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Sequence Number: 06-17-14
Rule ID(s): 5746
File Date: 6-17-14
Effective Date: 9-15-14

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. T.C.A. § 4-5-205

Agency/Board/Commission:	Tennessee Department of Finance and Administration
Division:	Bureau of TennCare
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Revision Type (check all that apply):

X Amendments
___ New
___ Repeal

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

Chapter Number	**Chapter Title**
0620-05-01	Cover Kids Rules
Rule Number	**Rule Title**
0620-05-01-.03	Cost-Sharing-Premiums and Co-Payments

(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)

Table of Contents Rule title 0620-05-01-.03 Cost-Sharing-Premiums and Co-Payments is deleted in its entirety and replaced with a new Rule title 0620-05-01-.03 which shall read as follows:

0620-05-01-.03 Benefits and Cost Sharing

Rule 0620-05-01-.03 Cost Sharing-Premiums and Co-Pays is deleted in its entirety and replaced with a new Rule 0620-05-01-.03 which shall read as follows:

0620-05-01-.03 Benefits and Cost Sharing.

(1) The following benefits are covered by the CoverKids program as medically necessary, subject to the limitations stated.

(a) Medical benefits.

1. Ambulance services (air and ground).
2. Chiropractic care.
3. Durable medical equipment. Limited to the most basic equipment that will provide the needed care.
4. Emergency room care.
5. Home health.
6. Hospice.
7. Hospital care.
8. Inpatient mental health treatment. Pre-authorization required.
9. Inpatient substance abuse treatment. Pre-authorization required.
10. Lab and X-ray.
11. Maternity care.
12. Medical supplies. Quantities for a single prescription will be limited to a 31-day supply.
13. Outpatient mental health and substance abuse treatment.
14. Physical, speech, and occupational therapy. Limited to 52 visits per calendar year, per type of therapy.
15. Physician office visits.
16. Prescription drugs.
17. Rehabilitation hospital services.
18. Routine health assessments and immunizations.
19. Skilled nursing facility services. Limited to 100 days per calendar year following an approved hospitalization.

20. Vision benefits.

(i) Annual vision exam including refractive exam and glaucoma screening.

(ii) Prescription eyeglass lenses. Limited to one pair per calendar year. $85 maximum benefit per pair.

(iii) Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. $100 maximum benefit per pair.

(iv) Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. $150 maximum benefit per pair.

(b) Dental benefits.

1. Dental services. Limited to a $1,000 annual benefit maximum per child.

2. Orthodontic services. Limited to a $1,250 lifetime benefit maximum per child. Covered only after a 12-month waiting period.

(2) The following benefits are excluded from coverage by the CoverKids program.

(a) Comfort or convenience items not related to an enrollee's illness.

(b) Dietary guidance services.

(c) Homemaker or housekeeping services.

(d) Maintenance visits when no additional progress is apparent or expected to occur.

(e) Meals.

(f) Medical social services.

(g) Non-treatment services.

(h) Private duty nursing services.

(i) Routine transportation.

(3) There are no premiums or deductibles required for participation in CoverKids.

(4) Copays. The following copays are required, depending upon family income.

Service	Copays When Family Income is Less than 150% of Poverty	Copays When Family Income is 150%-250% of Poverty
MEDICAL BENEFITS		
Chiropractic care	$5 per visit	$15 per visit
Emergency room (emergency—waived if admitted)	$5 per use	$50 per use
Emergency room (non-emergency)	$10 per use	$50 per use
Home health	$5 per visit	$15 per visit
Hospital care	$5 per admission; waived if readmitted within 48 hours for the same episode	$100 per admission; waived if readmitted within 48 hours for the same episode
Inpatient mental health treatment	$5 per admission	$100 per admission
Inpatient substance abuse treatment	$5 per admission	$100 per admission

Service	Copays When Family Income is Less than 150% of Poverty	Copays When Family Income is 150%-250% of Poverty
Maternity	$5 OB or specialist, first visit only $5 hospital admission	$15 OB or specialist, first visit only $20 per visit, specialist $100 hospital admission
Medical supplies	$5 per 31-day supply	$5 per 31-day supply
Outpatient mental health and substance abuse treatment	$5 per session	$20 per session
Physical, speech, and occupational therapy	$5 per visit	$15 per visit
Physician office visits	$5 per visit, primary care physician or specialist No copay for routine health assessments and immunizations rendered under the American Academy of Pediatrics guidelines	$15 per visit, primary care physician $20 per visit, specialist No copay for routine health assessments and immunizations rendered under the American Academy of Pediatrics guidelines
Prescription drugs	$1, generics $3, preferred brands $5, non-preferred brands	$5, generics $20, preferred brands $40, non-preferred brands
Rehabilitation hospital services	$5 per admission	$100 per admission
Vision services	$5 for lenses; $5 for frames (when lenses and frames are ordered at the same time, only one copay is charged)	$15 for lenses; $15 for frames (when lenses and frames are ordered at the same time, only one copay is charged)
DENTAL BENEFITS		
Dental	$5 per visit No copay for routine preventive oral exam, X-rays, and fluoride application	$15 per visit No copay for routine preventive oral exam, X-rays, and fluoride application
Orthodontic services	$5 per visit	$15 per visit
ANNUAL OUT-OF-POCKET MAXIMUM PER ENROLLEE		
Annual out-of-pocket maximum per enrollee	5% of the family's annual income	

(5) Eligible children in a family that does not pay a required copay remain enrolled in the program. An individual provider may at his discretion refuse service for non-payment of a copay unless a medical emergency exists. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay their copays.

Statutory Authority: T.C.A. §§ 4-5-202, 71-3-1104, 71-3-1106 and 71-3-1110.

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Department of Finance and Administration (board/commission/ other authority) on 05/05/2014 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 02/14/14

Rulemaking Hearing(s) Conducted on: (add more dates). 04/09/14

Date: 5/5/2014

Signature:

Name of Officer: Darin J. Gordon

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

ROBIN A. PAGE
STATE OF TENNESSEE
NOTARY PUBLIC
WILLIAMSON COUNTY, TN

Subscribed and sworn to before me on: May 5, 2014

Notary Public Signature: Robin A Page

My commission expires on: 10-18-2016

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.

Robert E. Cooper, Jr.

Robert E. Cooper, Jr.
Attorney General and Reporter

6-13-14
Date

Department of State Use Only

Filed with the Department of State on: 6-17-14

Effective on: 9-15-14

Tre Hargett
Secretary of State

2014 JUN 17 PM 3:37
SECRETARY OF STATE

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

Copy of response to comment included with filing.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

The rule is not anticipated to have an effect on small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

The rule is not anticipated to have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

(A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The rule changes the title of rule 0620-05-01-.03 from "Cost-Sharing-Premiums and Co-Payments" to "Benefits and Cost Sharing". The content of the rule is revised to point out that there is not a premium or deductible required for participation in CoverKids and also to point out and/or clarify the benefits and cost sharing requirements.

(B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

The rule is lawfully adopted by the Bureau of TennCare as a rulemaking hearing rule under T.C.A § 4-5-202, under CoverKids rulemaking authority at T.C.A. §§ 71-3-1104 and 71-3-1110.

(C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The persons and entities most directly affected by this rule are CoverKids enrollees and providers. The governmental entity most directly affected by this rule is the Division of Health Care Finance and Administration of the Tennessee Department of Finance and Administration.

(D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The Rule was approved by the Tennessee Attorney General. No additional opinion was given or requested.

(E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars ($500,000), whichever is less;

The promulgation of this rule is not anticipated to have an effect on state and local government revenues and expenditures.

(F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Donna K. Tidwell
Deputy General Counsel

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Donna K. Tidwell
Deputy General Counsel

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

310 Great Circle Road
Nashville, TN 37243
(615) 507-6852
donna.tidwell@tn.gov

(l) Any additional information relevant to the rule proposed for continuation that the committee requests.

GW10114092

RULES
OF
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF INSURANCE ADMINISTRATION

CHAPTER 0620-05-01
COVER KIDS RULES

TABLE OF CONTENTS

~~0620-05-01-.03 COST SHARING—PREMIUMS AND CO-PAYS.~~

~~(1) Premiums.~~

~~(a) CoverKids enrollees in families with income equal to or less than 250% of the Federal Poverty Limit will not be assessed premiums.~~

~~(b) CoverKids enrollees in families with income greater than 250% of the Federal Poverty Limit will be assessed a monthly full premium for each beneficiary. The enrollee family is responsible for payment of the premium each month.~~

~~(c) The premium will be determined by the State's insurance plan administrator based on its determination of historical costs and estimates of future costs over the life of the contract. This determination will be reviewed by CoverKids and will be posted on the website of the insurance plan administration. The website address and cost information will be distributed to the public by CoverKids.~~

~~(d) Payment of the first month's premium will be required for services to begin.~~

~~(e) Pregnant women with income greater than 250% of the Federal Poverty level shall pay a lump sum in advance for maternity related services only if she is presently enrolled in CoverKids program.~~

~~(2) Failure to Pay Premiums.~~

~~(a) If the enrollee is delinquent in paying premiums and fails to pay the appropriate premiums within 31 days of the due date of the premium, the enrollee will be considered delinquent and may be subject to disenrollment from CoverKids.~~

~~(b) When an enrollee is delinquent in paying a premium, the health plan will notify the family, in writing, of:~~

~~1. The amount due.~~

~~2. The date the past due premium must be paid.~~

~~3. The disenrollment from the health plan if the past due premium is not paid.~~

~~4. The date coverage will end.~~

5. The need to report any change in circumstances (for example: loss of income, additional family members, or requirement to pay child support for a child not living with the family) which may result in a new determination of eligibility.

6. The right to request a health plan review and a Department Review and the procedures to follow in requesting a review.

(c) A delinquency notice will be issued on the day that the payment is due if payment has not been received. A termination notice will issue if the payment is not received within 31 days of the due date.

(d) All reviews will be conducted according to the procedures in rule 0620-05-01-.05.

(e) Once disenrolled from CoverKids for failure to pay required premiums, applicants will not be eligible for CoverKids coverage until payment for unpaid amounts is made and for six (6) months after the disenrollment for nonpayment of premiums. In these cases, a new CoverKids application must be submitted. Applications received within one month of the month that follows the six month period will be accepted. Coverage will not begin before the first month's premium and all previously unpaid premium amounts have been paid.

(3) Co-Pays.

(a) CoverKids will assess co-pays for certain covered services as detailed in the chart attached as follows:

BENEFIT	FAMILY INCOME BETWEEN 150-250% FPL	FAMILY INCOME AT OR BELOW 150% FPL
Annual Deductible	None	None
Preexisting Condition Requirement	None	None
Physician Office Visit	$15 copay PCP; $20 copay specialist	$5 copay PCP or specialist
Hospital Care	$100 per admission (waived if readmitted within 48 hours for same episode)	$5 per admission (waived if readmitted within 48 hours for same episode)
Prescription Drug Coinsurance/Copay	$5 generic; $20 preferred brand; $40 non-preferred brand	$1 generic; $3 preferred brand; $5 non-preferred brand
Maternity	$15 copay OB, first visit only; $20 copay specialist; $100 hospital admission	$5 copay OB or specialist, first visit only; $5 hospital admission

Routine Health Assessment and Immunizations – Child	No copays for services rendered under American Academy of Pediatrics guidelines	No copays for services rendered under American Academy of Pediatrics guidelines
Emergency Room	$50 copay per use (waived if admitted)	$5 copay per use in case of an emergency (waived if admitted); $10 copay per use for non-emergency
Chiropractic Care	$15 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur	$5 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur
Ambulance Service – Air & Ground	No copay 100% of reasonable charges when deemed medically necessary by claims administrator	No copay 100% of reasonable charges when deemed medically necessary by claims administrator
Lab and X-ray	No copay 100% benefit	No copay 100% benefit
Physical, Speech & Occupational Therapy	$15 copay per visit; Limited to 52 visits per year per condition	$5 copay per visit; Limited to 52 visits per year per condition
Mental Health Inpatient (preauthorization required)	$100 copay per admission; Limited to 30 days per year	$5 copay per admission; Limited to 30 days per year
Substance Abuse Inpatient (preauthorization required)	$100 copay per admission; Limited to two 5-day detox stays per lifetime; plus one 28-day lifetime stay	$5 copay per admission; Limited to two 5-day detox stays per lifetime; plus one 28-day lifetime stay
Mental Health/Substance Abuse Outpatient (preauthorization required)	$20 copay per session; Limited to 52 sessions mental health and substance abuse combined	$5 copay per session; Limited to 52 sessions mental health and substance abuse

		~~combined~~
~~Annual Out-of-Pocket Maximums~~	~~5% of family income~~	~~5% of family income~~

~~No co-payments will be charged for well-child visits, immunizations, or lab and x-ray services. There is also no co-payment for ambulance services when deemed medically necessary by the health plan. For children in families with income at or below 150 percent of the Federal Poverty Limit, co-payments will not exceed $5.00, except the co-payment for non-emergency use of the emergency room will be $10.~~

~~(b) For enrollees with family income equal to or under 250% of the Federal Poverty Limit, the aggregate cost sharing for a family shall not exceed 5% of the family's annual income.~~

~~(c) As required by Federal law, American Indian and Alaska Native children as defined by the Indian Health Care Improvement Act of 1976 will be exempt from all cost sharing.~~

~~(d) A family that does not pay a required co-payment remains enrolled in the program. An individual provider may at his or her discretion refuse service for non-payment of a co-payment unless a medical emergency exists. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay co-payments.~~

~~(4) All cost sharing provisions of these rules are subject to changes in Federal laws, regulations, and binding legal directives from the Federal government.~~

0620-05-01-.03 Benefits and Cost Sharing.

(1) The following benefits are covered by the CoverKids program as medically necessary, subject to the limitations stated.

(a) Medical benefits.

1. Ambulance services (air and ground).

2. Chiropractic care.

3. Durable medical equipment. Limited to the most basic equipment that will provide the needed care.

4. Emergency room care.

5. Home health.

6. Hospice.

7. Hospital care.

8. Inpatient mental health treatment. Pre-authorization required.

9. Inpatient substance abuse treatment. Pre-authorization required.

10. Lab and X-ray.

11. Maternity care.

12. Medical supplies. Quantities for a single prescription will be limited to a 31-day supply.

13. Outpatient mental health and substance abuse treatment.

14. Physical, speech, and occupational therapy. Limited to 52 visits per calendar year, per type of therapy.

15. Physician office visits.

16. Prescription drugs.

17. Rehabilitation hospital services.

18. Routine health assessments and immunizations.

19. Skilled nursing facility services. Limited to 100 days per calendar year following an approved hospitalization.

20. Vision benefits.

(i) Annual vision exam including refractive exam and glaucoma screening.

(ii) Prescription eyeglass lenses. Limited to one pair per calendar year. $85 maximum benefit per pair.

(iii) Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. $100 maximum benefit per pair.

(iv) Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. $150 maximum benefit per pair.

(b) Dental benefits.

1. Dental services. Limited to a $1,000 annual benefit maximum per child.

2. Orthodontic services. Limited to a $1,250 lifetime benefit maximum per child. Covered only after a 12-month waiting period.

(2) The following benefits are excluded from coverage by the CoverKids program.

(a) Comfort or convenience items not related to an enrollee's illness.

(b) Dietary guidance services.

(c) Homemaker or housekeeping services.

(d) Maintenance visits when no additional progress is apparent or expected to occur.

(e) Meals.

(f) Medical social services.

(g) Non-treatment services.

(h) Private duty nursing services.

(i) Routine transportation.

(3) There are no premiums or deductibles required for participation in CoverKids.

(4) Copays. The following copays are required, depending upon family income.

Service	Copays When Family Income is Less than 150% of Poverty	Copays When Family Income is 150%-250% of Poverty
MEDICAL BENEFITS		
Chiropractic care	$5 per visit	$15 per visit
Emergency room (emergency—waived if admitted)	$5 per use	$50 per use
Emergency room (non-emergency)	$10 per use	$50 per use
Home health	$5 per visit	$15 per visit
Hospital care	$5 per admission; waived if readmitted within 48 hours for the same episode	$100 per admission; waiver if readmitted within 48 hours for the same episode
Inpatient mental health treatment	$5 per admission	$100 per admission
Inpatient substance abuse treatment	$5 per admission	$100 per admission
Maternity	$5 OB or specialist, first visit only $5 hospital admission	$15 OB or specialist, first visit only $20 per visit, specialist $100 hospital admission
Medical supplies	$5 per 31-day supply	$5 per 31-day supply
Outpatient mental health and substance abuse treatment	$5 per session	$20 per session
Physical, speech, and occupational therapy	$5 per visit	$15 per visit
Physician office visits	$5 per visit, primary care physician or specialist No copay for routine health assessments and immunizations rendered under the American Academy of Pediatrics guidelines	$15 per visit, primary care physician $20 per visit, specialist No copay for routine health assessments and immunizations rendered under the American Academy of Pediatrics guidelines
Prescription drugs	$1, generics $3, preferred brands $5, non-preferred brands	$5, generics $20, preferred brands $40, non-preferred brands
Rehabilitation hospital	$5 per admission	$100 per admission

Service	Copays When Family Income is Less than 150% of Poverty	Copays When Family Income is 150%-250% of Poverty
services		
Vision services	$5 for lenses; $5 for frames (when lenses and frames are ordered at the same time, only one copay is charged)	$15 for lenses; $15 for frames (when lenses and frames are ordered at the same time, only one copay is charged)
DENTAL BENEFITS		
Dental	$5 per visit No copay for routine preventive oral exam, X-rays, and fluoride application	$15 per visit No copay for routine preventive oral exam, X-rays, and fluoride application
Orthodontic services	$5 per visit	$15 per visit
ANNUAL OUT-OF-POCKET MAXIMUM PER ENROLLEE		
Annual out-of-pocket maximum per enrollee	5% of the family's annual income	

(5) Eligible children in a family that does not pay a required copay remain enrolled in the program. An individual provider may at his discretion refuse service for non-payment of a copay unless a medical emergency exists. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay their copays.

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