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312 Rosa L. Parks Avenue, 8th Floor Tennessee Tower
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Phone: 615-741-2650
Fax: 615-741-5133
Email: sos.information@state.tn.us

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Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. TCA Section 4-5-205

Agency/Board/Commission:	Tennessee Department of Human Services
Division:	Medical Services
Contact Person:	Phyllis Simpson
Address:	Office of General Counsel Citizens Plaza Building, 10th Floor 400 Deaderick Street Nashville, Tennessee
Zip:	37243-1403
Phone:	615-313-4731
Email:	phyllis.simpson@state.tn.us

Revision Type (check all that apply):

X Amendment
___ New
___ Repeal

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

Chapter Number	Chapter Title
1240-03-01	General Rules
Rule Number	**Rule Title**
1240-03-01-.02	Definitions

Chapter Number	Chapter Title
1240-03-03	Technical and Financial Eligibility Requirements for Medicaid
Rule Number	**Rule Title**
1240-03-03-.02	Technical Eligibility Factors

Chapter Number	Chapter Title
Rule Number	**Rule Title**

Chapter 1240-03-01
General Rules

Amendments

Rule 1240-03-01-.02 Definitions, is amended by inserting "caretaker relative" and "qualified long term care insurance policy" alphabetically as new subparagraphs under paragraph (1) and by renumbering the existing subparagraphs accordingly so that, as amended, subparagraph (c) through (w) under paragraph (1) shall read as follows:

(c) Caretaker relative: The father, mother, grandfather or grandmother of any degree, brother or sister of the whole or half-blood, stepfather, stepmother, stepbrother, stepsister, aunt or uncle of any degree, first cousin, nephew or niece, the relatives by adoption within the previously named classes of persons, and the biological relatives within the previous degrees of relationship, and the legal spouses of persons within the previously named classes of persons, even if the marriage has been terminated by death or divorce, with whom a child is living. A Caretaker relative may be included in the AFDC-MO Category if he/she is related in the previous degrees of relationship with a child in the home who is under age eighteen (18) years of age or a child who has not attained nineteen (19) years of age and who is a full-time student in a secondary school or the equivalent and who is expected to graduate by the nineteenth birthday. [TCA § 71-3-153]

(d) Categorically Needy. Categorically Needy individuals are entitled to the broadest scope of medical assistance benefits. All recipients of Medicaid based on Section 1931-AFDC-MO and the SSI program for the aged, blind or disabled are Categorically Needy. In addition, many adults, families, pregnant women and children who do not receive cash assistance receive the Categorically Needy level of benefits for Medicaid Only assistance.

(e) Code of Federal Regulations (C.F.R.). Federal regulations which transfer to regulatory form the specific requirements of Federal law.

(f) Co-insurance. Coinsurance amounts payable by the recipient under the provisions of Title XVIII, Part B for covered medical services rendered under the Medicare Program and becoming due after satisfaction of the deductible liability. [42 U.S.C. §§ 1395j et seq.]

(g) Deductible. Amounts payable by the recipient which fall within an aged beneficiary's deductible liability imposed by Title XVIII, Part B. Health Insurance for the Aged. [42 U.S.C. §§ 1395j et seq.]

(h) Eligible individual. A person who has applied for medical assistance and has been found to meet all applicable conditions for eligibility pertaining to Tennessee's Medical Assistance Program.

(i) Excess income. That portion of the income of the individual or family group, which exceeds amounts allowable to the individual or family group as disregarded income or income protected for basic maintenance and which results in a determination of ineligibility.

1. Excess Resources. That portion of the liquid assets or other resources of the individual or family group in excess of the amounts which may be retained for the individual or family group's security and personal use,

not exempted from consideration or otherwise accounted for by special specified circumstances, and which result in a determination of ineligibility.

2. Spenddown. The process by which excess income is utilized for recognized medical expenses and which, when depleted, results in a determination of eligibility if all other eligibility factors are met.

(j) Families First (FF) - Tennessee's TANF program (Temporary Assistance for Needy Families) which provides cash assistance to families with dependent children. [42 U.S.C. §§ 601 et seq.]

(k) Inpatient services. Those services rendered for any acute or chronic condition, including maternal and mental health care, which cannot be rendered on an outpatient basis.

(l) Level I care. Level I care is health care in a nursing facility which is more than room and board, but is less than skilled nursing care. (Level I care was formally called I.C.F. - Intermediate Care Facility).

(m) Level II care. Level II care is health care in a nursing facility which is a higher level of care than Level I, but less than inpatient hospitalization. (Level II care was formally called Skilled Nursing Care.)

(n) Medicaid. The State program of medical assistance as administered by the Department in compliance with Title XIX of the Social Security Act [42 U.S.C. §§ 1396 et seq.] and which is designed to provide for the medical care needs of Tennessee's medically indigent citizenry.

(o) Medical assistance drug list. A listing of drugs covered under the Medical Assistance Program, which includes the drug code, description, dosage strength, covered unit form, maximum dosage covered, and per unit price.

(p) Medically Needy – Individuals whose income or resources are under a certain limit and allows them to qualify for Medicaid by spending down their medical expenses.

(q) Medicare. The Federal program under Title XVIII of the Social Security Act [42 U.S.C. §§ 1395 et seq.] providing medical benefits to persons receiving Social Security Retirement payments or who have received Social Security benefits based on disability for a period of twenty-four (24) consecutive months.

1. Part A of Title XVIII. Hospital Insurance Benefits provides hospital care, nursing home care, and home health visits, subject to deductibles and co-insurance. [42 U.S.C. § 1395c]

2. Part B of Title XVIII. Supplementary Medical Insurance provides additional medical benefits to those persons eligible for Part A or any person sixty-five (65) years of age, but only if enrolled in the program and paying the monthly premium. [42 U.S.C. § 1395j]

(r) Nursing Facility (NF). A facility certified by the State to provide nursing care in what was formally called Intermediate Care Facility (I.C.F.) and Skilled Nursing Facility (S.N.F.).

(s) Outpatient services. Services provided, in other than inpatient circumstances, for any condition detrimental to the individual recipient's physical or mental health which cannot be taken care of in the home situation.

(t) Poverty Groups – Assistance groups whose gross income does not exceed various percentages of the Federal Poverty Level Income Standard.

(u) Qualified Long Term Care Insurance Policy – A long term care insurance policy issued on or after October 1, 2008, that has been pre-certified by the Tennessee Department of Commerce and Insurance pursuant to State Rule 0780-01-61as:

1. A policy that meets all applicable Tennessee Long Term Care Partnership requirements; or

2. A policy that has been issued in another Partnership state and which is covered under a reciprocal agreement between such other state and the State of Tennessee.

(v) Supplemental Security Income (SSI) – A federal income supplement program funded by general tax revenues and is designed to help aged, blind and disabled individuals who have little or no income. Applications for SSI benefits are filed at the Social Security office. Individuals who are eligible for SSI are automatically entitled to Medicaid. [42 U.S.C. §§ 1382 et seq.]

(w) Temporary Assistance for Needy Families (TANF) – Program which was created by the Welfare Reform Law of 1996. TANF became effective July 1996 and replaced what was then commonly known as the AFDC program. [42 U.S.C. §§ 601 et seq.]

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-3-153, 71-3-158(d)(2)(D), 71-5-101, 71-5-103 and 71-5-111; Acts 2007, Ch 31, § 11; 42 U.S.C. § 423, 42 U.S.C. §§ 601 et seq.; 42 U.S.C. §§ 1382 et seq.; 42 U.S.C. §§ 1395 et seq.; 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(e)(4); 42 U.S.C. § 1396p(b)(1)(C)(iii) and (b)(5), 42 U.S.C. § 1396r and 42 U.S.C. § 1396u-1; 42 C.F.R. § 435.4; PL 101-508 § 5103(e); PL 98-21 § 134, PL 100-203 § 9116, PL 104-193, and PL 109-171 § 6021; and TennCare II Medicaid Section 1115 Demonstration Waiver.

Rule 1240-03-01-.02 Definitions, is amended by deleting subparagraph (b) under paragraph (2) in its entirety and by substituting instead the following language, so that, as amended, subparagraph (b) under paragraph (2) shall read as follows:

(b) Caretaker relative. The father, mother, grandfather or grandmother of any degree, brother or sister of the whole or half-blood, stepfather, stepmother, stepbrother, stepsister, aunt or uncle of any degree, first cousin, nephew or niece, the relatives by adoption within the previously named classes of persons, and the biological relatives within the previous degrees of relationship, and the legal spouses of persons within the previously named classes of persons, even if the marriage has been terminated by death or divorce, with whom a child is living. A caretaker relative may be considered for SSD if he/she is related in the previous degrees of relationship with a child in the home who is under age eighteen (18) years of age or a child who has not attained nineteen (19) years of age and who is a full-time student in a secondary school or the equivalent and who is expected to graduate by the nineteenth birthday. [TCA § 71-3-153]

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-3-153, 71-3-158(d)(2)(D), 71-5-101, 71-5-103 and 71-5-111; Acts 2007, Ch 31, § 11; 42 U.S.C. § 423, 42 U.S.C. §§ 601 et seq.; 42 U.S.C. §§ 1382 et seq.; 42 U.S.C. §§ 1395 et seq.; 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(e)(4); 42 U.S.C. § 1396p(b)(1)(C)(iii) and (b)(5), 42 U.S.C. § 1396r and 42 U.S.C. § 1396u-1; 42 C.F.R. § 435.4; PL 101-508 § 5103(e); PL 98-21 § 134, PL 100-203 § 9116, PL 104-193, and PL 109-171 § 6021; and TennCare II Medicaid Section 1115 Demonstration Waiver.

Chapter 1240-03-03
Technical and Financial Eligibility
Requirements for Medicaid

Amendments

Rule 1240-03-03-.02 Technical Eligibility Factors, is amended by deleting current paragraph (8) "Reserved" in its entirety and by substituting the current language at paragraph (9) instead, and by inserting the following new language as (9), so that, as amended paragraphs (8), (9), (10) and (11) shall read as follows:

(8) By accepting medical assistance through the Medicaid program, every recipient is deemed to assign to the State of Tennessee all third party insurance benefits or other third party sources of medical support or benefits. Failure to cooperate in establishing the paternity of dependent children, or in securing or collecting third party medical insurance, benefits or support is grounds for denying or terminating medical eligibility.

(9) Asset Disregards for Qualifying Long Term Care Insurance Policies

(a) Individuals who purchase a qualified long term care insurance policy may have certain assets disregarded in the determination of eligibility for TennCare Medicaid. The Department of Human Services (DHS) shall disregard an individual's assets up to the amount of payments made by the individual's qualifying long-term care insurance policy for services covered under the policy at the time of TennCare application.

(b) The amount of the individual's assets properly disregarded under these provisions shall continue to be disregarded through the lifetime of the individual.

(c) Assets which were disregarded for purposes of Medicaid eligibility determination during the person's lifetime are also protected from estate recovery. When the amount of assets disregarded during the person's lifetime was less than total benefits paid by the qualified long term care insurance policy, additional assets may be protected in the estate recovery process up to the amount of payments made by the individual's qualifying long term care policy for services covered under the policy. If no assets were disregarded during the person's lifetime, the personal representative may designate assets to protect from estate recovery up to the lesser of the two options specified above, even if a qualified long term care policy's benefits were not completely exhausted.

(10) Institutionalized individuals in a medical institution (i.e., one organized to provide medical care, including nursing and convalescent care) must be continuously confined for thirty (30) consecutive days prior to attaining Medicaid eligibility based on institutionalization. Medicaid eligibility is retroactive to the later of: a) the date of

admission; or b) the date of application when thirty (30) consecutive days of institutionalization is met. Coverage of Home and Community Based Services (HCBS) requires a determination that the individual needs, and is likely to receive, HCBS services for thirty (30) consecutive days going forward.

(11) As a condition of receiving medical assistance through the Medicaid program, each applicant or recipient must furnish his or her Social Security Number (or numbers, if he/she has more than one) during the application process. If the applicant/recipient has not been issued a number, he/she must assist the eligibility worker in making application for a number or provide verification that he/she has applied for a number and is awaiting its issuance.

Authority: T.C.A. §§ 4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-102, 71-5-106, 71-5-107, 71-5-109, 71-5-120 and 71-5-141; 8 U.S.C. §§ 1611, 1612, 1613, and 1641, 42 U.S.C. § 402, 42 U.S.C. § 423, 42 U.S.C. § 672, 42 U.S.C § 673, 42 U.S.C. § 1315, 42 USC §§ 1382c(a)(3) and (4), 42 U.S.C. §§ 1396 et seq., 42 U.S.C. § 1396a(a)(10)(A)(ii)(I) and (V)(VI); 42 U.S.C. § 1396b(v)(1) and (x)(1), (2) and (3); 42 U.S.C. § 1396d and 42 U.S.C. 1396n(c) and 42 U.S.C. § 1396p(b)(1)(C)(iii) and (b)(5) and; 42 C.F.R. §§ 435.210, 435.217, 435.300, 435.301, 435.403, 435.406, 435.407, 435.530, 435.540, 435.622, and 435.914(c); PL 104-193 §§ 401, 402, 403 and 431, PL 109-432, Division B, Title IV § 405, December 20, 2006, PL 109-171 § 6036 and PL 109-171 § 6021; 71 FR 39214 (July 6, 2006); and TennCare Medicaid Section 1115 Demonstration Waiver.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Department of Human Services (board/commission/ other authority) on 01/09/2009 (mm/dd/yyyy), and is in compliance with the provisions of TCA 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 10/24/08

Notice published in the Tennessee Administrative Register on: 11/14/08

Rulemaking Hearing(s) Conducted on: (add more dates). 12/19/08

DEBRA E. BATTS
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires May 22, 2010

Date: January 9 2009

Signature: Phyllis Simpson

Name of Officer: Phyllis Simpson

Title of Officer: Assistant General Counsel

Subscribed and sworn to before me on: January 9 2009

Notary Public Signature: Debra E Batts

My commission expires on: May 22, 2010

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.

RE Cooper

Robert E. Cooper, Jr.
Attorney General and Reporter

2-22-09
Date

Department of State Use Only

Filed with the Department of State on: 2/24/09

Effective on: 5/10/09

Tre Hargett

Tre Hargett
Secretary of State

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January 8, 2009

Regulatory Flexibility Addendum
Pursuant to Public Chapter 464 of the 105th General Assembly, prior to initiating the rule making process as described in § 4-5-202(a)(3) and § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

The Centers for Medicare and Medicaid Services (CMS) approved TennCare's proposed State Plan amendment number 08-001 on May 13, 2008, with an effective date of October 1, 2008. This State Plan amendment adds requirements for long term care partnership insurance policies and eligibility asset and estate recovery exclusions. This amendment implements Section 6021 of the Deficit Reduction Act of 2005.

This State Plan amendment approval requires TennCare to allow an individual who is a beneficiary under a long term care insurance policy that meets certain requirements to be given a resource disregard for the amount of benefits paid by the policy for the individual. The amendment also requires TennCare not to seek recovery from the estate of a TennCare enrollee for the amount of benefits paid by the qualified long term care insurance policy. Sales of qualified long term care insurance policies will begin in the state of Tennessee on or after October 1, 2008. These rules are necessary to implement the long term care partnership policy as approved in State Plan amendment 08-001.

For purposes of Acts 2007, Chapter 464, the Regulatory Flexibility Act, the Department of Human Services certifies that these rulemaking hearing rules substantially codify existing federal law at 42 U.S.C. § 1396p(b)(1)(C)(iii) and (b)(5) of Title XIX of the Social Security Act, concerning qualified long term care insurance policies such that pursuant to Section 6 of the Regulatory Flexibility Act, the Regulatory Flexibility Act's provisions do not apply to these rules.

In addition, these rulemaking hearing rules do not appear to affect small businesses as defined in the Act because these rules will only affect Tennessee's long term care population who are not employable.