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Sequence Number: 01-11-13
 Rule ID(s): 5360
 File Date: 1/15/13
 Effective Date: 4/15/13

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. T.C.A. § 4-5-205

Agency/Board/Commission:	Tennessee Department of Finance and Administration
Division:	Bureau of TennCare
Contact Person:	George Woods
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Revision Type (check all that apply):

- Amendments
 New
 Repeal

Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
1200-13-14	TennCare Standard
Rule Number	Rule Title
1200-13-14-.01	Definitions
1200-13-14-.05	Enrollee Cost Sharing

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to <http://state.tn.us/sos/rules/1360/1360.htm>)

Rule 1200-13-14-.01 Definitions is amended by adding a new Paragraph (5) and renumbering the current Paragraph (5) as (6) and subsequent paragraphs renumbered accordingly so as amended the new Paragraph (5) shall read as follows:

- (5) Aggregate Cost-Sharing Cap. The maximum amount a family may pay out-of-pocket for TennCare covered services during a calendar quarter (January 1 through March 31, April 1 through June 30, July 1 through September 30, October 1 through December 31). Amounts paid for non-covered services, including payments for services that exceed a benefit limit, are not counted in the aggregate cost-sharing cap. Amounts paid by the family for third party insurance are not counted in the aggregate cost-sharing cap.

Rule 1200-13-14-.01 Definitions is amended by adding new Paragraphs (15) and (16) and renumbering the current renumbered Paragraph (15) as (17) with subsequent paragraphs being renumbered accordingly so as amended new Paragraphs (15) and (16) shall read as follows:

- (15) CHOICES 1 and 2 Carryover Group. See definition in Rule 1200-13-01-.02.

- (16) CHOICES At-Risk Demonstration Group. See definition in Rule 1200-13-01-.02.

Rule 1200-13-14-.01 Definitions is amended by adding a new Paragraph (31) and renumbering the current renumbered Paragraph (31) as (32) with subsequent paragraphs renumbered accordingly so as amended the new Paragraph (31) shall read as follows:

- (31) Copay. A fixed fee that is charged to certain TennCare enrollees for certain TennCare services.

Rule 1200-13-14-.01 Definitions is amended by adding a new Paragraph (38) and renumbering the current renumbered Paragraph (38) as (39) with subsequent paragraphs renumbered accordingly so as amended the new Paragraph (38) shall read as follows:

- (38) Deductible. A specified amount of money paid each year by an insured person for benefits before his health plan starts paying claims.

Rule 1200-13-14-.01 Definitions is amended by adding a new Paragraph (95) and renumbering the current renumbered Paragraph (95) as (96) with subsequent paragraphs renumbered accordingly so as amended the new Paragraph (95) shall read as follows:

- (95) PACE Carryover Group. See definition in Rule 1200-13-01-.02.

Rule 1200-13-14-.01 Definitions is amended by adding a new Paragraph (101) and renumbering the current renumbered Paragraph (101) as (102) with subsequent paragraphs renumbered accordingly so as amended the new Paragraph (101) shall read as follows:

- (101) Premium. A specified amount of money that an insured person is required to pay on a regular basis in order to participate in a health plan.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with a new Rule 1200-13-14-.05 Enrollee Cost Sharing which shall read as follows:

1200-13-14-.05 Enrollee Cost Sharing.

- (1) Premiums and deductibles.
 - (a) Enrollees are not required to pay premiums for TennCare.
 - (b) There are no TennCare deductibles.
- (2) Copays.
 - (a) The following TennCare Standard enrollees are exempt from TennCare copays:
 1. Enrollees who are receiving hospice services and who provide verbal notification of such to the provider at the point of service.
 2. Enrollees who are pregnant and who provide verbal notification of such to the provider at the point of service.
 3. Enrollees who are enrolled in any of the following CHOICES groups:
 - (i) The CHOICES 217-Like Group
 - (ii) The CHOICES 1 and 2 Carryover Group
 - (iii) The PACE Carryover Group
 4. Children who are enrolled in TennCare Standard and who have family incomes below 100% of poverty.
 - (b) The following TennCare services are exempt from TennCare copays for all enrollees:
 1. Emergency services, including the seventy-two (72) hour emergency supply of a medication in an emergency situation, as described in Rule 1200-13-14-.11.
 2. Family planning services and supplies.
 3. Preventive services as identified in Rule 1200-13-14-.04.
 - (c) Pharmacy copays.
 1. There is no pharmacy copay for covered generic prescription drugs.
 2. The following TennCare Standard enrollees have a pharmacy copay of \$3.00 per covered brand name prescription:
 - (i) TennCare Standard children with family incomes that are 100% of poverty or greater.
 - (ii) Enrollees in the Standard Spend Down program.
 - (iii) Enrollees in the CHOICES At-Risk Demonstration Group.
 - (d) Copays for other TennCare services. The following copays are applicable to TennCare Standard children.

Benefit	Copay if income is 0%-99% of poverty	Copay if income is 100%-199% of poverty	Copay if income is 200% of poverty or greater
Hospital emergency room use for non-emergency services (waived if admitted)	\$0	\$10	\$50
Primary care provider services other than preventive care	\$0	\$5	\$15
Community Mental Health Agency services other than preventive care	\$0	\$5	\$15
Physician specialists and dentists	\$0	\$5	\$20
Prescription or refill	\$0	\$3 for covered branded prescriptions; \$0 for generic prescriptions	\$3 for covered branded prescriptions; \$0 for generic prescriptions
Inpatient hospital admission	\$0	\$5	\$100

- (e) Copays for non-emergency services provided in an emergency department are not required unless the hospital has first provided the enrollee with assistance in gaining access to a non-emergency services provider (a physician's office, health care clinic, community health center, hospital outpatient department, or similar provider). This requirement on the part of the hospital can be met if, before providing non-emergency care subject to copay, the emergency room staff recommends that the enrollee or the enrollee's caretaker call the 24/7 nurse staffed call center for the enrollee's MCO to obtain help in locating an available provider in the community, and offers to assist with placing a call to the call center.

(3) Aggregate cost-sharing cap.

- (a) The aggregate cost-sharing cap is applicable only to TennCare copays incurred by TennCare Standard children with incomes at or above 100% of poverty and their TennCare family members.
- (b) The aggregate cost-sharing cap is calculated by combining the TennCare cost sharing for all TennCare family members who have TennCare cost-sharing obligations, and may not exceed 5 percent of the family's annual income, prorated to a quarterly equivalent. Family income will be calculated using the same methodology used to calculate income for the determination of eligibility, and the family will be assigned to the corresponding income band to determine the standardized aggregate cap, which is based on the lower end of the income band. The following income bands and the corresponding aggregate annual caps will be used:

Income Bands	Poverty levels	Standardized Annual Aggregate Cap
1	0% - 99%	Not applicable
2	100% - 149%	5% of the amount that corresponds to 100% FPL
3	150% - 199%	5% of the amount that corresponds to 150% FPL
4	200% - 249%	5% of the amount that corresponds to 200% FPL
5	250% - 299%	5% of the amount that corresponds to 250% FPL
6	300% - 349%	5% of the amount that corresponds to 300% FPL
7	350% - 399%	5% of the amount that corresponds to 350% FPL

8	400% - 499%	5% of the amount that corresponds to 400% FPL
9	500% - 599%	5% of the amount that corresponds to 500% FPL
10	600% and over	5% of the amount that corresponds to 600% FPL

- (c) Families of applicable TennCare Standard children are responsible for tracking their own incurred cost sharing obligations, including keeping copies of receipts and similar documentation, and notifying the Bureau of TennCare when they believe they have reached their aggregate cost-sharing cap for a particular calendar quarter.
 - (d) After receiving the information described in subparagraph (c), TennCare will notify families of applicable TennCare Standard children of the date when it has been determined that the aggregate cost-sharing cap, as prorated for the quarter, has been reached. When that occurs, there are no further TennCare cost-sharing obligations required for the remainder of the calendar quarter. Any TennCare copays that are paid by the family during the quarter after the family's aggregate cost-sharing cap, as pro-rated for that quarter, has been reached will be refunded to the family by TennCare.
- (4) This paragraph applies to all TennCare Managed Care Contractors and providers.
- (a) In accordance with 42 CFR § 447.53(e), providers may not refuse to deliver a covered service to an enrollee because of the enrollee's inability to make his copay.
 - (b) Managed care contractors participating in the TennCare program shall be specifically prohibited from waiving or discouraging TennCare enrollees from paying any applicable cost-sharing amounts.

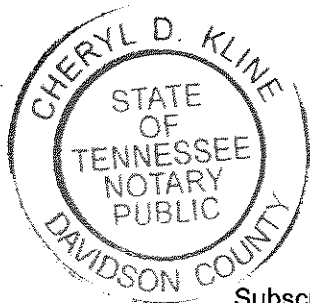
Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance and Administration (board/commission/ other authority) on 10/24/2012 (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: 08/21/12

Rulemaking Hearing(s) Conducted on: (add more dates). 10/10/12



Date: 10/24/2012

Signature: [Handwritten Signature]

Name of Officer: Darin J. Gordon
Director, Bureau of TennCare

Title of Officer: Tennessee Department of Finance and Administration

Subscribed and sworn to before me on: 10/24/12

Notary Public Signature: Cheryl D Kline

My commission expires on: 8/23/16

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.

[Handwritten Signature]
Robert E. Cooper, Jr.
Attorney General and Reporter
1-14-13

Date

Department of State Use Only

Filed with the Department of State on: 1/15/13

Effective on: 4/15/13

[Handwritten Signature]
Tre Hargett
Secretary of State

RECEIVED
2012 JAN 15 PM 2:34
SECRETARY OF STATE

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

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 as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

(If applicable, insert Regulatory Flexibility Addendum here)

The rules are not anticipated to have an effect on 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://state.tn.us/sos/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;

These rules are being promulgated to bring the Enrollee Cost Sharing rules into compliance with the Cost-Sharing Implementation Plan approved by the Centers for Medicare and Medicaid Services (CMS). The rules add definitions and outline the cost-sharing amounts and principles in the Cost-Sharing Implementation Plan.

- (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 Bureau of TennCare in accordance with §§ 4-5-202, 71-5-105 and 71-5-109.

- (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, organizations, corporations or governmental entities most directly affected by these Rules are the enrollees and the Bureau of TennCare, Tennessee Department of Finance and Administration.

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

These 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 promulgation of these rules is anticipated to have a minimal impact on TennCare's annual budget. We anticipate that very few enrollees will be impacted by changes in enrollee cost sharing.

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

Darin J. Gordon
Director, Bureau of TennCare

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

Darin J. Gordon
Director, Bureau of TennCare

- (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) 507-6443
Darin.J.Gordon@tn.gov

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

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GW10112283

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Revision Type (check all that apply):

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Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
1200-13-14	TennCare Standard
Rule Number	Rule Title
1200-13-14-.01	Definitions
1200-13-14-.05	Enrollee Cost Sharing

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Rule 1200-13-14-.01 Definitions is amended by adding a new Paragraph (5) and renumbering the current Paragraph (5) as (6) and subsequent paragraphs renumbered accordingly so as amended the new Paragraph (5) shall read as follows:

(5) Aggregate Cost-Sharing Cap. The maximum amount a family may pay out-of-pocket for TennCare covered services during a calendar quarter (January 1 through March 31, April 1 through June 30, July 1 through September 30, October 1 through December 31). Amounts paid for non-covered services, including payments for services that exceed a benefit limit, are not counted in the aggregate cost-sharing cap. Amounts paid by the family for third party insurance are not counted in the aggregate cost-sharing cap.

Rule 1200-13-14-.01 Definitions is amended by adding new Paragraphs (15) and (16) and renumbering the current renumbered Paragraph (15) as (17) with subsequent paragraphs being renumbered accordingly so as amended new Paragraphs (15) and (16) shall read as follows:

(15) CHOICES 1 and 2 Carryover Group. See definition in Rule 1200-13-01-.02.

(16) CHOICES At-Risk Demonstration Group. See definition in Rule 1200-13-01-.02.

Rule 1200-13-14-.01 Definitions is amended by adding a new Paragraph (31) and renumbering the current renumbered Paragraph (31) as (32) with subsequent paragraphs renumbered accordingly so as amended the new Paragraph (31) shall read as follows:

(31) Copay. A fixed fee that is charged to certain TennCare enrollees for certain TennCare services.

Rule 1200-13-14-.01 Definitions is amended by adding a new Paragraph (38) and renumbering the current renumbered Paragraph (38) as (39) with subsequent paragraphs renumbered accordingly so as amended the new Paragraph (38) shall read as follows:

(38) Deductible. A specified amount of money paid each year by an insured person for benefits before his health plan starts paying claims.

Rule 1200-13-14-.01 Definitions is amended by adding a new Paragraph (95) and renumbering the current renumbered Paragraph (95) as (96) with subsequent paragraphs renumbered accordingly so as amended the new Paragraph (95) shall read as follows:

(95) PACE Carryover Group. See definition in Rule 1200-13-01-.02.

Rule 1200-13-14-.01 Definitions is amended by adding a new Paragraph (101) and renumbering the current renumbered Paragraph (101) as (102) with subsequent paragraphs renumbered accordingly so as amended the new Paragraph (101) shall read as follows:

(101) Premium. A specified amount of money that an insured person is required to pay on a regular basis in order to participate in a health plan.

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

Rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with a new Rule 1200-13-14-.05 Enrollee Cost Sharing which shall read as follows:

1200-13-14-.05 Enrollee Cost Sharing.

(1) Premiums and deductibles.

(a) Enrollees are not required to pay premiums for TennCare.

(b) There are no TennCare deductibles.

(2) Copays.

(a) The following TennCare Standard enrollees are exempt from TennCare copays:

1. Enrollees who are receiving hospice services and who provide verbal notification of such to the provider at the point of service.

2. Enrollees who are pregnant and who provide verbal notification of such to the provider at the point of service.

3. Enrollees who are enrolled in any of the following CHOICES groups:

(i) The CHOICES 217-Like Group

(ii) The CHOICES 1 and 2 Carryover Group

(iii) The PACE Carryover Group

4. Children who are enrolled in TennCare Standard and who have family incomes below 100% of poverty.

(b) The following TennCare services are exempt from TennCare copays for all enrollees:

1. Emergency services, including the seventy-two (72) hour emergency supply of a medication in an emergency situation, as described in Rule 1200-13-14-.11.

2. Family planning services and supplies.

3. Preventive services as identified in Rule 1200-13-14-.04.

(c) Pharmacy copays.

1. There is no pharmacy copay for covered generic prescription drugs.

2. The following TennCare Standard enrollees have a pharmacy copay of \$3.00 per covered brand name prescription:

(i) TennCare Standard children with family incomes that are 100% of poverty or greater.

(ii) Enrollees in the Standard Spend Down program.

(iii) Enrollees in the CHOICES At-Risk Demonstration Group.

(d) Copays for other TennCare services. The following copays are applicable to TennCare Standard children.

<u>Benefit</u>	<u>Copay if income is 0%-99% of poverty</u>	<u>Copay if income is 100%-199% of poverty</u>	<u>Copay if income is 200% of poverty or greater</u>
<u>Hospital emergency room use for non-emergency services (waived if admitted)</u>	<u>\$0</u>	<u>\$10</u>	<u>\$50</u>
<u>Primary care provider services other than preventive care</u>	<u>\$0</u>	<u>\$5</u>	<u>\$15</u>
<u>Community Mental Health Agency services other than preventive care</u>	<u>\$0</u>	<u>\$5</u>	<u>\$15</u>
<u>Physician specialists and dentists</u>	<u>\$0</u>	<u>\$5</u>	<u>\$20</u>
<u>Prescription or refill</u>	<u>\$0</u>	<u>\$3 for covered branded prescriptions; \$0 for generic prescriptions</u>	<u>\$3 for covered branded prescriptions; \$0 for generic prescriptions</u>
<u>Inpatient hospital admission</u>	<u>\$0</u>	<u>\$5</u>	<u>\$100</u>

(e) Copays for non-emergency services provided in an emergency department are not required unless the hospital has first provided the enrollee with assistance in gaining access to a non-emergency services provider (a physician's office, health care clinic, community health center, hospital outpatient department, or similar provider). This requirement on the part of the hospital can be met if, before providing non-emergency care subject to copay, the emergency room staff recommends that the enrollee or the enrollee's caretaker call the 24/7 nurse staffed call center for the enrollee's MCO to obtain help in locating an available provider in the community, and offers to assist with placing a call to the call center.

(3) Aggregate cost-sharing cap.

(a) The aggregate cost-sharing cap is applicable only to TennCare copays incurred by TennCare Standard children with incomes at or above 100% of poverty and their TennCare family members.

(b) The aggregate cost-sharing cap is calculated by combining the TennCare cost sharing for all TennCare family members who have TennCare cost-sharing obligations, and may not exceed 5 percent of the family's annual income, prorated to a quarterly equivalent. Family income will be calculated using the same methodology used to calculate income for the determination of eligibility, and the family will be assigned to the corresponding income band to determine the standardized aggregate cap, which is based on the lower end of the income band. The following income bands and the corresponding aggregate annual caps will be used:

<u>Income Bands</u>	<u>Poverty levels</u>	<u>Standardized Annual Aggregate Cap</u>
<u>1</u>	<u>0% - 99%</u>	<u>Not applicable</u>
<u>2</u>	<u>100% - 149%</u>	<u>5% of the amount that corresponds to 100% FPL</u>
<u>3</u>	<u>150% - 199%</u>	<u>5% of the amount that corresponds to 150% FPL</u>
<u>4</u>	<u>200% - 249%</u>	<u>5% of the amount that corresponds</u>

		to 200% FPL
5	250% - 299%	5% of the amount that corresponds to 250% FPL
6	300% - 349%	5% of the amount that corresponds to 300% FPL
7	350% - 399%	5% of the amount that corresponds to 350% FPL
8	400% - 499%	5% of the amount that corresponds to 400% FPL
9	500% - 599%	5% of the amount that corresponds to 500% FPL
10	600% and over	5% of the amount that corresponds to 600% FPL

(c) Families of applicable TennCare Standard children are responsible for tracking their own incurred cost sharing obligations, including keeping copies of receipts and similar documentation, and notifying the Bureau of TennCare when they believe they have reached their aggregate cost-sharing cap for a particular calendar quarter.

(d) After receiving the information described in subparagraph (c), TennCare will notify families of applicable TennCare Standard children of the date when it has been determined that the aggregate cost-sharing cap, as prorated for the quarter, has been reached. When that occurs, there are no further TennCare cost-sharing obligations required for the remainder of the calendar quarter. Any TennCare copays that are paid by the family during the quarter after the family's aggregate cost-sharing cap, as pro-rated for that quarter, has been reached will be refunded to the family by TennCare.

(4) This paragraph applies to all TennCare Managed Care Contractors and providers.

(a) In accordance with 42 CFR § 447.53(e), providers may not refuse to deliver a covered service to an enrollee because of the enrollee's inability to make his copay.

(b) Managed care contractors participating in the TennCare program shall be specifically prohibited from waiving or discouraging TennCare enrollees from paying any applicable cost-sharing amounts.

1200-13-14-.05 ENROLLEE COST SHARING.

(1) Persons who are enrolled in TennCare Standard have premium obligations corresponding to their family size and income. No new premiums will be charged for periods of time from December 1, 2007, forward, notwithstanding anything in these rules to the contrary. The premium schedule in effect prior to December 1, 2007, is shown below:

Percentage of Poverty	0%—99%	100%—149%	150%—199%	200%—249%	250%—299%
Monthly Premium (Individual)	\$0	\$20	\$35	\$100	\$150
Monthly Premium (Family of 2 or more)	\$0	\$40	\$70	\$250	\$375

Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% and over
Monthly Premium (Individual)	\$200	\$250	\$350	\$450	\$550
Monthly Premium (Family of 2 or more)	\$500	\$625	\$875	\$1,125	\$1,375

~~(2) Premium Requirements.~~

- ~~(a) No persons enrolled in TennCare Standard will have premium obligations for periods of time from December 1, 2007, forward. Enrollees who had premium obligations prior to December 1, 2007, and who have not made all required premium payments are not relieved of the responsibility for making these past due payments to TennCare.~~
- ~~(b) At such time as (1) the enrollee has received at least two premium statements advising him of his arrearage AND (2) he is 60 days in arrears on his premium payments, coverage may be terminated for non-payment of premiums.~~
- ~~1. Enrollees who are in arrears two months in premium payments will be sent a notice of delinquency (a "demand letter"). The notice will identify the specific payments, including month and amount, that are past due. The demand letter will serve as notice to the individual that he will be terminated from TennCare Standard unless he pays the amount due within 30 days. The enrollee has the right to appeal that he is in fact current with his/her payments or that the premium amounts being charged are not the premium amounts he has been assigned.~~
 - ~~2. If at least partial payment is received by the Bureau of TennCare within 30 days after the date of the demand letter, the enrollee will no longer be 60 days in arrears, and coverage will continue without interruption. "Partial payment" will be payment sufficient to make the enrollee no longer 60 days in arrears. However, remaining past due amounts will continue to accrue. If the enrollee is again 60 days in arrears when the next cycle of demand letters is processed, the enrollee will again receive a demand letter and may subsequently be terminated in accordance with these rules.~~
 - ~~3. If an enrollee files an appeal in response to his demand letter by the 30th day following the date of the notice, coverage will not be terminated on the 30th day, pending resolution of the appeal. The premium appeal will be processed by DHS in accordance with its rules at 1240-05.~~
 - ~~4. If the enrollee does not pay at least a partial payment or file an appeal by the 30th day following the demand letter, his TennCare Standard coverage will be terminated. A termination notice will be sent with due process appeal rights. The date of termination is the date of the termination notice. An enrollee may appeal his notice of termination, but he is not entitled to continuation of benefits during the appeal. If the appeal is decided in his favor, he will be reinstated retroactively to the date of termination.~~

~~(3) There are no deductibles or out-of-pocket maximums in TennCare Standard.~~

~~(4) Copayments.~~

- ~~(a) TennCare Standard enrollees whose income is equal to or greater than 100% of poverty shall pay copayments for services other than preventive services. Preventive services are identified in Rule 1200-13-14.04(5).~~
- ~~(b) Copayment amounts are as shown below:~~

Benefit	Copayment if income is 0%-99% of poverty	Copayment if income is 100%-199% of poverty	Copayment if income is 200% of poverty or above
Hospital emergency room use for non-emergency services	\$0	\$10 (waived if admitted)	\$50 (waived if admitted)
Primary care provider services other than preventive care	\$0	\$5	\$10
Community Mental Health Agency services other than preventive care	\$0	\$5	\$10
Physician specialists (including Psychiatrists)	\$0	\$5	\$20
Prescription or refill (see (f) below)	\$0	\$3 for covered branded prescription; \$0 for covered generics	\$3 for covered branded prescription; \$0 for covered generics
Inpatient hospital admission	\$0	\$5 (waived if readmitted within 48 hours for the same episode)	\$100 (waived if readmitted within 48 hours for the same episode)

- ~~(c) Managed care contractors participating in the TennCare program shall be specifically prohibited from waiving, or discouraging TennCare enrollees from paying, the amounts described in this paragraph.~~
- ~~(d) Providers may not refuse to deliver a covered service to an enrollee because of the enrollee's failure or inability to make his copay.~~
- ~~(e) Enrollees who receive financial settlements, awards or judgments shall have their income levels adjusted to reflect the amount of the settlements, awards or judgments and may be assessed additional cost sharing obligations commensurate with their adjusted income level.~~
- ~~(f) Pharmacy and psychiatric pharmacy copayments.~~
- ~~1. All TennCare Standard enrollees with incomes at or above poverty who receive pharmacy services have nominal copayments for the services. The copays are \$3.00 for each covered branded drug and \$0 for each covered generic drug. Drugs which exceed the limit of five (5) prescriptions or refills per month per enrollee are not covered unless they are on the Automatic Exception List. Family planning drugs and emergency services are exempt from copay.~~
 - ~~2. The following groups (adults and children) are exempt from pharmacy copays:~~
 - ~~(i) Individuals receiving hospice services who provide verbal or written notification of such to the pharmacy provider at the point of service;~~
 - ~~(ii) Individuals who are pregnant who provide verbal or written notification of such to the pharmacy provider at the point of service; and~~
 - ~~(iii) Individuals who are receiving services in the CHOICES program, an Intermediate Care Facility for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded), or a Home and Community Based Services waiver.~~

- ~~3. The seventy two (72) hour emergency supply of a medication in an emergency situation, as described in rule 1200-13-14.11, shall not be subject to the pharmacy copayment requirement.~~

Statutory Authority: T.C.A. §§ 4-5-202, 71-5-105 and 71-5-109.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance and Administration (board/commission/ other authority) on _____ (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: 08/21/12

Rulemaking Hearing(s) Conducted on: (add more dates). 10/10/12

Date: _____

Signature: _____

Name of Officer: Darin J. Gordon

Director, Bureau of TennCare

Title of Officer: Tennessee Department of Finance and Administration

Subscribed and sworn to before me on: _____

Notary Public Signature: _____

My commission expires on: _____

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.

Robert E. Cooper, Jr.
Attorney General and Reporter

Date

Department of State Use Only

Filed with the Department of State on: _____

Effective on: _____

Tre Hargett
Secretary of State

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

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 as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

(If applicable, insert Regulatory Flexibility Addendum here)

The rules are not anticipated to have an effect on 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://state.tn.us/sos/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;

These rules are being promulgated to bring the Enrollee Cost Sharing rules into compliance with the Cost-Sharing Implementation Plan approved by the Centers for Medicare and Medicaid Services (CMS). The rules add definitions and outline the cost-sharing amounts and principles in the Cost-Sharing Implementation Plan.

- (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 Bureau of TennCare in accordance with §§ 4-5-202, 71-5-105 and 71-5-109.

- (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, organizations, corporations or governmental entities most directly affected by these Rules are the enrollees and the Bureau of TennCare, Tennessee Department of Finance and Administration.

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

These 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 promulgation of these rules is anticipated to have a minimal impact on TennCare's annual budget. We anticipate that very few enrollees will be impacted by changes in enrollee cost sharing.

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

Darin J. Gordon
Director, Bureau of TennCare

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

Darin J. Gordon
Director, Bureau of TennCare

- (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) 507-6443
Darin.J.Gordon@tn.gov

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

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