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Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204. For questions and copies of the notice, contact the person listed below.

Agency/Board/Commission:	Tennessee Department of Finance and Administration
Division:	Bureau of TennCare
Contact Person:	George Woods
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Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

ADA Contact:	ADA Coordinator
Address:	Bureau of TennCare 310 Great Circle Road Nashville, Tennessee 37243
Phone:	(615) 507-6474
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Hearing Location(s) (for additional locations, copy and paste table)

Address 1:	Bureau of TennCare 1st Floor East Conference Room 310 Great Circle Road		
Address 2:			
City:	Nashville, Tennessee		
Zip:	37243		
Hearing Date :	04/28/10		
Hearing Time:	9:00 a.m.	X CST ___EST	

Additional Hearing Information:

Revision Type (check all that apply):
X Amendment
___ New
___ Repeal

Rule(s) (**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
1200-13-14	TennCare Standard
Rule Number	**Rule Title**
1200-13-14-.01	Definitions
1200-13-14-.02	Eligibility
1200-13-14-.03	Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS)
1200-13-14-.04	Covered Services
1200-13-14-.05	Enrollee Cost Sharing
1200-13-14-.06	Managed Care Organization
1200-13-14-.08	Providers
1200-13-14-.10	Exclusions

(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)

Chapter 1200-13-14
TennCare Standard

Paragraph (6) Benefits of rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with a new paragraph (6) which shall read as follows:

(6) Benefits shall mean the health care package of services developed by the Bureau of TennCare and which define the covered services available to TennCare enrollees. Additional benefits are available through the TennCare CHOICES program, as described in the Bureau's rules at 1200-13-01-.05. CHOICES benefits are available only to persons who qualify for and are enrolled in the CHOICES program.

Rule 1200-13-14-.01 Definitions is amended by adding new paragraphs (13) CHOICES, (14) CHOICES 217-Like Group, (15) CHOICES Group 1, and (16) CHOICES Group 2 and the current paragraph (13) will be renumbered as (17) and subsequent paragraphs renumbered accordingly and the new paragraphs (13), (14), (15) and (16) shall read as follows:

(13) CHOICES. See "TennCare CHOICES in Long-Term Care."

(14) CHOICES 217-Like Group. See definition in Rule 1200-13-01-.02.

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

(16) CHOICES Group 2. See definition in Rule 1200-13-01-.02.

Rule 1200-13-14-.01 Definitions is amended by adding a new renumbered paragraph (25) Contract Provider and subsequent paragraphs are renumbered according so as amended the new renumbered paragraph (25) shall read as follows:

(25) Contract Provider shall have the same meaning as Participating Provider.

Paragraph (25) Cost Sharing renumbered as paragraph (30) of rule 1200-13-14-.01 Definitions is amended by deleting the words "premiums and/or" so as amended the renumbered paragraph (30) shall read as follows:

(30) Cost Sharing shall mean the amounts that certain enrollees in TennCare are required to pay for their TennCare coverage and covered services. Cost sharing includes copayments.

Paragraph (26) Covered Services renumbered as paragraph (31) of rule 1200-13-14-.01 Definitions is amended by adding the phrase " and in rule 1200-13-01-.05" after the word "rules" in subparagraph (a) and changing the number "1315" to "1915(c)" in subparagraph (b) so as amended renumbered paragraph (31) shall read as follows:

(31) Covered Services shall mean the services and benefits that:

(a) TennCare contracted MCC's cover, as set out elsewhere in these rules and in Rule 1200-13-01-.05; or

(b) In the instance of enrollees who are eligible for and enrolled in federal Medicaid waivers under Section 1915(c) of the Social Security Act, the services and benefits that are covered under the terms and conditions of such waivers.

Rule 1200-13-14-.01 Definitions is amended by adding a new renumbered paragraph (62) In-Network Provider and subsequent paragraphs are renumbered accordingly so the new renumbered paragraph (62) shall read as follows:

(62) In-Network Provider shall have the same meaning as Participating Provider.

Paragraph (62) Long Term Care renumbered as (68) of rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with a new renumbered paragraph (68) which shall read as follows:

(68) Long-Term Care shall mean programs and services described under Rule 1200-13-01-.01.

Paragraph (64) MCO (Managed Care Organization) renumbered as paragraph (70) of rule 1200-13-14-.01 Definitions is amended by deleting the word "and" and inserting a comma after "medical" and adding the punctuation and phrase ", and long-term care" after the word "behavioral" so as amended the renumbered paragraph (70) shall read as follows:

(70) MCO (Managed Care Organization) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical, behavioral, and long-term care services in the TennCare Program.

Rule 1200-13-14-.01 Definitions is amended by adding renumbered paragraphs (82) Non-Contract Provider, (83) Non-Participating Provider and (84) Non-TennCare Provider which shall read as follows:

(82) Non-Contract Provider shall have the same meaning as Non-Participating Provider.

(83) Non-Participating Provider shall mean a TennCare provider, as defined in these rules, who is not contracted with a particular enrollee's MCO. This term may include TennCare providers who furnish services outside the managed care program on a fee-for-service basis, as well as TennCare providers who receive Medicare crossover payments from TennCare.

(84) Non-TennCare Provider shall mean a provider who is not enrolled in TennCare and who accepts no TennCare reimbursement for any service, including Medicare crossover payments.

Rule 1200-13-14-.01 Definitions is amended by adding new renumbered paragraphs (87) Out-of-Network Provider and (88) Out-of-State Emergency Provider which shall read as follows:

(87) Out-of-Network Provider shall have the same meaning as Non-Participating Provider.

(88) Out-of-State Emergency Provider shall mean a provider outside the State of Tennessee who does not participate in TennCare in any way except to bill for emergency services, as defined in these rules, provided out-of-state to a particular MCC's enrollee. An Out-of-State Emergency Provider is not required to enroll with TennCare, but for the episode for which he is recognized as an Out-of-State Emergency Provider, he must abide by all TennCare rules and regulations, including the rules about provider billing of enrollees as found in rule 1200-13-14-.08. In order to receive payment from TennCare, Out-of-State Emergency Providers must be appropriately licensed in the state in which the emergency services were delivered, and they must not be excluded from participation in Medicare or Medicaid.

Rule 1200-13-14-.01 Definitions is amended by adding a new renumbered paragraph (90) Participating Provider and subsequent paragraphs renumbered accordingly so the new renumbered paragraph (90) shall read as follows:

(90) Participating Provider shall mean a TennCare provider, as defined in these rules, who has entered into a contract with an enrollee's Managed Care Contractor.

Paragraph (88) Provider renumbered as paragraph (100) of rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with a new renumbered paragraph (100) which shall read as follows:

(100) PROVIDER shall mean an appropriately licensed institution, facility, agency, person, corporation, partnership, or association that delivers health care services. Providers are categorized as either TennCare Providers or Non-TennCare Providers. TennCare Providers may be further categorized as being one of the following:

(a) Participating Providers or In-Network Providers

(b) Non-Participating Providers or Out-of-Network Providers

(c) Out-of-State Emergency Providers

Definitions of each of these terms are contained in these rules.

Rule 1200-13-14-.01 Definitions is amended by adding a new renumbered paragraph (124) TennCare CHOICES in Long-Term Care and subsequent paragraphs renumbered accordingly so the new paragraph (124) shall read as follows:

(124) TennCare CHOICES in Long-Term Care shall mean the program described in Rule 1200-13-01-.05.

Rule 1200-13-14-.01 Definitions is amended by adding a new renumbered paragraph (128) TennCare Provider and subsequent paragraphs are renumbered accordingly so the new renumbered paragraph (128) shall read as follows:

(128) TennCare Provider shall mean a provider who accepts as payment in full for furnishing benefits to a TennCare enrollee, the amounts paid pursuant to an approved agreement with an MCC or TennCare. Such payment may include copayments from the enrollee or the enrollee's responsible party. Except in the case of Out-of-State Emergency Providers, as defined in these rules, a TennCare provider must be enrolled with TennCare. TennCare providers must abide by all TennCare rules and regulations, including the rules regarding provider billing of patients as found in Rule 1200-13-14-.08. TennCare Providers must be appropriately licensed for the services they deliver and must not be providers who have been excluded from participation in Medicare or Medicaid.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

Subparagraph (b) of paragraph (1) of rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with a new subparagraph (b) which shall read as follows:

(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.

1. 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.

2. With respect to the eligibility of individuals applying for the TennCare CHOICES program, the Bureau is responsible for determining that the individual meets level of care eligibility criteria for the long-term care services or reimbursement requested. For enrollment into CHOICES Group 2, the Bureau is also responsible for determining the state's ability to provide appropriate Home and Community Based Services (HCBS) as determined by the availability of slots under the established enrollment target in accordance with Rule 1200-13-01-.05 and for confirming a determination by an Area Agency on Aging and Disability or TennCare Managed Care Organization that:

(i) The individual is an adult aged sixty-five (65) or older, or an adult aged twenty-one (21) or older with physical disabilities; and

(ii) Such individual can be safely and appropriately served in the community and at a cost that does not exceed the individual's cost neutrality cap pursuant to Rule 1200-13-01-.05.

3. The Bureau is responsible for granting, at its discretion, immediate eligibility for persons applying for enrollment into CHOICES Group 2, pursuant to Rule 1200-13-01-.05.

Subparagraph (b) of paragraph (3) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "or the CHOICES 217-like Group" at the end of the subparagraph so as amended subparagraph (b) shall read as follows:

(b) Provide a statement from his employer, if employed, concerning the availability of group health insurance. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group.)

Subparagraph (g) of paragraph (3) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "or the CHOICES 217-Like Group" at the end of the subparagraph so as amended subparagraph (g) shall read as follows:

(g) Not be eligible for or have purchased other health insurance as defined at Rule 1200-13-14-.01, except for persons in the category of uninsured children under the age of nineteen (19) whose family income is below two hundred percent (200%) of poverty and who have been continuously enrolled in TennCare Standard since at least December 31, 2001. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group.)

Subparagraph (h) of paragraph (3) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "or the CHOICES 217-Like Group" at the end of the subparagraph so as amended subparagraph (h) shall read as follows:

(h) Not be enrolled in, or eligible for participation in, Medicare. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group.)

Paragraph (7) of rule 1200-13-14-.02 Eligibility is deleted in its entirety and replaced with a new paragraph (7) which shall read as follows:

(7) TennCare Standard: CHOICES 217-Like Group

(a) Coverage group. Individuals age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the Nursing Facility (NF) level of care criteria, who could have been eligible for HCBS under 42 C.F.R. § 435.217 had the state continued its 1915(c) HCBS Waiver for persons who are elderly and/or physically disabled, and who need and are receiving HCBS as an alternative to Nursing Facility (NF) care. This group exists only in the Grand Divisions of the state where the CHOICES program has been implemented, and participation is subject to the enrollment target for CHOICES Group 2.

(b) Eligibility criteria:

1. Must be aged sixty-five (65) and older or aged twenty-one (21) and older with physical disabilities as defined in Rule 1200-13-01-.02;

2. Must meet the Nursing Facility level of care requirements;

3. Must have a current determination by an Area Agency on Aging and Disability or the TennCare MCO to which the individual is assigned, that he is able to be safely and appropriately served in the community and within his individual cost neutrality cap as defined in Rule 1200-13-01-.05;

4. May be enrolled in accordance with requirements pertaining to the enrollment target for CHOICES Group 2, as described in Rule 1200-13-01-.05;

5. Will be enrolled and begin receiving Home and Community Based Services (HCBS) upon determination of financial eligibility by DHS and continue to receive HCBS as a CHOICES Group 2 participant. Qualifying for enrollment into CHOICES Group 2 (HCBS) is not sufficient

to establish eligibility in the CHOICES 217-Like Group if the person will not actually be enrolled and receiving HCBS; and

6. Would be eligible in the same manner as specified under 42 C.F.R.§ 435.217, 435.236, and 435.726 and section 1924 of the Social Security Act (42 U.S.C.A, § 1396r-d), if the Home and Community Based Services (HCBS) were provided under a section 1915(c) waiver.

(c) Application procedures

1. To be eligible for the CHOICES 217-Like Group, each individual must meet all technical and financial requirements applicable to this category as described in DHS Rule Chapter 1240-03-03.

2. The effective date of eligibility shall be the date of approval by DHS.

The introductory sentence to paragraph (8) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "(other than CHOICES 217-Like Group)" at the end of the introductory sentence so as amended the introductory sentence shall read as follows:

(8) Redetermination of eligibility in TennCare Standard (other than CHOICES 217-Like Group).

Subparagraph (c) of paragraph (8) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase (access to insurance is not considered in determining eligibility in the Standard Spend Down category) after the word "insurance" in the first sentence so as amended subparagraph (c) shall read as follows:

(c) Information to be recertified includes changes in address, income, employment, family size, and access to health insurance (access to insurance is not considered in determining eligibility in the Standard Spend Down category). Redetermination appointments must be scheduled and kept regardless of whether any changes have occurred. It is the responsibility of the enrollee to furnish all information requested. The notice reminding the enrollee that he must have his eligibility redetermined will inform the enrollee of the documentation to be brought to the appointment.

Rule 1200-13-14-.02 Eligibility is amended by adding a new paragraph (9) and the current paragraph (9) is renumbered as paragraph (10) and subsequent paragraphs are renumbered accordingly so as amended the new paragraph (9) shall read as follows:

(9) Redetermination of eligibility in the CHOICES 217-Like Group.

An enrollee who qualifies for TennCare through DHS shall have his TennCare eligibility redetermined as required by the appropriate category of medical assistance as described in Chapter 1240-03-03 of the rules of DHS - Division of Medical Services. Prior to termination, eligibility will be reviewed in accordance with the following process:

(a) At least thirty (30) days prior to the expiration of his current eligibility period, the Bureau of TennCare will send a Request for Information to the enrollee. The Request for Information will include a form to be completed with information needed to verify continued eligibility in the CHOICES 217-Like Group.

(b) 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 continued eligibility for the CHOICES 217-Like Group.

(c) 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.

(d) If an enrollee provides some but not all of the necessary information to DHS to verify his continued eligibility for the CHOICES 217-Like Group 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.

(e) Enrollees who respond to the Request for Information within the thirty (30) day period shall retain their eligibility for TennCare (subject to any changes in covered services generally applicable to enrollees in their eligibility category) while DHS reviews their eligibility in the CHOICES 217-Like Group.

(f) 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 while DHS reviews their eligibility in the CHOICES 217-Like Group. If DHS determines that the enrollee remains eligible for his current CHOICES 217-Like category, the enrollee will remain enrolled in such category. If DHS makes a determination that the enrollee is not eligible for continued enrollment in the CHOICES 217-Like Group, the TennCare Bureau will send the enrollee a twenty (20) day advance Termination Notice.

(g) 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 coverage.

Subparagraph (a) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "or the CHOICES 217-Like Group" at the end of the subparagraph so as amended subparagraph (a) shall read as follows:

(a) The enrollee becomes eligible for participation in a group health insurance plan, as defined in these rules, either directly or indirectly through a family member. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group);

Subparagraph (b) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "or the CHOICES 217-Like Group" at the end of the subparagraph so as amended subparagraph (b) shall read as follows:

(b) The enrollee becomes eligible for Medicare. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group);

Subparagraph (c) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "(this does not apply to the CHOICES 217-Like Group, unless the enrollee begins receiving SSI)" at the end of the subparagraph so as amended subparagraph (c) shall read as follows:

(c) The enrollee is determined eligible for Medicaid (this does not apply to the CHOICES 217-Like Group, unless the enrollee begins receiving SSI);

Subparagraph (d) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "or the CHOICES 217-Like Group" at the end of the subparagraph so as amended subparagraph (d) shall read as follows:

(d) The enrollee purchases an individual health insurance plan as defined by these rules. (Access to insurance is not considered in determining eligibility in the Standard Spend Down category or the CHOICES 217-Like Group);

Subparagraph (m) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by deleting the word "or" at the end of the subparagraph so as amended subparagraph (m) shall read as follows:

(m) The Bureau determines that the enrollee does not actually have the medical condition(s) which rendered him "medically eligible" for TennCare Standard;

Subparagraph (n) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding the punctuation and word "; or" at the end of the subparagraph so as amended subparagraph (n) shall read as follows:

(n) The enrollee attains the age of nineteen (19) and has not been determined eligible in an open Medicaid category; or

Paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding a new paragraph (o) which shall read as follows:

(o) An enrollee in the CHOICES 217-Like Group no longer satisfies one or more of the eligibility criteria specified in these rules.

The unnumbered paragraph following new subparagraph (o) of paragraph (9) (Losing eligibility for TennCare Standard) renumbered as paragraph (10) of rule 1200-13-14-.02 Eligibility is amended by adding the phrase "or eligible for the CHOICES 217-Like Group, in accordance with these rules," after the words "Medicaid-eligible" in the first sentence so as amended the unnumbered paragraph shall read as follows:

TennCare Standard enrollees who are disenrolled from TennCare pursuant to these rules shall be allowed to re-enroll in the TennCare program at any time if they become TennCare Medicaid-eligible or eligible for the CHOICES 217-Like Group, in accordance with these rules, and shall not be required to pay arrearages as a condition of re-enrollment. However, nothing in this provision shall eliminate the enrollee's responsibility for unpaid premiums or copayments incurred under any previous period of eligibility

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

Subpart (i) of part 1. of subparagraph (b) of paragraph (1) of rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is amended by replacing the words "nineteen (19)" with the words "twenty-one (21)" so as amended subpart (i) shall read as follows:

(i) Children under the age of twenty-one (21) years who are eligible for Supplemental Security Income.

Subpart (iii) of part 1. of subparagraph (b) of paragraph (1) of rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is deleted in its entirety and replaced with a new subpart (iii) which shall read as follows:

(iii) Children under the age of twenty-one (21) years in an institutional eligibility category who are receiving care in a Nursing Facility or an Intermediate Care Facility for persons with Mental Retardation (or pursuant to federal law, Intermediate Care Facility for the Mentally Retarded) (ICF/MR), and children and adults in a Home and Community Based Services 1915(c) waiver for individuals with mental retardation.

Subpart (iv) of part 1. of subparagraph (b) of paragraph (1) of rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is amended by replacing the word "service" with the word "serve" so as amended subpart (iv) shall read as follows:

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

Paragraph (2) of rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is amended by adding a new subparagraph (c) and renumbering the current subparagraph (c) as (d) so the new subparagraph (c) shall read as follows:

(c) In the event that a CHOICES member is determined, based on an assessment of needs, to require a long-term care service that is not currently available under the MCO in which he is currently enrolled, but that is available through another MCO, the Bureau shall work with the current MCO to arrange for provision of the required service, which may involve providing such service out-of-network. It shall be considered to be a hardship reason to change MCO assignment only if the current MCO, after working with the Bureau, is unable to provide the required service. In such cases, the MCO that is unable to provide the required service after working with the Bureau may be subject to sanctions.

Paragraph (2) of rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is amended by adding a new subparagraph (e) which shall read as follows:

(e) TennCare shall only accept a request to change MCO assignment from the affected enrollee, his parent, guardian, spouse, child over age eighteen (18) or responsible party as defined in Rule 1200-13-14-.01.

Subparagraph (a) of paragraph (3) of rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is amended by adding the sentence "Disenrollment from the CHOICES program shall proceed as described in Rule 1200-13-01-.05" at the end of the subparagraph so as amended subparagraph (a) shall read as follows:

(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 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. Disenrollment from the CHOICES program shall proceed as described in Rule 1200-13-01-.05.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

The introductory paragraph of subparagraph (a) of paragraph (1) of rule 1200-13-14-.04 Covered Services is amended by adding a sentence at the end of the introductory subparagraph so as amended the introductory paragraph of subparagraph (a) shall read as follows:

(a) TennCare MCCs shall cover the following services and benefits subject to any applicable limitations described herein. TennCare MCCs shall cover TennCare CHOICES services and benefits in accordance with Rule 1200-13-01-.05.

The introductory paragraph to subparagraph (b) of paragraph (1) rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with a new introductory subparagraph (b) which shall read as follows:

(b) The following physical health and mental health benefits are covered under the TennCare managed care program. Benefits offered under the TennCare CHOICES program are also covered under the TennCare managed care program, as described in Rule 1200-13-01-.05. There are some exclusions to the benefits listed below. The exclusions are listed in this rule and in Rule 1200-13-14-.10.

Part 5. Convalescent Care of subparagraph (b) of paragraph (1) of the rule 1200-13-14-.04 Covered Services is deleted in its entirety and subsequent parts renumbered accordingly.

Part 10. Home Health Care renumbered as part 9. of subparagraph (b) of paragraph (1) of rule 1200-13-14-.04 Covered Services is amended by replacing the number "8" in parentheses with the number "7" in parentheses in the last sentence of the first paragraph of the "Benefit for Persons Under Age 21" and the "Benefit for Persons Aged 21 and Older" columns so as amended renumbered part 9. shall read as follows:

Service	Benefit for Persons Under Age 21	Benefit for Persons Aged 21 and Older
9. Home Health Care [defined at 42 CFR §440.70(a), (b), (c), and (e) and at Rule 1200-13-14-.01].	Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-14-.01. Prior authorization required for home health nurse and home health aide services, as described in Paragraph (7) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR § 440.70.	Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-14-.01. Prior authorization required for home health nurse and home health aide services, as described in Paragraph (7) of this rule. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR § 440.70.

Part 26. Pharmacy Services renumbered as Part 25. of subparagraph (b) of paragraph (1) of rule 1200-13-14-.04 Covered Services is amended by deleting the first paragraph of the "Benefit for Persons Aged 21 and Older" column and replacing it with a new first paragraph and by adding a new second paragraph so as amended renumbered part 25. shall read as follows:

Service	Benefit for Persons Under Age 21	Benefit for Persons Aged 21 and

		Older
25. Pharmacy Services [defined at 42 CFR §440.120(a) and obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy, or those administered to a long-term care facility (nursing facility) resident].	Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office, which are the responsibility of the MCO. For TennCare Standard children under age 21 who are Medicare beneficiaries, TennCare pays for medically necessary outpatient prescription drugs when they are covered by TennCare but not by Medicare Part D. Pharmaceuticals supplied and administered in a doctor's office to persons under age 21 are the responsibility of the MCO if not covered by Medicare.	Not covered; except for adults enrolled in the Standard Spend Down (SSD) category and in the CHOICES 217-Like Group. Adults enrolled in the Standard Spend Down (SSD) category have the same pharmacy benefits as adults in TennCare Medicaid, i.e., pharmacy services are limited to five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) of the five (5) can be brand name drugs. Additional drugs for these enrollees shall not be covered. Persons dually eligible for TennCare Standard and Medicare will receive their pharmacy services through Medicare Part D. Adults enrolled in the CHOICES 217-Like Group have the same pharmacy benefits as adults receiving TennCare-reimbursed services in a Nursing Facility as described in Rule 1200-13-13-04, with no quantity limit on the number of prescriptions per month. Prescriptions shall be counted beginning on the first day of each calendar month. Each prescription and/or refill counts as one (1). A prescription or refill can be for no more than a thirty-one (31) day supply. The Bureau of TennCare shall maintain an Automatic Exception List of medications which shall not count against such limit. The Bureau of TennCare may modify the Automatic Exception List at its discretion. The most current version of the Automatic Exception List will be made available to enrollees via the internet from the TennCare website and upon request by mail through the DHS Family Service Assistance Centers. Only medications that are specified on the current version of the Automatic Exception List that is available on the TennCare website located on the World Wide Web at www.state.tn.us/tenncare on the date of service shall be considered exempt from applicable prescription limits.

		The Bureau of TennCare shall also maintain a Prescriber Attestation List of medications available when the prescriber attests to an urgent need. The State may include certain drugs or categories of drugs on the list, and may maintain and make available to physicians, providers, pharmacists and the public, a list that shall indicate the drugs or types of drugs the State has determined to include. Drugs on the Prescriber Attestation List may be approved for enrollees who have already met an applicable benefit limit only if the prescribing professional seeks and obtains a special exemption. In order to obtain a special exemption, the prescribing provider must submit an attestation as directed by TennCare regarding the urgent need for the drug. TennCare will approve the prescribing provider's determination that the criteria for the special exemption are met, without further review, within 24 hours of receipt. Enrollees will not be entitled to a hearing regarding their eligibility for a special exemption if (i) the prescribing provider has not submitted the required attestation, or (ii) the requested drug is not on the Prescriber Attestation List. Pharmacy services in excess of five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) are brand name drugs, are non-covered services, unless: (a) each excess drug is specified on the current version of the Prescriber Attestation List and a completed Prescriber Attestation is on file for each listed drug as of the date of the pharmacy service; or (b) the excess drug is specified on the Automatic Exception List of medications which shall not count against such limit. Over-the-counter drugs for Medicaid adults are not covered even if the enrollee has a prescription for such service, except for prenatal vitamins for pregnant women. Pharmacy services are the responsibility of the PBM, except

		for pharmaceuticals supplied and administered in the doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are not covered by TennCare. Certain drugs known as DESI, LTE or IRS drugs are excluded from coverage.

Part 40. Sitter Services renumbered as part 39. of subparagraph (b) of paragraph (1) of rule 1200-13-14-.04 Covered Services is deleted in its entirety and subsequent parts renumbered accordingly.

Subparagraph (a) of paragraph (2) of rule 1200-13-14-.04 Covered Services is deleted in its entirety and replaced with a new subparagraph (a) which shall read as follows:

(a) MCCs shall be allowed, but are not required, to use cost effective alternative services if and only if:

1. These services are listed in the MCC contract and/or in Policy BEN 08-001; or

2. These services are provided under the CHOICES program in accordance with Rule 1200-13-01-.05; and

3. They are medically appropriate and cost effective.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

Subpart (iii) of part 2. of Subparagraph (f) of paragraph (4) of rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with a new subpart (iii) which shall read as follows:

(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.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

Rule 1200-13-14-.06 Managed Care Organizations is amended by deleting the word "and" and inserting a comma after the word "medical" and adding the punctuation and phrase ", and long-term care" after the word "behavioral" in the first sentence so as amended the content of rule 1200-13-14-.06 shall read as follows:

Managed Care Organizations participating in TennCare will be limited to Health Maintenance Organizations that are appropriately licensed to operate within the state of Tennessee to provide medical, behavioral, and long-term care services in the TennCare program. Managed Care Organizations shall have a fully executed contract with the Tennessee Department of Finance and Administration. MCOs, DBMs and PBMs shall agree to comply with all applicable rules, policies, and contract requirements as specified by the Tennessee Department of Finance and Administration as applicable. Managed Care Organizations must continually demonstrate a sufficient provider network based on the standards set by the Bureau of TennCare to remain in the program and must reasonably meet all quality of care requirements established by the Bureau of TennCare.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

Paragraph (1) of rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with a new paragraph (1) which shall read as follows:

(1) Payment in full.

(a) All Participating Providers, as defined in these rules, must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any copayment required by the TennCare Program to be paid by the individual.

(b) Any Non-Participating Providers who provide TennCare Program covered services by authorization from an MCC must accept as payment in full for provision of covered services to TennCare enrollees, the amounts paid by the MCC plus any copayment required by the TennCare Program to be paid by the individual.

(c) Any Non-Participating Provider, as defined in these rules, who provides TennCare Program covered non-emergency services to TennCare enrollees without authorization from the enrollee's MCC does so at his own risk. He may not bill the patient for such services except as provided for in Rule 1200-13-14-.08(5).

(d) Any Out-of-State Emergency Provider, as defined in these rules, who provides covered emergency services to TennCare enrollees in accordance with these rules must accept as payment in full the amounts paid by the MCC plus any copayment required by the TennCare Program.

Paragraph (2) of rule 1200-13-14-.08 Providers is deleted in its entirety and replaced by a new paragraph (2) which shall read as follows:

(2) Non-Participating Providers.

(a) In situations where a MCC authorizes a service to be rendered by a provider who is not a Participating Provider with the MCC, as defined in these rules, payment to the provider shall be no less than eighty percent (80%) of the lowest rate paid by the MCC to equivalent participating network providers for the same service.

(b) Covered medically necessary outpatient emergency services, when provided to Medicaid managed care enrollees by non-contract hospitals in accordance with Section 1932(b)(2)(D) of the Social Security Act (42 U.S.C.A. § 1396u-2(b)(2)(D)), shall be reimbursed at seventy-four percent (74%) of the 2006 Medicare rates for these services. Emergency care to enrollees shall not require preauthorization.

(c) Non-Participating Providers who furnish covered CHOICES services are reimbursed in accordance with Rule 1200-13-01-.05.

Subparagraph (b) of paragraph (3) of rule 1200-13-14-.08 Providers is amended by replacing the word "s/he" with "they", deleting the letter "s" from the word "practices" and replacing the words "his/her" with "their" so as amended subparagraph (b) shall read as follows:

(b) Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice, or licensure by the TDMHDD, if appropriate;

Subparagraph (c) of paragraph (3) of rule 1200-13-14-.08 Providers is amended by replacing the words "his/her" with the word "their" so as amended subparagraph (c) shall read as follows:

(c) Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);

Paragraph (5) of rule 1200-13-14-.08 Providers is amended by deleting the colon and adding a period after the word "circumstances" and inserting new language following the first sentence so that the paragraph shall read as follows:

(5) Providers may seek payment from a TennCare enrollee only under the following circumstances. These circumstances apply to all TennCare providers, as defined in these rules, including those who are Out-of-Network Providers in a particular enrollee's MCC. These circumstances include situations where the enrollee may choose to seek an out-of-network provider for a specific covered service.

Subparagraph (c) of paragraph (6) of rule 1200-13-14-.08 Providers is amended by deleting the word "payor" and replacing it with the word "payer" so as amended subparagraph (c) shall read as follows:

(c) The provider accepted TennCare assignment on a claim and it is determined that another payer paid an amount equal to or greater than the TennCare allowable amount.

Paragraph (6) of rule 1200-13-14-.08 Providers is amended by adding a new subparagraph (i) which shall read as follows:

(i) The provider is a TennCare provider, as defined in these rules, but is not participating with a particular enrollee's MCC and is seeking to bill the enrollee as though the provider were a Non-TennCare Provider, as defined in these rules.

Rule 1200-13-14-.08 Providers is amended by adding a new paragraph (12) which shall read as follows:

(12) All claims must be filed in accordance with the following:

(a) Claims filed with an MCC must be submitted in accordance with the requirements and timeframes set forth in the MCC's contract.

(b) All other fee-for-service claims for services delivered outside of the TennCare managed care program must be filed with the Bureau of TennCare as follows:

1. All claims must be filed within one (1) year of the date of service except in the following circumstances:

(i) Recipient eligibility was determined retroactively to the extent that filing within one (1) year was not possible. In such situations, claims must be filed within one (1) year after final determination of eligibility.

(ii) If a claim filed with Medicare on a timely basis does not automatically cross over from the Medicare carrier to the Bureau, a TennCare claim may be filed within six (6) months of notification of payment or denial from Medicare.

2. Should an original claim be denied, any resubmission or follow-up of the initial claim must be received within six (6) months from the date the original claim was filed. The Bureau will not process submissions received after the six (6) month time limit. The one exception is those claims returned due to available third party coverage. These claims must be submitted within sixty (60) days of notice from the third party resource.

3. Should a correction document involving a suspended claim be sent to the provider, the claim will be denied if the correction document is not completed by the provider and returned to the Bureau within ninety (90) days from the date on the document.

4. If claim is not filed within the above timeframes, no reimbursement may be made.

5. Claims will be paid on a first claim approved - first claim paid basis.

6. The Bureau will not reimburse providers for services for which there is no Federal Financial Participation.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

The introductory paragraph of paragraph (3) of rule 1200-13-14-.10 Exclusions is amended by adding the words "under the CHOICES program" after the word "covered" and by adding the words "Section 1915(c)" before the words "Home and Community Based Services Waiver" so as amended paragraph (3) shall read as follows:

(3) Specific exclusions. The following services, products, and supplies are specifically excluded from coverage under the TennCare Section 1115(a) waiver program unless excepted by paragraph (2) herein. Some of these services may be covered under the CHOICES program or outside TennCare under a Section 1915(c) Home and Community Based Services waiver when provided as part of an approved plan of care, in accordance with the appropriate TennCare Home and Community Based Services rule.

Statutory Authority: T.C.A. §§ 4-5-202, 4-5-203, 71-5-105 and 71-5-109.

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: 3/3/2010

Signature: D. Gordon

Name of Officer: Darin J. Gordon

Title of Officer: Director, Bureau of TennCare
Tennessee Department of Finance and Administration

Subscribed and sworn to before me on: 3/3/2010

Notary Public Signature: Marsha Thibault

My commission expires on: 10/25/2011

MARSHA THIBAULT
NOTARY PUBLIC
TENNESSEE
WILSON COUNTY

Department of State Use Only

Filed with the Department of State on: 3/3/10

Tre Hargett

Tre Hargett
Secretary of State

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