Notice of
Rulemaking Hearing

Tennessee Department of Finance and Administration

Bureau of Tenncare

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act Tennessee Code Annotated, Section 4-5-204 and will take place in the Bureau of Tenncare, 1st Floor East Conference Room, 310 Great Circle Road, Nashville, Tennessee 37243 at 9:00 a.m. C.S.T. on the 18th March 2008.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Finance and Administration, Bureau of Tenncare, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings) to allow time for the Bureau of Tenncare to determine how it may reasonably provide such aid or service. Initial contact may be made with the Bureau of Tenncare's ADA Coordinator by mail at the Bureau of -Tenncare, 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6474 or 1-800-342-3145.

For a copy of this notice of rulemaking hearing, contact George Woods at the Bureau of Tenncare, 310 Great Circle Road, Nashville, Tennessee 37243 or call (615) 507-6446.

Substance of Proposed Rules

Paragraph (2) Access To Health Insurance of rule 1200-13-13-.01 Definitions is deleted in its entirety and replaced with a new paragraph (2) which shall read as follows:

(2) Access To Health Insurance shall mean the opportunity an individual has to obtain group health insurance as defined elsewhere in these rules. If a person could have enrolled in work-related or other group health insurance during an employer's or group's open enrollment period and chose not to enroll (or had the choice made for him by a family member) that person shall not be considered to lack access to insurance upon closure of the open enrollment period. Neither the cost of an insurance policy or health plan nor the fact that an insurance policy is not as comprehensive as that of the Tenncare Program shall be considered in determining eligibility to enroll in any Tenncare category where being uninsured is an eligibility prerequisite.

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

(5) Application Period shall mean a specific time period determined by the Bureau of Tenncare during which the Bureau will accept applications for the Tenncare Standard Spend Down category as described in the Bureau's rules at 1200-13-14-.02.

Rule 1200-13-13-.01 Definitions is amended by adding a new paragraph (9) and the subsequent paragraphs are renumbered accordingly so as amended the new paragraph (9) shall read as follows:

(9) call-in line shall mean the toll-free telephone line used as the single point of entry during an open application period to accept new applications for the Standard Spend Down Program.

Rule 1200-13-13-.01 Definitions is amended by adding a new paragraph (12) and the subsequent paragraphs are renumbered accordingly so as amended the new paragraph (12) shall read as follows:

(12) Caretaker Relative shall mean that individual as defined at *Tennessee Code Annotated* § 71-3-153.

Paragraph (15) Community Service Area of rule 1200-13-13-.01 Definitions renumbered as paragraph (18), is deleted in its entirety and subsequent paragraphs are renumbered accordingly.

Rule 1200-13-13-.01 Definitions is amended by adding a new paragraph (29) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (29) shall read as follows:

(29) Demand Letter shall mean a letter sent by Tenncare to a Tenncare Standard enrollee with premium obligations notifying the enrollee that he is at least sixty (60) days delinquent in his premium payments.

Rule 1200-13-13-.01 Definitions is amended by adding a new paragraph (30) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (30) shall read as follows:

(30) Discontinued Demonstration Group shall mean the group of non-Medicaid eligible individuals who were enrolled in Tenncare Standard on April 29, 2005, when the categories in which they were enrolled were terminated, and who have not yet been enrolled in Tenncare Medicaid or disenrolled from the Tenncare program.

Rule 1200-13-13-.01 Definitions is amended by adding a new paragraph (43) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (43) shall read as follows:

(43) Grand Divisions Shall Mean The Three (3) Distinct Geographic Areas Of The State Of Tennessee, Known As Eastern, Middle, And Western, As Designated In *Tennessee Code Annotated* § 4-1-201.

Paragraph (82) Prospective Enrollment Of Rule 1200-13-13-.01 Definitions, Renumbered As Paragraph (87), Is Deleted In Its Entirety And Subsequent Paragraphs Are Renumbered Accordingly.

Rule 1200-13-13-.01 Definitions, Is Amended By Adding A New Paragraph (101) And Subsequent Paragraphs Are Renumbered Accordingly So As Amended The New Paragraph (101) Shall Read As Follows:

(101) Responsible Party(Ies) Shall Mean The Following Individuals, Who Are Representatives And/Or Relatives Of Recipients Of Medical Assistance Who Are Not Financially Eligible To Receive Benefits: Parents, Spouses, Children, Guardians; As Defined At *Tennessee Code Annotated* § 71-5-103(10).

Rule 1200-13-13-.01 Definitions, Is Amended By Adding A New Paragraph (105) And Subsequent Paragraphs Are Renumbered Accordingly So As Amended The New Paragraph (105) Shall Read As Follows:

(105) Standard Spend Down (Ssd) Shall Mean The Demonstration Eligibility Category Composed Of Adults Aged Twenty-One (21) And Older Who Have Been Found To Meet The Criteria In Rule 1200-13-14-.02.

Rule 1200-13-13-.01 Definitions, Is Amended By Adding A New Paragraph (106) And The Subsequent Paragraphs Are Renumbered Accordingly So As Amended The New Paragraph (106) Shall Read As Follows:

(106) Target Population Group (Tpg) Shall Mean A Group Identified By Means Of An Assessment Mechanism For Children And Adolescents Under The Age Of Eighteen (18) Which determines a service recipient's level of functioning and severity of impairment due to mental illness. Based on the assessment criteria, there are two (2) target population groups:

(a) TPG 2: Seriously Emotionally Disturbed (SED).

These are children and adolescents who are under eighteen (18) years of age with a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children are currently severely impaired as evidenced by a Global Assessment of Functioning score of 50 or less.

(b) TPG 3: At Risk of being SED.

These are children and adolescents who are under eighteen (18) years of age without a valid DSM-IV-TR (and subsequent revisions) diagnosis excluding substance use disorders, developmental disorders or V-codes. These children may or may not be currently seriously impaired as evidenced by a Global Assessment of Functioning. These children have psychosocial issues that can potentially place them at risk of becoming SED.

Paragraph (111) Tenncare Standard of rule 1200-13-13-.01 Definitions,, renumbered as paragraph (118), is deleted in its entirety and replaced by a new paragraph (118) which shall read as follows:

(118) Tenncare Standard shall mean that part of the Tenncare Program which provides health coverage for Tennessee residents who are not eligible for Medicaid and who meet the eligibility criteria found in rule 1200-13-14-.02.

Rule 1200-13-13-.01 Definitions, is amended by adding a new paragraph (119) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (119) shall read as follows:

(119) Tenncare Standard Eligibility Reforms shall mean the amendments to the Tenncare demonstration project approved by CMS on March 24, 2005, to terminate coverage for adults aged nineteen (19) and older in Tenncare Standard eligibility groups.

Rule 1200-13-13-.01 Definitions, is amended by adding a new paragraph (123) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (123) shall read as follows:

(123) Transition Group shall mean existing Medicaid Medically Needy adults age twenty-one (21) or older enrolled as of October 5, 2007, who have not yet been assessed for transition to the Standard Spend Down Demonstration population for non-pregnant adults age twenty-one (21) or older.

Paragraph (115) Transition Period of rule 1200-13-13-.01 Definitions,, renumbered as paragraph (124), is deleted in its entirety and subsequent paragraphs are renumbered accordingly.

Paragraph (119) Waiver Eligible of rule 1200-13-13-.01 Definitions,, renumbered as paragraph (127), is deleted in its entirety.

Rule 1200-13-13-.02 Eligibility is deleted in its entirety and replaced with a new rule 1200-13-13-.02 which shall read as follows:

1200-13-13-.02 Eligibility.

(1) Delineation of agency roles and responsibilities.

(a) The Tennessee Department of Finance and Administration (F&A) is the lead State agency for the Tenncare Program.

(b) The Bureau of Tenncare (Bureau) is the administrative unit within F&A with the responsibility for day-to-day operations of the Tenncare Program. The Bureau is responsible for establishing

policy and procedural requirements and criteria for Tenncare. With respect to the eligibility of children applying for Tenncare as medically eligible persons, the Bureau is responsible for determining the presence of a qualifying medical condition under Tenncare Standard.

(c) The Tennessee Department of Human Services (DHS) is under contract with the Bureau to determine initial eligibility for Tenncare Medicaid and Tenncare Standard, as well as to redetermine, at regular intervals, whether eligibility should be continued. DHS is not responsible for making decisions about the presence of a qualifying medical condition for those applying as medically eligible persons under Tenncare Standard.

(d) The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) Program. Tennessee residents determined eligible for SSI benefits are automatically eligible for and enrolled in Tenncare Medicaid benefits.

(e) The Tennessee Department of Health (DOH) determines presumptive eligibility under Tenncare Medicaid for pregnant women and for women diagnosed with breast or cervical cancer through administration of the Breast and Cervical Cancer Screening Program.

(2) Delineation of Tenncare enrollee's responsibilities.

(a) It is the responsibility of each Tenncare enrollee to report to the DHS any material change affecting any information given by the applicant/enrollee to DHS at the time of application or redetermination of his eligibility. This information includes, but is not limited to, changes in address, income, family size, employment, or access to insurance. The applicant/enrollee shall mail, or present in person, documentation of any such change to the DHS county office where the enrollee resides. This documentation must be presented within the time frame specified in Chapter 1240-1-16 of the rules of DHS.

(b) It is the responsibility of each Tenncare enrollee to report to his provider that he is a Tenncare enrollee.

(3) Technical and financial eligibility requirements for Tenncare Medicaid.

(a) To be eligible for Tenncare Medicaid, each individual must:

1. Meet all technical requirements applicable to the appropriate category of medical assistance as described in the DHS - Division of Medical Services rule 1240-3-3-.02, and all financial eligibility requirements applicable to the appropriate category of medical assistance as described in the DHS - Division of Medical Services rule 1240-3-3-.03; or

2. Meet the financial eligibility requirements of the SSI Program of the Social Security Administration and be approved for SSI benefits by the Social Security Administration; or

3. Be a woman who:

(i) Is under age sixty-five (65);

(ii) Is uninsured or has health insurance that does not provide coverage for treatment of breast or cervical cancer;

(iii) Is not eligible for Medicaid;

(iv) Is a U.S. citizen or qualified alien; and

(v) Has been diagnosed with breast or cervical cancer, including a precancerous condition, by a screening at a Centers for Disease Control and Prevention (CDC) site, and who needs treatment.

(4) General application requirements.

(a) By applying for Tenncare Medicaid, an applicant agrees to provide information to the Bureau, or its designee, about any third party coverage. Mccs shall release insurance information from their files to the Bureau of Tenncare on a regular basis, as required by contract between the mccs and the F&A.

(b) By applying for Tenncare Medicaid, an applicant grants permission and authorizes release of information to the Bureau, or its designee, to investigate any and all information provided, or any information not provided if it could affect eligibility, in order to determine Tenncare eligibility; and, if approved, the amount of, if any, cost sharing which may be required of the applicant as found in these rules. Information may be verified through, but not limited to, the following sources:

1. The United States Internal Revenue Service (IRS);

2. State income tax records for Tennessee or any other state where income is earned;

3. The Tennessee Department of Labor and Workforce Development, and other employment security offices within any state where the applicant may have received wages or been employed;

4. Credit bureaus;

5. Insurance companies; or

6. Any other governmental agency or public or private source of information where such information may impact an applicant's eligibility or cost sharing requirements for the Tenncare Program.

(c) By applying for Tenncare, an applicant understands it is a felony offense, pursuant to *Tennessee Code Annotated* § 71-5-2601, to obtain Tenncare coverage under false means or to help anyone get on Tenncare under false means.

(5) Current eligibility groups under Tenncare Medicaid.

(a) Eligibility for Tenncare Medicaid is currently limited to individuals who are Tennessee residents as defined at 42 C.F.R. § 435.403, *Tennessee Code Annotated* § 71-5-120, and who are listed in DHS rule Chapter 1240-3-2, Coverage Groups under Medicaid.

1. Individuals enrolled as Categorically Needy, as defined at rule 1200-13-13-.01.

2. Individuals enrolled as Medically Needy, as defined at rule 1200-13-13-.01. Enrollment in this category is limited to pregnant women and children under the age of twenty-one (21). Eligibility for this category shall be for a period of one (1) year. At the end of that year, eligibility must be reestablished in order for these individuals to continue in the program.

3. Individuals who are determined eligible for the SSI Program by the Social Security Administration.

4. Women who have been enrolled as a result of needing treatment for breast or cervical cancer and who meet the technical requirements found at 1200-13-13-.02(3)(a)3.

(b) Effective date of eligibility.

1. For SSI eligibles, the date determined by the Social Security Administration in approving the individual for SSI coverage.

2. For all other Medicaid eligibles, the date of the application or the date of the qualifying event (such as the date that a spend-down obligation is met), whichever is later.

3. For persons applying for Medicaid eligibility during a period when the DHS offices are not open, the date the faxed application is received at DHS.

(6) Redetermination of Tenncare Medicaid eligibility.

(a) Enrollees eligible for Tenncare Medicaid as a result of being eligible for SSI benefits shall follow the Redetermination requirements of the Social Security Administration.

(b) An enrollee who qualifies for Tenncare Medicaid through DHS shall have his Tenncare Medicaid eligibility redetermined as required by the appropriate category of medical assistance as described in Chapter 1240-3-3 of the rules of DHS - Division of Medical Services. Prior to termination of Medicaid eligibility for enrollees of the Core Medicaid Population, eligibility will be reviewed in accordance with the following process:

1. At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of Tenncare will send a Request for Information to all Core Medicaid enrollees. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories.

2. Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to DHS and to provide DHS with the necessary verifications to determine eligibility for open Medicaid categories.

3. Enrollees with a health problem, mental health problem, learning problem or a disability will be given the opportunity to request assistance in responding to the Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.

4. If an enrollee provides some but not all of the necessary information to DHS to determine his eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, DHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request.

5. Enrollees who respond to the Request for Information within the thirty (30) day period shall retain their eligibility for Tenncare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while DHS reviews their eligibility for open Medicaid categories.

6. Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices but before the date of termination shall retain their eligibility for Tenncare Medicaid while DHS reviews their eligibility for open Medicaid categories. If DHS determines that the enrollee remains eligible for his current Medicaid category, the enrollee will remain enrolled in such Medicaid category. If DHS makes a determination that the enrollee is eligible for a different open Medicaid category, DHS will so notify the enrollee and the enrollee will be enrolled in the new appropriate Tenncare Medicaid category. When the enrollee is enrolled in the appropriate Tenncare Medicaid category, his eligibility in the previous category shall be terminated without additional notice. If a child is reviewed for Medicaid eligibility and is found not to be eligible for any open Medicaid category, the child will be reviewed for eligibility for Tenncare Standard under rule 1200-13-14-.02. If DHS makes a determination that the enrollee is not eligible for any open Medicaid categories, the Tenncare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

7. Individuals may provide the information and verifications specified in the Request for Information after termination of eligibility. DHS shall review all such information pursuant to the rules, policies and procedures of DHS and the Bureau of Tenncare applicable to new applicants for Tenncare Medicaid coverage. The individual shall not be entitled to be reinstated into Tenncare Medicaid pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of the application, or (b) the date spend down eligibility is met.

(c) A woman who has been determined eligible for Tenncare Medicaid under 1200-13-13-.02(3)(a)3 of these rules shall annually recertify her eligibility in terms of continuation of active treatment, her address, and access to health insurance. If she is found to no longer be eligible through this review, the enrollee will be reviewed using the Redetermination process set forth in 1200-13-13-.02(6)(b) of these rules.

(7) Termination of eligibility.

(a) Eligibility for Tenncare Medicaid shall cease when:

1. The individual no longer qualifies for Tenncare Medicaid pursuant to Chapter 1240-3-3 of the rules of DHS; or

2. A woman determined eligible under 1200-13-13-.02(3)(a)3 of these rules:

(i) Reaches age sixty-five (65); or

(ii) Gains access to group health insurance that provides coverage for treatment of breast or cervical cancer as defined elsewhere in these rules; or

(iii) It has been determined that she no longer needs treatment for breast or cervical cancer, including pre-cancerous conditions.

(b) The Tenncare Bureau will send Termination Notices to all Core Medicaid Population enrollees being terminated pursuant to state and federal law who are not determined to be eligible for open Medicaid categories pursuant to the Request for Information processes described herein.

(c) Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.

(d) Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal the termination and will inform enrollees how they may request a hearing. Appeals will be processed by DHS in accordance with rule 1200-13-13-.12.

(e) Enrollees with a health problem, mental health problem, learning problem or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

(8) Disenrollment related to discontinued Medicaid categories.

Prior to the disenrollment of any enrollee in a discontinued Medicaid category based on coverage terminations resulting from Tenncare Medicaid Eligibility Reforms, Medicaid eligibility shall be reviewed in accordance with the following:

(a) Ex Parte Review.

DHS will conduct an ex parte review for open Medicaid categories for all enrollees in eligibility groups due to be terminated as part of the Tenncare Medicaid eligibility reforms. Such ex parte review shall be conducted in accordance with federal requirements as set forth by CMS in the Special Terms and Conditions of the Tenncare demonstration project.

(b) Request for Information.

1. At least thirty (30) days prior to the expiration of their current eligibility period, the Bureau of Tenncare will send a Request for Information to enrollees in eligibility groups being terminated pursuant to Tenncare Medicaid eligibility reforms. The Request for Information will include a form to be completed with information needed to determine eligibility for open Medicaid categories, as well as a list of the types of proof needed to verify certain information.

2. Enrollees will be given thirty (30) days inclusive of mail time from the date of the Request for Information to return the completed form to DHS and to provide DHS with the necessary verifications to determine eligibility for open Medicaid categories.

3. Enrollees with a health problem, mental health problem, learning problem or a disability will be given the opportunity to request assistance in responding to this Request for Information. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for responding to the Request for Information.

4. Enrollees will be given an opportunity until the date of termination to request one extension for good cause of the thirty (30) day time frame for responding to the Request for Information. The good cause extension is intended to allow a limited avenue for possible relief for certain enrollees who face significant unforeseen circumstances, or who, as a result of a health problem, mental health problem, learning problem, disability, or limited English proficiency, are unable to respond timely. The good cause exception does not confer an entitlement upon enrollees and the application of this exception will be within the discretion of DHS. Only one (1) thirty (30) day good cause extension can be granted to each enrollee. Good cause is determined by DHS eligibility staff. Good cause is not requested nor determined

by filing an appeal. Requests for an extension of the thirty (30) day time frame to respond to the Request for Information must be initiated by the enrollee. However, the enrollee may receive assistance in initiating such request. DHS will not accept a request for extension of the thirty (30) day time frame submitted by a family member, advocate, provider, or CMHC, acting on the enrollee's behalf without the involvement and knowledge of the enrollee, for example, to allow time for such entity to locate the enrollee if his whereabouts are unknown. All requests for a good cause extension must be made prior to termination of Medicaid eligibility. A good cause extension will be granted if DHS determines that a health problem, mental health problem, learning problem, disability or limited English proficiency prevented an enrollee from understanding or responding timely to the Request for Information. Except in the aforementioned circumstances, a good cause extension will only be granted if such request is submitted in writing to DHS prior to termination of Medicaid eligibility and DHS determines that serious personal circumstances such as illness or death prevent an enrollee from responding to the Request for Information for an extended period of time. Proof of the serious personal circumstances is required with the submission of the written request in order for a good cause extension to be granted. Good cause extensions will be granted at the sole discretion of DHS, and, if granted, shall provide the enrollee with an additional thirty (30) days inclusive of mail time from the date of DHS's decision to grant the good cause extension. DHS will send the enrollee a letter granting or denying the request for good cause extension. DHS's decisions with respect to good cause extensions shall not be appealable.

5. If an enrollee provides some but not all of the necessary information to DHS to determine his eligibility for open Medicaid categories during the thirty (30) day period following the Request for Information, DHS will send the enrollee a Verification Request. The Verification Request will provide the enrollee with ten (10) days inclusive of mail time to submit any missing information as identified in the Verification Request. Enrollees will not have the opportunity to request an extension for good cause of the ten (10) day time frame for responding to the Verification Request.

6. Enrollees who respond to the Request for Information within the thirty (30) day period or within any extension of such period granted by DHS shall retain their eligibility for Tenncare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while DHS reviews their eligibility for open Medicaid categories.

7. DHS shall review all information and verifications provided within the requisite time period by an enrollee pursuant to the Request for Information and/or Verification Request to determine whether the enrollee is eligible for any open Medicaid categories. If DHS makes a determination that the enrollee is eligible for an open Medicaid category, DHS will so notify the enrollee and the enrollee will be enrolled in the appropriate Medicaid category. When the enrollee is enrolled in the appropriate Tenncare Medicaid category, his eligibility in the discontinued Medicaid category shall be terminated without additional notice. If DHS makes a determination that the enrollee is not eligible for any open Medicaid categories or if an enrollee does not respond to the Request for Information within the requisite thirty (30) day time period or any extension of such period granted by DHS, the Tenncare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

8. Enrollees who respond to the Request for Information or the Verification Request after the requisite time period specified in those notices or after any extension of such time period granted by DHS but before the date of termination shall retain

their eligibility for Tenncare Medicaid (subject to any changes in covered services generally applicable to enrollees in their Medicaid category) while DHS reviews their eligibility for open Medicaid categories. If DHS makes a determination that the enrollee is eligible for an open Medicaid category, DHS will so notify the enrollee, and the enrollee will be enrolled in the appropriate Tenncare Medicaid category, and his eligibility in the discontinued Medicaid category shall be terminated without additional notice. If DHS makes a determination that the enrollee is not eligible for any open Medicaid categories, the Tenncare Bureau will send the enrollee a twenty-(20) day advance Termination Notice.

9. Individuals may provide information and verifications specified in the Request for Information after termination of eligibility. DHS shall review all such information pursuant to the rules, policies and procedures of DHS and the Bureau of Tenncare applicable to new applicants for Tenncare coverage. The individual shall not be entitled to be reinstated into Tenncare pending this review. If the individual is subsequently determined to be eligible for an open Medicaid category, he shall be granted retroactive coverage to the date of application, or in the case of spend down eligibility for Medically Needy pregnant women and children, to the latter of (a) the date of application, or (b) the date spend down eligibility is met.

(c) Termination Notice.

1. The Tenncare Bureau will send Termination Notices to all enrollees being terminated pursuant to Tenncare Medicaid eligibility reforms who are not determined to be eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in this subparagraph.

2. Termination Notices will be sent twenty (20) days in advance of the date upon which the coverage will be terminated.

3. Termination Notices will provide enrollees with forty (40) days from the date of the notice to appeal valid factual disputes related to the disenrollment and will inform enrollees how they may request a hearing.

4. Enrollees with a health problem, mental health problem, learning problem, or a disability will be given the opportunity to request additional assistance for their appeal. Enrollees with Limited English Proficiency will have the opportunity to request translation assistance for their appeal.

5. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day time frame in which to request a hearing.

Rule 1200-13-13-.03 Enrollment, Disenrollment, Re-Enrollment, And Reassignment is deleted in its entirety and replaced with a new rule 1200-13-13-.03 which shall read as follows:

1200-13-13-.03 Enrollment, Reassignment, And Disenrollment With Managed Care Contractors (mccs).

(1) Enrollment.

There are four different types of managed care entities that provide services to Tenncare enrollees. 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) Tenncare Managed Care Organizations (mcos) other than Tenncare Select.

1. Individuals or families determined eligible for Tenncare shall select a health plan (Managed Care Organization/MCO) at the time of application. The health plan must be available in the Grand Division of the state in which the enrollee lives. Every attempt will be made to enroll eligible family members in the same MCO with the exception of a family member assigned by the Bureau to Tenncare Select. An enrollee is given his choice of mcos when possible. If the requested MCO cannot accept new enrollees, the Bureau will assign each enrollee to an MCO that is accepting new enrollees. If no MCO is available to enroll new members in the enrollee's Grand Division, the enrollee will be assigned to Tenncare Select until such time as another MCO becomes available. The Bureau may also assign Tenncare children with special health care needs to Tenncare Select.

   Individuals enrolled as a result of being eligible for SSI benefits will be assigned to an MCO as they do not have the opportunity to select a health plan prior to the effective date of coverage, since they are enrolled through the Social Security Administration.

2. A Tenncare enrollee may change mcos one (1) time within the initial forty-five (45) calendar days (inclusive of mail time) from the date of the letter informing him of his MCO assignment, if there is another MCO in the enrollee's Grand Division that is currently permitted by the Bureau to accept new enrollees. No additional changes will be allowed except as otherwise specified in these rules. An enrollee shall remain a member of the designated plan until he is given an opportunity to change during an annual redetermination of eligibility. Thereafter, only one (1) MCO change is permitted every twelve (12) months, unless the Bureau 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 participating providers. If after notification of enrollment the enrollee has not chosen a primary care provider, 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 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.

   In the event a pregnant woman entering the MCO's plan is 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 1200-13-13-.08.

(b) Tenncare Select.

Tenncare Select is a prepaid inpatient health plan (PIHP), as defined in 42 CFR 438.2, which operates in all areas of the State and covers the same services as the mcos. The State's Tenncare Select contractor is reimbursed on a non-risk, non-capitated basis for services rendered to covered populations, and in addition receives fees from the State to offset administrative costs.

1. The Tenncare populations included in the Tenncare Select delivery system are as follows:

   (i) Children who are eligible for Supplemental Security Income.

   (ii) Children in state custody and children leaving state custody for six (6) months post-custody as long as the child remains eligible.

   (iii) Children in an institutional eligibility category who are receiving care in a Nursing Facility, an Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services 1915(c) waiver.

   (iv) Enrollees living in areas where there is insufficient MCO capacity to service them.

   After being assigned to Tenncare Select, persons in categories (i) and (iii) above may choose to disenroll from Tenncare Select and enroll in another MCO if one is available. Persons in categories (ii) and (iv) must remain in Tenncare Select. Tenncare Select is not open to voluntary selection by Tenncare enrollees.

2. Tenncare Select also provides the following functions:

   (i) It is the back-up plan should one of the mcos leave the Tenncare program unexpectedly. For Tenncare enrollees previously enrolled with the MCO, Tenncare Select provides medical case management and all MCO covered services.

   (ii) It is the only entity responsible for payment of the services described in 42 CFR 431.52, services provided to residents temporarily absent from the State, and provides all MCO covered services (primarily emergency services).

   (iii) It is the only entity responsible for payment of the services described in 42 CFR 440.255, limited services for certain aliens.

(c) Tenncare Behavioral Health Organization (BHO).

In any Grand Division of Tennessee where behavioral health services are not offered by mcos, enrollees shall be assigned to the Behavioral Health Organization (BHO) that corresponds with the mcos they have chosen.

(d) Tenncare Dental Benefits Manager (DBM).

Tenncare children shall be assigned to the Dental Benefits Manager (DBM) under contract with the Bureau to provide dental benefits through the Tenncare Program.

(e) Tenncare Pharmacy Benefits Manager (PBM).

Tenncare enrollees who are eligible to receive pharmacy services shall be assigned to the Pharmacy Benefits Manager (PBM) under contract with the Bureau to provide pharmacy benefits for both medical and behavioral health services through the Tenncare Program.

(2) Reassignment.

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

1. During the initial forty-five (45) day period following notification of MCO assignment as described at rule 1200-13-13-.03, a Tenncare enrollee may request a change of mcos.

2. A Tenncare 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 Tenncare 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 Tenncare Program, Tenncare will assign him to a MCO operating in his Grand Division, if one is available. The enrollee will be provided notice of the change and will have forty-five (45) days to select another MCO is his Grand Division. If no MCO is available to accept enrollees from an exiting plan, the enrollees will be assigned to Tenncare Select until such time as another MCO becomes available.

4. A Tenncare enrollee will be given an opportunity to change mcos during the annual redetermination of eligibility. Only one (1) MCO change is permitted every twelve (12) months, unless the Bureau 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.

(b) A Tenncare enrollee may change mcos if the Tenncare Bureau 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 primary care provider (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; or

(v) The enrollee is a Medicare beneficiary who (with the exception of pharmacy) may utilize choice of providers, regardless of network affiliation.

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) A member has a medical condition that requires complex, extensive, and ongoing care; and

(ii) The member's PCP and/or specialist has stopped participating in the member's current MCO network and has refused continuation of care to the member in his current MCO assignment; and

(iii) The ongoing medical condition of the member 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 member with the current PCP or 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 enrolled members (i.e., has not given notice of withdrawal from the Tenncare Program, is not in receivership, and is not at member capacity for the member's region).

Requests to change mcos submitted by Tenncare enrollees shall be evaluated in accordance with the hardship criteria referenced above. Upon denial of a request to change mcos, enrollees shall be provided notice and appeal rights as described in applicable provisions of rule 1200-13-13-.11.

(c) Enrollees who are out-of-state on a temporary basis, but maintain their status as Tennessee residents under federal and state laws, shall be reassigned to Tenncare Select for the period they are out-of-state.

(3) Disenrollment.

(a) When it has been determined that an individual no longer meets the criteria for Tenncare eligibility, that individual shall be disenrolled from the Tenncare Program. Services provided by the Tenncare MCO in which the individual has been placed, as well as the BHO, PBM, and DBM, if applicable, shall be terminated upon disenrollment. Such disenrollment action will be accompanied by appropriate due process procedures as described elsewhere in these rules.

(b) Coverage shall cease at 12:00 midnight, local time, on the date that an individual is disenrolled from Tenncare.

(c) Tenncare may reassign individuals from a designated MCO and place them in another MCO as described elsewhere in these rules. A Tenncare MCO may not reassign an enrollee without the permission of Tenncare. A Tenncare MCO shall not request the reassignment of a Tenncare enrollee for any of the following reasons:

1. Adverse changes in the enrollee's health;

2. Pre-existing medical conditions; or

3. High cost medical bills.

Coverage by a particular MCO shall cease at 12:00 midnight local time on the date that an individual has been reassigned by Tenncare from one MCO and placed in another plan. Coverage by the new MCO will begin when coverage by the old MCO ends.

Statutory Authority: T.C.A. 4-5-202, 4-5-203, 71-5-105, 71-5-109, Executive Order No. 23.

The notice of rulemaking set out herein was properly filed in the Department of State on the 30th day of January, 2008; DBID 810)