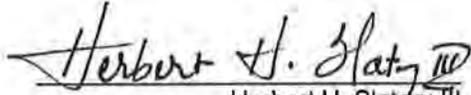
Director, Division of TennCare

Title of Officer: Tennessee Department of Finance and Administration

Agency/Board/Commission: Division of TennCare

Rule Chapter Number(s): 1200-13-21

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.


Herbert H. Slatery III
Attorney General and Reporter
1/8/2021
Date

Department of State Use Only

Filed with the Department of State on: 1/11/2021

Effective on: 4/11/2021


Tre Hargett
Secretary of State

RECEIVED

2021 JAN 11 PM 2:29

SECRETARY OF STATE
PUBLICATIONS

Public Hearing Comments

One copy of a document that satisfies T.C.A. § 4-5-222 must accompany the filing.

There were no public comments on these rules.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

The rule amendments do not specifically affect small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://publications.tnsosfiles.com/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly.)

The rules are not anticipated to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

- (A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The rules are being amended to transition the coverKids program from a fee-for-service program to a managed care program, leveraging TennCare's existing managed care infrastructure, in order to increase program efficiency. Specifically, the rule adds the federal authority to managed care requirements related to Title XXI (CHIP) programs and by adapting the language found in existing TennCare Medicaid and TennCare Standard rules to enable the CoverKids Program to utilize the existing TennCare managed care process, including Managed Care Organizations (MCOs), a Dental Benefits Manager (DBM) and a Pharmacy Plan Administrator (PPA).

- (B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The rules are lawfully adopted by the Division of TennCare in accordance with T.C.A. §§ 4-5-203, 4-5-204, 71-3-1106, 71-3-1110, 42 U.S.C. §§ 1397aa, et seq., and the Tennessee Title XXI Children's Health Insurance Program State Plan.

- (C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons and entities most directly affected by these rule amendments are CoverKids enrollees, providers, and managed care contractors. The governmental entity most directly affected by these rules is the Division of TennCare, Tennessee Department of Finance & Administration.

- (D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

The rules were approved by the Tennessee Attorney General. No additional opinion was given or requested.

- (E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The rules are not anticipated to have an effect on state and local government revenues and expenditures.

- (F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Donna K. Tidwell
Deputy General Counsel

- (G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Donna K. Tidwell
Deputy General Counsel

- (H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

310 Great Circle Road
Nashville, TN 37243
(615) 507-6852
donna.tidwell@tn.gov

(l) Any additional information relevant to the rule proposed for continuation that the committee requests.

GW10120275dkt.ag.dkt

Rules
of
Tennessee Department of Finance and Administration

Division of TennCare

Chapter 1200-13-21
CoverKids

Table of Contents

1200-13-21-.01 Scope and Authority
1200-13-21-.02 Definitions
1200-13-21-.03 Eligibility
1200-13-21-.04 Enrollment and Reassignment
1200-13-21-.045 Benefits
1200-13-21-.06 Exclusions
1200-13-21-.057 Cost Sharing
1200-13-21-.068 Disenrollment
1200-13-21-.079 Review of CoverKids Decisions
1200-13-21-.0810 Providers

1200-13-21-.02 Definitions.

- (1) ~~Covered services. Benefits listed in this Chapter and authorized by the Plan Administrator or Dental Benefits Manager.~~

Covered services. Benefits and services listed in this Chapter and provided for enrollees in the CoverKids program by an MCO, DBM, PPA or other entity under contract with the Division of TennCare.

- (2) CoverKids. The program created by T.C.A. §§ 71-3-1101, et seq., its authorized employees and agents, as the context of this Chapter requires, and administered through the Division of TennCare, which provides health coverage for children under nineteen (19) years of age and pregnant women, who do not have health insurance and do not qualify for TennCare.

- (3) CoverKids network. A group of health care providers that have entered into contracts with ~~the Plan Administrator or Dental Benefits Manager~~ an MCO, DBM, PPA or other entity under contract with the Division of TennCare to furnish covered services to CoverKids enrollees. ~~These contracts may take the form of general contracts or single case agreements.~~

- (4) CoverKids Pregnant Women. The part of the CoverKids program that provides coverage for the unborn children of pregnant women with no source of health coverage who meet the CoverKids eligibility requirements.

- (4 5) ~~CoverKids provider. An appropriately licensed institution, facility, agency, person, corporation, partnership or association, that delivers health care services and that participates in the Plan Administrator's or Dental Benefits Manager's network.~~

CoverKids provider. A health care provider who accepts as payment in full for furnishing benefits to a CoverKids enrollee the amounts paid pursuant to an approved agreement with a TennCare contractor. Such payment may include copayments from the enrollee or the enrollee's responsible party. A CoverKids provider, including an Out-of-State Emergency Provider as defined in Rule 1200-13-13-.01, must be

enrolled with TennCare and must abide by all CoverKids rules and regulations, including requirements regarding provider billing of patients as found in Rule .10. CoverKids providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in the federal Medicare, Medicaid or CHIP programs.

(910) Managed Care Organization (MCO). An appropriately licensed Health Maintenance Organization (HMO) approved by the Division of TennCare as capable of providing medical, behavioral, and long-term care services which has signed a Contractor Risk Agreement, as defined in 1200-13-13-.01, with the Division of TennCare and operates a provider network to provide covered services to CoverKids enrollees.

~~(9 11) Non-CoverKids provider. A health care provider of non-emergency services that does not participate in the Plan Administrator's or Dental Benefits Manager's network-network of a TennCare-contracted MCO, DBM, or PPA or other entity contracted to administer CoverKids benefits.~~

~~(4012) Parent. A natural or adoptive father or mother of a minor child; or, a guardian as defined by T.C.A. § 34-1-101, subject to court orders entered or recognized by the courts of the state of Tennessee.~~

~~(4113) Plan Administrator or PA. The entity or entities responsible for the administrative services associated with providing health care, pharmaceutical or other related services to CoverKids enrollees. This may be a private contractor, government agency, or Departmental entity.~~

Pharmacy Plan Administrator (PPA). The entity responsible for the administrative services associated with providing pharmaceutical related covered services to CoverKids enrollees.

1200-13-21-.04 Enrollment and Reassignment.

(1) Enrollment. CoverKids enrollees are enrolled into MCOs for the provision of covered medical and behavioral health services, a DBM for provision of covered dental services, and a PPA for administration of covered pharmacy services. Enrollment procedures differ according to the type of managed care entity, the geographic area, and the number of managed care entities operating in each geographic area.

(a) Managed Care Organizations (MCOs).

1. Individuals or families determined eligible for CoverKids shall select an MCO at the time of application. The MCO must be available in the Grand Division, as defined in Rule 1200-13-13-.01, in which the enrollee lives. All family members living in the same household and enrolled in CoverKids must be assigned to the same MCO. An enrollee is given his choice of MCOs when possible. If the requested MCO cannot accept new enrollees, the Division of TennCare will assign each enrollee to an MCO that is accepting new enrollees.

2. A CoverKids enrollee may change MCOs one (1) time within the initial ninety (90) calendar days (inclusive of mail time) from the date of the letter informing the enrollee of his MCO assignment, if there is another MCO in the enrollee's Grand Division that is currently accepting new enrollees. No additional changes will be allowed except as otherwise specified in this rule. An enrollee shall remain a member of the designated plan until he is given an opportunity to change once each year during an annual change period. The annual change period will occur each year in March for enrollees in West Tennessee, in May for enrollees in Middle Tennessee, and in July for enrollees in East Tennessee. Thereafter, an MCO change is permitted only during an annual change period, unless the Division of TennCare authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment as specified in paragraph (2)(b) below. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until he is enrolled in the requested MCO.

3. Each MCO shall offer its enrollees, to the extent possible, freedom of choice among CoverKids providers. If after notification of enrollment the enrollee has not chosen a primary care provider (PCP), one will be selected for him by the MCO. The period during which an enrollee may choose his primary care provider shall not be less than fifteen (15) calendar days.

4. In the event a pregnant woman entering an MCO's plan is:

- (i) Receiving medically necessary prenatal care the day before enrollment, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided within or outside the MCO's provider network until such time as the MCO can reasonably transfer the enrollee to a service and/or network provider without impeding service delivery that might be harmful to the enrollee's health.
- (ii) In her second or third trimester of pregnancy and is receiving medically necessary prenatal care services the day before enrollment, the MCO shall be responsible for providing continued access to the provider (regardless of network affiliation) through the postpartum period. Reimbursement to an out-of-network provider shall be as set out in Rule .10.

- (b) Dental Benefits Manager (DBM). Children enrolled in CoverKids shall be assigned to the DBM under contract with the Division of TennCare to provide dental benefits through the CoverKids Program.
- (c) Pharmacy Plan Administrator (PPA). CoverKids enrollees shall be assigned to the PPA under contract with the Division of TennCare to provide pharmacy benefits for both medical and behavioral health services through the CoverKids Program.

(2) Reassignment.

- (a) Reassignment to an MCO other than the current MCO in which the CoverKids enrollee is enrolled is subject to another MCO's capacity to accept new enrollees and must be approved by the Division of TennCare in accordance with one of the following:

- 1. During the initial ninety (90) day period following notification of MCO assignment as described at paragraph (1), a CoverKids enrollee may request a change of MCOs.
- 2. A CoverKids enrollee must change MCOs if he moves outside the MCO's Grand Division, and that MCO is not authorized to operate in the enrollee's new place of residence. Until the CoverKids enrollee selects or is assigned to a new MCO and his enrollment is deemed complete, his medical care will remain the responsibility of the original MCO.
- 3. If an enrollee's MCO withdraws from participation in the CoverKids Program, TennCare will assign him to an MCO operating in his Grand Division, if one is available. The enrollee will be provided notice of the change and will have ninety (90) days to select another MCO in his Grand Division.
- 4. An enrollee shall be given an opportunity to change MCOs once each year during an annual change period. Only one (1) MCO change is permitted every twelve (12) months, unless the Division of TennCare authorizes a change as the result of the resolution of an appeal requesting a "hardship" reassignment. When an enrollee changes MCOs, the enrollee's medical care will be the responsibility of the current MCO until enrolled in the requested MCO. If an enrollee changes MCOs during an annual change period, all family members living in the same household and enrolled in CoverKids shall also be changed.

- (b) A CoverKids enrollee may change MCOs if the Division of TennCare has granted a request for a change in MCOs or an appeal of a denial of a request for a change in MCOs has been resolved in his favor based on hardship criteria.

- 1. The following situations will not be determined to be "hardships":

- (i) The enrollee is unhappy with the current MCO or PCP, but there is no hardship medical situation (as stated in Part 2 below):

- (ii) The enrollee claims lack of access to services but the plan meets the state's access standard;
- (iii) The enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by the MCO;
- (iv) The enrollee is concerned that a current provider might drop out of the plan in the future;
- (v) The enrollee's PCP is no longer in the MCO's network, the enrollee wants to continue to see the current PCP and has refused alternative PCP or provider choices offered by the MCO.

2. Requests for hardship MCO reassignments must meet all of the following six (6) hardship criteria for reassignment. Determinations will be made on an individual basis.

- (i) An enrollee has a medical condition that requires complex, extensive, and ongoing care; and
- (ii) The enrollee's specialist has stopped participating in the member's current MCO network and has refused continuation of care to the enrollee in his current MCO assignment; and
- (iii) The ongoing medical condition of the enrollee is such that another physician or provider with appropriate expertise would be unable to take over his care without significant and negative impact on his care; and
- (iv) The current MCO has been unable to negotiate continued care for this enrollee with the current specialist; and
- (v) The current provider of services is in the network of one or more alternative MCOs; and
- (vi) An alternative MCO is available to the enrollee (i.e., has not given notice of withdrawal from the CoverKids Program, is not in receivership, and is not at member capacity for the member's region).

(c) Requests to change MCOs submitted by CoverKids enrollees shall be evaluated in accordance with the hardship criteria referenced in Subparagraph (b) above. If an enrollee's request to change MCOs is granted due to hardship, all family members living in the same household and enrolled in CoverKids will be assigned to the new MCO. Upon denial of a request to change MCOs, enrollees shall be provided notice and appeal rights as described in applicable provisions of Rule .09.

(d) The Division of TennCare shall only accept a request to change MCO assignment from the affected enrollee, his parent, guardian, or spouse.

1200-13-21-.04-5 Benefits.

(2) Mothers of eligible unborn children who are over age 19 receive all benefits listed in Paragraph (1), subject to the same limitations and as medically necessary, except chiropractic services, routine dental services, ~~and~~ vision services, ~~and hearing aids and cochlear implants~~ are not covered for these enrollees.

(4) ~~The following services and items are excluded from coverage by the CoverKids program:~~

~~(a) Comfort or convenience items not related to an enrollee's illness.~~

~~(b) Dietary guidance services.~~

~~(c) Homemaker or housekeeping services.~~

- ~~(d) Maintenance visits when no additional progress is apparent or expected to occur.~~
- ~~(e) Meals.~~
- ~~(f) Medical social services.~~
- ~~(g) Non-treatment services.~~
- ~~(h) Private duty nursing services.~~
- ~~(i) Routine transportation.~~

An MCO or DBM may provide non-covered items or services as cost effective alternatives to covered items or services. Such cost effective alternative services may be provided because they are either (1) alternatives to covered CoverKids services that, in the judgment of the MCO or DBM, are cost effective or (2) preventative in nature and offered to avoid the development of conditions that, in the judgment of the MCO or DBM, would require more costly treatment in the future. Cost effective alternative services are not covered services and are provided only at the discretion of the MCO or DBM, subject to approval by the Division of TennCare.

1200-13-21-.06 Exclusions.

- (1) The services and items set out in the TennCare Medicaid Exclusions Rule 1200-13-13-.10(1) and (3)(b) are excluded from coverage by the CoverKids program.
- (2) In addition to the services and items excluded by Paragraph (1), the following services, products and supplies are also excluded from coverage by the CoverKids program:
 - (a) Audiological therapy or training
 - (b) Beds and bedding equipment as follows:
 - 1. Powered air flotation beds, air fluidized beds (including Clinitron beds), water pressure mattress, or gel mattress
 - 2. Bead beds, or similar devices
 - 3. Bed boards
 - 4. Bedding and bed casings
 - 5. Ortho-prone beds
 - 6. Oscillating beds
 - 7. Springbase beds
 - 8. Vail beds, or similar beds
 - (c) Biofeedback
 - (d) Cushions, pads, and mattresses as follows:
 - 1. Aquamatic K Pads
 - 2. Elbow protectors
 - 3. Heat and massage foam cushion pads
 - 4. Heating pads

- 5. Heel protectors
- 6. Lamb's wool pads
- 7. Steam packs
- (e) Diagnostic tests conducted solely for the purpose of evaluating the need for a service which is excluded from coverage under these rules
- (f) Ear plugs
- (g) Floor standers, meaning stationary devices not attached to a wheelchair base and not built into the operating system of a power wheelchair that are designed to hold in an upright position an enrollee who uses a wheelchair and who has limited or no ability to stand on his own
- (h) Food supplements and substitutes including formulas
- (i) Humidifiers (central or room) and dehumidifiers
- (j) Medical supplies, over-the-counter, as follows:
 - 1. Alcohol, rubbing
 - 2. Band-aids
 - 3. Cotton balls
 - 4. Eyewash
 - 5. Peroxide
 - 6. Q-tips or cotton swabs
- (k) Nutritional supplements and vitamins
- (l) Purchase, repair, or replacement of materials or equipment when the reason for the purchase, repair, or replacement is the result of enrollee abuse
- (m) Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:
 - 1. Explanation of continuing medical necessity for the item, and
 - 2. Explanation that the item was stolen or destroyed, and
 - 3. Copy of police, fire department, or insurance report if applicable
- (n) Radial keratotomy
- (o) Reimbursement to a provider or enrollee for the replacement of a rented durable medical equipment (DME), as defined in 1200-13-13-.01, item that is stolen or destroyed
- (p) Repair of DME items not covered by CoverKids
- (q) Repair of DME items covered under the provider's or manufacturer's warranty
- (r) Repair of a rented DME item
- (s) Standing tables

1200-13-21-.05 ~~7~~ Cost Sharing.

- (1) There are no premiums or deductibles required for participation in CoverKids.
- (2) Copays.
 - (a) The following services are exempt from copays:
 1. Ambulance services.
 2. Emergency services.
 3. Lab and X-ray services.
 - ~~4. Maternity services. There are no copays for prenatal visits or for hospital admissions for the birth of a child.~~
 - ~~5~~4. Routine health assessments (well child visits) and immunizations given under American Academy of Pediatrics guidelines.
- (3) An enrollee's annual cost sharing obligations shall not exceed ~~5 percent~~ five percent (5%) of his household's annual income.
- (4) Eligible children who do not pay a required copay remain enrolled in the program. An individual provider may at his discretion refuse service for non-payment of a copay unless a medical emergency exists. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay their copays.
- ~~(5) Children receiving hospice services are exempt from all copay requirements.~~
- ~~(6) Pregnant enrollees are exempt from all copay requirements.~~

1200-13-21-.06 ~~8~~ Disenrollment.

1200-13-21-.07 ~~9~~ Review of CoverKids Decisions.

- (1) Eligibility and Enrollment Matters. Administrative review of matters related to eligibility and enrollment shall be conducted as set out in Chapter 1200-13-19.
- (2) ~~Health Services~~ Adverse Medical and Dental Benefit Determination Matters. A parent or authorized representative of a CoverKids enrollee may request review of a CoverKids action to delay, deny, reduce, suspend, or terminate health medical and dental services, or a failure to approve, furnish, or provide payment for health medical and dental services in a timely manner, according to ~~the following provisions:~~ Rule 1200-13-13-.11, except that enrollees shall not be entitled to continuation of benefits pursuant to 42 CFR 457.1260.
- ~~(3) Adverse Pharmacy Benefit Determination Matters. A parent or authorized representative of a CoverKids enrollee may request review of a CoverKids action to delay, deny, reduce, suspend, or terminate pharmacy services, or a failure to approve, furnish, or provide payment for pharmacy services in a timely manner, according to the following provisions:~~
 - (a) Notice. Any decision denying or delaying a requested health pharmacy service, reducing, suspending or terminating an existing health pharmacy service, or failure to approve, furnish or provide payment for pharmacy services in a timely manner shall be in writing and must contain the reason

for the determination, an explanation of review rights and procedures, the standard and expedited time frames for review, the manner of requesting a review, and the circumstances under which existing health pharmacy services may continue pending review unless there is question that the existing health pharmacy services are harmful.

- (b) Pharmacy Plan Administrator (PA) or Dental Benefits Manager (DBM) (PPA) Review. A parent or authorized representative may commence the review process by submitting a written request to the PA or DBM PPA within 30 days of issuance of written notice of the action or, if no notice is provided, from the time the enrollee becomes aware of the action, not to exceed six (6) months from when the action occurred. The PA or DBM PPA will review this request and issue a written decision within 30 days of receipt of this request. Expedited reviews (within 72 hours) will be available for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines the medical situation to be life threatening or would seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. This determination should be made in legible writing with an original signature.
 - (c) State Informal Review. After the PA's or DBM's PPA's internal review is completed, the parent or authorized representative of an enrollee who disagrees with the decision may request further review by telephone or by submitting a letter or form to the Division of TennCare, CoverKids Appeals, which must be received within 8 days of the PA's or DBM's PPA's decision. The Appeals Coordinator will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator will request review by the state's independent medical consultant and a written decision will be issued within 20 days of receipt of the request for further review.
 - (e) Time for Reviews. Review of all non-expedited health or dental pharmacy services appeals will be completed within 90 days of receipt of the initial request for review by the PA or DBM PPA. Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours at each of the PA or DBM PPA and State levels) for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines the medical situation to be life threatening or would seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. This determination should be made in legible writing with an original signature.
- (34) Scope of Review. CoverKids will not provide a review process for a change in enrollment, eligibility, or coverage under the health benefits package required by a change in the State plan or Federal and State law requiring an automatic change that affects all or a group of applicants or enrollees without regard to their individual circumstances.

1200-13-21-.~~08-10~~ Providers.

- (1) Payment in full.
 - (a) All CoverKids providers, as defined in this rule Chapter, must accept as payment in full for provision of covered services to a CoverKids enrollee, the amount paid by the PA or MCO, DBM, or PPA, plus any copayment required by the CoverKids program to be paid by the individual.
 - (b) Any non-CoverKids providers who furnish CoverKids covered services by authorization from the PA or MCO, DBM, or PPA must accept as payment in full for provision of covered services to CoverKids enrollees the amounts paid by the PA or MCO, DBM, or PPA plus any copayment required by the CoverKids program to be paid by the individual.
 - (c) CoverKids will not pay for non-emergency services furnished by non-CoverKids providers unless these services are authorized by the PA or MCO, DBM, or PPA. Any non-CoverKids provider who furnishes CoverKids Program covered non-emergency services to a CoverKids enrollee without authorization from the PA or MCO, DBM, or PPA does so at his own risk. He may not bill the patient for such services except as provided in Paragraph (3).
- (2) Non-CoverKids Providers.

- (a) When the ~~PA~~ of MCO, DBM, or PPA authorizes a service to be rendered by a non-CoverKids provider, payment to the provider shall be no less than 80% of the lowest rate paid by the ~~PA~~ of MCO, DBM, or PPA to equivalent participating CoverKids network providers for the same service, consistent with the methodology contained in Rule 1200-13-13-.08(2)(a).

(3) Participation in the CoverKids program will be limited to providers who:

- (a) Accept, as payment in full, the amounts paid by the MCO, DBM, or PPA, including copays from the enrollee, or the amounts paid in lieu of the MCO, DBM, or PPA by a third party (Medicare, insurance, etc.);
- (b) Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice, or licensure by the Tennessee Department of Mental Health and Substance Abuse Services, if appropriate;
- (c) Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);
- (d) Agree to maintain and provide access to the Division of TennCare and/or its agent all CoverKids enrollee medical records for ten (10) years from the date of service or upon written authorization from TennCare following an audit, whichever is shorter;
- (e) Provide medical assistance at or above recognized standards of practice; and
- (f) Comply with all contractual terms between the provider and the MCO, DBM, or PPA (as appropriate) and CoverKids policies as outlined in federal and state rules and regulations and CoverKids provider manuals and bulletins.
- (g) Failure to comply with any of the above provisions (a) through (f) may subject a provider to the following actions:
1. The provider may be subject to stringent review/audit procedures, which may include clinical evaluation of services and a prepayment requirement for documentation and justification for each claim.
 2. The Division of TennCare may withhold or recover payments to an MCO, DBM, or PPA in cases of provider fraud, willful misrepresentation, or flagrant noncompliance with contractual requirements and/or CoverKids policies.
 3. The Division of TennCare may refuse to approve or may suspend provider participation with a provider if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the US Title XX Services Program.
 4. The Division of TennCare may refuse to approve or may suspend provider participation if it determines that the provider did not fully and accurately make any disclosure of any person who has ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the US Title XX Services Program since the inception of these programs.
 5. The Division of TennCare shall refuse to approve or shall suspend provider participation if the appropriate State Board of Licensing or Certification fails to license or certify the provider at any time for any reason or suspends or revokes a license or certification.
 6. The Division of TennCare shall refuse to approve or shall suspend provider participation upon notification by the US Office of Inspector General Department of Health and Human Services

that the provider is not eligible under Medicare, Medicaid, or CHIP for federal financial participation.

7. The Division of TennCare may recover from an MCO, DBM, or PPA any payments made by an enrollee and/or his family for a covered service, in total or in part, except as permitted. If a provider knowingly bills an enrollee and/or his family for a covered service, in total or in part, except as permitted, the Division of TennCare may terminate the provider's participation in CoverKids.

(4) Solicitations and Referrals

(a) MCOs, DBMs, PPAs, and providers shall not solicit CoverKids enrollees by any method offering as enticements other goods and services (free or otherwise) for the opportunity of providing the enrollee with CoverKids-covered services that are not medically necessary and/or that overutilize the CoverKids program.

(b) An MCO, DBM, or PPA may request a waiver from this restriction in writing to the Division of TennCare. TennCare shall determine the value of a waiver request based upon the medical necessity and need for the solicitation. The MCO, DBM, or PPA may implement the solicitation only upon receipt of a written waiver approval from TennCare. This waiver is not transferable and may be canceled by TennCare upon written notice.

(c) CoverKids payments for services related to a non-waivered solicitation enticement shall be considered by the Division of TennCare as a non-covered service and recouped. Neither the MCO, DBM, PPA, nor the provider may bill the enrollee for non-covered services recouped under this authority.

(d) A provider shall not offer or receive remuneration in any form related to the volume or value of referrals made or received from or to another provider.

(35) Providers may seek payment from a CoverKids enrollee only under the following circumstances. These circumstances include situations where the enrollee may choose to seek a specific covered service from a non-CoverKids provider.

(a) If the services are not covered by the CoverKids program and, prior to providing the services, the provider informed the enrollee that the services were not covered.

(b) If the services are not covered because they are in excess of an enrollee's benefit limit and one of the following circumstances applies:

1. The provider has information in her own records to support the fact that the enrollee has reached his benefit limit for the particular service being requested and, prior to providing the service, informs the enrollee that the service is not covered and will not be paid for by CoverKids. This information may include:

(i) A previous written denial of a claim on the basis that the service was in excess of the enrollee's benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to the benefit limit is still in effect;

(ii) That the provider had personally provided services to the enrollee in excess of his benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit period is still in effect; or

(iii) The enrollee's ~~PA~~ MCO, DBM, or PPA has provided confirmation to the provider that the enrollee has reached his benefit limit for the applicable service.

2. The provider submits a claim for service to the ~~PA~~ MCO, DBM, or PPA and receives a written denial of that claim on the basis that the service exceeds the enrollee's benefit limit. After informing the enrollee and within the remainder of the period applicable to that benefit limit, the provider may bill the enrollee for services within that same exhausted benefit category

without having to submit claims for those subsequent services for repeated ~~PA or~~ MCO, DBM, or PPA denial. If the provider informed the enrollee prior to providing the service for which the claim was denied that the service would exceed the enrollee's benefit limit and would not be paid for by CoverKids, the provider may bill the enrollee for that service.

- (46) Providers may not seek payment from a CoverKids enrollee under the following conditions:
- (b) The claim submitted to the ~~PA or~~ MCO, DBM, or PPA for payment was denied due to provider billing error or a CoverKids claim processing error.
 - (e) The provider failed to submit or resubmit claims for payment within the time periods required by the ~~PA or~~ MCO, DBM, PPA, or CoverKids.
- ~~(7) Providers may seek payment from a person whose CoverKids eligibility is pending at the time services are provided if the provider informs the person that CoverKids assignment will not be accepted whether or not eligibility is established retroactively.~~
- ~~(8) Providers may seek payment from a person whose CoverKids eligibility is pending at the time services are provided. Providers may bill such persons at the provider's usual and customary rate for the services rendered. However, all monies collected for CoverKids-covered services rendered during a period of CoverKids eligibility must be refunded when a claim is submitted to CoverKids if the provider agreed to accept CoverKids assignment once retroactive CoverKids eligibility was established.~~
- ~~(9) Providers of inpatient hospital services, outpatient hospital services, skilled nursing facility services, independent laboratory and x-ray services, hospice services, and home health agencies must be approved for Title XVIII Medicare in order to be certified as providers under the CoverKids program; in the case of hospitals, the hospital must meet state licensure requirements and be approved by the Division of TennCare as an acute care hospital as of the date of enrollment in CoverKids. Children's hospitals and State mental hospitals may participate in CoverKids without having been Medicare approved; however, the hospital must be approved by the Joint Commission for Accreditation of Health Care Organizations as a condition of participation.~~
- (510) Pharmacy providers may not waive pharmacy copayments for CoverKids enrollees as a means of attracting business to their establishments. This does not prohibit a pharmacy from exercising professional judgment in cases where an enrollee may have a temporary or acute need for a prescribed drug, but is unable, at that moment, to pay the required copayment.
- ~~(11) All claims must be filed with an MCO, DBM, or PPA and must be submitted in accordance with the requirements and timeframes set forth in the MCO, DBM, or PPA's contract.~~

GW10120209ag.dkt.