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Sequence Number: 06-12-09
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File Date: 06/12/2009

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
	Bureau of TennCare
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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
	Bureau of TennCare
	310 Great Circle Road
Address:	Nashville, Tennessee 37243
Phone:	(615)507-6474
Email:	helen.moore@state.tn.us

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 :	*08/17/09*	
Hearing Time:	9:00a.m.	X CDT ___EST

Additional Hearing Information:

Revision Type (check all that apply):

X Amendments
___ New
___ Repeal

Rule(s) (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables)

Chapter Number	Chapter Title
1200-13-14	TennCare Standard
Rule Number	**Rule Title**
1200-13-14-.01	Definitions
1200-13-14-.03	Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS)
1200-13-14-.04	Covered Services
1200-13-14-.06	Managed Care Organizations

Substance of Proposed Rules

Chapter 1200-13-14
TennCare Standard

Amendments

Paragraph (7) BHO (Behavioral Health Organization(s) of rule 1200-13-14 Definitions is deleted in its entirety and subsequent paragraphs renumbered accordingly.

Paragraph (49) Health Plan to be renumbered as paragraph (48) of rule 1200-13-14-.01 Definitions is amended by adding the phrases "and behavioral" after the word "medical" so as amended the renumbered paragraph (48) shall read as follows:

(48) HEALTH PLAN shall mean a managed care organization authorized by the Tennessee Department of Finance and Administration to provide medical and behavioral services to enrollees in the TennCare Program.

Paragraph (64) MCC (Managed Care Contractor) to be renumbered as paragraph (63) of rule 1200-13-14-.01 Definitions is deleted in its entirety and replaced with a new renumbered paragraph (63) which shall read as follows:

(63) MCC (MANAGED CARE CONTRACTOR) shall mean:

(a) A managed care organization, pharmacy benefits manager, and/or a dental benefits manager which has signed a TennCare Contractor Risk Agreement with the State and operates a provider network and provides covered health services to TennCare enrollees; or

(b) A pharmacy benefits manager, behavioral health organization, or dental benefits manager which subcontracts with a managed care organization to provide services; or

(c) A State government agency (i.e., Department of Children's Services and Division of Mental Retardation Services) that contracts with TennCare for the provision of services.

Paragraph (65) MCO (Managed care Organization) to be renumbered as paragraph (64) of rule 1200-13-14-.01 Definitions is amended by adding the phrase "and behavioral" after the word "medical" so as amended the renumbered paragraph (64) shall read as follows:

(64) MCO (MANAGED CARE ORGANIZATION) shall mean an appropriately licensed Health Maintenance Organization (HMO) approved by the Bureau of TennCare as capable of providing medical and behavioral services in the TennCare Program.

Paragraph (80) PBM (Pharmacy Benefits Manager) to be renumbered as paragraph (79) of rule 1200-13-14-.01 definitions is amended by deleting the phrase "or BHO" at the end of the paragraph so as amended the renumbered paragraph (79) shall read as follows:

(79) PBM (PHARMACY BENEFITS MANAGER) shall mean an organization approved by the Tennessee Department of Finance and Administration to provide pharmacy benefits to enrollees to the extent such services are covered by the TennCare Program. A PBM may have a signed TennCare Contractor Risk Agreement with the State, or may be a subcontractor to an MCO.

Paragraph (110) TDMHDD (Tennessee Department of Mental Health and Developmental Disabilities) of rule 1200-13-14-.01 Definitions is deleted in its entirety and subsequent paragraphs renumbered accordingly.

Paragraph (116) TennCare Partners Program of rule 1200-13-14-.01 Definitions is deleted in its entirety and subsequent paragraphs renumbered accordingly.

Paragraph (117) TennCare Pharmacy Program to be renumbered as paragraph (114) of rule 1200-13-14-.01 Definitions is amended by deleting the phrase and comma "the behavioral health pharmacy benefit," so as amended the renumbered paragraph (114) shall read as follows:

(114) TENNCARE PHARMACY PROGRAMS shall mean any TennCare pharmacy carve-outs, including, but not limited to, enrollees with dual eligibility, and all pharmacy services provided by the TennCare managed care organizations (MCOs).

Paragraph (1) of rule 1200-13-14-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is amended by changing the word "four" in the first line of the introductory paragraph to "three (3)" and deleting subparagraph (c) in its entirety and relettering subsequent subparagraphs accordingly so as amended paragraph (1) shall read as follows:

(1) Enrollment.

There are three (3) 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.

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 1200-13-14-.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 under the age of nineteen (19) years 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 under the age of (19) years 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 also the only entity responsible for payment of the services described in 42 CFR 440.255, emergency services for certain aliens.

(c) 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.

(d) 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.

Subparagraph (a) of paragraph (3) of rule 1200-13-13-.03 Enrollment, Reassignment, and Disenrollment with Managed Care Contractors (MCCS) is amended by deleting the letters "BHO" after the words "well as the" 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.

Benefit for Persons Aged 21 and Older column of part 12. of subparagraph (b) of paragraph (1) of rule 1200-13-14-.04 Covered Services is amended by replacing the letters "BHO" in the second paragraph with the letters "MCO" so as amended part 12. shall read as follows:

SERVICE	BENEFIT FOR PERSONS UNDER AGE 21	BENEFIT FOR PERSONS AGED 21 AND OLDER
12. Inpatient and Outpatient Substance Abuse Benefits [defined as services for the treatment of substance abuse that are provided (a) in an inpatient hospital (as defined at 42 CFR §440.10) or (b) as outpatient hospital services (see 42 CFR §440.20(a)].	Covered as medically necessary.	Covered as medically necessary, with a maximum lifetime limitation of ten (10) detoxification days and $30,000 in substance abuse benefits (inpatient, residential, and outpatient). When medically appropriate and cost effective as determined by the MCO, services in a licensed substance abuse residential treatment facility may be provided as a substitute for inpatient substance abuse services.

The introductory paragraph of paragraph (5) of rule 1200-13-14-.04 Covered Services is amended by deleting the comma and phrase ", behavioral health organizations (BHOs)" so as amended the introductory paragraph shall read as follows:

(5) Preventive, Diagnostic and Treatment Services for Individuals Under Twenty-One (21).

The Bureau of TennCare, through its contracts with managed care organizations (MCOs) and other contractors (also referred to collectively as Contractors), operates an EPSDT program to provide health care services as required by 42 C.F.R. Part 441, Subpart B, and the "Omnibus Budget Reconciliation Act of 1989" to eligible enrollees under the age of 21.

Rule 1200-13-14-.06 Managed Care Organizations is deleted in its entirety and replaced with a new rule 1200-13-13-.06 which shall read as follows:

1200-13-14-.06 MANAGED CARE ORGANIZATIONS.

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 and behavioral 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, 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: 6/12/2009

Signature: D= J. G

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: 6-12-09

Notary Public Signature: Marsha Thibault

My commission expires on: 10/25/2011

MARSHA THIBAULT
STATE OF TENNESSEE
NOTARY PUBLIC
WILSON COUNTY

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Filed with the Department of State on: 6/12/09

Tre Hargett
Secretary of State

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