TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620
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.D.T. on the 18th day July 2006.

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

CHAPTER 1200-13-14
TENNCARE STANDARD

Rule 1200-13-14-.01 Definitions is amended by adding a new paragraph (27). The current paragraph (27) will be renumbered as (28) and subsequent paragraphs will be renumbered accordingly so as amended the new paragraph (27) shall read as follows:

(27) DEMAND LETTER shall mean a letter sent by TennCare to a TennCare Standard enrollee with premium obligations notifying the enrollee that he is a least 60 days delinquent in his/her premium payments.

Paragraph (22) of rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with a new paragraph (22) which shall read as follows:

(22) 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 premiums and/or copayments.

Paragraph (108) of rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with a new paragraph (108) which shall read as follows:

(108) TENNCARE STANDARD shall mean that part of the TennCare Program which provides coverage for Tennessee residents who are not eligible for Medicaid but who meet the requirements for TennCare Standard that are outlined in these rules.

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

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

(1) Persons who are enrolled in TennCare Standard have premium obligations corresponding to their family size and income. The premium schedule is shown below:

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

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

(2) Premium requirements.

(a) Individuals determined eligible for TennCare and who are required to pay premiums will be sent a notice indicating the amount of the premium. Premium payments are due on the first day of each month.

(b) Monthly premium statements are sent to enrollees with premium obligations. If the enrollee is delinquent in his payments, the monthly premium statements will so advise him.

(c) At such time as (1) the enrollee has received at least two premium statements advising him of his arrearage AND (2) he is 60 days in arrears on his premium payments, coverage may be terminated for non-payment of premiums.

1. Enrollees who are in arrears two months in premium payments will be sent a notice of delinquency (a “demand letter”). The notice will identify the specific payments, including month and amount, that are past due. The demand letter will serve as notice to the individual that he/she will be terminated from TennCare Standard unless he/she pays the amount due within 30 days. The enrollee has the right to appeal that he/she is in fact current with his/her payments or that the premium amounts being charged are not the premium amounts he/she has been assigned.

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2. If at least partial payment is received by the Bureau of TennCare within 30 days after the date of the demand letter, the enrollee will no longer be 60 days in arrears, and coverage will continue without interruption. "Partial payment" will be payment sufficient to make the enrollee no longer 60 days in arrears. However, remaining past due amounts will continue to accrue. If the enrollee is again 60 days in arrears when the next cycle of demand letters is processed, the enrollee will again receive a demand letter and may subsequently be terminated in accordance with these rules.

3. If an enrollee files an appeal in response to his demand letter by the 30th day following the date of the notice, coverage will not be terminated on the 30th day, pending resolution of the appeal. The premium appeal will be processed by DHS in accordance with its rules at 1240-5.

4. If the enrollee does not pay at least a partial payment or file an appeal by the 30th day following the demand letter, his/her TennCare Standard coverage will be terminated. A termination notice will be sent with due process appeal rights. The date of termination is the date of notice. An enrollee may appeal his notice of termination, but he is not entitled to continuation of benefits during the appeal. If the appeal is decided in his/her favor, he/she will be reinstated retroactively to the date of termination.

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

(4) Copayments.

(a) TennCare Standard enrollees whose income is equal to or greater than 100% of poverty shall pay copayments for services other than preventive services. Preventive services are identified in Rule 1200-13-14-.04(3).

(b) Copayment amounts are as shown below:

Benefit	Copayment if income is 0%-99% of poverty	Copayment if income is 100%-199% of poverty	Copayment if income is 200% of poverty or above
Hospital emergency room use for non-emergency services	$0	$25 (waived if admitted)	$50 (waived if admitted)
Primary care provider services other than preventive care	$0	$5	$10
Community Mental Health Agency services other than preventive care	$0	$5	$10
Physician specialists	$0	$15	$25
Prescription or refill	$0	$3 for covered branded prescription; $0 for covered generics	$3 for covered branded prescription; $0 for covered generics

Benefit	Copayment if income is 0%-99% of poverty	Copayment if income is 100%-199% of poverty	Copayment if income is 200% of poverty or above
Inpatient hospital admission	$0	$100	$200

(c) Managed care contractors participating in the TennCare program shall be specifically prohibited from waiving, or discouraging TennCare enrollees from paying, the amounts described in this provision.

(d) Providers may not refuse to deliver a covered service to an enrollee because of the enrollee's failure or inability to make his copay.

(e) Enrollees who receive financial settlements, awards or judgments, for instance, as the result of accidents or negligence, shall have their income levels adjusted retroactively to the date of the incident resulting in the settlement or other payment, and may be assessed additional cost sharing obligations commensurate with their adjusted income level retroactive to that date.

(f) Pharmacy and psychiatric pharmacy copayments.

1. All TennCare Standard enrollees with incomes at or above poverty who receive pharmacy service have nominal copayments for the services. The copays are $3.00 for each covered branded drug and $0 for each covered generic drug. Drugs which exceed the limit of five (5) prescriptions or refills per month per enrollee are not covered unless they are on the shortlist. Family planning drugs and emergency services are exempt from copay.

2. The following groups (adults and children) are exempt from pharmacy copays:

   (i) Individuals receiving hospice services who provide verbal or written notification of such to the pharmacy provider at the point of service;

   (ii) Individuals who are pregnant who provide verbal or written notification of such to the pharmacy provider at the point of service; and

   (iii) Individuals who are receiving services in a Nursing Facility, an Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver.

3. The seventy-two (72) hour emergency supply of a medication in an emergency situation, as described in rule 1200-13-14-.11, shall not be subject to the pharmacy copayment requirement.

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 May, 2006. (05-27)

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